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W 331	Continued From page 56 it is difficult for her by the look on her face while she is doing it, then after every swallow she chases it with......tea.....so she could swallow her food without chewing". 4/7/09 - While eating supper, R4 "placed a large piece of chicken into her mouth, then struggled to swallow it without chewing. She almost choked". 4/9/09 - During breakfast, R4 "placed a whole sausage in her mouth then tried to swallow it whole, choked and had to spit it out. I advised her to slow down. And suggested she cut up her food to smaller pieces". E1 was interviewed on 4/29/09 at 11:00 A.M. E1 told surveyor she had not seen the documentation about R4 choking. If she had E1 said she would have considered an objective for R4 and perhaps a swallowing evaluation. E1 also confirmed that if staff had contacted the nurse, they would have "written it down somewhere" - in the communication log or on an incident/accident form. The facility could find no documentation that the nurse had been notified of R4's rapid eating and choking episode.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1060e) 350.1060h) 350.1070 350.3240a) 350.3240f)	W9999		

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W9999	Continued From page 57 Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. Section 350.1070 Training and Habilitation Staff Appropriately qualified staff shall be provided in sufficient numbers to meet the training and habilitation needs of the residents. At a minimum, staffing shall be provided as described in Section 350.810(b) of this Part. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's	W9999		

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W9999	Continued From page 58 condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to implement their abuse policy when they failed to protect individuals from physical, mental, and emotional abuse inflicted by R1 for 8 of 8 individuals individuals residing in the facility (R2, R3, R4, R6, R7, R8, R9, R10) as evidenced by the facility's failure to: 1) Implement R1's current behavior plan and revise as needed to address R1's increased behaviors after R1's level of aggression increased in intensity and frequency from 2/1/09 to 4/27/09; 2) Investigate all incidents of aggression by R1 towards individuals (R2, R3, R4, R6, R7, R9, R10) and assess for trends and patterns; 3) Assess individuals (R2, R3, R4, R6, R7, R9, R10) for injury or harm after being repeatedly and aggressively targeted by R1; 4) Ensure sufficient staff are on duty and available to protect all individuals in the facility (R2 - R10); 5) Train staff in effective behavioral interventions for R1, including CPI (Crisis Prevention Intervention); and	W9999		

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6) Submit packet of information for CART (Clinical and Administrative Review Team) to the Department of Human Services for assistance with R1's behaviors.

Findings include:

Based on review of the facility's undated resident roster, there are 9 individuals residing in the facility ranging in age from 19 years old to 76 years old who function from the severe level of mental retardation to the mild level of mental retardation.

1) Review of physician's orders, dated 4/1/09 - 4/30/09, shows R1 functions at the moderate level of mental retardation with additional diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Depression, and Conduct Disturbance.

According to the resident roster (undated), R1 is his own guardian.

2) Review of the resident roster shows R2 is a 49 year old male who functions at the moderate level of mental retardation. Per observation during the survey on 4/2709 from 5:45 A.M. to 8:00 A.M. and from 3:00 P.M. to 4:30 P.M., R2 uses a walker for all ambulation.

3) The resident roster indicates R3 is a 45 year old female who functions at the moderate level of mental retardation.

4) Per review of the resident roster, R4 is a 32 year old female who functions at the mild level of mental retardation.

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5) The resident roster shows R6 is a 31 year old male. R6 functions at the moderate level of mental retardation.

6) According to the resident roster, R7 is a 58 year female who functions at the mild level of mental retardation.

7) The resident rosters shows R8 is a 66 year old male functioning at the moderate level of mental retardation.

8) Review of the resident roster shows R9 is a 45 year old male who functions at the severe level of mental retardation.

9) According to the resident roster, R10 is a 76 year old male and R10 functions at the moderate level of mental retardation.

Per review of the behavior notes from 3/1/09 to 4/27/09, staff documented the following incidents involving R1 and other residents:

3/1/09 - 2:00 P.M. (Sunday) R1 "was picking on (R4 and R11)." When E4, DSP (Direct Support Person), asked R1 to stop, R1 "started yelling and cussing" at staff. R1 was asked to go to his room and while staff was going into R5's room to change R5, R1 threw a hanger at staff.

3/1/09 - 5:30 P.M. R1 "was picking on the other clients" and was asked to leave the dining table and go to his room to calm down. However, R1 did not calm down and threw R9's radio at E4. "Then he started yelling and cussing at (E4) saying that when he get a chance he was going to cut my throat and burn the house down."

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3/1/09 - 8:00 P.M. - R1 "started his behaviors again." R1 said he was going to kill himself "after he kill (killed) some of the clients" and E4.

3/1/09 - 10:00 P.M. - R1 "kept messing with the clients." When E4 asked R1 to leave the other residents alone, R1 started cursing at staff, making inappropriate sexual remarks. R1 said "he was going to burn the house down with everybody in it."

E4 called E2, RN (time unknown) after R1 refused to take his medications because he was having behaviors. E2 instructed E4 to call the QMRP (E1/Qualified Mental Retardation Professional) because R1 "needs to go to the hospital." E4 documented that she called the QMRP three times, at 8:30 P.M., 9:00 P.M. and 10:00 P.M., and left a message each time. E4 called E8, Owner, who told E4 to call an ambulance. R1 was taken to the Emergency Room then transferred to a psychiatric unit where he remained until 3/10/09.

The next behavior note for R1 is dated 3/18/09 written by E4, stating R1 was "already doing what put him in the hospital the first time" and was counseled by E1 regarding his behaviors. E4 documented that "we learned that (R1) had pulled a kitchen knife on this mom and dad. He told them that he would kill them." E1 told R1 he was not allowed in the kitchen where knives are kept.

After the QMRP left the facility, R1 "started having behaviors" telling E4 that he would go into the kitchen and get a knife. When E4 told R1 no, he became aggressive, grabbed E4, and dug his

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W9999	Continued From page 62 fingernails into her hand, drawing blood. E4 called E1 (time unknown) and E1 "said take him to the hospital" referring to R1. However, R1 refused to go to the hospital. When E4 could not reach E1, she called E8 who instructed E4 to call the police. E4 was interviewed on 4/23/09 at 2:00 P.M. E4 said R1 repeatedly threatened the residents, kicked R2, tried to hug R4, and rub up against her. E4 said residents spend most of their time in their rooms because they are afraid of R1. E4 said she was not sure of R1's behavior plan, but someone told her to put R1 on "1:1 when he got aggressive but that doesn't work; sometimes there are no staff here to give him 1:1." E4 confirmed she was by herself on 3/18/09 when R1 became abusive towards the other residents and had to call the police at the direction of the owner. E4 said she was unable to reach E1 and called the owner like they have been told to do. E4 said she has worked on weekends on different shifts and has been the only staff at the facility. R1 was taken to the hospital and transferred to a psychiatric unit. R1 remained in the hospital until 3/25/09. 3/25/09 - 5:30 P.M. Upon R1's return from the hospital, staff documented on R1's behavior notes that R1 "has been bothering the other residents by filming them with his camcorder." R2 "went to his room to escape." R10 "also went to his room to get away from (R1)" as did R3 and R6. When R2 returned to the living room to watch television, R1 stood between the television and R2, refusing to move. The notes state R1's behaviors "have been going on for well over an	W9999		

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W9999	Continued From page 63 hour, non-stop." 3/29/09 - Noon -7:30 P.M. (Sunday) E9/LPN notes R1 "continues to be rude and aggressive to other residents." R1 cursed and threatened staff with residents present. R1 also kicked and punched the wall repeatedly, then struck staff. R1 was taken to the emergency room. 4/13/09 - 6:00 P.M. Staff documented R1 began repeatedly pacing back and forth from the dining room to the kitchen. E3 told R1 he was creating a safety hazard because he was blocking the walkway to the dining room and the servers needed to put the food on the table. R1 refused and "began saying he beat up everyone in his family and he can't wait to beat everyone up here." R1 also bragged about pulling a knife on his mother and "he could do that here too." R1 went to the dining room to eat dinner. He became angry, threw food and his fork on the floor, "closely followed by his plate. (R1) threatened to take a piece of broken plate and start cutting everyone.....He threatened to burn the house with everyone in it," saying he liked to burn people. 4/17/09 - At supper time, R1 became angry and threatened staff. "Then he stated he wanted to have sex with (R4) and have a baby with her...........then stated he was going to burn down this f****** place." 4/17/09 - 9:00 P.M. R1 began pacing "and saying he was going to scratch (R4)." Then R1 threatened to pull someone's hair and spit on them. He proceeded to spit on the floor and stomped around some more, then "came up to	W9999		

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(R3) and pulled her hair hard, jerking her head back." Staff told R1 it was time for his meds which he refused and resumed stomping around. "He walked by (R4) and yanked her hair, jerking her head back."

At 9:30 P.M., staff asked R1 again to take his medications. R1 refused, cursed at staff, "stomped around some more, stopping by (R4) again and pulling her hair and jerking her head back once again. Staff documented that E1 was called and "staff explained what had happened. Then owner (E8) was notified as well explaining to him what was going on. Also the RN was notified of him (R1) not taking his meds."

At 9:45 P.M., R1 "threatened to rape (R4) because he 'loved' her." No further entries were documented.

4/18/09 - 11:00 A.M. (Saturday) R1 "initiated mal-behavior when he attempted to provoke (R4) verbally. She was directed to ignore him, he wanted to hit her and inappropriately gestured with his hand at her".......R1 then "threatened to hit R6, rushed at him" and was stopped by staff. R1 became even angrier, spitting and cursing at staff.

Staff told R1 to go to his room to calm down. On his way to his room, R1 "flipped over a chair in the living room....punched the door and walls," yelling staff couldn't make him go. "He calmed down and came out of the room to go on an outing. Then went outside to get into the van. He then began cussing and yelling at other clients."

R1 then "went to the shed to get a board that he threatened to smash the windows on the cars in

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the parking lot."

4:00 P.M. R1 "threatened to throw rocks at R4 and R6, using inappropriate language, then threw the rocks." Staff called E1 who "said to tell him (R1) that (staff) would call the ER if behavior continued."

5:25 P.M. R1 "grabbed (R6) on the behind, was verbally redirected about inappropriate behavior. (R1) threatened to stab me (staff) with a fork." Staff tried to redirect R1 but he refused to go to his room. R1 "began threatening to hit (R2), then threatened to punch (R4). He threatened to kick (R2). Then threatened to beat and rape all the women because he hates all women. He was put on 1:1 with (staff) after exposing his backside."

4/19/09 - (Sunday) "Starting around noon, (R1) has been aggravating (R2, R3, R4, R6, R7) by saying he wants to have sex with (R4), also stated he was going to hit (R4, R6, R7, R10)." Staff asked R1 to stop but he just said "f*** you, I don't have to listen to you. R1 has been flipping the residents off."

During lunch, R1 was eating rapidly, shoveling food into his mouth. Staff asked him to slow down so he would not choke. R1 began cursing, refused to change his shirt, and refused to go to his room to calm down as directed by staff.

2:20 P.M. R1 continued to aggravate residents by taking the remote control so they could not watch what they wanted on television.

While staff was making supper, (R1) "came into the kitchen causing trouble. He stated he was going to go run into the road so he could get hit

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W9999	Continued From page 66 and go to the hospital. Then he stated he was going to rape (R4) and any other female he came into contact with." R1 was repeatedly told that what he was threatening was wrong and inappropriate. R1 began cursing and yelling, and started throwing things in the kitchen. R1 "then spit on (R4) and stated 'your a f****** b****, so you have to have sex with me right now!" Staff again explained to R1 that he "shouldn't do that or say that cause it's not nice." R6 came in to set the table and R1 told R6 to "give him a big kiss." Then he said "I'm going to rape you (R6)." Staff told R1 to go to his room to calm down, but R1 refused and began cursing at staff. 4/20/09 Around 7:30 A.M., (R1) "was in the kitchen while (R4) was washing off her dishes. (R1) pulled down his pants. Staff asked him to please pull up his pants." R1 refused, said "f*** you. He then hit (R4's) shoulder." Staff told R1 not to hit people but then R1 "threw the chairs from the kitchen table and other assorted items." R1 began hitting R6 who ran down the hall away from R1. Staff got between R1 and R6, blocking R1. Staff told R1 to "stop, you cannot be hitting people." R1 replied that he "can do what he wants." At 8:15 A.M., (R6) "showed staff that his left forearm had scratches from (R1) when he was hitting and chasing (R6) before staff could break the situation up." No further behavior notes for this date were found.	W9999		

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W9999	Continued From page 67 In an interview with E1 on 4/23/09 at 8:45 A.M., E1 said R1 was back in the psychiatric unit. R1 was admitted on 4/20/09. The next staff's entry on behavior notes is dated 4/25/09 (Saturday) and timed 8:50 A.M. Staff documented R1 "picked up the fly swatter" and."brought it to the dining room where (R6) was sitting at the table eating breakfast. (R1) told (R6) to give him a kiss. (R6) told (R1) no and to leave him alone. (R1) hit (R6) in the head with the fly-swatter." 4/27/09 - 4:10 P.M. R1 started aggravating R2, messing with his walker, took the movie R2 was watching, and threatened to break the windows. R1 became very disruptive, spitting on the floor, "telling everyone he has sex with guys, throwing things around in the kitchen." E6, DSP, charted "staff can't do their jobs, he has the whole house in their rooms, don't want staff to finish cooking so everyone can eat, spitting at people in the kitchen, making threats to other residents." At approximately 5:15 P.M., E6 called E1. E1 spoke with R1 on the phone. After R1 hung up from talking to E1, according to E6's entries on the behavior notes, R1 "pulled his pants down, showed his butt, called his mom, and kept spitting on the floor." R1 threatened to throw his dinner plate at (R10), threatened to burn down the house, trying to cut his self with a butter knife so he threw the knife at staff." R1 said he was going to stab people with his fork and started throwing chairs. R1's behaviors continued to escalate. R1 went at staff with a fork, showed "his butt to residents	W9999		

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while they are trying to eat, digging in his butt then trying to get food." R1 kept pestering R10, tried to make residents spill their drinks, and kept touching R6's silverware. The other residents became so upset that they moved away from the table. R1 "put his hands on (R6) and (R10).....pulled (R3's) hair. R1 then put R6's "hamster's head inside his mouth and didn't want to give it back."

5:45 P.M. E1 arrived at the facility to "provide 1:1 staffing with (R1)." After reading E6's notes and how R1's behaviors had escalated, R1 was taken to the emergency room for assessment, then transferred to a psychiatric unit.

R3 was interviewed on 4/23/09 at 10:15 A.M. R3 said she did not want to get anyone in trouble when asked if she was afraid of R1, but admitted R1 "scares me. I just stay away from him."

R4 was interviewed on 4/23/09 at 10:55 A.M. R4 said R1 "bothers me and wants to boss me around." R4 also said she is afraid of R1.

R6 was interviewed on 4/29/09 at 2:30 P.M. R6 told surveyor he was afraid R1 would hurt his hamster and said R1 "is mean. He scares me."

R10 was interviewed on 4/29/09 at 2:15 P.M. R10 told surveyor he wished R1 "would move. I hate him!"

In an interview with E6, DSP, on 4/28/09 at 1:20 P.M., E6 said she has just started working at the facility on 4/21/09 and she first met R1 on 4/27/09. E6 said she had not received specific instructions about how to handle R1. E6 stated all the residents were afraid of R1 and that R1 was

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W9999	Continued From page 69 "spitting everywhere last night - you (meaning surveyor) might be sitting in it!" E6 said she thought if there was a serious problem with R1 they should call the QMRP first and then the owner if they could not reach E1. E7, DSP, was interviewed on 4/28/09 at 1:25 P.M. E7 said he was hired recently and confirmed that he worked with E6 on 4/27/09. E7 said he saw R1 hit R6 on the head with the fly swatter on 4/26/09 and that R1 kept grabbing R6, trying to pull R6 down the hall. E7 also said R6 was afraid of R1 "a lot." E7 also confirmed R1 kept pestering R4, "groping her, wanting her to kiss him (R1)." When asked by surveyor what training he received to deal with R1's behaviors, E7 said "I haven't had any specific instructions if (R1) gets out of hand." E7 said he just tried to intervene and redirect R1. E3, DSP, was interviewed on 4/23/09 at 2:40 P.M. E3 said he did see R1 abuse the residents and they were afraid of him. Surveyor asked what protocol E3 was to follow when R1 became abusive towards residents. E3 said R1 has a behavior plan and staff are to start by trying to de-escalate R1's behaviors. E3 said if a crisis develops with R1 staff could call 911. Surveyor asked E3 if he ever called emergency services and E3 said no, they always try to contact the QMRP first, then the owner. E9, DSP, was interviewed on 4/28/09 at 1:10 P.M. E9 said they were told to call E1 first in an emergency, then the owner if E1 could not be reached. Interview with E1 on 4/27/09 at 1:00 P.M. confirmed the facility did not have a 911 policy or	W9999		

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protocol in place outlining the criteria for an emergency. E1 said staff are told to call the QMRP first, then the owner.

Behavior Plan Not Implemented

On 4/23/09, surveyor reviewed R1's chart as well as the program book used by direct care staff to document objectives after implementation and behavioral incidents.

The only Behavior Treatment Program in either book was one written by the psychologist, dated 3/9/09. This program targets intimidation and suicidal threats.

According to the program, staff are to implement the following behavioral interventions if R1 exhibits threatening behavior:

1. "If (R1) is in the act of intimidating peers or staff give a firm verbal prompt to 'stop.'

2. If (R1) is compliant with the prompt attempt to resolve what was upsetting him and try to resolve the issue.

3. Staff should not allow (R1) to extend the disruptive behavior by manipulating staff to carry on extended/supportive conversations while exhibiting disruptive behaviors.

4. If (R1) remains agitated/intimidating attempt to redirect to an alternative activity - if he refuses an alternative activity allow him to escape the situation by going to his room or outdoors weather permitting.

5. If (R1) remains agitated and is an imminent

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danger to self or others and all other alternatives have been exhausted use non-violent physical crisis intervention as instructed/modeled by CPI or facility procedure.

6. Each month the QMRP will review with (R1) data recorded on the behavioral tracking sheets, seek and/or make suggestions from him on how to reduce his behaviors.

7. Three times a week staff should remind (R1) that he is on a behavioral program, what the behavior program targets, and that he should work towards getting off the program in 6 months.

8. The QMRP will randomly provide verbal reminders of special events that are coming up (Basketball/Community outings, etc) and that to attend these activities he can not be yelling, threatening or intimidating people.

9. With his mother's assistance/approval the QMRP will remind (R1) that home visits are contingent upon his actively working towards improving his behaviors."

Surveyor could find no evidence that R1's behavior plan has been consistently implemented. Facility did not present any documentation that R1's mother has been involved in this plan's implementation; no documentation was presented to show new staff had been trained in CPI techniques, that new staff had been instructed on how to intervene when R1 exhibits aggressive behaviors, or that R1 was reminded of community events he might like to attend contingent on his behavior.

E1 was interviewed on 4/23/09 at 8:45 A.M.

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During this interview, E1 stated the "other residents are afraid" of R1. E1 said R1's aggressive behaviors started with verbal threats, then R1 became physically aggressive. E1 also said R1's mother comes and gets R1 frequently for home visits, noting R1 "has no structure."

E1 also said she had not submitted a packet of R3's information to a pre-screening agency with a request for behavioral assistance through CART (Clinical and Administrative Review Team). E1 stated the pre-screening agency could not refer R1 to a different residential site without first having a CART review.

During this interview, surveyor asked E1 if she had a behavior plan in place for R1 prior to the psychologist's plan of 3/9/09, especially since R1 takes psychotropic medications and had a psychiatric admission in 1/09. E1 said "it was just a generic one that targeted non-compliance and verbal aggression."

On 4/27/09, E1 gave surveyor two behavior treatment programs, both dated 2/1/09. One plan targeted verbal and physical aggression with the other one addressing non-compliance and depression. The plan for aggression states staff are to notify the RSD/QMRP when R1 "is in the act of being verbally or physically aggressive." CPI is to be used if R1's agitation continues and he "presents as an imminent danger to self or others.....if (R1's) verbal aggression includes statements about killing himself or others, contact the RSD/QMRP immediately." The plan also outlines reinforcers (both positive and negative) for staff to use to deal with R1's behaviors.

Surveyor saw no evidence that staff were trained

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in the above behavior plan, that the RSD/QMRP was immediately called when R1 became aggressive, or that the incentives outlined in the plan were implemented.

E1 was re-interviewed on 4/28/09 at 10:15 A.M. E1 confirmed she has almost all new staff, with only two former staff still working at the facility. E1 stated the new staff have not been trained in CPI. E1 agreed "there's not always enough staff to handle crisis situations, especially with (R1)." E1 said she is the only on-call person to fill in when the facility is short-staffed.

Surveyor asked E1 if the Behavior Management Committee had met and reviewed the incidents which had occurred between 3/1/09 to 4/27/09. E1 gave surveyor copies of the two behavior management meetings held in February, 2009. E1 confirmed that the committee had not met since 2/09.

On 2/11/09, the committee had recommended psychiatric evaluations and medication evaluation along with 1:1 staffing when R1 "making threats." The committee discussed the problem behaviors already displayed by R1 as making statements of killing himself, threats of rape towards females at facility, threats of doing harm to himself and blaming it on staff or peers, property destruction, aggression, and non-compliance.

On 2/19/09, the behavior management committee met after the psychiatrist told E1 that he would not "provide any further services until the committee got together and discussed (R1's) behavior and he received the treatment recommended by the committee."

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W9999	Continued From page 74 The facility provided no evidence of further behavior management committee meetings. (A) 350.1210b) 350.1230b)6)7) 350.1610b) 350.1610e)1) 350.3240a) 350.3750 Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. d) Direct care personnel shall be trained in, but	W9999		

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are not limited to, the following:
2) Basic skills required to meet the health needs and problems of the residents.

Section 350.1610 Resident Record Requirements

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

e) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.
1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change.

Section 350.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

Section 350.3750 Consultation Services and Nursing Services

Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member

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W9999	Continued From page 76 shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month. These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure 2 of 2 sampled individuals (R3, R4) and 1 outside sample (R5) receive nursing services according to their health status needs as as evidenced by nursing's failure to: 1) Monitor and assess R3 who has chronic cellulitis of her lower extremities requiring hospitalizations or emergency room treatment on 10/17/08, 12/3/08, 2/1/09, 3/13/09, and 4/21/09; 2) Monitor and assess R5 who was hospitalized on 3/5/09 for a pressure wound on his coccyx which was acquired in the facility. R5 received intravenous antibiotics and wound care while in the hospital and was discharged to a skilled nursing facility on 3/10/09 where he still resides; and 3) Implement nursing precautions for R4 who was treated for MRSA (Methicillin Resistant - Staph Aureus) on her left knee. Findings include: 1) According to physician's orders dated 4/1/09 - 4/30/09, R3 functions at the moderate level of mental retardation with additional diagnoses of	W9999		

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Cellulitis (Lower Extremities), Chronic Kidney Disease, Hypertension and Depression.

Per review of a hospital discharge summary dated 10/28/08, R3 was admitted to the hospital on 10/17/08 with Cellulitis of the left leg, Sepsis, Blister on Hip, Leg Infection and Renal insufficiency. R3 was discharged on 10/28/08 to a skilled nursing facility for wound care.

The hospital's report states R3 was first seen in the emergency room on 10/17/08 for left leg pain and swelling which started 10/16/08. The physician noted R3's leg was warm to the touch and R3 has a "history of cellulitis of her right leg, chronic stasis." In the emergency room, R3's blood pressure was 91/59. Emergency room physician documented R3 had complained of her redness and pain in her left leg for 24 hours. "Feels warm. Painful to touch....red streak going from left knee up to left thigh" R3 was directly admitted to the hospital from the emergency room.

Per review of nurse's notes written by E2, RN/facility nurse, no documentation was found to indicate the nurse had been contacted prior to R3 going to the emergency room or that staff had assessed and taken R3's vital signs.

Other than an undated nursing notation stating R3 has "a 2 cm open area on L lower leg. Clean with no drainage noted. No redness or odor," the only nursing documentation in R3's chart is the initial nursing assessment when R3 was admitted to the facility on 6/25/08, then the next entry on 11/12/08.

No further nursing assessments of R3's condition

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W9999	Continued From page 78 was documented. Review of nurse's notes shows R3 returned to the facility from skilled care on 11/12/08. The nurse documented an elastic wrap had been applied to R3's left lower leg, noting R3 had a small area on the shin of her left lower leg with the left leg being "very red." The next nursing entry by E2 is dated 12/4/08 which states "staff notified writer of (patient's) leg being edematous, red & purple. (Patient) unable to bear wt on it." R3 was sent to the hospital by ambulance and admitted with cellulitis. Per review of the hospital's discharge summary dated 12/10/08, R3 was admitted to the hospital on 12/3/08 "with infection and redness on her lower extremities, right worse than left." R3's wound(s) were cultured and the hospital's report states "wound culture produced staph aureus with sensitivities attached." The admitting report of 12/3/08 states R3 "has chronic venous insufficiency of the lower extremities and cellulitis." R3 was discharged back to the facility on 12/10/08. Nurse's notes of this date show E2 was not able to assess R3's legs because the facility did not have Iodoform dressing to re-bandage R3's legs. E2 documented the dressing was changed before R3 left the hospital. E2 wrote "will change dressing in 24 hours and notify QMRP (E1/Qualified Mental Retardation Professional) to obtain needed supplies." However, no nursing documentation was found until the next entry by E2 on 2/1/09. There is no documentation to show that assessments of R3's	W9999		

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W9999	Continued From page 79 legs, dressing changes and wound treatments were done. Physician's progress note dated 12/19/08 states R3's lower leg cellulitis is improving with "slight stasis dermatitis noted." On 1/9/09, according to physician's progress notes, R3 was taken for follow-up "management for stasis dermatitis." The physician noted R3's legs were better but still red. On 2/1/09, E2 documented in the nurse's notes that R3 was taken to the emergency room for redness and pain in the right lower leg. R3 was admitted to the hospital from the emergency room. There is no documentation showing how nursing monitored R3 from 12/10/08 to 2/1/09. Per nursing notes of 2/10/09, R3 returned to the facility on this date. E2's skin assessment shows R3's "right lower leg from just below her knee to above the ankle on the right posterior side is angry, red and black with 3 open areas 0.2 cm deep." E2 noted she applied Bactroban with a dry dressing covered with an elastic bandage. No further wound assessments or wound measurements by the nurse were documented. The next nursing entry is dated 3/15/09 which states R3 was taken to the emergency room on 3/14/09 "for a leg wound. Area on leg measured 2 X 1 cm open and approximately 2 - 3 cm in depth." Facility could not present surveyor documentation showing when E2 was notified about R3's wound, nor could facility provide documentation showing the nurse had further assessed or measured R3's wounds from the	W9999		

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time of her discharge from the hospital on 2/10/09 to her emergency room visit on 3/14/09.

According to a facility's medical visit synopsis/consultation form, dated 3/17/09, direct care staff took R3 to her doctor for medical follow-up to the emergency room visit on 3/14/09. The physician documented "continue Bactrim for total of 14 days, daily wound care, elevating leg as much as possible throughout the day."

There is no nursing documentation to show R3 was evaluated by E2 since her assessment on 3/15/09.

E2 was interviewed on 4/27/09 at 1:50 P.M. by telephone. E2 said she did not do the dressing changes for R3. E2 stated she taught staff how to do the dressing which consisted of Neosporin or Bactroban ointment covered by a gauze dressing and kept in place by an elastic bandage. E2 confirmed she relied on direct care staff to notify her if R3 needed further care. E2 told surveyor she was in the facility a lot but only documented in the nurse's notes "if she did anything to her (R3)." E2 said R3's legs "are a constant problem."

According to nurse's notes dated 4/16/09, staff reported to E2 that on 4/15/09, R3's "left leg very red warm to touch" and R3 complains of "severe pain in leg. Staff instructed to elevate leg - not to send client to workshop and to send her to urgent care. So treatment could be started before leg begins to have open areas." R3 was seen by the physician on 4/16/09 and new medications were ordered.

E2 also documented in her 4/16/09 nurse's notes

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"assessment of leg revealed lower leg deep angry red warm to touch and edematous."

Per review of the staff communication log, dated 4/18/09, night shift staff documented R3 "reported that her leg has been hurting and it has been difficult to sleep. Her leg appears to be darker in color & appears to be swollen. Told day shift staff."

Another entry on the staff communication log dated 4/20/09 states R3's "leg swelled noticeably, and began oozing in places. Called RN (E2), she said to keep leg elevated above heart w/pillows and keep it wrapped loosely for drainage. If anything changes, or if condition worsens, call her" immediately.

E10, DSP, was interviewed on 4/29/09 at 1:50 P.M. E10 explained that she had taken R3 to the hospital on 4/19/09 for a follow-up on her right leg and the physician said it had improved. The physician also looked at R3's left leg and noted it was irritated but not inflamed. Overnight, the left "leg got really bad" and she scheduled an appointment for R3 to see her doctor again on 4/21/09. On 4/20/09, R3's left leg was unwrapped at the hospital for an ultrasound which was done as an out-patient, and it "began oozing so badly that the liquid dripped all over" R3's wheelchair. E10 said the "affected area was all the way from R3's left knee to her left ankle."

The next nursing entry is dated 4/24/09 and E2 states R3 returned to the facility from the hospital. E2's notes do not reference when R3 was admitted to the hospital or why. Per E2's assessment, R3's right leg is red from knee to ankle and cool to touch. R3's left leg very red,

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cool to touch, purple in areas. R3 has no open areas and no edema reported at this time.

According to R3's History and Physical (H & P), dated 5/5/09, R3 was admitted to the hospital on 4/21/09 at 7:00 P.M. The H & P shows that R3 had been seen by the physician's assistant on 4/16/09 and "was found with an infected leg, left pretibial. Admission was advised." R3 was admitted with diagnosis of "Cellulitis of the left pretibial area" and treated with intravenous antibiotics.

During her hospital stay, R3 was referred to and treated by "Wound Care and given Rocephin, 1 gm every 24 hours." R3 was discharged on 4/24/09 with orders for Ceftin 500 mg twice per day for 7 days and R3 "should continue daily wound care with peroxide cleansing, Iodoform gauze and wrapping."

E1 was interviewed on 4/23/09 at 11:40 A.M. Surveyor asked E1 for documentation concerning wound assessments and dressing changes for R3. E1 said she assumed nursing documentation is in the nurse's notes of R3's main chart, so if E2 did any assessments or dressing changes, E1 "would expect them to be in the nursing notes." E1 said she did not have any information on R3's recent hospitalization stating "that's a nursing issue."

R3 has a care plan (undated) to address her history of cellulitis to lower extremities. R3's goal is to "have no open areas to lower extremities. Staff to monitor clients legs for redness, extreme edema and open areas. Staff to notify R.N. of any open areas on clients lower extremities." The nursing care plan does not address how often the

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W9999	Continued From page 83 nurse will assess R3, how staff should monitor R3 or how staff are to determine what is considered extreme edema. The plan does not incorporate any preventive measures for staff to implement for R3. 2) Per review of the facility's undated resident roster, R5 functions at the severe level of mental retardation and has Alzheimer's Disease. Review of R5's ICAP (Inventory for Client and Agency Planning), dated 8/18/08 shows R5 has an overall age equivalent of 3 years. According to nurse's notes dated 11/17/08, "staff notified writer (E2) of red area to buttocks. Area assessed - redness approx 0.5 cm x 1 cm. Staff instructed to keep clean & dry" and reposition frequently, every 1 - 1/12 hours. E2 wrote in the nurse's notes "will monitor closely." No documentation was found, however, to show whether or not R5's condition was monitored by the nurse. There is no nursing documentation showing any further assessments or wound measurements for R5. The next entry in the nurse's notes is dated 11/30/08 which states E2 reviewed physician's orders and the medication administration record (MAR). The following nursing entry is dated 12/30/08 which shows E2 did her quarterly nursing assessment and reviewed physician's orders. In addition, a nursing care plan dated 12/30/08 to address skin breakdown states, "Client will have no skin breakdown related to incontinence." The plan states staff are to:	W9999		

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* Check R5 every 1 1/2 to 2 hours to go to the bathroom.

* Assist R5 as needed to bathroom.

* Assist with pericare as needed

* Monitor for skin breakdown due to incontinence

* Keep R5 clean and dry to prevent skin breakdown

The nursing care plan does not address if and how often the nurse will assess R5, how staff should monitor R5 or when and how often staff are to call the nurse.

On 1/29/09, E2 documented R5 had been taken to the emergency room on 1/28/09 due to "edema, redness with warmth to touch" on R5's right knee. R5 was sent home from the emergency room with a leg brace. E2 assessed R5 on 1/29/09 and noted pitting edema and warmth to the area surrounding the knee. "Staff instructed to keep brace in place," to apply ice every hour for 20 minutes while awake and "no weight bearing until follow-up" appointment with primary physician.

E2 saw R5 on 2/4/09, noting pitting edema to R5's right leg. E2 left instructions for staff to monitor for complications of non-weight bearing and edema. E2 noted R5 was having surgery the next day for "dislocated patella, will follow this."

According to a Pressure Ulcer Assessment completed by E2 on 2/1/09, R5 scored a 17 and is considered at high risk for pressure ulcers.

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W9999	Continued From page 85 This assessment states "Scoring of 6 or above, initiate prevention protocol" which was addressed in R5's care plan of 12/30/08. Nurse's notes of 2/7/09 state R5 returned from same day surgery with dressing intact and orders to leave on until next appointment. E2 assessed R5 and noted he "has a bruise from IV & lab test on R (right) back of left hand." No further skin issues were documented. This is the last nursing entry in R5's chart. According to the facility's incident/accident report dated 2/9/09, staff "were putting (R5) to bed when we were changing him and we noticed 2 blisters on his rear end." The incident report was signed by E1 and E2 on 2/10/09. Recommendations by E1 on the incident report include "ensure RN checks, keep dry, follow RN recommendations." However, no documentation was found in the nurse's notes indicating E2 had assessed R5 or that E2 had given any instructions to staff regarding R5's condition. Review of a care plan for R5, dated 2/24/09, two weeks after staff noticed the blisters on R5's buttocks on 2/9/09, to address skin breakdown on (R5's) buttocks," the following interventions were included in the care plan: * "Staff will check client every 1 1/2 - 2 hours for incontinence. * Staff will give client appropriate skin care after each episode of incontinence. * Treatment ordered per MD will be completed as ordered.	W9999		

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W9999	Continued From page 86 * R.N. will assess open areas weekly for decline or improvements. * RN will instruct staff as needed on pressure relieving methods. * Client will be repositioned at least every 2 hours. * Pressure relieving cushion will be obtained for w/c (wheelchair)". However, the facility had no documentation to show E2 had monitored R5's skin condition, had assessed open areas weekly, or what pressure relieving methods were to be implemented by staff. Per review of hospital admission records, dated 3/6/09, R5 was seen in the physician's office on 3/5/09 for a pressure ulcer on his buttocks which had been bleeding. R5 was admitted to the hospital for intravenous antibiotics and wound care due to "right lateral buttox (buttocks) blisters." A hospital report titled Nursing/Wound Screen/Evaluation, dated 3/5/09, states R5 was assessed with a wound on his buttocks with bloody, moderate serosanguinous drainage. The wound was "unstageable" according to this evaluation. Subsequent hospital 24 hour flowsheets, dated 3/5/09, 3/6/09, 3/7/09, 3/8/09, 3/9/09, and 3/10/09 show R5 received wound care from the time of his admission until his discharge on 3/10/09 to a skilled care facility. A notation on a wound care	W9999		

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W9999	Continued From page 87 flowsheet of 3/10/09, states R5's was assessed as having a Stage 2 pressure wound on his coccyx. Z4, physician, was interviewed on 5/12/09 at 8:20 A.M. Z4 said R5 had surgery on his patella on 2/5/09. Z4 said R5 "just never bounced back after that." Z4 said he saw R5 in his office on 3/5/09 and was shocked by R5's appearance. Z4 stated R5 "was slumped over and non responsive" and also said he was rather "surprised that they (facility staff) weren't 'worried about it.'" Z4 explained that he admitted R5 to the hospital for wound care and intravenous antibiotics therapy, then discharged R5 to a nursing facility. Z4 said he felt they "could not have taken care of him at (name of facility)." Z4 also stated that skin conditions like R5 had usually reflect "patients not having been moved around very much." E2 was interviewed on 4/27/09 at 1:50 P.M. by telephone regarding assessments after staff notified E2 that R5 started showing skin problems on 11/17/08. E2 said she was in the facility frequently and if she "did anything with the residents," she documented in the nursing notes. E1 was interviewed on 4/29/09 at 9:15 A.M. Surveyor asked E1 about R5's blisters documented in the hospital's report of 3/6/09. E1 said they were "acquired after he got back from the hospital" from knee surgery. E1 stated R5 "wanted to stay in bed all the time." Telephone interview with Z2, physician's office nurse, on 5/6/09 at 2:15 P.M., confirmed R5's blisters "started after R5 was discharged from the hospital when he had knee surgery."	W9999		

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W9999	Continued From page 88 3) According to the resident roster (undated), R4 functions at the mild level of mental retardation. A) Review of facility's document titled Medical Visit Synopsis/Consultation, dated 4/7/09, staff took R4 to her physician for "what appears to be a boil on her left knee. Her sister called indicating that she (R4's sister) had 'MRSA' (Methicillin-resistant Staphylococcus aureus) 6 months ago. So we felt she should have area on knee examined as soon as possible." The physician's response/recommendation, dated 4/7/09, on the consultation form states R4 presented for a boil on her left knee, possible MRSA. He ordered Bactrim DS 800 mg twice a day for 10 days and warm compresses three times a day for R4's knee. Twice a day, physician ordered triple antibiotic cream with an adhesive bandage covering the area. The physician also told R4 to stay off her feet for 10 days. On 4/27/09 at 10:00 A.M., surveyor asked E1 what precautions were put in place in case the area on R4's knee turned out to be MRSA. E1 said she did not know if the knee was cultured or if R4 had MRSA. E1 said the nurse takes care of this and she assumes the nurse had been monitoring R4. On 5/11/09 at 10:00 A.M., E1 said staff followed the doctor's orders and made sure R1 elevated her leg and that the wound was always covered by a sterile bandage. According to nurse's notes dated 4/7/09, E2 noted R4 had a raised area on her left knee "with yellow center approximately 1 cm." R4 taken to the doctor with a diagnosis of "boil with possible	W9999		

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W9999	Continued From page 89 MRSA....New orders noted and initiated." E11, RN consultant, was in the facility 4/27/09 and she called the physician's office about R4. E11 gave surveyor the faxed results from R4's doctor's appointment. According to the physician's progress notes dated 4/7/09, R4's knee was red and draining. R4 also complained of her knee being painful. The physician noted R4's wound was a quarter size area which was drained and cultured. The results of the culture indicates R4's wound did contain MRSA. E2 was interviewed on 4/27/09 at 1:50 P.M. by telephone. E2 said she was in the facility frequently and if she "did anything with the residents," she documented it in the nursing notes. B) Per review of a staff communication log located in R4's program book, the following entries were noted: 4/5/09 - R4 was eating supper when staff noticed that she was putting her food in her mouth and without chewing it just swallowing it. You can tell it is difficult for her by the look on her face while she is doing it, then after every swallow she chases it with......tea.....so she could swallow her food without chewing." 4/7/09 - While eating supper, R4 "placed a large piece of chicken into her mouth, then struggled to swallow it without chewing. She almost choked." 4/9/09 - During breakfast, R4 "placed a whole sausage in her mouth then tried to swallow it	W9999		

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whole, choked and had to spit it out. I advised her to slow down. And suggested she cut up her food to smaller pieces."

E1 was interviewed on 4/29/09 at 11:00 A.M. E1 told surveyor she had not seen the documentation about R4 choking. If she had E1 said she would have considered an objective for R4 and perhaps a swallowing evaluation.

E1 also confirmed that if staff had contacted the nurse, they would have "written it down somewhere" - in the communication log or on an incident/accident form.

The facility could find no documentation that the nurse had been notified of R4's rapid eating and choking episode.

(A)