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F 323	Continued From page 12 ongoing as staff report to work each shift until all staff are aware of the new policies. 5. On 3/27/09, the new policies were added to the orientation packet for new employee education.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)6) 300.3240a) 300.3240b) 300.3240f) 300.7010a) 300.7010b) 300.7050b) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and	F9999		

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F9999	Continued From page 13 emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to Section 300.3240 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 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 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) Section 300.7010 Admission Criteria a) The unit shall have clearly defined admission, admission exclusion, and discharge criteria. This shall include a policy specifying the individuals whom the unit will admit and retain based on the	F9999		

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F9999	Continued From page 14 stages of Alzheimer's disease, individuals' behaviors, or other definable needs. These criteria shall reflect the unit's mission and scope of services. A copy of these criteria shall be provided to the resident, resident's family, resident's representative, and prospective residents and their family/representative prior to admission. b) All unit residents shall have a diagnosis of Alzheimer's disease or other types of dementia. Section 300.7050 Staffing b) The unit shall have assigned, consistent staff. There shall be enough staff to meet the scheduled and unscheduled needs of each resident, as defined in the care plan, taking into account the purpose of the setting, the severity of dementia, and the resident's physical abilities, behavior patterns, and social and medical needs. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to identify one of one resident with a history of severe aggressive behavior towards other residents (R2) in the facility's Alzheimer/Dementia Unit as a potentially serious threat to the safety of 26 other peers. The facility failed to develop and implement precautions, resulting in a serious resident to resident abuse incident that caused injury to R1. Findings include: A facility incident report dated 3/19/09 stated that an altercation took place between female residents R1 and R2 that morning at 6:50 AM.	F9999		

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The report provided the following details:
R1 and R2 were found on the floor of the B wing dining room by E5 (nurse aide) while R2 was kicking R1. R1's face was bleeding, and there was blood on R2's hands and feet from injuries inflicted to the peer. The two residents were separated and monitored 1:1 by staff until the ambulance arrived. R1 had lacerations and bruising to her face and neck. Both residents were sent to the local hospital for evaluation and treatment. R1's status was unknown at the time of the report, and R2 was admitted to the hospital's psychiatric unit.

R1's hospital Emergency Department Chart dated 3/19/09 indicated that R1 was assessed with: "multiple lacerations with a total length of 3-4 cm (centimeters) noted over the right TMJ (temporal mandibular joint) and cheek; bruising and scratches over that area; multiple lacerations with a total length of 2-3 cm noted over the left TMJ and cheek; bruising and scratches over this area; scratch marks over the left forehead, nose and left mouth and cheek; a superficial abrasion over the cervical spine and posterior neck; two lacerations with a total length of 1-2 cm noted over the posterior scalp, and bruising of the left and right wrists."

The above record also indicated that R1 received a CT (Computerized Tomography) scan of the head while at the hospital, which found "no acute depressed skull fractures and no acute intracranial injury."

R2's hospital Emergency Department Chart dated 3/19/09 included the following progress note: "This patient appears to have a very explosive - aggressive personality disorder. This

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patient is mildly and chronically depressed. The exam, past history, and clear-cut paranoid ideation are consistent with a classic paranoid schizophrenia. Primary Diagnosis: Schizophrenia-paranoid type, Psychosis."

R2's psychiatric assessment conducted by Z2 (Psychiatrist) on 3/20/09 indicated that R2 "has a history of schizophrenia, chronic paranoid type, and recently developed some dementia problems and a significant history of agitation aggression, psychotic symptoms, severe in the past." The assessment stated under the Mental Status Examination segment that "The patient is confused, disoriented to the day, date, and year, and seems to be having suspicions or paranoid thoughts, agitation, and verbally aggressive. Also showed limited cognitive functioning." The Treatment Recommendations segment stated, "The patient is admitted for safety reasons."

E2 (Assistant Administrator) stated on 3/25/09 at 10:15 AM that R1 had been taken by her family from the hospital emergency room on 3/19/09 upon discharge and transported to another nursing home. E2 also stated that R2 was still currently in the hospital psychiatric unit, but that she had no intention of allowing R2 to return back to the facility for resident safety.

Z2 (Psychiatrist) stated on 3/26/09 at 10:00 AM that R2 was "pretty psychotic, agitated, and paranoid" when she first saw R2 at the hospital last week. Z2 stated that she has made some adjustments to R2's medication regime, and that R2 has been on continuous one to one observation on the psychiatric unit for the past week. Z2 said that this high level of supervision was discontinued yesterday, as a result of R2's

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F9999	Continued From page 17 diminishing aggressive behavior with time. Z2 also said that the resident is very confused, has slowed and difficult to understand speech, and has a very difficult mental status to assess. R1, when interviewed on 3/26/09 at 11:30 AM at her new location, did not recall the altercation with R2 last week or how her face got cut. R1 was oriented to person and day of the week only at that particular time, and had no complaint of pain. E5 (nurse aide) stated on 3/25/09 at 10:50 AM that she was in the process of getting residents up out of bed early on the morning of 3/19/09, when she heard a moaning sound coming from the B wing dining room. E5 said that she looked in the doorway and saw R1 and R2 lying on the floor of that room with R2 kicking R1. E5 said that R1 then sat up and "looked shocked." E5 said that R1 "had blood running down her face" and R2 had blood on the bottom of her feet. E5 said she called for the nurse and another nurse aide for help to separate R1 and R2. E5 stated on 3/30/09 at 2:00 PM that on the morning of the incident, she was scheduled to work as the activity aide in the B wing dining room starting at 6:00 AM, but was re-assigned to work as a nurse aide on the B hall due to a staff call-off. E5 said that no staff member was in the B dining room to monitor residents until breakfast was to be served at 7:15 to 7:30 AM. E5 said that when assigned as the activity aide, she was supposed to stay in that room. E5 said that this situation occurred "probably four times a week" prior to the incident, when she was re-assigned to work the floor and leave the dining room unattended. E5 stated that she had not observed	F9999		

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F9999	Continued From page 18 R2 abusing other residents while working first shift on the unit, but she "did not think (R2) belonged on that unit." E5 said that R2 was very ambulatory and would "overwalk" the other slower residents and sometimes take another resident's chair while they were trying to sit down in it. E5 said that she had previously worked at another nearby facility housing psychiatric residents like R2, where R2 resided at that time. E5 said that in that setting, R2 was in with more higher functioning mobile residents who were less vulnerable. E6 (nurse) stated on 3/25/09 at 11:10 AM that on the early morning of 3/19/09, she was called to B wing immediately to assist with the incident involving R1 and R2. E6 said that she helped "clean up" R1, who had blood "all over her face" at the time. E6 said that R1 had purple bruising on her cheeks, and there was an open area approximately one inch by one-third inch with a hanging skin flap on the right cheek. E6 said that R1 had numerous scratches on her face, was bleeding from her nose, from a cut on her bottom lip, and had blood in the hair at the back of her head. E6 said that R1 told her, "That man (referring to R2) did this to me, I don't know what I did." E6 also stated that the other resident R2 said nothing about the incident at the time. E6 further stated that R2 had a history of being aggressive to both staff and residents by grabbing and scratching other residents, and trying to use "choke holds" on staff. E6 said that R1 also could be aggressive, but usually toward staff when resisting care. E6 also stated on 3/30/09 at 10:30 AM that she did not believe that R2 "belonged on that unit."	F9999		

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F9999	Continued From page 19 E6 said that R2 was a diagnosed schizophrenic who did not really have "memory issues," but was in the facility Dementia Unit primarily for supervision of her behaviors, not dementia. E6 said that R2 was independently ambulatory and could do many tasks herself, but that she had "a lot of behaviors." E6 stated, "I would never turn my back on her." E6 said that R2 would "go after people." E6 said that one time while she was on duty, she witnessed R2's aggression toward another resident, but that staff were able to intervene to stop it that time. E6 also added that other staff would give R2 soda and snacks after "she acted out," thus making R2's behavior worse, in her opinion. E6 said that she has not worked on the B wing Dementia Unit for a couple months now, since she went from working second shift to first shift. E6 said that often on second shift on the Unit, due to a nurse aide call-off, an activity aide would be reassigned from the dining room to work the B hallway. E6 said that this would then leave no staff to supervise the dining room, so she would do her work in the dining room so it was not unattended. R2's original admission information document dated 6/12/07 indicated that the resident was admitted to the B wing Dementia Unit on that date with numerous diagnoses including Paranoid Schizophrenia and Major Depressive Disorder, with no diagnosis of Dementia listed. This was confirmed by interview with E2 (Assistant Administrator) on 3/30/09 at approximately 1:00 PM. R2's Special Care Unit Assessment dated 6/12/07 indicated some of R2's current personality traits to be "Fatalistic", "Serious" and "Suspicious." This assessment also rated R2's "overall cognitive ability" as	F9999		

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F9999	Continued From page 20 "poor." The facility's Admission Criteria-Special Care Unit policy dated only "2004" stated that the purpose of the policy was "To insure proper placement on the special care unit of an individual with dementia." This policy stated under point # 1: "Persons being considered for placement on the special care unit must have a diagnosis of dementia made by the physician. The dementia is of the non-reversible type, adult onset." The facility's Admission Exclusion-Special Care Unit policy dated only "2004" stated that the purpose of the policy was "To insure the rights of the individual, to insure proper placement and to protect the rights of the other residents on the unit." This policy stated under point # 1: "No person will be admitted to the special care unit if they do not have a diagnosis of a dementia, Alzheimer's type or other." R2's Physician Order sheet dated 3/9/09 indicated additional diagnoses of Altered Mental Status and Moderate Depression with Dementia. R2's care plan dated 1/27/09 under the Mood section stated: "Resident displays verbal and physical aggression with staff during cares and redirection. Resident also displays these behaviors with other residents at times as well." Updates to this section included at least six specific dated entries of agitation or aggression on R2's part toward other residents. The approaches listed for staff response to R2's behaviors included giving the resident "her space," assisting the resident back to her room or a calmer area, offering the resident snacks in between meals, or offer diversional activities.	F9999		

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Facility incident reports for 2009 and the last 6 months of 2008 which involved events of R2 being physically aggressive to other residents totaled at least ten. Some of these events are documented as follows:

3/15/09 at 9 AM in B wing dining room - R2 put her arm around R3's head with a tight grip while R3 was sitting in a chair. No provocation of R2 was noted.
3/13/09 at 5 PM in B wing dining area - R2 grabbed R4's hair and scratched R4's nose.
1/19/09 at 1:30 PM in B wing hallway- R2 grabbed R5 from behind and covered R5's face with her hands, leaving red marks below R5's left eye and forehead.
10/1/08 at 11:15 AM in B wing dining room - R2 came up behind R6 sitting in a chair "for no known reason" and put her hands around R6's neck and tried to choke the resident. Staff intervened and R2 was sent out to the hospital for evaluation.
9/30/08 at 8 AM in B wing dining room - R2 was noted to be choking R7 when staff walked into the room, and was "pulled" off R7 by those staff. R7 had received a purple area on the left side of her mouth, scratches on the left side of her neck and a bloody nose.
9/25/08 at 11:30 AM in B wing dining room- R2 came up behind R6 and covered R6's face with her hand "blocking airway then followed by wrapping her arm around neck." Staff then took R2 back to her room, and assessed R6 to have no injuries. R2 was then sent to the hospital for evaluation.

E3 (Director of Nursing) stated on 3/25/09 at 2:00 PM that she believed that R2 had been on

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scheduled staff monitoring due to R2's behaviors, but shortly thereafter when she checked with the medical records person, stated that R2 was not on any scheduled staff monitoring prior to the incident of 3/19/09. E3 also said that there was no provision for this in R2's care plan either. E3 added that there was supposed to be staff in the B-wing dining room "at all times."

E3 stated at 2:00 PM on 3/26/09 that on the early morning of 3/19/09, E5(activity/nurse aide) was scheduled to work in activities in the B wing dining room starting at 6:00 AM, but was assigned to work B hall instead due to a nurse aide call-off. E3 said that E4 (Dementia Unit Coordinator) usually does the activity program on the unit when activity staff are reassigned, but on the morning in question, E4 was not at work until 7:30 to 8:00 AM.

E4 stated on 3/25/09 at 10:00 AM that she has known R2 since her admission to the facility. E4 said that R2 had "dementia behaviors" that were verbal and physical to staff and residents, and that she thought R2 was on behavioral tracking. E4 said that she was not yet at the facility on the morning of 3/19/09 when the incident occurred.

E4 also stated on 3/30/09 at 11:15 AM that R2 was a "typical resident for that unit." E4 said that she observed R2's behaviors worsening and becoming more frequent this past winter. E4 said that the facility had sent R2 out to the hospital more often as of late for psychiatric evaluations, but that the hospital would "just send her back." E4 said that staff on the Unit would "try to watch her (R2) more" and that E4 would re-direct R2 on occasion by giving her snacks as "a reward system." E4 said that sometimes staff would

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direct R2 to sit by the B nurses' station when she was having behaviors and give R2 something to eat. E4 said that prior to the incident, she had an inservice with her staff that the dining room/activity room is to be monitored at all times.

An In-Service Training Report dated 3/16/09 and conducted by E4, with no times given and containing numerous staff signatures on the back, stated the following under the contents section: "Dining room is to have coverage by staff at all times to monitor residents."

Another In-Service Training Report dated 3/19/09 and conducted by E4, with no times given and containing numerous staff signatures on the back, stated the following under the contents section: "Dayroom area is to be covered at all times with staff coverage to monitor residents."

Daily Assignments staffing sheets for the first 19 days of the month of March 2009 indicated that activity aides that were scheduled to work in the B wing dining/activity room beginning at 6:00 AM until 2:00 PM were reassigned to work as nurse aides on B hall on the following days: 3/14, 3/15 and 3/19/09.

E7 (Social Service Designee/Abuse Coordinator) stated on 3/26/09 at approximately 3:00 PM that she was aware that R2's behavior was escalating last fall. E7 said that staff could find no cause for her outbursts and no evidence of pain or discomfort associated with them. E7 said that she was "alarmed" by R2's aggression toward the neck or face of others. E7 said that she contacted several other facilities more familiar with caring for mental health patients in the area for alternate placement, but that none of them would accept

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F9999	Continued From page 24 R2. E7 stated that staff had tried one to one sessions with R2, approach by different staff members, activities, supervision of R2 when she was around other residents, and re-direction to her room during periods of agitation with no real success. E7 said that even though R2's behaviors improved early this past winter, the improvement did not last. E7 said (regarding R2's behaviors) that she "felt we did everything we could to protect staff and residents. It is a shame someone got hurt because of her." E2 (Assistant Administrator) stated on 3/30/09 at approximately 11:30 AM that she was unaware of R2's increased behaviors this past winter. E2 said that had she known, she would have transferred R2 to the hospital insisting on a psychiatric admit and instituted constant monitoring of R2 while at the facility. E3 (Director of Nursing) stated on 3/30/09 at approximately 1:30 PM that she became the nursing director around the first of this year, and since that time, she was not made aware of the behavioral incidents involving R2 prior to the 3/19/09 incident with R1. E1 (Administrator/Facility Bookkeeper) stated on 3/30/09 at approximately 3:10 PM that she was unaware of all of the behavioral incidents with R2, including the attempted choking incidents. (A)	F9999		