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F 514	Continued From page 53 E7(Licensed Practical Nurse), said that she was approached by E2 on 4/5/09 to initiate an incident report for R3 and R5 for the 3/22/09 incident. E7 said that she told E2 that she already completed the initial incident reports on 3/22/09 and notified the family of R3 and R5's incident. E7 said that E2 then asked her to rewrite the incident report because the original report was misplaced. E7 said she attempted to rewrite the report but could not remember every detail she originally wrote. E7 said that R3 and R5's chart was already in medical record and she was unable to use the charts as a reference. E7 indicated the area's of the incident report that she completed, and the other area's were completed by someone else.(date, diagnosis, vitals signs, age, physician time of notification). E2 said she asked nurses to rewrite incident reports and but did not asked them to rewrite nurses notes.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1010h) 300.1210a) 300.1210b)3) 300.3240a) 300.3240f) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest	F9999		

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F9999	Continued From page 54 decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 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. 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) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a	F9999		

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F9999	Continued From page 55 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) These REGULATIONS are not met as evidenced by: Based on interviews and record reviews, the facility: 1. Failed to interact and supervise to prevent resident-to resident altercations. 2. Failed to update and revise care plans after an incident. 3. Failed to review penitent information regarding resident behavior prior to and shortly after admission. The facility failed to develop a comprehensive treatment plan with interventions for dealing with physical and verbal aggression for R1, R2, R4, and R5 and failed to update the treatment plan after new incidents of aggression for R1, R2, R4, and R5. This failure resulted in R3 dying from injuries sustained from an incident with R5 on March 22, 2009. R5 has a long history of physically aggressive behavior that was not care planned or addressed by the facility.	F9999		

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The facility failed to monitor R5's behavior and provide supervision after R5 was hospitalized for hitting staff on February 18, 2009. R5's treatment plan was not updated after R5's return to the facility.

The facility failed to supervise and provide interventions for dealing with R4's aggressive behavior. R4 was also involved in an incident with R3 on March 28 or 29, 2009, that was not fully investigated. R4's behavior was not monitored or supervised before or after that incident. This failure lead to R4 hitting R3 on March 28 or 29, 2009.

These failures lead to R5 hitting R3 on March 22, 2009 and R4 hitting R3 on March 28 or 29, 2009. R3 later died as a result of injuries sustained from the altercations. These failures have the potential to effect 81 residents in the facility with severe mental illness and behavior issues.

Findings include the following:

1. R5 was first admitted to the facility in October of 2008 and then re-admitted to the facility on November 13, 2008. In between the October and November admission, R5 had resided in another nursing facility and had left and lived in the streets.

R5 had been admitted to the hospital from the community for depression and suicidal ideation. According to the hospital record of November 3, 2008, R5 had been living in the streets and had attempted to kill herself and had not been taking her medications. The hospital psychosocial assessment dated November 5, 2008, documents under history, "This is the patient's

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sixth hospitalization with her first being on 8-19-08 and her last being on 10-6-08."

The assessments continues with, "Patient is currently homeless for at most two weeks. Patient was discharged to facility on October 15, 2008, and was a resident of another nursing facility." "Patient reported that she was arrested last year and in jail for 3 months for cutting her mother's boyfriend with a knife." "Patient has a history of altercations with peers. Patient displays poor impulse control and low frustration tolerance. Patient has limited insight into her mental illness."

R5 was again admitted to the hospital on December 12, 2008, for refusing to eat and becoming psychotic. R5 was transferred to another facility and then once again transferred back to the facility on February 4, 2009.

On February 18, 2009, R5 was discharged to the hospital for scratching a staff member. According to E2 (Director of Nursing), R5 was so agitated that the staff could not calm her down, therefore she was sent out to the hospital.

The hospital Psychiatric Evaluation dated February 19, 2009 states, "This patient is a 24 year old African American female brought from the nursing home as the patient was hostile aggressive, physically abusive and scratched on of the staff with her nails and he had to go the emergency room." The evaluation also states the following as a criteria for hospitalization: "Destructive behavior as immediate threat. Magnitude of deviant behavior not tolerable to the patient or society."

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F9999	Continued From page 58 R5 was then re-admitted to the facility on February 26, 2009, and was transferred to a sister facility on March 24, 2009, after the incident with R3. A review of R5's MS (Minimum Data Set) Assessment dated February 16, 2009 indicates that according to that assessment, R5 had no behavioral issues. Furthermore the section S of the MDS codes R5 as having no self-injurious attempts, no behavioral issues, and no recent violent issues. A review of the care plan or treatment plan dated February 25, 2009, indicates that the facility failed to develop a plan for dealing with R5's aggressive behavior. The treatment plan was not updated nor were interventions added when R5 returned to the facility after the incident of February 18, 2009. E14 (Psychiatric Rehab Services Coordinator) stated during interview of June 17, 2009, that he had not updated R5's plan of care after the February incident. E14 stated that he did conduct a verbal counseling session. A review of social service notes and assessments indicate that E14 did not address R5's history of aggressive physical behavior. A treatment plan with interventions for direct care staff to use when R5 became aggressive was not developed. A standardized care plan was placed in R5's record, however specific interventions for behavior were not added nor was the plan individualized to meet R5's needs. E14 stated during the interview that he had only been employed at the facility for a short time. E14 stated that he did not review the past information	F9999		

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F9999	Continued From page 59 or hospital records concerning R5. E1 (Administrator) and E2 verified on June 17, 2009 that the treatment plan should have been updated after the physical aggressive behavior and that past history should be used when developing a treatment plan. According to nursing notes of March 22, 2009, R5 was involved in an incident with R3 and according to the facility nursing notes R5 "slapped R3 on the face." According to E2 this incident was charted in the nursing notes after the fact as a late entry. An incident report was generated on April 5, 2009, days after the incident. The Psychiatrist was not notified of the incident nor did the facility conduct an investigation of the incident. 2. R4 was also involved in an incident that occurred on March 28 or March 29, 2009, with R3. R4 was admitted to the acute Psychiatric Hospital for behavior. The Psychiatric Evaluation and Comprehensive Treatment Plan of April 6, 2009 states, "Was admitted to the Hospital on referral from nursing home after he was observed to be extremely agitated, hostile, verbally abusive and reportedly one of the guys in the wheel chair. Reports from the nursing home indicated the patient had been actively hallucinating and was talking to self. His behavior has been out of control. Because of his violent behavior and delusional thinking he was referred to Hospital for further evaluation and treatment." R4 was re-admitted to the facility on April 16, 2009, and had another incident on May 28, 2009. The incident report states, "resident involved in	F9999		

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F9999	Continued From page 60 altercation with co-peer; no injuries sustained. Resident given as-needed medication." R4 has a long history of aggressive behavior requiring hospitalization. September 2008, R4 was also hospitalized for hostile and violent behavior. A review of R4's treatment plan dated March 30, 2009, indicates that R4 does not have a program plan for aggressive behavior. A standardized treatment plan for resisting care was added March 30, 2009, but this plan was not updated to meet R4's needs. Specific programing and interventions for aggressive physical and verbal behavior were not included in R4's treatment plan. During the survey of June 17, 2009, R4 was noted to be in his room or pacing outside in the hallway. R4 was not actively engaged in programing. E5 (Psychiatric Rehabilitative Services Director) stated during interview of June 17, 2009, at 3:30pm that he could not locate an update for R4's plan of care. There is no evidence that R4 is actively engaged in Psychiatric Rehabilitative services. According to E5 on June 18, 2009, R4 attends skills training but also refuses to attend and refuses to attend outside programs. E5 stated that R4 spends most time in activities or by himself and not in structured programing. The last documenting of R4's programs is dated March 31, 2009. E5 then stated that the programs or groups a resident should attend should be listed on the front page of the care plan. E5 and the surveyor reviewed this document and no programs were listed. The treatment plan was also reviewed and no programs were listed.	F9999		

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3. R2 was admitted to the facility May 4, 2009 from the acute care hospital. R2 had been admitted to the hospital for aggressive physical behavior in which he hit another resident. Upon admission to the facility from the hospital, the treatment plan did not include monitoring R2 for aggressive physical aggression or psychiatric services for dealing with aggressive behavior.

R2's MDS assessment dated May 14, 2009, under section S, codes R2 as having no history of violent behavior. R2's final care plan of May 18, 2009, does not specify the programing component for R2. R2 was discharged to the hospital on May 18, 2009 for "inappropriately touching a female resident and continually displays sexually inappropriate behaviors." When R2 returned to the facility on June 2, 2009 the treatment plan had not been updated.

4. R1 was admitted to the facility December 30, 2008 and readmitted on February 12, 2009, after Psychiatric hospitalization for behavior. R1 was again sent out on June 15, 2009, for behavior issues. A review of the treatment plan dated January 12, 2009, indicates that the facility did not update the treatment plan after hospitalization.

The treatment plan for conflict is a standardized one without individualization for R1. E2 stated on June 17, 2009, that R1 had broken down on June 15th and needed to be sent out. There is no documentation on the symptoms exhibited by R1 or the behavior that caused R1 to be discharged to the Psychiatric Hospital. A review of the

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F9999	Continued From page 62 treatment plan indicates that there are no interventions or psychiatric programs listed for R1 to deal with her behaviors. 5. Z2 (Medical Doctor) was interviewed by phone on June 16, 2009 at 1:10pm. Z2 stated that he had discharged R3 to the hospital on April 1, 2009, for routine treatment related to R3's renal disease and missing dialyses treatments. Z2 stated that R3 often refused dialyses and needed hospitalization for his condition. Z2 stated that since the resident was directly admitted to the unit in the afternoon and was not sent to the Emergency Room, he did not see R3 that day. Z2 stated that the hospital staff advised him that R3 had facial bruising, but since R3 was acting like himself, he did not transfer R3 to the Intensive Care Unit. Z2 stated that he had not been aware of the facial bruising or trauma when he gave orders to transport R3 to the hospital. Z2 stated that he would have discontinued the Heparin (Anticoagulant Medication) and would have sent R3 out to the hospital sooner. Z2 stated that the injury R3 suffered was of great force like that of a "baseball bat." Z2 also stated that he was aware that R3 died from the head injury. Z3 and Z4 (Ombusman Agency) were interviewed on June 16, 2009 at 2:40pm. Z3 and Z4 stated that they have witnessed numerous fights and altercations between residents. Z3 stated that on numerous occasions she has witnessed residents fighting and staff does nothing to stop the fights. Z3 and Z4 stated that this in an ongoing problem in the facility.	F9999		

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R3 was a 63 year old male with diagnosis of hypertension, diabetes mellitus, schizo affective disorder, right side below the knee amputation, end stage renal diease, and schizophrenia. R3 has a history of being verbally inappropriate with staff and other residents. A review of R3's closed record and staff interviews R3 has a history of being verbally abusive to staff and other residents. R3's closed record indicates incidents of verbal abusive behavior.

An interview with E2 (Director of Nursing), said that she was aware of the allegations of a physical altercation between R3 and R4. E2 said when she asked a E9 (activity aide), about the incident, E9 said that E4 only jabbed R3 in the face, and E2 said she didn't investigate the alleged abuse because she thought the two residents were only horse playing.

A review of the facility's abuse prevention program facility policy indicates that physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.

The facility's policy also indicates supervisors shall immediately inform the administrator or designee of all reports of potential mistreatment. Upon learning of the report, the administrator or designee shall initiate an incident investigation.

E2 was asked in two separate interviews if she investigated the allegations of resident-to-resident abuse and E2 said no. A review of the facility's policy injury of unknown origin indicates that it is the policy to investigate all skin tears, bruises, and injuries in an effort to determine possible causes. A review of the

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F9999	Continued From page 64 facility's policy incident reports indicates that incident reports should be completed thoroughly and accurately, immediately after the incident occurs. An interview with Z5 (state police officer), Z5 said that R3 was hit in the face by R4 for arguing with a staff member. Z5 said that the altercation occurred between the 3/28/09 and 3/30/09. Z5 said the facility could not produce an incident report documenting the altercation. Z5 also said the CME (coroners medical examiner) report noted R3 had aspirated blood in his lungs. Z5 said that E16 (Certified Nurses Aide) found R3 yelling in his room at 2:00am and again at 4:00am. During E16's 6:00am rounds E16 found dried blood on the floor under R3's bed and on R3 lips. E16 reported his findings to E3 (Licensed Practical Nurse). (A)	F9999		