STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145715	A. BUILDING _____ B. WING _____	10/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEATON CARE CENTER	**1325 MANCHESTER ROAD WHEATON, IL 60187**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 458	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide 80 square feet in multiple resident rooms. Examples include; Rooms A18, A19, A22, A24, A26, A28, A30, A31, A32, A33, A34, B2, B3, B7 and B8 provide approximately 78 square feet per resident. The administrator stated the residents in these rooms are alert and ambulatory. The room size doesn't prevent medical treatment.	F 458		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.1220b)2) 300.1220b)3) 300.3240f) 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. Section 300.1210 General Requirements for	F9999		

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F9999	Continued From page 32 Nursing and Personal Care b)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 see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect	F9999		

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F9999	Continued From page 33 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) These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to: 1. Provide supervision and monitoring for R28 who is identified as physically and verbally abusive. (a) R28 hit R20 in the back and was verbally abused by R28 on May 2009. (b) R 28 hit R 29 (the roommate) on 04-21-09. (c) R28 punched the staff in the chest on 07-30-09. Develop a plan to prevent R 20 from being hurt and abused by other residents. Develop a plan to prevent R28 from physically and verbally abusing other residents. This resulted in R 20 displaying psychosocial harm as evidence by self isolation and fear of going to the dining room. 2. Provide a safe environment for residents from R27's resident to resident altercations which resulted in R21 being hit in the neck with a walker on 9/12/09 by R27 causing "excruciating" pain and hospital evaluation.	F9999		

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F9999	Continued From page 34 3. Implement interventions to prevent one resident (R18) from wandering in and out of other residents' rooms, eating off of other residents' trays and drinking an unidentified substance that was found in another resident's room. The facility failed to respond to one resident (R26) who was observed coughing heavily while eating her lunch. This was for 5 of 23 residents in the sample. Findings include: 1. On 10-06-09 at 12:10 PM, R20 was observed in the room and lunch tray was served. R20 claimed she's been eating in her room for her own safety. R20 stated, "I used to like going in the dining room but I'm scared someone will hurt me again. Three months ago I got hit by another patient in the dining. I was using the public phone, this patient came in on a wheelchair and told me to move and started hitting me on my back. People saw it, there were staff present, I called for help but no one came and helped me. I beg her not to hurt me and to stop; she keeps calling me "bitch" and continued hitting me. I had a severe pain in my back already because when I was in the other nursing home I was beaten by another resident too. I end up having surgery on my back. They (the staff) didn't do anything to her, that's why I don't go in the dining room anymore. I don't want anybody to hit and hurt me anymore, so I just eat in my room. I guess I'm safer here." The facility had not developed a plan on how they are going to protect R20 from similar incidents happening. The Psycho Social Coordinator	F9999		

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F9999	Continued From page 35 disclosed that R20 had a history of being abused by other residents. The Care Plan Coordinator was asked if there was a plan developed for R20. The Care Plan Coordinator disclosed there was no plan developed and said, "I don't know how to identify patients that are potential for abuse." There was no documentation found in R28's January thru October 2009 progress notes addressing the incident on May 2009, in which R28 physically hit R20 in the dining room. There were other incidents in the progress notes that R28 was physically and verbally abusive to residents and staff. (1) On 04-21-09 at 10:01 PM, R 28's progress notes read: observed resident by C.N.A that she had behavior at 7:15 PM, she stated that resident was in her room and hit her room mate(R 29) ...(2) 07-30-09 at 12:17 PM, started screaming at staff member and punched her in the chest. R 28's plan of care disclosed that R28 was diagnosed with bipolar disorder. The facility was aware and documented the following problems for R28 on the care plan but no specific and individualized interventions were developed and implemented to address and control R28's behavioral problems. · Have verbally abusive behavioral symptoms (others were threatened, screamed at, cursed at). · Has a history of abusive behavioral symptoms as evidence by she will hit and kick staff when she is redirected from going downstairs to smoke. · Has a socially inappropriate/disruptive behavioral symptom as evidenced by screaming for staff to change the channel on her television, and yelling at staff when they bring her the wrong kind of sandwich for lunch.	F9999		

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F9999	Continued From page 36 · Risk for mood disturbance and behavior problems (problem start date 02-10-09). There was no plan developed to monitor and supervise rsidents to prevent R28 from physically and verbally abusing other residents. On 10-15-09 10:30 AM, E10 confirmed that R28 has behavior problems. E10 stated, "yes I was told she has a history of verbal and physical abuse." E 10 was not aware of the identity of the Abuse Coordinator. E10 has been working in the facility for 10 months. R 28's care plan reads: others were threatened, screamed at, curse at. 2. A review of the facility's incident report of 9/12/09 at 8:00 a.m., R21 was struck on the left side of his neck by R27 with her walker. An 10/8/09 interview with R21 stated, "R27 just came out of the blue and hit me with the walker, there was no reason for that." R21 said R27 not only hit him but had hit other residents in the building and the facility continues to let it happen . R21 stated he had a lot of pain after being hit. The incident report documents that after R21 was hit with the walker he had aching, burning, stabbing excruciating pain at a (10) worst possible. The pain interfered with his ability to carry on with daily routines, socialization or sleep. R21 was crying, agitated and anxious. R21 had to be sent to the hospital for medical treatment. A review of the clinical record for R27 documents on 9/10/09, R27 was verbally abusive and throwing her tray in the dinning room. On 8/30/09, R27 was aggressive and combative with another resident requiring R27's admission to	F9999		

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F9999	Continued From page 37 the hospital for psych evaluation. On 8/13/09, R27 was extremely agitated and physically abusive to another resident and staff by throwing a glass vase, punching and kicking with no apparent reason. Staff were unable to redirect R27 and again R27 was sent to the hospital for psych evaluation .On 8/12/09, R27 was witnessed hitting another resident by throwing a chair and was sent to hospital. The facility had no information from the hospital on how to care for R27, the plan of care was not reviewed with interventions to address R27's behaviors. There was no plan in place to show how the facility would keep residents safe from incidents and injury. 3. During the group meeting on 10/7/09, all member of the group complained that R18 wanders in and out of other resident rooms. All stated that R18 eats off of other residents' trays. R18 was observed at the time of the meeting going into another resident room, removing a cup and drinking the entire content of the cup. There was no staff intervention observed. R18 is located on the garden floor level of the facility where most of the residents are assessed as independent. A review of the facility's Minimum Data Assessment for R18 assesses R18's cognitive level as moderately impaired. (A) 300.4010c)3)C) 300.4010d) 300.4020 300.4030 300.4040	F9999		

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F9999	Continued From page 38 Section 300.4010 Comprehensive Assessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S c) A comprehensive assessment must be completed by the IDT no later than 14 days after admission to the facility. Reports from the pre-admission screening assessment or assessments conducted to meet other requirements may be used as part of the comprehensive assessment if the assessment reflects the current condition of the individual and was completed no more than 90 days prior to admission. The assessment shall include at least the following: 3) A skills assessment performed by a social worker, occupational therapist, or PRSD or PRSC with training in skills assessment. The skills assessment shall include an evaluation of the resident's strengths, an assessment of the resident's levels of functioning, including but not limited to the following areas: C) Community living skills (including use of telephone, transportation and community navigation, avoidance of common dangers, shopping, money management, homemaking (cleaning, laundry, meal preparation), and use of community resources); d) Based on the results of all assessments, the PRSD or PRSC shall develop a narrative statement for the IDT review that summarizes findings regarding the resident's strengths and limitations; indicates the resident's expressed interests, expectations, and apparent level of motivation for psychiatric rehabilitation; and prioritizes needs for skill development related to	F9999		

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improved functioning and increased independence. The IDT's assessment of overall rehabilitation focus for the resident will also be identified as one of the following levels:
1) Basic skills training and supports with opportunities for community integration;
2) Intensive skills training and supports with an increasing focus on community integration; or
3) Advanced skills training and supports with active linkage and use of community services in preparation for expected discharge within six months

Section 300.4020 Reassessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

a) At least every three months, the PRSC shall document review of the resident's progress, assessments and treatment plans. If needed, the PRSC shall inform the appropriate IDT members of the change in resident's condition. The appropriate IDT member will reassess the individual and update the resident's assessment, assuring the continued accuracy of the assessment.
b) Complete comprehensive reassessments shall be conducted as needed but at least every 12 months in the following areas:
1) Psychiatric evaluation;
2) Psychosocial assessment update (including significant events, e.g., death of a significant other since the last reassessment);
3) Skills assessment update, including an assessment of resident levels of functioning and reassessment of rehabilitation potential (an evaluation of the individual's strengths, potentials, environmental opportunities and ability to achieve or likelihood of achieving maximum functioning);

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F9999	Continued From page 40 and a narrative statement of the individual's strengths and potential as they directly relate to the individual's functional limitations with recommendations for treatment and/or services, and the potential of the individual to function more independently. A complete reassessment shall be required if changes in the resident's functional level make the current assessment inapplicable. If a complete reassessment is not required, the update must include a narrative summary of the reevaluated assessment; 4) Recreation and leisure activities updates, including the resident's participation, perceived enjoyment, frequency of self-initiated involvement versus staff coaxing or refusal, and recommended interventions; 5) Physical examination update, including, but not limited to: A) Medical history and medication history updates, including any illness and changes in medical diagnosis and medication prescription or indication of administration compliance that have occurred since the last assessment; B) Oral screening update completed by a dentist or registered nurse; C) Nutritional update completed by a dietician or the food service supervisor under the direction of the dietician; and 6) Other assessments needed, as determined by the interdisciplinary team. Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) On admission, information received from the admission source (e.g., resident, family, preadmission screening (PAS) agent) shall be used to develop an interim treatment plan. In	F9999		

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F9999	Continued From page 41 developing an individual's interim treatment plan (IITP), the facility shall review the PAS/MH assessments and "Notice of Determination" and consider the use of this information in developing the interim treatment plan. The IITP shall focus on those behaviors and needs requiring attention prior to development of the individualized treatment plan (ITP). Each IITP shall be based on physician's orders and shall include diagnosis, allergies and other pertinent medical information. The following information shall also be considered, as appropriate, to allow for the identification and provision of appropriate services until a final plan is developed: 1) Known risk factors (e.g., wandering, safety issues, aggressive behavior, suicide, self-mutilation, possible victimization by others); 2) Observable resident medical/psychiatric conditions that may require additional immediate assessment or consultation; 3) Therapeutic involvement that might be of interest to the resident, be recommended based on referral information, aid in orientation or provide meaningful data for further professional assessment; and 4) Other known factors having an impact on the resident's condition (e.g., family involvement, social interaction patterns, cooperation with treatment planning). b) An ITP shall be developed within seven days after completion of the comprehensive assessment. c) The plan for each resident shall state specific goals that are developed by the IDT. The resident's major needs shall be prioritized, and approaches or programs shall be developed with specific goals, to address the higher prioritized needs. If a lower priority need is not being addressed through a specific goal or program, a	F9999		

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F9999	Continued From page 42 statement shall be made as to why it is not being addressed or how the need will be otherwise addressed. d) The ITP shall contain objectives to reach each of the individual's goals in the plan. Each objective shall: 1) Be developed by the IDT; 2) Be based on the results obtained from the assessment process; 3) Be stated in measurable terms and identify specific performance measures to assess; and 4) Be developed with a projected completion or review date (month, day, year). e) Services designed to implement the objectives in the resident's ITP shall specify: 1) Specific approaches or steps to meet the objective; 2) Planned skills training, skill generalization technique, incentive/behavior therapy, or other interventions to accomplish the objectives, including the frequency (number of times per week, per day, etc.), quantity (in number of minutes, hours, etc.) and duration (period of time, i.e., over the next 6 months) and the support necessary for the resident to participate; 3) The evaluation criteria and time periods to be used in monitoring the expected results of the intervention; and 4) Identification of the staff responsible for implementing each specific intervention. f) Whenever possible, residents shall be offered some choice among rehabilitation interventions that will address specific ITP objectives using techniques suited to individual needs. g) ITP Documentation: 1) Significant events that are related to the resident's ITP, and assessments that contribute to an overall understanding of his/her ongoing level and quality of functioning, shall be	F9999		

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F9999	Continued From page 43 documented. 2) The resident's response to the ITP and progress toward goals shall be documented in progress notes. h) The ITP shall be reviewed by the IDT quarterly and in response to significant changes in the resident's symptoms, behavior or functioning; sustained lack of progress; the resident's refusal to participate or cooperate with the treatment plan; the resident's potential readiness for discharge and actual planned discharge; or the resident's achievement of the goals in the treatment plan. i) The resident's individual treatment plan shall be signed by all members of the IDT participating in its development, including the resident or the resident's legal guardian. j) If the resident refuses to attend the IDT meeting or refuses to sign the treatment plan, the PRSC shall meet with the resident to review and discuss the treatment plan as soon as possible, not to exceed 96 hours after the treatment plan review. Evidence of this meeting shall be documented in the resident's record. k) The resident's treating psychiatrist shall review and approve the resident's treatment plan as developed by the IDT. The date of this review and approval shall be entered on the resident's treatment plan and be signed by the attending psychiatrist. l) The ITP shall be based upon each resident's assessed functioning level, appropriate to age, and shall include structured group or individual psychiatric rehabilitation services interventions or skills training activities, as appropriate, in the following areas: 1) Self-maintenance; 2) Social skills; 3) Community living skills;	F9999		

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F9999	Continued From page 44 4) Occupational skills; 5) Symptom management skills; and 6) Substance abuse management. m) Activity interventions for individual residents shall be part of, but not used to replace, psychiatric rehabilitation programming and should provide for using skills in new situations. Activity programs shall comply with Section 300.1410 of this Part. n) Residents' attendance in therapeutic programs shall be recorded. o) The PRSC shall assess the reason for the failure to attend whenever a resident fails to attend at least 50 percent of any programs included in his or her ITP over a 30 day period. Within 14 days after noting this failure, the PRSC shall document why the resident's attendance was less than 50 percent and that the resident's attendance is, at the time of the documentation, more than 50 percent, or the PRSC shall conduct an IDT meeting. This IDT meeting shall result in a change in components of the resident's treatment plan or shall indicate why a change is not needed. p) The PRSC is responsible for coordinating staff in the delivery of psychiatric rehabilitation services programs, oversight of data collection, and the review of the resident's performance. 1) At least quarterly, and prior to the treatment plan reviews, the PRSC shall meet with the resident to review and discuss the resident's current treatment plan, progress toward achieving the objectives, and obstacles inhibiting progress. Based upon this review, the PRSC, in consultation with the appropriate IDT members, shall revise the resident's ITP as needed. The revised treatment plan shall be submitted to the appropriate IDT members for review, approval and signature.	F9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 45 2) At least quarterly, the PRSC shall record the resident's response to treatment in the clinical record. q) The psychiatric rehabilitation services aides shall record the resident's response to those areas overseen by the aide. Section 300.4040 General Requirements for Facilities Subject to Subpart S a) The psychiatric rehabilitation services program of the facility shall provide the following services as needed by facility residents under Subpart S: 1) 24 hours of continuous supervision, support and therapeutic interventions; 2) Psychotropic medication administration, monitoring, and self-administration; 3) Case management services and discharge preparation and training; 4) Psychiatric rehabilitation services addressing major domains of functioning and skills development: self-maintenance, social and community living, occupational preparedness, symptom management, and substance abuse avoidance; 5) Crisis services; and 6) Personal care assistance. b) The psychiatric rehabilitation services programs in the facility shall be designed to improve or maintain the resident's level of functioning and independence. c) The facility's psychiatric rehabilitation program shall have the following overall goals: 1) Encourage the engagement of each resident in his/her recovery and rehabilitation; 2) Increase acquisition, performance, and retention of skills to enhance independence and promote community integration; 3) Support the progressive assumption of as	F9999		

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	145715	A. BUILDING _____ B. WING _____	10/16/2009

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F9999	Continued From page 46 much personal responsibility, self-management, and self-determination as each resident can manage; 4) Broaden the use of living, coping, and occupational skills to new environments with an ultimate goal of discharge to a more independent living arrangement, as appropriate; 5) Decrease psychotic, self-injurious, antisocial, and aggressive behaviors; 6) Decrease the impact of cognitive deficits as an impediment to learning new skills; and 7) Foster the human dignity, personal worth, and quality of life of each resident. d) The psychiatric rehabilitation program shall provide education and training to maximize residents' capacities for self-management of psychotropic medications and utilization of other supportive mental health services, such as cooperation with prescribed treatment regimen, self-medication, recognition of early symptoms of relapse, and interactive effects with other drugs and alcohol. e) The facility shall have written policies and procedures related to smoking, including smoke-free areas, risk assessment for individuals who smoke, and the conditions and locations where smoking is permitted in the facility, if permitted at all. f) A facility shall document all leaves and therapeutic transfers. Such documentation shall include date, time, condition of resident, person to whom the resident was released, planned destination, anticipated date of return, and any special instructions on medication dispensed. These Regulations were not met as evidenced by: Based on observation, interviews and record	F9999		

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F9999	Continued From page 47 review facility failed to assure that 86 of 86 identified Serious Mentally Ill (SMI), residents receive necessary specialized rehabilitative services, failed to complete a comprehensive skills level of functioning and behavioral risk assessment and develop and implement an interim care plan consistent with any specialized services the resident is required to receive based on a completed preadmission screening and annual resident review (PASARR) , failed to provide a structured environment to diminish tendencies toward isolation and withdrawal, to develop, maintain and consistently implement skills training, crisis intervention and psychotherapy and failed to develop a personal support network and formal behavior modification programs. Findings include: Throughout the entire survey, 15 of 16 sampled SMI residents (R1, R3, R4, R5, R6, R10, R11, R12, R13, R14, R15, R16, R20, R21 and R22), were observed in facility, in bed, wandering around hallways or sitting in dining room. Review of facility provided lists documented that facility has 86 SMI residents of which only 9 attend outside programs and 9 attend a half hour "Symptom Management" in house group up to 3 times a week. 15 of 16 sampled SMI residents (R1, R3, R4, R5, R6, R10, R11, R12, R13, R14, R15, R16, R20, R21 and R22), do not attend any in house or out-side psych rehab programs. The pre-admission screening (PAS/MH) did not include any information or recommendations that would assist facility in developing an Interim treatment plan and no interim treatment plan has	F9999		

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F9999	Continued From page 48 been developed on R1, R14, R15 and R16. During interviews with E7 (corporate social worker), E8 (corporate recreational services), E6 (corporate clinical specialist) and E9 (psych rehab service director - PRSD), surveyor was told that not all of facility's SMI residents have a completed SLOF assessment. On 10/09/09 E7 told surveyor that facility has not yet evaluated which SMI residents have completed an up to date SLOF assessments but that next week facility was going to start completing SLOF's on SMI residents. On 10/08/09 E6 told surveyor that SLOF assessments have not been completed on SMI residents to date but they are going to start assessing residents next week now that the facility has a new PRSD. R1, R14, R15 and R16's medical records did not include a social service or psych rehab interim care plan addressing psycho-social adjustment difficulties. - R14 was observed up and about in her room. R14 was admitted to facility 6/04/04 with diagnosis to include manic depressive psychosis, schizo-affective disorder (SAD) and suicidal ideation. R14 has recent history of suicidal ideations with a prolonged psych hospitalization in July 2009. R14 has auditory hallucinations and unrealistic fears, believes staff are murderers. R14 is independent with ambulation, dressing, grooming and eating . R14 stated that she sometimes attends craft activities and sees a psychologist but has no other programing, and has concerns about dietary staff being course and short with her. R14's skilled level of functioning assessment (SLOF) was not completed until 10/09/09.	F9999		

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F9999	Continued From page 49 - R1 observed in bed in a darkened room. R1 was admitted to facility 12/17/03 with diagnosis to include SAD and extra pyramidal symptoms (EPS). R1 is very hard of hearing and independent with eating and ambulation, and requires supervision with hygiene and grooming. R1's record indicates that he is isolative. R1's current physician order sheet includes "may participate in psych rehab services." R1 is not listed on either in or outside program attendance lists. R1's 3/27/09 and 7/28/09 care plan includes diagnosis of Schizo-affective disorder and the need for symptom management, using psycho-active medications. The only interventions listed for this problem documented on care plan are encourage group activity involvement, provide support and re-assurance, and psych consult. R1's 3/31/09 last annual minimum data set assessment (MDS) and resident assessment protocols (RAP's), do not include a psycho-social well being or behavior RAP - R15 observed in a darkened room asleep in bed and refusing to respond to surveyor when spoken to. R15 was admitted to facility 4/16/09 with diagnosis to include SAD and EPS. R15 has documentation in progress notes of anger and aggressive behaviors in September and October 2009. R15 has no SLOF or risk assessment for aggressive behaviors completed. R15's progress notes included a history of multiple episodes of smoking cigarettes in unauthorized areas (including his room). Facility did not complete a smoking risk assessment until 10/07/09. R15 was not added to the supervised smoking program until 10/09/09, after surveyor questioned staff about this behavior. R15's 11/26/08 care plan	F9999		

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F9999	Continued From page 50 included that R15 violated smoking rules. R15's care plan included that he requires training and skill practice in dressing and grooming but no skills training program was provided by facility. R15's community survival skill assessment was not completed until after an incident 8/30/09 of becoming intoxicated while independently out on pass. R15's care plan also includes diagnosis of SAD and the need for symptom management via use of psych medications. R15 is also documented as at risk of mood disturbance and behavior problems. The only documented approaches for these problems are to give medications, obtain psych consult and monitor for constipation. R15's 01/27/09 care plan did not include intimidation/violent tendency behaviors or decreased social interaction as listed on the sub - part S section of his 01/27/09 MDS and there is no behavior care plan for his documented non-compliant behaviors. R15's 7/07/09 MDS notes at times socially inappropriate, withdrawn , decreased social interaction, loss of interest, non-compliant with eating, showering and smoking in appropriate areas, unkept appearance and at times ignores staff re-direction. R15's record included that he stays awake at night and is somnolent during the day. - R16 observed in a darkened room, in bed with bed covers over his head and at times refusing to respond when spoken to. R16 was admitted to the facility 5/15/09 with diagnosis to include paranoid schizo-phrenia. R16's 8/06/09 psych notes include that R16 paces, has poor	F9999		

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F9999	Continued From page 51 judgement and insight and wants to know when he can be discharged but has no post discharge living arrangements planned. R16's SLOF was not completed until 9/11/09 and his current care plan does not include psych rehab programing. R16's most recent 6/24/09 MDS includes socially inappropriate daily, aimlessly wanders the hallways and eats with his fingers. On 8/20/09 R16 was found smoking cigarettes in the ground level dining room and on 6/21/09 staff found 2 cigarette butts in R16's bed. R16 was not assessed for smoking risk until 10/07/09, after surveyor questioned staff about his smoking privileges, at which time he was placed on supervised smoking program. R16 refuses invitations to activities and seldom socializes. R16 usually watches television in the dining room. R16's current care plan does not address his decreased socialization and withdrawn behaviors. E9 told surveyor that the only current in house program was a Symptom Management Program that is held 3 times a week for a half an hour and there are currently 9 residents attending this program. E9 also said that only 9 SMI residents out of 86 in house are attending an outside day program. E9 said that the outside program has decreased from 5 days a week to only 2 days a week since 10/01/09 due to a decrease in funding. On 10/07/09 E6 said he was aware that the facility has a lot of young residents that stay in bed right now but this is going to change. On 10/07/09 E6 and E7 told surveyors that the facility was unable to run proper skills programing	F9999		

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F9999	Continued From page 52 due to lack of adequate trained staff but now facility has a new PRSD, and on 10/11/09 a new PRSC (psych rehab service counselor) is starting, so facility will start providing Subpart S services to SMI residents. E7 said that SMI's will be broken up into three groups and placed in skills training based on their SLOF assessment results. E7 said that facility is planning to start using the 6 area modules in skill training. We are going to start evaluating community/group programing and day programs. During a 10/08/09 interview E8 said that facility does not perform a separate risk assessment for aggressive behaviors. (B)	F9999		