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F 461	Continued From page 31 (iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in the resident ' s bedroom with clothes racks and shelves accessible to the resident. CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations-- (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents ' health and safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a comfortable bed for R33. Example includes; R33 is 6 feet 8 inches tall. R33 was observed in bed. His feet and head were touching the head and foot board. R33 said, "There's no room for the sheet to go over my feet. It bothers my toes and I bump my head." The administrator said, "R33 never complained about his bed."	F 461		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1220b)2)	F9999		

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F9999	Continued From page 32 300.4010c)2)B) 300.4010c)3)E) 300.4030a)1) 300.4030c) 300.4040a)1) 300.4040a)4) 300.4040a)5) 300.4040c)5) 300.4050a)4) 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. 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:	F9999		

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F9999	Continued From page 33 2) Psychosocial assessment performed by the Psychiatric Rehabilitation Services Director (PRSD), a social worker, a or the Psychiatric Rehabilitation Service Counsellor if reviewed and countersigned by the PRSD. The assessment shall cover the following points: B) Reason for admission including specific problems and how long the problems have existed in their current state, contributing factors to exacerbation of problems, most recent psychiatric treatment and effects, goals of nursing facility and articulated by the referral source. 3) A skills assessment performed by a social owrker or PRSD or PRSC with trainig in the skills assessment. The skills assessment shall include an evaluation of the resident's strengths, an assessment of the resident's levels of functioning including: E) Symptom Management skills including symptom monitoring and coping strategies; stress identification and management; impulse control; medication management and self-medication capability; relapse prevention. 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 including Pre Admission Screening and transferring facility shall be used to develop an individual's interim treatment plan (IITP). The IITP shall focus on those behaviors and needs requiring attention prior to development of the IITP. The following information shall also be considered as appropriate to allow for the identification and	F9999		

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provision of appropriate services until a final plan is developed:
1) Known risk factors (wandering safety issues, aggressive behavior, suicide, self-mutilation, possible victimization by others).

c) The plan for each resident shall state specific goals that are developed by the Inter Disciplinary Team (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 statement shall be made as to why it is not being addressed or how the need will be otherwise addressed.

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;
4) Psychiatric rehabilitation services addressing major domains of function and sills development including self maintenance, social and community living, occupational preparedness, symptom management.
5) Crisis Services.

c) The facility's psychiatric rehabilitation program shall have the following overall goals:
5) Decrease psychotic, self-injurious, antisocial, and aggressive behaviors.

Section 300.4050 Psychiatric Rehabilitation Services for Facilities Subject to Subpart S

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a) The facility shall develop and implement a psychiatric rehabilitation program. a facility may contract with an outside entity to provide all or part of the psychiatric rehabilitation program as long as individual residents' needs are ment. The program shall be designated to allow a wide arry of group and individual therapeutic activities, including but not limited to:
4) Aggression prevention and management, including resident screening (history of aggressive and assaultive behavior, precipitating factors, signals of escalating risk, and effective de-escalation strategies.

These Regulations are not met as evidenced by:

Based on observation, record review and interview the facility failed to:
(1) Conduct a thorough and accurate psychological assessment to include the history of residents' Physical and Verbal Aggression, and Criminal History for the residents who are Identified Offenders;
(2) Develop individualized interventions to resident to resident altercations and decrease undesirable behaviors.
(3) Have staff trained and proficient to provide Psychiatric Rehabilitation Services (PRS) including Crisis Preventions Interventions (CPI) to intervene in crisis.
(4) Develop a plan of care to monitor and supervise R5 with a criminal history of multiple sexual offenses and retail theft and R13 with a history of multiple and recent suicide attempts and current ideation.
(5) provide adequate supervision for the management of R20 who was identifed to have Mental Retardation by identifying and assessing

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the level of retardation.
(6) Thoroughly evaluate the Specific Levels of functions for R20's Severe Mental illness that are required to help R20 maintain daily functional need,s and define specific interventions that identify triggers for R20's suicidal ideations.
(7) Know the where abouts of R20 from 10/3/2009 till 10 /4/2009 when he was missing from the facility and engaged in a physical altercation outside the facility.

As a result:
(a) R9 had the history of Criminal Convictions for Battery, Aggravated Arson, Physical Assault and Violation of Probation prior to the admission to the facility. R9 attacked female residents on two separate occasions unprovoked.
(b) R20 who was identified to be unsafe in the community and has been expressing suicidal ideations and expressing physical aggression towards others remained out of the facility from 10/3/09 to 10/4/09 unsupervised. The Police returned R20 to the facility on 10/4/09.

This is for 6 of 15 Identified Offenders (R9, R10, R13, R1, R7 and R16) who have mental illness in the sample and three other residents (R23, R15, and R20) in the sample who have mental illness.

Findings include:

1. R9 from 10/20 to 10/23/09 spent most of the time in his room, except he came out for meals and medications. R9 stated he does not go to any of the groups in the facility because he is not interested in them. He used to attend outside the facility day treatment. The facility administration staff stated that since last month outside programs were stopped because of budget

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restrictions.

R9 a 38 year old male was admitted to the facility on 11/10/07 with diagnoses including Schizoaffective Disorder, Schizophrenia, Hypertension and Obesity. The facility had information on record from the transferring Long Term Care (LTC) facility and Hospital prior to R9's admission to the facility. R9 was at two different LTC facilities. At the first LTC facility R9 has become irritable, hostile, paranoid, delusional and attacked another resident. At the second LTC facility R9 attacked staff. Both times R9 underwent acute psychiatric hospitalization.

R9 also has identified offenses including Battery, Bodily Harm, Attempted Aggravated Arson, Violation of Probation and served Prison Sentence six times: 27 days; 4 years; 72 days; and 30 days; 60 days and 4 years; and remained on special probation three times: 1 year; 2 years; and 2 years.

The Department of Public Health Identified Offenders Program Criminal History Analysis Security Recommendation Report notes R9 is low risk. The low risk requires closer observation of behavioral changes in an open facility. The facility did not specify what type of closer observations are required for R9 to prevent his further aggression.

R9's 8/5/09 Social/Psychosocial History Assessment did not identify R9's physical aggression at the other long term care facilities and criminal offenses history prior to his admission to this facility.

R9's 8/5/09 Behavior Profile Screening

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Assessment noted he talks about/threatens self harm or harm towards others and engaged in self destructive, suicidal behavior and/or agressiveness towards others and is noncompliant with medications. These behaviors were not further evaluated to prevent such undesirable behaviors. These behaviors were not further evaluated nor were specific individualized interventions to prevent such undesirable behaviors developed or implemented.

R9's 10/1/09 Specific Level of Functioning (SLOF) social acceptability section noted he is rarely verbally and physically abusive to others. R9 has extensive criminal history and abuse to others physically and verbally. The SLOF comments section was left blank and the facility did not evaluate these behaviors.

R9's 8/5/09 Strength, Defict and Priority Needs Summary noted he has Psychosis under Deficits Section. In the priority treatments it was noted to encourage to attend anger management; Activity of Daily Living; and to attend outside day program. R9 is not attending any of the programs.

After R9 was admitted to the facility he attacked and hit two female residents on two different occasions unprovoked. Once on 5/8/09 at 8:30 pm, R9 went to the Nurse requesting for his bed time medications. The Nurse told R9 he could wait until she comes back because she is having an emergency with other residents downstairs. After the Nurse left R9 at the Nurses station, he hit a female resident in her face repeatedly. The second time on 8/16/09 at 3:50 pm the Nurse told R9 that his mother was not going to take him on a weekend pass. At this time R9 was in the day

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room seated at a table with a female resident. After the Nurse left, R9 hit the female resident on the face and cheek. Both times R9 was sent for acute psychiatric hospitalization for physical aggression and suicidal ideations. Both times upon R9's return to the facility, the facility did not plan to change interventions to prevent further episodes of physical aggression.

R9's annual assessment 11/6/08 Section S noted he is a Subpart S eligible candidate, but the rest of the section was left blank. His quarterly assessment of 8/5/09 Section S noted he is a Subpart S eligible candidate, noted he has Schizophrenia and is violenct to others. The facility provided a list of Subpart S residents who have severe mental illness. R9 was not listed on the Subpart S list. The assessment 12/7/08 summary for Mood noted to see summary. There was no summary found for Mood or Behavior.

2. R10 is a 62 year old male admitted to the facility on 5/12/09 with multiple diagnoses including Schizophrenia, Bipolar Disorder, Major Depression and Parkinsons. R10's 5/20/09 initial MDS Section S was left blank, his 3/17/09 Pre-Admission Screening noted he has serious mentall illness and requires psychiatric rehabilitation services. R10's Social History Assessment is not comprehensive to include his history of mental illness. R10's 5/14/09 Strengths and Deficit and Priority Needs Summary noted his deficits are: he lacks creativity, minimal or absent of support. His priorities noted were: resident to come to case manager, encourage to attend groups. The deficits and priorities were not coordinated, no goals or objectives were established, and no individualized interventions developed for the deficits. R10's SLOF identified

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problems in the areas of Activities of Daily Living (ADL) and Community Living Skills. The problems identified in SLOF and Strengths and Deficits are not coordinated.

R10 on 9/29/09 had a physical altercation with a female resident in the smoking area and hit the female resident on the arm. R10 on 10/23/09 stated he does not attend any programs in the facility, people argue and sometimes fight with each other.

3. R23 is a 41year old male admitted to the facility on 1/7/08 with diagnoses including Paranoid Schizophrenia, Bipolar Disorder and Hypertension. R23's 1/20/08 assessment, Subpart S Assessment and Pre-Admission Screening identified him as having severe mental illness. R23's Social Service Assessment is not comprehensive to indicate his history of mental illness. R23's Strength, Deficit and Priority Needs Summary noted treatment priorities: encourage to attend conflict resolution, anger management, mens group social skills and health and hygienes, but established no goal or objectives. No individualized interventions were developed.

R23's assessment identified problems in the area of mood and behavior and to see assessment summary. The summary noted R23 is sad, gets easily upset, flickers cigarette butts, and to monitor behavior changes. There was no assessment to indicate what triggers his upset behaviors or how the staff monitors his behaviors.

It was noted in R23's Nurses Notes that on 7/28/09 at 2:45 pm he had a physical altercation with a female resident on 1st floor hall way and

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he hit the female resident on her cheek. R23 stated the groups do not do any good, he does not attend any of the groups, and he is depressed and frustrated.

4. R15's most recent assessment of 9/15/09 shows that R15 is 36 year old female. The facility identified her as not qualifying for Subpart S services. R15's psychosocial history dated 9/28/09 states R15 was admitted to the facility on 11/10/08 from a psychiatric hospital with diagnoses including depression, anxiety disorder, borderline personality disorder and bipolar disorder. R15 has had numerous psychiatric hospitalizations since the age of 16. R15's social service progress notes and nurses notes show that R15 has multiple behavioral issues involving pain meds, aggression towards staff and other residents, being found on floor, and being hospitalized in emergency room multiple time for the treatment of injuries.

5. R20 is a 35 year old admitted to the facility 10/13/08 with diagnosis of Paranoid Schizophrenia , unspecified Mental Retardation and Bipolar Disorder. From clinical record review, the 4/6/04 report of the Health Information Management MANAGEMENT PSYCHIATRIC documents R20 was admitted for increasing psychosis and agitation; R20 was agitated, yelling and screaming with little improvement in behavior. R20 began threatening staff and later hit a particular staff member. R20 continues to run around the food trays and was not redirectablbe. R20 then started to go for the window and wanted to climb out of the window.

On 1/27/09 at 7:30 p.m., R20 put a belt around his neck and stated he will kill himself.

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Psychosocial Dept staff took the belt from resident. Earlier R20 was upset with roommate (resident thinks his room mate is going to kill him). R20 was sent to the hospital for evaluation. Recommendation from the hospital was to place R20 on suicidal precautions and close observation for aggressive behavior.

The 10/4/09 4:30 p.m. nursing documentation describes R20 as highly agitated, yelling and screaming Staff has under 1:1 observation. R20 still trying to run away. R20 yelling ,screaming attempt to get out door, very difficult tore direct, attempted to hit staff and threatened them with a leather belt.

On 10/29/09 at 2:00 p.m., PRSD stated there is a policy for the contraband items for the drugs, but there is nothing to restrict having belt for the residents who are expressing suicidal ideations and aggressive behaviors towards others.

On 10/3/2009 8:45 p.m., R20 had altercation with another resident per record review and ran out of the building.

6. R13 was admitted to facility 7/27/09 from the hospital after a recent suicide attempt with diagnosis to include Depression, Bipolar disorder, and cocaine addiction.

R13's 8/06/09 screening for aggressive/harmful andor inappropriate behaviors form includes not at risk for self destructive behavior, no history of substance abuse and no history of criminal behaviors.

R13 has a positive criminal background with convictions for manufacturing and delivering of a

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F9999	Continued From page 43 controlled substance, solicitation retail theft, criminal trespassing to land, forgery and robbery. R13's 8/28/09 CHAR report assessed him as a moderate risk, and states "the resident requires closer supervision and more frequent observation than standard or routine for most residents in an open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on a time limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient." R13's individual criminal offenses are not addressed in his social service assessments or progress notes, and nor in his care plan R13's pre-admission screening (PAS/MH) identifies R13 as SMI (seriously mentally ill). R13's 7/20/09 PAS/MH includes the need of the following special services: Aggression/anger management, mental health rehabilitation activities, substance use/abuse management and illness self management. R13 is not being provided any programing or groups and is not listed on any of the in house program lists. R13's name is also not on facility's individual counseling list. R13's social service notes do not indicate any involvement in groups or programing. During a 10/22/09 1:30PM interview with E4 (psych rehab director), E4 stated that if a resident is attending any programing, social services is supposed to document such in their progress notes. R13's current care plan includes: "history of suicidal thoughts and substance abuse" problem.	F9999		

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F9999	Continued From page 44 The only interventions listed for this problem are: -discuss the residents situation with psychiatrist and interdisciplinary team. - encourage resident to come to case worker as needed and provide any type of help resident needs and wants if can. 7. R1 has a diagnosis of depression and schizophrenia. R1 is an identified offender. The preadmission screening indicates R1 needs assistance with illness management, reintegration to the community and substance abuse management. R1 indicated he has no group programs for these concerns. There is no analysis of these concerns and no plan of care to address these identified needs. Criminal history analysis and security recommendation report identifies R1 at moderate risk for burglary. R1 requires closer supervision and more frequent observation. Periodic assessment should ascertain whether the level of supervision is sufficient. There is no analysis of these concerns and no plan of care addressing these identified criminal offences 8. R7 has a diagnosis of depression and bipolar disorder. R7 is an identified offender. The preadmission screening indicates R7 needs assistance with illness management, incentive program and reintegration to the community. R7 indicates he has no group programs for these concerns. There is no analysis of these concerns and no plan of care to address these identified needs. Criminal history analysis and security recommendation report identifies R7 at moderate risk for theft and burglary. R7 requires closer	F9999		

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supervision and more frequent observation. Periodic assessment should ascertain whether the level of supervision is sufficient. There is no analysis of these concerns and no plan of care addressing these identified criminal offenses

9. R16 has a diagnosis of schizophrenia and schizoaffective disorder. R16 is an identified offender with a history of theft and burglary. Criminal history analysis and security recommendation report identifies R16 at moderate risk. R16 requires closer supervision and more frequent observation. Periodic assessment should ascertain whether the level of supervision is sufficient. R16 indicates he does not have any group programs for these concerns There is no analysis of these concerns and no plan of care addressing these identified criminal offenses.

The facility currently has no staff trained in Crisis Prevention Interventions (CPI). On 10/23/09 at 1:00 p.m., E4, the Psychosocial Rehabilitation Services Director (PRSD) stated that she is trained for CPI, but it was a couple years ago. No evidence was presented to verify her training.

The facility Psychiatric Rehabilitation Services (PRS) Department is currently managed by one PRSD and three Psychiatric Rehabilitation Services Counselors (PRSC). None of these staff have no formal training to provide PRS in the facility. The facility Administrator on 10/20/09 at 11:30 am stated he has Masters Degree and two other staff members have formal training to provide PRS, but these staff members are not involved in providing the PRS.

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300.1220b)8)
300.3240a)

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations are not met as evidence by the following:

Based on record review, interview and observation the facility failed to:

1) protect two residents (R15 and R20) from the use of excessive force by a staff persons.

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2) have policy with specific procedures / interventions for dealing with escalating behaviors

3) provide crisis prevention intervention (CPI), training for all staff.

4) prevent staff (E5) from wrongfully taking one resident's (R15) cell phone to prevent her from calling 911 and kept it for 6 days at his house.

These failures led to inappropriate staff treatment toward two residents (R15 and R20) and also has the potential for increased abuse of residents because staff is not trained in CPI (Crisis Prevention Intervention). This has the potential to affect 110 current residents of which 67 have psychiatric diagnosis and/or behaviors.

Findings include:

1) Review of facility incident report dated 10/16/09 states that R15 came to nurse's station and claimed that a psychosocial staff hit her in the face earlier during a behavior incident. This note states that R15 now has slight swelling on the left cheek and superficial bruise on the right inner wrist. The time of the incident listed on the report is 9:10pm.

Interview with E5 on 10/21/09 at 3:20pm stated he grabbed R15 from behind and enclosed his arms around her body while restraining R15 's arms. E5 stated he took R15 to her room this way. E5 stated R15 was very upset while he was taking her to the room and remained so after he put her in the room. E5 also confirmed that he took R15's cell phone. E5 stated no residents are to have cell phones and that he did not know if

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F9999	Continued From page 48 R15 had it back. E5 confirmed that he prevented R15 from calling 911 because she is always calling 911. Interview with E4 (Psych/social rehab director) stated to surveyor on 10/22/09 at 1:30pm that E5 had taken R15's cell phone and she (E4) told E5 to return it to R15. E4 stated E5 had taken it home after the incident (10/16/09) and did return it to R15 on 10/22/09. E4 stated residents are allowed to have cell phones. E4 also stated that she spoke with R15 about the incident the day after it happened and that R15 was distraught and crying while giving E4 her statement of the incident. Interview with E5 on 10/21/09 at 3:20pm stated he grabbed R15 from behind and enclosed his arms around her body while restraining R15's arms. E5 stated he took R15 to her room this way. E5 stated he has not had any training in CPI (crisis prevention intervention). E5 said that he just knows what type of action he needs to take when residents begin to act out and it depends on the situation. Interview with E7 on 10/22/09 at 3:00pm stated that around 9:00pm, R15 came to the nurse's station with a tray in her hand. "I didn't know she [R15] was asking a nurse's aide about where to put the tray. I just saw her walking towards the elevator and told her that she couldn't go off the floor again, it's after 9:00. She [R15] said I'm just looking for a place to put the tray and I told her she could give it to me and she threw it across the floor and called me a b----. We started arguing and I told her 'I heard about you and how you can go off at the drop of hat.' That's when she came up and pushed the med cart into me. I	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F9999	Continued From page 49 told her, you are going to stop this attitude and that's when she put up her fist." E7 stated to surveyor that she has been on staff for 3 months and has not had any training on how to handle behaviors from mentally ill residents. 2) R20 has diagnosis to include Paranoid Schizophrenia and mental retardation. Facility abuse investigation reports included a 9/26/09 11:00am incident involving R20 and E8 (nurse aide). This abuse investigative report included that on 9/26/09 at 11:00am, in the 3rd floor shower room, E8 physically pushed R20 and was speaking inappropriately calling R20 a racial name ("N--ga') when the resident came towards her in a threaten manner. This investigation report included written statements from staff that witnessed the abuse. - E9's (nurse) 9/26/09 written statement includes, "R20 was found walking in the hallway and then suddenly approached E8 who was standing outside the nurses station. R20 appeared agitated and E8 approached R20 in a threatening manner, yelling and physically pushing R20 toward the dining room. This action made R20 fight back. E9 spoke to E8 about the correct way to direct R20 to the dining room and E8 responded by saying, 'I feel like I just have to restrain him.' E8 insisted E9 send R20 to the hospital immediately and became threatening toward E9 stating 'Do you want me to get ghetto?', etc." - E10's, psychiatric rehabilitation service assistant (PRSA), 9/26/09 written statement includes "E8 hit / pushes R20 and yells and screams at E9, saying Do you want me to get ghetto?, in a threatening manner. E8 was very	F9999		

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ignorant and sarcastic to E9 in a very very disrespectful way."

- E11's (PRSA), 9/26/09 written statement includes, "I heard E8 hollering out loud this (N--ga), wont let me shower him." E8 observed to walk out of the shower room and leave R20 alone and naked. E11 called for other staff to assist R20 getting dressed.

During a 10/29/09 9:35AM telephone interview, E4 stated that E8 was immediately terminated 9/26/09 for two reasons: (1) for physically pushing and yelling at R20 and (2) for insubordination toward the nurse (E9).

Facility's policy and procedures failed to include specific procedures/interventions for dealing with escalating behaviors.

During 10/21/09 interview with E4 (psycho social rehab director), E4 said that facility does not provide CPI to facility staff. E4 also said that she had CPI training years ago but E4 was unable to provide any documentation proving her attendance and certification in crisis intervention.

E8's personnel records and inservice attendance sign in records failed to include any training on how to handle aggressive behaviors or crisis prevention interventions.

During a 10/29/09 10AM telephone interview E3 (ADON), stated that E8 had only worked 4-6 months at the facility. Review of E8's work history documented no experience with Mental illness.

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