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	145938	A. BUILDING _____ B. WING _____	02/09/2010

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KENWOOD HEALTHCARE CENTER	6125 SOUTH KENWOOD CHICAGO, IL 60637

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F 516	Continued From page 132 asked for on 1/21/10 during the daily status meeting. No policy was presented during survey.	F 516		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1620a) 300.1220b)2) 300.1220b)3) 300.1220b)7) 300.3240a) 300.4020a) 300.4030c) 300.4030d) 300.4030e) 300.1210 General Requirements ofr Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial 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. 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. These medications shall be administered as ordered by the licensed prescriber and at the disignated time.	F9999		

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F9999	Continued From page 133 300.1220 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, snesory and physical 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. 7) Coordinating the care and services provided to residents in the nursing facility. 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). 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 Section 300.4030 Individualized Treatment Plan	F9999		

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F9999	Continued From page 134 for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S 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 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	F9999		

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F9999	Continued From page 135 intervention; and 4) Identification of the staff responsible for implementing each specific intervention. These requirements are not met as evidenced by: A. Based on observations, interviews and record reviews the facility neglected to provide Psychiatric Rehabilitate Services to 11 residents out of a sample of 30 residents (R6, R8, R29, R7, R1, R11, R3, R10, R9, R2,and R13). The facility neglected to develop a comprehensive treatment plan with interventions for dealing with physical and verbal aggression for R6, R29, R1, R8, R7, R3, R9, R21, R11, and R10. The facility neglected to provide training and education to staff on aggressive behavior and mental illness. The facility failed to assure that direct care staff was knowledgeable in the appropriate interventions to diffuse and prevent physically aggressive behavior. This failure resulted in numerous physical altercations between residents: R1, R6, R29, R8, R7, R21, and R29. This failure resulted in R29 harming R6 with a scissors when both residents were on monitoring status from previous fights on December 15, 2009. The facility neglected to update and revise treatment plans after resident refusal to attend programs and develop alternatives to promote psychiatric rehab for R1, R11, R2, R13, R27, R24, and R15. The facility failed to train staff to address aggressive behavior and implement interventions for behavior for R3, R8, R21. The facility failed to develop and implement policies and procedures for assessing, tracking	F9999		

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F9999	Continued From page 136 and treating maladaptive behaviors in the facility from fighting to treatment noncompliance. This failure has the potential to affect residents in the facility with severe mental illness and behavior issues. The facility lacked therapeutic groups for residents with issues related to anger, aggression, medication compliance, and coping mechanisms. E1 (Administrator) was interviewed and stated that the Case Manager has the responsibilities to conduct in house groups and that groups are developed based on resident needs after assessments are done. Per review of facility groups, the facility lacked in house groups and therapy dealing with anger management. According to the facility's CMS-672 (Resident Census and Condition), the facility has 145 residents with Psychiatric diagnosis out of a total census of 232, and 122 residents receiving health rehabilitative services for MI/MR (Mentally Ill/ Mentally Retarded). The facility also identified 133 residents in the building with behavioral symptoms and of them 133 residents on behavior management programs. Review of facility incident and accident reports for the past 6 months indicated numerous fights and physical aggression between residents. Many of these fights were noted to happen either on the facility's elevator or outdoor smoking area. After such incidents, the policy of the facility was to notify the resident's psychiatrist of the incident with 72 hour observation. During the survey, E1 was asked several times for the policy and finally stated on January 21 and 22, 2010 that the facility did not have a written policy for "72 hour	F9999		

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F9999	Continued From page 137 observation." A three line policy was provided to the survey team on January 22, 2010. Interview with Z1 (Psychiatrist) revealed that the order for 72 hour observation was to provide increased monitoring and supervision of residents after incidents. The facility lacked a systematic approach to monitoring and updating treatment plans after significant incidents. The direct care staff on the major Psychiatric unit (6th Floor) were mostly new employees with little to no previous work experience in dealing with residents with severe mental illness. The facility lacked policies and procedures for assessing residents upon admission for physical aggression risk and communicating this to staff working on the unit. After incidents, residents were not monitored and continued behaviors without consequences. B. Based on observations, interviews and record review the facility neglected to monitor residents on the Psychiatric Unit for unsafe smoking, neglected to assure that resident were smoking only in designated areas and failed to assess residents upon admission for smoking risk and implement a care plan with interventions for unsafe smokers issues. R1's room was noted with smoke and cigarettes and R1 admitted to the survey team and the facility staff that he was smoking in bed in his room. R8, R33, and R6 were also noted with evidence of smoking in nonauthorized areas without care plans or staff intervetnitons. This deficient practice places all residents at risk for injury related to possible fire safety. C. Based on observations, record reviews and interviews the facility neglected to prevent one resident in the sample, R24 from leaving the	F9999		

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F9999	Continued From page 138 facility. R24 requires total care and has a Guardian that gave specific orders that R24 is not to leave the facility without staff supervision and was not to have contact with family members. In addition, the facility neglected to update and revise R24's plan of care after one failed attempt at elopement. This failure resulted in R24 leaving the facility without the consent of the Guardian and going to the family home. The resident was noted to leave the facility without the knowledge of staff and travel during inclement weather to her family home. When notified, the facility did not retrieve the resident until the next day. In addition, the facility failed to provide supervision to R24 by failing to inform the Guardian of R24's sexual relations with a peer and failed to provide sex education to R24. Findings include: A.1. R29 was discharged from the facility on December 17, 2009 after an incident involving R6. The facility decided not to let R29 return to the facility because of the continuing conflict with R6. According to E1 during daily meeting of January 21, 2010, R29 was stating to hospital staff that she would "kill R6." A review of R29's nursing notes and universal progress notes for September 18, 2009 indicate that R29 had a previous incident at the day program in which R29 attempted to choke another client for calling her a name. The resident was noted to be counseled at the time of the incident. R29's care plan dated October 2, 2009 was reviewed during the survey of January 19, 20, 21, and 22 and there is no evidence that this treatment plan was updated for R29's physically aggressive behavior on September 18, 2009. The facility was asked several times for the care plan and it was not	F9999		

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F9999	Continued From page 139 provided. On December 15, 2009 at 2:00pm, R29 and R6 were involved in an altercation in the elevator in which according to the facility's incident report, R6 struck R29 from behind on the head. According to R6 (during interview on January 19, 2010), R29 ran over his toes with her wheel chair and would not apologize. R6 stated to surveyor that he hit R29 on the head because she would not say sorry and she just kept trying to run over his toes. The facility's incident report indicates that the local police were notified and that Z1 gave orders for 72 hour observation for both R6 and R29. Both residents were also given PRN (as needed) medication to calm them down. Later that same day at 3:15pm, R29 went into the activity department and picked up a pair of scissors and went after R6. R6 was noted to sustain an injury to the buttocks. R29 was sent out to the hospital for treatment after the incident. These two incidents happened within 90 minutes of each other. Both residents were noted to have orders for "72 hour observation" which according to Z1 is increased monitoring and supervision of the resident. The staff allowed these two residents to have contact with each other after a significant outburst. The staff allowed R29 to harm R6 with a scissors. During the survey of January 19, 20, 21, and 22, R6 was again noted to become agitated and "snatched money being passed out to residents and threw it in the face of staff." R6 was interviewed and admitted to hitting R29 on the elevator and that R29 just "came at me with the scissors and stabbed my butt." R6 admitted during the interview that he was "angry with staff" about his potential discharge and he was also	F9999		

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F9999	Continued From page 140 upset about his medications and his care and treatment by Z1. Once again, R6 admitted to throwing items at the staff because his community passes were revoked. R6 was discharged by the facility on January 26, 2010. It was also noted during record review that R6 is an offender with a conviction in his record of battery and assault. E10 (Case Worker/Social Worker) was interviewed on January 19, 2010 at 3:30pm and stated she was unaware of the recent behavior issue with R6. In addition, E10 stated that she knew that R6 was involved in the incident with R29. E10 also stated that she was fairly new to the facility and was still learning about all of the residents. A review of R6's care plan dated October 29, 2009 indicates that behavior has been an issue for R6. The problem is stated as, "resident can be easily agitated and escalates becoming verbally and physically aggressive towards staff and peers." Interventions are listed as, "Provide 1 to 1," "Encourage resident to use coping skills," "Monitor and make sure resident is compliant with medicine" and "Encourage resident to attend therapeutic groups." Resident has another care plan dated August 9, 2009 concerning aggressive behavior that was noted with no changes in interventions or approaches. On October 21, 2009, R6 was involved with another incident in which R6 "slapped his peer for calling him a name." R6 is also a known offender with a history of assault. The facility failed to revise R6's treatment plan after he was physically aggressive on December 15, 2009 and October 21, 2009. The	F9999		

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F9999	Continued From page 141 interventions were not updated or revised after a significant altercation. In addition, the staff failed to supervise R6 and R29 after a physical altercation. E1 and E2 were asked during the daily meeting of January 21 and 22, 2010 about the 72 Observation policies. E1 stated that the facility did not have a policy. Z1 stated during interview that he thought the policy was to monitor closely the resident after a behavior to prevent additional behaviors. Direct care staff on the unit were unaware of the procedure for monitoring residents after behavior. E11 (Psy Tech), E12 (Psy Tech), and E13 (Psy Tech) were interviewed on January 20, 2010 and stated they were given inservice training on breaking up fights but were unaware of the procedure for "72 hour" observation. All three of these staff member were new employees and lacked previous experience in dealing with clients with mental illness. 2. R8 is a 45 year old resident admitted to the facility on November 7, 2008 with the diagnosis of Schizo Affective Disorder. R8 is also a listed offender. On December 12, 2009, R8 was hit for stealing R7's boots. R8 has a history of roaming around the unit and going into other resident rooms. In addition, R8 also has a behavior of inappropriate smoking in his room and other non designated areas in the facility. R8 was involved in an incident on July 5, 2009 in the elevator in which he hit a staff person in the face. On July 15, 2009, R8 threatened another resident with a knife. On May 26, 2009, R8 was involved in another incident in the facility elevator involving several other residents. R8 has a history of poor personal hygiene and noncompliance with his treatment plan. R8 has a history of substance abuse and is a listed offender. A review of the	F9999		

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F9999	Continued From page 142 MDS (Minimum Data Set) Assessment dated November 7, 2009 indicates R8 has daily behavior problems that are not easily altered. The facility failed to supervise R8 from wandering and taking others' belongings that resulted in R8 being hit by R7. 3. R21 is a 53 year old female with a long history of Mental Illness and has been a resident in numerous other facilities. R21 is also a listed offender. R21 was first admitted to the facility on June 16, 2008 and has a diagnosis of Bipolar Disorder. In the past 4 months R21 has been involved in numerous physical altercations and has had numerous behaviors on and off the unit. The following incidents were noted in R21's nursing and Universal notes: -On October 20, 2009, R21 was noted with "bizarre behavior" and urinated on the elevator and laid on the floor of the elevator and refused to leave. Resident was given a PRN medication. -On October 22, 2009, R21 was noted with "aggressive behavior towards staff" and was given a PRN medication. Later, R21 continued with the behavior and the Psychiatrist was called and R21 was sent out to the Psychiatric Hospital for treatment and was readmitted to the facility on October 29, 2009. -On December 1, 2009, R21 hit another resident with a garbage can on the smoking patio. -On December 20, 2009, R21 was noted with increasing anxiety and was given a PRN (As needed) medication. -On December 30, 2009, R21 hit another resident after he touched her while waiting for the elevator. -On January 2, 2010, R21 was noted with loud and behavior -On January 16, 2010 R21 was involved in an	F9999		

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F9999	Continued From page 143 incident of physical aggression on the elevator -On January 19, 2010 R21 was involved in an incident in which R21 allegedly hit another resident During the survey, R21 was observed to be dressed in the same clothing for 3 out of 4 days and exhibited numerous behaviors on the unit such as the following: -R21 was observed on January 21, 2010 in the 6th floor day room. The morning group was scheduled to start and R21 refused to leave the area. R21 became loud and argumentative with staff attempting to set up the group. R21 was noted to swear and refuse to leave. R21 stated to staff, "If you touch me I will beat your ass!" None of the staff present were able to redirect R21 and the staff present were not knowledgeable in methods for dealing with behaviors. E11 attempted numerous times to get R21 to leave the room, yet R21 kept on with threatening behavior. E11 finally walked away. R21 finally left the room but not without disrupting the group. R21 continued with the disruptive behavior and was given a PRN medication. -On 1/20/10 at 2:05 p.m., R21 and R27, both roommates, were yelling at each other about one wearing the other's jacket. When the psych tech intervened, it just made both angrier. The jacket was removed from R27, who became very upset and needed a jacket so she could outside for a cigarette smoke. A smaller sized jacket was given to her from the caseworker's office and both residents were allowed to go out for a smoke. Later at 2:21p.m., R21 was at the 6th floor nurses' station complaining about a previous memory from her childhood (sexual assault by a	F9999		

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F9999	Continued From page 144 family member) when she screamed at another male resident because he said something to her. Staff were present but failed to re-direct. A review of R21's MDS for 12-3-09 codes R21 as having behaviors in the area of resisting care, verbal and physical behaviors. R21's care plan has not been revised with appropriate interventions for her aggressive behavior. The plan of care was not modified after acute hospitalization or upon quarterly review. R21's plan of care did not address interventions for staff to utilize during behavioral outburst. 4. R1 is a 39 year old male admitted to the facility on October 7, 2009 with the following diagnosis: Bipolar Disorder and Impulsive Behavior. R1 stated during interview with surveyor that he had been in numerous facilities and had issues with "anxiety." Per nursing notes, R1 was noted to refuse to have his blood drawn for lab values on November 27 and November 23, 2009. The physician uses these values to evaluate the levels of medication. R1 was observed throughout the survey to either be eating or sleeping. R1 was observed with evidence of smoking in his room during the survey of January 19, 2010 and admitted to the surveyors that he had been smoking. R1 was noted to get agitated and upset with a facility nurse during medication pass observation on January 19, 2010. On January 10, 2010, R1 was involved in a physical altercation with another resident in the dining room and hit the female resident over a food item. The resident was counseled. R1 was involved in another incident on January 20, 2010. R1 stated numerous times during interview with the survey team that he was "so unhappy, and I don't want to be here." R1	F9999		

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F9999	Continued From page 145 stated he did not need the prescribed medications and he was, "depressed." A review of the care plan dated October 13, 2009 indicates that the treatment plan was not updated or revised after the incident of January 10, 2010. The interventions have not been adjusted nor have the goals of being free from aggressive behavior. 5. R11 is a 54 year old, ambulatory male who was admitted to the facility on 6/23/08 and re-admitted on 12/7/09 per his face sheet. Review of the physician order sheet (P.O.S.) documents R11's diagnoses include paranoid schizophrenia, seizure/epilepsy disorder and Schizo-affective disorder. His medications include Risperdal, Clozapine and Dilantin. Per the December '09 MDS and RAPS, R11 is oriented times three with delusional thoughts and repetitive statements. R11 has some minimum cognition loss. Throughout the week, R11 walked the facility talking to himself and anyone who would listen. It was the same thing over and over, about people stealing from him, he should be in a veteran home and he has connection to high powered police personnel from his past neighborhood. R11 was restless and never stayed too long in one place. R11 observed to wander in and out of programming not participating and grabbing snacks, smoking outside in the patio and not eating the noon meals because he claimed not to be hungry. Review of the universal progress notes 12/23/09 and his care plan contradict each other. The care plan (12/30/09) documents R11 resists attending	F9999		

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F9999	Continued From page 146 day programs and therapeutic programs and is repetitive about items taken from him. The universal note documents R11 continues to go to structured groups on the unit and can be re-directed when he exhibits verbal aggression. The universal progress notes (11/5/09, 11/30/09, 12/1/09, 12/4/09, 12/17/09, 12/21/09) document verbal and physical altercations with peers. Review of the facility's incident reports document R11 involved in two fights on 11/29/09. R11 verbally and physically attacked a male peer in the 1st floor dining room. Later, in the outside patio, R11 was involved in a verbal and physical altercation with R10, R19 and two other residents. Review of R11's care plan documents his non-compliance with day programming, unsafe smoking in the facility, verbal and physical aggression toward others and refusal to attend activities. The care plan documents that R11 only wants to smoke and watch television. There was nothing in the care plan about him being an identified offender. Review of the State's list of identified offenders had him listed but the facility failed to provide a background check on him. The approaches are to counsel resident on compliance with facility's rules, give medication to calm resident and/or give the resident a cigarette to calm down or as a reward. This was confirmed by E10 on 1/20/10 at 1:35 p.m.. There have been no changes to these approaches when proven not to be working due to R11's continuous non-compliance with smoking, verbal and physical altercations and no attendance to programs. The approaches have been the same since admission. 6. R3 is 46 year old, ambulatory male who was	F9999		

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F9999	Continued From page 147 admitted to the facility on 1/27/09 with diagnoses that includes Schizo-affective disorder, substance abuse and post-traumatic stress disorder per R3's face sheet. Review of the current physician order sheet (POS) documents medications to include Zyprexa and Trazodone. R3 has been assessed to be oriented times three (person, place and time) with no cognition loss per the October '09 MDS (minimum data set) and RAPs (resident assessment protocol). Throughout the week, R3 was observed to be wandering the facility, never attending any programming, or to be out of facility on pass. On 1/20/10 at 10:00 a.m., R3 stated that he attends the in-house programming five days a week, Monday through Friday at 10:30 a.m. to 11:30 a.m., and that he would be attending today. R3 stated he works Monday, Wednesday and Friday for 1.5 hours each day in the Safe Harbor Work Program (An in-house work program for residents). R3 stated he works in the Central Supply and stocks the clean utility rooms with supplies. R3 stated that he gets paid $6 a week for this job. R3 denied any physical altercation with any other residents including R9 on 1/1/10. R3 stated he was upset with R9 for changing his television program. R3 stated he had done jail time once for a short period of time. During this interview at the 6th floor nurses' station, R3 was observed dressed in light blue hospital-type scrubs (shirt and pants), a name tag dangling from his neck and a back support belt with shoulder straps. At first, the surveyor thought he was an employee until another resident pointed him out as R3. Later at 11:25 a.m., R3 was dressed in a long sleeve red shirt, green khakis, a name tag and back support belt; the same clothing (red shirt and name tag) required by the	F9999		

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F9999	Continued From page 148 facility's psychiatric technicians (psych tech) to wear when working. On 1/19/10 during the initial tour, R3 was angry and slammed his room door in the face of fellow surveyors. Later, R3 was seen yelling at peers to shut up and sit down in the 6th floor dayroom. At first, because of his dress apparel, surveyors believed him to be an employee. Review of January '10 social service notes and nurses' notes document R3 is alert, oriented times three and displays continuous aggressive behavior and is non-compliant with the facility's rules and leaves the facility as he wishes and without permission. R3 is easily agitated, uses profanity and yells threats of doing bodily harm to others. The Universal progress notes document physical and verbal altercations with residents and/or staff on 9/7/09, 10/23/09, 10/24/09, 12/3/09, and 1/1/10. The 9/7/09 universal note documents R3 exchanged sex for a cigarette with female resident then recanted the offer to give her a cigarette after having sex with her. The 10/23/09 note documents R3 pushed another resident against the wall of the elevator and a 10/24/09 note documents verbal aggression from R3 toward staff when he was re-directed to follow the facility's rule of not taking food from the dining area. R3 threatened to have his sons come to the facility to "get" them. The 12/3/09 note documents R3 becoming verbally aggressive toward a male peer. The 1/1/10 note documents a physical altercation with his then roommate, R9. R9 stated that R3 hit him in the face. R3 claimed he only yelled at him to shut up because R9 was making threatening statements to R3. Another female resident witnessed R3 hit R9 when she was entering their room.	F9999		

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F9999	Continued From page 149 On 1/20/10, R19 stated R3 threatened him with bodily harm when he was on the elevator. R3's care plan (11/2/09) documents he refuses the day program, solicits sex from peers, does not respond well to re-direction, becomes fixated and threatening toward staff, has a history of drug abuse, and is verbally and physically abusive. The care plan documents he is assessed for low risk and requires supervision in an open facility due to being on parole for possession of cannabis. R3 is an identified offender but it is not in his care plan. Review of R3's background check documents his offenses as possession of controlled substance, retail theft, aggravated assault, and driving under the influence and domestic battery. The criminal history analysis report documents him as "moderate: risk." The approaches in the care plan are to re-direct maladaptive behaviors, counsel him on appropriate behaviors and if needed, give a PRN (as needed) medication to calm the resident's behavior. There has been no changes in the approaches noted not to be working for this resident. Interviews with caseworker, E10 on 1/20/10 at 1:35 p.m. and E9 on 1/20/10 confirm these approaches. Review of the facility's list of residents on the in-house work program documents R3 works in the Central Supply. 7. R10 is a 46 year old, ambulatory male who was admitted to the facility on 7/25/09 with diagnoses that includes Bipolar disorder, Schizo-affective disorder and acute psychosis per the face sheet. Review of the current POS	F9999		

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F9999	Continued From page 150 documents his medications to include Depakote, Clozapine and Haldol. R10 is oriented times three with minimum cognition loss per the October '09 MDS, RAPs and current care plan. Review of the universal notes document on 9/11/09 that R10 was found with cannabis on him while at the outside day program and the local police were called. The progress note dated 9/19/09 documents R10 involved in a physical altercation with 2 other residents in the outside patio. R10 claimed he pushed a female resident who would not get out of his way and staff intervened. As staff and R10 were all walking inside to the facility, R10 hit a male peer in the back of his head because this other male peer was making comments to him. R10 was counseled and received medication to calm down. The nurses' note dated 12/1/09 documents R10 claiming he was involved in a physical altercation with a male peer in the outside patio. No injuries were noted. The universal progress note dated 12/4/09 documents R10 being involved in a physical altercation on 11/29/09. Review of the facility's incident report dated 11/29/09 documents a physical altercation between R19, R11, 2 other male peers and R10. This altercation took place in the outside patio. R10's current care plan (10/27/09) documents non-compliance with medications, has internal stimuli, response to auditory hallucinations, has delusions, has served time in prison but does not say for what offense, prefers independent activities and attempts to medicate himself so has limited community access. Review of R10's background check documents his offenses as sexual assault, criminal damage and trespassing, and aggravated battery. The	F9999		

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F9999	Continued From page 151 criminal history analysis report documents R10 to be high risk. R10 does have a private room but it is several doors down from the nurses' station. R10's floor also houses female residents. Review of the facility's list of residents on pass restriction does not have R10's name on it. In fact, there are only 5 names out of 232 residents residing in the facility on this list. On 1/21/10 at 4:00 p.m., E7 (director of the psych/social department for 5th and 6th floors) stated that restriction means the 5 residents on the list can leave the facility with escort and not independently. E7 stated all other resident can leave without an escort. Throughout the week, whenever a resident wanted to leave the facility, he would approach staff and ask for a pass. The pass would get them access to the community. No residents were observed to be refused passes. B.1. During the orientation tour of January 19, 2010 at 10:00am with E9 (Case Worker), Room 614 was noted with matches and a strong odor of cigarette smoke, and cigarette ashes on the toilet seat. R1, the resident in the room admitted to surveyors that he had been smoking. R1 was observed to be lying in bed and there was a pungent odor of smoke in the room. Later that afternoon, R1 was again observed in his room with a strong odor of cigarette smoke in the room. In addition, the next day during interview in the first floor dining room, R1 was noted with an unlit cigarette in his hands and was waving this in front of the surveyor. In addition the following rooms on the sixth floor were noted with evidence of smoking.	F9999		

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F9999	Continued From page 152 - Room 611 there was a strong odor of cigarette smoke. - Room 612 was noted with a cup under the bed with cigarette butts - Room 616 was noted with a cigarette butt on the floor - Room 617 was noted with cigarette ashes on the toilet seat - Room 624 was noted with cigarette butt on the floor - Room 623 was noted with cigarette ashes in the bathroom - Room 622 was noted with a cigarette butt on the bed, a used Oxygen Concentrator with Unlabeled tubing - Room 619 with odors of smoke and ashes on the toilet seat and loose tiles in the bathroom - Room 618 was noted with ashes on the toilet seat, dark cigarette marks on the wall of the Bathroom - Room 610 was noted with ashes on the toilet - Room 607 was noted with burns on the toilet seat and ashes on the floor - Room 604 was noted with cigarette ashes on the sides and top of toilet seat - Room 602 was noted with cigarette ashes on the floor. The sixth floor houses mostly residents with Serious Mental Illness and most residents are up and about the unit and must leave the sixth floor and go outside to smoke. Most of the residents on the sixth floor smoke cigarettes. 2. During the environmental tour on 1/21/10 between 9:50 a.m. to 12:45 p.m. with E14 (Maintenance Director), E15 (Environmental Director) and E16 (Maintenance staff), the following evidence of unsafe smoking was noted.	F9999		

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F9999	Continued From page 153 The floors were coated with black and green sticky substance, dirt, cobwebs, chemical corrosion, rust, paper, cigarette butts and ashes and/or paper debris in the Central Supply room, Medical Records room, Laundry room, the basement resident storage room, the service elevator, the 4th and 6th floors soiled utility rooms, the 6th floor ice machine room and the 5th floor wheel-chair storage room. The cigarette ashes, butts and cigarette smell were present in the 4th floor North and South, and 5th and 6th floor Common Bathrooms. These doors are kept locked but all staff have keys to these rooms. R33 was found in the locked 4th floor North Common shower area sitting on a plastic chair. There was cigarette smell present in the toilet area. In addition, there were cigarette burns on the toilet seat and a butt in the toilet. R33 appeared confused. Review of R33's current care plan documents non-compliance with smoking and has diminished cognition due to dementia/Alzheimer's disease. Staff failed to explain how R33 got into the room. 3. The facility failed to implement an assessment upon admission and a follow up plan for assuring safe smoking in the facility. Interview with E10 (Case worker) on January 19, 2010 at 3:15pm indicated that the only smoking area in the facility is located outside on the patio. E10 stated that staff does not hold smoking materials for residents and that staff is notified of resident smoking issues. E10 is also the case worker for R1 who admitted to surveyors during the tour that he had been smoking in his room. E10 was unaware of R1's smoking issues, yet R1 had a care plan for smoking dated December, 2009.	F9999		

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F9999	Continued From page 154 E10 was not aware of any policy or procedure for screening residents for high risk smoking. E10 stated, "we monitor the residents." 4. E7 (Program Director) stated during interview of January 21, 2010 that the facility recently started the smoking policy and procedure. The policy had been started on the week prior to the survey. E1 (Administrator) also stated that this was a new policy for the facility. E1 also confirmed that a smoking risk assessment is not done upon admission. 5. When a resident is found to be non compliant with the smoking policy, the facility does not impose consequences for that behavior. Smoking materials are not held and care plans are not updated or revised to deal with improper smoking behavior. For example, R1's care plan was not revised after the facility became aware of improper smoking during the survey of January and R1 was observed with smoking material after these observations. R8 is another known smoker with noted evidence of smoking in the room as evidenced by cigarette ashes and marks on the bathroom wall. Later that same day at 2:25pm, evidence of smoking was once again noted in R8's room R8 was observed with care plan dated November 3, 2008 that had no change in interventions or approaches since started. The facility failed to follow up and devise a plan to assure that R8 smokes safely. Universal progress notes dated February 13, 2009 state the following: "Resident continuously smokes in this facility and when confronted acts as if he doesn't understand what the problem is or denies he was smoking." R8's issues with smoking have been on going, yet R8 is still allowed to carry and hold his own smoking materials. R6 is another	F9999		

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F9999	Continued From page 155 resident that is a known smoker that was observed with evidence in his room. R6's plan of care contained no care plan for unsafe smoking. C. R24 was originally admitted to the facility on 5/2/09 with diagnoses that included Bipolar, Schizoaffective Disorder, History of Motor Vehicle Accident-Head Injury, Urinary Incontinence and Wheelchair Bound. Upon admission, staff documented that the resident had a left arm amputation, right sided weakness, used a wheelchair for mobility and was in need of staff assistance to pivot and transfer as well as being incontinent of bowel and bladder. R24 has a Guardian who contacted the facility on 7/9/09 (as documented in the facility record) to instruct the facility that R24 was not to have any family contact by phone calls or visits. The Guardian specifically stated that R24's Mother was not to have any contact with the resident. On 7/16/09 the resident's Guardian met with the facility to also instruct that the resident was not to have any passes (into the community) other than social events and with supervision until further notice. At that time the Guardian reiterated that there was not to be any family contact with R24. On 7/14/09 Social Service staff documents informing R24 of the visitation/contact restriction. On two separate occasions (7/30/09 and 12/16/09) R24 eloped from the facility to travel to her Mother's home. Social Service Note of 7/31/09 documents that at approximately 5:00PM on 7/30/09 R24 had left the facility and gone to her mother's home where she spent the night. On 12/16/09 R24 again left the facility without staff	F9999		

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knowledge, went to her mother's house and spent the night. During both incidents, the facility knew where the resident was; the resident's mother had contacted the facility to inform them of R24's whereabouts, but the facility did not immediately retrieve her. No measures were put into place after the elopement of 7/30/09 to prevent any further such occurrence. It was not until the elopement of 12/16/09 that the facility put any measures into place to prevent R24 from further elopement attempts even though upon her return to the facility 7/31/09, the resident informed the facility that she did not want to stay at the facility and would leave again.

When interviewed on 12/24/09 E5 (Social Service Director) and on 1/22/10, E26 (nurse) each admitted that R24 had eloped from the facility in the past. E5 stated that on 12/16/09, R24 left the facility and went to her mother's house where she stayed overnight. The next day the Director of Nurses (E2) went with staff to pick up the resident.

Additionally, on 1/22/10 during interview, E26 stated that she had been the nurse working on 12/16/09 when R24 left. As stated by E26, R24 had requested a pass to the community on 12/16/09, but was refused and was informed that she was on a pass restriction because her Guardian did not was her to go out without supervision. E26 continued on to say that R24 had been present for her 5:00PM medications, but was missing when staff looked for her later. As of now, E26 stated that R24 will sit at the nursing station or by the elevator in an attempt to leave the floor. The surveyor did actually observe R24 as the resident sat by the elevator. There was not an alarm sounding to announce her

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F9999	Continued From page 157 presence. It was not until the elopement of 12/16/09 that the facility did initiate a care plan to address this behavior, nor did the care plan actually provide approaches/interventions to describe any actions that would be taken to prevent further elopement attempts. One of the approaches listed required that the resident attend mood/group 3 times weekly. The most recent Minimum Data Set (MDS) for R24 dated 10/11/09 assessed the resident as having modified independence in Cognitive Skills for Daily Decision Making, and as totally dependent in bed mobility, transfers, eating toilet use and personal hygiene and bathing. The resident was assessed as unable to walk, requiring the use of a wheelchair for mobility/locomotion and experiencing some loss in range of motion and voluntary movement of extremities. The MDS also assessed R24's Conditions/diseases as making her cognitive, ADL (Activity of Daily Living) , mood or behavior patterns unstable. When interviewed on 12/24/09, R24 admitted that she had left the facility 12/16/09 to visit her mother; that she had wanted to see her for Christmas and had gone to her Mom's house. R24 also admitted that she had not told anyone from the facility that she was going. R24 stated that she had left the facility through the front lobby door and that the receptionist had looked at her as she left. When asked what she had been wearing, R24 stated that she had had on an orange fleece and pants, but no panties. Her jacket was across the back of her wheelchair.	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 158 The facility neglected to provide the necessary supervision to prevent R24 from leaving the facility. The resident continued on to say that she had also left the facility during the summer to go visit her Mom, but was unable to remember the day/date. She did say that she had spent the night that time also. During the interview, the surveyor noted that R24 had a left arm below elbow amputation, had right arm paralysis and weakness of the lower extremities. R24 denied attending any in house groups since she returned to the facility last month. R24 continued on to inform the surveyor that she was sexually active in the facility. When asked with whom, R24 replied R6 and named the resident by his first name only. When asked how it occurred, R24 stated that one night she had been sleeping in her room, woke up and he was standing over her bed. When she asked him what he wanted, he replied that he wanted to have sex with her and R24 said OK. R24 denied knowing R6's last name, denied that he was her boyfriend, and denied having used any condoms/protection during the sexual encounter. R24 informed the surveyor that R6 still lives at the facility, but that they had not had any further sexual encounters. R24 was unable to tell the surveyor the day this had happened, but did say it had not been too long ago. When interviewed on 12/24/09 regarding residents having sexual relations in the facility, E5 stated that if it is consensual, sex is permitted, that residents are asked to be polite and respectful of roommates. E5 informed the	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	02/09/2010

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F9999	Continued From page 159 surveyor that staff teaches residents about safe sex at Resident Council Meetings and in one to ones (if staff becomes aware). E5 provides condoms to resident who request them and they are available at nursing stations. E5 was unaware whether R24 was having sex with peers and as of 1/22/10 was unable to provide verification that the resident had been educated on safe sex. E5 provided the surveyor with the full name of R6. This surveyor informed E5 that R24 alleges to have had sex with R6. Nurses Notes for R24, dated 7/30/09, documents R24 as being "out of facility without authorization. Mother called the facility stating that the resident was with her at home...mother stated that she would keep resident till next day." The resident did not return to the facility until 7/31/09 at 7:00PM. At that time the resident was agitated and stated that she did not want to be at the facility and would leave again. Even though the resident had already proven to staff that she was able to leave the facility undetected, the facility failed to put into place measures to prevent future elopements and thus ensure R24's safety. Nursing Note of 12/16/09 at 4:00PM documented R24's request for a pass to leave the facility, but was denied and informed of the reason for the denial. At 7:15PM of the same day, staff documented that the resident was observed getting onto the elevator to smoke. At 10:00PM the same day staff noted that the resident was not in her room during rounds. Nursing Supervisor, MD and Police were notified. It was not until the next day, 12/17/09 at 11:30AM that the facility learned the location of R24 and it was only through the Police contacting the facility to inform them that the resident was at her mother's	F9999		

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F9999	Continued From page 160 home. The resident returned to the facility on 12/17/09 at 1:00PM; was physically and verbally abusive and transferred to the hospital. While at the hospital, R24 was assessed as having impaired judgment and lacking insight. On 12/21/09 R24 returned to the facility from the hospital. A monitoring bracelet was placed onto the resident's ankle. When reinterviewed on 1/21/10 R24 gave the surveyor the same information as stated on 12/24/09 during our initial interview. R24 stated that she had had on an orange fleece jacket; she did have on pants, but no panties when she left the facility last month (December, 2009). R24 admitted to continuing to have sex with other residents in her room "and other places" and not using condoms or protection. The resident informed the surveyor that since last month she now has to wear a bracelet on her ankle and showed the surveyor the ankle monitor. R24 also stated that she now has to have staff accompany her to smoke, and has not been allowed to leave the facility. The resident restated that she does not attend any in house groups. R24 continued on to admit that she had also left the facility a couple of times before during the summer, but was unable to remember the dates of those times. When asked what she would have done if her mother had not returned home last month when she left the facility without permission R24 stated that she would have slept on the porch until her mom got home. On 1/21/10 when interviewed, E18 (nurse) stated	F9999		

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F9999	Continued From page 161	F9999		

that since R24's elopement last month the resident is now escorted off the floor and through out the building. E18 denied R24 having a day pass and informed the surveyor that the resident now wears a monitoring device. E18 stated that R24 is still sexually active and will initiate the contacts.

E19 (Certified Nurses Assistant) was interviewed on 1/21/2010 and stated that R24 has to be fed and requires total care, is non ambulatory requiring a wheelchair for mobility. R24 was described as in need of hands on assistance to transfer. E19 was unaware whether R19 is sexually active.

While interviewing staff the surveyor observed R24 as the resident got onto the elevator with staff. R24 was going to smoke. After getting off the elevator, staff escorted R24 and other residents into the lobby and through a glass door onto the porch. This surveyor followed R24 to the glass door which was opened by a resident; there was not any alarm that sounded. When asked, E2 stated that there are not any alarms at the elevators, but that the lobby doors are set to alarm when the resident's monitoring device gets close. The surveyor informed E2 that the lobby doors did not alarm when R24 went through them.

When interviewed 1/21/10 Z1 (Psychiatrist) informed the surveyor that R24 would not be safe in the community; that she has is impulsive and immature with poor judgment and is depressed. On 1/26/10 and 1/27/10 the surveyor interviewed Z2 (R24's Guardian). Z2 informed the surveyor that she had been aware of the resident's leaving the facility, but had not been aware that the