STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E506	A. BUILDING _____ B. WING _____	C 02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW BEACH CARE CENTER	**7325 SOUTH EXCHANGE CHICAGO, IL 60649**

(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 000	INITIAL COMMENTS Complaint Investigation: 0985397/ IL 45133 - No deficiencies. Incident Report Investigation of 12/09/09/ IL 45441 F223, F323 and F490 . Incident Report Investigation of 01/18/10/ IL 45908 F223, F323 and F490 A partial extended survey was conducted.	F 000		
F 223 SS=J	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that a resident is free from physical abuse by failing to supervise R6, with known history of physically aggressive behavior, resulting in R6 punching another resident (R5) in the face with a closed fist resulting in an injury with a fractured nose. The facility's failure to monitor and periodically re-assess R6's negative behavior led to this serious preventable injury for another resident and caused harm. R6 had been identified by facility as having a history of	F 223		3/1/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 223	Continued From page 1 aggressive and violent behavior prior to this incident. An immediate jeopardy was called on 02/11/10 at 1:00pm with E1 (Administrator), E2 (Director of nurses), E4 (investigative nurse) E5, PRSD (psychiatric rehabilitation service Director) and E7 (admission director). The immediate jeopardy was determined to have begun on 01/18/10 at approximately 5:25pm when R6 punched R5 in the face with a closed fist knocking R5 to the floor, breaking R5's eye glasses and fracturing R5's nose. The Immediate Jeopardy was removed on 02/15/10, however the facility remains out of compliance at severity level 2, to allow the facility to fully implement and evaluate the effectiveness of the new plan. R4, as well has a history of aggressive/violent behavior in the facility. R4's aggression has resulted in 7 physical assaults to residents in the facility. R4 was never separated/moved to another unit to protect 3 residents (R3, R12 and 14) from further abuse, following physical assault. Findings include: 1) Record Review shows that R6 is a 54 year old resident admitted to the facility on 12/28/08 with diagnosis including Schizophrenia. The most recent MDS (minimum data set) dated 01/05/10 indicates R6's cognition is coded as modified. The initial screening done on 12/23/08 identified R6 as mentally ill and receiving psychotropic medications and was approved for nursing facility	F 223		

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F 223	Continued From page 2 level of care. Review of medical record during survey of 02/10/10 through 02/16/10 indicated that R6 has had physically aggressive behaviors toward residents and staff since 2 months after admission. R6 has had aggressive/violent behaviors as follows: -12/2009 = newly admitted to the facility. - 02/11/09 = R6 upset pulled soap dispenser off wall. - 03/25/09 = R6 struck 2 peers (R7 and R8) for no apparent reasons. Interview with E4 (investigative nurse) on 02/11/10 indicated that R6 was hearing voices at the time which told R6 to strike both residents, so R6 slapped R7 and R8 while on the elevator. There was no evidence of psychotropic medication changes or adjustments even though R6 indicated hearing voices at time of abuse to R7 and R8. - 04/01/09 = R6 got out of his chair and hit R9 in the face. Interview with E4 on 02/11/10 indicated that R6 punched R9 in the face with a closed fist. R9 face had some redness and swelling. Per Physician's orders R9 was sent to a local hospital for x-ray of the face. R6 went to hospital psych evaluation. 04/08/09 = readmitted to the facility with new psychotropic medication order. 04/17/09 = A new psychotropic added to R6's medication. 05/21/10 = nurses notes indicated that 2 of R6's	F 223		

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F 223	Continued From page 3 psychotropic medications were discontinued and a new one started. There was no evidence provided that R6 was monitored for tolerance of or signs and symptoms of adverse effects of this new psychotropic medication and the discontinuance of the previous psychotropic medications. - 08/10/09 = R6 on unit very agitated, throwing chairs down hallway, states, he is very frustrated for unknown reasons. R6 noted beating hand on wall. Resident to hospital. -08/15/09 = R6 readmitted to the facility. Facility staff did not provide evidence of a change in R6's medication or treatment plan upon this readmission. - 08/17/09 (2 days after readmit) = R6 agitated, throwing things at staff, in the hallway. -08/20/09 = R6 in smoke room stated he had stuck a cigarette in his left ear. Staff noted small piece of cigarette sticking out from inner ear. R6 to local hospital. -12/08/09 = R6 very agitated complaint of constipation, then picked up chair and threw it down hallway. 01/07/10 = R6 with recent episode of attempting to come into PRSC (psychiatric rehabilitation service co-coordinator) office to attack a female staff member. Aggression was non provoked and unexpected. Code yellow called (a code used by facility staff and announced over the facility's intercom system indicating staff assist needed due to residents' behavior)	F 223		

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F 223	Continued From page 4 01/18/10 = R6 struck R5 in face for no apparent reason. R5 sent to local hospital. X-ray of R5's face revealed a nasal fracture. Interview with E4 regarding this incident indicated that on 01/18/10 a verbal altercation occurred between R5 and R6 while they were in line awaiting Dinner to be served. Staff intervened and R6 appeared to have backed away, but within minutes R6 punched R5 in the face with a closed fist, knocking R5 to the floor and breaking her glasses. E4 continued, "R5 was noted with a laceration to the bridge of her nose, redness to the left eye and a scrape to R5's inner bottom lip. Upon further interview E4 stated, "R5 was sent to the hospital where x-ray showed a broken nose". Facility staff did not provide evidence of a treatment plan for R6 based on these identified areas of aggression, behavior, impulsiveness, anger toward residents and staff . During interview regarding treatment plan for R6, who qualifies under Subpart S(Seriously Mentally Ill), E5 stated we use the resident's care plan as the treatment plan, however surveyor's review of R6's care plan dated 02/8/09 states the following in one narrative paragraph: " R6 has physically abusive behavioral symptoms. R6 destroys facility property when upset. 03/25/09 R6 has displayed physically abusive behaviors toward other residents; hitting peers while on elevators, claiming he was hearing voices that was frustrating him. 04/10/09 R6 physically attacked (punched) a female resident who walked pass him, while R6 was sitting quietly in a chair in front of the 4th floor nurses station because he said the voices that he hears told him to do so. 1/9/10 R6 had physically aggressive incident in which he	F 223		

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F 223	Continued From page 5 attempted to attack a female staff member. Incident was unprovoked and expected. Male staff member (first to respond to behavior) and others restrained R6 who was struggling with staff to get to female staff member. Code yellow was called and R6 was sent out to hospital per Doctor's order. 1/19/10 R6 had physically aggressive incident which involved R6 and female peer standing behind each other in line, asked resident to get his stomach off her. The corresponding goal is for R6 will not harm self or others or destroy facility's property due to physically abusive behavior. There was a goal date of 04/19/10. This goal date was updated each time an incident occurred, however this goal date and the approaches have not been revised or evaluated, even though the goal has not been achieved. There were no interventions including R6's psychiatrist and medication adjustment even though following some incidents R6 consistently stated hearing voices caused the altercation. Further review of the on-going violent behavior of R6, and even though some of the injuries were minor, the pattern of behavior by R6 reveals instant frustration and often times immediate physical aggression toward residents and the staff attempting to diffuse the situation. Record review shows facility documenting behaviors as they occur, but facility's approach is minimal and not specific to the current altercation and usually includes to explore and continue to encourage. This failure to update and assess and reassess this ongoing aggressive/violent behavior in spite of programming and medication regimen does not constitute a comprehensive	F 223		

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F 223	Continued From page 6 reassessment nor has it not been analyzed for its effectiveness in changing R6's aggressive behaviors towards residents and staff. Interview with E2 (Director of nurses) on 02/11/10 stated to surveyor and later provided evidence that R6 had medication added/adjustment in 04/09 and 05/09, however E2 failed to provide evidence that facility staff was monitoring these medications when added or discontinued for potential adverse/ negative effects on R6. 2) Review of most recent MDS (minimum data set) dated 10/14/09 shows that R4 is 43 years old and admitted to facility 7/06/09 with diagnosis including Bipolar, Schizophrenia Paranoid type, Etoh (alcohol) abuse. R4's cognition is coded as moderately impaired and R4 has a history of substance abuse, alcohol, marijuana and cocaine use. The initial screening done prior to admission identified R4 as mentally ill and receiving psychotropic medications and was approved for nursing facility level of care. R4 was transferred to this facility from another facility secondary to aggression toward peer. Record review indicated R4 (a 3rd floor resident) with aggressive behavior in the facility as follows: - 08/04/09 (1 month after admission) = R4 struck a female resident. -08/20/09 = R4 punched another resident on the head. - 09/07/09 at 10am = R4 tried to run out front door of facility after altercation with R10. R4 was not separated from R10 or moved from this floor, putting R10 at risk for further abuse.	F 223		

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F 223	Continued From page 7 -09/07/09 at 6pm = R4 punched R11 in the face. Code yellow called and diffused the altercation, however R4 still agitated punched fire extinguisher sustaining a 2 cm laceration to right thumb with active bleeding. R4 was sent to local hospital. -10/18/09 = R4 struck R12 in the cheekbone with a closed fist. R12 to hospital for x-ray per physician's orders. R4 remained on this floor with R12, putting R12 at risk for further abuse. -11/19/09 = R4 verbally abusive to another resident for unknown reasons. -11/21/09 = R4 punched R13 in face for reason unknown. During interview on 02/11/10, E4 added, "upon assessment by staff R13 had redness to left eye and per physician's order was sent to local hospital for x-ray. -12/15/09 - R4 in front lobby stating wanting out of this mother fuc---" R4 then threw fist into picture on wall. -12/09/09 = R4 ran out unauthorized alarmed door when not allowed to smoke became physically and verbally threatening toward staff. Code yellow called however before staff could arrive R4 hit R3 (3rd floor resident) in jaw with a closed fist. The aggression was impulsive and unprovoked. R4 was sent to local hospital but returned to same floor when readmitted, R4 was never separated from R3 putting R3 at risk for further abuse. - 01/13/10 = R4 agitated on floor, hit R14 and	F 223		

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F 223	Continued From page 8 was undirectable code yellow called. There was no treatment plan for R4 even though R4 qualifies under subpart S. Interview with E5 indicates that the care plan is used for the treatment plan. Review of the care plan (regarding aggression) for R4 dated 10/20/09 documents altercations as they occurred in a narrative paragraph. There was a goal of R4 to decrease his anger aggression by consulting staff when feeling angry and frustrated. The goal date is 01/05/10. This goal was never met. There was also another care plan developed dated 01/05/10 with a repeat of the incidents as they occurred written in same narrative paragraph form, with a goal of R4 to decrease anger aggression by consulting staff when angry and frustrated. The goal date was 03/05/10, however the facility's approach is minimal and not specific to the current altercation and has interventions of resident was encouraged to speak with staff before becoming upset, remove resident to quieter area, offer PRN to decrease symptoms of agitation. This failure to update and assess and reassess this ongoing aggressive/violent behavior does not constitute a comprehensive reassessment nor has it not been analyzed for its effectiveness in changing R6's aggressive behaviors towards residents and staff. During interview on 02/11/10 E1 and E2 also failed to provide evidence that R4 was moved to a different floor or unit (to protect the resident from further abuse) following physical abuse to R10, R12 and R3. The facility submitted the following plan to remove the Immediacy Jeopardy:	F 223		

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F 223	Continued From page 9 1. R6 was discharged from the facility January 25,2010. R4 was discharged from the facility January 20,2010. 2. The facility has identified all residents at high risk for aggression/potential for violence. 3. Staff was re-inserviced on the following: a. Identifying signs and symptoms of potential aggression/aggressive situations,including precipitating factors, signals of escalating risk,and effective de-escalation strategies. b. Action to be taken in potential aggressive situations including Code Yellow Policy. Emergency resident counsel meetings will be held over the next week for all residents informing them of the facility's policy and house rules. 4. The IDT (interdisciplinary team) will review all aggressive behaviors/incidents to determine if staff management was appropriate and will re-inservice staff as needed. A summary of findings will be presented to the Qa (quality assurance) committee and medical director monthly for review. Date of completion February 26,2010.	F 223		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		3/1/10

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F 323	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide necessary supervision for one resident (R6) with known history of physically aggressive behavior from punching another resident (R5) in the face with a closed fist which resulted in an injury with a fractured nose. R6 had been identified by facility as having a history of aggressive and violent behavior prior to this incident. The above facility's failure resulted in an Immediate Jeopardy. E1 (Administrator), E2 (Director of nurses), E4 (investigative nurse) E5, PRSD (psychiatric rehabilitation service Director) and E7 (admission director) was notified of the Immediate Jeopardy on 02/11/10 at 1:00pm. The immediate jeopardy was determined to have begun on 01/18/10 at approximately 5:25pm when R6 punched R5 in the face with a closed fist knocking R5 to the floor, breaking R5's eye glasses and fracturing R5's nose. While the Immediate Jeopardy was removed on 02/11/10, the facility remained out of compliance at severity level 2, to allow the facility to, fully implement and evaluate the effectiveness of the new plan. R4 also has a history of aggressive/violent behavior and showed continued aggressive and violent behavior in the facility without on-going reassessment and supervision. The facility's	F 323		

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F 323	Continued From page 11 failure to supervise/monitor R4's aggression has resulted in 7 physical assaults to residents in the facility. Findings include: 1) R6 is a 54 year old resident admitted to the facility on 12/24/08 with diagnosis including Schizophrenia. The initial screening done on 12/23/09 identified R6 as mentally ill and receiving psychotropic medications and was approved for nursing facility level of care. R6 has had aggressive/violent behaviors in the facility as follows: -12/20/09 = newly admitted to the facility. - 02/11/09 = R6 upset pulled soap dispenser off wall. - 03/25/09 = R6 struck 2 co-peers (R7 and R8) for no apparent reasons. Interview with E4 (investigative nurse) on 02/11/10 indicated that R6 was hearing voices at the time which told R6 to strike both residents, so R6 slapped R7 and R8 while on the elevator. There was no evidence of staff supervision/ monitoring even though R6 displayed aggressive behavior prior to this incident. - 04/01/09 = R6 got out of his chair and hit R9 in the face. Interview with E4 on 02/11/10 indicated that R6 punched R9 in the face with a closed fist. R9 face had some redness and swelling. Per Physician's	F 323		

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F 323	Continued From page 12 orders R9 was sent to a local hospital for x-ray of the face. R6 went to hospital psych evaluation. 04/08/09 = readmitted to the facility with new psychotropic medication order. 04/17/09 = A new psychotropic added to R6's medication. 05/21/10 = nurses notes indicated that 2 of R6's psychotropic medications were discontinued and a new one started. There was no evidence provided that R6 was monitored for tolerance of or signs and symptoms of adverse effects of this new psychotropic medication and the discontinuance of the previous psychotropic medications. - 08/10/09 = R6 on unit very agitated, throwing chairs down hallway, states, he is very frustrated for unknown reasons. R6 noted beating hand on wall. Resident to hospital. -08/15/09 = R6 readmitted to the facility. ** Facility staff did not provide evidence of a change in R6's medication or treatment plan upon this readmission. - 08/17/09 (2 days after readmit) = R6 agitated, throwing things at staff, in the hallway. -08/20/09 = R6 in smoke room stated he had stuck a cigarette in his left ear. Staff noted small piece of cigarette sticking out from inner ear. R6 to local hospital. -12/08/09 = R6 very agitated complaint of	F 323		

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F 323	Continued From page 13 constipation, then picked up chair and threw it down hallway. 01/07/10 = R6 with recent episode of attempting to come into PRSC (psychiatric rehabilitation service co-coordinator) office to attack a female staff member. Aggression was non provoked and unexpected. Code yellow called (a code used by facility staff and announced over the facility's intercom system indicating staff assist needed due to residents' behavior) 01/18/10 = R6 struck R5 in face for no apparent reason. R5 sent to local hospital. X-ray of R5's face revealed a nasal fracture. Interview with E4 regarding this incident indicated that on 01/18/10 a verbal altercation occurred between R5 and R6 while they were in line awaiting Dinner to be served. Staff intervened and R6 appeared to have backed away, but within minutes R6 punched R5 in the face with a closed fist, knocking R5 to the floor and breaking her glasses. E4 continued, "R5 was noted with a laceration to the bridge of her nose, redness to the left eye and a scrape to R5's inner bottom lip. Upon further interview E4 stated, "R5 was sent to the hospital where x-ray showed a broken nose". Facility staff did not provide evidence of a treatment plan for R6 based on these identified areas of aggression, behavior, impulsiveness, anger toward residents and staff . During interview regarding treatment plan for R6, who qualifies under Subpart S, E5 stated we use the resident's care plan as the treatment plan, however surveyor's review of R6's care plan dated 02//8/09 states the following in one narrative paragraph: " R6 has physically abusive behavioral symptoms. R6 destroys facility	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E506	A. BUILDING _____ B. WING _____	C 02/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW BEACH CARE CENTER	7325 SOUTH EXCHANGE CHICAGO, IL 60649

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F 323	Continued From page 14 property when upset. 03/25/09 R6 has displayed physically abusive behaviors toward other residents; hitting peers while on elevators, claiming he was hearing voices that was frustrating him. 04/10/09 R6 physically attacked (punched) a female resident who walked pass him, while R6 was sitting quietly in a chair in front of the 4th floor nurses station because he said the voices that he hears told him to do so. 1/9/10 R6 had physically aggressive incident in which he attempted to attack a female staff member. Incident was unprovoked and expected. Male staff member (first to respond to behavior) and others restrained R6 who was struggling with staff to get to female staff member. Code yellow was called and R6 was sent out to hospital per Doctor's order. 1/19/10 R6 had physically aggressive incident which involved R6 and female peer standing behind each other in line, asked resident to get his stomach off her. The corresponding goal is for R6 will not harm self or others or destroy facility's property due to physically abusive behavior. There was a goal date of 04/19/10. This goal date was updated each time an incident occurred, however this goal date and the approaches have not been revised or evaluated, even though the goal has not been achieved. There were no interventions including R6's psychiatrist and medication adjustment even though following some incidents R6 consistently stated hearing voices caused the altercation. Further review of the on-going violent behavior of R6, and even though some of the injuries were minor, the pattern of behavior by R6 reveals instant frustration and often times immediate physical aggression toward residents and the	F 323		

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F 323	Continued From page 15 staff attempting to diffuse the situation. Record review shows facility documenting behaviors as they occur, but facility's approach is minimal and not specific to the current altercation and usually includes to explore and continue to encourage. This failure to update and assess and reassess this ongoing aggressive/violent behavior in spite of programming and medication regimen does not constitute a comprehensive reassessment nor has it not been analyzed for its effectiveness in changing R6's aggressive behaviors towards residents and staff. Interview with E2 (Director of nurses) on 02/11/10 stated to surveyor and later provided evidence that R6 had medication added/adjustment in 04/09 and 05/09, however E2 failed to provide evidence that facility staff was monitoring these medications when added or discontinued for potential adverse/ negative effects on R6. The facility also failed to provide evidence that R6 had on-going staff monitoring after each incidence to prevent further abuse and aggression. 2) R4 is 43 years old and admitted to facility 7/06/09 with diagnosis including Bipolar, Schizophrenia Paranoid type, Etoh (alcohol) abuse. R4's cognition is coded as moderately impaired and R4 has a history of substance abuse, alcohol, marijuana and cocaine use. The initial screening done prior to admission identified R4 as mentally ill and receiving psychotropic medications and was approved for nursing facility level of care. R4 was transferred to this facility from another facility 2ndary to aggression toward peer.	F 323		

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F 323	Continued From page 16 R4 (a 3rd floor resident) has documented aggressive/violent behavior in the facility as follows: - 08/04/09 (1 month after admission) = R4 struck a female resident. -08/20/09 = R4 punched another resident on the head. - 09/07/09 at 10am = R4 tried to run out front door of the facility after altercation with R10. -09/07/09 at 6pm = R4 punched R11 in the face. Code yellow called and diffused the altercation, however R4 still agitated punched fire extinguisher sustaining a 2 cm laceration to right thumb with active bleeding. R4 was sent to local hospital. -10/18/09 = R4 struck R12 in the cheekbone with a closed fist. R12 to hospital for x-ray per physician's orders. R4 remained on this floor with R12, putting R12 at risk for further abuse. -11/19/09 = R4 verbally abusive to another resident for unknown reasons. -11/21/09 = R4 punched R13 in face for reason unknown. During interview on 02/11/10, E4 added, "upon assessment by staff R13 had redness to left eye and per physician's order was sent to local hospital for x-ray. -12/15/09 - R4 in front lobby stating wanting out of this mother fuc---" R4 then threw fist into picture on wall.	F 323		

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F 323	Continued From page 17 -12/09/09 = R4 ran out unauthorized alarmed door when not allowed to smoke became physically and verbally threatening toward staff. Code yellow called however before staff could arrive R4 hit R3 (3rd floor resident) in jaw with a closed fist. The aggression was impulsive and unprovoked. R4 was sent to local hospital but returned to same floor when readmitted, R4 was never separated from R3 putting R3 at risk for further abuse. - 01/13/10 = R4 agitated on floor, hit R14 and was undirectable code yellow called. There was no treatment plan for R4 even though R4 qualifies under subpart S. Interview with E5 indicates that the care plan is used for the treatment plan. Review of the care plan (regarding aggression) for R4 dated 10/20/09 documents altercations as they occurred in a narrative paragraph. There was a goal of R4 to decrease his anger aggression by consulting staff when feeling angry and frustrated. The goal date is 01/05/10. This goal was never met. There was also another care plan developed dated 01/05/10 with a repeat of the incidents as they occurred written in same narrative paragraph form, with a goal of R4 to decrease anger aggression by consulting staff when angry and frustrated. The goal date was 03/05/10, however the facility's approach is minimal and not specific to the current altercation and has interventions of resident was encouraged to speak with staff before becoming upset, remove resident to quieter area, offer PRN to decrease symptoms of agitation. This failure to update and assess and reassess this ongoing aggressive/violent behavior does not constitute a comprehensive reassessment nor has it not been analyzed for its	F 323		

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F 323	Continued From page 18 effectiveness in changing R6's aggressive behaviors towards residents and staff. There was no evidence that R4 was supervised/monitored by facility staff following each altercation to prevent further aggression/violence harm to other residents. The Immediate Jeopardy was removed on 02/15/10, however the facility remains out of compliance at severity level 2, to allow the facility to fully implement and evaluate the effectiveness of the new plan. The facility submitted the following plan to remove the Immediate Jeopardy: F323 1. R6 was discharged from the facility January 25,2010. R4 was discharged from the facility January 20,2010. 2. The facility has identified all residents at high risk for aggression/potential for violence. All residents identified at high risk for aggression will have an individualized treatment plan put in place with the consideration of the following: identification and modification of environmental risk factors (eg, room placement), provision of skills training, behavioral interventions (e.g, behavioral contract), and psychopharmacological interventions based on individualized resident assessment. This will be completed by the interdisciplinary team and reviewed quarterly and in response to significant changes in the residents' symptoms, behaviors, and medication changes. Nursing staff will	F 323		

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F 323	Continued From page 19 conduct rounds hourly on all residents identified at high risk for aggression. The facility will provide closer observations for residents on a case by case basis. Further, each resident identified at high risk will have a special interdisciplinary team care plan meeting to develop and address aggression risk with the resident. 3. Clinical staff will be re-inserviced by the PRSD/designee regarding the completion of the aggression risk , review of resident background information obtained from resident, family, and physician. 4. The administrator will review round sheets daily to monitor the supervision of residents identified at high risk for aggression. The PRSD/designee will review the individualized treatment plans for residents identified at high risk for aggression upon admission, in response an incident and behavior occurrences and make modifications to the plan when needed and will re-inservice the PRSC. The IDT will review all incidents of aggressive behaviors and determine appropriate interventions on a case by case basis. The QA team medical/ psychiatrist will review interventions implemented monthly. Date of completion Feb 26,2010.	F 323		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490		3/1/10

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F 490	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to provide effective administrative services to effectively and efficiently use it resources to prevent one sampled resident (R5) from a physical harm by another resident (R6) . R6 has a known history of physically aggressive/violent behavior since 2 months after admission. The facility's failure to use administrative resources available to it has led to this serious preventable injury for another resident and caused harm. R6 had been identified by facility as having a history of aggressive and violent behavior prior to this incident. An immediate jeopardy was called on 02/11/10 at 1:00pm with E1 (Administrator), E2 (Director of nurses), E4 (investigative nurse) E5, PRSD (psychiatric rehabilitation service Director) and E7 (admission director). The immediate jeopardy was determined to have begun on 01/18/10 approximately 5:25pm when R6 punched R5 in the face with a closed fist knocking R5 to the floor, breaking R5's eye glasses and fracturing R5's nose. The Immediate Jeopardy was removed on 02/15/10, however the facility remains out of compliance at severity level 2, to allow the facility to fully implement and evaluate the effectiveness of the new plan. R4 also has a history of aggressive/violent behavior and showed continued aggressive and violent behavior in the facility since 1 month after admission to the facility . The facility's failure to use resources available has resulted in 7	F 490		

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F 490	Continued From page 21 physical assaults to residents in the facility by R4. The facility also failed to separate/move R4 to protect 3 residents (R3, R12 and 14) from further abuse, following physical assault. Findings include: 1) Record Review shows that R6 is a 54 year old resident admitted to the facility on 12/28/08 with diagnosis including Schizophrenia. The most recent MDS (minimum data set) dated 01/05/10 indicates R6's cognition is coded as modified. The initial screening done on 12/23/08 identified R6 as mentally ill and receiving psychotropic medications and was approved for nursing facility level of care. R6 has had aggressive/violent behaviors as follows: -12/2009 = newly admitted to the facility. - 02/11/09 = R6 upset pulled soap dispenser off wall. - 03/25/09 = R6 struck 2 co-peers (R7 and R8) for no apparent reasons. Interview with E4 (investigative nurse) on 02/11/10 indicated that R6 was hearing voices at the time which told R6 to strike both residents, so R6 slapped R7 and R8 while on the elevator. There was no evidence of psychotropic medication changes or adjustments even though R6 indicated hearing voices at time of abuse to R7 and R8.	F 490		

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F 490	Continued From page 22 - 04/01/09 = R6 got out of his chair and hit R9 in the face. Interview with E4 on 02/11/10 indicated that R6 punched R9 in the face with a closed fist. R9 face had some redness and swelling. Per Physician's orders R9 was sent to a local hospital for x-ray of the face. R6 went to hospital psych evaluation. 04/08/09 = R6 readmitted to the facility with new psychotropic medication order. 04/17/09 = A new psychotropic added to R6's medication. 05/21/10 = nurses notes indicated that 2 of R6's psychotropic medications were discontinued and a new one started. Surveyor noted there was no evidence provided that R6 was monitored for tolerance of or signs and symptoms of adverse effects of this new psychotropic medication and the discontinuance of the previous psychotropic medications. - 08/10/09 = R6 on unit very agitated, throwing chairs down hallway, states, he is very frustrated for unknown reasons. R6 noted beating hand on wall. Resident to hospital. -08/15/09 = R6 readmitted to the facility. Facility staff did not provide evidence of a change in R6's medication or treatment plan upon this readmission. - 08/17/09 (2 days after readmit) = R6 agitated, throwing things at staff, in the hallway. -08/20/09 = R6 in smoke room stated he had	F 490		

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F 490	Continued From page 23 stuck a cigarette in his left ear. Staff noted small piece of cigarette sticking out from inner ear. R6 to local hospital. -12/08/09 = R6 very agitated complaint of constipation, then picked up chair and threw it down hallway. 01/07/10 = R6 with recent episode of attempting to come into PRSC (psychiatric rehabilitation service co-coordinator) office to attack a female staff member. Aggression was non provoked and unexpected. Code yellow called (a code used by facility staff and announced over the facility's intercom system indicating staff assist needed due to residents' behavior) 01/18/10 = R6 struck R5 in face for no apparent reason. R5 sent to local hospital. X-ray of R5's face revealed a nasal fracture. Interview with E4 regarding this incident indicated that on 01/18/10 a verbal altercation occurred between R5 and R6 while they were in line awaiting Dinner to be served. Staff intervened and R6 appeared to have backed away, but within minutes R6 punched R5 in the face with a closed fist, knocking R5 to the floor and breaking her glasses. E4 continued, "R5 was noted with a laceration to the bridge of her nose, redness to the left eye and a scrape to R5's inner bottom lip. Upon further interview E4 stated, "R5 was sent to the hospital where x-ray showed a broken nose". Facility staff did not provide evidence of a treatment plan for R6 based on these identified areas of aggression, behavior, impulsiveness, anger toward residents and staff . During interview regarding treatment plan for R6,	F 490		

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F 490	Continued From page 24 who qualifies under Subpart S, E5 stated we use the resident's care plan as the treatment plan, however surveyor's review of R6's care plan dated 02/8/09 indicates facility documenting behaviors as they occur, but facility's approach is minimal and not specific to the current altercation and usually includes to explore and continue to encourage. This failure to update and assess and reassess this ongoing aggressive/violent behavior does not constitute a comprehensive reassessment nor has it not been analyzed for its effectiveness in changing R6's aggressive behaviors towards residents and staff. The corresponding goal is for R6 will not harm self or others or destroy facility's property due to physically abusive behavior. There was a goal date of 04/19/10. This goal date was updated each time an incident occurred, however this goal date and the approaches have not been revised or evaluated, even though the goal has not been achieved. There were no interventions including R6's psychiatrist and medication adjustment even though following some incidents R6 consistently stated hearing voices caused the altercation. Further review of the on-going violent behavior of R6, and even though some of the injuries were minor, the pattern of behavior by R6 reveals instant frustration and often times immediate physical aggression toward residents and the staff attempting to diffuse the situation. Interview with E2 (Director of nurses) on 02/11/10 stated to surveyor and later provided evidence that R6 had medication added/adjustment in 04/09 and 05/09, however E2 failed to provide evidence that facility staff was monitoring these	F 490		

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F 490	Continued From page 25 medications when added or discontinued for potential adverse/ negative effects on R6. 2) Review of most recent MDS (minimum data set) dated 10/14/09 shows that R4 is 43 years old and admitted to facility 7/06/09 with diagnosis including Bipolar, Schizophrenia Paranoid type, Etoh (alcohol) abuse. R4's cognition is coded as moderately impaired and R4 has a history of substance abuse, alcohol, marijuana and cocaine use. The initial screening done prior to admission identified R4 as mentally ill and receiving psychotropic medications and was approved for nursing facility level of care. R4 was transferred to this facility from another facility 2ndary to aggression toward peer. Record review indicated R4 (a 3rd floor resident) with aggressive behavior in the facility as follows: - 08/04/09 (1 month after admission) = R4 struck a female resident. -08/20/09 = R4 punched another resident on the head. - 09/07/09 at 10am = R4 tried to run out front door of facility after altercation with R10. R4 was not separated from R10 or moved from this floor, putting R10 @ risk for further abuse. -09/07/09 at 6pm = R4 punched R11 in the face. Code yellow called and diffused the altercation, however R4 still agitated punched fire extinguisher sustaining a 2 cm laceration to right thumb with active bleeding. R4 was sent to local hospital. -10/18/09 = R4 struck R12 in the cheekbone with	F 490		

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F 490	Continued From page 26 a closed fist. R12 to hospital for x-ray per physician's orders. R4 remained on this floor with R12, putting R12 at risk for further abuse. -11/19/09 = R4 verbally abusive to another resident for unknown reasons. -11/21/09 = R4 punched R13 in face for reason unknown. During interview on 02/11/10, E4 added, "upon assessment by staff R13 had redness to left eye and per physician's order was sent to local hospital for x-ray. -12/15/09 - R4 in front lobby stating wanting out of this mother fuc---" R4 then threw fist into picture on wall. -12/09/09 = R4 ran out unauthorized alarmed door when not allowed to smoke became physically and verbally threatening toward staff. Code yellow called however before staff could arrive R4 hit R3 (3rd floor resident) in jaw with a closed fist. The aggression was impulsive and unprovoked. R4 was sent to local hospital but returned to same floor when readmitted, R4 was never separated from R3 putting R3 at risk for further abuse. - 01/13/10 = R4 agitated on floor, hit R14 and was undirectable code yellow called. There was no treatment plan for R4 even though R4 qualifies under subpart S(Serious Mental Illness). Interview with E5 indicates that the care plan is used for the treatment plan. Review of the care plan (regarding aggression) for R4 dated 10/20/09 documents altercations as they occurred in a narrative paragraph. There was a	F 490		

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F 490	Continued From page 27 goal of R4 to decrease his anger aggression by consulting staff when feeling angry and frustrated. The goal date is 01/05/10. This goal was never met. There was also another care plan developed dated 01/05/10 with a repeat of the incidents as they occurred written in same narrative paragraph form, with a goal of R4 to decrease anger aggression by consulting staff when angry and frustrated. The goal date was 03/05/10, however the facility's approach is minimal and not specific to the current altercation and has interventions of resident was encouraged to speak with staff before becoming upset, remove resident to quieter area, offer PRN to decrease symptoms of agitation. This failure to update and assess and reassess this ongoing aggressive/violent behavior does not constitute a comprehensive reassessment nor has it not been analyzed for its effectiveness in changing R6's aggressive behaviors towards residents and staff. During interview on 02/11/10 E1 and E2 also failed to provide evidence that R4 was moved to a different floor or unit (to protect the resident from further abuse) following physical abuse to R10, R12 and R3. The facility submitted the following plan to remove the Immediate Jeopardy: F490 1. Facility administration will ensure that all residents at high risk for aggression have been identified and an individualized treatment plan is developed in conjunction with the physician. 2. Facility administration staff will ensure that	F 490		

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F 490	Continued From page 28 staff training is completed in each of these areas: a. Identifying signs and symptoms of impending aggression/aggressive situations, including precipitating factors, signals of escalating risk, and effective de-escalation strategies. b. Action to be taken in potential aggressive situation including Code Yellow Policy. c. Clinical staff will be re-inserviced by the PRSD/designee regarding the completion of the aggression risk assessment, review of resident background check and IDPH risk assessment, and background information obtained from resident, family and physician. 3. Facility administrator will conduct an emergency resident counsel meeting concerning the facility abuse policy and house rules. 4. Facility administration will ensure the IDT team reviews all aggressive behaviors/incidents to determine if staff management was appropriate and will re-inservice staff as needed. A summary of findings will be presented the QA committee and medical director monthly for review.	F 490		

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F 490	Continued From page 29	F 490		
F9999	. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)6) 300.1220b)3) 300.3240a) 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be	F9999		

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F9999	Continued From page 30 made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to 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: 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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's	F9999		

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F9999	Continued From page 31 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 requirements are not met as evidenced by: Based on record review and interview the facility failed to ensure that a resident is free from physical abuse by failing to supervise R6, with known history of physically aggressive behavior, resulting in R6 punching another resident (R5) in the face with a closed fist resulting in an injury with a fractured nose. The facility's failure to monitor and periodically re-assess R6's negative behavior led to this serious preventable injury for another resident and caused harm. R6 had been identified by facility as having a history of aggressive and violent behavior prior to this incident. R4, as well, has a history of aggressive/violent behavior in the facility. R4's aggression has resulted in 7 physical assaults to residents in the facility. R4 was never separated/moved to another unit to protect 3 residents (R3, R12 and 14) from further abuse, following physical assault. Findings include: 1) Record Review shows that R6 is a 54 year old resident admitted to the facility on 12/28/08 with diagnosis including Schizophrenia. The most recent MDS (minimum data set) dated 01/05/10 indicates R6's cognition is coded as modified independence. The initial screening done on	F9999		

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F9999	Continued From page 32 12/23/08 identified R6 as mentally ill and receiving psychotropic medications and was approved for nursing facility level of care. Review of medical record during survey of 02/10/10 through 02/16/10 indicated that R6 has had physically aggressive behaviors toward residents and staff since 2 months after admission. R6 has had aggressive/violent behaviors as follows: -12/2009 = newly admitted to the facility. - 02/11/09 = R6 upset pulled soap dispenser off wall. - 03/25/09 = R6 struck 2 peers (R7 and R8) for no apparent reasons. Interview with E4 (investigative nurse) on 02/11/10 indicated that R6 was hearing voices at the time which told R6 to strike both residents, so R6 slapped R7 and R8 while on the elevator. There was no evidence of psychotropic medication changes or adjustments even though R6 indicated hearing voices at time of abuse to R7 and R8. - 04/01/09 = R6 got out of his chair and hit R9 in the face. Interview with E4 on 02/11/10 indicated that R6 punched R9 in the face with a closed fist. R9 face had some redness and swelling. Per Physician's orders R9 was sent to a local hospital for x-ray of the face. R6 went to hospital psych evaluation. 04/08/09 = readmitted to the facility with new psychotropic medication order. 04/17/09 = A new psychotropic added to R6's medication.	F9999		

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F9999	Continued From page 33 05/21/10 = nurses notes indicated that 2 of R6's psychotropic medications were discontinued and a new one started. There was no evidence provided that R6 was monitored for tolerance of or signs and symptoms of adverse effects of this new psychotropic medication and the discontinuance of the previous psychotropic medications. - 08/10/09 = R6 on unit very agitated, throwing chairs down hallway, states, he is very frustrated for unknown reasons. R6 noted beating hand on wall. Resident to hospital. -08/15/09 = R6 readmitted to the facility. Facility staff did not provide evidence of a change in R6's medication or treatment plan upon this readmission. - 08/17/09 (2 days after readmit) = R6 agitated, throwing things at staff, in the hallway. -08/20/09 = R6 in smoke room stated he had stuck a cigarette in his left ear. Staff noted small piece of cigarette sticking out from inner ear. R6 to local hospital. -12/08/09 = R6 very agitated complaint of constipation, then picked up chair and threw it down hallway. 01/07/10 = R6 with recent episode of attempting to come into PRSC (psychiatric rehabilitation service co-coordinator) office to attack a female staff member. Aggression was non provoked and unexpected. Code yellow called (a code used by facility staff and announced over the facility's intercom system indicating staff assist needed	F9999		

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F9999	Continued From page 34 due to residents' behavior) 01/18/10 = R6 struck R5 in face for no apparent reason. R5 sent to local hospital. X-ray of R5's face revealed a nasal fracture. Interview with E4 regarding this incident indicated that on 01/18/10 a verbal altercation occurred between R5 and R6 while they were in line awaiting Dinner to be served. Staff intervened and R6 appeared to have backed away, but within minutes R6 punched R5 in the face with a closed fist, knocking R5 to the floor and breaking her glasses. E4 continued, "R5 was noted with a laceration to the bridge of her nose, redness to the left eye and a scrape to R5's inner bottom lip. Upon further interview E4 stated, "R5 was sent to the hospital where x-ray showed a broken nose." Facility staff did not provide evidence of a treatment plan for R6 based on these identified areas of aggression, behavior, impulsiveness, and anger toward residents and staff . During interview regarding treatment plan for R6, who qualifies under Subpart S (Seriously Mentally Ill), E5 stated they use the resident's care plan as the treatment plan, however surveyor's review of R6's care plan dated 02/8/09 states the following in one narrative paragraph: "R6 has physically abusive behavioral symptoms. R6 destroys facility property when upset. 03/25/09 R6 has displayed physically abusive behaviors toward other residents; hitting peers while on elevators, claiming he was hearing voices that was frustrating him. 04/10/09 R6 physically attacked (punched) a female resident who walked pass him, while R6 was sitting quietly in a chair in front of the 4th floor nurses	F9999		

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station because he said the voices that he hears told him to do so. 1/9/10 R6 had physically aggressive incident in which he attempted to attack a female staff member. Incident was unprovoked and expected. Male staff member (first to respond to behavior) and others restrained R6 who was struggling with staff to get to female staff member. Code yellow was called and R6 was sent out to hospital per Doctor's order. 1/19/10 R6 had physically aggressive incident which involved R6 and female peer standing behind each other in line, asked resident to get his stomach off her.

The corresponding goal is that R6 will not harm self or others or destroy facility's property due to physically abusive behavior. There was a goal date of 04/19/10. This goal date was updated each time an incident occurred, however this goal date and the approaches have not been revised or evaluated, even though the goal has not been achieved.

There were no interventions including R6's psychiatrist and medication adjustment even though following some incidents R6 consistently stated hearing voices caused the altercation. Further review of the on-going violent behavior of R6, even though some of the injuries were minor, the pattern of behavior by R6 reveals instant frustration and often times immediate physical aggression toward residents and the staff attempting to diffuse the situation.

Record review shows facility documenting behaviors as they occur, but facility's approach is minimal and not specific to the current altercation and usually includes to explore and continue to encourage. This failure to update and assess

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F9999	Continued From page 36 and reassess this ongoing aggressive/violent behavior in spite of programming and medication regimen does not constitute a comprehensive reassessment nor has it not been analyzed for its effectiveness in changing R6's aggressive behaviors towards residents and staff. Interview with E2 (Director of nurses) on 02/11/10, E2 stated to surveyor, and later provided evidence, that R6 had medication added/adjustment in 04/09 and 05/09, however E2 failed to provide evidence that facility staff was monitoring these medications when added or discontinued for potential adverse/negative effects on R6. 2) Review of the most recent MDS (minimum data set) dated 10/14/09 shows that R4 is 43 years old and admitted to facility 7/06/09 with diagnosis including Bipolar, Schizophrenia Paranoid type, Etoh (alcohol) abuse. R4's cognition is coded as moderately impaired and R4 has a history of substance abuse, alcohol, marijuana and cocaine use. The initial screening done prior to admission identified R4 as mentally ill and receiving psychotropic medications, and was approved for nursing facility level of care. R4 was transferred to this facility from another facility secondary to aggression toward peer. Record review indicated R4 (a 3rd floor resident) with aggressive behavior in the facility as follows: - 08/04/09 (1 month after admission) = R4 struck a female resident. -08/20/09 = R4 punched another resident on the head.	F9999		

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F9999	Continued From page 37 - 09/07/09 at 10am = R4 tried to run out front door of facility after altercation with R10. R4 was not separated from R10 or moved from this floor, putting R10 at risk for further abuse. -09/07/09 at 6pm = R4 punched R11 in the face. Code yellow called and diffused the altercation, however R4 still agitated punched fire extinguisher sustaining a 2 cm laceration to right thumb with active bleeding. R4 was sent to local hospital. -10/18/09 = R4 struck R12 in the cheekbone with a closed fist. R12 to hospital for x-ray per physician's orders. R4 remained on this floor with R12, putting R12 at risk for further abuse. -11/19/09 = R4 verbally abusive to another resident for unknown reasons. -11/21/09 = R4 punched R13 in face for reason unknown. During interview on 02/11/10, E4 added, "upon assessment by staff R13 had redness to left eye and per physician's order was sent to local hospital for x-ray." -12/15/09 - R4 in front lobby stating wanting out of this mother fuc---" R4 then threw fist into picture on wall. -12/09/09 = R4 ran out unauthorized alarmed door when not allowed to smoke became physically and verbally threatening toward staff. Code yellow called however before staff could arrive R4 hit R3 (3rd floor resident) in jaw with a closed fist. The aggression was impulsive and unprovoked. R4 was sent to local hospital but returned to same floor when readmitted, R4 was	F9999		

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F9999	Continued From page 38 never separated from R3 putting R3 at risk for further abuse. - 01/13/10 = R4 agitated on floor, hit R14 and was undirectable code yellow called. There was no treatment plan for R4 even though R4 qualifies under subpart S. Interview with E5 indicates that the care plan is used for the treatment plan. Review of the care plan (regarding aggression) for R4 dated 10/20/09 documents altercations as they occurred in a narrative paragraph. There was a goal of R4 to decrease his anger aggression by consulting staff when feeling angry and frustrated. The goal date is 01/05/10. This goal was never met. There was also another care plan developed dated 01/05/10 with a repeat of the incidents as they occurred written in same narrative paragraph form, with a goal of R4 to decrease anger aggression by consulting staff when angry and frustrated. The goal date was 03/05/10, however the facility's approach is minimal and not specific to the current altercation and has interventions of resident was encouraged to speak with staff before becoming upset, remove resident to quieter area, offer PRN to decrease symptoms of agitation. This failure to update and assess and reassess this ongoing aggressive/violent behavior does not constitute a comprehensive reassessment nor has it been analyzed for its effectiveness in changing R6's aggressive behaviors towards residents and staff. During interview on 02/11/10 E1 and E2 also failed to provide evidence that R4 was moved to a different floor or unit (to protect the resident from further abuse) following physical abuse to R10, R12 and R3.	F9999		

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F9999	Continued From page 39 (A)	F9999		