

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

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COLUMBUS MANOR RES CARE HOME

0007781

Facility Name

I.D. Number

5107 – 21 WEST JACKSON BOULEVARD, CHICAGO, ILLINOIS 60644

Address, City, State, Zip

27639, 18196

JULY 6, 2010

Reviewed By

Date of Survey

ANNUAL HEALTH

02437, 02569, 08705, 12642, 16746

Type of Survey

Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

“A” VIOLATION(S):

**300.1210a)
300.1210b)3)
300.3240a)
300.3240d)**

Section 300.1210 General Requirements for Nursing and Personal Care

- a) Committee consisting of at least the administrator, the advisory physician or the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
- b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
 - 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect

- a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)*
- d) *A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)*

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These Requirements are not met as evidenced by:

Based on record review and interview the facility neglected to assure that 5 of 24 sampled residents (R15, R16, R17, R18 and R19) are free of abuse.

This failure had the potential to impact all 134 residents of the facility.

Findings Include:

1. PRSD (Psychiatric Rehabilitation Services Director) note dated 09/21/09 by E9 (Former PRSD) stated that R17 was upset and tearful this evening. R17 stated she had been yelled at by another resident while in the dining room line. During this conversation it was noted that R17 had a sore on her left forearm. R17 stated that she had been burned with a cigarette by a peer, approximately two days ago in the morning, after telling peer to extinguish the cigarette. R17 was resistant to, but eventually disclosed the name of the individual who she alleged had burned her. R17 was fearful that peer's boyfriend would retaliate.

Investigation report dated 09/21/09 by E9 (Former PRSD) states that on 09/21/09 R17 alleged that a female peer had burned R17 on the right forearm two to three days ago.

Administrative staff presented an Investigation Report of this incident initiated and completed on 09/21/09. Investigation does not identify the person R17 alleged burned her. Investigation does not address R17's concerns about possible retaliation by accuser's boyfriend. There is no evidence a statement was taken by accused peer. Report does indicate accused peer was counseled and smoking materials were confiscated. There was no evidence presented that the Illinois Department was notified of this alleged abuse.

During interview with E3 (abuse coordinator) on 05/12/10 surveyors were informed that from another interview with R17 facility learned that the abuser was R30. E3 stated R30's record was reviewed and no information was documented in nurse's notes, PRSC notes or care plan regarding allegation that R30 burned R17 with a cigarette.

On 5/17/10 facility provided documentation which acknowledged there was no documentation of interventions to protect R17 or others from peer in abuse investigation report beyond counseling both clients and confiscating cigarettes. Identification of mental abuse (intimidation) was not made in abuse report. Investigation into the probable causes of behavior was not identified in abuse investigating. Reporting was also lacking considering no evidence of reporting either the preliminary or the final abuse investigation report to IDPH was found.

2. R15 is 67 years old and diagnoses include chronic undifferentiated schizophrenia and atypical psychosis. Nurse's note dated 09/23/09 at 10:45p.m. State R15 was in her room when a male resident (R24) entered the room and put his hands down her pants and asked her to perform oral sex. R15 refused and R24 punched her in the mouth and started choking her. Other residents in neighboring rooms came to see what was going on and the male resident fled from the scene.

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R15's physician and brother were notified of the incident that occurred at 7:40p.m. There was no documentation in nurse's notes, at time of incident, of any assessment of R15 for injury or psychosocial well being after attack.

Note of 09/24/09 at 9:00a.m. States E6(LPN) went to R15's room to talk with R15. R15 explained what happened and how she fought off the male resident. R15 stated a tooth was loose but refused to see dentist. Subsequent note timed as 7:00a.m. States R15 refused to go to the hospital.

R15 does have a legal guardian of person and finance (Z1). Z1 was notified of the incident but there is no evidence that he was informed of the need to send R15 to the hospital.

Note of 09/24/09 at 11:00a.m. States staff went to R15's room where R15 stated how upset she was about the attack on her. R15's physician was called and order was made for R15 to be sent to the hospital for an evaluation.

An investigation of this incident, dated 09/24/09 was presented to surveyors. Incident report lists two residents (R31 & R40) as witnesses. During investigation R31 stated "I heard screaming and hollering, I went to the room, I turned the light on, the man was on top of her, he put his shoes on and walked out of the room. R15 stated that the man wanted her to suck his dick."

R40 stated "I heard someone yelling for help and it went to the hallway, I saw R24 leaving R15's room. When I went to the room R15 was really upset and said she had been attacked."

PRSC notes dated 09/24/09 states that the prior evening at approximately 7:30p.m. R15 was attacked by a male peer. Per nursing report R15 had pulled her call light and staff responded.

Investigation did not include any statement by staff who responded to call light.

There is no documentation in the record or presented to surveyors of how R15 was protected/monitored after this attack and through the night until 7:00a.m. The following morning. R15 was hospitalized on 09/24/09 and was readmitted to the facility on 10/05/09. After return from the hospital, nurses' notes, PRSC notes or care plan do not address the sexual or physical abuse to R15 or her psychosocial well being.

Review of Medical History & Physical Examination dated 05/20/09 completed at the hospital prior to R24's admission to the facility, states the chief complaint for hospitalization was being in someone's room and he was not supposed to be there. This document indicates that R24 was in a girl's room at the previous nursing facility and apparently should not have been. This behavior was not addressed as a problem/concern in R24's care plan nor was the possibility of the need for increased supervision.

During interview on 05/12/10 E3 (PRSD) stated she was not aware of this history for R24.

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Other information found in record indicates that in the past R24 had been charged with indecent exposure. Care plan listed behaviors as disrobing or engaging in sexual behavior in public, exposing self, public masturbation and attention seeking behavior.

On 5/17/10, facility presented documentation which acknowledged the abuse investigation report does not describe protection of resident or other residents between incident and police presence, though nursing note does mention monitoring R15 in courtyard. Investigation was not completed thoroughly due to delay in resident being sent to hospital or was R15 otherwise thoroughly assessed for injury. R15 is documented to have refused, but is deemed by the courts to lack sufficient judgment and has a guardian. This was resolved the next morning. Also, the investigation does not attempt to ascertain antecedents to incident. Finally, reporting was not sufficiently addressed as no evidence of preliminary or final report was sent to IDPH. Further, the abuse investigation report does not identify any changes made to reduce likelihood of future incidents.

3. Incident Report dated 04/25/10 states at 5:00a.m. R16 was attacked by roommate (R20). R16 was hit several times and pinned down on the floor. R16 was also threatened by roommate.

Nurses' notes of 04/25/10 at 5:00a.m. States examination of R16 showed no visible injuries and R16 did not complain of any pain or discomfort.

R20's diagnoses include chronic paranoid schizophrenia. Physician orders for psychoactive medications were Fazaclo 100mg at 6:00 a.m. and 150mg. at hour of sleep (8:00p.m.). Review of April 2010 medication administration record (MAR) shows that R20 was not given Fazaclo 150mg. at hour of sleep from 04/19/10 to 04/25/10. MAR also indicates Fazaclo was not given 04/10/10 at 6:00a.m., 04/15/10 at 8p.m., 04/16/10 at 6:00a.m., 4/24/10 at 6:00a.m. and 04/25/10 at 6:00a.m. MAR does not indicate reasons Fazaclo was not administered on the above dates/times.

Neither nurse's notes nor PRSC (Psychiatric Rehabilitation Services Coordinator) address R20 not taking medications. R20's care plan does not address medication non-compliance.

On 04/25/10, R20 was hospitalized for increased paranoid delusions, physical aggression, attacking her roommate without provocation and refusing psychoactive medications. R20 was readmitted on 05/07/2010 back to her old room. Neither nurse's notes nor PRSC notes for R16 addressed any safety concerns after R20 was readmitted and returned as R16's roommate. On 05/12/10 R16 was interviewed and stated that she currently feels safe having R20 as a roommate. R16 stated R20 has been her roommate for a long time.

On 05/13/10 Administrative staff informed surveyors that R16 has been moved to another room.

There was no investigation of this incident presented to Surveyors.

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E3 (Psychiatric Rehabilitation Service Coordinator-abuse coordinator) stated during abuse protocol interview on 5/12/10 she was unaware of the incident involving R16 and R20.

On 5/17/10 facility presented documentation acknowledging there was no documentation available of how staff protected Leek in the 2.75 hours following the incident, including monitoring of (R20-perpetrator) for further aggression. Further, prevention was not addressed by staff not obviously intervening with R20's medication noncompliance. There is no evidence of reporting to IDPH in the preliminary 24 hour incident report despite reasonable evidence of resident-on-resident abuse. No apparent abuse investigation was conducted. No evidence of a final report was made to IDPH within the 5 day window about the abuse investigation. Lacking an abuse investigation, no documentation of changes in procedure to prevent further incidences was noted.

4. R18 is 81 years old and diagnoses include schizophrenia disorganized type. Comprehensive assessment of 03/14/10 indicates R18 is cognitively impaired.

Incident report dated 11/04/09 states R18 was in the dining room when she was hit in back of the head by another resident (R23) at 7:15p.m.

Investigation Report dated 11/05/09 at 9:00a.m. States R18 said he (R23) hit me in the back of the head; it hurts here (pointing to the back of her head). Investigation included a statement by R23 (not dated). R23 states "she was bothering me so I went like this (gestured movement of his fist to back of head). I didn't hurt her though. "

E7 (Nurse Aide) witnessed incident. Investigation showed E7 stated "It was about 7:15. I saw R23 go up to the front where R18 was at and hit her in the head with his fist. When asked he said she was 'bothering me.' But R18 was just sitting there."

Incident report indicates the steps to take to prevent recurrence. Steps are listed as R23 told to keep his hands to himself and not to hit another person in the future.

On 5/17/10, facility provided documentation which acknowledged there was no documentation of how R18 was to be protected from R23 or of protecting other residents from R23 beyond telling R23 not to hit another person in the future. Further, reporting was not conducted with IDPH apparently not notified of the preliminary 24 hour report based on reasonable suspicion of abuse, or the final report following the abuse investigation.

5. Incident Report dated 11/05/09 at 7:45a.m. States R19 was struck in the face by a younger peer in the dining room which was witnessed by dietary staff.

R19 is 79 years old and diagnoses include schizophrenia paranoid type and cancer of the prostate. As part of investigation R19 stated "he (R23) hit me, but not hard. I'm okay, I'm tired of it. "During investigation R23 stated "he (R19) ran into my elbow and I didn't like it. I didn't

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hit him." During investigation E8 (Cook) stated "R19 was walking past R23 and punched R19 in the face with a closed fist."

Facility Investigation Report denotes on 11/4/09 R23 hit a resident (R18) in the head. Nurses notes dated 11/4/09 at 7:15 PM include documentation R23 had hit R18 in back of head with fist. R23's physician was notified and an order was given to send R23 to hospital for evaluation. Facility was notified no bed was available at hospital until next day 11/5/10.

Documentation on 11/4/09 at 11:45 PM denotes R23 had refused a bed change stating, "I don't need to change room I am not afraid of any one, they better be afraid of me." Nurses' notes on 11/5/09, at 7:45 AM, indicate R23 apparently struck older male peer in face (R19), which was witnessed by staff. At 8:35 AM was transferred to hospital by local police department for psychiatric evaluation.

R23's diagnosis includes Schizophrenia, paranoid type. R23's Minimum Data Set of October 2009 assessed R23 for physically abusive behavior.

Record review reveals R23 had multiple hospitalizations for threatening and abusive behavior towards staff or peers. Social service incidental notes denote the following incidents regarding R23's abusive behavior:

-11/2/09 writer met with client after female peer alleged that R23 had verbally threatened her. R23 was informed of consequences of repeated threats or hostility towards peers. Per observation, R23 exhibiting an increase in paranoia and is preoccupied with the affairs of other peers. Staff will continue to monitor.

-Per peer report, client threatened peer and a friend while crossing the street from the store. R23 admitted to allegation stating he told peer "we can fight whenever your want to." R23 was informed that regardless of location, threats to fight others are inappropriate. Staff will continue to monitor.

-11/4/09 writer was notified by phone at approximately 7:30 PM that client had struck a female peer in the back of the head. Writer informed that client's psychiatrist was notified and client was placed on close observation.

-11/5/09 staff reported while on close observation, client (R23) walked away from his table and walked passed a male peer (R19) and struck R19 in the face with his fist (witnessed). R23 was then placed on 1:1 observation until local police escorted R23 to hospital.

On 5/17/10, facility provided documentation that protection was not documented as to how R19 should be kept safe from R23 or as to how other residents should be kept from R23 prior to his transfer to the hospital. Reporting apparently was not addressed as no evidence was found that either the preliminary report or the final report was delivered to DPH. There were no

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safeguards in place for protecting R18, R19 and all other 131 residents in the facility from R23's aggressive physical behavior.

Facility abuse investigation policy and procedure (including: neglect, injuries of unknown source, and misappropriation) includes:

-Nursing homes must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property, are reported immediately to the Administrator of the facility and the Abuse Coordinator.

-It is the policy of Columbus manor that all reports of resident abuse, neglect and injuries of an unknown source shall be promptly reported and thoroughly investigated by the Abuse Coordinator and or facility management as required by the federal guidelines

-All incidences of abuse, neglect or mistreatment are reported to Public Health and any or all qualifying appropriated State agencies within 72 hours. It is also the obligation of Columbus Manor to notify the residents immediate contact family member or representative within a 24 hour period of all allegations as well as facility policy and procedure concerning internal investigations, outside sources contacted concerning the allegation and any and all facility findings and outcomes of allegation.

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“A” VIOLATION(S):

**300.1210a)
300.1210b)3)6)
300.4010c)3)C)**

Section 300.1210

General Requirements for Nursing and Personal Care

- a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
- b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
 - 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
 - 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 300.4010

Comprehensive Assessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

- c) A comprehensive assessment must be completed by the IDT no later than 14 days after admission to the facility. Reports from the pre-admission screening assessment or

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assessments conducted to meet other requirements may be used as part of the comprehensive assessment if the assessment reflects the current condition of the individual and was completed no more than 90 days prior to admission. The assessment shall include at least the following:

- 3) A skills assessment performed by a social worker, occupational therapist, or PRSD or PRSC with training in skills assessment. The skills assessment shall include an evaluation of the resident's strengths, an assessment of the resident's levels of functioning, including but not limited to the following areas:
 - C) Community living skills (including use of telephone, transportation and community navigation, avoidance of common dangers, shopping, money management, homemaking (cleaning, laundry, meal preparation), and use of community resources);

These Requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that residents received appropriate supervision to prevent:

A. 7 residents with community pass restrictions from leaving the facility unsupervised (R1, R23, R24, R25, R26, R27 & R29).

B. the potential risk of fire related incidents related to inappropriate smoking and/or possession of smoking material: R21

These failures had the potential to impact all 134 residents of the facility.

Findings include:

A.

1. R1 has history of frequent elopements. Care plan was developed 12/03/09 to address elopement. Interventions developed to intervene if resident elopes include: limit the number of staff who redirect resident, don't overwhelm resident, walk in the same direction, don't force direction change, chat with resident, and use strategy such as a therapeutic fib to bring resident to area you want them. Care plan also states assist client/escort client for needed trips in the community.

Social Services note dated 03/11/10 by E11 (Psychiatric Rehabilitation Services Coordinator-PRSC) states R1 reported by Administrator (E1) as out of facility approaching cares, knocking on windows asking for money. As a result of this behavior E11 wrote that he restricted R1's independent pass privilege. Care plan reflected that R1 was to have an escorted pass. R1 was subsequently hospitalized and found to have cocaine in her system.

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When R1 returned to the facility, care plan interventions to address behaviors were not revised.

Nurse's note dated 04/20/10 at 11:00p.m. States R1 walked out of facility at 8:45p.m. despite staff asking her not to leave the facility. There is no evidence any staff implemented the interventions listed in care plan if the resident elopes. Again after elopement of 04/20/10 there was no revision of care plan interventions.

Skills Assessment completes at time of admission did not include a Community Survival Skill Assessment. Community Survival Skills Assessment was requested from Administrative staff. Assessment was provided which was not completed until 05/18/10.

During the daily status on 05/17/10 at 4:15p.m Administrative staff was being informed of the elopements. E1 (Administrator) responded in a very loud and threatening voice that residents have the right to leave the facility and we cannot lock them in. E3 (Psychiatric Rehabilitation Services Director-PRSD) then proceeded to also speak loudly that facility cannot lock in residents and they have a right to leave.

2. R23 was readmitted to facility on 10/31/09 with diagnosis of Paranoid Schizophrenia. Review of record denotes R23 had multiple hospitalizations for increased agitation and aggressive behavior. Review of R23's social service incidental note dated 11/1/09 documents R23 left facility while on restriction and without signing out. R23 has been psychiatrically unstable for some time and has been on restriction to the facility for observation. R23 returned to the facility shortly thereafter. R23 was reminded of facility policy on leaving the building, as well as asked to stay inside and observed for signs of elopement or increases in symptoms.

R23's care plan was last updated in July 2009. There was no documentation of interventions as to how the facility would supervise R23 and address unauthorized leaves from the facility.

3. R29 was admitted to facility with diagnosis of Bipolar Disorder on 3/11/10. Review of R29's unauthorized departure risk assessment dated 3/28/10 assessed R29 "at risk" for unauthorized departure. Nurses' notes dated 4/1/10 denote R29 went out on pass with family. Left at 2:30 PM, no medications sent with R29. On 4/5/10 facility staff contacted R29;s family and advised to return R29 back to facility to sign AMA (against medical advice). The family stated they understand. There is no further documentation regarding R29's return to facility on 4/5/10. The next documentation is dated 4/16/10 when R29 was readmitted back to facility from hospital with diagnosis of schizophrenia. Nurse notes dated 4/20/10 at 4:10 PM document R29 put a chair by the fence at 33 building and threw 2 bags of clothes over the fence herself. The nurses and CNA called to her to come back, R29 started running down Laramie heading South. The staff did not run after her. A police report was done at 6:35 PM on 4/20/10 and R29's family called to inform facility at 6:40 PM that R29 was at home, requesting facility staff or police to come and bring her back. There is no further documentation what happened to R29 after jumping over the barb wire fence. R29's initial care plan did not address R29's "at risk" for unauthorized leave.

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4. R24 was admitted to facility in May 2009 from hospital with diagnosis of Schizophrenia. R24's initial MDS assessed R24 as moderately cognitively impaired, easily distracted, with periods of restlessness, and lethargy with mental functioning varying over the day. R24 was assessed as having a history of wandering, verbally abusive and resistive to care. R24's initial social service assessment dated 5/31/09 assessed R24 as high risk of elopement due to R24 eloping from facility on first day. Nurses notes of 6/11/09 at 4:00 PM denote R24 had left facility without supervision and without staff knowing. Physician and mother notified. Further documentation notes R24's mother called facility at 9:30 PM informing facility R24 was at police station. R24 returned to facility by family on 6/15/09 from police station after being in lock up for 3 days. On 7/24/09 at 9:45 PM facility was notified by R24's family, R24 was at home and will bring R24 back in AM. On 8/7/09 at 7:00 PM facility staff was notified R24 had left facility, attempted to talk to resident and ran away, will monitor his return. At 10:00 PM staff called R24's guardian and facility was informed R24 was at parents' home. On 8/26/09 at 11:00 AM R24 walked out of front door without signing out or saying anything to anyone before eloping. At 11:00 PM, resident returned to the facility. On 9/1/09 at 8:00 PM, R24 out of facility, notified by family R24 was at there home. Review of R24's care plan identified R24 as an elopement risk, but was not updated after each elopement. There was no monitoring or supervision of R24 after return from each elopement. There was no investigation by facility as to how R24 was getting out of the facility in the evening without staff being aware. R24 was involuntary discharged from the facility on 9/24/09 after an allegation of sexual assault.

5. R27 is 41 years old and was admitted to the facility on 04/13/10 at 4:00p.m. from a local hospital. R27's diagnoses include schizoaffective disorder.

Incident report dated 04/15/10 at 8:45p.m. states R27 signed out of the facility at 9:20a.m. and has not returned. Nurses note of 04/17/10 (no time) states R27 has not returned. A friend called and said R27 is not coming back to facility.

Facility Pass Privilege and Resident Level System Policy and Procedure states facility requires a two week (fourteen day) observation period in the facility prior to any pass privilege. There was no documentation presented to Surveyor as to why R27 was able to sign out on a pass after less than 48 hours in facility.

6. R26 is a 42 year old male resident with multiple diagnoses to include Chronic Schizophrenia, NIDDM (Non-insulin dependent Diabetes Mellitus) and HTN (Hypertension). R26's annual MDS (minimum data set) dated 4/5/10 shows that the resident is moderately impaired with cognitive skills for daily decision making. R26 has a wandering behavior which was scored as "2-1," indicating that the resident exhibits this behavior 4 to 6 days but less than daily, and that the behavior is not easily altered. R26 also was assessed as being resistive to care, with the score of "1-1," indicating that this behavior occurred 1 to 3 days in the last 7 days, and that the behavior is not easily altered.

Review of R26's PAS (Pre-assessment screening) treatment recommendations dated 4/28/00

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shows that the resident was recommended to have the following treatments: Psycho-social rehab, day structure; Individual therapy; and Medication management. Under comments: "R26 requires structure until his Medical condition is more under control. He currently lives with his parents who we feel are unable to manage him currently. He would benefit from day structure & 1:1 counseling to further process his new diagnosis."

During interview held on 5/13/10 at 2:00 PM, R26 stated that he does not attend any activity or group therapy in the facility or outside the facility. R26 stated that he normally stays in his room if he is not walking around the facility. Per R26, he goes to the community on pass unescorted. R26 claims that he does not leave the facility past curfew time of 9:00 PM. Per R26, he always make sure to come back to the facility before 9:00 PM.

Review of R26's nurses' progress notes shows the following documentation:

- 8/9/09 (9:50 PM), "Call received from front desk saying this resident had walked out of the front door. resident refused to remain in the facility."

- 8/9/09 (11:00 PM), "Resident has not returned. Above endorsed to the 11-7 shift."

This documentation indicated that R26 was out of the facility for 7 hours. R26's whereabouts at that time were unknown.

- 10/7/09 (10:45 PM), "Resident noted not to be in facility at 4PM and at 10:30 PM, resident still hadn't returned to facility. I called Police to file a missing person report."

- 10/7/09 (11:00 PM), "Resident returned to facility at 11PM with no c/o (complaint of) pain and no noted s/s (signs and symptoms) of distress."

- 11/21/09 (3:00 AM), "Notified by the front desk that resident left out of the facility by the front door."

- 11/21/09 (9:00 AM), "Called resident's mother's house to inform her that R26 had not returned yet. She stated 'he still had not been to her house.'"

- 11/21/09 (10:15 AM), "Police arrived and missing person report was filed."

- 11/21/09 (11:15 AM), "Resident returned to facility with father. Resident didn't want to communicate with staff."

This documentation indicated that R26 was out of the facility for at least 8 hours. R26's whereabouts at that time were unknown.

- 2/13/10 (11:00 PM), "Res. not in facility on rounds with 3-11 shift, who claim res. left facility at 10PM, but spoke with family who claim they will return him tonight, awaiting arrival."

- 2/14/10 (12:10 AM), "Rec'd. call from res. father inquiring if res. returned to facility, informed that she thought he would be returning res, but he claims he is not aware of res. whereabouts, but will return him if he comes home."

- 2/14/10 (12:15 AM), "Call placed to Police Department to file missing person report."

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- 2/14/10 (12:20 AM), "Call placed to E5 (physician) informed res. continue to leave facility with whereabouts unknown, doesn't disclose where he has been, is talking to self, gives non-sensical comments, is easily agitated & refusing meds, stated to call his service when res. returns."

- 2/14/10 (12:30 AM), "E2 (Psychiatrist/Medical Director) informed, res. out of facility with whereabouts unknown for 3rd time this week, without order."

- 2/14/10 (1:00 PM), "Rec'd. call from res. sister, stated res. is at parents house, unable to locate father to tell him, while he is looking for him."

- 2/14/10 (2:15 AM), "Res. returned to facility accompanied per father"

- 2/14/10 (2:30 AM), E5 was called and gave order to send R26 to the hospital.

This documentation indicated that R26 was out of the facility for 4 and a half hours. The facility did not know R26's whereabouts for 3 hours. R26 was allowed to leave the facility after 9:00 PM.

- 2/24/10 (3:30 PM), R26 was readmitted to the facility. "Was told that he had to stay in facility for 3 days. resident walked right out of door."

- 2/24/10 (7:30 PM), Missing person report made to Police department.

- 2/25/10 (6:30 AM), "Resident returned to facility at this time, accompanied by his father. Resident states he walked downtown & walked back. Alert no c/o pain/discomfort. No distress noted. Very cheerful & talkative. Resident counseled on leaving facility in bad weather condition & the pass policy of facility."

This documentation indicated that R26 had walked out of the facility right after being readmitted post hospitalization. R26 was out of the facility for 15 hours and his whereabouts were unknown.

- 2/28/10 (11:30 PM), "Resident not in facility during rounds. Will observe for return to facility."

- 3/01/10 (6:00 AM), "Resident remains out of facility at this time."

- 3/01/10 (9:30 PM), "Resident still has not returned to facility. Father was here, said he had not seen R26. Police department was notified."

- 3/01/10 (10:15 PM), "Resident returned to facility escorted by his father."

This documentation indicated that R26 was out of the facility for at least 23 hours. R26's whereabouts were unknown to the facility during that time.

- 3/18/10 (10:15 PM), "Resident not in facility for rounds."

- 3/19/10 (1:20 AM), "Resident's sister called & stated that resident was at his parent's home & she will bring him back to facility."

- 3/19/10 (1:30 AM), "Resident returned to facility with his sister. Alert & responsive with no c/o voiced. No s/s distress noted. Resident encouraged to not leave the facility late at night & when he do go out walking, leave early so he can return before curfew & let the nsg. (nursing) staff know when he leaves."

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This documentation indicated that R26 was out of the facility for at least 3 hours. R26's whereabouts were unknown to the facility, until the resident's sister called the facility.

- 3/23/10 (11:00 PM), "Resident out of facility. Call placed to resident family. Sister say she had seen the resident a couple of hours earlier. Sister say, resident say he was going to return to the facility."
- 3/24/10 (2:35 AM), "Resident's sister called & stated that resident was there at their home at this time & she will bring him back to the facility now."
- 3/24/10 (2:55 AM), "Resident returned to facility."

This documentation indicated that R26's whereabouts were unknown to the facility for several hours.

- 4/19/10 (10:00 PM), "Resident signed out at 8 PM & have not returned to facility at 10:00 PM. Police called & will come to facility."
- 4/19/10 (11:30 PM), "Missing person's report filed."
- 4/20/10 (3:20 AM), "Resident returned to facility at this time. A/O x 3 (Alert/oriented x 3). No c/o voiced. No s/s distress noted. Resident states he was just out walking & did not go to his family's home.

This documentation indicated that R26 was allowed to leave the facility past curfew time (9:00 PM). R26 was out of the facility for more than 5 hours and his whereabouts were unknown to the facility.

- 5/10/10 (1:00 AM), "Resident signed out of facility at 5:47 PM on 5/9/10 & has not returned to facility at this time. Resident has hx (history) of signing OOP (out on pass) & not returning until 3AM or 4AM. Will observe for return to facility."
- 5/10/10 (6:00 AM), "Resident has not returned to facility. Police department called to do a missing person's report."
- 5/10/10 (6:30 AM), " Placed a call to resident's parents home & spoke with his sister, who stated resident did come by their home on Sunday evening & left saying he was returning to the facility."
- 5/10/10 (9:45 PM), "Resident returned to facility."

This documentation indicated that R26 was out of the facility for at least 28 hours and his whereabouts were unknown to the facility.

- 5/12/10 (4:45 PM), "Res. walking in hallway appeared angry, pushed staff member, left facility."
- 5/12/10 (9:15 PM), "Returned back to facility."

This documentation indicated that the facility allowed R26 to leave the facility angry, after pushing a staff member. R26 was out of the facility for more than 4 hours and his whereabouts were unknown to the facility during this period.

Review of R26's care plan dated 4/10/10 shows that the "Resident expresses the desire to receive

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an outside, independent pass. The resident requires the support of a long term care facility secondary to compromised mental health status." The goal, "The resident will comply with level four pass privilege." The approaches included, informing the resident that gaining an outside pass is a privilege and this privilege may be revoked based upon reports of inappropriate conduct and explaining to the resident that receiving and maintaining an on-going pass privilege is contingent upon compliance with his care/treatment plan. Further review of R26's care plan dated 4/8/10 shows that the resident is resistive to care (refuses medications, therapy) and non-compliant with facility policies regarding pass privilege and curfew. One of the approaches indicated, "Change pass privilege status if compliance with facility policy & curfew doesn't increase or improve." The facility does not have a care plan in place to address R26's elopement behavior.

Review of Social Service quarterly report dated 4/24/10 shows, "He continues to refuse to attend day program, despite staff encouragement." "Continues to exhibit difficulty in adhering to the facility policies re: outside pass privilege and curfew." The social service progress notes dated 1/24/10 states, "repeatedly refuses his medication, as well as refusing his doctors appointments. Client also continues to refuse to attend a day program, despite staff encouragement and prompts." Review of social service quarterly report dated 1/24/10 state, "He continues to refuse to attend day program, despite staff encouragement." "Client has been non-compliant with medications and doctor's appointments for much of the quarter. As a result, client has exhibited an increase in psychiatric symptoms, including irritability, aggressive/threatening bx (behavior), and delusional ideation. Client had one incident of leaving the facility without following proper procedures."

Review of the facility policy regarding pass privilege and level system shows under, The level system: "Level 1- Restricted for monitoring/escorted by staff or family only, Level 4 - Unescorted for up to four (4) hours/evaluate by nurse upon leaving and returning." Under the same policy, "Inappropriate and Unacceptable Behaviors: #7. Intimidating or harassing other residents or staff- The result will be an immediate drop to level 1." This procedure was not followed since R26 was still allowed to have a level 4 pass after the resident pushed a staff member on 5/12/10. Further review of the same policy states under rules states: "#12. I will return to my floor, nursing unit and/or room by the designated curfew time (as established by the facility). If I need additional time away from the floor/unit I will make sure the charge nurse is aware of my whereabouts and I will return as agreed. This policy was not followed by R26. However, the facility kept the resident on the same pass privilege level and the resident was not assessed.

There were at least 11 documented incidents from August 2009 through May 2010 (9 months) of R26 leaving the facility with his whereabouts unknown to the facility staff. On several occasions R26 was out of the facility for extended period of hours. There was no evidence that the facility assessed R26's community survival skills, elopement risk and pass privilege to ensure that the resident is safe to navigate in the community and to identify potential safety risk factors. The

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CONT. facility failed to evaluate and analyze the risk factors, failed to implement interventions to reduce the risk factors and failed to monitor and modify the effectiveness of the interventions each time R26 eloped from the facility to prevent a potential accident.

7. R25 has a diagnoses of Paranoid Schizophrenia. Date of Birth 10/23/52. Admit date 2/24/20. On 5/7/10 at 3:00 p.m. R25 walked to the local hospital. R25 was assessed to have unescorted privileges outside of facility up to 1 hour unescorted. Resident signed himself and then left the hospital. R25 readmitted back to facility on 5/12/10. The facility failed to reassess pass privileges, for elopement risk and community access, resulting in failure to ensure residents safety.

8. On 5/13/10, surveyors observed the back gate outside the kitchen wide open during a delivery. There were no staff present in the area, however there were 3 residents noted walking and sitting outside the patio area. Surveyors were able to enter and exit the facility in the alley way without difficulty. There was no direct observation of the exit doorways by staff.

E11 (Psychiatric Rehab Service Coordinator) stated on 5/13/10 when asked how residents are getting out of the facility, E11 responded maybe they jump the fence. E11 was asked if the courtyard is supervised by staff, E11 stated "I don't know." When asked who follows up on elopements, E11 stated "maybe E3 (PRSD)."

Facility AMA/Elopement /Discharge Policy and Procedures states for Elopement: Any resident who leaves the facility without signing himself/herself out is considered missing. Depending on the mental status of each resident, police must be notified within 8 hours. Attending physician and family are to be notified immediately. The resident's chart is to be documented. Missing Person Guideline for Contacting Police:

Resident with a level 1 or 2: Contact police immediately

Resident with a level of 3, 4, or 5: Contact police within 8 hours

An incident report must be completed and faxed to the state within 24 hours

B.

The following was observed during the environmental tour on 5/11/10. E27 (Maintenance Director) was with the surveyor at 2:05 P.M. during the environmental tour. The door to residents' room 1507 was about 2 inches open. Cigarette smoke was coming from the room. E27 knocked and entered the room. R21 could be seen from the doorway sitting on her bed smoking a cigarette. R21 put the cigarette in an empty pop can on the window ledge and stood up. R21 then walked out of the room. There was no one else in the room at this time. Smoke was observed coming out of the top of the pop can.

R27 is a 77 year old female, with a diagnosis including Chronic Schizophrenia, Depression and Dementia. Document review shows that R21 was identified as a high risk smoker. R21 was care planned as a non compliant smoker. A 12/10/09 Social Service Quarterly note states that R27 is a non compliant smoker and always smokes in her room.

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5107 – 21 WEST JACKSON BOULEVARD, CHICAGO, ILLINOIS 60644

Address, City, State, Zip

27639, 18196

JULY 6, 2010

Reviewed By

Date of Survey

ANNUAL HEALTH

02437, 02569, 08705, 12642, 16746

Type of Survey

Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE:

THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

“B” VIOLATION(S):

**300.4030a)1)
300.4050**

Section 300.4030

**Individualized Treatment Plan for Residents with Serious
Mental Illness Residing in Facilities Subject to Subpart S**

- a) On admission, information received from the admission source (e.g., resident, family, preadmission screening (PAS) agent) shall be used to develop an interim treatment plan. In developing an individual's interim treatment plan (IITP), the facility shall review the PAS/MH assessments and "Notice of Determination" and consider the use of this information in developing the interim treatment plan. The IITP shall focus on those behaviors and needs requiring attention prior to development of the individualized treatment plan (ITP). Each IITP shall be based on physician's orders and shall include diagnosis, allergies and other pertinent medical information. The following information shall also be considered, as appropriate, to allow for the identification and provision of appropriate services until a final plan is developed:
- 1) Known risk factors (e.g., wandering, safety issues, aggressive behavior, suicide, self-mutilation, possible victimization by others);

Department Use ONLY

Facility Designee

Reviewed By

Signature

Acceptable Date

Title

Unacceptable Date

Date

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Section 300.4050 Psychiatric Rehabilitation Services for Facilities Subject to Subpart S

- a) The facility shall develop and implement a psychiatric rehabilitation program. A facility may contract with an outside entity to provide all or part of the psychiatric rehabilitation program as long as individual residents' needs are met and subsection (c)(4) is met. The program shall be designed to allow a wide array of group and individual therapeutic activities, including, but not limited to, the following:
- 1) Skills training programs addressing a comprehensive range of skill areas, including the major domains of self-maintenance, social functioning, community living, occupational preparedness, symptom management, and substance abuse management. Skills training programs should:
 - A) Include available published, validated modules with highly structured curricula for teaching targeted skills (e.g., trainer's manuals and videotapes that demonstrate the skills to be learned);
 - B) Proceed within a training-to-mastery framework that addresses discrete sets of skill competencies, introduces targeted skills in a graded fashion, and regulates the difficulty of exercises to create a momentum of success;
 - C) Include focused instructions and modeling, frequent repetition of new material, auditory and visual representation, role playing and practice, and immediate positive feedback for attention and participation; and
 - D) Be adjusted in content, form and duration to match residents' profiles in terms of stress tolerance, learning impairments, and motivational characteristics. Environmental conditions shall be arranged to help compensate for deficits in resident concentration, attention, and memory (e.g., reduction of distracting stimuli and extensive use of supportive reminder cues), as needed.
 - 2) Incentive programs, such as motivational interviewing, behavioral contracting, shaping or individual positive reinforcement, and token economy.
 - 3) Strategies for skill generalization, such as homework, in vivo training, resource management skills, problem-solving skills, and self-management skills (self-monitoring, self-evaluation and self-reinforcement).
 - 4) Aggression prevention and management, including resident screening (history of aggressive and assaultive behavior, precipitating factors, signals of escalating risk, and effective de-escalation strategies); identification and modification of environment risk factors (e.g., physical plant and resident mix); provision of skills training, behavioral, and appropriate psychopharmacological interventions based on individualized resident assessment; and policies and procedure for rapid response to behavioral emergencies.
 - 5) Substance dependence and abuse management services, including toxicological screens, psychopharmacology, alcohol and drug education, group interventions, recovery programs (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Mentally Ill Substance Abusers (MISA)), and harm reduction.

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- b) The facility's psychiatric rehabilitation program shall be integrated with other services provided to residents by the facility to develop a cohesive approach to each resident's overall needs and consistent plan of care.

- c) Each facility shall have a written description of the components provided by the psychiatric rehabilitation program. Documentation shall include a description of psychiatric rehabilitation principles, the specific rehabilitation techniques and methods, and the type/level of staff utilization in providing each service to the residents.
 - 1) The facility's psychiatric rehabilitation program shall develop, apply and evaluate strategies to create opportunities for residents to practice, transfer, and utilize skills both in the facility and in the broader community.
 - 2) The facility's psychiatric rehabilitation program shall demonstrate close working alliances with community mental health and vocational service providers through such indicators as joint staff training and planning activities, mutual referrals, collaborative resident treatment planning, and effective resident transition.
 - 3) Resources utilized outside of the facility for service provision, consultation, or referrals shall be included in this documentation.
 - 4) If a facility uses consultants or contracts all or part of the psychiatric rehabilitation program to another entity:
 - A) A contract shall include a written description of the components, the name of the person responsible for each component, and the type/level and number of staff used in each component.
 - B) The facility shall have a policy that indicates coordination between facility staff and the entity or consultants, including unannounced visits by designated facility management to the site of the components of the program.
 - C) Consultants contracting directly with the facility or through another entity who are not physicians shall have participated in an Illinois Department of Public Aid-approved Psychiatric Rehabilitation Training Program.
 - D) Contracted personnel shall meet the same education and experience requirements as facility personnel under this Subpart.

These Requirements are not met as evidenced by:

Based on interview, observation and record review the facility failed to provide mental health rehabilitative services for mental illness for 19 of 24 sampled residents and 2 residents outside the sample. (R1, R2, R3, R4, R5, R6, R7, R8, R10, R11, R12, R13, R15, R16, R17, R18, R19, R20, R21, R25 & R26).

The facility also failed to provide physical therapy for 1 resident (R6) who suffered a recent fracture and had physician orders for therapy.

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The facility failed to provide programs based on recommendations from the Pre-Admission Screening and Resident Review (PASRR).

The facility failed to have criteria/validated modules with structured curricula for teaching targeted skills.

The facility failed to keep records of topics/content of programs.

The facility failed to follow their Pass Privilege and Level System policy and procedure.

This systemic failure has the potential to affect all 134 residents in the facility that suffer from mental illness.

Findings Include:

1. On 05/10/10 at approximately 2:00p.m. E3 (Psychiatric Rehabilitation Services Director- PRSD) was interviewed regarding staff providing mental health rehab. E3 stated staff is herself and three Psychiatric Rehabilitation Services Coordinator's (PRSC), E11, E14 & E30. E3 presented each caseload. E3 has 29 residents, E11 has 35 residents, E14 has 35 residents and E30 has 35 residents.

E3 provided a schedule of Psychosocial In-House Groups. Facility provides five groups each scheduled one time a week. Schedule is as follows:

Tuesday 2:00p.m. Human Sexuality with E30

Tuesday 3:30p.m. Stress Management with E30

Wednesday 2:30p.m. Substance Abuse with E14

Wednesday 3:00p.m. Money Management with E14

Saturday 1:00p.m. Discharge Planning

E3 was asked for lists of residents who attend these groups and the how it is determined a resident will be assigned a group. E3 stated that all residents are invited to all groups.

E3 stated Human Sexuality and Stress Management are posted and residents can attend by choice. Twenty two residents were listed for the Substance Abuse Group. Eighty-two residents were listed for the Money Management. There was nothing provided regarding the Discharge Planning Group

During interview on 05/11/10 E30 was asked to provide content information for groups. E30 stated there are no criteria/modules for programs. E30 stated he decides what the topic of his groups will be on the day of the group. E30 was asked to provide information on topics of previous groups. E30 stated subject of previous groups are not kept. E30 was specifically asked how residents are assigned to groups. E30 could not provide a clear answer to this question. He did state that R42 attends most groups because she likes to have something to do.

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Attendance at programs is documented as follows:

Money Management - 82 residents listed who should participate

05/05/10 - no one showed

04/28/10 - one resident in attendance

04/21/10 - cancelled due to other meetings per PRSD

04/14/10 - three residents in attendance

04/07/10 - three residents in attendance

03/31/10 - no one showed

03/16/10 - two residents in attendance

03/10/10 - no one showed

03/03/10 - one resident in attendance

02/25/10 - one resident in attendance

02/17/10 - one resident in attendance

02/10/10 - three residents in attendance

02/03/10 - two residents in attendance

01/27/10 - one resident in attendance

01/20/10 - three residents in attendance

01/13/10 - two residents in attendance

01/06/10 - four residents in attendance

Substance Abuse Group - 22 residents listed who should participate

05/05/10 - 10 residents in attendance

04/28/10 - 10 residents in attendance

04/21/10 - 13 residents in attendance

04/14/10 - 11 residents in attendance

04/07/10 - 15 residents in attendance

03/31/10 - 10 residents in attendance

03/16/10 - 15 residents in attendance

03/10/10 - 10 residents in attendance

03/03/10 - 11 residents in attendance

02/25/10 - 12 residents in attendance

02/17/10 - 12 residents in attendance

Discharge Planning - nothing presented to surveyors

Stress Management Group - 12 residents listed who should participate

05/11/10 - 16 residents in attendance

05/04/10 - 14 residents in attendance

04/27/10 - No attendance presented to surveyor

04/20/10 - No attendance presented to surveyor

04/13/10 - 11 residents in attendance

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04/06/10 - 10 residents in attendance
03/30/10 - 10 residents in attendance
03/23/10 - 10 residents in attendance
03/18/10 - 12 residents in attendance
03/09/10 - No attendance presented to surveyor
03/02/10 - No attendance presented to surveyor
February 2010 - No attendance presented to surveyor

Human Sexuality Group - 12 residents listed who should participate

05/11/10 - 8 residents in attendance
05/04/10 - 9 residents in attendance
04/27/10 - 6 residents in attendance
04/20/10 - No attendance presented to surveyor
04/13/10 - 9 residents in attendance
04/06/10 - 11 residents in attendance
03/30/10 - 10 residents in attendance
03/23/10 - 10 residents in attendance
03/18/10 - No attendance presented to surveyor
03/09/10 - No attendance presented to surveyor
03/02/10 - No attendance presented to surveyor
02/23/10 - No attendance presented to surveyor
02/16/10 - 9 residents in attendance
02/09/10 - 10 residents in attendance
02/02/10 - 10 residents in attendance

2. E3 also stated facility has a Pass Privilege and Level System. Pass level is for community access with supervision or independence. E3 stated residents move form level to level based on compliance with medication, behavior, safety, previous community pass and behavior, personal care and compliance with treatment plan.

Level System consists of 5 levels of achievement:

1. Restricted for monitoring/escorted by family or staff only
2. Escorted by staff, community service, family or friend
3. Unescorted for up to one hour
4. Unescorted for up to four hours
5. Unescorted for up to eight hours

Pass privileges can be lost for smoking in non-designated areas, stealing, physical aggression, refusal of medications, substance abuse, excessive verbal aggression and inappropriate behavior.

To receive an increase in level a resident must maintain the following:

personal hygiene

compliance with diet, meal times, schedules, appointments, medications and treatments with only one reminder

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keep personal space in clean and neat manner
follow smoking rules
attend groups and activities
maintain behavior compliance
no substance abuse (alcohol or drugs)

Investigation for the implementation of this policy showed that facility staff does not follow/implement this policy as stated. Examples of this include:

-R7 stated he does not attend any programs in the facility or outside the facility. Care plan indicated that R7 has a level four pass even though he does not attend any programs.

-Social Services note dated 03/11/10 by E11 (PRSC) states R1 reported by Administrator (E1) as out of facility approaching cars, knocking on windows asking for money. As a result of this behavior E11 wrote that he restricted R1's independent pass privilege. Care plan reflected that R1 was to have an escorted pass. R1 was subsequently hospitalized and found to have cocaine in her system. R1 returned to the facility on 03/16/10 and maintained a level three pass. R1's current record shows that she is frequently non compliant with medications and does not attend programs on a regular basis. During survey R1 was observed out in the community alone. R1 has maintained a level three pass even though she is non-compliant with meds and programs.

-R15 refuses all psychoactive medications, frequently other medication and does not attend any programs. R15 maintains a level three community pass.

3. R6 had a fall on 03/31/10 and suffered a patellar fracture. R6 was sent to the hospital and returned with an immobilizer. On 05/05/10 physician ordered knee brace to be discontinued and physical therapy (P.T.) evaluation and treatment two to three times per week for six weeks. There was no P.T. assessment found in record or any evidence that R6 has received therapy. On 05/12/10 E18 (Assessment Coordinator) was asked if R6 was received P.T. or had been assessed. E18 stated he did not know. E4 (Assistant Director of Nurses) stated the Therapist was on vacation. R6 is not receiving P.T. as recommended by physician.

R6 was admitted to the facility on 1/08/09. R6 is 54 years old and diagnoses include bipolar disorder with psychotic features. Pre-Admission Screening and Resident Review (PASRR) Screening indicated that nursing facility services are appropriate and should provide the following Specialized Services for R6:

- Professional observation (Physician/Registered Nurse) for medication monitoring, adjustment and/or stabilization
- Instrumental Activities of Daily Living training/reinforcement
- Mental Health Rehabilitation activities
- Aggression/Anger management
- Incentive program to improve participation in treatments
- Community re-integration activities

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-Substance use/abuse management

The only Specialized Service addressed in care plan is attendance at Day Program. During observations made on 05/10/10, 05/11/10, 05/12/10 and 05/13/10 R6 did not go to any Day Program. R6 was observed to lie in bed, eat meals and stand in the courtyard.

4. R7 was admitted to the facility on 02/24/10 from another nursing facility. R7 is independent in all activities of daily living. During interview on 05/11/10 at 11:50a.m., R7 stated he does not attend any programs in the facility or outside the facility. R7 stated he structures his own activities. R7 was observed to be very well groomed and neatly dressed. During interview R7 stated he would like to move out with his girlfriend or transfer to another nursing facility.

On 04/16/10 E11 (Psychiatric Rehabilitation Services Coordinator-PRSC) wrote in progress notes that R7 attends an outside day program, is prompted by staff to attend every session and is encouraged to work towards achievement, self-sufficiency and independence.

R7 also has an Outside Pass Privilege at a Level 4. This pass is a revocable privilege earned by appropriate conduct and compliance with treatment plan.

E11 was interviewed on 05/12/10 at approximately 11:00a.m. E11 was asked why notes document that R7 attends an outside day program when he actually does not attend. E11 stated that he documented that R7 attends the day program because R7 said he would go. E11 was also asked why R7 is at a Level 4 Pass Privilege (Independent pass up to four hours for those who follow treatment plan) when he does not participate in any outside or in house programs. E11 stated that R7 was recently admitted from another nursing facility that closed and he did not want to be punitive to the resident.

Care Plan Long Term Goals are R7 will reach maximum independence with the facility, R7 will participate in job training and improve work skills and will become independent in medication, knowledge of meds, time and dose. There was no plan found in record or presented to surveyor of any methods developed to assist resident to reach these goals.

5. Records indicate R1 was readmitted to the facility on 11/23/09 after a psychiatric hospitalization. Psychiatric evaluation completed 11/16/09 states that R1 had lived at facility for a few months. She left the facility and went to live with a church related program and group home. Evaluation states she apparently walked out of the group home, has been without psychiatric medications for at least three months and is currently un-domiciled.

There was no evidence facility contacted the State Mental Health Authority to have a current PASRR screening conducted.

During interview on 05/10/10 at 2:00p.m. R1 stated she would like to be discharged from the facility but does not get any help or information from facility staff aimed at discharge. There was no discharge assessment found in record.

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R1 does attend a Day Program twice weekly from 8:30a.m. to 11:30a.m. There was no documentation in record or PRSC notes as to what R1 does at the Day Program. There was no evidence of any integration of services between the facility and Day Program.

R1's care plan states she will participate in a Money Management Program. Documentation of this program was reviewed for three months of participation and there was no evidence R1 ever attended program.

6. Incident Report dated 04/25/2010 states at 5:00 a.m. R16 was attacked by roommate (R20). R16 was hit several times and pinned down on the floor. R16 was also threatened by roommate.

R20's diagnoses include chronic paranoid schizophrenia. Physician orders for psychoactive medications were Fazacllo 100mg at 6:00 a.m. and 150mg. at hour of sleep (8:00 p.m.). Review of April 2010 medication administration record (MAR) shows that R20 was not given Fazacllo 150mg. at hour of sleep from 04/19/2010 to 04/25/2010. MAR also indicates Fazacllo was not given 04/10/10 at 6:00 a.m., 04/15/10 at 8:00 p.m., 04/16/10 at 6:00 a.m., 04/24/10 at 6:00 a.m. and 04/25/10 at 6:00 a.m. MAR does not indicate reasons Fazacllo was not administered on the above dates/times.

Neither nurse's notes nor PRSC (Psychiatric Rehabilitation Services Coordinator) address R20 not taking medications. R20's care plan does not address medication non-compliance. On 04/25/10 R20 was hospitalized for increased paranoid delusions, physical aggression, attacking her roommate without provocation and refusing psychoactive medications. R20 was readmitted on 05/07/10.

R20 maintained a level four pass even though she refused psychoactive medications, assaulted her roommate and was hospitalized for behavior. Care plan was not revised until 05/13/10 to address non-compliance of medications and aggression toward roommate.

7. R16's diagnoses include chronic undifferentiated schizophrenia and atypical psychosis. Current Care Plan dated 02/25/10 states R16 refuses to take medications with include antipsychotic Risperdal and other medications Tapazole and Lipitor. Care Plan states R16 will attend a Day Program. R16 does not attend a Day Program. Record did not contain any plan or mental health rehab.

During survey R16 was observed at meals and in her bedroom.

Care Plan indicates R16 maintains a Pass Level 4 even though she refuses medication and does not participate in any programs.

The only psychosocial group identified for R16 to attend is Money Management. Four months of group attendance was reviewed and R16 was not listed in attendance.

8. R5 has a diagnoses of Schizophrenia and Anxiety. Date of Birth 7-22-59. R18 has a

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diagnoses of Schizophrenia Disorganized Type with Anxiety. Date of Birth 2-26-29. On all days of the survey 5-10, 5-11, 5-12, and 5-13-10, both residents R5 and R18 did not attend programs. Both residents were observed walking and or pacing the facility. Interview with E28 (Activity Director) on 5-12-10 at 10:25 a.m. in the Dining Room stated that these residents received 1 to 1 activities, 3 times a week for 10 minutes each. Interview with E11 (PRSC) on 5-11-10 indicated that R5 and R18 do not attend any outside or inside programs.

9. R13, R25, R12 and R19 do not attend a structured rehabilitative program with information on what the program is about and with attendance sheets.

10. R3 is a 30 years old male, who was admitted to the facility on 2/12/10 with diagnosis of Schizophrenia.

R3's PAS/MH (Pre-assessment screening/Mental Health) Level II Notice of Determination dated 2/23/2010, shows that the resident requires the following special services: Professional Observations for medication monitoring, adjustment and/or stabilization, Instrumental Activities of Daily Living training/reinforcement, mental Health Rehabilitation activities, Incentive program to improve participation in treatments, Community re-integration activities and Substance use/abuse management.

During an interview held on 5/10/10 at 2:45 PM, R3 stated that he attends the outside group program called "Step of faith" every Thursday and Friday from 9:00 AM to 11:30 AM. Per R3 he does not attend any in house programs. R3 stated that he attends activities in the facility like card games and coloring.

During observations made during the survey from 5/10/10 through 5/12/10, R3 was observed on numerous random occasions not engaged in any activities and/or programs in the facility. On 5/10/10 at 2:45 PM, R3 was observed pacing inside the activity area. At 3:00 PM, R3 was at the court yard smoking. At 3:45 PM, R3 was sitting inside the dining room. On 5/11/10 at 9:45 AM, R3 was at the court yard smoking. At 1:00 PM, R3 was sitting inside the dining room, and at 2:00 PM, R3 was walking back and forth near the social service area and dining room. R3 was asked at this time if he attended any activity that morning or if he plans on attending any activity that afternoon. R3 responded that he has no plans. On 5/12/10 at 11:00 AM, R3 was at the courtyard smoking, and at 1:00 PM and 2:30 PM, R3 was observed sitting inside the activity area. R3 was asked on 5/12/10 at 2:30 PM, if he attended any morning activity and if he plans on attending any afternoon activity that day. R3 responded that he have no plans to attend any activity today.

Review of R3's care plan dated 3/3/10, with goal date of 6/3/10 states, "The resident is minimally involved in the life of the facility and demonstrates limited social interaction related to a diagnosis of mental illness. Symptoms and problems are manifested by: only occasionally joining programs." The goals for these are for R3 to engage in a meaningful interactive

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group/program 3 times a week and for R3 to demonstrate enhanced involvement by engaging in bingo or Pokeno, table games or any activity of interest 3 times a week. One of the approaches/interventions is for the facility to provide group focused sessions 5 or more times per week emphasizing increased socialization, responsibility and involvement.

This activity care plans were not met based on the observations made on 5/10/10 through 5/12/10.

Review of R3's current POS (Physician order sheet) shows an order for, "May attend Day program 1-6 days/week." This order started on 3/4/10. Further review of R3's POS also shows orders for, "Activities Ad Lib." This order started 2/13/10 and "Activities & Social Rehab in house and out W/O (without) C/I (contraindication)," this order was started on 2/13/10.

Review of R3's initial MDS (minimum data set) dated 2/25/10 shows that the resident is modified independent with cognitive skills (with some difficulty in new situations only). R3 is independent with all his ADL's (Activities of daily living).

Review of R3's records shows that the resident has been arrested and convicted of possession and delivery of controlled substances, and unwillful possession of weapon. R3's Social Service progress notes dated 4/16/10 show, "Re: criminal history one of the goals he is working with is use his leisure time in a productive way."

Based on the above information, R3 does not participate in any specialized rehabilitative programs in the facility to help enhance his sense of well-being and to maintain or achieve as much independence and self determination as possible. The facility failed to provide mental health rehabilitation activities, incentive program to improve participation in treatments, community re-integration activity services and Substance use/abuse management services required by the resident based on the PAS/MH (Pre-assessment screening/Mental Health) Level II Notice of Determination.

11. R2 is a 51 year old male with multiple diagnoses to include Schizophrenia, and history of substance abuse. Review of R2's records shows that the resident has a history of committing a crime of a sexual nature and is a registered sex offender.

R2's PAS/MH dated 10/21/08, shows that the resident requires the following special services: Professional Observations for medication monitoring, adjustment and/or stabilization, Instrumental Activities of Daily Living training/reinforcement, mental Health Rehabilitation activities, Aggression/Anger management, Illness self management, Incentive program to improve participation in treatments and Community re-integration activities.

During observations made on 5/10/10 at 2:50 PM, R2 was observed inside the activity area, playing cards with other male residents. R2 was observed on 5/11/10 at 9:50 AM, sitting inside the activity area not engaged in any activity. Interview with R2 stated that he attends the outside group program called "Step of faith" every Thursday and Friday. Per R2 the bus picks them up

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at around 7:30 AM and comes back to the facility at around 12:00 noon. According to R2, he does not have any plans of attending any activity that day except the card games, if they will have any in the afternoon. During a random observation made on 5/12/10 at 11:00 AM, R2 was again sitting, inside the activity area, not engaged in any activity. R2 stated that he does not attend any in house activity except card games, which are usually held in the afternoon. Review of R2's care plan dated 1/29/10 shows that the resident engages in the following leisure/recreation pursuits: "Attending organized activities" and "community pass privilege." The approaches includes: "encourage the resident to pursue formal and informal leisure interest opportunities," "Discourage unhealthy behavior(s) and/or activities that have a negative effect on the resident's overall health" and "allow the resident to engage in activities of his own interest." Further review of R2's care plan dated 4/29/10, shows that the resident has a history of criminal behavior. Under the goal it states, "The resident will participate with in-house activities and social functions as a method of using his leisure in a positive way." The approach included, "Resident will receive prompts by staff to assist resident to have his leisure time filled with positive activities to help keep resident occupied in a positive manner. Resident will meet with staff to discuss the positives of maintaining busy with activities of his choice."

Review of R2's current quarterly MDS dated 4/28/10 shows that the resident is moderately impaired with cognitive skills, independent with all his ADL's.

Based on the above information, R2 does not participate in any specialized rehabilitative programs in the facility to help enhance his sense of well-being and to maintain or achieve as much independence and self determination as possible. The facility failed to provide mental health rehabilitation activities, illness self management services, incentive program to improve participation in treatments, community re-integration activity services and Aggression/Anger management services required by the resident based on the PAS/MH (Pre-assessment screening/Mental Health) Level II Notice of Determination.

12. R8 is a 61 year old female with diagnosis of Schizophrenia. R8's PAS/MH dated 6/25/09, shows that the resident requires the following special services: Professional Observations for medication monitoring, adjustment and/or stabilization, Instrumental Activities of Daily Living training/reinforcement, Mental Health Rehabilitation activities, Illness self management, Incentive program to improve participation in treatments and Community re-integration activities.

During observations made on 5/10/10 at 3:00 PM, R8 was laying in bed, staring at the ceiling inside her room. R8 verbalized no interest in joining any activities that the facility have scheduled. R8 stated, "I am not interested in doing anything" and R8 told the surveyor to leave the room. On 5/11/10 at 9:55 AM, R8 was again observed laying in bed, staring at the ceiling inside her room. R8 was not engaged in any activity. R8 was uncooperative with the surveyor, refused to answer questions and told the surveyor to leave the room. On 5/11/10 at 2:30 PM, R8 was inside her room in bed, starring at the ceiling. R8 refused to talk to the surveyor.

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During interview held on 5/12/10 at 9:30 AM, E3 (PRSD/Psychiatric Rehabilitation Service Director) stated that R8 only attends faith & fellowship prayer groups and refuses to attend any other activity in the facility. Per E3, at times R8 would go to the TV (Television) room. E3 stated that 1:1 is being provided to R8 but the resident is resistive and would tell the staff to get out of the room. Surveyor requested E3 to show R8's 1:1 documentation. E3 stated that she will get it from E23 (Activity Director). R8's 1:1 activity documentation was not given to the surveyor for review.

During interview held on 5/12/10 at 9:40 AM, E23 stated that R8 only comes out of her room during spiritual activities and birthday parties at times. Per E23, R8 stays most of the time in the room. E23 stated that R8 is not on a 1:1 activity.

Review of R8's care plan dated 4/6/10 shows, "The resident demonstrates significant mood distress related to: a diagnosis and/or history of depressive illness." "Problems/needs are manifested by: Remaining secluded in his/her room for the majority of the day. Decreased interest in various activities and the environment." Part of the approach for this concerns included, "Assist resident in structuring leisure time, prompt social interaction."

Based on the above information, R8 does not participate in any specialized rehabilitative programs in the facility to help enhance his sense of well-being and to maintain or achieve as much independence and self determination as possible. The facility failed to provide Mental Health Rehabilitation activities, Illness self management services, incentive program to improve participation in treatments and community re-integration activity services required by the resident based on the PAS/MH (Pre-assessment screening/Mental Health) Level II Notice of Determination.

13. R26 is a 42 year old male resident with multiple diagnoses to include Chronic Schizophrenia, NIDDM (Non-insulin dependent Diabetes Mellitus) and HTN (Hypertension). R26's annual MDS (minimum data set) dated 4/5/10 shows that the resident is moderately impaired with cognitive skills for daily decision making. R26 has a wandering behavior which was scored as "2-1," indicating that the resident exhibits this behavior 4 to 6 days, but less than daily and that the behavior is not easily altered. R26 also was assessed as being resistive to care, with the score of "1-1," indicating that this behavior occurred 1 to 3 days, in the last 7 days and that the behavior is not easily altered.

Review of R26's PAS treatment recommendations dated 4/28/00 shows that the resident was recommended to have the following treatments: Psycho-social rehab, day structure; Individual therapy; Medication management. Under comments: "R26 requires structure until his Medical condition is more under control. He currently lives with his parents who we feel are unable to manage him currently. He would benefit from day structure & 1:1 counseling to further process his new diagnosis.

During interview held on 5/13/10 at 2:00 PM, R26 stated that he does not attend any activity or

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group therapy in the facility or outside the facility. R26 stated that he normally stays in his room, if he is not walking around the facility. Per R26, he goes to the community on pass unescorted. R26 claims that he does not leave the facility past curfew time of 9:00 PM. Per R26, he always makes sure to come back to the facility before 9:00 PM.

Review of R26's nurses' notes shows, at least 11 documented incidents from August 2009 through May 2010 (9 months) of R26 leaving the facility with his whereabouts unknown to the facility staff. On several occasions R26 was out of the facility for extended period of hours.

Review of Social Service quarterly report dated 4/24/10 shows, "He continues to refuse to attend day program, despite staff encouragement." "continues to exhibit difficulty in adhering to the facility policies re: outside pass privilege and curfew." The social service progress notes dated 1/24/10 states, "repeatedly refuses his medication, as well as refusing his doctors appointments. Client also continues to refuse to attend a day program, despite staff encouragement and prompts." Review of social service quarterly report dated 1/24/10 states, "He continues to refuse to attend day program, despite staff encouragement." "Client has been non-compliant with medications and doctor's appointments for much of the quarter. As a result, client has exhibited and increase in psychiatric symptoms, including irritability, aggressive/threatening bx (behavior), and delusional ideation. Client had one incident of leaving the facility without following proper procedures."

Review of R26's records including the nurses' notes, care plan and social service progress notes shows no evidence that the resident attends any structured program and structured individual therapy inside or outside the facility.

Based on the above information, R26 does not participate in any specialized rehabilitative programs in the facility to help enhance his sense of well-being and to maintain or achieve as much independence and self determination as possible. The facility failed to provide the recommended treatments for R26 based on the Pre-assessment screening.

Examples also include R4, R9, R10, R11, R17 & R21.

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