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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS CARE CENTER	605 EAST CHURCH STREET, P O BOX 600 KEWANEE, IL 61443

(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 223	Continued From page 16 and indicators that may lead to aggressive behavior with employee in-services education completed on 4/19/11. 6. 4/14/11 in-servicing education provided to staff regarding spotting impending anxious and aggressive behavior and seeking assistance for intervention. Completed on 4/19/11 for all staff. 7. On 4/15/11 all resident charts on "Unit" reviewed for last 3 months of documentation to identify residents who have shown verbal or physical aggression toward staff or other residents. 8. 4/15/11 - QA (Quality Assurance) committee Behavior Referral and Episodic Behavior Log has been reinstituted to facilitate communication of behaviors to the department supervisors for review and consideration for care plan review and/or further investigation. 9. 4/15/11 - 4/19/11 Admission Notice, Change in Care Needs Notice, DON/Administrator Required Notification Listing....and Behavior Referral In-serviced to employees at shift change.	F 223		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.3240a) 300.3240f) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 17 a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 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 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) The Requirements were not met as evidenced by: Based on record review, interview, and observation, the facility failed to protect one of five residents (R1) in the sample of five from being physical assaulted by another resident (R2) who was identified as being physically aggressive. R2 lunged at R1, grabbed R1 by the hair, knocked her to the concrete pavement and	F9999		

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hit R1's face on the concrete. This failure resulted in R1 being sent to the hospital with a laceration to her forehead, swelling and bruising of her forehead and eyes as well as pain in her shoulders, head, arms and legs. This deficient practice has the potential to effect all 56 residents (R1-R5 and R7-R57) residing on the locked behavioral unit.

Findings include:

The incident report dated 4/13/11 at 11:30 am faxed to the Illinois Department of Public Health (IDPH) Regional Office documents on 4/11/11 at 4:45 pm states:

"R1 ... 74 year old female admitted to facility 3/29/11....History of restlessness, agitation with resulting disruptive behavior at previous nursing home not evident in this facility since admission.....
R2....29 year old female admitted on 12/31/10...Has history of aggression and distrust of staff with behavior of unprovoked aggression toward staff and depressive symptoms with threats of self harm since admission.....
Multiple residents and one staff member in attendance at time of incident and additional staff members called to aide were interviewed.....
According to witness accounts and investigation - Approximately 4:45 pm residents were in the courtyard for 'smoking pass' attended to by CNA (Certified Nursing Assistant). R1 and R2 were seated near each other and were engaged in conversation.....which escalated when R1 accused R2 (of stealing) her CD (compact disc) cord. R2 lunged toward R1 knocking her to the ground then climbed atop her pulling at her hair.

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(Another resident) and CNA attempted to remove R2 from R1 unsuccessfully. (Another resident) then summoned assistance from (Nurse) and (Unit Aide). (Nurse) and (Unit Aide) removed R2 from atop R1 and removed her from the scene."

On 4/15/11 at 10:05 am R7 stated, "I was in on the fight.....(R2) grabbed (R1's) hair and began shaking her like a rag doll. Both fell, (R2) was on top beating and beating her. I tried to pull (R2) off (R1) a couple times. I went to the door and yelled 'staff/staff.' (E5/Certified Nursing Assistant/CNA) was sitting on the picnic table and did nothing! I couldn't believe it. Staff came and told me to go and everyone to go inside so there was no audience. (R2) has been verbally abusive and threatening to hurt me. (R2) and (R3) make me scared. They say they'll hurt us and stuff."

On 4/15/11 at 9:40 am R8 stated she observed the altercation on the patio on 4/11/11 between (R1) and (R2) and stated, "(E5/Certified Nursing Assistant/CNA).....did not try to stop it."

On 4/14/11 at 10:00 am R1 (victim) stated, "I am aching from being attacked in the yard. I have to keep everything locked up. I was beat up on Sunday I believe. (R2) keeps stealing my cord for my CD (compact disc) player. I live for my classical music. The second time she stole it I was out in the yard - I went out to enjoy the day. I asked (R2) to give me back my cord. (R2) said 'no.' I said give it back to me now. (R2) grabbed my hair and dragged me across the concrete - I am black and blue all over and have an awful headache. Some residents went to get staff and they came out. I went in the ambulance and

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don't remember much....I have a bad back but it's much worse. I still live next to (R2). They should have gotten rid of her right away. I feel very tense because she is still right there."

Observation on 4/14/11 at 10:00 am verified R1 and R2 reside in connecting bedrooms by a shared bathroom. Doors are available so residents in both rooms have access to the bathroom as well as both rooms.

On 4/14/11 at 2:30 pm R2 (perpetrator) stated, "(R1) instigated me outside about her radio cord. I said I didn't have it. Then we ended up getting into an altercation. (R7) was yelling and trying to get me off (R1). (E5/CNA) was out smoking. I think he yelled for other staff. I don't know I was busy....(R7) shouldn't have been trying to coddle (R1). (R1) deserved it. I had a laceration in my left eyeball and my sutures opened up. I went to the hospital. My finger is messed up worse now."

On 4/11/11 at 4:45 pm nursing notes documented by (E8/Unit Manager/Licensed Practical Nurse/LPN) state, "Resident (R2) out in court yard with peers and staff supervising. Res (R2) became argumentative with peer (R1). Suddenly became explosive...lunged at peer and engaged in aggressive physical behavior harming another peer.....Staff...separated both res. Staff attempted to redirect and divert res (R2). Res (R2) continued with psychotic delusional behavior swinging, hitting, swearing and threatening staff.....PRN given without results. Staff continue with 1:1 supervision and redirection as res (R2) continued to escalate."

Nursing notes by (E19/Licensed Practical

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Nurse/LPN) on 4/11/11 at 4:45 pm for R1 state "This nurse was (summoned) to patio, upon entering the area, resident (R1) was observed laying on stomach. (R2) was sitting on top of (R1) with both (R2's) hands in (R1's) hair. This nurse and staff member immediately intervened and removed (R2) from (R1). This nurse went to assess (R1) on which laceration was noted to forehead with sanguinous drainage present..... (R1) did verbalize pain to right side of body, forehead and back. While performing tx (treatment) to (R1), (R2) was very belligerent and stating 'You f***ing b****. I hope you die (to R1).' R2 was (moved) and SSD (Social Services Director) notified."

On 4/15/11 at 3:30 pm E5 (Certified Nursing Assistant/CNA) stated, "I was passing cigarettes and went off to my right side to light a cigarette. When I turned back (R2) had (R1) on the ground and pulling fistfuls of hair. I went over to attempt to release (R1's) hair from (R2's) grasp..... (Before aggressive incident) (R2) was starting to get loud but at that time I still wasn't seeing a warning that (R2) would attack (R1).....I didn't think about getting extra help when (R2) was getting loud and defensive.....I was not aware of (R2) being physically aggressive with other residents prior to this time with (R1)."

On 4/14/11 at 11:05 am E1 (Administrator) stated, "(R2's) altercations have been with staff in the past. It's a way for her to get drugs (Haldol/Ativan). She has Huntington's....when she (R2) lays down at night she (R2) can feel the chorea (jerking type) movements. Her (R2) doctor and staff believe she acts out to get the drugs."

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F9999	Continued From page 22 On 4/14/11 at 11:05 am the facility accident/incident log for the past three months was requested including resident to resident altercations with investigations and recommendations as well as resident to staff altercations with investigations and recommendations. The nursing notes for R2 from admission date of 12/30/10 to 4/15/11 were reviewed and an additional 12 incidents of aggression to staff, self and/or other residents are documented. 1. Nursing notes for R2 on 1/1/11 at 1:00 pm state "at 12 n (noon) resident (R2) became a little agitated trying to run staff and peers over without success. Res (resident) redirected to room. PRN (as needed) Klonopin given....Res attempting to kick at staff.....attempted (to counsel resident) on her behavior and she then stopped eyes appear heavy and sleepy." 2. At 6:50 pm on 1/1/11 nursing notes for R2 state "Res (R2) in room 1:1 in place, tried to harm self banging her head on window in her room then swinging her wrist in the air looking for something to cut them on.....wants to kill herself. Res redirected.....still very aggressive." 3. On 1/2/11 at 2:00 am nursing notes for R2 state "Res (R2) became aggressive with staff, staff attempted to redirect res with much difficulty.....PRN Haldol/Ativan given." 4. On 1/3/11 at 3:00 pm nursing notes for R2 state "...(R2) Got up and approached staff stating that she 'wanted to kill herself.' Res continued to	F9999		

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state that she wanted to 'jump through the glass window.' When questioned why she denied SI (suicidal ideation) earlier in shift res stated 'I just told you what you wanted to hear.'...."

5. The nursing notes for R2 show on 2/7/11 at 5:55 am "Res (resident) asked to leave room so this nurse (E21/Licensed Practical Nurse) could assess her roommate - Res started screaming and spitting that this F***ing B**** was not getting her to leave room. Resident started spitting and swinging arms - walked out in the hallway and started swinging at a staff member spitting at staff member and cursing loudly - using profane language....Calling staff f***ing b****es and spitting at staff - swinging arms appears to be trying to connect with staff member....." This behavior continued and nursing notes state "(R2) walked to hall (male resident hall) to another resident's (R3) room appearing to hide by bed - climbed in bed with the other resident trying to get ahold of resident to keep staff away- still calling us profane names and spitting - other resident (R3) telling (R2) to get out of bed - staff attempted to get (R2) out of (R3's) bed. (R2) still cursing and spitting at staff - swinging arms - kicking legs.....gave IM (Intramuscular medication). Resident spit at this nurse and called this nurse profane names.....(R2) still cursing loudly and swinging arms and spitting at staff...."

6. On 2/28/11 at 12:00 am nursing notes document "Res (R2) (resident) upset and at the desk crying/yelling at staff. Unable to calm resident down. PRN (as needed) medication given."

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F9999	Continued From page 24 7. On 3/10/11 at 9:30 pm nursing notes state "Resident (R2) in dining room yelling at staff....Very hard to redirect and get her to understand...directed to try and calm down was getting more and more anxious as staff was trying to intervene....was able to (calmly) take resident down to her room, laid in bed allowing staff to talk to her....was calm for just a few minutes when resident jumped OOB (out of bed) trying to attack a staff member grabbing at her clothing - staff member trying to step away from resident ..... Resident then lost balance as she was pushing staff - landing on floor on stomach causing a laceration approx (approximately) 1 cm (centimeter) on left lateral cheek bone near eye. Resident extremely combative and (aggressive) kicking, screaming at staff - refusing care, very hard to calm or redirect. PRN (as needed) Ativan/Haldol given.....New order received to send to ER (emergency room)." R2 returned to the facility with a finger splint to her right middle finger which is documented as being swollen and bruised. Xray report from a local hospital dated 3/10/11 documents under "IMPRESSION: Nondisplaced spiral fracture, proximal third phalanx." 8. On 3/17/11 at 7:15 pm nursing notes state "This nurse (E19/LPN) summoned to another residents room - (R2) had (another resident/R9) blocked in the corner of (R9's) room and was attempting to hit her - (R9's roommate/R8) in the room and grabbed R2 from behind and tried to push (R2) back. Staff intervened and asked (R2) to leave (R8 and R9's) room. (R2) left the area after cursing and calling R9 a fat a** skanky b****. (R9) noted to have a red mark on the side of her neck - (R9) stated (R2) had (thrown) a	F9999		

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DVD (digital video disc) at her because she (R2) thought (R9) was trying to talk to her (R2) boyfriend....Upon questioning, she (R2) thought (R9) was trying to steal her boyfriend.....This nurse spoke with (R2) regarding the fact that she can not enter another residents room and she should not be trying to hit or throw things at people. (R2) stated she understood and would leave (R9) alone. SSD (Social Services Director), DON (Director or Nursing) and Administrator notified of the situation."

On 4/15/11 at 9:40 am R9 stated (in regard to incident on 3/17/11),"We were out to get fresh air. I was on 1:1 at the time. I sat down on the couch and she accused me of flirting with (R3). She (R2) said 'Give me back my DVD's then I said ok. I told her to stand by the door (of room) and I would get them. She came at me and grabbed the CD's and threw them at me. There was a big red mark on my neck from the 2 CD's hitting me in the neck. She (R2) threw pop and got it all over me. I went to get staff - she (R2) grabbed my leg. R8 (my roommate) came and pulled (R2) off. The next few days she (R2) was spitting on me and said she would burn me with a cigarette. I was scared to go in my room."

R8 was in the room at the time of interview with R9 and confirmed R9's statement.

9. At 8:15 pm on 3/17/11 nursing notes document "This nurse (E19/Licensed Practical Nurse/LPN) in (R9's) room administering meds when (R2) was noted to be standing in the doorway calling (R9) names - calling her fat a** etc. Medical records staff member asked resident to move from in front of other resident

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door.....(R2) became agitated and started yelling - attempting to hit medical records staff....staff went to the dining room to call for help and (R2) started throwing objects at staff - hitting, kicking, biting - unable to redirect - resident (R2) given PRN (as needed) injection of Haldol/Ativan and held onto the floor by staff as she (R2) was being a threat to herself and other residents...911 called...." When resident returned to the facility at 10:45 pm nursing notes stated she (R2) was placed on "strict 15 minute checks."

10. On 3/24/11 at 12:30 am nursing notes state "Res (R2) had been laying in hall and would not go in room. Very difficult to redirect....told this nurse (E22/Registered Nurse/RN) she (R2) would like to take her PRN medications but when trying to give them she (R2) would not take them even after several attempts. Res laid on dining room floor and began screaming and kicking. Res (R2) began throwing things at staff. After being able to get resident to stop she then remained on the dining room floor. Staff had to escort res (R2) to room.....Res (R2) did try to attack staff but had to be restrained by staff..."

11. On 3/28/11 at 4:30 am nursing notes state "Res (R2) started throwing things out of her room...Came out of room - yelling and cursing at staff - spitting at staff - yelling loudly - cursing loudly - difficult to redirect. Res (R2) allowed to vent - still cursing loudly at staff .... staff backed away from resident allowed resident to lay on floor - resident (R2 kicking out and spitting. Resident screaming 'I want a shot.' ... Nurse explained to resident that already had PRN Ativan at 2:00 am and it was every 4 hours....Resident calmed down and went back

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F9999	Continued From page 27 into her own room." 12. On 4/1/11 at 12:00 pm nursing notes state "(R2) started yelling loudly calling this nurse (obscene) names states 'I'm gonna stick my foot up your a**.' SSW (Social worker) redirected (resident) to her room. Tearful but appears to be calmer." On 4/15/11 at 3:30 pm E1 and E2 were informed of the 12 other documented incidents of aggressive behavior by R2 to other residents and staff. On 4/14/11 at 2:30 pm E1(Administrator) and E2 (Director of Nursing) provided one resident to resident altercation which was investigated by the facility dated 4/11/11. E2 stated this was the only resident to resident altercation she was aware of that she had investigated. E1 also provided one resident to staff altercation involving R2 which was investigated occurring on 2/7/11. On 4/15/11 at 3:30 pm E2 (Director of Nursing) stated she was unaware of the incidents or the gravity of the incidents documented. E2 confirmed she had not done investigations into any additional incidents as she had not been informed. E2 stated she was told about the incident on 3/17/11 but not that it escalated to physical aggression or that (R9) had red marks from the CD's being thrown at (R9). The face sheet for R1 (victim) shows admission date of 3/29/11 with diagnoses including: Bipolar, Bilateral lower extremity edema, senile kyphoscoliosis and history of paranoid ideation.	F9999		

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On 4/14/11 at 10:00 am R1 was in her room sitting in a reclining chair leaning over due to the rounding of her upper back from kyphoscoliosis. R1 appears elderly with the medical record listing her age at 74. R1 rubbed her head in a circular motion. R1 stated she gets "severe" headaches now from (R2) yanking and pulling her hair when (R2) "beat her up." A gash (approximately 2 cm (centimeters) in length) is on R1's forehead extending down between her eyebrows towards the top of her nose. Two steri-strips were intact on this area. Her forehead was black and blue and both eyes were slightly swollen. During the interview R1 was guarding her left hand and stated she has been having pain in the left wrist making it very painful to move.

The hospital emergency report dated 4/11/11 documents a 2 cm laceration to R1's forehead with a "Head CT (computerized tomography)" done at the hospital on 4/11/11 noting ".. soft tissue swelling is seen posteriorly on the left."

The face sheet for R2 (perpetrator) lists admission date of 12/31/10 with diagnoses including: Huntington's, Bipolar disorder, Delusional disorder, psychosis and anxiety. The face sheet documents R2 is currently 29 years old.

On 4/14/11 at 2:15 pm R2 was in the hall of the unit on 1:1 status (one staff member watching R2). R2 was moving about the unit freely with the 1:1 staff in place.

On 4/15/11 at 2:03 pm E7 (Certified Nursing Assistant/CNA) stated,"About 2 weeks ago we

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had to de-escalate (R2). It was at lunch she (R2) was upset about meds. We moved (R2) so the other residents could get out. The residents were in line for smoke break. (E4/Social Services/SS) and E10 (Social Services) were with (R2). She (R2) was moving kind of wild. (R2) threw her coat.....she (R2) was getting in (R10's) face. (R2) was mad. I was taking (R11) to the bathroom. (R2) followed us and started coming in the room and threw a big rabbit at (R11's) head. I went over - I am trying to keep the door shut - (R2) was trying to get in. E4 (SS) was trying to talk to (R2). I feel the other residents are in danger. I think she (R2) knows who she can and can't do this to (be aggressive). Another time we came in one day - myself, (E15/Unit Aide) and (E16/CNA). (R2) was going nuts...(R12) was her (R2's) roommate (at the time). Something was wrong with (R12) and the nurse (E21/LPN) asked (R2) to leave.....She (R2) ran down the hall to (R3's) room and got in bed with (R3). I'm a CNA - the nurse (E21) wanted us to get her away from (R3) - she (R2) was kicking, hitting and spitting. She (R2) was pulling (R3) out of bed. (R3) was telling (R2) 'leave me alone' - meantime I heard (E15) yell 'Ow, she bit me.' (R2) grabbed (E16's) uniform and ripped it."

On 4/15/11 at 2:15 pm E13 (Unit Aide) stated,"... (R2) is a little out of control.....usually starts verbal and goes to physical aggression.....She (R2) went after (E16/CNA) and grabbed her shirt and started spitting on us."

At 2:15 pm on 4/14/11 a male resident (R13) walked up to (R2) while on 1:1, slapped R2 on the butt 5-6 times and stated, "(E18/Community Relations Coordinator) tells me you've been very

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bad." The person assigned to be watching R2 on the 1:1 (E4/Social Worker) was several steps ahead of R2, not looking at R2 and said nothing to the male resident."

On 4/15/11 at 10:35 am E2 (Director of Nurses) stated the facility began in-servicing staff on the correct way to provide 1:1 supervision for R2. The inservice education that was to be provided by administrative staff to all staff prior to working on the unit includes monitoring R2 on 1:1 basis. This training includes: "(R2) is to be on strict 1:1 which means staff needs to be present and watch what she (is) doing or saying to others. Staff needs to redirect resident away from peers when having behaviors. (R2) is able to socialize with others but (R2) needs to monitored for appropriateness. (R2) can socialize with peers in TV room and in Dining Room with 1:1 staff present. (R2) is able to attend activities and groups with staff. Whoever is 1:1 with (R2) is not to do (smoke pass). Other staff needs to pass out cigarettes - this is (due to) her impulsive behaviors. Some of (R2's) indicators of aggression could be resident could be delusional making comments about staff or peers that are not realistic, weepy, crying - (R2) is unpredictable and can cry one minute and become angry the next. Is manipulative will go to one staff to next to try to get what she wants. She (R2) is attention seeking - demands meds - she (R2) is embarrassed of her uncontrollable body movements and believes people stare at her and make fun of her which can also cause her to be aggressive."

On 4/15/11 at 3:30 pm R5 (Certified Nursing Assistant/CNA) stated, "I was not aware of (R2)

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F9999	Continued From page 31 being physically aggressive with other residents prior to this time with (R1)." On 4/19/11 at 11:35 am E6 (Unit Aide) stated she does 1:1 with (R2) "pretty regular." E6 stated when she is on 1:1 she (E6) is to stay with (R2) all the time and not stray from her. E6 also stated she prefers to sit outside (R2's) room and she (E6) has not been told anything specific about where she is to sit when watching R2. E6 states the last time she was trained in 1:1 monitoring was "about one year ago" but "was trained in CPI (Crisis Prevention Intervention) recently." E6 was unable to state some of the major points discussed during the training. On 4/19/11 at 3:00 pm E2 (Director of Nurses) was informed E6 stated she had not yet been trained in the 1:1 monitoring guidelines for R2. E2 stated the training is ongoing and was to be completed today (4/19/11). The care plan for R2 intimally dated 12/30/10 lists one of R2's "problems" as "History of explosive behavior." This care plan last updated 4/11/11 shows the incident of 3/17/11 and the incident of 4/11/11. The only new intervention noted on the care plan is dated 4/11/11 when R2 was placed on 1:1 status. On 4/15/11 at 10:35 am E2 (Director of Nursing) stated,"(E5/CNA) is on suspension at this time because the facility doesn't feel he did what should have been done with the altercation." E2 stated E5 was not going to be working on the SMI (serious mentally ill) wing anymore. (A)	F9999		

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F9999	Continued From page 32 300.4010a) 300.4010c)1)A) 300.4010c)2) Section 300.4010 Comprehensive Assessments for Residents with Serious Mental Illness (SMI) residing in facilities subject to Subpart S a) The facility shall establish and Interdisciplinary Team (IDT) for each resident. The IDT is a group of persons that represents those professions, disciplines, or service areas that are relevant to identifying an individuals's strengths and needs, and that designs a program to meet those needs. The IDT includes, at a minimum, the resident; the resident's guardian; a Psychiatric Rehabilitation Services Coordinator (PRSC); the resident's primary service provider , including an RN (Registered Nurse) or an LPN (Licensed Practical Nurse) with responsibility for the medical needs of the individuals; a psychiatrist; a social worker; an activity professional; and other appropriate professionals and care givers as determined by the resident's needs. The resident or his or her guardian may also invite other individuals to meet with the IDT and participate in the process of identifying the resident's strengths and needs. c) A comprehensive assessment must be completed by the IDT no later than 14 days after admission to the facility. Reports from the pre-admission screening assessment or assessments conducted to meet other requirements may be used as part of the comprehensive assessment if the assessment	F9999		

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F9999	Continued From page 33 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: 1) A psychiatric evaluation completed by a board certified or board eligible psychiatrist or, if countersigned by a board certified or board eligible psychiatrist, the evaluation may be completed by a person who is a certified psychiatric nurse, a nurse with a Bachelor of Science in Nursing (BSN) and two years of experience serving individuals with serious mental illness, or a registered nurse with five years experience serving individuals with serious mental illness; a licensed clinical social worker; a physician; a licensed psychologist; or a licensed clinical professional counselor (LCPC) under the Professional Counselor and Clinical Professional Counselor Licensing Act (225 ILCS 107). The psychiatric evaluation shall include: A) Psychiatric history with present and previous psychiatric symptoms. 2) Psychosocial assessment performed by the PRSD, a social worker, an occupational therapist, an LCPC, or the PRSC if reviewed and countersigned by the PRSD. These Requirements are not met as evidenced by: Based on interview and record review, the facility failed to establish an IDT (Interdisciplinary Team) for three residents (R1, R2, R3) in a sample of five residents, failed to have a psychiatrist, PRSD or LCPC countersign assessments completed by the facility PRSC's. On 4/14/11 at 2:50 PM E2 (Director of Nursing)	F9999		

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stated,"We don't have a psychiatrist right now either for the ones under 55. (Local community health center) lost one of the psychiatrists and haven't been able to replace him in like October or November, 2010.

On 4/14/11 at 3:10 pm E1 (Administrator) stated,"(E22) is our psych medical director. He's not board certified but he's the medical director here and sees those residents."

On 4/15/11 at 1:32 pm E4 (Social Services) stated,"I just took over as Social Services Director/PRSC in October or November of 2010.....The graduation certificate for E4 shows a BSW (Bachelors in Social Work). E1 (Administrator) stated E4 has not taken the LCPC board examination yet since she has to have two years of clinical experience before taking the exam.

On 4/15/11 at 1:42 pm E10 (Social Services) stated she had her BSW as well and was currently working on her Masters Degree.

E1 confirmed this statement and also stated,"(E10) doesn't have her LCPC yet either. She doesn't have the required amount of on the job experience needed." The local community health center we utilize has people with their Masters Degrees in Social Work.

The Psychosocial assessments for R1 is dated 12/30/10 and signed by E10. There is no initial psychiatrist assessment of R1 since admission date of 12/30/11.

The Psychosocial assessment for R2 is dated

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F9999	Continued From page 35 3/29/11 and signed by E10. The Psychosocial assessment for R3 is dated 5/5/09 and signed by E10. There are no co-signatures on any of these assessment by a qualified person as outlined in the regulation. (B) 300.4040a)5) 300.4040d) Section 300.4040 General Requirements for Facilities Subject to Subpart S. a) The psychiatric rehabilitation services program of the facility shall provide the following services as needed by facility residents under Subpart S: 5) Decrease psychotic, self-injurious, antisocial and aggressive behaviors d) The psychiatric rehabilitation program shall provide education and training to maximize residents' capacities for ...recognition of early symptoms of relapse and interactive effects with other drugs and alcohol. This requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to provide mental health rehabilitative treatment groups for three (R1, R2, R3) of three sampled residents.	F9999		

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F9999	Continued From page 36 Findings include: 1. R1 was admitted on 3/29/11 with diagnoses including: Bipolar and paranoid ideations. The PARR (Preadmission Screening and Resident Review) dated 11/19/10 shows R1 requires psychiatric mental health services. 2. R2 was admitted on 12/30/10 with diagnoses including: Huntington's, Bipolar, Depression, psychosis, delusional and anxious. The PARR dated 1/7/11 shows R2 requires psychiatric mental health services. 3. R3 was admitted on 5/5/09 with diagnoses including: Congenital Myasthenia Gravis, Depression and history of drug abuse. The PARR screen dated 9/28/09 shows the reason R3 is admitted to the facility is due to depression and should receive psychiatric mental health services. On 4/15/11 at 1:32 pm E4 (Social Services Director/SSD) stated she had recently (October-November 2010) taken over the position of SSD. E4 stated some of the groups times had been changed to fit her (E4) schedule. E4 provided a copy of this schedule which included: Monday and Wednesday 2:00 pm and 4:00 pm: Stress Depression and Mental Illness Tuesday 9:45 am and 1:30 pm: Dealing with Anger Thursday: 9:30 am, 1:30 pm and 4:00 pm: Relapse Prevention Friday 2:00 pm and 4:00 pm: Think good feel good.	F9999		

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F9999	Continued From page 37 E4 stated these group last approximately 30 minutes and "just about any resident" is invited to attend. E4 stated she copies handouts for each group and will sometimes give the residents homework to complete before the next group. This represents 4.5 hours of group psychiatric mental health therapy per week. R1 ad R3 were on the unit on 4/14/11, 4/15/11 and 4/19/11 outside smoking during smoke break, watching television in the main lounge area or sleeping it their rooms. R3 stated he becomes very bored living at the facility and feels there is nothing to do. R2 was generally observed in her room listening to music. R2 stated she is afraid to leave her room as other residents come in and steal her belongings. (B)	F9999		