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F 323	Continued From page 13 10) The Social Worker, DON, ADON, and Nursing Supervisor will conduct observational audits on the unit 6x per month to cover each shift starting 8/15/11. This will include observations of staff interventions while dealing with residents with behavioral issues. The result of this audit will be presented to QA starting 8/17/11. 11) The QA coordinator will hold an emergency QA meeting on 8/12/11 to cover the above plan and implementation.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.1220b)3) 300.3240a) 300.3240f) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures: b)6) All necessary precautions shall be taken to	F9999		

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F9999	Continued From page 14 assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b)3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.(Section 2-107 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's 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	F9999		

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F9999	Continued From page 15 residents and employees of the facility. (Section 3-612 of the Act) These Regulations were not met as evidenced by: Based on record review and interview, the facility failed to supervise 1of 5 residents reviewed for wandering (R2) in the sample of 10, which resulted in an aggressive, agitated and territorial resident (R3) pushing R2, causing R2 to fall. R2 sustained a laceration to the lip, fractured right orbital floor, subarachnoid hemorrhage, traumatic subdural hematoma, and multiple contusions. R2 wandered into R3's room which resulted in R2 and R3 pushing each other, and causing R2 to fall to the floor sustaining multiple injuries. R2 was transferred to the hospital and later discharged back to the facility on 6/24/11. On 6/25/11 R2 was transferred back to the hospital due to lethargy and vomiting. R2 subsequently expired at the hospital on 7/14/11. The facility did not supervise R2 to prevent her from wandering into R3's room after being left unsupervised in the small dining room. R3 has a documented history of verbal and physical aggression to other residents who wander into R3's room. The facility did not provide immediate supervision of R3 after the altercation with R2 to prevent potential risk of aggression towards the other residents on the unit. Findings include: 1) R2 has a diagnosis of Dementia with Agitation. Hospital record dated 6/24/11 indicated that R2 is 4 feet 11 inches in height, and weighs 129 lbs.	F9999		

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F9999	Continued From page 16 R2's SOAP note dated 6/10/11 indicated that R2 is disoriented to place and time, does not follow commands, long term and short term memory are poor, attention span is limited to poor, thought process is loose, thought content is confusional, and insight and judgment are poor. It also said that R2 is confused, and is often walking the floor. R2's care plan dated 6/17/11 and 5/20/11 also identified her as a wanderer. They mention that R2 exhibits confusion and disorientation as evidenced by inability to find own room and locate other areas of the facility. During the following interviews, all of these staff below, indicated that R2 is a wanderer, and would go to other residents' rooms, including R3's room: a) E8 (CNA/ Certified Nurse Aide) - interviewed on 7/28/11 at 2:00 PM b) E5 (Rehab Aide) - interviewed on 7/28/11 at 2:15 PM c) E4 (7-3 nurse) - interviewed on 8/10/11 at 1:16 PM d) E9 (11-7/7-3 CNA) - interviewed on 8/10/11 at 1:50 PM e) E3 (11-7 CNA) - interviewed on 8/10/11 at 2:15 PM f) E6 (7-3 nurse) - interviewed on 8/10/11 at 4:30 PM R3 has a diagnosis of Dementia with behavioral disturbance and Agitation. Facility record dated 7/2/11 shows that R3 is 5 feet 2 inches tall and weighs 181.2 lbs. R3 is heavier than R2. Review of the following nurses notes showed that	F9999		

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F9999	Continued From page 17 R3 has a history of being agitated, territorial, and verbally and physically aggressive towards other residents who wander into R3's room, and those who R3 thinks are going towards her room : a) 11/30/09 at 10:00 AM, R3 pushed R7 out of her room. b) 2/11/10 at 6:00 PM, R3 pushed an unidentified resident out of her room. R3 was also heard yelling at a female resident who wandered in to her bedroom. c) 2/19/10 at 7:30 PM, while standing in the hallway, R3 pulled another unidentified resident's collar saying "You're not going in my bedroom." When redirected, R3 became angry and became verbally abusive to staff and other resident. d) 3/18/10 5:45 PM, R3 became angry and agitated when she found another resident R7 inside her room. At 5:50 PM, R7 stated that R3 pushed her and she ended up sitting on the floor. R3 stated that "She's terrible. She's always going in my room." e) 3/19/10 11:00 AM, R3 was very impatient and got off even from simple noise or distraction, and gets more agitated when redirected. f) 3/22/10 1:00 PM, R3 was noted with aggressive behavior, screaming at other residents coming her way. Very impatient and argumentative. g) 4/23/10 Monthly charting - "Has 1 episode of physical abuse." h) 5/7/10 5:30 PM, R3 was noted coming out of her room and following R7. R3 stated "She is tearing the bed apart, I pulled her out of the room." i) 5/10/10 11:30 AM, R3 screams and yells at anyone coming her way. R3 also pushes other residents who sit on her table.	F9999		

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F9999	Continued From page 18 j) 10/22/10 Monthly Nursing Summary Charting - Gets upset easily when provoked. k) 12/23/10 Monthly Nursing Summary Charting - indicated that R3 easily gets upset. l) 1/22/11 1:00 PM, R3 will scream at other residents getting in her way. m) 7/24/11 Monthly Nursing Summary Charting - indicated that R3 gets easily upset when provoked. R3's Social Service Notes dated 3/1/11 and 5/23/11 also indicated that R3 becomes very angry and physically aggressive if someone intrudes upon her space. It also said that staff must continue to monitor other residents and R3 for intrusion upon R3's personal space. According to E8 (morning CNA) on 7/28/11 at 2:00 PM, R3 does not want anyone going in her room. E8 said that she saw R3 yell at R2 before, for going in R3's room. E8 added that R2 is confused and she goes to R3's room. Similarly, E5 also said during 7/28/11 interview at 2:15 PM, that she saw R2 wander to R3's room once or twice, approximately a month prior to 6/21/11. E5 said that R3 gets agitated when she sees another resident inside her room. Per R2's nurses notes, on 6/21/11, at 6:40 AM, R3 came out of room 165 yelling, "Get her out of my room. She is back again." This nurses note indicated that R2 was found on the floor on her back, with the back of her head resting against the corner of a closet. Additionally, it was observed that R2 had a cut on the right upper lip and there was a lot of blood. 911 was called and R2 was sent to the hospital.	F9999		

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F9999	Continued From page 19 According to E5 during 7/28/11 interview at 2:15 PM, when E6 (nurse) and she got to R3's room, R2 was lying on her back on the floor with her head against the corner of a drawer. E5 said R2 was bleeding. E5 continued that R3 said that R2 pushed her (R3), so she pushed R2 back. According to E3 on 8/10/11, R2 had a cut across her lip, her face was swollen, and there was blood all over. During 8/10/11 interview at 2:15 PM, E3 said that she was assigned to R2 on night shift on 6/20/11 until 7:00 AM of 6/21/11. E3 said that after R2 woke up early, she took R2 to the dining room at around 6:15 AM. E3 said that E4 was passing medications to the residents during this time. E3 said this was the last time she saw R2, prior to being found bleeding inside R3's room. E4 said during 8/10/11 interview at 1:16 PM, that she last saw R2 in the dining room when she was passing meds,15 to 20 minutes before R2 was found in R3's room. E7 (morning shift CNA) said on 8/10/11 interview at 12:09 PM, that although she came in at 6:00 AM, she showered a resident and did not see R2 prior to the incident. Per E5 on 7/28/11 at 2:15 PM, although she came to work at 6:30 AM, she did not see R2 until R3 yelled to get R2 out of her room. On 8/10/11 at 4:30 PM, E6 (morning shift nurse) also said that she did not see R2 when she came in until she rushed to go inside R3's room and found R2 lying bloody on the floor. Although R2 has a care plan to identify her wandering behavior, there was really no intervention in place to prevent her from going to the room of R3 who is aggressive, territorial, and	F9999		

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F9999	Continued From page 20	F9999		

physically and verbally abusive toward other residents who wanders to her room. Per E3 during 8/10/11 interview at 2:15 PM, if the staff sees R2 wandering, they redirect R2. Other than that, there was no further intervention in place to provide R2 or other wandering residents like R6 and R7 with supervision to prevent them from going to R3's room. E3 said that she is not aware that R3 can be physically aggressive to other residents who enter her room. E3 said no one told her that R3 had pushed other residents out of her room in the past. Similarly, E8, E9, and E6 also verbalized during above individual interviews that they are not aware of R3's behavior of being physically aggressive towards residents who wander inside her room. According to E3 on 8/10/11, if she knew R3 can be physically aggressive to other residents, E3 would have stayed with R2 that morning of 6/21/11 until E4 was done with her work.

Added to the lack of supervision for the wandering residents, the facility also failed to ensure that R3, who pushed R2 and caused her injuries was immediately supervised and closely monitored after the altercation with R2 on 6/21/11. Although R3 said that she pushed R2 after R2 pushed her first, R2's lip laceration and swollen face is in front, and is not consistent with her falling backwards and landing on her back and the back of her head.

During 7/28/11 interview with E5 at 2:15 PM, E5 said that while the staff were taking care of R2, R3 walked to the dining room and sat with about 3 residents. E5 said that there was no staff with her during this time. E7 also said on 8/10/11 at 12:09 PM, that while the nurses were treating R2

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F9999	Continued From page 21 in R3's room, E7 did not see R3 in the hallway or the dining room. E7 said she went to the dining room for about 15 minutes, then went to the rooms. After that, E7 said that we went back to the dining room to assist residents with breakfast. E7 said that at this time, she saw R3 sitting with 2 female residents (one of which is R5), and she was joined by male resident later in the small dining room. E7 said there were no staff in the small dining room to watch R3 because this dining room is for independent residents who do not need staff during meal time. E7 said that if she was standing by the TV in the dining room, she could see R3 in the small dining room. E7 said she fed the other residents by the refrigerator which has no visual access to the small dining room and R3. R3's nurses notes showed that on 6/22/11 at 2:00 PM, R3 continued to be physically aggressive to other residents. R3 grabbed another resident's hand and tried to twist it. On 6/22/11 at 10:00 PM, R3 was noted yelling at other residents. On 7/19/11, R3's nurses notes indicated that R3 is easily agitated and territorial. (A)	F9999		