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F 000	INITIAL COMMENTS Complaint Investigations: 1191928/IL53451 - F323 1191936/IL53463 - no deficiency Incident of 3/17/11/IL53329 - no deficiency An partial extended survey was conducted.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide supervision to 2 of 5 residents (R2 and R3) who are demented and aggressive and are wanderers in the sample of 15. This failure resulted to R3 wandering into the room of R2, who has a history of pushing other residents and staff, regardless if he was provoked or not. This failure resulted to an Immediate Jeopardy which started on 6/6/11 at 2:00 PM, when R3 wandered inside R2's room unsupervised, and was pushed on her back, causing her to fall on the floor face first, causing a laceration and bleeding on the lip, hematoma on the left eye and left eye injury.	F 323		9/1/11

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

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F 323	Continued From page 1 The Administrator (E1) was notified of the Immediate Jeopardy on 8/25/11 at 1:04 PM While the Immediate Jeopardy was removed on 6/8/11, the facility remains out of compliance at severity level 2, because the facility has yet to inservice the new hires on all shifts, has yet to assess if new interventions and policies are effective on the possible affected residents, and evaluate the new plan of care that has yet to be done. Findings include : Per facility's incident report dated 6/6/11, at 2:00 PM, R3 was found on the hallway floor with injuries. R3 stated she was accosted and knocked down by another resident. In a separate incident investigation sheet dated 6/6/11 (without a time), R3 wandered into R2's room and was pushed to the ground by R2. R3 sustained a hematoma to the left eye and sustained a laceration on the lip. Per E10 (CNA - Certified Nursing Assistant) 8/23/11 at 2 PM, on 6/6/11, she was walking from the supply room after lunch when a housekeeper flagged her and said R2 pushed R3. E5 (housekeeper) on 8/23/11 at 2:20 PM,said that she interpreted E6's (housekeeper) statement as E6 was the only staff who saw what happened. E5 said that E6 said that she was in the isolation room next to R2's room when she heard a noise coming from R2's room. E6 peeked at the door and saw R2 push R3 on the back causing R3 to fall on the floor.	F 323		

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F 323	Continued From page 2 E6 stated on 8/24/11 at 2:05 PM (thru an interpreter) that she was cleaning the isolation room 43 when she heard a noise coming from R2's room next door. E6 said that when she looked outside she saw R2's hands pushing R3 who fell on the floor. E6 said that there were no staff members with R3 or with R2 during this time. According to E15 (nurse) on 8/24/11 at 2:35 PM, she last saw R3 in the corridor prior to the incident on 6/6/11. E15 added that R2 might have been in his room that time. On 8/25/11 at 10:10 AM, E15 stated she was in a meeting prior to the incident and by the time she got to the unit, a CNA told her that R3 was lying on the floor already. According to E17 (CNA) on 8/26/11 at 1:43 PM, the last time she saw R3 was during lunch time while R3 was eating lunch in the dining room. Z1 at 10:16 AM said that their investigation showed that there is only 1 witness in the 6/6/11 incident between R2 and R3. The hospital's History and Physical dated 6/7/11 states R3 sustained a left eye injury secondary to fall. This fall resulted from R2 pushing R3 to the floor after R3 wandered to R2's room unsupervised. R3's care plan dated 5/25/11 indicated that R3 has dementia and her behaviors are manifested by wandering, pacing, roaming in and out of peer's rooms, motor agitation, verbal and physical aggression, restlessness, rummaging, and	F 323		

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F 323	Continued From page 3 repetitive movement. During 8/23/11 interview at 3:25 PM, E2 (Dementia Unit Coordinator) said that R3 has long term and short term memory deficit, poor safety awareness, wanders in and out of other resident's room and rummages through their belongings, and would swing at staff when being redirected at times. On 8/23/11 between 1:33pm and 2:55pm, E8 (nurse), E9 (Certified Nurse Aide / CNA), E4 (CNA) and E14 (activity staff) all confirmed that R3 is a wanderer and has the behaviors mentioned by E2. (CNA) stated 8/23/11 at 2 PM, she heard that R2 can be aggressive to staff if asked to change his clothes or shower. E10 also added that R2 doesn't like to be touched. E3 (CNA), E4 (CNA), E10 (CNA), E17(CNA), said on 8/23/11 and 8/26/11 at 2:30 PM and 2:40pm that although R2 never says a word, R2 can be physically aggressive if being redirected by staff, has pushed staff and residents without provocation, does not like to be touched, resists care (showers and changing clothes). E3 added that she is sure that R3 had been in R2's room before because R2's room is close to R3's room. On 8/23/11 at 3:25 PM, E2 (Dementia Unit Coordinator) stated the she was not even aware that R2 had pushed staff and residents alike in the past with and without provocation and was physically aggressive. No one has reported these behaviors to her since she started working in the facility.	F 323		

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F 323	Continued From page 4 Despite staff knowledge of R2's physically aggressive behaviors towards staff and other residents, there was no indication of any facility assessment, care plan or monitoring plan to ensure that wanderers like R3 do not go into rooms of aggressive residents like R2. There was no plan to supervise R2's behaviors. Per facility's policies and procedures on Aggressive Residents states: "If an episode of Resident to Staff aggression occurs, the staff should report the situation immediately to the head nurse manager or designee, whose responsibility will be to advise the Administrator. If this incident occurs, the facility is going to evaluate precipitating / triggering circumstances regarding the incident, institute a 24 hr monitoring of the residents, complete an incident report, and document the incident and resident's response to immediate interventions in the clinical notes. The aggressive resident's existing care plan will be modified to reflect the resident's potential for future aggressions. The facility should reassess the resident, the interventions, and any other potentially triggering situations on a regular basis". Per the facility's policy and procedure on Resident to Resident Aggression states: "The above procedure will be implemented in case a resident to resident aggression occurs". None of these procedures were done when E4, E3, E10 and E17 experienced, heard, and witnessed physical aggression from R2. E17 also did not report witnessed pushing of other residents in the past by R2. This resulted in R2's	F 323		

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F 323	Continued From page 5 physical aggression not being assessed and addressed. All of these failures were prior to 6/6/11 altercation between R2 and R3 which resulted to R3's facial and eye injury. The facility took the following steps to correct the Immediate Jeopardy : 1) R2 was sent out to the hospital immediately on 6/6/11 for evaluation. Upon his return to facility, R2 was placed on 1:1 supervision. During this readmission, he declined physically and is unable to be physically capable of physically pushing other residents. R3 was sent out to the hospital immediately and did not return to the facility. 2) The Administrator, Assistant Director of Nursing (ADON), and Dementia Unit Coordinator immediately inserviced staff starting 6/7/11, reporting aggressive and wandering behaviors to the nurse, Dementia Coordinator, or to he Dementia Activity Director immediately. Any resident identified with wandering and aggressive behaviors will be placed on 1:1 monitoring, stop signs will be placed on the aggressive residents' doors, and they will be separated to prevent altercation. Their care plans will be updated immediately. This inservice was completed on 6/8/11. Part of this inservice was to redirect wanderers away from aggressive residents at all times. 3) The Dementia Unit Coordinator and her staff reassessed all aggressive and wandering residents on 6/7/11 and completed the assessment on 6/8/11. Beginning 6/8/11,	F 323		

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F 323	Continued From page 6 screening for residents with aggressive and wandering behaviors upon admission was implemented. The list of these identified residents was given to staff on 6/8/11 and will be kept in a binder at the nurses station, and will be updated as needed. The list will be discussed during morning meeting and will be monitored on a daily basis. 4) New staff were trained on supervision policy beginning 6/8/11 by the Administrator, DON, ADON, and Dementia Unit Coordinator. 5) As part of the QA process, inservicing by the Administrator, DON, ADON, and Dementia Unit Coordinator was started for the month of June on 6/7/11 and will be done monthly. The nurse consultant will monitor that this is done on a monthly basis. 6) The nurse consultant will also review all allegations of altercations on file on a quarterly basis, to see if facility is compliant with plan of correction put in place.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a	F9999		

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F9999	Continued From page 7 Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's	F9999		

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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)

These regulations are not met as evidenced by the following:

Based on observation, interview, and record review, the facility failed to provide supervision to 2 of 5 residents (R2 and R3) who are demented and aggressive and are wanderers. This failure resulted in R3 wandering into the room of R2, who has a history of pushing other residents and staff, regardless of whether he was provoked or not. R3 wandered inside R2's room unsupervised, and was pushed on her back, causing her to fall on the floor face first, causing a laceration and bleeding on the lip, hematoma on the left eye and left eye injury.

Findings include :

Per facility's incident report dated 6/6/11, at 2:00 PM, R3 was found on the hallway floor with

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injuries. R3 stated she was accosted and knocked down by another resident.

In a separate incident investigation sheet dated 6/6/11 (without a time), R3 wandered into R2's room and was pushed to the ground by R2. R3 sustained a hematoma to the left eye and sustained a laceration on the lip.

E10 (CNA - Certified Nursing Assistant) on 8/23/11 at 2:00 PM, stated that on 6/6/11, she was walking from the supply room after lunch when a housekeeper flagged her and said R2 pushed R3.

E5 (housekeeper) on 8/23/11 at 2:20 PM, said that she interpreted E6's (housekeeper) statement as E6 was the only staff who saw what happened. E5 said that E6 said that she was in the isolation room next to R2's room when she heard a noise coming from R2's room. E6 peeked at the door and saw R2 push R3 on the back causing R3 to fall on the floor.

E6 stated on 8/24/11 at 2:05 PM (thru an interpreter) that she was cleaning the isolation room 43 when she heard a noise coming from R2's room next door. E6 said that when she looked outside she saw R2's hands pushing R3 who fell on the floor. E6 said that there were no staff members with R3 or with R2 during this time.

According to E15 (nurse) on 8/24/11 at 2:35 PM, she last saw R3 in the corridor prior to the incident on 6/6/11. E15 added that R2 might have been in his room that time. On 8/25/11 at 10:10 AM, E15 stated she was in a meeting prior to the

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incident and by the time she got to the unit, a CNA told her that R3 was lying on the floor already.

According to E17 (CNA) on 8/26/11 at 1:43 PM, the last time she saw R3 was during lunch time while R3 was eating lunch in the dining room.

Z1 at 10:16 AM said that their investigation showed that there is only 1 witness in the 6/6/11 incident between R2 and R3.

The hospital's History and Physical dated 6/7/11 states R3 sustained a left eye injury secondary to fall. This fall resulted from R2 pushing R3 to the floor after R3 wandered to R2's room unsupervised.

R3's care plan dated 5/25/11 indicated that R3 has dementia and her behaviors are manifested by wandering, pacing, roaming in and out of peer's rooms, motor agitation, verbal and physical aggression, restlessness, rummaging, and repetitive movement.

During 8/23/11 interview at 3:25 PM, E2 (Dementia Unit Coordinator) said that R3 has long term and short term memory deficit, poor safety awareness, wanders in and out of other residents' rooms and rummages through their belongings, and would swing at staff when being redirected at times.

On 8/23/11 between 1:33 PM and 2:55 PM, E8 (nurse), E9 (Certified Nurse Aide/CNA), E4 (CNA) and E14 (activity staff) all confirmed that R3 is a wanderer and has the behaviors mentioned by E2.

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E10 (CNA) stated 8/23/11 at 2:00 PM, she heard that R2 can be aggressive to staff if asked to change his clothes or shower. E10 also added that R2 does not like to be touched.

E3 (CNA), E4 (CNA), E10 (CNA), E17(CNA), said on 8/23/11 and 8/26/11 at 2:30 PM and 2:40 PM that although R2 never says a word, R2 can be physically aggressive if being redirected by staff, has pushed staff and residents without provocation, does not like to be touched, and resists care (showers and changing clothes). E3 added that she is sure that R3 had been in R2's room before because R2's room is close to R3's room.

On 8/23/11 at 3:25 PM, E2 (Dementia Unit Coordinator) stated the she was not even aware that R2 had pushed staff and residents alike in the past with and without provocation and was physically aggressive. No one has reported these behaviors to her since she started working in the facility.

Despite staff knowledge of R2's physically aggressive behaviors towards staff and other residents, there was no indication of any facility assessment, care plan or monitoring plan to ensure that wanderers like R3 do not go into rooms of aggressive residents like R2. There was no plan to supervise R2's behaviors.

The facility's policies and procedures on Aggressive Residents states:
"If an episode of Resident to Staff aggression occurs, the staff should report the situation immediately to the head nurse manager or

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designee, whose responsibility will be to advise the Administrator. If this incident occurs, the facility is going to evaluate precipitating / triggering circumstances regarding the incident, institute a 24 hr monitoring of the residents, complete an incident report, and document the incident and resident's response to immediate interventions in the clinical notes. The aggressive resident's existing care plan will be modified to reflect the resident's potential for future aggressions. The facility should reassess the resident, the interventions, and any other potentially triggering situations on a regular basis."
"The above procedure will be implemented in case a resident to resident aggression occurs."

None of these procedures were done when E4, E3, E10 and E17 experienced, heard, and witnessed physical aggression from R2. E17 also did not report witnessed pushing of other residents in the past by R2. This resulted in R2's physical aggression not being assessed and addressed.

All of these failures were prior to 6/6/11 altercation between R2 and R3 which resulted to R3's facial and eye injury.

(A)