STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	09/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	3500 SOUTH GILES AVENUE CHICAGO, IL 60653

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Validation Survey for Subpart U: Alzheimer Unit (See 9999 for finding = 300.7050) Licensure Survey for Subpart S : SMI Complaint Investigations: 1182313/IL53900- No Deficiencies 1182329/IL53913- No Deficiencies 1182389/IL53981- F-166, F-225, F-226, F-280	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to respect the rights of a resident who refuses to sign consent of the administration of psychotropic medications for 1 of 14 residents R26, in a sample of 30. Findings include: On 9/15/11 at 3:00pm R26 said that he has refused to sign for the administration of psychotropic medication, because he feels that he don't need them. R26 said that he refuses to take the medication most days. R26 said that staff crushes his medication and places in his	F 155		9/17/11

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

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F 155	Continued From page 1 food. According to R26's clinical record informed consent for hypnotic/sedative medication Zolpidem 10mg at hours of sleep and as needed, is unsigned and undated. The informed consent for Haldol 5mg every 2 hours as needed is noted to be unsigned and undated. According to the medication administration record dated 8/1/11 - 8/31/11 indicates that R26 was administered Haldol 5mg tablet twice a day for 25 of 31 days. According to R26's clinical record physician order sheet R26 has an order to okay to crush medication and mix in food telephone order dated 9/15/11	F 155		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		9/17/11

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F 157	Continued From page 2 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to notify the physician of a significant weight loss involving 1 of 3 residents reviewed for weight loss(R 14), in a sample of 30. Findings Include: On 09-13-11 at 10:00 AM, surveyor observed R 14 sitting in a wheel chair. Resident appears thin in physical stature. Record review of the Dietary notes indicates that on 8-20-11, resident had a significant weight loss resulting in a 11.0 % weight loss in 6 months. Further record review, including review of nurses notes, does not indicate that the physician was notified. Interview with R 14 on 9-13-11 at 10:00 AM stated that his appetite is poor, and has been poor for some time. Interview with E 7(Registered Dietician) on	F 157		

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F 157	Continued From page 3 9-14-11 at 10:30 AM stated that R 14' s' appetite has been poor for some time and that nutritional supplements were added. Interview with E 1(Administrator) on 9-15-11 at 3:30 PM stated that physician notification would be indicated in the nurses notes. This was not done.	F 157		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow their grievance policy and document a family members concern and provide the family member resolution for 1 of 1 residents (R18) in a sample of 30. Findings include: On 9/14/11 at 1:30pm Z6 said that she has made formal complaints to both E1 (administrator), and to E2 (director of nursing). Z6 said that both E1/E2 would tell her that they will look into her her concerns, but never get back to her with any resolutions to her concerns. Z6 said that she has complained to both E1/E2 about incontinent concerns, related to R18. Z6 said that she has complained to both E1/E2 about not being notified of when R18 is going out for dental procedures because she wants to attend. Z6 said that she complained to E1/E2 with care concerns	F 166		9/17/11

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F 166	Continued From page 4 within the last 2 months with no resolution. On 9/16/11 at 11:00am E1 said that Z6 concerns were care related and that it was E2's responsibility to provide Z6 with resolution. E1 said that he can't recall Z6 complaining to him related R18. on 9/16/11 at 11;10am E2 said that Z6 has spoken to him on different occasions related to concerns about R18's care. E2 said that he tries to meet Z6's need when she approaches him with concerns. E2 said the facility grievance policy indicates that when a family member make voices a concern a grievance form is completed noting the concern, and providing the complainant with a resolution to their concern. E2 said that after Z6 complained to him he didn't complete the grievance form. E2 was unable to provide the survey team with any documentation that indicated Z6 was provided with resolution to any of her concerns. According to the facility's grievance policy, grievances must reduced to writing and signed by the guest or legal representative before submission to the administrator. The grievance / complaint procedure and form will be utilized for this purpose. A review of a blank grievance form indicates receipt of grievance / concern, documentation of grievance / concern, documentation of follow up by facility, and resolution of grievance. A review of the facility's grievance/concern log for 2011 there were entries or forms completed related to R17.	F 166		

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F 225 SS=G	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility 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 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		9/17/11

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F 225	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete investigations and report to the Illinois Department of Public Health (IDPH) , injuries of unknown origin for 2 of 2 residents (R4 and R18) and incidents of alleged abuse for 2 of 2 residents (R1, R4) in the 30 sampled residents reviewed for Abuse/Neglect. Findings include: 1 R4 is a 20 year old female with a diagnoses that includes anoxic brain damage and convulsions. On 2/15/11 at 12:30 PM, nursing progress notes indicate R4 stated to a Certified Nursing Assistant (CNA) that R4 was slapped on the left side of her face by another CNA. The first CNA informed R4 she should not say these things if they did not happen, as both CNAs were in the room providing care. R4 began to cry and apologized, saying accused CNA did not hit her. Nursing assessment was completed with no redness or skin break was noted. Review of facility's incident reports and incident report log on 9/14/11 show no incident report was completed. On 9/14/11 at approximately 2:00 PM, E2 (Director of Nurses) stated he was unaware of the incident and verified no incident report or investigation was completed. On 9/14/11, E1 (Administrator) also stated no incident report or investigation was completed, as the resident recanted the story. Review of facility's Abuse Prevention Program	F 225		

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F 225	Continued From page 7 states the following: Employees are required to report all occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the Administrator. Upon learning of the report, the administrator or designee shall initiate an incident The administrator or designee is then responsible for forwarding a final report and any corrective action taken to IDPH within 5 working days of the reported incident. 2) Per nursing progress notes on 8/30/11 at 11:05 AM, R4 began complaining of pain to the right wrist. R4 was then medicated with pain medications. There was no documentation of physician notification. Physical Therapy Weekly Progress Notes for the week on 8/24-30/11 states barriers to progress include pain to right wrist. On 8/29/11, x-ray to right wrist was ordered and completed. On 8/30/11 x-ray results indicated impacted fracture to the right distal radius with no significant displacement. Resident was then sent to hospital for evaluation. Review of facility's incident and incident report log on 9/14/11 show no incident report was completed. On 8/16/11 at 10:00 AM, E1 (Administrator) was asked if an incident report was completed on the incident. E1 stated no incident report was done as it was a complaint of pain. E1 was then asked if the incident was reported to IDPH once the fracture was confirmed. E1 stated the fracture was not reported to IDPH. Review of facility's Abuse Prevention Program states the following:	F 225		

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F 225	Continued From page 8 The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. Upon learning of the report, the administrator or designee shall initiate an incident investigation. The administrator or designee is then responsible for forwarding a final report and any correction action taken to IDPH within 5 working days of the reported incident. The facility's Accident/Investigation policy states the Administrator, DON/ADON, or designee shall investigate all incident/accidents. 3. According to the nurse note dated 2/6/11 7:14pm indicates that facility staff was informed by R18's family member that R18 was observed with swollen lips. The nurse indicates that R18 was observed sitting in the dining room in a wheel chair with a swollen top and bottom lip. R18 was assessed with no cuts to either lip. The indicates that the attending physician was notified and no new orders were given. A review of the facility accident and incident reports for February, 2011 there was no incident from completed for R18's injury of unknown origin. On 9/16/11 at 11:00am E1 (administrator)was asked if there was an investigation for R18's injury of unknown origin to the upper and lower lips. E1 said he would check to if there were any investigations. E1 failed to provide survey team with an investigation related to R18's injury of unknown origin. E1 said that the State survey agency was not notified of the injury.	F 225		

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F 225	Continued From page 9 On 9/16/11 at 8:30am in the dinning room R18 was observed with 3 dried scab like area to the left elbow. On 9/16/11 at 8:35am, E21 (nurse), said that occurred over the weekend, but wasn't sure what happened. E21 said that it should be documented in the nurse notes what occurred. According to R18's nurse notes dated 9/10/11 10:36pm indicates that R18's family member wants R18 evaluated by rehab, due to R18 leaning to the left of wheelchair causing scratching on left arm. A review of the facility accident and incident reports for September, 2011 there was no incident from completed for R18's injury of unknown origin. On 9/16/11 at 11:00am E1 (administrator) was asked if there was an investigation for R18's injury injury of unknown origin to the left elbow. E1 said he would check to if there were any investigations. E1 failed to provide survey team with an investigation related to R18's injury of unknown origin. E1 said that the State survey agency was not notified of the injury. According to the facilities abuse prevention policy nursing staff are responsible for reporting on a facility incident report the appearances of bruises, lacerations or other abnormalities as they occur. Upon report of such occurrence the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator. According to the facility abuse prevention polciy the facility will report to the state survey agency	F 225		

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F 225	Continued From page 10 as soon as possible within 24 hours of the incident of the occurence. 3) R1, per Physician Order Sheet dated 7/19/11 was admitted to the facility on 7/19/11 with a diagnoses of acute osteomyelitis, chronic obstructive pulmonary disease, seizure disorder, morbid obesity, and bipolar disease. Per MDS (minimum data set) dated 7/26/11, R1 requires the use of a wheelchair for mobility and has impairment on both sides of lower extremities. On 8/5/11 per Social Service note, R1 informed E15 (Social Service), that she had a visitor on 8/4/11 who "forced himself on her sexually." E15 documented that E1 (Administrator) and E2 (Director of Nurses) were notified. On 9/16/11 at 9:40 am, E1 stated "I don't think an incident report was ever filled out". I would have to ask E1 about whether Illinois Department of Public Health (IDPH) was notified. On 9/16/11 at 10:09 am E1 stated "there are no incident report and no IDPH report. The facility Accident and Incidents policy states: #5 The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form. Per Accident/ Incident report, on 8/29/11 at 7:45 pm, R1 was involved in a physical altercation with another resident that resulted in an injury. On 9/15/11 at 2:07 pm, E1 stated that everything was in the accident/incident book and that was "all they had." The facility policy for Accident/Incident Investigations states " It is the policy of this facility that the Administrator, DON (Director of Nurses)/ADON (Assistant Director of Nurses), or Designated staff to investigate all	F 225		

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F 225	Continued From page 11 accidents/incidents."	F 225		
F 226 SS=G	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement its own policies and procedures that prohibit abuse. The facility failed to complete investigations and report to the State Agency , injuries of unknown origin for 2 of 30 residents (R4, R18) and incidents of alleged abuse for 2 of 30 residents (R1,R4), in a sample of 30 residents reviewed for Abuse/Neglect. 1) R4 is a 20 year old female with a diagnoses that includes anoxic brain damage and convulsions. On 2/15/11 at 12:30 PM, nursing progress notes indicate R4 stated to a Certified Nursing Assistant (CNA) that R4 was slapped on the left side of her face by another CNA. The first CNA informed R4 she should not say these things if they did not happen, as both CNAs were in the room providing care. R4 began to cry and apologized, saying accused CNA did not hit her. Nursing assessment was completed with no redness or skin break was noted. Review of facility's incident reports and incident report log on 9/14/11 show no incident report was completed. On 9/14/11 at approximately 2:00	F 226		9/17/11

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F 226	Continued From page 12 PM, E2 (Director of Nurses) stated he was unaware of the incident and verified no incident report or investigation was completed. On 9/14/11, E1 (Administrator) also stated no incident report or investigation was completed, as the resident recanted the story. Review of facility's Abuse Prevention Program states the following: Employees are required to report all occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the Administrator. Upon learning of the report, the administrator or designee shall initiate an incident investigation. The administrator or designee is then responsible for forwarding a final report and any correction action taken to IDPH within 5 working days of the reported incident. 2) Per nursing progress notes on 8/30/11 at 11:05 AM, R4 began complaining of pain to the right wrist. R4 was then medicated with pain medications. There was no documentation of physician notification. Physical Therapy Weekly Progress Notes for the week on 8/24-30/11 states barriers to progress include pain to right wrist. On 8/29/11, x-ray to right wrist was ordered and completed. On 8/30/11 x-ray results indicated impacted fracture to the right distal radius with no significant displacement. Resident was then sent to hospital for evaluation. Review of facility's incident and incident report log on 9/14/11 show no incident report was completed. On 8/16/11 at 10:00 AM, E1 (Administrator) was asked if an incident report was completed on the incident. E1 stated no	F 226		

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F 226	Continued From page 13	F 226		

incident report was done as it was a complain of pain. E1 was then asked if the incident was reported to IDPH once the fracture was confirmed. E1 stated the fracture was not reported to IDPH.

Review of facility's Abuse Prevention Program states the following:
The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur.
Upon learning of the report, the administrator or designee shall initiate an incident investigation.
The administrator or designee is then responsible for forwarding a final report and any correction action taken to IDPH within 5 working days of the reported incident.
The facility's Accident/Investigation policy states the Administrator, DON/ADON, or designee shall investigate all incident/accidents.
3. According to the nurse note dated 2/6/11 7:14pm indicates that facility staff was informed by R18's family member that R18 was observed with swollen lips. The nurse indicates that R18 was observed sitting in the dining room in a wheel chair with a swollen top and bottom lip. R18 was assessed with no cuts to either lip. The indicates that the attending physician was notified and no new orders were given.

A review of the facility accident and incident reports for February, 2011 there was no incident from completed for R18's injury of unknown origin.

On 9/16/11 at 11:00am E1 (administrator), was asked if there was an investigation for R18's

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ALL FAITH PAVILION	3500 SOUTH GILES AVENUE CHICAGO, IL 60653

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F 226	Continued From page 14	F 226		

injury to the upper and lower lips. E1 said he would check to if there were any investigations. E1 failed to provide survey team with an investigation related to R18's injury of unknown origin. E1 said that the state survey agency was not notified of the injury.

On 9/16/11 at 8:30am in the dining room R18 was observed with 3 dried scab like area to the left elbow. On 9/16/11 at 8:35am, E21 (nurse), said that occurred over the weekend, but wasn't sure what happened. E21 said that it should be documented in the nurse notes what occurred.

According to R18's nurse notes dated 9/10/11 10:36pm indicates that R18's family member wants R18 evaluated by rehab, due to R18 leaning to the left of wheelchair causing scratching on left arm.

A review of the facility accident and incident reports for September, 2011 there was no incident from completed for R18's injury of unknown origin.

On 9/16/11 at 11:00am E1 (administrator) was asked if there was an investigation for R18's injury to the left elbow. E1 said he would check to if there were any investigations. E1 failed to provide survey team with an investigation related to R18's injury of unknown origin. E1 said that the state survey agency was not notified of the injury.

According to the facilities Abuse Prevention policy nursing staff are responsible for reporting on a facility incident report the appearances of bruises, lacerations or other abnormalities as they occur. Upon report of such occurrence the

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F 226	Continued From page 15 nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. Upon learning of the report, the administrator or designee shall initiate an incident investigation. The administrator or designee is then responsible for forwarding a final report and any correction action taken to IDPH within 5 working days of the reported incident. The facility's Accident/Investigation policy states the Administrator, DON/ADON, or designee shall investigate all incident/accidents. 3. R1, per Physician Order Sheet dated 7/19/11 was admitted to the facility on 7/19/11 with a diagnoses of acute osteomyelitis, chronic obstructive pulmonary disease, seizure disorder, morbid obesity, and bipolar disease. Per MDS (minimum data set) dated 7/26/11, R1 requires the use of a wheelchair for mobility and has impairment on both sides of lower extremities. On 8/5/11 per Social Service note, R1 informed E15 (Social Service), that she had a visitor on 8/4/11 who "forced himself on her sexually." E15 documented that E1 (Administrator) and E2 (Director of Nurses) were notified. On 9/16/11 at 9:40 am, E1 stated "I don't think an incident report was ever filled out". I would have to ask E1 about whether Illinois Department of Public Health (IDPH) was notified. On 9/16/11 at 10:09 am E1 stated "there are no incident report and no IDPH report. The facility Accident and Incidents policy states: #5 The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of	F 226		

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F 226	Continued From page 16 Incident/Accident form. Per Accident/ Incident report, on 8/29/11 at 7:45 pm, R1 was involved in a physical altercation with another resident that resulted in an injury. On 9/15/11 at 2:07 pm, E1 stated that everything was in the accident/incident book and that was "all they had." The facility policy for Accident/Incident Investigations states " It is the policy of this facility that the Administrator, DON (Director of Nurses)/ADON (Assistant Director of Nurses), or Designated staff to investigate all accidents/incidents."	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: 0000) During initial tour on 9/13/11 at 9:45 AM, R38 was observed in bed wearing a t shirt only with underwear, diaper, or pants. R35 also is not covered and his scrotum is exposed while in bed. 2). On 9/14/11 during the initial tour along with E13 (nurse), E37 was observed sitting on a bed side commode, E37 was observed to be sleep. E37 was sitting on the commode, with an open front gown, R37's breast were completely exposed, along with R37's pelvic area. on 9/14/11 E13 said that staff shouldn't leave R37 sitting unattended half dressed. E16 said that	F 241		9/17/11

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F 241	Continued From page 17 she would have the assigned certified nurse aid cover R37 up. Based on observation and interview facility failed to maintain dignity for one of one sampled resident (R3) reviewed for dignity out of sample size of 30 and three residents (R34,R35,R36) in the supplemental sample. Findings Include: During initial tour on 9-13-11 with E8 (Psychiatric Rehabilitation Service Coordinator) and E11 (Licensed Practical Nurse) observed in R3's room with ripped privacy curtain at 9:50 AM and at 10:15 AM no privacy curtains for R34, R35 and R36 beds one, two and three. Interview with E8 at 10:15 AM, states that she couldn't recall when there were privacy curtains in these 3 residents room. Interview with E11 at 10:16 AM, states he told maintenance yesterday and today about R3's privacy curtains being ripped. E11 states maintenance has already been notified about the need for R34, R35 and R36 privacy curtains and was told they were on back order.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced	F 246		9/17/11

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F 246	Continued From page 18 by: Based on record review and interview facility failed to provide reading material for the blind for one of two residents (R12) that had assistive devices out of sample size of 30. Findings Include: Interview with R12 on 9-14-11 at 9:45 AM, states if you give me any books to read I'll read them. Interview with E8 (Psychiatric Rehabilitation Service Coordinator) on 9-14-11 at 9:45 AM states activity would have to know about getting Braille reading and writing material for R12. Interview with E12 (Activity Director) on 9-14-11 at 10:25 AM, states we have been reading books and using sensory objects to R12 in the day room. E12 states R12 asked her about Braille books last week and now we are looking into the school for the blind to get books for R12. E12 states she just started researching this week. Record review of R12's care plan dated 9-4-09 denotes problem; visual impairment blindness, nurses arrange for referrals. Interview with E3 (Assistant Director of Nursing) on 9-14-11 at 10:30 AM, states we have not done any referrals for R12 as part of her care plan for visual impairment. Interview with E2 (Director of Nursing) on 9-14-11 at 10:35 AM, states residents are to get eye exam every two years. E2 states R12 has not had an eye examination since 2005. E12 states he spoke to R12's primary doctor and received order for R12 to have an eye exam.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		9/17/11

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F 253	Continued From page 19 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interveiw, the facility failed to ensure that facility's common areas (shower rooms) and indivivual rooms are not in disrepair and not cluttered for 3 out of 4 floors in the facility. This has the potential to affect all residents in the 4th and 2nd floors, and residents in supplemental sample (R66, 67, 68 , R69, 70, 71, 72, R73, 74 R75, 76, 77 . Findings include : 1) During 9/14/11 environmental tour with E20 (Maintenance Director) at 10:03 AM. the following were observed : a) 4th floor north shower room - gerichair with an air mattress pump in one of the 2 shower staff, square hole by the toilet in the tub room, peeling paint in the shower room walls b) 3rd floor north shower room and tub rooms - peeling paint, holes and gouges in the walls, missing tiles by the shower area c) 3rd floor soiled utility room - personal belongings in several plastic bags on the floor, hopper, in both sinks, all of which are cluttered inside the room d) 3rd floor north shower room - large hole in the tub room	F 253		

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F 253	Continued From page 20 e) room 322 - multiple peeling paint and large holes on the 4 walls of the room 2) During initial tour of the 1st floor and 3rd floors on 9/13/11 at 9:45 AM, the following were observed: a) boxes and plastic bags filled with personal belongings on the floor and on the over bed table in room 100 bed 2 and 3, room 109 bed 2 and 3 , and room 118 bed 3. b) boxes and plastic bags filled with belongings are also noted on top of the room cabinet in rooms 109, 110, and 117. c) peeling paint on the walls in rooms 119 and 109 bed 4. The wall in 109 is also gouged. d) a stand fan with dirty and dusty grills blowing towards the whole room in room 116. e) hole in the wall exposing electrical junction box in room 322 f) window curtain off track in room 321 g) missing privacy curtain in room 321 h) closet door off track in room 317 i) missing lights in head of bed in rooms 309 and 318. On 09-14-2011 at 11:00 AM, the Maintenance Director-E20 stated during this tour, he is working on fixing these holes and cleaning up the clutter in the 3rd floor soiled utility room.	F 253		

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F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure siderail assessments were completed, and/or completed in a timely manner for one of one resident R 5, reviewed for restraints in a sample of 30 , and 3 residents from the supplemental sample R 31,R 32,R 33. Findings include: 1. On 9/14/11 during the initial tour along with E 13 (nurse), R 31 was observed lying in bed with 4 siderails up. According to R 31' s' clinical record R 31 was assessed for use of side rails was indicated. R 31' s' most current siderail assessment was dated 7/13/2010. 2. On 9/14/11 during the initial tour along with E 13 (nurse), R 32 was observed lying in bed with full siderails up on both sides of the bed. According to R 32' s' clinical record siderail assessments R 32' s' most current assessment was completed on 7/13/11, however the assessment was noted to be incomplete, the	F 276		9/17/11

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F 276	Continued From page 22 assessment failed to indicate if the siderails are indicated, there was no medical symptoms noted. 3. On 9/14/11 during the initial tour R 33 was observed in bed with full siderails up on both sides of the bed. A review of R 33' s' clinical record there was no siderail assessment found. On 9/16/11 E 1 (administrator), and E2 (director of nursing), was notified of the missing siderail assessment. The facility failed to provide survey team with a copy of R 33' s' current siderail assessment. 4. On 9/16/11 at 9:00 am along with E 16 (wound nurse), R 5 was observed in bed with full siderails up on both sides of the bed. A review of R 5' s' clinical record there was no siderail assessment found. On 9/16/11 E 1 (administrator), and E 2 (director of nursing), was notified of the missing siderail assessment. The facility failed to provide survey team with a copy of R 5' s' current siderail assessment. On 9/16/11 at 11:00 am E 2 (director of nursing), said that siderail assessment are completed at admission, and quarterly and as needed.	F 276		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		9/17/11

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F 279	Continued From page 23 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to develop comprehensive careplans involving 2 of 3 residents reviewed for weight loss(R14,R27), in a sample of 30. Findings Include: 1. On 9-13-11, surveyor observed R14 sitting in a wheel chair. Resident appears thin in physical stature. Record review of the Dietary notes indicates that on 8-20-11, resident had a significant weight loss resulting in a 11.0 % weight loss in 6 months. Review of R14's comprehensive careplans does not indicate that a nutritional careplan to address this concern, there are no problems,approaches, or goals to address R14's weight issues. exists. Interview with R14 on 9-13-11 at 10:00 AM he stated that his appetite is poor, and has been poor for some time. Interview with E7(Registered Dietician) on 9-14-11 at 10:30 AM stated that R14's appetite has been poor for	F 279		

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F 279	Continued From page 24 some time and that nutritional supplements were added. 2. Per clinical record review, R27 is a 42 year old female admitted to the facility on 3/24/11. Per record review on 9/15/11, R27 experienced an 8.64 % weight loss (140.1 pounds to 128 pounds) from April 2011 to May 2011. R27 experienced an additional 2.5% weight loss from May 2011 to June 2011. Per dietary note dated 4/25/11, staff are to encourage meal replacements when 75% of the meal is not accepted. Per dietary note dated 6/24/11, Megace was ordered and recommendation to offer med pass 90 ml three times daily. Review of R27's care plan indicate there are no problems,approaches, or goals to address R27's weight issues.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		9/17/11

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F 280	Continued From page 25	F 280		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview facility failed to revise the care plans for three residents of thirty residents (R12, R13, R18) whose care plans were reviewed out a sample 30 residents.

Findings Include:

1 Record review of R12's care plan dated 9-4-09 denotes problem; visual impairment blindness, nurses arrange for referrals.
Interview with E3 (Assistant Director of Nursing) on 9-14-11 at 10:30 AM, states we have not done any referrals for R12 as part of her care plan for visual impairment.
Interview with E2 (Director of Nursing) on 9-14-11 at 10:35 AM, states residents are to get eye exam every two years. E2 states R12 has not had an eye examination since 2005. E12 states he spoke to R12's primary doctor and received order for R12 to have an eye exam.
Interview with R12 on 9-14-11 at 9:45 AM, states if you give me any books to read I'll read them.
Interview with E8 (Psychiatric Rehabilitation Service Coordinator) on 9-14-11 at 9:45 AM states activity would have to know about getting Braille reading and writing material for R12.
Interview with E12 (Activity Director) on 9-14-11 at 10:25 AM, states we have been reading books and using sensory objects to R12 in the day room. E12 states R12 asked her about Braille books last week and now we are looking into the school for the blind to get books for R12. E12

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F 280	Continued From page 26 states she just started researching this week. 2. During initial tour with E8 (Psychiatric Rehabilitation Service Coordinator) and E11 (Licensed Practical Nurse) on 9-13-11 observed writing on the walls of R13's room. Interview with E8 on 9-13-11 at 10:25 AM, states R13 has been writing on the walls. E8 states that there are some new writings on the walls. Interview with E3 (Director of Nursing) on 9-14-11 at 8:50 AM, states she was informed yesterday that there was more writing, like a new paragraph. E3 states the care plan should be amended. Interview with E10 (Psychiatric Rehabilitation Service Director) on 9-14-11 at 8:55 AM, states based on the content of R13's writing there should have been specifically addressed in the care plan and documented. Interview with E9 (Psychiatric Rehabilitation Service Coordinator) on 9-14-11 at 9:05 AM, states the writing on the wall was documented and at the time did not think it was nessary to care plan. E9 states he noticed the new writing and will make a care plan today. 3. According to the facility's accident and incident report dated 5/3/11 R18 was involved in a fall incident, R18 was observed standing up from wheel chair and tripped over leg rest and fell to the floor, with no visible injuries noted, On 5/8/11 R18 was involved in another fall incident R18 was noted as standing up out of wheel chair and fell to the floor, no visible injuries noted. On 5/10/11 again R18 was involved in another fall incident, while ambulating in the hallway, R18 was guided to the floor by staff after she loss her balance, no injuries noted. According to R18's nurses notes 5/3/11, 5/8/11,	F 280		

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F 280	Continued From page 27 and 5/10/11 all reflected R18 was involved in fall incidents without noted injuries. A review of R18's clinical record safety /fall assessment tool, R18 was initially assessed for fall risk on 4/14/11. R18 was again assessed for fall risk on 7/13/11. There was no fall risk assessment completed after R18 was involved in 3 separate fall incidents in May 2011. A review of R18's plan of care indicates R18 was at risk for falls, dated 12/29/2010, there was no new entries noted on the plan of care for fall risk after R18 was involved in 3 separate fall incidents. There were no new interventions noted on the fall risk care plan after 12/29/2010. On 9/16/11 at 11:00am in the conference room E2 (director of nursing), said that fall risk assessment are completed quarterly, and after residents are involved in fall incidents, E2 also said that care plans are updated, revised , and/or evaluated after each fall incident. According to the fall policy and procedure indicates after a fall update fall assessments, and update care plan as needed.	F 280		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		9/17/11

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F 309	Continued From page 28 This REQUIREMENT is not met as evidenced by: (1). Based on record review, and interview, the facility failed to follow physician orders involving 1 of 3 residents(R9) reviewed for physician orders and failed to monitor Valproic Acid levels consistently involving 1 of 3 residents reviewed for laboratory assessment(R14) in the sample of 30. These failures resulted in R4's Anemia not addressed, and R14 newly diagnosed as being Thrombocytopenic. Findings Include: (1) R9 was admitted to the facility on 7/25/11 with diagnoses of anemia and Kidney disease. Per R9's Physician Order Sheet (POS) dated 8/12/11, an order for Stool for Occult Blood x3, Iron, B12, and Folate level were ordered. Review of nurses notes and lab results showed no indication the specimen were collected and the test were drawn. During 9/13/11 interview of Z5 at 2:52 PM, Z5 said that there were no requisition to draw these lab tests nor was there any stool specimen sent to the laboratory for occult blood. E1 (Administrator) said during daily status on 9/15/11 that the facility is still investigating why these were not followed up. On 9/16/11, E1 said they did not find anything.	F 309		

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F 309	Continued From page 29 (2).Review of R14's POS(Physician Orders Sheet), for September of 2011 indicates that the resident receives Divalproex Sodium Extended Release 500 milligrams twice daily. The order start date is 8-2-10. This medication is used for the treatment of Seizures. Potential side effects associated with this medication includes Thrombocytopenia. Thrombocytopenia is defined as reduced levels of blood platelets in the circulating blood. Platelets is defined as blood cells associated with clotting. Review of R14's lab history indicates that the last Valproic Acid level was drawn in January of 2011. Further lab review for 2011 indicates that the CBC(Complete Blood Count) shows that R14's platelet levels from 10-6-10 thru 8-18-11 were below normal. Review of Z2's(Nurse Practitioner), progress note for August and September of 2011, indicates that R14 added medical diagnosis is Thrombocytopenia. Interview with Z2 on 9-14-11 at 10:45 AM stated that the Valproic Acid levels should be drawn quarterly. Surveyor informed Z2 that the last level was drawn in January of 2011. Z2 stated that perhaps it was not picked up but will notify the facility. Based on observation, interview and record review, the facility failed to provide the necessary care and services to evaluate the reasons for pain and identify a fracture for one resident (R4) in a sample of 5 residents reviewed for fractures, in a sample of 30. R4 is a 20 year old female with a diagnoses that includes anoxic brain damage and convulsions.	F 309		

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F 309	Continued From page 30 During initial tour on 9/13/11, R4 was observed attending activities in the first floor day room with an immobilizer cast in place on her lower right arm. Per nursing progress notes dated 8/30/11 at 11:05 AM, R4 began complaining of pain to the right wrist. R4 was then medicated with pain medications. There was no documentation of physician notification. Physical Therapy Weekly Progress Notes for the week on 8/24-30/11 states barriers to progress include pain to right wrist. On 8/29/11, x-ray to right wrist was ordered and completed. On 8/30/11 x-ray results indicated impacted fracture to the right distal radius with no significant displacement. Resident was then sent to hospital for evaluation. Review of facility's incident and accident report log on 9/14/11 show no incident report was completed. On 8/16/11 at 10:00 AM, E1 (Administrator) was asked if an incident report was completed on the incident. E1 stated no incident report was done as it was a complaint of pain. E1 also stated no investigation was completed to address possible reasons/causes for the fracture, once the fracture was confirmed.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		9/17/11

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F 314	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to use specialized air mattress properly to prevent pressure ulcers for 1 resident out of 5 residents (R24) checked for pressure sores in the sample of 30. Findings include : R24 has diagnoses of Diabetes Mellitus, Anemia, Hypertension, and Stroke. R24 is immobile in bed and is in need of total assistance from staff for ADLs. R24 is high risk for pressure sore as she is immobile, contracted, and incontinent. On 9/13/11 and 9/14/11 at 9:45 AM and 3 PM, R24 was observed laying in her Microair Turn Q Plus mattress. Her weight entered in the mattress' was 160 lbs for 9/13/11 and 9/14/11. Per R24's record, R24 weighs 126.5 lbs in September 2011. During 9/16/11 interview at 1:50 PM, E16 (Treatment Nurse) said that one of the reasons why R24 is in this air mattress is to prevent sores. E16 said that it is probably restorative department that enters R24's weight on the air mattress pump. Per Z4 during 9/16/11 interview at 1:40 PM, Z4 said that it is important that the resident's weight is entered as accurately as possible as it will determine the amount of lateral support the mattress will provide to the resident while R24 is	F 314		

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F 314	Continued From page 32 in bed. Z4 also said that its important that the thinnest possible pad should be used when the resident is in bed. E16 said that the facility has supply of thin disposable pads, which she mainly use for treatments to prevent contamination of sheets during treatment.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation and interview and record review the facility failed to ensure that 2 of 5 residents (R5, R17) reviewed for gastrostomy tube feedings in a sample of 30, and 1 resident R39 from the supplemental sample receive the prescribed amount of feeding. Finding include: During the initial tour on 9/14/11 at 9:45am along with E13 (nurse), in R17's room R17 was observed lying in bed and connected to a feeding pump, and the pump was noted as delivering Jevity 1.5 at 55ml/hour. The bottle hanging was observed to be a 1000ml bottle, the contents of the bottle was observed to be 900ml in the bottle, this amount of feeding was verified by E13. The	F 322		9/17/11

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label on the feeding bottle indicated that the feeding bottle was started at 3:45am 9/14/11. The feeding bottle was noted to have been running for 6 hours at 55ml for 6 hours to equal 330ml that should have infused, the bottle was noted with only 100ml that infused at time of observation.

According to R17's physicians orders sheet indicates Jevity 1.5 to be administered at 55ml over 20 hours.

During the initial tour on 9/14/11 at 10:00am along with E13 (nurse), in R39's room R39 was observed in bed, with a tube feeding pump running at 75cc/hour. The feeding bottle was observed hanging, it was noted to be a 1500cc bottle of Glucerna 1.2 the label on the bottle indicated that the feeding was started at 6:00pm 9/13/11. At 10:00am the feeding bottle was observed to have 600 ml in the bottle. The bottle was noted to be hanging for 16 hours at 75 ml/hour equals 1210 ml should have infused, the bottle was noted with only 900ml that infused at time of observation.

According to R39's physician order sheet indicates Glucerna 1.2 to be administered at 75ml over 21 hours.

On 9/14/11 at 10:10am E13 said that feeding tube pumps are initiated during the 11:00pm shift and should be monitored throughout the shift to ensure the prescribed amount has infused, or if there was a problem it should be documented in the nursing notes.

According to the nurse notes dated 9/14/11 for

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F 322	Continued From page 34 R17, and R39 there were no entries indicating any problems noted with their feeding pumps. On 9/16/11 at 9:00am in during a dressing change observation along with E16 (wound nurse), R5 was observed in bed connected to a feeding pump infusing Jevity 1.5 tube feeding. The feeding pump was noted to be infusing at a rate of 70ml/hour. The label on the Jevity 1.5 indicated that the feeding was initiated at 3:00am 9/16/11 at the rate of 70ml/hour. The bottle hanging was observed to have 800ml of feeding in the bottle, and the contents were verified by E16. The bottle of feeding was noted to have started at 3:00pm at 70ml/hour for 6 hours to equal 420ml that should have infused, the bottle was noted with only 200ml that infused at time of observation. According to the physician order sheet indicates Jevity 1.5 to be administered at 70ml over 20 hours. On 9/16/11 at 9:00am E16 verified that the amount of feeding in the bottle was what should have been infused based on the start time of the feeding. E16 said that she is responsible for wounds, but the feeding tube are started on the night shift. According to the nurse notes dated 9/16/11 for R5, there were no entries indicating any problems noted with their feeding pumps According to the facility's policy gastric tube feeding via continuous pump denotes the ensure that the equipment and devices are are working properly by performing any calibrations or	F 322		

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F 322	Continued From page 35 checks. The policy also indicates the purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourisment orally.According to the nurse notes dated 9/14/11for R17, and R39 there were no entries indicating any problems noted with their feeding pumps	F 322		
F 323 SS=E	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 assess and determine cause of falls and put in place interventions to prevent further falls for 1 resident out of 5 residents (R10) in the sample of 30. This failure resulted to R10 falling on 9/7/11 and sustaining a 0.5 x 0.1 cm cut to the left upper eye and bleeding. R10 was sent to the hospital for evaluation.. Findings include : 1) R10 has diagnoses of Cardiac Dysrhythmia, Unsteady Gait and Seizures. During observation on 9/13/11 to 9/15/11, R10 was observed as wheelchair bound, non - verbal, and needs assistance of 2 staff for transfers and ambulation.	F 323		9/17/11

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Review of facility's incident reports indicated that R10 fell on the following dates :

a) 4/28/11 at 7 PM, R10 was observed lying in the bathroom floor in front of his wheelchair. No injuries.

b) 5/16/11 at 10 PM, R10 was observed on his knees on the floor, by the bed in his room. No injury.

c) On 5/24/11 Nurses Notes Late Entry, R10 was reported by his roommate that he feel in the bathroom. R10 sustained an injury to his upper lip and was charted as with swelling to the right side of the face and cheek, and dried blood on inner lips. No incident report was made during this incident.

d) 7/3/11 at 11:30 AM, R10 was observed on the floor with his wheelchair on top of him and urinal by his side. R10 sustained 2 lacerations to the lower chin.

e) Nurses notes indicated that on 7/4/11, R10 was observed on his buttocks in the hallway at 1 PM. No incident report in facility's record.

f) 7/9/11 at 4 PM, R10 was found sitting on the floor in the hallway. No injury.

g) Per nurses notes dated 7/12/11 at 11 AM, R10 was found sitting on the floor in the hallway. R10 stood up from his wheelchair, lost his balance and fell forward to the floor. No injury. No incident report made.

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h) Per nurses notes dated 7/16/11 at 9 AM, R10 fell on to the floor in the hallway across the nurses station. Prior to this, R10 was sitting in his wheelchair. No incident report was made.

i) Although the incident report dated 8/1/11 did not indicate that R10 fell, the facility's incident log indicated that on 8/1/11 at 3:18 PM, R10 was found on the floor.

j) 8/16/11 at 7:30 PM, R10 was noted lying on the floor and was not able to verbalize what happened. No injury.

k) 9/7/11 at 5:45 PM, R10 pointed at the wall in his bathroom, which was observed as with blood by the toilet area. R10 tried to remove blood from his face and hair by washing it in the sink. R10's chair alarm was noted to be turned off and his helmet was also off. R10's nurses notes of the same date written at 6:43 PM indicated that R10 had a .5 x .1 cut to this left upper eye from this incident. R10 was charted as with poor safety awareness.

Review of above incidents showed no indication that post fall assessments were done to determine cause of R10's falls, each time he is found on the floor. During 9/14/11 interview of E2 (Director of Nursing) and E17 (Restorative Nurse) at 1:10 PM, E1 said that the post fall assessment was only started on 8/5/11, after the facility was given a deficiency finding on falls by the IDPH. E2 said that prior to that, there was no post fall assessment. Review of R10's post fall assessment however, like the 7/12/11 up to 9/17/11, showed no indication that the facility investigated the falls, and determined causes of

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F 323	Continued From page 38 R10's numerous falls listed above. E17 also said that she started with her position not too long ago, and started care planning R10's falls on 7/3/11, despite of the lack of post fall assessment. However, review of R10's care plan showed that interventions starting with 7/3/11 falls are not really appropriate for the corresponding fall incidents. Without determination of what really caused R10 to fall on 7/3/11, E17 put in R10's care plan that a call light is to be placed within reach of R10, R10 is to be reminded to call for assistance when needed, and safety precaution needs to be maintained. However, during 9/14/11 interview of E18 (nurse aide) at 11:50 AM, E18 said that R10 is restless and stubborn and does not follow directions. Added to this, R10 did not fall from bed therefore, call light is not even an applicable intervention to this situation, as he mostly fell from his wheelchair away from his bed. E17 said that maintaining safety precaution includes making sure the environment if free of clutter or spillage etc, which again is not appropriate to R10's individual falls, as none of them were caused by wet floor or clutter. Review of other interventions for each of the above falls were not based on post fall assessments and were not appropriate interventions to prevent R10 from falling further. E17 said that R10's chair alarm was put in place on 7/9/11, and R10 had been using his helmet for a long time now. Review of above incidents indicated that R10 fell also on 7/12/11, 7/16/11, 8/1/11, 8/16/11, and 9/7/11. All of these falls were after R10's chair alarm was put in place. Review of R10's care plan interventions however showed no revision of R10's chair alarm	F 323		

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despite of him falling while using it. Added to this, there is no assessment as to how R10 fell with the alarm, or if he is able to remove this alarm, rendering it ineffective. During above interview, E17 was not able to explain why there are no new interventions put in place to prevent R10 from falling further, and why the chair alarm was not discontinued. E17 said that she is aware that R10 is able to take his alarm off without triggering it and that R10 does not follow directions.

During above interview, E18 also said that R10 is able to remove his chair alarm without triggering it. E18 added that R10 is very restless and constantly tries to get out of his chair. E18 continued that R10 had his chair alarm for about 3 months now and had been constantly taking it off since it was put on him. E18 also added that R10 would stand up averagely 3x on her shift.

During 9/14/11 observation at 11:50 AM, R10 was in the room with his roommate. After staff took R10 out of his room and left R10 in the room, it was noted that R10's chair alarm is not connected to him. During 9/14/11 interview, at 11:50 AM, E18 said that she just assisted R10 to the bathroom and connected his chair alarm afterwards.

Per record review, when R10 fell on 9/7/11 R10 was sent to the hospital for laceration of the left upper eye. R10 returned to the facility on 9/8/11 at 5:45 AM still with left eye swelling.

Based on observation and interview the facility failed to ensure that liquid soap was safely

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secured and dispensed liquid soap on 1 of 4 resident nursing units (4th), The 4th floor is identified as a certified alzheimer dementia units. This failure has the potential to affect all 50 residents on currently residing on the 4th floor. The facility also failed to maintain a safe resident environment and prevent a metal shoe stretcher with two sharp edges from hanging in the bathroom of 2 residents of the supplemental sample R42 and R43.

Findings include:

During the initial tour on 9/14/11 at 9:30am along with E13 (nurse), and E14 (admissions), there were plastic drinking cups observed in all residents rooms on the 4th floor, and in 2 of 2 shower and tub rooms on the 4th floor nursing unit. The plastic drinking cups were observed to have a blue/green substance in the cups.

On 9/14/11 E13 said that it was soap in the drinking cups. E3 was asked if the 4th floor was a certified alzheimer unit and E3 said yes, E3 also agreed that residents on the 4th floor were identified to have wandering behavior, and were identified to be confused. E3 said that the soap was placed in the cups to prevent residents from pulling the soap dispenser from the walls. E3 didn't reply when asked if confused residents could drink the soap from the drinking cups.

On 9/14/11 at 4:00pm during the daily status meeting E1 (administrator), said that he agreed that the cups of blue/green soap was a hazard for confused residents.

During the initial tour at 10:05am along with E13

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F 323	Continued From page 41 (nurse), in the bathroom of R42 and R43 there was a metal shoe stretcher hanging on the towel rack, the shoe stretcher was observed with two sharp metal prongs protruding from it approximately 5 inches on both sides. On 9/14/11 at 10:05am E13 said that she was unaware of why the metal shoe stretcher was hanging in the bathrooms of R42/R43, E13 said that both residents were assessed to have some confusion.	F 323		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on record review and interview facility failed to provide therapeutic services for two residents (R16, R22) for one month out of a sample of 15 residents reviewed for specialized rehab in a sample size of 30. Findings include: 2) Record review of R22's care plan dated 7-30-11; provide supportive 1:1 intervention per	F 406		9/17/11

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F 406	Continued From page 42 week. Social service notes document two entries; the first one written 7-30-11 and the second written 9/7/11. There are no other entries between these dates. Interview with E10 (Psychiatric Rehabilitation Service Director) on 9-15-11 at 11:05 AM states that E9 (Psychiatric Rehabilitation Service Coordinator) should have documented his 1:1 interviews with R22. Interview with E9 (Psychiatric Rehabilitation Service Coordinator) on 9-15-11 at 11:10 AM, states he meets with R22 once a week but should have documented his meetings and failed to document his meetings in august. 1) R16 is a 62 year old female with a diagnoses that includes a history of substance abuse. On 2/8/11 R16 tested positive for opiates. Per social service notes dated 2/10/11, resident was to be referred to Gateway Substance Abuse program. There was no documentation of referral or attendance of R16 to the Gateway Substance Abuse program. On 4/19/11 R16 again tested positive for opiates. Per social service notes dated 4/20/11, resident was informed that she will be referred to Gateway for substance abuse groups. There was no documentation of referral or attendance of R16 to the Gateway Substance Abuse program. Per interview with E19 (PRSC-Psychiatric Rehabilitation Service Coordinator) on 9/14/11 at 1:35 PM, R16 does not currently attend the Gateway Substance Abuse program. Per interview with E15 (PRSC) R16 was not able to attend Gateway, as there were no vacancies. There was no documentation in R16's chart to support this. R16's care plan states she will be encouraged to participate in Gateway substance abuse programming.	F 406		

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F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		9/17/11

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F 431	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to label medication vials upon opening them for 1 resident out of 30 residents (R20) reviewed for medications in the sample of 30, and for 3 residents (R33, 39, and 40) in the supplemental sample. Findings include : During environmental tour with E20 (Maintenance Supervisor) on 9/14/11 at 10:03 AM, the following were observed : a) R40's Ativan vial in the 4th floor nurses station refrigerator opened and unlabelled. Per pharmacy sheet, this was used on 7/20/11, 7/26/11, and 8/20/11. b) R33's Lantus insulin vial opened and unlabelled in the 4th floor refrigerator. c) R35's Novolog and Lantus insulin vials opened and unlabelled in the 4th floor refrigerator. Initially when 1 vial was brought up to E22, E22 (nurse) on 9/14/11 at 9:30 AM said that , sometimes the top of the vial pops out, but that it is actually unused. 3 more vials (above) were brought to E22's attention. When asked how does the facility track then if the vials were used already, E22 replied, it is tracked thru labelling. E22 is unable to further explain in case the vial is already opened, what measures does the facility put in place to ensure that the vial which were unlabelled but opened, is really unused without	F 431		

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F 431	Continued From page 45 the top. Furthermore, when E22 was notified that the ativan vial was opened and unlabelled, E22 said she is going to check using medication book, if Ativan like the insulins, have expiration upon opening and thus, should be labelled too upon opening. d) 1 PPD vial was noted opened and unlabelled in 3rd floor refrigerator. e) R20's Humulin R was observed as had expired on 9/13/11, but still in the 2nd floor refrigerator.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		9/17/11

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F 441	Continued From page 46 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide soap for resident washrooms in room numbers 301, 302, 311, 312, 317, 319, 320 and 322 affecting these residents (R44-R66) outside the sample and one resident (R23) in the sample of 30. Facility failed to properly store oxygen masks for one resident (R1) out of four reviewd for oxygen in a sample of 30 and one resident (R41) from the supplemental sample. Findings Include: During initial tour E8 (Psychiatric Rehabilitation Service Coordinator and E11 (Licensed Practical Nurse) on 9-13-11 observed that rooms 301, 302, 311, 312, 317, 319, 320 and 322 had no soap in the washrooms. Observed on initial tour of third floor on 9-13-11, green soap in a cup on the washroom sinks in all the other residents' rooms.	F 441		

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F 441	Continued From page 47 Interview with E8 on 9-13-11 at 10:20 AM, states the residents use the green soap that is in the cup for bathing and washing hands. Interview with E11 on 9-13-11 at 10:21 AM states he did not know why there was no soap in the rooms that had no soap. Interview with E1 on 9-13-11 at 3:45 PM, states the residents on the third floor shouldn't have soap in there rooms because they might drink the soap. Record review of the facility's hand washing/hygiene policy denotes that resident, family and / or visitors will be encouraged to practice hand hygiene. During the initial tour on 9/13/11 at 9:30am along with E13 (nurse), in R41's room there was a nebulizer mask connected to the nebulizer machine on the bedside table. The mask was noted to be uncovered lying open to air on table top. On 9/14/11 at 9:35am E13 said that the nebulizer mask should be coved or bagged after use and not open to air. According to the facility's oxygen and nebulizer policy the the nebulizer mask should be placed in a bag when not in use. On 9/13/11 at 10:20 am, during ititial tour of R1's room, an oxygen nasal cannula was noted undated and uncovered on top of the oxygen tank. a nebulizer mouth piece was noted on the bedside table undated and uncovered. The facility's Oxygen and Nebulizer Use policy states	F 441		

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F 441	Continued From page 48 all oxygen tubing and nebulizer tubing are to be labeled with the date. All respiratory related epuipment tubing are to be bagged when not in use.	F 441		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documented evidence of emergency water policy availability when there is a loss of normal water supply. This has the potential to affect all residents within the facility. Findings Include: Review of the emergency policy presented to the surveyor for review, does not list procedures to ensure that water is available to essential areas when there is loss of normal water supply. Interview with E1(Administrator) on 9-16-11 at 11:30 AM stated that the presented policy is what he always have had. When informed that the presented policy does not state a plan related to emergency water supply, E1 stated that he will follow up.	F 466		9/17/11
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 49 300.690a) 300.1010h) 300.3240a) 300.3240b) 300.3240d) 300.3240f) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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) b) A facility employee or agent who becomes	F9999		

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aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 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)

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)

These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement its own policies and procedures that prohibit abuse. The facility failed to complete investigations and report to the State Agency , injuries of unknown origin for 2 of 0 residents (R4, R18) and incidents of alleged abuse for 2 of 30 residents (R1,R4), in a sample of 30 residents reviewed for Abuse/Neglect. In addituion, the facility failed to timely notify R4's physian regarding her wrist pain. R4 was found to have a fracture of the distal radius.

Findings include:

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Review of facility's Abuse Prevention Program states the following:
The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur.
Upon learning of the report, the administrator or designee shall initiate an incident investigation.
The administrator or designee is then responsible for forwarding a final report and any correction action taken to IDPH within 5 working days of the reported incident.
The facility's Accident/Investigation policy states the Administrator, DON/ADON, or designee shall investigate all incident/accidents.

1) R4 is a 20 year old female with a diagnosis that includes anoxic brain damage and convulsions. On 2/15/11 at 12:30 PM, nursing progress notes indicate R4 stated to a Certified Nursing Assistant (CNA) that R4 was slapped on the left side of her face by another CNA. The first CNA informed R4 she should not say these things if they did not happen, as both CNAs were in the room providing care. R4 began to cry and apologized, saying accused CNA did not hit her. Nursing assessment was completed with no redness or skin break was noted.

Review of facility's incident reports and incident report log on 9/14/11 show no incident report was completed. On 9/14/11 at approximately 2:00 PM, E2 (Director of Nurses) stated he was unaware of the incident and verified no incident report or investigation was completed. On 9/14/11, E1 (Administrator) also stated no incident report or investigation was completed, as

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F9999	Continued From page 52 the resident recanted the story. 2) Per nursing progress notes on 8/30/11 at 11:05 AM, R4 began complaining of pain to the right wrist. R4 was then medicated with pain medications. Physical Therapy Weekly Progress Notes for the week on 8/24-30/11 state barriers to progress include pain to right wrist. There was no documentation of physician notification. On 8/29/11, x-ray to right wrist was ordered and completed. On 8/30/11 x-ray results indicated impacted fracture to the right distal radius with no significant displacement. Resident was then sent to hospital for evaluation. Review of facility's incident and incident report log on 9/14/11 show no incident report was completed. On 8/16/11 at 10:00 AM, E1 (Administrator) was asked if an incident report was completed on the incident. E1 stated no incident report was done as it was a complaint of pain. E1 was then asked if the incident was reported to IDPH once the fracture was confirmed. E1 stated the fracture was not reported to IDPH. 3. According to the nurse note dated 2/6/11 7:14pm indicates that facility staff was informed by R18's family member that R18 was observed with swollen lips. The nurse indicates that R18 was observed sitting in the dining room in a wheelchair with a swollen top and bottom lip. R18 was assessed with no cuts to either lip. The indicates that the attending physician was notified and no new orders were given. A review of the facility accident and incident reports for February, 2011 there was no incident	F9999		

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F9999	Continued From page 53 from completed for R18's injury of unknown origin. On 9/16/11 at 11:00am E1 (administrator) was asked if there was an investigation for R18's injury to the upper and lower lips. E1 said he would check to if there were any investigations. E1 failed to provide survey team with an investigation related to R18's injury of unknown origin. E1 said that the state survey agency was not notified of the injury. On 9/16/11 at 8:30am in the dining room R18 was observed with 3 dried scab like area to the left elbow. On 9/16/11 at 8:35am, E21 (nurse), said that occurred over the weekend, but wasn't sure what happened. E21 said that it should be documented in the nurse notes what occurred. According to R18's nurse notes dated 9/10/11 10:36pm indicates that R18's family member wants R18 evaluated by rehab, due to R18 leaning to the left of wheelchair causing scratching on left arm. A review of the facility accident and incident reports for September, 2011 indicated there was no incident form completed for R18's injury of unknown origin. On 9/16/11 at 11:00am E1 (administrator) was asked if there was an investigation for R18's injury to the left elbow. E1 said he would check to if there were any investigations. E1 failed to provide survey team with an investigation related to R18's injury of unknown origin. E1 said that the state survey agency was not notified of the injury.	F9999		

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F9999	Continued From page 54 4) R1, per Physician Order Sheet dated 7/19/11 was admitted to the facility on 7/19/11 with a diagnoses of acute osteomyelitis, chronic obstructive pulmonary disease, seizure disorder, morbid obesity, and bipolar disease. Per MDS (minimum data set) dated 7/26/11, R1 requires the use of a wheelchair for mobility and has impairment on both sides of lower extremities. On 8/5/11 per Social Service note, R1 informed E15 (Social Service), that she had a visitor on 8/4/11 who "forced himself on her sexually." E15 documented that E1 (Administrator) and E2 (Director of Nurses) were notified. On 9/16/11 at 9:40 am, E1 stated "I don't think an incident report was ever filled out." I would have to ask E1 about whether Illinois Department of Public Health (IDPH) was notified. On 9/16/11 at 10:09 am E1 stated "there are no incident report and no IDPH report. The facility Accident and Incidents policy states: #5 The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form. Per Accident/ Incident report, on 8/29/11 at 7:45 pm, R1 was involved in a physical altercation with another resident that resulted in an injury. On 9/15/11 at 2:07 pm, E1 stated that everything was in the accident/incident book and that was "all they had." The facility policy for Accident/Incident Investigations states " It is the policy of this facility that the Administrator, DON (Director of Nurses)/ADON (Assistant Director of Nurses), or Designated staff to investigate all accidents/incidents." (B)	F9999		

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300.1210b)
300.1210d)2)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care

b) 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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
2) All treatments and procedures shall be administered as ordered by the physician.

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 were not met as evidenced by:

Based on record review, and interview, the facility failed to follow physician orders involving 1 of 3 residents (R9) reviewed for physician orders and

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failed to monitor Valproic Acid levels consistently involving 1 of 3 residents reviewed for laboratory assessment (R14) in the sample of 30. These failures resulted in R4's Anemia not being addressed, and R14 being newly diagnosed as being Thrombocytopenic.

Findings Include:

1) R9 was admitted to the facility on 7/25/11 with diagnoses of anemia and Kidney disease.
Per R9's Physician Order Sheet (POS) dated 8/12/11, an order for Stool for Occult Blood x3, Iron, B12, and Folate level were ordered. Review of nurse's notes and lab results showed no indication the specimen were collected and the test were drawn.

During 9/13/11 interview of Z5 at 2:52 PM, Z5 said that there was no requisition to draw these lab tests nor was there any stool specimen sent to the laboratory for occult blood.

E1 (Administrator) said during daily status on 9/15/11 that the facility is still investigating why these were not followed up. On 9/16/11, E1 said they did not find anything.

2).Review of R14's POS (Physician Orders Sheet) for September of 2011 indicates that the resident receives Divalproex Sodium Extended Release 500 milligrams twice daily. The order start date is 8-2-10. This medication is used for the treatment of Seizures. Potential side effects associated with this medication includes Thrombocytopenia. Thrombocytopenia is defined as reduced levels of blood platelets in the circulating blood. Platelets are defined as blood

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cells associated with clotting. Review of R14's lab history indicates that the last Valproic Acid level was drawn in January of 2011. Further lab review for 2011 indicates that the CBC (Complete Blood Count) shows that R14's platelet levels from 10-6-10 thru 8-18-11 were below normal. Review of Z2's (Nurse Practitioner) progress note for August and September of 2011 indicates that R14's added medical diagnosis is Thrombocytopenia. Interview with Z2 on 9-14-11 at 10:45 AM stated that the Valproic Acid levels should be drawn quarterly. Surveyor informed Z2 that the last level was drawn in January of 2011. Z2 stated that perhaps it was not picked up but will notify the facility.

Based on observation, interview and record review, the facility failed to provide the necessary care and services to evaluate the reasons for pain and identify a fracture for one resident (R4) in a sample of 5 residents reviewed for fractures, in a sample of 30.

R4 is a 20 year old female with a diagnosis that includes anoxic brain damage and convulsions. During initial tour on 9/13/11, R4 was observed attending activities in the first floor day room with an immobilizer cast in place on her lower right arm. Per nursing progress notes dated 8/30/11 at 11:05 AM, R4 began complaining of pain to the right wrist. R4 was then medicated with pain medications. There was no documentation of physician notification. Physical Therapy Weekly Progress Notes for the week on 8/24-30/11 states barriers to progress includes pain to right wrist. On 8/29/11, x-ray to right wrist was ordered and completed. On 8/30/11 x-ray results indicated impacted fracture to the right distal radius with no

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significant displacement. Resident was then sent to hospital for evaluation.

Review of facility's incident and accident report log on 9/14/11 show no incident report was completed. On 8/16/11 at 10:00 AM, E1 (Administrator) was asked if an incident report was completed on the incident. E1 stated no incident report was done as it was a complaint of pain. E1 also stated no investigation was completed to address possible reasons/causes for the fracture, once the fracture was confirmed.

300.7050a)4)

Section 300.7050 Staffing

4) The unit director shall obtain at least 12 hours of continuing education every year, especially related to serving residents with Alzheimer's disease and other dementia.

This Regulation was not met as evidenced by:

Based on interview and record review the facility failed to ensure that (E23) Alzheimer Coordinator obtained the required continuing educations hours.

Findings include:

On 9/13/11 during the initial tour of the 4th floor nursing unit along with E13 (nurse), E13 said that the alzheimer dementia unit residents census was 50 residents.

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F9999	Continued From page 59 According to E23's personnel education record, E23 attended 3 hours of continuing education in the last year 2010 (Dining with dignity), and 3 hours of continuing education for 2011 (emotional connections with people with dementia). On 9/16/11 at 4:00pm E1(administrator), said that he provided all the education hours that E23 provide to the facility. E1 said that E23 was out of town on vacation. (B) 300.4040a)1) 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: 1) 24 hours of continuous supervision, support and therapeutic interventions; This Regulation was not met as evidenced by: Based on interviews and record review the facility failed to provide weekly 1:1 interventions for 1 of 17 residents (R22) reviewed for Subpart S requirements. Findings Include: Record review of R22's care plan dated 7-30-11 included provide supportive 1:1 intervention per week. Social service notes document two entries. The first entry is written on 7-30-11. The second entry was written on 9-7-11. There are	F9999		

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F9999	Continued From page 60 no other entries/documentation between these dates. During interview with E10 (Psychiatric Rehabilitation Service Director) on 9-15-11 at 11:05 AM, E10 stated that E9 (Psychiatric Rehabilitation Service Coordinator) should have documented his 1:1 interviews with R22. During interview with E9 (Psychiatric Rehabilitation Service Coordinator) on 9-15-11 at 11:10 AM, E9 stated he meets with R22 once a week but should have documented his meetings and failed to document his meetings in August. (AWL) 300.4030m) 300.4040b) Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S m) Activity interventions for individual residents shall be part of, but not used to replace, psychiatric rehabilitation programming and should provide for using skills in new situations. Activity programs shall comply with Section 300.1410 of this Part. Section 300.4040 General Requirements for Facilities Subject to Subpart S b) The psychiatric rehabilitation services programs in the facility shall be designed to improve or maintain the resident's level of	F9999		

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F9999	Continued From page 61 functioning and independence. These Regulations were not met as evidenced by: The facility failed to provide services to maintain or improve vision and/or provide adaptive devices for 1 of 17 residents (R12) reviewed for Subpart S requirements. In addition, the facility failed to provide activity interventions for R12 in relation to his vision impairment. Findings Include: Record review of R12's care plan dated 9-4-09 denotes problem; visual impairment blindness, nurses arrange for referrals. During interview with E3 (Assistant Director of Nursing) on 9-14-11 at 10:30 AM, E3 stated we have not done any referrals for R12 as part of her care plan for visual impairment. During interview with E2 (Director of Nursing) on 9-14-11 at 10:35 AM, E2 stated residents are to get eye exam every two years. E2 stated R12 has not had an eye examination since 2005. E12 stated he spoke to R12's primary doctor and received an order for R12 to have an eye exam. During interview with R12 on 9-14-11 at 9:45 AM, R12 stated if you give me any books to read I'll read them. During interview with E8 (Psychiatric Rehabilitation Service Coordinator) on 9-14-11 at 9:45 AM, E8 stated activity would have to know about getting Braille reading and writing material	F9999		

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F9999	Continued From page 62 for R12. During interview with E12 (Activity Director) on 9-14-11 at 10:25 AM, E12 stated we have been reading books and using sensory objects to R12 in the day room. E12 stated R12 asked her about Braille books last week and now we are looking into the school for the blind to get books for R12. E12 states she just started researching this week. (AWL)	F9999		