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F 497	Continued From page 59 document that there has been no in-service education in the last 12 months on providing for resident safety, interventions for residents with cognitive/behavioral issues, prevention of falls/accidents, or fire/safety education. On 03/27/12 at 7:40 a.m., a couch was positioned across the end of the west hall blocking the emergency fire exit. At 7:45 a.m., E6 (CNA) moved this couch from blocking the exit and verified that the couch should not be there. At 4:00 p.m. on 03/27/12, E1 (Administrator) stated she didn't know why the couch was blocking the exit, that staff know better. On 04/03/12 at 7:30 a.m., the couch was positioned across the end of the west hall blocking the emergency fire exit. By 7:45 a.m., this couch was moved back to the lounge. At 9:50 a.m., E5 (CNA) stated that she didn't put the couch in front of the exit door, the previous shift did. On 04/03/12 at 2:00 PM E1 (Administrator) verified the accuracy of the in-service education list provided for the last 12 months.	F 497		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 60 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. Restorative measures shall include, at a minimum, the following procedures: d)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	F9999		

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F9999	Continued From page 61 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to evaluate the circumstances of resident injuries and falls, to review and revise care plans, to supervise residents at risk for injuries and falls and to develop and implement interventions to prevent further injuries and falls for two of three residents (R1 and R2) sampled for injuries and fall risks on the sample of four and two residents (R5 and R6) on the supplemental sample. R1 sustained at	F9999		

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least fifteen incidents of falls or injuries in a three month period resulting in severe bruising and swelling of his face and head.

Findings include:

1. According to admission forms and nurses notes dated 12/05/11, R1 was admitted to the facility on 12/05/11 with diagnoses including Vascular dementia with behavioral disturbances, Wernicke Korsakoff syndrome, hypertension, and history of alcohol abuse. From 12/27/11 - 01/05/12, R1 sustained six falls resulting in two transfers to the emergency room for treatment.

R1's care plan dated 12/15/11 identifies that R1 is at risk for falls and injuries due to unsteady gait. R1's fall care plan goal is that R1 "will have no injury related to falls." Care plan approaches for R1's fall prevention are "gait unsteady at times - hold hand and walk slowly with resident. Keep area free of clutter. Encourage rest periods."

Nurses notes dated 01/08/12 at 4:35 a.m., document that R1 was found with a skin tear on his right hand near thumb and blood found on a hallway chair and the floor beside the chair. There was no incident report of this injury and no investigation of possible causes or environmental factors that could cause R1's injury. The nurse did document that R1 continues to walk around bumping into things, keeping his head down and eyes closed as he walks. On 01/08/12 6-2 shift, the nurse documents that R1 is in "constant motion" "poor gait and posture" "several almost falls" "center of gravity off with forward bending walk" "appears to fall asleep while walking." This nurses note continues that R1 has a skin tear on

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his left elbow. The incident report dated 01/08/12 (no time documented) states that R1 was found with a skin tear, but does not include a thorough investigation of environmental factors and possible causes of R1's skin tear. This incident report states under interventions "monitor."

On 01/08/12 at 4:35, R1 sustained his third injury of the day, when the nurse documents, "Heard big crash by Adm (Administrator's) office. Found (R1) laying on his back with legs extended." R1 "hollered and grimaced in pain when touching left hip and buttock area." R1 was sent to local emergency room for evaluation and treatment. The fall investigation report dated 01/08/12 at 4:35 p.m., is left blank and includes no information under the area interventions to prevent fall from occurring again. The care plan dated 12/15/11 addresses that R1 is at high risk for falls and notes R1's two skin tear injuries of 01/08/12 and his fall of 01/08/12, but includes no new interventions to prevent further injuries. The nurses note dated 01/08/12 at 8:40 p.m., states that R1 was admitted to the hospital for dehydration.

Nurses notes document that R1 returned to the facility on 01/11/12. On 01/12/12 (no time documented) the nurse writes that R1 was in "constant motion walking back and forth into other res (residents') rooms. "will continue to monitor." Nurses notes dated 01/12/12, 2-10, states that R1 was sitting in a chair, fell asleep and fell forward out of chair onto his (R1's) head with bruising noted to R1's forehead. The corresponding incident report dated 01/12/12 is blank under interventions to prevent fall from occurring again. The care plan dated 12/15/11

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notes R1's fall of 01/12/12, but does not include any new or revised interventions to prevent further falls and injuries.

Nurses notes dated 01/17/12 6 A.M.-6 P.M. documents that R1 is very busy, standing on chairs, in and out of rooms, urinating while walking in the hallway. On 01/18/12 the nurse documents that R1 continues to roam all over going into other residents' rooms, often getting behind curtains and furniture or in closets making it difficult to find him. Nurses notes 01/18/12 -02/02/12 continue to document R1's continuous roaming, wandering in and out of rooms, moving furniture, as well as inappropriate, aggressive and combative behaviors.

A physical therapy screening dated 01/24/12 states that R1 should use a soft helmet when up, participate in activities to increase attention span, possibly have an eye exam, and use recliner with a body pillow for positioning.

On 02/02/12 at 9:00 p.m., nurses notes state that R1 wandered aimlessly throughout the building, is non compliant with helmet, taking it off 5 minutes after staff apply it (helmet), running/walking into everything. This nurses note continues that R1 has bumps and discoloration throughout his cephalic region. There is no incident report or investigation of R1's injuries corresponding to this nurses note. This was verified by E1 (Administrator) on 03/15/12 at 2:00 p.m. R1's care plan has no new approaches of interventions added to direct the staff in measures to prevent R1 from further injuries.

Nurses notes from 02/03/12-02/17/12 document

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that R1 is in constant motion, wandering, roaming, banging his head into something. On 02/17/12, 6-2 the nurse documents that R1 has many lumps, bumps and bruises on his forehead, one lump over right eyebrow the size of a walnut. Nurses notes continue that it is not known where he has gotten these although we do see R1 walking with his head down and R1 will not leave his helmet on. There is no incident report that corresponds with this nursing documentation and no investigation of R1's bruising and bumps. This was verified by E1 (Administrator) on 03/15/12 at 2:00 p.m. On 02/18/12 2-10 p.m., nurses notes state that R1 seemed to be showing signs of pain, holding his back and crying, holding his head and crying.

On 02/20/12, 2-10 p.m., The nurses notes state that R1 "ran into the wall while walking to DR (dining room)." Nurses notes document that the physician was in the facility, saw R1 and determined that R1 had not broken his nose. The investigation report dated 02/20/12 is not a thorough investigation of R1's incident. On this form under interventions to prevent injury, it states "soft helmet" and "monitor" and fails to include any new approaches, interventions, or specific directions for monitoring R1. R1's care plan has a note dated 02/20/12 that notes R1's incident, but has no revisions or interventions to prevent R1 from further injuries.

Nurses notes dated 02/22/12 document that R1 continues "to use head as a battering ram-Running into anything in his path. face swollen/ bruised from fluid pooling from injury sites." On 02/23/12 at 4:00 a.m., nurses notes state that R1 wandered in hall until midnight, ran into walls

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several times.

An incident report dated 02/23/12 at 10:55 a.m., states that R1 "continues to walk blindly into everything, pulls out drawers, upsets chairs, continuously walks into walls. Staff heard noise and res (R1) had pulled off closet door. we think it hit him on the nose as he had a small amt (amount) of nose bleed." This report states that both eyes, forehead, under eyes, and cheeks are black blue and purple. The investigation of this incident is not a comprehensive investigation of R1's incident and does not include any new interventions or approaches, but only directs for staff to use the soft helmet and monitor R1. R1's care plan has a note describing R1's incident, but the only intervention to prevent R1 from further injuries states that closet doors were removed.

On 02/25/12 at 12:00 p.m., nurses notes document that she heard a loud bang at the aides station and R1 was holding the left side of his forehead and crying. The investigation of this incident is not a thorough investigation of the circumstances of the incident and under interventions to prevent injury states "soft helmet," "monitor" and "walk with resident (R1)." R1's care plan did not address this incident and included no new interventions to prevent further injuries.

On 02/26/12, 6 a.m.-6 p.m., nurses notes state that R1 continues to walk blindly into walls, door jambs, etcetera, sleeps in nurses station briefly bent completely forward with his head drifting toward floor. Nurses note dated 02/26/12 11:45 a.m., states that R1's family was present and R1's daughter was cradling R1's head and

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sobbing loudly. Nurses note continues stating R1's family wanted R1 sent into the hospital. On 03/14/12 at 1:15 p.m., Z1 (family member) stated that when she saw R1 on 02/26/12, she couldn't believe it, his head was swollen twice the normal size and his whole face and head was bruised black and blue with both eyes swollen shut.

The hospital physical examination dated 02/26/12 at 14:38 (2:38 p.m.) notes left ear contusion, right external ear contusion, ecchymosis and swelling left upper and lower eyelid, ecchymosis and swelling right upper and lower eyelid, tongue contusion, and multiple contusions on extremities. Facial and body diagrams show ecchymosis of R1's face, neck, and knees.

On 03/27/12 at 3;20 p.m., E3 (CNA) stated that R1 would walk with his head down into doors, walls, and cabinets. E3 said she tried to check him as often as she could about every 15 minutes. E3 said that she works second shift and the staffing for second shift is one nurse, one aide 2 - 10 p.m. and one aide 3-8 p.m. E3 stated that some nights she was the only aide on duty for the whole shift and she had seventeen residents to provide care for. E3 stated that R1 took down his closet doors and needed continuous supervision.

On 03/27/12 at 2:45 p.m., E4 (CNA) stated that R1 was in constant motion, would not sit for more than two seconds. E4 said that R1 would walk with his head down into everything and that R1 "Needed eyes on him all the time." E4 said that R1 "was like a pinball machine bouncing off the walls, walking all over." E4 said that R1 broke his closet door trying to take it down and would take

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pictures off the walls. E4 said that she tried to monitor R1, she would provide care for another resident, then check on R1, then provide care for another resident, then check R1.

On 03/27/12 at 11:00 a.m., E2 (Director of Nurses and floor nurse) stated that R1 would walk with his head down into walls and would not wear the soft helmet. E2 stated that one day she was trying to redirect R1, and was behind R1 with her arms around him. E2 stated that although R1 is half her size, he bent forward pulling her on his back with her feet off the floor. E2 said that two contractors who were working in the building came running to help, thinking that R1 was going to flip her (E2). E2 stated that R1 tried to dismantle his closet, took shelves off the walls, pulled the support legs off the bathroom sink, and tried to dismantle a heating unit. E2 stated that R1 had no safety awareness and she had found him standing on a slippery chair in the foyer. E2 stated that the facility "does not have the staff to walk with (R1) one to one." E2 stated that trying to keep R1 safe was a "full time job." When asked how R1 was monitored, E2 stated " we would run when we saw something about to happen" and we would check on R1 when ever we went down the hall. E2 said that R1 had multiple bruises on his face and forehead that had dissipated down his face with swelling. E2 stated that on 02/26/12 when R1's family came in, they were very upset and accusatory.

On 03/15/12 at 11:50 a.m. and 03/17/12 at 2:30 p.m. and 4:00 p.m., E1 (Administrator) verified the facility's staffing-one nurse and two aides on days, one nurse and an aide on second shift with an aide from 3 p.m. - 8 p.m. and an aide and a

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nurse on third shift. E2 stated that there are times that only one aide is on the shift because of call ins that cannot be replaced. E1 stated that she does the Minimum Data set assessments and the care plans and verified that R1's care plan was not revised after every incident. E1 verified that the facility had an intervention to "monitor" R1, but had no specifics regarding frequency of monitoring. E1 stated that the facility did not have staff skilled to meet R1's needs and did not have staff to monitor R1 continuously.

Nurses discharge note dated 02/27/12 written by E1 states that R1 runs into walls, falls frequently, some falls with injury. (R1) sent to hospital emergency room due to facial and head injury. "Unable to readmit to facility-Not properly staffed to care for resident."

On 03/15/12 at 2:00 p.m., R1 was seen at the hospital. R1's face had only slight yellow bruising remaining. R1 was wearing a baseball hat and ambulating in the hallway with Z3 (Hospital aide). Z3 stated that staff walk with R1 one on one and that when the brim of R1's hat touches the wall or door, he stops and turns around.

2. Admission forms indicate that R2 was admitted on 02/09/12 and physician's orders for March 2012 that document that R2 has diagnoses including dementia with aggression, recent intracranial hemorrhage, recent right carotid stent and hypertension. From 02/09/12-03/26/12, R2 sustained five falls and two skin tears of unknown origin. R2's nurses notes dated 02/09/12 at 1:00 am, and 8:00 pm, 02/15/12 at 10:00 pm, 02/21/12 (no time), 2/22/12 (no time), 03/13/12 at 4:00 am and 03/26/12 at 10:30 am document R2's falls

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and injuries. The corresponding incident and investigation reports do not comprehensively assess the circumstances of R2's incidents and do not include development or implementation of approaches or interventions to prevent the occurrence of further incidents.

The care plan dated 02/21/12 states that R2 has a history of falls due to CVA (cerebral vascular accident) with left side weakness with a potential for self injury. This care plan instructs staff to remind and encourage R2 to ask for and wait for assistance with transfer and ambulation and to keep the call light in reach at all times. Handwritten notations by E1 (Administrator) are dated 02/15/12, 02/09/12, 02/20/12 and 03/13/12 and note R2's skin tears and treatments, but the only intervention added is to ambulate R2 up to 25 feet with a wheeled walker and one assist and to to passive range of motion exercises twice daily. On 03/27/12, R2 ambulated independently about the facility and at 12:00 ambulated with verbal cueing to the dining room .

3. The facility admission record for R5 documents the date of admission as 07/19/07 and the following diagnoses: Pickes Disease and Senile Dementia. An Incident Report for R5 dated 03/31/12 at 6:00 AM documents the following: "Responded immediately to resident yelling. Resident tipped wheelchair over. Resident complained of hitting head, otherwise no injuries. Neuro checks normal." The nurses notes for R5 dated 03/31/12 document that resident tipped wheelchair over. R5 complained of hitting head on floor. Nurse noted slight bruise forming on the back of R5's head. No other injury noted. Care plan for R5 dated 01/24/12 documents that R5

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has behavioral symptoms and wander seemingly oblivious to needs or safety on a daily or more frequent basis. The same care plan has no new interventions related to the fall on 6:00 AM on 03/31/12.

Incident report dated 03/31/12 at 8:25 PM documents that R5 removed personal alarm and lap buddy and was seen ambulating in the hall when resident stumbled, falling backwards onto buttocks. Nurses notes for 03/31/12 document that facility CNA saw resident stumble, falling backwards onto buttocks and received a small skin tear to right elbow. The care plan for R5 contains no new interventions related to the fall of 03/31/12 at 8:30 PM. There was no investigation report available for either of the falls R5 sustained on 03/31/12 when requested on 04/03/12.

4. The admission form for R6 documents the date of admission as 01/13/12 and the following diagnoses: Cardiovascular Disease and History of Embolism. The nurses notes for R6 dated 03/17/12 during the 6:00 AM to 2:00 PM shift document that R6 rolled out of bed onto the floor mat then proceeded to roll under the bed. The nurses notes for R6 dated 03/17/12 during the 2:00 PM to 10:00 PM shift document that R6 rolled our of bed and onto the floor on mat four times "this shift." There was no incident report or investigation made for the falls on 03/17/12 and no updates made to R6's care plan.

The nurses notes for R6 dated 03/25/12 document that R6 rolled out of bed onto the floor mat. No injury just some "slight bruising."

On 04/03/12 at 1:00 PM E1(Administrator) stated,

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(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
F9999	Continued From page 72 "I didn't know (R6) had those falls on 03/17/12. The nurses didn't make out an incident report so I didn't do an investigation or new care plan. I had the incident report (for R6) for 03/25/12 on my desk but just haven't had the time to do the investigation and care plan update." (A) 300.810a) 300.810b) 300.3240a) Section 300.810 General a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. As a minimum, there shall be at least one staff member awake, dressed, and on duty at all times. b) The number and categories of personnel to be provided shall be based on the following: 1) Number of residents. 2) Amount and kind of personal care, nursing care, supervision, and program needed to meet the particular needs of the residents at all times. 3) Size, physical condition, and the layout of the building including proximity of service areas to the resident's rooms. 4) Medical orders. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	F9999		

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F9999	Continued From page 73 agent of a facility shall not abuse or neglect a resident. These Requirements were not met as evidenced by: Based on observation, record review, and interview the facility failed to provide adequate staff to monitor, deliver care, and maintain residents at their highest mental, physical, and psychosocial degree. Facility staffed one CNA (Certified Nurse Aide) on day shift on several occasions, one CNA on second shift routinely, relies on ancillary departments to fill in as CNAs, requires CNAs to do laundry, removing them from the floor during their work days, and has no CNA coverage during staff meal breaks. This deficient practice created a systemic failure which placed all 16 residents at risk for serious harm . Findings include: On 03/27/12 at 2:30 p.m., E1 (Administrator) stated that she does the staffing schedules for the nurses and CNAs (Certified Nurse Aides). E1 described the staffing as: day shift-one nurse, one CNA from 6 a.m. to 2:15 p.m., and one CNA from 6 a.m. to 1 p.m. Evening shift: one nurse, one CNA from 2:00 p.m. to 10:30 p.m. and one CNA from 3: 00 p.m. to 8:00 p.m., Night shift: one nurse and one CNA from 10:30 p.m. to 6:30 a.m. E1 confirmed that this scheduling routinely provided only one CNA on duty from 1:00 p.m. to 2:00 p.m. and from 8 p.m. to 6:00 a.m. E1 stated that with call ins and absences, she is not always able to staff two CNAs on day shift or a 3:00 p.m. to 8:00 p.m. CNA for the evening shift. On 04/03/12 at 3:00 p.m., E1 reviewed the staff	F9999		

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schedules from January 28 through April 3, 2012 and verified that of the 67 day shifts, 18 were staffed with one CNA (27%). Also during this time frame, E1 verified that 11 of the 67 (16%) evening shifts were staffed with only one CNA. E1 confirmed that not all instances where only one CNA worked a shift was due to call ins, and that sometimes there was only one CNA available to schedule. E1 stated that on 02/06/12, E4 called in for the evening shift, but had to work anyway, since E1 could not replace her (E4). E1 stated that when there is one CNA on days who would normally complete the shift at 1:00 p.m., she will stay until 2:15 p.m., or E9 (Activity Director) will cover the floor. E1 stated that the both the CNAs and Nurses work extra shifts and stay over for twelve hour shifts as needed.

Job description for CNA(undated) provided by E1/Administrator on 04/03/12 documents that "Resident care units must be covered by at least one CNA at all times."

On 04/03/12 at 1:45 p.m., E2 (Director of Nurses) and E6 (CNA) were running up the hallway. E2 and E6 went out the door, into the laundry, where R2 had wandered. R2 was aggressive, resistive and hit E6 in her jaw. E6 stated that E1 had been sitting in her office, saw R2 going out the door, and called E6 and E2 on the intercom. E6 confirmed that she was the only aide on duty, that E5 had left at 1:00 p.m. E6 verified that R2 has no safety awareness, that the wash machine and dryer were operating when R2 was in the laundry, that no staff were present in the laundry, the doors unlocked, and that there are chemicals automatically dispensed to the washer that were assessable to R2.

On 04/03/12 at 3:15 PM E2/DON stated, "We had a resident (R2) who wanders and went out the

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front door and into the laundry room. E1/Administrator was sitting at her desk and saw the resident go out the door. Rather than go after R2, E1/Administrator picked up the phone and got on the intercom and notified me that the resident went out the front door. I had to grab the only CNA left here and go after the resident. E1/Administrator didn't get up and help at all."

On 03/27/12 at 9:45 a.m., Z4 (visitor for R3) stated that she had come to the facility at 5:30 p.m. on March 14, 2012. Z4 stated that there were two staff present in the dining room with the residents and no one was assisting R3. Z4 said that R3 was sitting with her head down eating off the table. Z4 said that she was appalled and that "No one should be treated like that." Z4 said that "it was awful, I was so upset to see her (R3) like that."

On 03/28/12 at 1:00 p.m., Z5 (R3's visitor) stated that she was with Z4 on 03/14/12 to visit R3. Z5 said that R3 couldn't use her hands and that she was feeding herself with her face to the table "like a dog." Z5 said that she was so upset that she "was just sick" when she left and will never go back to the facility again.

On 03/27/12 at 8:40 a.m., R3 was sitting in a wheelchair, dressed appropriately and propelled outside by E6 (CNA- Certified Nurse Aide) for a cigarette. E6 lit R3's cigarette and put it into her (R3's) mouth. R3 could hold the cigarette with her lips and teeth, but E6 flicked off the ashes and extinguished the cigarette when R3 was finished.

On 03/27/12 at 8:50 a.m., R3 stated that she is unable to feed herself and cannot hold the

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silverware. R3 demonstrated that she could not move her right arm, using her trunk to lift her shoulder, but was unable to raise her arm or bend her elbow. R3 did raise her left arm, bent her elbow and was able to move her hand toward her mouth, but in an uncontrolled manner. R3 stated that she needs assistance with all her care needs and needs to be fed by staff. R3 stated that sometimes she has to wait too long for help and puts her head down and eats off her plate. R3 said that she and the staff don't like it, that she "looks like a dog." R3 said that she is hungry and otherwise her food gets cold. R3 said that there are seven or eight residents who need to be fed or assisted with their meal and usually two staff to help them.

On 03/27/12 at 2:45 p.m., E4 (CNA- Certified Nurse Aide) stated that R3 can't use her hands and that she tries to assist her with her supper. E4 said that R3 will start eating with her head down to the plate, while staff are still taking other residents into the dining room. E4 stated that there are at least five residents that need to be fed and usually one or two aides to assist them. In interviews on 03/27/12, E3 (CNA) at 3:20 p.m., E5 (CNA) at 10:55 a.m., E6 (CNA) at 10:10 a.m., and E2 at 11:00 a.m. (Director of Nurses) all stated that they have witnessed R3 eating with her face down to the table.

On 04/13/12 at 11:50 AM E5 (CNA) stated, "I worked 16 hours on Sunday, then they called me at 11:30 PM and wanted me to come in to work at 2:30 AM. I told them I just couldn't do it. If someone calls in then we have to stay over. There isn't anyone else to cover. When I used to work third shift it was just me and the nurse. The

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nurse tries to help as much as possible but she had a stroke and can't help a lot. Sometimes she even uses a wheelchair to get around the building. We also have to do laundry through the night. It (laundry) is in a different part of the building off the resident unit. When we are there doing laundry and folding things we can't hear the residents or call lights. That is really a problem now with (R2's) behavior being like it is."

ON 04/03/12 at 2:00 PM E6 (CNA) stated, "They called me in to work recently on a weekend. I didn't want to, but the CNA who was supposed to went home sick. They had (E13/Housekeeper) working the floor. (E13) used to be a CNA years ago, but just recently had a fractured hip and was even a resident here while recovering, so I felt bad and came on into work. After 11:30 AM we have to do laundry. That's when laundry leaves and we have to do linens and washcloths, which takes us off of the floor."

Light Duty Job Description for E12 (CNA) provided by E1(Administrator) on 04/03/12 documents the following duties: Cut fingernails of all residents; feed residents; shave all men and ladies; go through all bed side tables and throw old cards and trash away; clean and straighten all closets; clean all wheelchairs and put clean pads in bottom of wheelchairs for next shift; pass ice water; oral hygiene and denture care on all residents; record all intake and output; record all BM's (bowel movements); wash faces of all residents who need assistance after meal; and put clothes in washer/dryer and fold clothes and linen. The same job description does not include any form of lifting or transferring of residents.

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On 04/03/12 at 3:00 PM E4 (CNA) stated, "I work second shift. I'm usually the only CNA and sometimes we have a CNA who works from 3:00 PM until 8:00 PM but E12(CNA) is on light duty and can't lift. That makes her totally useless to me. The nurse who works tries to help as much as possible but has her own job to do also. When there isn't a 3:00 PM to 8:00 PM CNA then we just work alone. If we leave for our supper then we have to clock out, but there are times when it is so busy we don't even get that opportunity. (R2) really has bad behaviors through the evening, especially after supper and wanders all over, into other residents rooms. I am constantly trying to re-direct (R2) but sometimes I am in another resident's room. We also have to do laundry during this shift which is located off the resident's unit. When I am doing laundry that doesn't leave any CNA's on the floor."

During the time frame from 02/09/12 through 02/27/12, R2 had thirteen episodes of wandering, verbal abusiveness, physically abusive combativeness, or elopement behaviors. Nurses notes R2 was hospitalized for chest pain from 02/27/12-02/29/12.

Nurses notes from 03/16/12-04/02/13 document that R2's behaviors have resumed with fourteen episodes of combative, physically abusive, verbally abusive aggressive, exit seeking and wandering behaviors. Nurses notes dated 03/16/12 at 8:20 p.m., document that R2 tried to exit the facility, a CNA (Certified Nurse Aide) attempted to redirect, R2 became physically and verbally abusive, striking the CNA in the left ear. The CNA notes dated 03/16/12 state that R2 wanders into other resident's room, attempts to

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leave the building and attacks staff, yells, screams, says he is going to use a bomb to kill all women. Nurses notes dated 03/20/12 at 9:00 p.m. state that R2 "wandered in and out of other res (residents') rooms attempted to leave the facility numerous times, became combative and physically aggressive with nurse." On 03/21/12 2-10 p.m., nurses notes state that R2 was found in a female resident's room, wouldn't move, put his fist up to hit staff. Nurses note continues that, a while later R2 was in another female resident's room, naked, cussing and trying to hit staff. On 03/21/12, (no time documented) the CNA notes state that R2 is "very abusive toward staff, wandering into other res (resident's) room, throwing stuff. trying to hurt other res, and attempting to leave." On 03/22/12 2-10 pm, nurses notes document that R2 exited the facility, hit staff, was screaming down the hall, going naked into other resident's rooms, was back up at 9:00 p.m., in other resident's rooms, "hitting staff all the way back to his room." On 03/23/12 (no time noted) the CNA notes state that R2 wanders into other resident room "abusive towards other resident and staff" refused to leave other resident' room. On 03/25/12 2-10 p.m., Nurses notes state that R2 is up and down hall, in everyone's room, got out the exit door, cussing staff. At 8:00 p.m. (03/25/12) nurse documents that R2 got "outside the building into other building." On 03/26/12 at 9:30 p.m., wandering in and out of resident rooms, climbing into their beds, tried to exit facility. On 03/27/12 at 9:30 p.m., nurses notes state that R2 had gone into another resident's room, became resistive, and sustained a fall, tripping over a CNA's feet.

On 04/01/12 at 6:00 p.m., the Nurses notes state

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that R2 "became violent to staff, hitting CNA calling her a 'Devil Bitch', kicked her and got out the door, but came back inside, turn (turned) to the nurse and said' now it's your turn Bitch' threw a container of dirty cups at nurse, threw anything he could find at the nurse, tried to tip nurse's med cart over stating 'I'm going to kill you.' " At 7:40 p.m. (04/01/12) nurse documents that R2 was up going in everyone's room, "Ladies are afraid of him and so is staff tonite."

On 03/27/12 at 7:40 a.m., a couch was positioned across the end of the west hall blocking the emergency fire exit. At 7:45 a.m., E6 (CNA) moved this couch from blocking the exit and verified that the couch should not be there. At 4:00 p.m. on 03/27/12, E1 (Administrator) stated she didn't know why the couch was blocking the exit, that staff know better.

On 04/03/12 at 7:30 a.m., the couch was positioned across the end of the west hall blocking the emergency fire exit. By 7:45 a.m., this couch was moved back to the lounge. At 9:50 a.m., E5 (CNA) stated that she didn't put the couch in front of the exit door, the previous shift did. E5 stated that the other night she stayed over (onto the second shift) and R2 was going out that door. At 11:15 a.m.(on 04/03/12), E5 and E6 (CNA) stated that the aides (on all shifts) are required to do the laundry as part of their job duties because the laundry is staffed only until 11:30 a.m. The laundry is located away from resident rooms in another building of the facility. The building which houses the facility's laundry is connected by a hallway to the original building. The laundry is about twenty feet up a ramp and though two doors from the closest end of the

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resident room hallway. E5 said that when working in the laundry, you can't hear the door alarm or what is happening on the care unit. E5 and E6 stated that there is often only one aide on days and/ or one aide on second shift.. E5 and E6 said that R2 has "sundowners" and his behaviors escalate after supper.

List of residents requiring assistance with eating and transferring dated 10/25/11 provided by E1 (Administrator) documents that of the 16 residents in the facility, eight residents require staff assistance with feeding and 10 residents require two persons to transfer. Facility MDS(Minimum Data Set)/Roster Matrix documents 13 residents with exhibited behavior issues.

On 04/03/12 at 3:20 PM E3 (CNA) stated, "I have worked here for over a year now. I love the residents here and want to do so much for them but our hands are tied down because there isn't enough help. I usually work alone. The CNA on light duty isn't able to help lift and she stays away from (R2) because she is afraid (R2) will hit her. Supper time is a nightmare and we only have a short period of time to get everyone fed so the kitchen can clean the dining room. Some evenings it's just hit and miss. We need more help. This is a joke here. Most of the residents that need to be lifted should have two people to transfer, but there is just me so I have to do it alone or get the nurse if she is able. I love my residents and am so scared that (R2) is going to really hurt someone. (R2) gets so mean and hits the staff. I know a couple of weeks ago I was told he hit another resident. I was off that evening. The CNA who was here has since then quit. I just

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F9999	Continued From page 82 do the best I can." On 04/03/12 at 3:00 PM E2(DON/Director of Nursing) stated, "This is not an ideal situation and I will probably lose my job, but we just don't have enough help with the type of residents we currently have here. It is not a safe situation. I love the residents and they deserve better. What staff we do have are good but there just isn't enough. They have to transfer residents alone. I have 20 year old CNAs with bad backs. It should not be that way. I have one CNA quitting from third shift, one just quit on second shift, and I am hearing that two more are looking elsewhere for other jobs." 300.510a) 300.510b) 300.1220b) Section 300.510 Administrator a) There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act (Ill. Rev. Stat. 1987, ch. 111, par. 3651 et seq.) full-time for each licensed facility. The licensee will report any change in administrator to the Department, within five days. b) The administrator shall delegate in writing adequate authority to a person at least 18 years of age who is capable of acting in an emergency during his or her absence. Such administrative assignment shall not interfere with resident care and supervision. The administrator or the person	F9999		

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F9999	Continued From page 83 designated by the administrator to be in charge of the facility in the administrator's absence, shall be deemed by the Department to be the agent of the license for the purpose of Section 3-212 of the Act, which requires Department staff to provide the licensee with a copy of their report before leaving the facility. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 4) Recommending to the administrator the number and levels of nursing personnel to be	F9999		

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	14E253	A. BUILDING _____ B. WING _____	C 04/10/2012

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F9999	Continued From page 84 employed, participating in their recruitment and selection and recommending termination of employment when necessary. 5) Participating in planning and budgeting for nursing services, including purchasing necessary equipment and supplies. 6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel. 7) Coordinating the care and services provided to residents in the nursing facility. 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out. 9) Participating in the development and implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group. (See Section 300.610(a).) 10) Participating in the screening of prospective residents and their placement in terms of services they need and nursing competencies available. These Requirements were not met as evidenced by: Based on observation, record review, and	F9999		

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interview the facility failed to be effectively administered in order to attain or maintain each resident's highest practicable physical, mental, and psychosocial well being. The facility was not administered in a way to provide continuity of care to the population of mixed geriatric and mentally ill geriatric residents with behavioral issues. This deficient practice created a systemic failure which placed all 16 residents at risk for serious harm .

The facility failed to report allegations of abuse. The facility failed to protect residents during allegations of abuse. The facility failed to ensure that investigations and follow up interventions were in place for residents involved in accidents/falls. The facility failed to ensure that monitoring of resident acuity was involved in determining the staffing levels of the facility. The facility failed to ensure that residents physicians orders were followed and physicians notified of abnormalities in laboratory values. The facility failed to provide dignity during the dining experience.

Findings include:

Facility Roster Matrix provided by E1 (Administrator) on 04/03/12 documents the current facility census was 16 residents. Of the 16 residents, the same Roster Matrix documents that seven of the residents have some form of mental illness and 11 residents have behavioral symptoms.

On 04/03/12 at 9:50 AM during interview with E1(Administrator) the following information was provided:

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E1 (Administrator) has been at the facility in the Administrator capacity for several years and is a Registered Nurse (RN). The facility census has fluctuated from 11 residents to as high as 18 residents in the past year. Most of the referrals the facility receives come from the Behavioral Unit at the local hospital. E1 (Administrator) does all the marketing and screening of incoming residents. Screening of residents is done by E1(Administrator) either by phone or by going and reviewing the record onsite.

Other responsibilities of E1 (Administrator) include the following: All scheduling for all departments; all resident MDS's (Minimum Data Sets); all resident Care Plans; All resident admission paperwork; assist with care delivery; feed residents during meals; all Social Services duties; maintaining of all medical records; receptionist duties; order all facility supplies; maintain personnel records; determine staffing levels; process staff payroll; interview and hiring of all facility staff; discipline of all facility staff; Infection Control Infectionist; all psychosocial/psychotropic monitoring assessments and reduction program; Abuse Coordinator; passing medications as needed; all resident assessments; and all staff education. Continuing this same interview E1(Administrator) states, "I do everything except cooking and fixing plumbing. I am not allowed to spend over 1,000 dollars without approval from the owner, who tells me that we have no budget and cannot add anymore services until census is better, at least up to 20 residents. It would be nice to have more help. Last year I had to have major surgery and could not afford to take time off, so I returned in

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one week and just sat at my desk and answered questions. While I was off that week the staff had to call me about everything. I was not in the building that week."

Continuing the same interview E1 stated that there are two RN's (Registered Nurses) who share the responsibilities of the DON (Director of Nursing) positions. One of the RN's works night shift and the other day/evening shifts. Both RN's are responsible for delivery of care and spend little to no time doing any administrative duties.

Facility Job Description for Director of Nurses (undated) documents the following responsibilities: Supervise nursing care and the maintenance of a sanitary environment; carry out personnel policies as they relate to the nursing staff; conduct regular scheduled in service training; study procedures and ways to upgrade; determine the kind and amount of nursing care required; responsible for checking charts on a regular basis to make sure that nursing procedures are being followed; and cover the floor in emergencies until the home can cover."

On 04/03/12 at 3:15 PM E2 (DON) stated, "I have been an RN for over 15 years. Most of my work experience has been in psychiatric settings. I work day shift mostly and some evenings. The other RN works night shift and really only does the skin monitoring and treatments and since her stroke that is all she is really able to do along with working as the nurse on third shift. Whenever I am here working I have absolutely no time to devote to any staff issues or any duties related to my position as Director of Nursing.
E1/Administrator does not consult me on any new

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resident we get or any hiring of new staff when that happens. I am solely working the floor, doing medication passes, treatments, and assisting the CNAs (Certified Nurse Aides) with the delivery of care. I am not allowed to make any administrative decisions and can't even give a prn (as needed) psychotropic medication without conferring with E1 first and getting permission, and my focus as a nurse has always been psychiatric nursing. I don't function as the DON, I function as the floor nurse here. When we document in the nurses notes we have to word what we say according to directions E1/Administrator gives us. We don't have the equipment we need to provide care accordingly. Our (mechanical lift) is ancient and not safe enough to use. It only has one size sling and residents can easily wiggle out of it, so the staff just don't use it and do manual lifts on residents instead. None of our beds go into the low position, so if a resident rolls out of bed they fall a good distance, even though there are mats on the floor next to the bed. We currently run with one CNA on evening shift and one who works only five hours from 3 PM to 8 PM. That half shift CNA is on light duty and can't do any lifting. We had a resident (R2) who wanders and went out the front door and into the laundry room. (E1/Administrator) was sitting at her desk and saw the resident go out the door. Rather than go after R2, (E1/Administrator) picked up the phone and got on the intercom and notified me that the resident went out the front door. I had to grab the only CNA left here and go after the resident. (E1/Administrator) didn't get up and help at all."

On 04/03/12 at 2:00 PM E6 CNA (Certified Nurse Aide) stated, "(R2) went out the front door and got

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into the laundry room. (E2/DON) came and got me and we had to go get (R2) out of the room I was the only CNA left on the floor then and (E2/DON) was the only nurse. (E1/Administrator) was sitting at her desk and saw (R2) go out the door. (E1/Administrator) called (E2/DON) about the resident leaving and didn't get up from her desk to help."

During the interview with E1 on 04/03/12 at 9:40 AM E2/DON entered the conference room and asked E1 if a resident exhibiting negative behaviors could be given a prn psychoactive medication. E1/Administrator questioned E2/DON as to whether other alternatives had been used and then gave permission to have the medication administered. After E2/DON left the conference room, E1/Administrator stated, "I have to do everything around here."

On 04/03/12 at 3:15 PM two notes hanging in the facility Medication Room document the following statements signed by E1/Administrator, "No matter what the circumstance (E1) is to be contacted first before anything is done." "No resident is to receive any prn (as needed) psychotropic medication without contacting (E1/Administrator) first and getting permission to administer."

Facility in-service records provided by E1/Administrator on 04/03/12 contain no documentation of the following required inservices: Infection Control, Pressure Ulcer Prevention, and Fire/Safety. On 04/03/12 E1/Administrator verified the in-service records provided.

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F9999	Continued From page 90 On 04/03/12 at 4:50 PM E1/Administrator stated, "I'm looking into getting a sit to stand mechanical lift. I've heard other facilities have used them. If a CNA needs help, then I have to go help. Do you think I need an Assistant Administrator?" During this survey there were serious concerns found in the following areas: the failure to provide supervision follow up interventions for residents involved in accidents; the failure to provide for adequate staffing based on facility census/current condition of residents with behavioral issues, the failure to report a potential resident to resident abuse, and the failure to operationalize the facility's abuse policy. (A)	F9999		