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F 371	Continued From page 28 During a tour of the facility's kitchen on 7/10/12 at 2:30 PM, E3 (dietary manager) was observed washing large cutting boards and juice pitchers in the 3 compartment sink. E3 was observed to submerge the items in the sinks sanitizer for 10 seconds. E3 stated that the facility's kitchen uses chlorine as a sanitizer and that items should be submerged in the sanitizing solution for 30 seconds. The posted directions above the 3 compartment sink is the manufactures recommendations with instructions to staff that dishes are to be submerge in the chlorine sanitizing solution for one minute to ensure proper sanitization of the items.	F 371		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.610a) 300.1210a) 300.1210d)1)3)6) 300.1220b)2)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance	F9999		

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F9999	Continued From page 29 with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and	F9999		

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F9999	Continued From page 30 determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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.	F9999		

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F9999	Continued From page 31 These regualtions are not met as evidenced by the following: Based on interviews, and record review, the facility's psycho-social service staff failed to provide care planning with interventions for residents in the facility with behavioral problems. The psycho-social staff failed to develop a comprehensive treatment plan with interventions for dealing with medication compliance, reassessment for safe smoking practices, and to address physical and verbal aggression for 1 of 1 (R13) residents from a sample of 18. The facility failed to develop a plan of care with interventions to monitor 1 of 18 residents (R13) reviewed for verbal and physical aggressive behaviors in the sample of 18. The facility failed to provide a safe and hazard free environment for residents in the facility by failing to follow their smoking policy and re-assess 1 of 3 residents (R13) reviewed for unsafe smoking in the sample of 18. These failures resulted in R13 setting a mattress on fire in the facility. These failures had the potential to affect all 86 residents in the facility. Findings include: The physician's order sheet documents that R13 is a 55 year old male who was admitted to the facility on 5/17/12 with diagnoses that include Schizoaffective Disease and Hypertension. Hospital records that were sent to the facility when R13 was admitted, noted that R13 had been in several other facilities which resulted in many hospitalizations due to R13's physical and verbal aggressive behaviorals. The hospital discharge report further stated that R13 had	F9999		

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thrown a chair at a television set in the facility's day room, that R13 was observed making verbal threats towards the staff and peers, and had been refusing to take any prescribed medications since his admission to the other facility. R13 was also observed to be expressing paranoid delusional thoughts, and threatening to harm other peers, stating "I will kill somebody."

The most recent MDS (minimum data set) dated 5/29/12 that was completed after R13 had been admitted to the facility documented that R13 had some difficulty remembering the date, and year, and had a cognitive summary score of 8 out of. 15. R13 had hallucinations, delusions, verbal behavioral symptoms directed toward others (threatening, screaming, cursing at others). .

E12 PRSC (professional rehab service coordinator) stated on 7/13/12 at 10:30 AM, that she was aware of R13's past behavior as documented in the hospital records. E12 further stated that since being admitted to the facility R13 had been refusing all medications, was verbally aggressive toward the staff and other peers. E12 stated that no interventions other 1:1 counseling had been planned to address R13's behaviors.

A review of the facility's MAR (medication administration report) documented that R13 had been refusing to take any medications that had been prescribed by the physician since R13 had been admitted to the facility on 5/17/12.

The initial psychosocial of 5/18/12 documents that R13 a 54 year old male was admitted with diagnoses of Schizo-Affective Disorder and Hypertension. R13 was ambulatory, alert and

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oriented x 3. R13 previously resided at another facility where R13 was referred for a psychiatric evaluation due to R13 destroying that facility's property. R13 busted a television set. The note further noted that R13 has fair cognition/hygiene, displays a guarded mood, was euphoric, consistently laughing, even when it is inappropriate to do so. R13 was counseled on safe sex practices, community safety, community pass policy, substance abuse policy, call light system, residents rights and smoking policy. On 6/4/12 R13 was counseled by social service on taking his medications. The PRSC (professional rehab service coordinator) documents that R13 was counseled on 6/6/12 concerning R13's aggressive behavior towards the nursing staff. There was no documentation indicating that a plan or interventions had been put into place addressing R13's noncompliance with taking medications or to address R13's aggressive behaviors. Nor was a suggestion documented to have R13 attend any group sessions or receive 1:1 counseling on a regular basis.

The PRSC note dated 6/4/12 and 6/6/12 documents that R13 had to receive 1:1 counseling due to verbal aggressive behavior towards the nursing staff. R13 was refusing to have blood work done, called the phlebotomist a "vampire". As an intervention, R13 was advised to attend onsite skills training group 3 times a week to increase social, coping, and symptoms management skills. The note documented that social service would provide 1:1 counseling as appropriate to increase compliance with medical care. No plan or frequency for the 1:1 counseling was documented by the PRSC.

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The facility's skills training attendance log for 6/15/12 thru 7/3/12 was reviewed. The logs failed to document that R13 had ever attended the group sessions.

Nursing documented that on the day of admission (5/17/12), R13 was refusing all medications stating "don't give me that dope", I don't want to take it. There was no documentation by nursing from 5/17/12 to 6/16/12 indicating that R13 had been refusing to take any medications and that the attending physician had been notified of R13's refusals. In addition, nursing documented that R13 was observed to be agitated and aggressive toward the staff and other residents on the unit. All attempts to calm and redirect R13 failed. Nursing documented that prn (as needed) medications were offered and refused by R13.

A incident report and a nursing progress note dated 6/16/12 at 7:30 AM, documents that R13 was involved in a physical altercation with R30 at breakfast. R13 attempted to bully R30 by stating that R30 was sitting in R13's seat. R13 was observed to throw his breakfast tray and hit R30 in the top of the head. Attempts by nursing to redirect R13 failed. R13 became agitated and yelled profanities at R30. The police was called who took R13 out for a walk, was allowed to return to the facility. On return to the facility nursing documents that R13 continued to display aggressive behavior, using profanity and calling the staff names. The physician was notified and orders for R13 to be sent to the hospital for a psychiatric evaluation were given.

E22 (nurse aide) stated on 7/26/12 at 2:45 PM, that after the police had left the facility R13 was

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walking around yelling that someone was going to get hurt.

On 6/16/12 at 12:24 PM R13 was engaged in a verbal altercation with R30 which escalated into a physical altercation. The PRSC documented that R13's was not easily redirected and that R13 continued to attempt to hit R30. R13 was sent to the hospital for a psychiatric evaluation.

R13 returned to the facility from the hospital on 6/22/12 refusing the nurses physical assessment and medications. There was no documentation in the record indicating that R13's plan of care had been updated by the psycho-social staff to include interventions to encourage R13 to take his medications and comply with medical care.

The last PRSC note documentation dated 7/5/12 (after R13 was sent to the hospital on 6/30/12) noted that R13 was involved in a physical altercation with R10. The note further documents that R13 was counseled on the rules of the facility, and medication compliance. R13 remained agitated.

Facility policy titled Facility Smoking Safety Policy documents that smokers will be evaluated to determine their ability to comply with safety rules and their ability to carry smoking materials. Residents requiring supervision shall receive this monitoring consistent with their assessment and plan of care. The following behaviors and/or conditions will jeopardize and cause revocation of the person's independent privileges: 1. Smoking in any non-designated area, such as resident rooms, bathrooms, hallways, elevators, stairways and/or smoke-free courtyard. Consequences of

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non-compliance 1. Residents will be instructed, educated and counseled abut their inappropriate behavior...Documentation will be entered in the record accordingly. 2. Further incidents of non-compliance may result in loss of independent privileges which means smoking materials will be turned over to a designated staff member, held in a secure location and the resident will only be allowed to smoke when supervised.

The smoking safety risk assessment completed by the PRSC dated 6/9/12 documents that R13 was safe and independent smoker and did not require supervision.

R9 stated on 7/27/12 at 2:45 PM that on 6/24/12 around 3:00 AM in the morning R9 was awaken with the smell of smoke in the bathroom shared with the next room. R9 stated that when he opened the bathroom door R9 observed R13 sitting on the toilet smoking a cigarette. R13 was observed to drop the cigarette in the toilet. R9 further stated that he told R13 that smoking was not allowed in the bathrooms, R13 stood up and began yelling profanities at R9. R13 attempted to hit R9. R13 also stated that the nursing call light was pulled and a nurse aide came into the room and observed the ashes on the floor and in the sink. R9 stated that the charge nurse nor administrator did not attempt to interview R9 concerning the event.

E22 (nurse aide) stated that she entered the shared bathroom of R9 and R13, the smell of smoke and ashes were observed on the bathroom floor. E22 further stated that the incident was reported to the nurse.

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E1 (administrator) on 7/27/12 at 12:10 PM stated that the above incident was brought to her attention. E1 further stated that when R13 was approached, R13 denied smoking in the bathroom. E1 also stated that R13 was counseled by the PRSC. There was no documentation in the clinical record indicating that R13 had been counseled by the PRSC or that R13's smoking privileges had been reassessed and that R13 was placed on the supervised smoking list.

E12 (PRSC) stated on 7/26/12 at 11:00 AM, that she was aware that R13 had been smoking in the bathroom. R13's room was searched but R13's smoking was not reassessed for needing supervision.

There was no documentation in the nursing notes, incident report or the concerns log concerning the above occurrence

R13's initial plan of care dated 5/17/12 failed to include goals and interventions to address R13 noncompliance with taking prescribed medications, or R13's aggressive behaviors.

The PRSC updated plan of care dated 5/25/12 included interventions of providing incentives for R13 to compliant with care; 6/21/12 to attend symptoms management group at least 2 times per week. The plan of care failed to include the types of incentive interventions to be used, or that R13 smoking privileges should be reevaluated.

An incident report dated 6/30/12 at 11:15 PM, documents that R13 was involved in an altercation on the smoking patio with R31. E8

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documented in the progress notes that on 6/30/12 R13 hit R31 with a broomstick. The police were called. R13 demanded that the police arrest R31. When the police refused, telling R13 that he started the altercation, R13 became verbally abusive using profanity toward the police. The police took R13 out side for a walk but R13 was allowed to returned to the facility and his room. R13 remained agitated, verbally aggressive using profanity toward the staff. R13 refused all medications. At 11:30 PM R13 continued to be agitated pacing back and forth on the unit, laughing and using profanity stating "I'm going to hurt somebody. I'm going to kill a ----". At 11:45 PM, R13 came from his room and sat in the dining room. At 12:00 AM E8 (nurse) noted that an alarm sounded, black smoke from R13's room filled the area, and the water fire sprinklers became active. The fire department was called. The police was again called and R13 was removed from the facility.

Z4 (physician) stated on 7/27/12 at 1:00 PM that when R13 was making statement intending to harm the staff or other peers, R13 should have been sent to the hospital by the nursing staff for an psych evaluation. Z4 stated that when a resident is threatening violent against him or herself or the staff the police should be contacted and the resident should be sent out by calling 911.

E8 (nurse) stated on 7/26/3:00 PM that E22 did report that she did attempt to ask R13 for his cigarettes and lights but R13 refused to give them to E8. E8 also stated that this incident was reported to the PRSC the next day.

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F9999	Continued From page 39 E8 stated on 7/12/12 at 11:00 AM, that on 7/1/12 at 12:00 AM, black smoke was observed coming from R13's room. When the door to the room was opened, R13's bed was on fire. E8 (nurse) further stated that all residents had to be evacuated from the facility and the fire department was called. E8 further stated that R13 had been assessed to be a safe smoker and allowed to keep his own cigarettes and lighter. E2 (director of nursing) stated on 7/27/12 at 11:15 AM, that the nurse in charge should have attempted to take R13's cigarettes and lighter and reported the above incident to the PRSC who should have addressed and reassessed R13's smoking privileges. E2 stated that since the fire no residents are allowed to have cigarette lights or matches. On 7/13/12 at 1:30 PM and 2:00 PM, R37 and R38 was observed by the surveyor returning to the facility from outside after smoking cigarettes and handing a cigarette light to E17 (receptionist). E17 stated at this time that independent residents are allowed to take their lights outside when they smoke and return the lighters to E17. E17 also stated that it was possible that not all independent smoker would remember to return the lighters to her. B 300.610a) 300.1210a) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies	F9999		

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F9999	Continued From page 40 a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) Section 300.1220 Supervision of Nursing Services	F9999		

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F9999	Continued From page 41 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 regulations are not met as evidenced by the following: Based on record review and interview, the facility failed to assess, develop and implement a plan of care with interventions to prevent a fecal impaction for one of one resident (R2) reviewed for bowel management in a sample of 18. These failures resulted in R2 being treated at the hospital for fecal impaction. Findings include: R2's current diagnoses, per July 2012 Physician Order Sheets, includes Grand Mal Seizures, Mental Retardation, Gastroesophageal Reflux Disease, Cerebral Palsy, Stricture Encephalopathy, Complex Partial Seizures with	F9999		

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	145947	A. BUILDING _____ B. WING _____	08/15/2012

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Multiple Breakthrough Seizures. The Physician Order Sheets from February 2012 through July 2012 do not list either constipation or fecal impaction as part of R2's diagnosis. R2 receives nothing by mouth and receives Fibersource 70 milliliters per hours from 2pm until 10am daily.

The nurses' note dated 3/6/12 document R2 was referred to the hospital for evaluation of coffee ground emesis. At the hospital, R2 was referred to Z3 (gastroenterologist consultant) on 3/6/12 by E13 (Facility Medical Director and Attending Hospital Physician) for an evaluation. Z3's report of consultation documents a history which includes "during the last admission, R2 did have a significant amount of impaction." Z3's consultation report documents an impression which includes "fecal impaction- patient does have a large amount of stool in his rectum. He needs some disimpaction and and then we will once again treat him with Miralax and GOLytely through his gastrostomy tube. Z3 ordered manual disimpaction and Miralax and GOLytely per the gastrostomy tube."

R2 was re-admitted back to the facility on 3/10/12 per nurses' note. The Clinical Record for March, April, and May 2012 lacks documentation of initiation of a bowel regimen interventions or monitoring to prevent further occurrences of fecal impaction.

Nurses' note dated 6/9/12 documents R2 was sent to the hospital for evaluation of two incidents of coffee ground emesis. At the hospital, R2 was referred again to Z3 on 6/9/12. Z3's report of consultation documents R2 "has a history of recurrent fecal impactions. Despite that fact, R2

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has been discharged back to the nursing home on Miralax and stool softeners, I note he is not on any at this time. At this time of his admission, he is vomiting large amount of brownish fluid." Z3's consultation report documents the impression as "1. Recurrent fecal impaction- unfortunately there is nothing new for this particular problem. He needs manual disimpaction followed by soapsuds enemas and then finally large volumes of GOLytely. In the past he has responded well to this therapy. Hopefully, when he gets discharged back to the nursing home this time, they will continue him on Miralax on a regular basis. 2. Nausea and vomiting- it is likely due to the impaction. I would note that he has been started on some Reglan. We will certainly continue that medication while he is being treated for an impaction." Recommendations by Z3 included manual disimpaction, three soap suds enemas, and 4 liters of GOLytely.

R2 was re-admitted back to the facility on 6/13/12 per nurses' note. The Physician Order Sheet on 6/13/12 documents an order for Miralax 17 grams per gastrostomy tube twice daily. The Clinical Record from 6/13/12 to 7/11/12 there were no development of a comprehensive plan of with interventions to decrease R2's occurrence of fecal impaction, and no plan of care to assess and monitor R2 for constipation and/or bowel movement frequencies.

On 7/12/12 at 9:55am, E2 (Director of Nursing) stated when a resident returns from the hospital, the hospital records remain on the unit for 7 days then go to Medical Records. They are available for the physicians to review when the resident returns. The nurses also refer to them for the

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admission. Z3 follows R2 both here and at the hospital so Z3 is aware of R2's history and treatment during hospitalizations.

On 7/12/12 at 10:00am, E4 (Nurse), stated "the hospital records are used by the nurses to re-admit the residents and then they are sent to Medical Records. If the physician requests the records I get them for the physician. I am not aware R2 has any history of constipation or fecal impactions."

On 7/12/12 at 1:35pm, E13 stated "R2 did have fecal impactions in the hospital. Fecal impaction is an issue for R2. He has multiple co-morbidities. R2 is difficult to assess because he has mental retardation and doesn't speak. I am not sure why he wasn't started on a bowel regime or monitoring upon his return from the hospital in March."

On 7/12/12 at 1:50pm, E2 stated "I wasn't aware of the hospital documentation of fecal impactions. R2 doesn't have a plan of care in place and he should. Residents with an impaction issue should have a care plan in place to monitor bowel movements."

The facility's Bowel Elimination Management Policy documents "for residents with cognition deficits, the nurse aide is to note the occurrence, frequency and character of bowel movements and the results are to be given to the charge nurse for follow up. For residents who have had no bowel movement for 2 days (6 shifts) are to be offered 4 ounces of prune juice at supper or at bedtime. Residents who have had no bowel movement for 3 days (9 shifts) will be observed

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F9999	Continued From page 45 for the possibility of fecal impaction. If the assessment reveals suspected impaction, review the physicians orders for authorization to perform a rectal exam or notify the physician of assessment findings and request an order to perform a rectal examination to check for fecal impaction and treatment orders. The unit manager/charge nurse will monitor bowel elimination documentation at least weekly." There is no documentation in the Clinical Record by the nursing assistant or nurses of bowel movements, interventions or of any notification or follow-up by nursing staff regarding R2's bowel elimination on the following dates: 3/16/12, 3/21/12, 3/23/12, 3/29/12-4/1/12, 4/9/12-4/13/12, 4/16/12-4/20/12, 4/21/12, 4/22/12, 4/24/12, 4/25/12-4/27/12, 4/28/12, 5/2/12-5/4/12, 5/6/12-5/10/12, 5/13/12-5/14/12, 5/16/12-5/18/12, 5/19/12, 5/24/12-5/27/12, 5/29/12-5/30/12, 6/1/12-6/3/12, and 6/15/12 per the nurse and nurse aide entries.. B	F9999		