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	IL6002109	A. BUILDING: _____ B. WING _____	C 10/03/2014

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PALM TERRACE OF MATTOON	1000 PALM MATTOON, IL 61938

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S1230	Section 300.1230 Direct Care Staffing This Regulation is not met as evidenced by: LICENSURE VIOLATIONS: 300.1230 k) Staffing Effective September 12, 2012 a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satify the remaining 75% of the nursing and personal care time requirements. This finding are not met as evidenced by the following: Based on record review and interview the facility failed to have 10% of nursing and personal care time provided by a Registered Nurse for 6 of 15 days reviewed. The facility failed to have 75% of nursing and personal care provided by a direct care staff for 2 of 15 days. This has the potential to affect all 145 residents residing in the facility. Findings include: The undated spread sheet provided by E2, Director of Nursing on 9/30/14 at 3:45 pm documents the period of time reviewed for staffing was from 9/05/14 - 9/19/14. The spread sheet documents 18 skilled residents and 127 intermediate residents for that time period, which requires a minimum of 381.86 hours of direct care staff. The total hours of direct care staff calculated (381.86 hours) times 10% equals the number of RN (Registered Nurse) time (38.18 hours). The minimum RN hours per 24 hour	S1230		10/14/14

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S1230	Continued From page 1 period are calculated to be 38.18 hours. The total hours of direct care staff hours calculated (381.86) times 25% equals the number of Licensed Nurses time (95.45). The minimum Licensed Nurse hours per 24 hour period are calculated to be 95.45 hours.The total hours of direct care staff f (381.86) minus the minimum RN hours (38.18) and Licensed hours (95.45) calculate to be 286.48 minimum additional direct care staff hours needed per 24 hour period. The undated spread sheet documents the following hours per 24 hour period for RN's: 9/06/14 - 32 RN hours 9/07/14 - 32 RN hours 9/13/14 - 32 RN hours 9/14/14 - 24 RN hours 9/15/14 - 32 RN hours 9/16/14 - 32 RN hours The undated spread sheet documents the following hours per 24 hour period for direct care staff: 9/13/14 - 232.5 Certified Nurses Assistant (CNA) hours 10.55 hours of extra nurses 2.40 hours of social services 245.5 hours total with added staff . 9/14/14 - 232.5 CNA hours with additional hours calculated for nurses and socail services: 10.55 hours of extra nurses 2.40 hours of social services 245.5 hours total with added staff .	S1230		

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S1230	Continued From page 2 On 9/30/14 at 3:45 pm E2, Director of Nursing stated "this spread sheet incorporates the actual hours worked." The Facility Data Sheet dated 9/11/14 documents a census of 145 residents. (AW)	S1230		
S9999	Final Observations 300.680a) 300.680c) 300.682a) 300.682b) 300.3240a) Section 300.680 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. These policies shall be developed by the	S9999		

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S9999	Continued From page 3 medical advisory committee or the advisory physician with participation by nursing and administrative personnel. c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience. Section 300.682 Nonemergency Use of Physical Restraints a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on: 1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective; 2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being; 3) consultation with appropriate health professionals, such as rehabilitation nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and 4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. b) A physical restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of	S9999		

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S9999	Continued From page 4 motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact. 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 are not met as evidenced by: Based on observation, record review and interview, the facility failed to complete a physical restraint assessment, obtain informed consent and physician's order for the use of a restraint. Nursing staff applied a physical restraint to R7 that was not necessary to treat a medical symptom, but rather for staff convenience. This failure resulted in R7 being distraught and fearful. R7 is one of three residents reviewed for physical restraints in the sample of eighty nine. Findings include : R7's Physician Order Sheet (POS) dated 9/1/14 - 9/30/14 documents diagnoses of Huntington's Chorea with associated Dementia without behaviors, Anxiety, Depression, Muscle Wasting and Disuse Atrophy. R7's Minimum Data Set (MDS) dated 8/15/14 documents a Brief Interview for Mental Status (BIMS) as 10/15 (mild cognitive impairment). On 9/25/14 at 9:22 am, Z2, Psychiatrist stated that " (R7)'s cognition is indeed intact, she is very reliable. Staff have told me that (R7) can get loud, I believe that is necessary for (R7) to speak more clear with Huntington's affecting her speech delivery."	S9999		

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S9999	Continued From page 5 On 9/25/14 at 10:30 am E13, Certified Nursing Assistant (CNA) stated " (R7) does get up by herself and walks from her wheelchair when she gets to her room." On 9/30/14 at 10:25 am R7 stated " I will show you how I can get up and transfer to my wheelchair." R7 scooted to the front of her recliner chair, checked to make sure the brakes were locked on her wheel chair, stood without assistance facing the chair, turned around and sat down. On 9/25/14 at 10:35 am R7 stated " I can walk a little but need help with long distances. I get up in my room and use the furniture to keep me from falling." On 9/24/14 at 1:00 pm E18, CNA stated " (R7) was up at the nurses station hollering and yelling that she wanted to go to bed but she wouldn't stay in bed. She (R7) is a fall risk that's why second shift got her (R7) up and brought her to the nurses station because she kept trying to get out of bed. (R7) was yelling she wanted to go to bed. We (E17, Registered Nurse and E18) told her (R7)when she calmed down we'd put her in bed..... Then (E17) tied the sheet on one side of the wheel chair arm and I (E18) tied the other to the bar in front of the wheel chair arm." On 9/23/14 at 4:38 pm, E17 stated " (R7) was put to bed and got on her call light constantly. (R7) wanted a (disposable incontinence brief) on so she could go (urinate) in her bed if she wanted to..... (R7) continued restless, trying to climb out of bed and on the call light. We got her up in the wheel chair, she (R7) had on a hospital gown on when we brought her to the nurses station. The oncoming nurse is male so I tied the bed sheet to	S9999		

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S9999	Continued From page 6	S9999		

the arms of the wheel chair to cover the resident who was bucking and thrusting her pelvis forward.....I wanted her (R7) covered for her own dignity while I gave (E14, Licensed Practical Nurse (LPN) report. I told (E18) to come over and help me with the sheet..... I'm talking to (R7) telling her she needed to calm down. We would take her to the bathroom anytime she needed to go and put her in bed, once she was calm. I finished report and did some paper work, left a little late and (R7) was still in the chair and had not calmed down."

On 9/25/14 at 5:30 am E19, Certified Nursing Assistant (CNA) stated that "(E18, CNA) told (E19,CNA), (R7) was gotten up out of bed and taken to the nurses station so she wouldn't fall." E19 then stated that "the nurse (E17, Registered Nurse, RN) stooped down beside the wheelchair while (R7) was trying to stand up and heard (E17) tell (R7) to behave. " E19 stated " I saw that (R7) had a bed sheet tied tight enough around her, to keep her in her wheelchair so she wouldn't fall. (R7) was very irritated and kept trying to tell (E17) that she wanted to go to bed." "(R7) was louder that she usually was when I worked." "I heard (E17) tell (R7) that (R7) was already in bed and wouldn't in stay there."

On 9/25/14 at 8:05 am E14 stated that on 9/5/14 he received in report from E17 that E17 got R7 up and put R7 at the nurses station to watch her so she doesn't fall.

On 9/24/14 at 8:25 am, R7 stated " I was really scared then (9/5/14) and again last night, that's the same nurse (E17) who was working that night. (E17) kept telling me I was bad because I wanted to go to the bathroom.... I wear underpants and had those and a nightgown on

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S9999	Continued From page 7 when the nurse (E17)got mad because I would not wear that diaper..... (E17) and (E18) tied the bed sheet behind the back of my wheelchair. They (E17 and E18) don't like me that's why they did it." " (E17) wouldn't take it (bed sheet) off my wheel chair so I finally got the sheet untied myself, then (E18) took me to the bathroom and let me go to bed." R7's Chart review was devoid of a physical restraint assessment, documentation of informed consent, a physicians order for application of a physical restraint and identification of a medical symptom being treated by the physical restraint. On 9/25/14 at 9:55 am, E2, Director of Nursing stated "I looked in her (R7) chart too, there is no restraint assessment, consent or order from her physician for a restraint. ... we viewed this as a dignity issue." The Facility Restraint Policy dated 01/02 documents that "a physical restraint will not be used for the purpose of discipline or convenience and must treat a physical symptom." Procedures include: "A complete restraint assessment, a consent and a physicians order." (B) 300.610a) 300.1210b) 300.1210d)6) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall	S9999		

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S9999	Continued From page 8 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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: 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 300.3240 Abuse and Neglect 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	S9999		

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S9999	Continued From page 9 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to prevent a witnessed physical assault on R8 by R9 which resulted in a right humerus and right femoral neck fracture. R8 and R9 are two of eight residents reviewed for abuse in the sample of eighty nine. Findings include: R9's Admission Face Sheet is dated 11/06/13. R8's Admission Face Sheet is dated 11/07/13. R9's Physician Order Sheet (POS) dated 9/1/14 - 9/30/14 documents diagnoses of Schizophrenia, Depression and Blindness. R8's POS documents diagnoses of Schizophrenia and Epilepsy. R9's admission assessment for violence dated 11/6/13 documents that R9 has had a history of physical violence and the physical ability to cause harm. There was no documented evidence of R9's physical aggression toward others on file. R9's Minimum Data Set (MDS) dated 7/21/14 documents a Brief Interview for Mental Status (BIMS) of 11/15 (mild cognitive impairment). R8's MDS dated 7/17/14 documents a BIMS score of 14/15 (no cognitive impairment). On 9/25/14 at 9:22 am, Z2, Psychiatrist stated " (R9) is cognitively intact. He (R9) is very aware of what he is doing. (R8) is cognitively intact and I am not aware of any indication of aggression towards other residents."	S9999		

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S9999	Continued From page 10 R9's Nursing Notes, signed by E12, Registered Nurse (RN) and dated 9/19/14 at 5:00 pm document "resident was in the dining room and drinking coffee. He (R9) flung his coffee across the room.....Resident was helped back to his room after this incident as other residents were complaining about being made wet." On 9/25/14 at 9:05 am, R10 stated " I was out in the dining room when (R9) threw his coffee. The cup hit me and the coffee landed on them (R14 and R15). Then (R9) said 'I threw the coffee, so sue me.'" On 9/25/14 at 9:40 am, R15 stated " I was leaving my table when (R9) threw the cup of coffee and hit (R10 and R14). I was in a direct line to be hit if I hadn't been leaving the table." On 9/25/14 at 4:15 pm, R14 stated " I started yelling help, help, help to the staff as (R9) raised his hot cup of coffee, aimed at me and threw it directly at me. Hot coffee got all down my left arm. Three CNA Staff (unknown names) came running. Then another CNA (E15) took (R9) to his room." On 9/24/14 at 2:10 pm, E15 Certified Nursing Assistant (CNA) stated "(R9) spilt his coffee and I took him to his room to helped him wash his hands. He (R9) said he was going to take a nap." R9 remained in his room while others continued in the dining room. R9's Facility Nursing Notes, signed by E12, Registered Nurse (RN) and dated 9/19/14 at 6:00 pm documents " (R9) was seen by (E10, CNA) to push another resident (R8)."	S9999		

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S9999	Continued From page 11 On 9/23/14 at 2:38 pm, E10 stated "I saw (R9) push (R8). (R8) flew across the room and landed on his right side." On 9/24/14 at 2:30 pm, E12 stated "I was called to the floor Stat (immediately), (R8) was on the floor. I knew right away that his (R8) leg was broken, it was rotated outward and he complained of pain in his leg and shoulder. (E10) told me that (R8) needed to use the bathroom (which is connected to R9's room) they were yelling about it when (E10) saw (R9) push (R8). (E10) told me (R8) flew across the room landing on his right side." On 9/24/14 at 1:20 pm, E25 CNA stated " I worked the night (R9) pushed (R8) down. I can usually calm (R9) down but not that night. He (R9) kept saying I want to fight him (R8).....R8 was on the floor in his (R8) room and (R9) just kept yelling. I couldn't calm him (R9) down so another (E15)CNA came to help me." On 9/24/14 at 5:45 pm, R8 stated " about every night since I've been in this room (connected by the bathroom to R9's room) every couple of nights (R9) wakes me up slamming doors and yelling.....Now I know what he's (R9) is capable of, it's not just (R9) threatening me now he (R9)can physically hurt me again. I can't continue to fear him because of this assault." The Emergency Room Note dated 9/19/14 at 8:17 pm documents R8 suffered a right femur fracture and a right humerus fracture and was admitted the hospital for surgical repair. The Emergency Room Note dated 9/19/14 at 7:33 pm documents that R9 was treated for a right posterior trapezius strain after he punched	S9999		

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S9999	Continued From page 12 another resident (R8) at the facility. E12 stated on 9-24-14 at 2:30 p.m. that R9 was returned to the facility and placed on a behavioral care unit under one to one supervision. The Facility Policy titled "Abuse Prevention Program" dated 11/11/11, documents .....Residents who allegedly mistreat another resident will be removed from contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of other residents and employees of the facility...." (B)	S9999		