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	145947	A. BUILDING _____ B. WING _____	C 08/30/2011

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PLAZA NURSING AND REHAB CTR	**3249 WEST 147TH STREET MIDLOTHIAN, IL 60445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigations: 1191258 - No deficiencies 1191997 - F152 and F314 1192118 - F223 and F323 An parital extended survey was conducted	F 000		
F 152 SS=G	483.10(a)(3)&(4) RIGHTS EXERCISED BY REPRESENTATIVE In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to seek a legal guardian for 1 of 8 sampled residents (R8) who was unable to make decisions for herself. As a result of the facility's inaction, the resident's medical condition deteriorated resulting in malnutrition, dehydration, infection and anemia. Findings include: R8's was admitted to the facility on 2-25-11 with diagnoses that include dementia and failure to	F 152		

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

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F 152	Continued From page 1 thrive. Admission social service notes for R8 dated 3-19-11 (a late entry for 3-4-11) document "Resident is a widow with no children. Resident has no listed family members. Resident is alert and oriented times 2." Nursing notes dated 4-6-11 at 11:34PM notes, "R8 has a very poor diet. R8 never eats full meals and rarely eats 1/3 of meals." Nursing notes dated 4-16-11, 4-17-11, 4-21-11, 4-25-11, 4-27-11 continue to state that the resident has a poor a appetite, refusing to swallow, and eating less than 1/3 of meals. Dietician notes dated 4/7/11 show that a 2 week calorie count was ordered, her diet downgraded and health shakes added. A recommendation for a gastrostomy tube placement was made if the oral intake did not improve. Nursing notes dated 4-8-11 at 10:32PM ,"abscess to right scalp area". Nursing notes dated 4-29-11 notes" stage 2 acquired right hip pressure sore". Social service notes dated 4-12-11 at 12:26PM (a late entry for 4-11-11) notes, "R8 deemed in need of guardianship due to not having any family or friends that could be used as power of attorney with making healthcare decisions. R8 is being referred for state guardianship." E3 (social service) stated on 7-8-11 at 3:30PM that he found out about R8's medical condition and then began working on a guardianship because R8 was declining. E3 had no comments	F 152		

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F 152	Continued From page 2 as to why this process was not started when the resident was admitted prior to R8's physical decline. E3 also stated that he told E2 (Administrator) about the need for guardian. Z8 (R8's Attending Physician) stated on 7-8-11 at 4:00PM and 7-20-11 at 1:30PM, "The delay in treatment was due to no one available to sign for consent for the surgical procedure (gastrostomy tube placement) that needed to be done. "It was the local hospital who is responsible for the delay." Z8 stated that R8 was sent to the hospital twice within 30 days. The initial visit the hospital refused to place the gastrostomy tube because R8 had no one to sign. The hospital sent R8 back to the facility. Z8 also stated that the hospital notified the facility of the need to obtain a legal guardian so the surgical interventions could be done. R8 returned to the facility and continued to decline. Z8 also stated that he told the administrator that the facility needed to pursue a guardian for R8 before R8's medical decline. "R8's decline in medical condition is directly related to her inability to eat. Z8 stated that her body began to breakdown. The damage has already begun". E2 (Administrator) on 7-8-11 at 4:00PM stated that she found out about the need for R8 to have a legal guardian when the hospital called and requested that she, as the administrator should sign for the surgical procedure (gastrostomy tube placement) in April, 2011. E2 stated that administrators cannot sign for surgical procedures. E2 stated that she notified the court systems and "just had to wait until the court date that was assigned to R8". The court date that was assigned to R8 was May 6, 2011.	F 152		

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F 152	Continued From page 3 Z9(Medical Director) stated on 7-21-11 at 1:30PM, that no one from the facility made him aware of R8's declining condition. The local hospital brought it to his attention and this is where he gave his assistance in getting R8 a legal guardian. Z9 stated that it took only 48 hours to obtain a legal guardian. R8 had the gastrostomy tube placed on 5-9-11. Hospital records indicate that R8 was admitted 5/1/11 with a diagnosis of malnutrition, hypernatremia, dehydration, anemia and urinary tract infection. Z14 (Temporary State Guardian) stated on 8-24-11 at 9:35AM, "My records indicate that the Administrator (E2) initiated,(R8's) state guardianship on May, 4, 2011. On May 6 an order from the courts were obtained and a consent for the surgery was received on May 9, 2011, the day of surgery." E2 did not initiate a state guardianship until 5-4-11. R8 began her medical decline on 4-7-11 (33 days prior). E2 also did not make the medical director (Z9) aware of the resident's declining condition, the need for guardianship to insert a gastrostomy tube, or the problems with the hospital not pursuing guardianship on R8's two previous admissions. Z8 did not contact Z9 and relate the problems regarding the resident's declining condition and the need for guardianship for the gastrostomy placement.	F 152		
F 223 SS=J	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION	F 223		

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F 223	Continued From page 4 The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility failed to protect and prevent the abuse of 1 of 8 sampled residents (R1) from a former resident (R2) who had a history of inappropriate behaviors with R1. The facility staff allowed R2 to re-enter the building without supervision and R2 proceeded to R1's room and sexually assaulted her. This failure resulted in an Immediate Jeopardy. E2 (Administrator) was notified of the Immediate Jeopardy on July 21, 2011 at 10:36AM. The Immediately Jeopardy was determined to have begun July 2, 2011 at 11:15PM when R1 was sexually assaulted. Findings Include: E4 (staff nurse) stated on 7-8-11 at 11:00AM "(R2) left the facility Against Medical Advice (AMA) on 7-1-11 at about 12:00PM. (R2) was not allowed back into the building because of his inability to follow instructions not to be near (R1). These instructions were not to touch her body, not to feed her, and not to sit by her. (R2) had options to go to the hospital or leave. (R2) left	F 223		

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the facility. I was going to tell the night nurses about (R2's) behaviors and the facility's request that he go to the hospital or leave. I let (R2) in the building just to get a blanket because he said he was cold."

E6, CNA (Certified Nurse Aide) on 7-8-11 at 2:00PM stated on 7-1-11 at about 11:15PM, she observed R2 with his head between R1's inner thighs. R2 was standing at the foot of the bed. R2 had slurred speech and had a strong smell of alcohol. E6 stated after she told R2 to stop, he raised his head and began to lick his lips. E6 stated that R1 was lying in the bed unable to make any sounds, nervous, shaking all over and had the call light in her hand squeezing it tightly.

Z2 (R1's Attending Physician) stated on 7-8-11 at 11:00AM, "(R1) has severe anoxic brain damage and she is unable to speak or verbalize any of her needs. (R1) also needs extensive assistance with all aspects of physical concerns. (R1) would not have been able to call for help."

R1's assessments from 3/7/11 and care plan from 8/10/11 confirm that the resident was totally dependent upon staff for care and was non verbal.

R2 's assessments and care plan dated 6/1/11 show that the resident is independent in all activities of daily living.

R2 was admitted to the facility on 4/27/11. Documentation from this date to discharge on 7/1/11 show episodes of R2 sitting close to R1, rubbing her arms, feeding the resident, playing with her hair and being found in her room. R2

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F 223	Continued From page 6	F 223		

was redirected each time, but the behaviors continued.

E3 (Social Service Director) stated on 7-8-11 at 4:00PM that the staff had been complaining about R2's frequent inappropriate touching of R1. E3 stated that he witnessed this several times and counseled R2 several times. E3 stated nothing further was implemented to address or prevent this behavior from reoccurring.

Z5 (Psychiatric Physician) stated on 8-23-11 at 10:00AM, "I gave orders to send (R2) to get a psychiatric evaluation because he was displaying behavior that the facility could not manage. These behaviors were touching a young girl inappropriately who could not defend herself ."

Emergency room records dated 7-2-11 at 12:00AM note the following: "The final diagnosis is sexual assault. Unable to perform the physical examine because of (R1's) mental and physical disabilities. A series of sexual transmitted test were done".

Police report dated 7-1-11 at 11:25PM states that R2 was taken into custody outside the facility and detained while a investigation was done. The resident was arrested and charged with criminal sexual assault.

The Immediate Jeopardy was removed on July 21, at 3:00PM. The facility still remains out of compliance at a Severity and Scope - Level 2 because of the need to allow for the facility to complete staff training and nursing in -services. The facility will also need to evaluate the

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F 223	Continued From page 7 effectiveness of the revised policies/protocols/monitoring and assessments for abuse/sexual assault and inappropriate behaviors. The facility took the following measures to remove the immediate jeopardy: 1). All staff were re- in -serviced on following the facility Abuse Protocols and procedures. 2). All of the residents in the facility have been re-educated on the Abuse Protocol prevention and reporting through a meeting with the residents. 3). An Abuse Investigation was conducted. 4). The final report was submitted to the Illinois Department of Public Health. 5). All employees have been re- in-serviced on the policy of Against Medical Advice (AMA). 6). All employees have been re - in-serviced on visitation policies of the facility. 7). The 2 nurses who failed to follow the facility's Abuse Policy and Procedures are no longer employed at the facility. 8). The Administrator/designee will conduct Abuse Investigation in accordance with the regulations. 9). The Administrator will review the employee in- services to ensure compliance. 10). Upon discovery of failure to follow the Abuse Policy and Procedures an investigation will ensue. 11). QA will be done/monitor by the Director of Nursing for abuse compliance Quartey. 12). QA the monitoring will be done 3-5 times per week.	F 223		
F 314 SS=J	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 8 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to maintain a pressure relieving device for 1 of 2 residents (R8), reviewed for pressure sores in a sample of 8. These failures resulted in R8 acquiring multiple pressure sores that required hospital admission for antibiotic therapy and surgical intervention. The lack of nutritional intervention and resulting decline in R8's physical condition resulted in an Immediate Jeopardy. E2 (Administrator) was notified of the Immediate Jeopardy on July 21, 2011 at 10:36AM. The Immediate Jeopardy was determined to have begun May 1, 2011 at 3:00PM when R1 was admitted to the hospital for surgical debridement of necrotic tissue of multiple pressure sores and treatment for malnutrition, dehydration, anemia, infection and hypernatremia. . Findings include: R8's was admitted to the facility on 2-25-11 with	F 314		

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diagnoses that include dementia and failure to thrive. Admission skin assessment showed no skin breakdown.

Physician notes dated 4-1-11 notes," transferred to hospital for evaluation of altered mental status and returned to the facility with no new orders."

Nursing notes dated 4-6-11 at 11:34PM notes, "R8 has a very poor diet. R8 never eats full meals and rarely eats 1/3 of meals."
Nursing notes dated 4-16-11, 4-17-11, 4-21-11, 4-25-11, 4-27-11 continue to state that the resident has a poor a appetite, refuses to swallow, and is eating less than 1/3 of meals.

Wound care notes document the following:
- 4-29-11 (R8) has a stage 2 acquired right hip pressure sores."
- 5-19-11 acquired stage 3 to left knee and acquired stage 2 pressure sore to sacrum."
- 5-27-11 acquired unstageable pressure sores to right medial leg,
- 6-4-11 acquired unstageable to left hip along with unstageable acquired pressure sores to right and left heels."

Dietician notes dated 4/7/11 show that a 2 week calorie count was ordered, her diet downgraded to puree and health shakes added. A recommendation for a gastrostomy tube placement was made if the oral intake did not improve.

R8's yearly weight records for 2011 documents the following: February, 139 lb' s', March 137.8 lb's, April 134 lb' s', May (hospital weight) 115.8#'s. This is a 29 lb. unintentional weight

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F 314	Continued From page 10 loss within 4 months. Nursing notes dated 4-8-11 at 10:32PM ,"abscess to right scalp area". Nursing notes dated 4-29-11 notes" stage 2 acquired right hip pressure sore". Z7(R8's Attending Physician) on 7-12-11 at 3:00PM stated that R8's pressure sores and other co-morbidities (dehydration, malnutrition and hypernatremia) development are directly related to lack of food consumption/very poor appetite and poor nutrition. Z7 stated he sent R8 to the hospital. for the placement of a gastrostomy tube for R8 to increase her nutrition before any of the skin breakdown began. The hospital refused to place a gastrostomy tube because R8 had no family member or legal guardian to give consent for the surgery. Z7 stated it was the hospital's fault and not the facility's fault that she developed pressure sores. Z7 stated he sent R8 to the hospital and they did nothing; the hospital just sent her back to the facility. Z7 also stated that he discussed the nutritional needs of R8 ,(gastrostomy tube placement and legal guardian) with the Administrator. Z8 (Registered Dietician) on 7-21-11 at 2:30PM confirmed the recommendations of gastrostomy tube because of the decrease in oral intake. Z8 also stated that from 4-12-11 to 5-20-11 she did not assess or follow up on her own recommendations for R8's gastrostomy tube placement. Z8 stated," it was up to the physician." Z8 had no comments about the multiple pressure sores R8 developed between 4-12-11 to 5-20-11 the 29 lb weight loss or the	F 314		

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medical problems related to lack of nutrition. Z8 stated that the next time she assessed R8 was May 20, 2011 after the placement of the gastrostomy tube.

Social service notes dated 4-12-11 at 12:26PM (a late entry for 4-11-11) notes," R8 deemed in need of guardianship due to not having any family or friends that could act as power of attorney with making healthcare decision. R8 is being referred for state guardianship."

E3 (social service) stated on 7-8-11 at 3:30PM, that he found out about R8's medical condition and then began working on guardianship because R8 was declining. E3 had no comment as to why this was not done upon admission or before R8's physical decline started. E3 also stated that he told E2 (Administrator) about the need for guardianship.

Review of hospital lab results dated 5-1-11 notes: sodium 163 (norm 136 to 145), chloride 128 (norm 98 to 107), BUN 52 (norm 7 to 18), albumin 2.2 (norm 3.4 to 5.0) , Hemoglobin 11 (normal 12 to 16).

Hospital records dated 5-9-11 notes:"received a gastrostomy tube on 5-9-11."

Hospital Discharge notes dated 5-11-11 notes: "renal consult was obtained for electrolyte imbalance, Patient was continued on intravenous hydration. Due the patient's failure to thrive, dehydration, malnutrition and a (Percutaneous Esophageal Gastrostomy) PEG was recommended and placed after consent was obtained from family. The PEG is functioning,

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intervenous fluids were weaned, patient became more alert."

Z7 stated again on 7-20-11 at 1:30PM ," It is the hospital's fault because the hospital sent (R8) back to the facility and (R8) continued to decline and have skin breakdown. (Z7) stated I sent her to the hospital twice before the hospital would do something. (Z7) also stated ,"I am surprised R8 is still alive because of her low lab results, multiple pressure sores, not eating, hazards of immobility and the steady decline in her overall physical condition. Z7 stated that without eating for a length of time once the gastrostomy placement was done it was too late. Once the gastrostomy tube was inserted (4 weeks later) by the hospital it was too late, pressure sores had already developed, the damage was done". Z7 gave no reason as to why he did not inform Z9 (Medical Director) about R8's declining condition"

Z9 stated on 7-20-11 2:30PM that the local hospital told him that R8 needs a gastrostomy tube because of multiple pressures sores and inability to eat. Z9 states that he assisted the facility in getting R8 a legal guardian. This process was done within 48 hours. Z9 stated if he would have known or been aware of the need for R8 to receive a medical treatment (gastrostomy tube placement) he would have intervened earlier. Z9 stated neither the facility or Z7 informed him of R8's declining medical condition.

R8's dressing changes were observed on 7-9-11 at 9:30AM with E9. The right and left outer hips and sacrum were all Stage IV in size with

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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
F 314	Continued From page 13 copious drainage on the dressings. The Stage III pressure sores on each heel had DuoDerm in place, and the lower leg had a Stage I pressure sore with a dressing in place. Observations of R8 on 7-8-11 at 10:00AM and on 7-12-11 from 9:30AM to 10:30AM, showed R8 was lying in bed on a deflated air mattress directly on the metal portion of the bed. E1, (Director of Nursing) and E9 (Treatment Nurse) on 7-8-11 at 4:00PM stated," they were not aware of the air mattress not working correctly. E9 stated she did not know the connections were not staying in place to keep air in the mattress. The Immediate Jeopardy was removed on July 21, at 3:00PM. The facility still remains out of compliance at a Severity and Scope - Level 2. The facility needs to allow time to complete staff training and Nursing in - services, and to evaluate the effectiveness of the revised policies/protocols/monitoring and assessments for pressure sores The facility took the following measures to remove the immediate jeopardy: 1). the resident is receiving treatment to pressure sores as ordered. 2). wounds and assessed weekly per treatment nurse and or charge nurse. 3). preventative measures continue to prevent further breakdown will be assess daily. 4). All resident have been assess for pressure sores by completing a skin assessment of each	F 314		

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	145947	A. BUILDING _____ B. WING _____	C 08/30/2011

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F 314	Continued From page 14 resident. 5). All residents will be assess upon admission to the facility. 6). All staff have been re-in-service regarding pressure sores preventions and care. 7). Care plans for residents with pressure sores have been revised, ,skin alteration noted for improvement or deterioration. 8). the physician will be notified for residents developing, having deterioration, non-healing wounds or signs and symptoms of infections with pressure sores. 9). Mechanical interventions for pressure sores will be monitored daily dure by nursing staff. 10). Maintenance Director will be notified of devices not functioning properly and the repair contractor will be called as needed. 11). Family and or legal representative will be notified for changes in would status. 12). Changes to the wounds will be reported upon discovery. 13). Social services will determine residents who have no family or legal representative and an application will be initiated. 14). The Director of Nursing will review the shower sheets daily, review reports for changes an development of new wounds. the Director of Nursing will monitor the Treatment Nurse's notification of the physician and notification of the family or legal representative. 15). Quality Assurance using a audit tool 3-5 times weekly will monitor the discovery, treatment, family/legal representative interaction. 16). the results of the audit will be discuss at the monthly quality Assurance meeting.	F 314		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 15 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to provide supervision for 1 of 8 sampled residents, R2, who was a previous resident. R2 was allowed to re-enter the facility unsupervised and sexually assault R1. R2 had a history of inappropriate behaviors toward R1 which the facility was aware of. This failure resulted in an Immediate Jeopardy. E2 (Administrator) was notified of the Immediate Jeopardy on July 21, 2011 at 10:36AM. The Immediate Jeopardy was determined to have begun July, 2011 at 11:15PM when R1 was sexually assaulted. Findings include: E4 (evening nurse) stated on 7-13-11 at 11:30AM , "I let (R2) back into the facility after leaving the facility against medical advice (AMA). (R2) was requesting a blanket because he was cold and needed to go to his room to get a blanket. This happened during the change of shift and we were in our nursing report. During the same time I was telling the night nurse that (R2) was barred from the building because of inappropriate sexual behaviors with (R1). Then	F 323		

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(E6 -certified nurse aide) came to the nursing station and reported to the night nurse about the sexual act she witnessed between (R1) and (R2). I continued to finish my paper work to go home. The police came and the ambulance arrived and I just let the night nurses handle it. I did not go into the room to assess (R1) because the night nurses were caring for her." E4 also stated that during the evening shift; residents in the facility constantly come and go out the back door. "All of the residents know the code."

E6 stated on 8-23-11 at 10:40AM, "I saw (R2) sitting in a chair by the door when we came into work that night. (E4) told me that the resident was not allowed in the building. E5 (night nurse) called E1(administrator). (E1) said to escort (R2) out of the building so we got him out of the building. On rounds at 11:30PM (R1's) call light went off and I saw (R2's) head between (R1's) thighs and (R2) was performing oral sex on (R1)."

R2 was able to re-enter the facility after he was escorted out by E5 and E6 and enter R1's room undetected.

Z2 (R8's Medical Physician) stated on 7-8-11 at 11:30AM, (R1) has severe anoxic brain damage and she is unable to speak or verbalize any of her needs. (R1) also needs extensive assistance with all aspects of physical concerns. Z2 stated (R1) would not have been able to call for help.

Random interviews on 7-8-11 with E11(social service aide), E12(Rehab aide), E13 (staff nurse) and E14 (dietary aide) between the hours of 9:00AM to 12:00PM, all told surveyor that the

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facility's administration told every staff member not to allow R2 close to R1 because of inappropriate behaviors. All of them stated that this was well known in the facility. All of them stated they have seen R2 inappropriately touch R1 several times, they all said they have reported it several times. E10 (Housekeeping Supervisor) stated that she reported R2's behavior of sitting very close to R1 and rubbing her arm on 7-1-1 to administration.

E3 (social service) stated on 7-8-11 at 4:00PM, "(R2's) physicians order on 7-1-11 were directly related to (R2's) feeding and playing with R1's hair and inappropriately touching her. (R2) had been told several times not to go near (R1). (R2) refused to obey these instructions knowing that (R1) cannot communicate that she is willing to accept sexual affection. (R2) left the facility and was instructed not to come back because of his inappropriate sexual behaviors toward (R1)." E3 also stated on 7-8-11 at 4:00PM that the staff had been complaining about R2's frequent inappropriate touching of R1. E3 stated that he witnessed this several times and counseled R2 several times but nothing else was put in place to protect R 1 or further address R2's behaviors.

Z5 (Psychiatric Physician) stated on 8-23-11 at 10:00AM, "I gave orders to send R2 to get a psychiatric evaluation (7/1/11) because he was displaying behavior that the facility could not manage. These behaviors were touching a young girl inappropriately who could not defend herself ."

E2 (Administrator) stated on 7-8-11 at 10:00AM, "everyone was told on 7-1-11 that (R2) is not

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allowed in the building because of his sexual gestures toward (R1)". E2 confirmed that no written formal instructions were given to the facility staff regarding R2.
On 7-13-11 at 3:00PM, she said she was not aware that E4 allowed R2 back into the building. E2 stated that every staff member in the building was fully aware not to allow R2 back into the building; "this was no secret".

E1(Director of Nursing) stated on 7-8-11 and again on 8-23-11 at 10:30AM, E1 stated that everyone in the building on the day shift and evening shift knew not to let R2 back in the building. R2 was not allowed back into the building because he left against medical advice (AMA) and because of his sexual behaviors toward R1.

E17, E18 and E20 (Certified Nurse Aides) stated on 8-23-11 between 10:00AM and 11:00AM that they were not aware that R2 was barred from the building. All of these nurses were working the day R2 left AMA and none were informed by facility's administration that R2 was barred from the building.

R2's social service notes 6-17-11 (late entry for the actual date of 6-13-11) dated 7-5-11, (a late entry for the actual date of 6-1-11) document that the resident was met with to discuss his continued attempts of being around another peer whom he was instructed to remain away from due to the other resident's inability to communicate. R2 was instructed that if he was non-compliant and not following staff direction, he would be sent out for psychiatric evaluation.

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F 323	Continued From page 19 There is no further documentation of any other interventions or monitoring done of R2 after the resident was counciled and the inappropriate behavior continued. R2 was allowed to sign out AMA on 7/1/11 and then allowed that evening to come back into the facility. The Immediate Jeopardy was removed on July 22, at 3:00PM. The facility still remains our of compliance at a Severity and Scope - Level 2. The facility needs to complete staff training and Nursing in - services, to evaluate the effectiveness of the revised policies/protocols/monitoring and assessments for /abuse - sexual assault and inappropriate behaviors. The facility took the following measures to remove the immediate jeopardy: 1). The Police were notified. 2). The former resident, R2 was removed from the facility. 3). The resident, R1 was sent to the hospital for evaluation. 4). The Director of Nursing came to the facility and made rounds to ensure all other residents in the facility were safe. 5). An Abuse investigations was initiated. 6). The facility door alarms were inspected and the codes were changed. 7). The facility was provided instructions on changing the door alarms codes. The codes to the door alarm will be changed monthly, or if the code is obtained by an unauthorized person. 8). resident in the facility were re-educated regarding the Door Alarms, Resident Safety and	F 323		

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F 323	Continued From page 20 Visitor Policy with the facility including discharged residents. 9). New residents will be informed of the Policies during the Social Service Admission Process. 10). All staff were re-in-served regarding Door alarms, discharged residents, AMA, supervision and notification of the police. 11). In-services will be scheduled quarterly on door alarms, discharges, supervisions and notification of the police and for new employees. 12). Door alarms will be tested daily to ensure they are functions properly. 13). Maintenance Director will report to the Administrator, any malfunctions with door codes or alarms. 14). The results on the test of the door will be documented on a Quality Assurance Audit. 15). The results will be discussed in the monthly QA meetings. 16). These results will be supervised by the Administrator.	F 323		