DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. BUILDING ______ B. WING ______	C 10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM TERRACE OF MATTOON	1000 PALM MATTOON, IL 61938

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F 000	INITIAL COMMENTS Complaint # 1463917 / IL71838-No deficiency Complaint # 1463941 / IL71863-No deficiency Complaint # 1464105 / IL72043-F155, F221, F225, F226, F241 Complaint # 1464167 / IL72110-F223, F225, F226, F279 Complaint # 1464230 / IL 72193-F159 A partial extended survey was conducted.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to permit one resident (R7) the right to refuse the use of a physical restraint. R7 is one of three residents reviewed for 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 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." On 9/25/14 at 5:30 am E19, Certified Nursing Assistant (CNA) stated that "(E18, CNA) told (E19), (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) 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 than she	F 155		

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usually was when I worked."

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 the arms of the wheel chair to cover the resident who bucking and thrusting her pelvis forward......I wanted her (R7) covered for her own dignity while I gave (E14, 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 9/24/14 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 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."

On 9/24/14 at 1:00 pm E18 stated " (R7) was up

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F 155	Continued From page 3 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 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 4:10 pm, E21, Licensed Practical Nurse stated that on 9/7/14 night shift E19, Certified Nursing Assistant (CNA) told E21 that E17 had tied R7 in the wheelchair with a sheet on 9/5/14. The Facility Admission Contract dated 6/09 documents that a Written Acknowledgment of Residents Rights which include a right to refuse treatment is signed as part of the contract on admission.	F 155		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a	F 159		

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separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that 89 of 133 residents (R1, R3 through R10, R13, R14, and R17 through 94) having resident funds deposited in the pooled

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F 159	Continued From page 5 interest bearing checking account are available for resident use immediately following the deposits. The finding includes: E22, Business Office Assistant and E23, Business Office Manager were interviewed on 10-1-14 at 10:00 A.M. regarding the facility's procedure for management and handling Resident Trust Funds. Resident Trust Funds are held in an interest bearing pooled checking account in a local bank. E23 makes deposits of cash and checks received at the facility. The majority of the deposits at made as direct electronic deposits of the resident's monthly Social Security checks. E23 and E22 stated that the individual resident deposits are posted by the Corporate Office. E23 stated that the local bank transmits the list and the amounts of the individual resident's deposits made into the Trust Fund Account. This deposit information is transmitted to the facility the same day the deposit was made. E23 stated that once the deposit information was transmitted to facility, E23 creates a spreadsheet of the amounts from the Social Security checks to be posted in the individual resident account and the amount to posted to the resident liability. E23 stated that the spreadsheet is transmitted to the Corporate office the same day the deposit is made. E22 stated that the facility gets verification from the Corporate office when the individual resident deposits are credited (posted) to the individual resident Trust Fund account. E22 stated that she does not give funds to residents until E22 gets verification. E22 acknowledged that credit may not be posted until up to 7 days after the deposit.	F 159		

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E23 provided examples of the delays in posting by Corporate office for R17, R18, and R19. The facility's "Resident Trust Fund Inquiry" showed the following:

Residents, Date of deposit, Date posted by Corporate

R17, R18, R19, 9-3-14, 9-10-14
" , 8-1-14, 8-6-14
" , 7-3-14, 7-8-14
" , 6-3-14, 6-4-14
" , 5-2-14, 5-7-14

According to the "Social Security Beneficiary Report" from the bank and the facility's "Trust Fund Balance Report as of 9-30-14", 89 of 133 residents (R1, R3 through R10, R13, R14, and R17 through 94) have resident funds deposited in the pooled interest being checking account. The 89 residents that have their Social Security checks deposited, have to wait to have their monies until the deposit is credited (posted) to their account.

The facility's "Resident Funds Policy and Procedure" states at the end of the first paragraph, "In this manner the resident will have access to his/her monies within the same day." The paragraph refers to funds deposited with the facility.

F 221 SS=G — 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS — F 221

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to

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treat the resident's medical symptoms.

This REQUIREMENT is 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."

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."

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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 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

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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 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.

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F 221	Continued From page 10 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."	F 221		
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION 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	F 223		

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F 223	Continued From page 11 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." 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	F 223		

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F 223	Continued From page 12 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)." 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."	F 223		

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PALM TERRACE OF MATTOON	**1000 PALM MATTOON, IL 61938**

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F 223	Continued From page 13 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 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	F 223		

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F 223	Continued From page 14 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...."	F 223		
F 225 SS=F	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

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The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
A. Based on record review and interview, the facility staff failed to identify and report possible abuse of R7 when a physical restraint was applied against her wishes. The facility failed to protect R7 and others by permitting the alleged perpetrators to have continued unrestricted access to all residents. The facility also failed to identify this as alleged abuse which caused a delay in the abuse investigation and report of the allegation to the State Survey Agency. R7 is one of eight residents reviewed for abuse in the sample of eighty nine. These failures have the potential to affect all 145 residents residing in the facility.

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.

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R7's Minimum Data Set (MDS) dated 8/15/14 documents a Brief Interview for Mental Status (BIMS) as 10/15. On 9/25/14 at 9:22 am, Z2, Psychiatrist stated that " (R7) 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."

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) 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 than she usually was when I worked. I heard (E17) tell (R7) that (R7) was already in bed and wouldn't in stay there."

On 9/23/14 at 4:38pm, 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 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, LPN) report. I told (E18)

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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 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 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."

On 9/24/14 at 1:00 pm E18 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 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

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arm."

On 9/23/14 at 4:10 pm, E21, Licensed Practical Nurse (LPN) stated that on 9/7/14 night shift E19, Certified Nursing Assistant (CNA) told E21 that E17 had tied R7 in the wheelchair with a sheet on 9/5/14. E21 reported this to E20, Assistant Director of Nursing (ADON) 9/8/14 at 6:00 am.

On 9/24/14 at 10:25 am, E20 stated that she reported the allegation to E2, Director of Nursing when she came in the morning of 9/8/14.

On 9/24/14 at 10:30 am, E2 stated that she thought it (tying the bed sheet to the wheel chair) was for R7's dignity and confirmed this with E17 the evening of 9/8/14. " I did not view this as abuse."

On 9/24/14 at 9:50 am, E1, Administrator stated " The (E2) Director of Nursing did not view this (9/5/14, R7 being restrained with a bed sheet) as abuse. I was informed on 9/9/14, reported and investigated it as abuse because it could have been interpreted as abuse." The facility Nurse/Certified Nursing Assistant (CNA) schedule documents that on 9/8/14, E17 continued to work before an investigation was initiated. E18 continued to work 9/8/14, 9/9/14 and 9/10/14 before and during the investigation into R7 being restrained with a bed sheet. The alleged perpetrators, E17and E18 had unrestricted access to all residents until the investigation was initiated 9/9/14.

The Investigation Report documents that the State Survey Agency was not notified until 9/19/14 at 12:08 pm of the incident that occurred 9/5/14

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F 225	Continued From page 19 Facility Data Sheet dated 9/11/14 documents a census of 145. B. Based on record review and interview the facility failed to protect R8 from R9 after an incident when R9 had thrown coffee at other residents (R10, R14 and R15) in the dining room. R9 then assaulted R8 who suffered a humerus and femur fracture. Staff had knowledge of this alleged physical abuse and failed to identify it, report it, investigate it and provide protection to prevent the physical abuse on R8. R8, R9, R10, R14 and R15 are five of eight residents reviewed for abuse in the sample of eighty nine. These failures have the potential to affect all 145 residents residing in the facility. Findings include: R9's Admission Face Sheet is dated 11/06/14. 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. R9's Physician Order Sheet dated 9/1/14 - 9/30/14 documents diagnoses of Schizophrenia, Depression and Blindness. R9's Minimum Data Set (MDS) dated 7/21/14 documents a Brief Interview for Mental Status (BIMS) of 11/15 (mild 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." R9's Nurse Notes signed by E12, Registered	F 225		

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Nurse 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." This same Nurses Note is devoid of any intervention initiated to prevent R9 from further aggression towards others.

R9's Nursing Notes, signed by E12, Registered Nurse and dated 9/19/14 at 6:00 pm document " (R9) was seen by staff to push another resident (R8) from the next room. One on one observation by staff initiated."

R9's Nursing Notes, signed by E12, Registered Nurse (RN) and dated 9/19/14 at 7:00 pm document (R9) asked where (R8) was as (R9) wanted to fight (R8).

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 help him wash his hands. He (R9) said he was going to take a nap.... (E15) I headed back down to the hall towards the dining room."

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."

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F 225	Continued From page 21 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." R9 remained in his room while other residents continued in the dining room. The Investigation Report documents R9 threw coffee on 9/19/14 at 5:00 pm. (E12 documented in Nurses Notes 9/19/14 that he had knowledge of the alleged abuse). This allegation was not reported to the E1, Administrator, State Survey Agency or investigated until the surveyor reported this allegation to the E1, Administrator on 9/25/14 at 10:00 am. Facility Data Sheet dated 9/11/14 documents a census of 145. C. Based on record review and interview the facility failed to identify, report, investigate and provide protection after R9 disclosed alleged sexual abuse by an unknown perpetrator. The facility subsequently failed to report the allegation to the State Survey Agency. R9 is one of eight residents reviewed for abuse in the sample of eighty nine. These failures have the potential to affect all 145 residents residing in the facility. Findings include: R9's Physician Order Sheet dated 9/1/14 - 9/30/14 documents diagnoses of Schizophrenia, Depression and Blind. R9's Minimum Data Set (MDS) dated 7/21/14	F 225		

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documents a Brief Interview for Mental Status (BIMS) of 11/15 (Mild 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."

R9's Nursing Notes, signed by E11, Licensed Practical Nurse (LPN) and dated 8/22/14 at 5:45 am, documents that " resident began yelling and slamming doors at 5:15 am (R9) complained that man touched my penis, the yelling started when that man told me not to tell anyone he touched my penis, but I am going to tell."

On 9/24/14 at 11:57 am E11 stated "(R9) said the man in the mirror told him not to tell anyone that a man touched his penis.... I did not report what he (R9) said regarding his penis because he referred to the man in the mirror."

On 9/24/14 at 4:55 pm R9 stated " I can't remember anybody trying to touch my penis recently but it has happened in the past. That's all I want to say about that."

On 9/24/14 E2, Director of Nursing stated " we weren't aware of the sexual abuse allegation until we saw it in the nurses notes we copied for you (surveyor) regarding (R9) physical assault (allegation) on (R8)."

The Investigation Report documents that the State Survey Agency was not notified until 9/23/14 at 18:56 pm of the allegation of sexual abuse on R9 by an unknown perpetrator 8/22/14. The report delay prevented protection of R9 and an investigation of the alleged sexual abuse. The same report documents the local police department was notified 9/23/14 at 7:00 pm.

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F 225	Continued From page 23 Facility Data Sheet dated 9/11/14 documents a census of 145. The Facility Policy titled "Abuse Prevention Program" dated 11/11/11, documents that all employees "report any incident, allegation or suspicion of potential abuse, neglect or misappropriation of property they observe, hear about, or suspect to the administrator or an immediate supervisor who must then report it to the administrator....Supervisors shall immediately inform the administrator or in the absence of the administrator, the person in charge of the facility, of all reports, incidents, allegations or suspicion of potential abuse, neglect or misappropriation of property. Upon learning of the report, the administrator, or in the absence of the administrator the person in charge of the facility , shall initiate an incident investigation......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....Employees of the facility who have been accused of mistreatment, neglect, abuse or misappropriation of residents property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee."	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		

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F 226	Continued From page 24 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review, the facility failed to operationalize their policy to effectively identify potential abuse by residents and staff, report alleged abuse, remove alleged perpetrators, investigate allegations of abuse and report to the State Survey Agency. The facility failed to identify, report and protect R7 from possible abuse when physical restraint was applied against her (R7) wishes. The alleged perpetrators had continued access to all residents. The facility failed to protect R8 from R9 after an incident where R9 had thrown coffee at three other residents (R10, R14 and R15) in the dining room. R9 then assaulted R8 who suffered a humerus and femur fracture. Staff had knowledge of and failed to identify this incident as a possible allegation of abuse, failed to report and investigate. The facility failed to identify, report, investigate and provide protection after R9 disclosed alleged sexual abuse by an unknown perpetrator to E11 Licensed Practical Nurse (LPN). The facility subsequently failed to report to the State Survey Agency. R7, R8, R9, R10, R14 and R15 are six of eight residents reviewed for abuse in the sample of eighty nine. These failures have the potential to affect all 145 residents residing in the facility. Findings include :	F 226		

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F 226	Continued From page 25 The Facility Policy titled "Abuse Prevention Program" dated 11/11/11, documents that all employees "report any incident, allegation or suspicion of potential abuse, neglect or misappropriation of property they observe, hear about, or suspect to the administrator or an immediate supervisor who must then report it to the administrator....Supervisors shall immediately inform the administrator or in the absence of the administrator, the person in charge of the facility, of all reports, incidents, allegations or suspicion of potential abuse, neglect or misappropriation of property. Upon learning of the report, the administrator, or in the absence of the administrator the person in charge of the facility , shall initiate an incident investigation......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....Employees of the facility who have been accused of mistreatment, neglect, abuse or misappropriation of residents property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee. External Reporting of Potential Abuse , The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, misappropriation of resident property, and reasonable suspicion of a crime are reported immediately to the administrator of the facility and to other officials in accordance with the State law through established procedures. If the event that	F 226		

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caused the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least one law enforcement agency of jurisdiction and the State Survey Agency immediately after forming the suspicion (but no later than two hours after forming the suspicion), Otherwise, the report must be made not later than 24 hours after forming the suspicion."

1. 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."

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) 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

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(R7) that (R7) was already in bed and wouldn't stay there."

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 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) 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 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 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.

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F 226	Continued From page 28 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." On 9/24/14 at 1:00 pm E18 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 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 4:10 pm, E21, Licensed Practical Nurse (LPN) stated that on 9/7/14 night shift E19, Certified Nursing Assistant (CNA) told E21 that E17 had tied R7 in the wheelchair with a sheet on 9/5/14. E21 reported this to E20, Assistant Director of Nursing (ADON) 9/8/14 at 6:00 am. On 9/24/14 at 10:25 am, E20 stated that she reported the allegation to E2, Director of Nursing (DON) when she came in the morning of 9/8/14. On 9/24/14 at 10:30 am, E2 stated that she thought it (tying the bed sheet to the wheel chair) was for R7's dignity and confirmed this with E17 the evening of 9/8/14. " I did not view this as abuse." On 9/24/14 at 9:50 am, E1, Administrator stated " The (E2) Director of Nursing did not view this	F 226		

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(9/5/14, R7 being restrained with a bed sheet) as abuse. I was informed on 9/9/14, reported and investigated it as abuse because it could have been interpreted as abuse." The facility Nurse/Certified Nursing Assistant (CNA) schedule documents that on 9/8/14, E17 continued to work before an investigation was initiated. E18 continued to work 9/8/14, 9/9/14 and 9/10/14 before and during the investigation into R7 being restrained with a bed sheet. The alleged perpetrators, E17and E18 had unrestricted access to all residents until the investigation was initiated 9/9/14.

The Investigation Report documents that the State Survey Agency was not notified until 9/19/14 at 12:08 pm of the incident that occurred 9/5/14

2. R9's Admission Face Sheet is dated 11/06/14 documents.

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 Physician Order Sheet dated 9/1/14 - 9/30/14 documents diagnoses of Schizophrenia, Depression and Blindness.

R9's Minimum Data Set (MDS) dated 7/21/14 documents a Brief Interview for Mental Status (BIMS) of 11/15 (mild 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."

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R9's Facility 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."

R9's Facility Nursing Notes, signed by E12, Registered Nurse (RN) and dated 9/19/14 at 6:00 pm document " (R9) was seen by staff to push another resident (R8) from the next room."

R9's Facility Nursing Notes, signed by E12, Registered Nurse (RN) and dated 9/19/14 at 7:00 pm document (R9) asked where (R8) was as (R9) wanted to fight (R8).

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 too helped him wash his hands. He (R9) said he was going to take a nap." R9 remained in his room while other residents continued with dining.

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

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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."

The Investigation Report documents R9 threw coffee on 9/19/14 at 5:00 pm. (E12 documented in Nurses Notes 9/19/14 that he had knowledge of the alleged abuse). This allegation was not reported to the E1, Administrator, State Survey Agency or investigated until the surveyor reported this allegation to the E1, Administrator on 9/25/14 at 10:00 am.

3. R9's Physician Order Sheet dated 9/1/14 - 9/30/14 documents diagnoses of Schizophrenia, Depression and Blindness.

R9's Minimum Data Set (MDS) dated 7/21/14 documents a Brief Interview for Mental Status (BIMS) of 11/15 (mild 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."

R9's Facility Nursing Notes, signed by E11, Licensed Practical Nurse (LPN) and dated 8/22/14 at 5:45 am, documents that " resident began yelling and slamming doors at 5:15 am (R9) complained that man touched my penis, the yelling started when that man told me not to tell anyone he touched my penis, but I am going to tell."

On 9/24/14 at 11:57 am E11 stated "(R9) said the man in the mirror told him not to tell anyone that a

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man touched his penis....."I did not report what he (R9) said regarding his penis because he referred to the man in the mirror."

On 9/24/14 at 4:55 pm R9 stated " I can't remember anybody trying to touch my penis recently but it has happened in the past. That's all I want to say about that."

The Investigation Report documents that the State Survey Agency was not notified until 9/23/14 at 4:13 pm of the incident that occurred 8/22/14. The same report documents the local police department was notified 9/23/14 at 7:00 pm.

Facility Data Sheet dated 9/11/14 documents a census of 145.

B. Based on interview and record review, the facility failed to form a suspicion of a crime and recognize the need to report as a possible crime to local law enforcement when R9 assaulted R8. R8 and R9 are two residents of eight 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

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physical violence and the physical ability to cause harm. There is 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."

R9's Nursing Notes, signed by E12, Registered Nurse (RN) and dated 9/19/14 at 6:00 pm documents " (R9) was seen by (E10) staff to push another resident (R8)."

On 9/23/14 at 2:38 pm, E10, Certified Nurse Assistant (CNA) 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

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F 226	Continued From page 34 (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 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. On 9/23/14 at 2:38 pm E10 stated " I reported to my nurse (E12) right away. I did not know if this was a crime, the administrator (E1) does that, we don't call the police we just report to our nurse." On 9/24/14 at 8:00 am E1, Administrator stated " I did not view that (R9 to R8, 9/19/14 assault) situation as a crime. I think of physical assault as a person being beat up, not pushed once. That's why police weren't called."	F 226		

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F 226	Continued From page 35 On 9/24/14 at 2:30 pm E12 Registered Nurse stated " I did not report this to the police because I viewed this incident as just a resident to resident altercation. I reported to (E26, Assistant Administrator) right away. If this had happened outside of here to me I would have called it assault and a crime." The Investigation Report documents that the local police department was not notified until 9/23/14 at 4:15 pm. The Facility Policy, External Reporting of Potential Abuse states " The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, misappropriation of resident property, and reasonable suspicion of a crime are reported immediately to the administrator of the facility and to other officials in accordance with the State law through established procedures. If the event that caused the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least one law enforcement agency of jurisdiction and the State Survey Agency immediately after forming the suspicion (but no later than two hours after forming the suspicion), Otherwise, the report must be made not later than 24 hours after forming the suspicion."	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		

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plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to develop a comprehensive care plan with safety interventions to address R9's propensity for violent aggressive behavioral issues. R9 is one of three residents reviewed for changes in condition on the care plan in the sample of eighty nine.

Findings include:

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 is no documented evidence of R9's physical aggression toward others on file.

R9's Physician Order Sheet dated 9/1/14 - 9/30/14 documents diagnoses of Schizophrenia, Depression and Blind.

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	145584	A. BUILDING ______ B. WING ______	C 10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM TERRACE OF MATTOON	1000 PALM MATTOON, IL 61938

(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
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R9's Minimum Data Set (MDS) dated 7/21/14 documents a Brief Interview for Mental Status (BIMS) of 11/15 (mild 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."

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."

R9's Nursing Notes, signed by E12, Registered Nurse (RN) and dated 9/19/14 at 6:00 pm document " (R9) was seen by staff to push another resident (R8) from the next room."

R9's Nursing Notes, signed by E12, Registered Nurse (RN) and dated 9/19/14 at 7:00 pm document (R9) asked where (R8) was as (R9) wanted to fight (R8).

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

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directly at me. Hot coffee got all down my left arm. Three (Certified Nurse Assistants) CNA' Staff (unknown names) came running. Then another CNA (E15) took (R9) to his room."

R9's Nursing Notes, signed by E12, Registered Nurse (RN) and dated 9/19/14 at 6:00 pm documents "(R9) was seen by (E10) staff to push another resident (R8)."

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

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(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 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.

R9's Behavioral Tracking Sheet since admission document that the only behaviors R9 had been monitored for were "self isolation" and "socially inappropriate."

R9's Care Plan dated 7/17/14 documents no problem statement or interventions were documented on admission related to R9's history of violent physical behaviors. R9's care plan was not updated to reflect R9's aggressive behaviors on 9/19/14.

On 9/24/14 at 7:57 am E30 (Social Service Director) stated " I can see the behavior tracking should be more specific, it's vague for sure. That pretty much explains why the care plans aren't as specific as they probably should be."

The Facility Policy Comprehensive Assessment / Care Planning, undated documents "to comprehensively assess, in a timely manner, each resident on admission. The results of this

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F 279	Continued From page 40 assessment shall serve as a basis for determining resident need and subsequently how care shall be planned for each resident...."	F 279		