

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

PRINTED: 08/27/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145836</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/26/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHELBYVILLE REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565</b>	
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F 000	INITIAL COMMENTS	F 000		
F 223 SS=J	<p>Annual Licensure and Certification Survey</p> <p>Complaint Investigation #0963450/IL42995--F223, F225</p> <p>An Extended Survey was conducted 483.13(b), 483.13(b)(1)(i) ABUSE</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to identify R14's willful act of assault on R15 as an act of abuse. R14 and R15 are 2 of 4 residents sampled for abuse. The facility failed to protect 1 of 1 assault victim (R15) from potential further abuse following a witnessed resident to resident attack carried out by R14. This failure resulted in an Immediate Jeopardy situation.</p> <p>While the immediacy was removed on 8-20-09, the facility remained out of compliance at a Severity level 2 due to ongoing intensive monitoring of R14's potentially explosive behaviors, ongoing re-education of direct care and administrative staff regarding identification of abuse, management and investigation of behaviors, and ongoing measures by corporate</p>	F 223		

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 223	<p>Continued From page 1</p> <p>staff to ensure proper implementation of abuse prohibition procedures.</p> <p>Findings include:</p> <p>A facility "Quality Care Reporting Form" dated 8-7-09 documents that R14 "assaulted another resident" at 4:10 p.m. The report states that the incident was witnessed by E3, Registered Nurse who reported the incident at that time to E1, Administrator who was present in the building at the time of the occurrence. The report states that the perpetrator, R14, was provided "counseling by (E3) &amp; (E1)" and was "removed from the area". The report further indicates that R14 was "on 15 min. (minute) behavior checks."</p> <p>A facility "Quality Care Reporting Form" dated 8-7-09 documents that R15 was "assaulted by another resident" at 4:10 p.m. The report states that the incident was witnessed by E3, Registered Nurse who reported the incident at this time to E1, Administrator who was present in the building at the time of the occurrence. The report states that R15 was assessed with no injuries and was "removed from situation/area".</p> <p>R15's nurse's notes dated 8-7-09 at 4:10 p.m. state "(R15) was sitting calmly in (wheelchair) in (dining room) near another res (resident) table. Other res approached this res from behind said nothing at first. Put this res in a choke hold, stood up from his w/c (wheelchair) &amp; began punching this res in head then began yelling @ (at) him. Writer (E3) ran from nurse's station over to area &amp; separated residents..."</p> <p>R14's nurse's notes dated 8-7-09 at 4:10 p.m. state "res approached another resident in DR</p>	F 223			

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F 223	<p>Continued From page 2</p> <p>(dining room). Other res was sitting in wc near this res table. This res got other res in choke hold &amp; proceeded to repeatedly punch other res in head--then began yelling at him. Writer (E3) ran from nurse's station over to area &amp; res sat back down in w/c. Other resident immediately removed from area &amp; assessed (with) (no) injury noted. Returned to this res &amp; questioned. States "he was in my spot." Asked if res asked other res to move--states "no I just attacked him--he made me mad." Administrator here &amp; aware. Res returned to room &amp; administrator went to speak (with) him. Res currently on 15 min behavior checks. Will continue to monitor."</p> <p>R14's nurse's notes dated 8-7-09 at 5:15 p.m. states "res (return) to DR. Asked for cheese sandwich &amp; saltines &amp; milk. Kitchen staff serving trays &amp; informed res would make sandwich. Res became angry &amp; yelling &amp; wheeled self back down to room yelling he didn't want to wait." A 9:40 p.m. nurses note states "no further behaviors."</p> <p>R14 stated on 8-18-09 at 2 p.m. that he had recently been in a physical altercation with R15 in the dining room. R14 stated that "it was close to supper time" and that he had informed R15 that he was occupying his dining table spot. R14 stated that R15 refused to move and uttered an expletive to R14. R14 further stated that R15 threatened to "blow my head off with a gun." R14 stated that he then "grabbed him by the nose and put his head down to his knees to see if he had a gun or knife or anything." R14 stated that staff (E3 and E1) then "pulled me away from him." R14 stated that immediately following this incident R15 "calmed down" and "I went on about my business."</p>	F 223			

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F 223	<p>Continued From page 3</p> <p>During discussion with R14 at this time about the incident he denied hitting R15. R14 stated that this was not the first time that R15 had threatened him. R14 stated that he was not scared of R15 but "concerned". R14 stated that he was in the special forces in the Army and was trained to "apply immediate action" and did so.</p> <p>An undated Incident Investigation Form completed by E1 states that E1 spoke to R14 in his room following the incident. E1 documented that R14 denied hitting R15 and asserted that R15 had threatened him by stating he "was going to shoot him w/a (with a) gun when (R14) went into the D/R (dining room) for supper." R14 related to E1 in the document that he had "pushed his nose down making sure he did not have a gun."</p> <p>E1 stated in interview on 8-18-09 at 2:40 p.m. that R14's assault on R15 on 8-7-09 was not viewed as abuse but rather viewed as a behavior.</p> <p>Interviews with E11, Licensed Practical Nurse, on 8-19-09 at 12:40 p.m. and E3, Registered Nurse on 8-19-09 at 2:20 p.m. reflected that both were witnesses to this incident and were present at the dining room nurse's station. Both stated that they witnessed R14 hitting R15 in the back and side of the head with a closed fist. Both stated that R14 had one arm encircling R15's neck while he was hitting R15. Both stated R14 was placed on 15 minute behavior checks following this incident.</p> <p>On 8-19-09 at 1 p.m. E2, Director of Nursing was asked to provide evidence of increased supervision and 15 minute checks being implemented for R14 following the 8-7-09 assault</p>	F 223			

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F 223	<p>Continued From page 4</p> <p>of R15. E2 stated that 15 minute checks were to be documented on log sheets maintained at the nurse's station. E2's search yielded no evidence of R14 ever being placed on increased supervision or 15 minute checks since the incident. E2 verified on 8-20-09 at 3:45 p.m. that such documentation did not exist. E2 stated that the 15 minute checks should have been started and could not explain why they were not.</p> <p>Interviews with Certified Nurse Aides (CNAs) E12 (8-19-09 at 12:35 p.m.), E4 and E5 (8-19-09 at 2:10 p.m.) indicated that they were routine care givers for R14 and that to their knowledge he was not on 15 minute checks and had not documented any such checks. All three stated they were not familiar with any history of physical aggression by R14.</p> <p>R14's 8-1-09 Physician Order Sheet (POS) reflects diagnoses including Schizoaffective Disorder, Dementia with Agitation, Bipolar Disorder, Chronic Anxiety, and Depression. His most recent (11-29-06) psychiatric clinical note documents Manic Depression with Psychotic Features. His most recent Minimum Data Set assesses him as having a short term memory problem with no long term memory problem. He is assessed as having impaired cognitive/decision making ability and has mental function that varies over the course of the day. He is assessed as having a mood issue related to persistent anger and behaviors including being verbally abusive, socially inappropriate. R14 is assessed as having no physically abusive behaviors.</p> <p>R14's Care Plan updated 8-5-09 reflects "...has history of making accusations--accuses former</p>	F 223			

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F 223	<p>Continued From page 5</p> <p>staff &amp; current staff of stealing items--verbal abuse toward others--when interviews investigations begin--resident will then revamp his story &amp; or refuse to tell staff who was involved." The plan or approach for this problem states to "follow through with any &amp; all investigations--interviews needed." Another problem statement reflects "Soc (socially) inapp (inappropriate) Resident will yell, scream, curse at other residents during meals--activities &amp; has become physically aggressive disrupts others." Approaches for this problem include "redirect to quiet location, allow to vent--assess &amp; assist, explain inapp. &amp; how outbursts affect others."</p> <p>There is nothing documented in R14's Care Plan that addressed any type of increased supervision or means to segregate R14 from R15 given the assault that occurred on 8-7-09.</p> <p>On 8-18, 8-19, and 8-20-09 R14 independently ambulated about the facility in his wheelchair without restriction or presence of staff observing his whereabouts, including trips to and from his room to the dining/activity areas, in and out of common areas, and resident living corridors all occupied by other residents.</p> <p>R15's Nurse's notes document that R15 expired on 8-12-09. Interview with Z2, R15's attending Physician on 8-20-09 at 11:00 a.m. reflected that his death was attributed to a chronic medical condition and could not correlate it to the recent incident.</p> <p>An Immediate Jeopardy situation was identified on 8-19-09. The Immediate Jeopardy situation was identified to have begun on 8-7-09 when R14 was witnessed to assault R15 and the facility</p>	F 223			

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F 223	Continued From page 6 failed to identify it as abuse and provide necessary resident protections for all its residents. E1, Administrator was notified of the Immediate Jeopardy on 8-19-09 at 4:25 p.m.  The surveyor confirmed through interview, observation, and record review that the facility took the following actions to remove the Immediate Jeopardy:  --R14 was placed on 15 minute visual checks 24 hours a day, monitored by the Director of Nursing, on 8-19-09.  --R14 was provided a private room on 8-19-09.  --An intensified supervision program was implemented for R14 while he is present in the dining room to monitor for explosive behaviors. If such occurs will be placed on individual one to one supervision until his physician is notified and orders obtained or resident is calm. Other residents in his seating will be removed to another area of the dining room.  --Secured physician order for R14's Psychiatric evaluation. On site diagnostic assessment of R14 conducted by Shelby County Community Services on 8-19-09.  --Inservice re-education on 8-20-09 provided Corporate Regional Director, for all staff including administrative personnel related to the facility abuse prevention policy, with added emphasis on protection of residents. All resident to resident altercations to reported to Corporate Regional Director.	F 223			
F 225 SS=L	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS	F 225			

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F 225	<p>Continued From page 7</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>A.) Based on observation, interview and record review the facility failed to protect 1 of 1 assault victim (R15) from potential further abuse following a witnessed resident to resident attack carried out by R14. Following this incident, the facility also failed to protect each of the remaining 39 in-house residents from potential abuse by R14. This failure resulted in an Immediate Jeopardy situation.</p> <p>While the immediacy was removed on 8-20-09, the facility remained out of compliance at a Severity level 2 due to ongoing intensive monitoring of R14's potentially explosive behaviors, ongoing re-education of direct care and administrative staff regarding identification of abuse, management and investigation of behaviors, and ongoing measures by corporate staff to ensure proper implementation of abuse prohibition procedures.</p> <p>Findings include:</p> <p>A facility "Quality Care Reporting Form" dated 8-7-09 documents that R14 "assaulted another resident" at 4:10 p.m. The report states that the incident was witnessed by E3, Registered Nurse who reported the incident at that time to E1, Administrator who was present in the building at the time of the occurrence. The report states that the perpetrator, R14, was provided "counseling by (E3) &amp; (E1)" and was "removed from the area". The report further indicates that R14 was "on 15 min. (minute) behavior checks."</p> <p>A facility "Quality Care Reporting Form" dated 8-7-09 documents that R15 was "assaulted by</p>	F 225			

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F 225	<p>Continued From page 9</p> <p>another resident" at 4:10 p.m. The report states that the incident was witnessed by E3, Registered Nurse who reported the incident at this time to E1, Administrator who was present in the building at the time of the occurrence. The report states that R15 was assessed with no injuries and was "removed from situation/area".</p> <p>R15's nurse's notes dated 8-7-09 at 4:10 p.m. state "(R15) was sitting calmly in (wheelchair) in (dining room) near another res (resident) table. Other res approached this res from behind said nothing at first. Put this res in a choke hold, stood up from his w/c (wheelchair) &amp; began punching this res in head then began yelling @ (at) him. Writer (E3) ran from nurse's station over to area &amp; separated residents..."</p> <p>R14's nurse's notes dated 8-7-09 at 4:10 p.m. state "res approached another resident in DR (dining room). Other res was sitting in wc near this res table. This res got other res in choke hold &amp; proceeded to repeatedly punch other res in head--then began yelling at him. Writer (E3) ran from nurse's station over to area &amp; res sat back down in w/c. Other resident immediately removed from area &amp; assessed (with) (no) injury noted. Returned to this res &amp; questioned. States "he was in my spot." Asked if res asked other res to move--states "no I just attacked him--he made me mad." Administrator here &amp; aware. Res returned to room &amp; administrator went to speak (with) him. Res currently on 15 min behavior checks. Will continue to monitor."</p> <p>R14's nurse's notes dated 8-7-09 at 5:15 p.m. states "res (return) to DR. Asked for cheese sandwich &amp; saltines &amp; milk. Kitchen staff serving trays &amp; informed res would make sandwich. Res</p>	F 225			

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F 225	<p>Continued From page 10</p> <p>became angry &amp; yelling &amp; wheeled self back down to room yelling he didn't want to wait." A 9:40 p.m. nurses note states "no further behaviors."</p> <p>R14 stated on 8-18-09 at 2 p.m. that he had recently been in a physical altercation with R15 in the dining room. R14 stated that "it was close to supper time" and that he had informed R15 that he was occupying his dining table spot. R14 stated that R15 refused to move and uttered an expletive to R14. R14 further stated that R15 threatened to "blow my head off with a gun." R14 stated that he then "grabbed him by the nose and put his head down to his knees to see if he had a gun or knife or anything." R14 stated that staff (E3 and E1) then "pulled me away from him." R14 stated that immediately following this incident R15 "calmed down" and "I went on about my business."</p> <p>During discussion with R14 at this time about the incident he denied hitting R15. R14 stated that this was not the first time that R15 had threatened him. R14 stated that he was not scared of R15 but "concerned". R14 stated that he was in the special forces in the Army and was trained to "apply immediate action" and did so.</p> <p>An undated Incident Investigation Form completed by E1 states that E1 spoke to R14 in his room following the incident. E1 documented that R14 denied hitting R15 and asserted that R15 had threatened him by stating he "was going to shoot him w/a (with a) gun when (R14) went into the D/R (dining room) for supper." R14 related to E1 in the document that he had "pushed his nose down making sure he did not have a gun."</p>	F 225			

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F 225	<p>Continued From page 11</p> <p>E1 stated in interview on 8-18-09 at 2:40 p.m. that R14's assault on R15 on 8-7-09 was not viewed as abuse but rather viewed as a behavior and opted to not report to the State Survey and Certification Agency or the local Police as such.</p> <p>The facility policy titled "Abuse Prevention Program" states under section "VII. External Reporting of Potential Abuse...Initial reporting of allegations. If, during the course of an incident investigation, the administrator or designee has determined that there is reasonable cause to suspect mistreatment has occurred, the resident's representative and the Department of Public Health shall be informed within 24 hours. Public Health shall be informed that an occurrence of potential mistreatment has been reported and is being investigated." This section further states under "Informing Law Enforcement Authorities...Depending on the seriousness of the incident and the presenting evidence, the administrator may notify the local police."</p> <p>The same policy states under section "V. Protection of residents...The facility will take steps to prevent mistreatment while the investigation is underway...Residents who allegedly mistreat another resident will be removed from contact with that resident 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...Accused individuals not employed by the facility will be denied unsupervised access to the resident during the course of the investigation..."</p>	F 225			

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F 225	<p>Continued From page 12</p> <p>Interviews with E11, Licensed Practical Nurse, on 8-19-09 at 12:40 p.m. and E3, Registered Nurse on 8-19-09 at 2:20 p.m. reflected that both were witnesses to this incident and were present at the dining room nurse's station. Both stated that they witnessed R14 hitting R15 in the back and side of the head with a closed fist. Both stated that R14 had one arm encircling R15's neck while he was hitting R15. Both stated R14 was placed on 15 minute behavior checks following this incident.</p> <p>On 8-19-09 at 1 p.m. E2, Director of Nursing was asked to provide evidence of increased supervision and 15 minute checks being implemented for R14 following the 8-7-09 assault of R15. E2 stated that 15 minute checks were to be documented on log sheets maintained at the nurse's station. E2's search yielded no evidence of R14 ever being placed on increased supervision or 15 minute checks since the incident. E2 verified on 8-20-09 at 3:45 p.m. that such documentation did not exist. E2 stated that the 15 minute checks should have been started and could not explain why they were not.</p> <p>Interviews with Certified Nurse Aides (CNAs) E12 (8-19-09 at 12:35 p.m.), E4 and E5 (8-19-09 at 2:10 p.m.) indicated that they were routine care givers for R14 and that to their knowledge he was not on 15 minute checks and had not documented any such checks. All three stated they were not familiar with any history of physical aggression by R14.</p> <p>R14's 8-1-09 Physician Order Sheet (POS) reflects diagnoses including Schizoaffective Disorder, Dementia with Agitation, Bipolar Disorder, Chronic Anxiety, and Depression. His</p>	F 225			

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F 225	<p>Continued From page 13</p> <p>most recent (11-29-06) psychiatric clinical note documents Manic Depression with Psychotic Features. His most recent Minimum Data Set assesses him as having a short term memory problem with no long term memory problem. He is assessed as having impaired cognitive/decision making ability and has mental function that varies over the course of the day. He is assessed as having a mood issue related to persistent anger and behaviors including being verbally abusive, socially inappropriate. R14 is assessed as having no physically abusive behaviors.</p> <p>R14's Care Plan updated 8-5-09 reflects "...has history of making accusations--accuses former staff &amp; current staff of stealing items--verbal abuse toward others--when interviews investigations begin--resident will then revamp his story &amp; or refuse to tell staff who was involved." The plan or approach for this problem states to "follow through with any &amp; all investigations--interviews needed." Another problem statement reflects "Soc (socially) inapp (inappropriate) Resident will yell, scream, curse at other residents during meals--activities &amp; has become physically aggressive disrupts others." Approaches for this problem include "redirect to quiet location, allow to vent--assess &amp; assist, explain inapp. &amp; how outbursts affect others."</p> <p>There is nothing documented in R14's Care Plan that addressed any type of increased supervision or means to segregate R14 from R15 given the assault that occurred on 8-7-09.</p> <p>On 8-18, 8-19, and 8-20-09 R14 independently ambulated about the facility in his wheelchair without restriction or presence of staff observing</p>	F 225			

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F 225	<p>Continued From page 14</p> <p>his whereabouts, including trips to and from his room to the dining/activity areas, in and out of common areas, and resident living corridors all occupied by other residents.</p> <p>R15's Nurse's notes document that R15 expired on 8-12-09. Interview with Z2, R15's attending Physician on 8-20-09 at 11:00 a.m. reflected that his death was attributed to a chronic medical condition and could not correlate it to the recent incident.</p> <p>An Immediate Jeopardy situation was identified on 8-19-09. The Immediate Jeopardy situation was identified to have begun on 8-7-09 when R14 was witnessed to assault R15 and the facility failed to identify it as abuse and provide necessary resident protections for all its residents. E1, Administrator was notified of the Immediate Jeopardy on 8-19-09 at 4:25 p.m.</p> <p>The surveyor confirmed through interview, observation, and record review that the facility took the following actions to remove the Immediate Jeopardy:</p> <p>--R14 was placed on 15 minute visual checks 24 hours a day, monitored by the Director of Nursing, on 8-19-09.</p> <p>--R14 was provided a private room on 8-19-09.</p> <p>--An intensified supervision program was implemented for R14 while he is present in the dining room to monitor for explosive behaviors. If such occurs will be placed on individual one to one supervision until his physician is notified and orders obtained or resident is calm. Other residents in his seating will be removed to</p>	F 225			

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F 225	<p>Continued From page 15 another area of the dining room.</p> <p>--Secured physician order for R14's Psychiatric evaluation. On site diagnostic assessment of R14 conducted by Shelby County Community Services on 8-19-09.</p> <p>--Inservice re-education on 8-20-09 provided Corporate Regional Director, for all staff including administrative personnel related to the facility abuse prevention policy, with added emphasis on protection of residents. All resident to resident altercations to reported to Corporate Regional Director.</p> <p>B.) Based on interview and record review the facility failed to investigate 2 of 3 allegations reviewed involving 1 sampled and 1 non sampled resident (R14, R19). The facility failed to properly and thoroughly screen 2 Certified Nurse Aides hired in the past year in that they failed to initiate a criminal background check within 10 days of hire for E4 and failed to conduct an eligibility inquiry to the Health Care Worker Registry for E7 before permitting her to work as a Nurse Aide. Findings include the following:</p> <p>1.) In interview with R14 on 8-18-09 at 2 p.m. he stated that he had recently been in a physical altercation with R15 in the dining room (8-7-09). R14 stated that "it was close to supper time" and that he had informed R15 that he was occupying his dining table spot. R14 stated that R15 refused to move and uttered an expletive to R14. R14 further stated that R15 threatened to "blow my head off with a gun". R14 stated that he then "grabbed him (R15) by the nose and put his head</p>	F 225			

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F 225	<p>Continued From page 16 down to his knees to see if he had a gun or knife or anything".</p> <p>An undated Incident Investigation Form completed by E1, Administrator, states that E1 spoke to R14 in his room following the incident (on 8-7-09). E1 documented that R14 denied hitting R15 and asserted that R15 had threatened him by stating he "was going to shoot him w/a (with a) gun when (R14) went into the D/R (dining room) for supper". R14 related to E1 in the document that he had "pushed his nose down making sure he did not have a gun".</p> <p>E1 stated in interview on 8-18-09 at 2:40 p.m. that R14's allegation against R15 on 8-7-09 was not viewed as potential abuse but rather viewed as a behavior and opted to not investigate it or report it to the State Survey and Certification Agency as such.</p> <p>2.) A facility "Incident Report Form" dated 2-9-09 completed by E1, Administrator documents an investigation of alleged "Inappropriate Behavior" against R18 by E8, Certified Nurse Aide (CNA). Documentation within the report states that E8 was witnessed by another CNA to throw a sweater in the face of R18. In the facility's Final Report of the allegation the facility concluded that "no abuse occurred."</p> <p>Review of this documented allegation and investigation on 8-20-09 yielded evidence of further allegations that came to light during the facility's investigation that were not pursued and investigated. Documentation maintained in E1's investigative file about this case reflected notes written by E1 that summarized witness accounts specific to treatment of them by E8.</p>	F 225			

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F 225	<p>Continued From page 17</p> <p>Documentation specific to R19 indicates "(R19) states (E8) is rough"...(R19) says everyone is rough...(R19)--they are all to (sic) rough--(R19) everyone gets rough putting me to bed..."</p> <p>Documentation in the same investigative note also reflects staff witness information related to this case from E10 which indicates "0 (nothing) witnessed anything...(E10) states (E8's) size &amp; wants to get the job done might make her a little rough..."</p> <p>E1 stated in interview on 8-20-09 at 4:00 p.m. that the investigative notes reviewed were made by her and that she had not identified the allegations of rough treatment as potential abuse, had not reported them as potential abuse, nor had she ever investigated them as potential abuse. E1 verified at this time that there were no other documents related to further investigation of these allegations.</p> <p>C.) Personnel file documentation maintained by Business Office Manager, E13, reflected that E4, CNA was hired on 10-14-08. Records show that E4 was permitted to begin working in the facility without a Criminal Background Check being conducted within 10 days of hire. Instead, the facility accepted a background check that was in excess of 1 year old which was dated 7-11-06. E13 acknowledged on 8-20-09 at 1 p.m. that E4's background check had not been done in a timely manner.</p> <p>Personnel file documentation maintained by Business Office Manager, E13, reflected that E7, CNA was hired on 10-4-08. Documentation in E7's personnel file reflected that an inquiry was</p>	F 225			

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F 225	Continued From page 18 made to the Health Care Worker Registry on 10-30-08, 26 days after she began working, rather than prior to beginning work in the facility. E13 verified this failure in interview on 8-20-09 at 1 p.m.	F 225			
F 258 SS=E	483.15(h)(7) ENVIRONMENT- SOUND LEVELS  The facility must provide for the maintenance of comfortable sound levels.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain comfortable sound levels during nine of nine observations made in the dining/activity area for all residents present during four days of this survey. This resulted in disruptions during resident activities, and made it difficult for residents to socialize during meals and activities.  Findings include:  During Resident breakfast and lunch observations, over a period of three days 8/18 through 8/20/09 frequent (at times every 3-4 minutes), loud and shrill alarms were noted to sound. Sometimes two different alarms went off at the same time, while all residents were present. Also during these meal times R20 was observed to keep her hands over her ears while seated at the dining table and waiting for her meal to arrive, only removing them to eat, and keeping them covered until she was out of the dining room. R20 was observed on 8/20/09 to be in her room laying in bed without her hands over her ears, resting comfortably.	F 258			

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F 258	Continued From page 19  On 8/19/09 at 10:10 AM in the dining room during coffee hour, two very shrill, loud and disruptive alarms sounded frequently , at the same time, with residents stating, "that's loud!" Again on 8/19/09 during Bingo at 11:05AM two loud , shrill repetitious alarms sounded frequently. The alarms again sounded at 11:20AM with multiple residents still present in the activity/dining room.  During the confidential group interview the residents stated that the noise level in the dining/activity room from frequent alarms and call lights is a problem. In an interview on 8/21/09 at 8:45AM, R20 stated the noise does bother my ears in there. R21 also stated on 8/21/09 at 8:50AM, the noise does bother me it's very noisy out there. E5 CNA (Certified Nurses Aide) stated on 8/20/09 at 3:30PM that R20 always sits in the dining room with her hands over her ears. I have never seen her do that anywhere else, just in the dining room.	F 258			
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION  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 observation, interview and record review the facility failed to fully assess environmental risks related to the use of an electromechanical lift chair in order to prevent	F 323			

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F 323	<p>Continued From page 20</p> <p>potential continued falls for one (R5) of three residents sampled for falls. Findings include the following:</p> <p>Review of the Physicians Order Sheet dated 8/1/09 lists R5's current diagnoses as Congestive Heart Failure, Large Ventral Hernia, History of Colon Cancer, Chronic Obstructive Pulmonary Disease, Left Knee Replacement, Right Hip Replacement (times three), Cellulitis of the lower legs and Chronic Anxiety. The MDS (Minimum Data Set) dated 6/1/09 shows R5 to require extensive assistance with transfers and to be non-ambulatory. The "Facility Fall Risk Assessment," dated 4/7/09 through 8/12/09 shows R5 to be at high risk for falls. The Physical Therapy Plan of Care dated 8/14/09 through 9/14/09 states R5 has gross bilateral lower extremity weakness with decreased balance and decreased tolerance affecting independence with all functional skills and safety. Review of the facility "Quality Care" Reporting Forms show that R5 had falls on 4/7/09, two on 4/8/09, 5/21/09 and 8/12/09. All of the falls except 8/12/09 list "knee or legs giving out" as a possible cause. Nurses notes dated 8/15/09 document the resident sitting up in her lift chair/recliner leaning forward. R5's plan of care, last updated 7/6/09, does not address R5's safe use of her lift/recliner chair.</p> <p>Observation of R5 on 8/18/09 at 12 noon showed her to have complete facial bruising and swelling to her forehead, face and neck. She also had a large laceration with sutures, to her forehead covered by a dressing, and bruises to both hands, arms, and knees. According to the Quality Care Report form these injuries were acquired as a result of R5's last fall on 8/12/09.</p>	F 323			

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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 323	<p>Continued From page 21</p> <p>While eating lunch in her room at 12:20PM on 8/18, R5 was observed to use the remote control on her lift chair to lift herself up and tip the chair forward. Her feet were touching the floor while seated at the edge of her chair for her meal. She remained in this position until 1:25PM.</p> <p>During an interview with Z1, Daughter in Law, on 8/18/09 at 4PM she stated, " I have talked to administration and nursing about (R5's) lift chair. I am worried, I think the chair is dangerous, I have seen her several times with it lifted up and forward." I talked with E6 SSD ( Social Services Designee)about it last week. I asked them to not let her use the controls , take them out of her reach, or to get her a different chair. She stated the facility could not get her a different chair, and it was her right to have the controls." " I told her that (R5) is stubborn and is afraid she is too heavy for the girls to lift so she will continue to try to use the lift to get herself up even though she is weak."</p> <p>On 8/19/09 at 11:45AM E2, DON (Director of Nursing) stated she was aware of the concerns regarding R5's use of her lift chair and was also worried about it. In an interview on 8/19/09 at 1PM E6 stated she was also worried about R5's use of the chair, and had seen her leaning forward at times. She was aware of the family's concerns regarding R5's use of the lift chair. E6 stated she did not know if anyone from therapy had ever done a safety assessment on R5's use of the lift chair. E9 PTA (Physical Therapy Assistant) stated on 8/20/09 at 8:30 AM that no one had asked therapy to do a safety assessment regarding R5's use of her lift chair, they had only been called in to inservice staff on</p>	F 323			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 323	Continued From page 22 safe transfers.	F 323			
F 458 SS=C	483.70(d)(1)(ii) RESIDENT ROOMS  Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.  This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide 80 square feet of space per resident in multi-resident bedrooms located on 3 of 4 resident living corridors.  The finding is:  Review of historical room size documentation indicates that 32 two- bed rooms on the 100, 200, and 300 halls do not provide at least 80 square feet of space per resident.  The following bedrooms provide only 73 square feet per resident: 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 201, 202, 203, 204, 205, 206, 207, 208, 209, and 210.  The following bedrooms provide only 78 square feet per resident: 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, and 311.  All of the undersized rooms are Medicaid (Title 19) Certified. During resident Quarterly Care Plan conferences, the size of the resident rooms are assessed to meet the needs of the residents	F 458			