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	14E866	A. BUILDING ______ B. WING ______	C **09/11/2006**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT HILL VILLAGE	**1010 WEST NORTH STREET** **GIRARD, IL 62640**

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F 354	Continued From page 22 of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that they use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Findings include: 1. Review of the schedule from 8/13/06 through 9/2/06 indicates the facility is without a registered nurse (RN) for at least 8 consecutive hours a day on 8/14, 8/15, 8/17, 8/21, 8/22, 8/28, 8/29, 8/30 and 8/31. Interview with E1, Administrator, on 9/7/06 at 9:30 indicates she is aware that the facility does not have adequate RN coverage according to the regulations during this time frame.	F 354		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.1210a) 300.1210b)3) 300.1210b)6)	F9999		

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F9999	Continued From page 23 300.1220b)2) 300.1220b)3) 300.3240f) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b)3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. b)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional	F9999		

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status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility.

These Requirements are not met as evidenced by:

Based on record review and interview, the Facility failed to assess, monitor and develop interventions for 1 of 3 residents on the sample, R1, who was identified by the Facility as having

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F9999	Continued From page 25 personal histories that rendered R1 at risk for abusing other residents. Findings include: 1. R1, a 47 year old resident, was admitted to the Facility's Alzheimer's Special Care Wing from the psychiatric unit of the hospital, on 8/16/05. R1 had an admitting diagnoses of Wernicke Korsakoff Syndrome, Status Epilepticus with anoxia causing permanent brain damage and Cerebral Vascular Accident. An undated Facility form entitled "Resident Risk Assessment, Behavior Screening Tool," was in R1's clinical record. According to E2, this form was completed upon R1's admission to the Facility. This form lists the following "Resident Risk Factors: Wanders into Other Resident's Rooms, Physical Aggression, Verbal Aggression and Alcohol Abuse." There are no other assessments regarding R1's behavior in R1's clinical record. No Minimum Data Set (MDS) or Resident Assessment Protocols (RAP's) had been completed for R1. The Facility did have copies of R1's History and Physicals (H & P), dated 7/26/06 and 8/2/06 from her recent hospitalization. At the hospital it was noted that R1 had periods of crying and confusion with easy agitation which was worse in the evenings. R1 also had visual hallucinations. It was determined that the patient would require admission to the psychiatric floor either on an involuntarily or voluntary basis. R1 was transferred from the medical floor after they realized her behavior was unmanageable. The Facility failed to utilize this information in assessing R1 for admission to the Facility's	F9999		

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F9999	Continued From page 26 Alzheimer's Special Care Unit, or after R1's admission to the Facility. R1's Facility interim plan of care did not address any behaviors. The Facility began to monitor R1 for behaviors of elopement and agitation (hitting at staff, biting, etc.) on 8/18/06, and for depression and wandering in and out of residents rooms beginning on 8/24/06. Facility nurses notes show that R1 began having behaviors in the Facility on the same day she was admitted, 8/16/06, as follows: "8/16/06, 2055 (8:00 PM), Res went outside into courtyard, wanting to go home, upset with her husband because she can't reach him. CNA (Certified Nurses Aide) tried to redirect res to come inside. Res refused. Res started knocking on windows to other res's rooms, yelling. Continued to redirect res - turned on hose in courtyard and squirted the CNA. Writer went outside to redirect res and res squirted writer with hose. Res started pounding on windows to rooms. Res wanted to go and check on the children, Res walked into building, looked into other residents room and stated that 'they're all here and safe.'" "8/17/06, 2100 (9:00 PM), Continuing to touch and try to reposition other residents. 1:1 given continuously, slapped writers hand x 2 while trying to administer medications to a resident. Also noted to remove this same residents body alarm. 2130 (9:30 PM), res slapped CNA as she arose from the nurses desk. 2145 (9:45 PM), sitting under nurses's desk stating 'shh, they're coming to get me.' 2230 (10:30 PM), Writer notified Dr. of resident's behavior this evening. Dr. stated that all psychiatric beds are taken. Dr. stated that he would call and have them put her	F9999		

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on a waiting list to be admitted to the hospital. Order for Haldol 5 milligrams (mg) and Ativan 2 mg intramuscularly (IM) or orally (PO) every 2 hours was given."

"8/18/06, 1130 (11:30 AM), Resident has shown increased agitation and behaviors since admit. This resident's behaviors are becoming more violent as well, she has slapped staff members. I am very concerned that she may react violently to one of our elderly residents who also have aggressive behaviors. We would like to avoid hospitalization however, her current medicine regimen is ineffective in decreasing these behaviors and would like to request scheduled meds for maintenance. Resident also has an increase in delusional thinking, stating, 'they're coming to get me; you are all trying to hurt me; there are people hiding in the corn, don't you see them? they are trying to get us.' I greatly appreciate any solution you may come up with as it is imperative that we maintain some control of behaviors and aggression. Resident appears to begin to escalate about 11:30 AM and progressively increases throughout the evening hours in spite of night time medication dosing."

E2, Director of Nurses, had signed the above nurses note. E2 was interviewed on 8/26/06 regarding the note of 8/18/06. E2 stated that the above nurses note was faxed to R1's physician. R1's physician subsequently telephoned E2 and told E2 that all of the beds on the psychiatric unit at the closest hospital were full and R1 was on a waiting list for an available bed on the psychiatric unit.

Nurses notes reflect that R1's behaviors continued to escalate. R1 attempted to climb over the courtyard fence numerous times, went

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F9999	Continued From page 28 into other resident's rooms and took things, tried to "help" other residents, and barred staff from entering rooms. A review of the R1's Medication Administration Record (MAR) dated 8/16 - 8/31/06, shows R1 received 1 mg of Haldol twice a day and 1 mg of Ativan three times a day, every day until 8/25/06, when she was admitted to the hospital. Facility "Summary of Incident of Resident to Resident Altercation occurring 8/25/06 at 1946 (7:46 PM)," reflects that the following occurred: "on Facility's secured dementia unit, a CNA heard a noise in R2's room, upon entering room, CNA noted R1 sitting on top of R2 who was lying on his back on the floor. R1 was yelling and holding a bedspread over R2's mouth. R2 does sleep with blanket or bedspread pulled over his face, this is a usual habit for R2. R2 was noted to be bleeding. One CNA immediately attempted to remove R1 while the other CNA paged the nurse to the room STAT (immediately). R1 was noted to be violent. Upon arrival of both nurses scheduled to work, one instructed the other to call 911 for police and ambulance. CNA successful in removing R1 so that nurse could assess R2. Several skin tears noted, hematoma to side of head noted, R2 kept immobile on floor and covered with a blanket until EMS (emergency services) arrived. Administrator and family notified of incident. R2 was transported to the emergency room for evaluation and treatment. R1 was give medication due to increased agitation/aggression. R1's physician was notified and R1 was transported to the hospital for evaluation via ambulance. R2 returned to the Facility at 0020 on 8/26/06, in POA's personal vehicle with multiple bruises and	F9999		

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F9999	Continued From page 29 skin tears. Further investigation by E2 shows that at 1940 (7:40 PM), on 8/25/06, R1 went to the kitchenette area and obtained 3 pieces of cake from CNA, who was monitoring C Hallway dining room while 2 other CNA's were assisting residents in their rooms. R1 walked down the hall with her cake while the CNA who was monitoring C Hallway assisted another resident who was in the dining room area. The CNA heard a noise and went to investigate and found residents on the floor as stated above. The nurse asked R1 what happened and R1 said "We were at a dance and I didn't want to dance." (No dance had occurred). R1 then said "he was in my house, that man was in my house." It appears that in her confusion she entered the wrong room walked through the bathroom and into R2's room and was startled by a man being in her house which triggered her violent aggression towards resident R2." A review of R2's clinical record shows that he sustained a large hematoma to the right side of his head, a 10 centimeter skin tear to his right elbow, a 12.5 centimeter skin tear to his left hand from the 5th finger to the wrist, and abrasions to his nose, cheek and forehead. R2 has diagnoses, in part, of Alzheimer's Dementia with agitation and Peripheral Vascular Disease. R2 most recent MDS shows that he is ambulatory, has short and long term memory problems, behaviors of wandering and moderately impaired vision. According to E2, R2 spends most of his time in bed, covered head to toe with a blanket. Throughout all days of the survey, when not up eating, R2 was observed lying in bed with a blanket covering his head. An interview with R2 was attempted on 9/7/06. R2	F9999		

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F9999	Continued From page 30 was unable to answer questions. A copy of the local police department's "Officer Narrative" was obtained and the following was noted by Z1: "I responded to (Facility). Dispatch stated a male subject was being battered by a female. Upon arrival at the (Facility), we went to room and observed an elderly male laying on the floor. A nurse was trying to calm the male subject down. The male subject had cuts to both his hands, lower lip, bruising on face. Male subject was transported to hospital. Next observed a female laying on the bed and observed blood on her shirt, pants and face. I identified the female as (R1). Upon talking to R1, she blurted 'I tried to kill him.' I then read the Miranda Warning to R1 and asked if she understood her rights. R1 stated 'Yes' and agreed to answer questions. I asked R1 what happened to R2 tonight and did she fight with R2. R1 said that R2 attacked her daughter and her dog. I observed that there was no dog in the room and asked the nurse if R1's daughter was in the room. The nurse said that R1 is under the care of a psychiatrist. I asked the nurse to write a statement. The nurse said that she heard a noise, went in R2's room and saw R1 sitting on top of R2. R1 had a blanket over R2's head trying to suffocate him. The nurse asked R1 what she was trying to do and and R1 replied, 'I'm trying to kill him.'" Besides R2, there were 26 other residents on the Alzheimer's Special Care Unit on 8/25/06, who were at risk for abuse by R1. (A)	F9999		