STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E669	A. BUILDING _____ B. WING _____	05/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE ISLAND NURSING HOME	2427 WEST 127TH STREET BLUE ISLAND, IL 60406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Certification and Licensure Complaint 0791906/IL28579 = F224 & F324 An extend survey was conducted.	F 000		
F 152 SS=D	483.10(a)(3)&(4) EXERCISE OF RIGHTS In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide R4 with a surrogate or representative that does not have a conflict of interest. E3 (Activity Director/ Social Service Director/ Psychiatric Rehabilitation Services Coordinator) an employee of the facility has Power of Attorney (POA) over R4's health. Findings Include: 1. Per record review, E3 is R4's POA over health. 5/9/07, during a meeting that started at approximately 10:56am, E3 confirmed she was R4's POA over health, although she is a full time employee of the facility.	F 152		6/15/07

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

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F 174 SS=C	483.10(k) TELEPHONE The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide reasonable access to use of a telephone where calls can be made without being overheard. Findings include: 1. During the Group Interview (05/08/2007 at 1:45 PM) residents stated that they use the telephone in the facility's office or in the facility's living room and conversations can be overheard by staff and residents. 2. R11 stated during interview (05/08/2007 at 1:00 PM), she goes to a store to use the pay phone to make personal phone calls. 3. Review of R12's medical record (12/05/2006 at 7:00 PM) documents that R12's wife complained that R12 was making harassing phone calls to her and she did not want R12 to call her throughout the night. Further review (12/05/2006 at 7:30 PM) documents after R12 was informed of the claim made by his wife, every phone call thereafter was monitored. 4. E1(Administrator) stated during interview (in Room 9 on 05/09/2007 at 10:56 AM) that residents may make phone calls on the facility's office phone or a phone in the facility's living room.	F 174		6/10/07

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F 203 SS=D	483.12(a)(4)-(6) TRANSFER AND DISCHARGE REQUIREMENTS Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental	F 203		6/10/07

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F 203	Continued From page 3 disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide R9 with a 30 day notice of transfer and discharge, along with a letter and self addressed envelope instructing the resident on how to appeal his involuntary discharge from the facility. Findings Include: 1. At approximately 10:45am, 5/7/07, R9 was transferred to the hospital. No Physician's order was found in R9's clinical record for transfer to the hospital. Z1 (Physician)was interviewed by telephone and asked, if he had ordered R9 transfer to the hospital, 5/8/07, at approximately 11:30am? Z1 stated that he was in the facility, 5/7/07, and had a discussion with the family of R9. He told the family that if the R9 kept eloping from the facility, he would have to send him out to the hospital and suggest another more secure facility. Z1 said, "I did not write an order or call in an order for the resident to be transferred to the hospital, 5/7/07." Z1, then asked where was the resident?	F 203		

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F 203	Continued From page 4 2. 5/9/07 at approximately 8:30pm, Z2 (Cousin of R9) was interviewed by telephone. Z2 was asked about R9's transfer from the facility. Z2 stated that he was in the facility, Monday, 5/7/07. Spoke with R9's Physician, who told him that if his cousin continues to elope. He will have to send him out. Later, the facility calls him and tells him that R9 was transferred to the hospital. The hospital called Z2 and told him that the facility refused to take the resident back and he would have to find somewhere else for him to go. Z2 was asked if either he or R9 had received a 30 day notice of involuntary discharge from the facility. He said, "No." 3. Per record review, R9 was involuntarily transferred to the hospital with the reason being "Judicial admission of the mentally retarded. (405 ILCS 5/4-500)." Under giving a detailed description of any acts significant to support his transfer to the hospital, the facility wrote, "Deppersion & Schiziona". R9's clinical record did not contain any incident of suicidal ideations or threats to other residents. R9 does not have a diagnosis of Mental Retardation.	F 203		
F 224 SS=L	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to: 1. ensure 26 of 26 residents in the facility are not	F 224		6/15/07

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F 224	Continued From page 5 neglected. The facility failed to provide nursing staff coverage on 5/05/2007 between 3:30pm and 4:42pm. All of the on duty nursing staff members left the residents in the facility alone without supervision. 2. protect 2 residents (R8 & R13), on 1/27/2007, from an aggressive resident (R12). R12 assaulted R8 and R13 injuring both residents. This resulted in all the residents in the facility on 5/05/2007, lacking adequate services and supervision. The facility has 12 residents independent and 14 residents dependent of staff assistance for bathing; 18 residents independent and 8 residents dependent on staff assistance for dressing; 23 residents independent and 3 residents dependent on staff for transferring; 23 residents independent and 3 residents dependent on staff for toilet use; and 25 residents independent and 1 resident dependent on staff for eating. This failure was identified as an Immediate Jeopardy on 5/07/2007. On 5/10/2007 the survey team at 3:10pm, during the daily status, informed E2 (director of nursing/DON) of the Immediate Jeopardy. Findings include: 1. Per record review, R9 had eloped from the facility 4/19/07, 5/5/07 and 5/6/07. R9 had walked 3.25 miles to the home of (Z2) each elopement and was returned to the facility by Z2. After R9's first elopement, 4/19/07, R9's Elopement assessment was updated from a score of 6 to 8, making the resident at risk for elopement. -On all 3 elopement incidents, R9 walked away from the facility from the back patio where	F 224		

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F 224	Continued From page 6 residents smoke. On 5/07/2007, the surveyor observed the facility's back patio is not fenced in and residents who smoke were not being monitored continuously while smoking. -R9 has an elopement care plan dated 4/3/07 stating that the resident has no community access. R9 was not to leave the facility without an escort (staff, family). Staff was to closely monitor resident when he sits outside and follow the facility's Elopement Policy when resident is missing. E10 (RN), who was the nurse on duty when R9 eloped Saturday, 5/5/07 was interviewed, 5/7/07 at approximately 2:56pm. E10 stated that she observed R9 at 3pm. R9 went out of the building to smoke on the back patio. At 3:30pm, E10 started looking for R9 and could not find the resident. E10 went out of the building with a CNA/nurse aide (E11) to search for the resident. E10 thought a second CNA (E7) was still in the building monitoring the remaining residents. She later found out that E7 had signed in for the second shift, but had left the building to get a hair cut without telling E10. The remaining residents were left in the building with only the Cook (E9). E10 reported, the police was called when she returned to the facility. On 5/10/2007 the surveyor with the assistance of Z6 (state police),obtained information from the local police department regarding emergency calls from the facility. According to the local police's recorded calls on 5/05/2007 at 1642 hour (4:42pm), a call from facility came to the police emergency call system. At that time, there was a reported missing person. E9 was interviewed, 5/9/07 at approximately 4:06pm. E9 stated that Saturday, 5/5/07, he was	F 224		

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F 224	Continued From page 7 not aware that R9 had eloped from the building. "I take my break on the back patio around 3pm before I start preparing dinner. R9 was on the patio smoking when I was out there, breaking. He was acting like his usual self. I left him on the patio when after break. I did not know he had eloped Saturday. I did not know that I was the only one in the building with the residents at 3:30pm." E9, further stated that he knew about the elopement, Sunday 5/6/07, because E12 (LPN/nurse) came and got him to see if he could talk R9 back in the building. He couldn't get R9 to come back and R9 continued to walk away. E7 was interviewed, 5/9/07 at approximately 4:28pm. E7 stated that he worked 5/5/07 and saw R9 when he signed in at 3pm. E7 subsequently left the building without informing E10. He found out, that R9 had eloped upon his return to the facility at or about 4:30pm. On 5/9/07, E7 was discharged from his job because he jeopardized the safety of the residents when he left the building. -The facility's Elopement Policy States that everyone except the nurse on duty is go out and search for a missing resident. 5/5/07, E10, the nurse on duty left the building to search for a missing resident. Per record review R9's updated elopement assessment stated, R9 did not have community access. The resident could only go out of the facility with staff or family. R9's record did not contain an physician order for permission for access to community or no permission for access to community. 5/7/07, E3 (Activity Director/ CNA Supervisor/Social Service Director/ Psychiatric	F 224		

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F 224	Continued From page 8 Rehabilitative Coordinator) was interviewed and asked why R9 never had community access? E3 stated that she never assessed him for community access because R9 never asked to go out in the community. -5/9/07, E13 (nurse aide), who is a direct care personnel, was interviewed and asked about R9's cognitive ability and community skills. E13 stated that R9 was not able to function in the community. "R9 would say to me, 'Here's a dollar. Buy me a candy bar', and would be handing me a five dollar bill." -5/9/07, during a telephone interview, Z2 was asked about the elopements; how the resident arrived at his house and his community skills. Z2 stated that all 3 times that the resident eloped, he walked 3.25 miles to his house. Z2 complained about the condition the resident arrived. "He always had on clothes that smelled. He needed a bath. I complained to the facility about it." Z2 further stated that he was completely surprised that R9 knew how to get to his house because he had no community skills. His father took him everywhere. "Yes, he probably had a few dollars in his pocket. I didn't check, but he wouldn't know what to do with it. He does not know how to get on a bus." 2. On 5/10/07 at approximately 12:15pm, R13 was interviewed concerning incident dated 1/27/07. R13 stated that he and R12 were in R8's room talking together, when R12 asked R8 to do something. He did not remember exactly what R12 asked R8 to do. R12 did not like R8's answer and slapped the resident in the face. (R8's left eye was scratched causing bruising) R12, then turned his anger to R13. R12 tried to	F 224		

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F 224	Continued From page 9	F 224		

turn R13 over in his wheelchair. R13 grabbed R12 around the waist in order to stop from hitting the floor, head first. The noise could be heard out in the hallway and finally brought the staff to the scene. E7 (CNA) was one of the staff members that responded. R13 got back in his wheelchair and left the room. R12 followed and tried to hit the resident in the hallway between resident room 2 and 3. R13 wheeled himself into his room and R12 tried to follow. E7 tried to bar R12 from the door of room 2. R12 hit E7 trying to get to R13. R13 was asked if there was any alcohol involved? R13 admitted that he and R12 were "friends" before the incident and had been drinking in the facility. R13 stated the R8 had not had any alcohol. R13 was asked about how R12 obtained the alcohol? The resident stated that there is a store around the corner where he buys it. Per record review, the police were called and R12 was transferred to the hospital.

Next, R12's clinical record shows that the resident had been escalating in behavior without intervention for over a month. 12/3/07 at 12:50am, R12 left the facility without signing out. Police and Physician were notified. R12's Elopement assessment was not updated. 12/5/06, R12's wife complained to the facility about harassing phone calls from R12. 12/31/06 at 12am, R12 was found in R8's room. Staff asked resident to return to his room. The resident became angry and verbally abusive. Staff noticed alcohol on the residents breath. Staff went to call the police, when R12 blocked the front office door in order to stop staff from calling the police. R12 eventually left without signing out and the police were called. R12 has a care plan dated 11/27/06, that instructs staff to monitor his relationship with a female resident (R8) and call the police when

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F 224	Continued From page 10 the resident becomes too aggressive to handle. R8 had complained to staff about feeling "uncomfortable" around R12 (Social Service note, 12/21/06). The immediate jeopardy was removed on 5/10/2007. However, the severity remains at the second level. The surveyor confirmed the facility took the following actions to remove the Immediate Jeopardy: -All resident's diagnoses were reviewed and assessed as related to implementation and evaluation of the requirements of Sub Part S. Appropriate staff will continue this practice with new admissions to maintain compliance with the regulation. Each resident identified in need of programing has an individualized program. Completed by 5/15/2007 to be monitored for compliance by social service. -Residents most at risk for elopement (residents that smoke, but do not have community access) were identified. -Residents at risk will have their photos taken and placed in the medication room and the break room. -Facility will have a staff member assigned to monitor the front and back doors for 24 hours a day until the electric monitoring device system is installed and electric monitoring device safety devices have been applied to all residents who do not have community access. This will start by 7pm on 5/09/2007. -Any resident who does not have community access will not be allowed out of the building without an escort. -This procedure will remain in effect until the electric monitoring device system has been installed. Estimated installation date is Friday,	F 224		

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F 224	Continued From page 11 May 11, 2007.	F 224		
F 226 SS=F	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to have an abuse policy and procedures which address the training of all staff members and to provide adequate abuse training for all staff members. Findings include: On 5/8/2007 the surveyor reviewed the facility's written abuse policy and procedures. The policy did not have any outline or requirement for employee's abuse training. On 5/9/2007 the surveyor interviewed E2 (director of nurses), who was one of the facility's designated abuse coordinators. The surveyor asked about who was responsible for the staff abuse training? E2 replied, I am. The surveyor asked what type of training do all the staff members receive? E2 replied, It's an one to one individual training. The surveyor requested any documentation regarding abuse training within the last year. On 5/9/2007 at 3pm, E2 reported, She did not have any documentation regarding staff members abuse training. During the abuse interview with staff members the following was stated:	F 226		6/7/07

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F 226	Continued From page 12 -E14 (Nurse aide/CNA) and E15(Activity Aide) were interviewed on 05/08/2007 regarding Abuse Prohibition. Both staff members informed the surveyor they had not received any training or attended any in services at the facility related to Abuse Prohibition. -E4 (nurse/LPN) stated, His Abuse Prohibition training consisted of reading a pamphlet and talking to E2 (DON) for 15 minutes. -E16(CNA) and E17(CNA) were interviewed on 05/10/2007 regarding Abuse Prohibition. E16 stated she did receive Abuse Prohibition training at the facility. When asked by the surveyor what the training consisted of, E16 responded: "E2 asked me what I would do if I came across any abuse and if I had any CNA experience." E17 informed the surveyor that she had not received any training at the facility related to Abuse Prohibition.	F 226		
F 272 SS=F	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272		6/10/07

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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 272	Continued From page 13 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to 1. complete an accurate initial assessment for 2 residents (R9 and R12) 2. maintain a standardized reproducible assessment for Subpart S of minimum data sheet (MDS), for all 10 sampled residents (R1, R2, R3, R4, R5, R6, R7, R8, R9 & R10) and 18 residents outside of the sample (R11-R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27& R28). Findings include: 1. Per record review, R12's admission Minimum Data Set (MDS) dated 11/20/2006 under Section E. Mood and Behavior Patterns all indicators were recorded as zero (0), the indicator was not exhibited. Under Section F. Psychosocial Well-Being, the facility stated that the resident was at ease interacting with others; at ease doing structured activities; and makes friends and	F 272		

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	14E669	A. BUILDING _____ B. WING _____	05/16/2007

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F 272	Continued From page 14 responds costively to new activities. The facility never did a significant change when the resident became physically and verbally abusive. Refused to attend day programing. Became socially inappropriate when he push himself of R8 who expressed an uncomfortable feeling to E3. R8 was not at ease with staff. Refused to go to the day programs and left the facility more than twice without signing out. R9's admission MDS dated 3/28/07, was changed under Section B Cognitive Patterns; Section C Communication/Hearing Patterns; and Section E. Mood and Behaviors Patterns. Per interview with E1 (DON), 5/8/07, E1 admitted that she did not receive input from all direct care staff involved with R9. Therefore, the changes on the MDS. 3. The surveyor reviewed all the residents MDS in the facility and 2 closed record (R10 and R12). No Subpart S sections were included in any full or quarterly MDSs for residents within the last year. On 5/07/2007 in Room 9 at 4:30pm, E2 (director of nurses/ DON) stated during interview the Subpart S section of the MDS was completed for all residents. However, due to a computer problem, the facility is unable to print out and place the Subpart S section for any residents medical records. E2 told the surveyors, the resident's record would contain a hand written Subpart-S section for the residents by 5/08/2007. On 5/08/2007 the surveyor reviewed some resident's charts and noted a daft copy of the	F 272		

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F 272	Continued From page 15 Subpart-S. This draft copy was not an exact duplication of the Subpart S for the state required assessment instrument.	F 272		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and record review, facility staff failed to meet professional standards by pre-signing for medications before administering for 2 of 10 sampled residents and 5 residents outside the sample (R1, R2, R11, R13, R19, R25, and R26). Findings include: E5 (nurse/LPN) was observed during the afternoon medication pass on 05.08.2007 from 4:08 PM to 4:17 PM. E5 prepared and administered medications to 7 residents (R1, R2, R11, R13, R19, R25 and R26). E5 pre-signed all medications before administering them to the residents. Review of the MAR (Medication Administration Record) for the above residents documented that E5 pre-signed all medications for the residents. The surveyor reviewed a reference book, "Fundamental Concepts and Skills for Nursing." In the reference, under Medication Administration it reads as follows: "Documentation of an administered dose is done after the patient has taken the medication."	F 281		6/10/07

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F 319 SS=D	483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide one resident in the sample (R9) and one resident outside the sample (R12) with psychosocial treatment and services from the facility to ease adjustment to living in a long term care facility. R9 and R12 were living at home prior to entering the facility. Both residents had behavior problems because of the change in their living conditions that were not addressed by the facility. This lack of treatment resulted in both residents being involuntarily discharged from the facility without a 30 day notice. Finding Include: 1. Per record review, R9 has a diagnosis of Schizophrenia and Depression. The resident was living at home with his father before entering the nursing, 3/21/07. R9's father had recently passed away which is the reason for his being placement in a nursing home. In Social Service notes dated, 4/26/07 and 5/4/07 written by E3 (Activity Director/Social Service Director / Psychiatric Rehabilitation Coordinator), the facility was aware of the resident's father passing away and that he wanted to return to the home that he had lived in	F 319		6/15/07

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F 319	Continued From page 17 all his life. A care plan dated 4/3/07, referenced his father's death and his problem adjusting to the facility. The approaches did not include 1:1 treatment with exact times and dates for talking to the resident. The facility's intervention consisted of sending the resident to a work shop that did not specifically deal with his problems. At a Daily Status meeting, E3 stated that the resident did not talk and felt that R9 did not understand that his father was dead. One of the approaches E3 wrote on his care plan was "Give him time to talk about DAD & change of environment". 5/9/07, Z2 (cousin of R9) was interviewed by telephone at approximately 8:30pm. Z2 was asked about R9's father's death and his problem adjusting to the nursing home. Z2 stated that R9 attended his father's funeral and he totally understood what it meant. " I explained to him about the the death and that he was staying at the home only until family issues could be resolved. His father wanted him to stay at home and he knew that was his father's wish. R9 has 'no affect' and cannot outward show that he understands but he does." Z2 was asked if the facility ever gave R9 grief counseling. Z2 stated, "No, they called me on the telephone and told me to do it and I did." By not receiving adequate psychosocial treatment from the facility, R9 eloped from the facility on 3 occasions (4/19/07, 5/5/07, 5/6/07) resulting in the facility involuntarily discharging the resident without proper notice. 2. Per record review, R12 has a diagnosis of Major Depression, Alcohol Dependency, Cocaine Abuse and Schizoaffective. The resident was involuntarily discharged from the facility without proper notice, 1/27/07 for hitting 2 residents and 1 staff member. R12 had a care plan dated, 11/27/06, for abusing alcohol. The approach was	F 319		

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F 319	Continued From page 18 support group. The facility has no in house groups and their outside groups are not individualized. 5/10/07, during interview, E2 (DON) stated that the resident lived at home before coming to the facility. Social Service did not address his adjustment problems. R12's Admission papers dated 11/6/06 stated the resident had "Placement issues" that were not addressed by the facility.	F 319		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the residents' environment remains as free of accident hazards as possible. Findings include: 1. On 5/08/2007 between 2:30pm and 2pm, the surveyor conducted an environmental tour while accompanied by E1 (Administrator). The surveyor observed there were no grab bars in either the east or the west bathrooms. When questioned by the surveyor about the lack of grab bars in either of these bathrooms, E1 responded: "No one ever told me about the grab bars before." -In the patio area, the surveyor observed a long handle hole, rake and shovel unattended and unlocked. The tools were leaning against a shed. 2. E8 (Nurse/LPN) was observed during the	F 323		6/10/07

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F 323	Continued From page 19 afternoon medication pass from 12:15 PM to 12:18 PM. E8 prepared medication for R6. E8 then took the medication to where R3 was sitting and administered R3's medication. E8 left the medication cart unlocked and out of direct visual contact. When questioned by the surveyor, E8 had no response.	F 323		
F 324 SS=L	483.25(h)(2) ACCIDENTS The facility must ensure that 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: 1. adequately supervise 1 of 10 sampled residents (R9) and one resident outside the sample (R12) 2. provide adequate interventions to prevent R9 from eloping from the facility on 3 separate occasions (4/19/07, 5/5/07, and 5/6/07). 3. provide staff to adequately supervise 25 of 26 residents left in the facility on 5/5/07 between 3:30pm and 4:42pm, while staff members search the community for R9. 4. monitor R12 consumption of alcohol in the facility. R12 after consumption of alcohol physically abused, two residents (R8, R13) and one staff member (E7). Due to the facility's inability to supervise residents: -One cognitively impaired resident (R9), eloped 3	F 324		6/15/07

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F 324	Continued From page 20 times. -Two residents (R8 & R13) were injured. -Twenty-five residents were left without qualified nursing personnel to supervise. The facility has 10 residents identified with behavioral symptoms. In addition, the facility has 12 residents independent and 14 residents dependent of staff assistance for bathing; 18 residents independent and 8 residents dependent on staff assistance for dressing; 23 residents independent and 3 residents dependent on staff for transferring; 23 residents independent and 3 residents dependent on staff for toilet use; and 25 residents independent and 1 resident dependent on staff for eating. This failure was identified as an Immediate Jeopardy on 5/07/2007. On 5/10/2007 the survey team at 3:10pm, during the daily status, informed E2 (director of nursing/DON) of the Immediate Jeopardy. Findings Include: 1. Per record review, R9 had eloped from the facility 4/19/07, 5/5/07 and 5/6/07. R9 had walked 3.25 miles to the home of (Z2) each elopement and was returned to the facility by Z2. After R9's first elopement, 4/19/07, R9's Elopement assessment was updated from a score of 6 to 8, making the resident at risk for elopement. -On all 3 elopement incidents, R9 walked away from the facility from the back patio where residents smoke. On 5/07/2007, the surveyor observed the facility's back patio is not fenced in and residents who smoke were not being monitored continuously while smoking. -R9 has an elopement care plan dated 4/3/07	F 324		

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F 324	Continued From page 21 stating that the resident has no community access. R9 was not to leave the facility without an escort (staff, family). Staff was to closely monitor resident when he sits outside and follow the facility's Elopement Policy when resident is missing. E10 (RN), who was the nurse on duty when R9 eloped Saturday, 5/5/07 was interviewed, 5/7/07 at approximately 2:56pm. E10 stated that she observed R9 at 3pm. R9 went out of the building to smoke on the back patio. At 3:30pm, E10 started looking for R9 and could not find the resident. E10 went out of the building with a CNA/nurse aide (E11) to search for the resident. E10 thought a second CNA (E7) was still in the building monitoring the remaining residents. She later found out that E7 had signed in for the second shift, but had left the building to get a hair cut without telling E10. The remaining residents were left in the building with only the Cook (E9). E10 reported, the police was called when she returned to the facility. On 5/10/2007 the surveyor with the assistance of Z6 (state police),obtained information from the local police department regarding emergency calls from the facility. According to the local police's recorded calls on 5/05/2007 at 1642 hour (4:42pm), a call from facility came to the police emergency call system. At that time, there was a reported missing person. E9 was interviewed, 5/9/07 at approximately 4:06pm. E9 stated that Saturday, 5/5/07, he was not aware that R9 had eloped from the building. "I take my break on the back patio around 3pm before I start preparing dinner. R9 was on the patio smoking when I was out there, breaking. He was acting like his usual self. I left him on the	F 324		

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F 324	Continued From page 22 patio when after break. I did not know he had eloped Saturday. I did not know that I was the only one in the building with the residents at 3:30pm." E9, further stated that he knew about the elopement, Sunday 5/6/07, because E12 (LPN/nurse) came and got him to see if he could talk R9 back in the building. He couldn't get R9 to come back and R9 continued to walk away. E7 was interviewed, 5/9/07 at approximately 4:28pm. E7 stated that he worked 5/5/07 and saw R9 when he signed in at 3pm. E7 subsequently left the building without informing E10. He found out, that R9 had eloped upon his return to the facility at or about 4:30pm. On 5/9/07, E7 was discharged from his job because he jeopardized the safety of the residents when he left the building. -The facility's Elopement Policy States that everyone except the nurse on duty is go out and search for a missing resident. 5/5/07, E10, the nurse on duty left the building to search for a missing resident. Per record review R9's updated elopement assessment stated, R9 did not have community access. The resident could only go out of the facility with staff or family. R9's record did not contain an physician order for permission for access to community or no permission for access to community. - 5/7/07, E3 (Activity Director/ CNA Supervisor/Social Service Director/ Psychiatric Rehabilitative Coordinator) was interviewed and asked why R9 never had community access? E3 stated that she never assessed him for community access because R9 never asked to	F 324		

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F 324	Continued From page 23 go out in the community. -5/9/07, E13 (nurse aide), who is a direct care personnel, was interviewed and asked about R9's cognitive ability and community skills. E13 stated that R9 was not able to function in the community. "R9 would say to me, 'Here's a dollar. Buy me a candy bar', and would be handing me a five dollar bill." -5/9/07, during a telephone interview, Z2 was asked about the elopements; how the resident arrived at his house and his community skills. Z2 stated that all 3 times that the resident eloped, he walked 3.25 miles to his house. Z2 complained about the condition the resident arrived. "He always had on clothes that smelled. He needed a bath. I complained to the facility about it." Z2 further stated that he was completely surprised that R9 knew how to get to his house because he had no community skills. His father took him everywhere. "Yes, he probably had a few dollars in his pocket. I didn't check, but he wouldn't know what to do with it. He does not know how to get on a bus." 2. On 5/10/07 at approximately 12:15pm, R13 was interviewed concerning incident dated 1/27/07. R13 stated that he and R12 were in R8's room talking together, when R12 asked R8 to do something. He did not remember exactly what R12 asked R8 to do. R12 did not like R8's answer and slapped the resident in the face. (R8's left eye was scratched causing bruising) R12, then turned his anger to R13. R12 tried to turn R13 over in his wheelchair. R13 grabbed R12 around the waist in order to stop from hitting the floor, head first. The noise could be heard out in the hallway and finally brought the staff to the	F 324		

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F 324	Continued From page 24 scene. E7 (CNA) was one of the staff members that responded. R13 got back in his wheelchair and left the room. R12 followed and tried to hit the resident in the hallway between resident room 2 and 3. R13 wheeled himself into his room and R12 tried to follow. E7 tried to bar R12 from the door of room 2. R12 hit E7 trying to get to R13. R13 was asked if there was any alcohol involved? R13 admitted that he and R12 were "friends" before the incident and had been drinking in the facility. R13 stated the R8 had not had any alcohol. R13 was asked about how R12 obtained the alcohol? The resident stated that there is a store around the corner where he buys it. Per record review, the police were called and R12 was transferred to the hospital. Next, R12's clinical record shows that the resident had been escalating in behavior without intervention for over a month. 12/3/07 at 12:50am, R12 left the facility without signing out. Police and Physician were notified. R12's Elopement assessment was not updated. 12/5/06, R12's wife complained to the facility about harassing phone calls from R12. 12/31/06 at 12am, R12 was found in R8's room. Staff asked resident to return to his room. The resident became angry and verbally abusive. Staff noticed alcohol on the residents breath. Staff went to call the police, when R12 blocked the front office door in order to stop staff from calling the police. R12 eventually left without signing out and the police were called. R12 has a care plan dated 11/27/06, that instructs staff to monitor his relationship with a female resident (R8) and call the police when the resident becomes too aggressive to handle. R8 had complained to staff about feeling "uncomfortable" around R12 (Social Service note, 12/21/06).	F 324		

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F 324	Continued From page 25 The immediate jeopardy was removed on 5/10/2007. However, the severity remains at the second level. The surveyor confirmed the facility took the following actions to removal the Immediate Jeopardy: -All resident's diagnosis were reviewed and assessed as related to implementation and evaluation of the requirements of Sub Part S. Appropriate staff will continue this practice with new admissions to maintain compliance with the regulation. Each resident identified in needed of programing has an individualize program. Completed by 5/15/2007 to monitored for compliance by social service. -Residents most at risk for elopement (residents that smoke, but do not have community access) were identified. -Residents at risk will have their photos taken and placed in the medication room and the break room. -Facility will have a staff member assigned to monitor the front and back doors for 24 hours a day until the electric monitoring device system is installed and electric monitoring device safety devices have been applied to all residents who do not have community access. This will start by 7pm on 5/09/2007. -Any resident who does not have community access will not be allowed out of the building without an escort. -This procedure will remain in effect until the electric monitoring device system has been installed. Estimated installation date is Friday, May 11, 2007.	F 324		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of	F 332		6/10/07

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F 332	Continued From page 26 medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure that it is free of medication error rates of 5% or greater. 40 opportunities were observed with a total of 4 medication errors for a medication error rate of 10%. Findings include: 1. E4 (LPN) was observed for the afternoon medication pass on 05.07.2007 from 4:29 PM to 4:52 PM. E4 prepared 1 tablet of Clonidine 0.1mg for R26. E4 administered the medication to E4 at 4:41 PM. After administering the medication, E4 stated: "I gave this one too early, it's due at 6 PM." Reconciliation of R26's medical record noted a Physician's Order for Clonidine HCl 0.1 mg, take 1 tablet by mouth every 6 hours, 6A/12P/6P/12A. 2. E4 prepared medications for R19 including Metformin HCl 500 mg (Glucophage) 3-1/2 tablets for a total dose of 750 mg. E4 then administered the medication to R19 at 4:48 PM. Reconciliation of R19's medical record noted a Physician's Order for Metformin HCl 500 mg, take 3 half tablets (750 mg) by mouth every evening. Take with food or meals. E4 did not administer the medication with food or a meal. 3. E5(LPN) was observed for the afternoon medication pass on 05.08.2007 from 4:08 PM to 4:17 PM. E5 administered 2 puffs of Combivent via metered dose inhaler to R2. E5 did not wait a	F 332		

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F 332	Continued From page 27 minute between puffs. 4. E4 prepared medications for R19 including Metformin HCl 500 mg (Glucophage) 3-1/2 tablets for a total dose of 750 mg. E4 then administered the medication to R19 at 4:48 PM. Reconciliation of R19's medical record noted a Physician's Order for Metformin HCl 500 mg, take 3 half tablets (750 mg) by mouth every evening. Take with food or meals. E4 did not administer the medication with food or a meal.	F 332		
F 406 SS=J	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to: 1. provide structural programs for 3 of 10 sampled residents (R7, R8, & R9) and 2 residents outside the sample (R11& R12), according to each resident's identified needs. 2. provide structural programing for R7 and R11 who are both high functioning residents and not engaged in any meaningful programs. 3. provide a psychosocial program that addressed R12 aggressive behavior and	F 406		6/10/07

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F 406	Continued From page 28 substance abuse. According to R12's care plan R12 should have received a drug treatment program. No evidence was found of R12 receiving the program. 4. provide R9, a confused resident, demonstrating an adjustment problem with a treatment plan to address the problem. R9 had 3 elopements from the facility since admission 3/21/2007. R9 on 5/07/2007 had an involuntary hospital transfer due to this behavior. 5. provide psychosocial services which is based of each resident's functional level and age group. (R1, R5, R8, R11, R14, R22 & R24) The lack of the facility to provide adequate programing lead to R9's elopements from the facility. R9 walked 3.25miles away from the facility to a relative's (Z2) home. R9 a confused resident, was assessed by the facility to be not appropriate for unsupervised community access. This failure was identified as an Immediate Jeopardy on 5/07/2007. On 5/10/2007 the survey team at 3:10pm, during the daily status, informed E2 (director of nursing/DON) of the Immediate Jeopardy. Findings include: 1. Per record review, R9 has a diagnosis of Schizophrenia and Depression. The resident's Preadmission Screening and Annual Resident Review (PASARR) indicates that R9 needed specialized mental health Rehabilitative services. The needed services listed in the PASARR screening were the following: -Medication Management	F 406		

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F 406	Continued From page 29 -Daily Supervision -Structured Environment -Development of Personal Support Network -Assistance with Self - Maintenance & Community Living Activities. On three separate occasions (4/19/07, 5/5/07,5/6/07), R9 was allowed to eloped from the facility. The facility's patio area where resident smoke and sit outside is not fenced. This area is not continuously monitored by staff. R9 eloped from the patio due to lack of supervision. Per interview with Z2 (cousin of R9) 5/9/07, did not have any community skills because his father took him everywhere. The resident was put at risk for harm when allowed to elope. R9 was not assessed and a treatment program developed for the resident which would have included a structured environment. R9 did not attend a day program. And the facility has no in house programing. Examples of the individualized programing that the facility failed to provide R9 is grief counseling when his father died, Self maintenance and community skills. Per interview with E3 (Activity Director/ CNA Supervisor/ Social Service Director/ Psychiatric Rehabilitative Service Coordinator) 5/7/07, R9 never received community skills training because the resident never asked and his Physician never checked a box on his Physician's order saying the resident could go out into the community. During the interview with Z2 concerning R9's elopements from the facility, Z2 stated that he complained to the facility about R9's body odor and smelly clothing. 2. R8 has a diagnosis of Major Depression and Unspecified Psychosis. R8's PASARR screening	F 406		

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F 406	Continued From page 30 indicates that the resident needs specialized mental health rehabilitatives services. The PASARR completed 10/23/06 states, "The plan would be for the client to become stabilized and return home within 6 months." Per record review, R8's Specific Level of Functioning Assessment dated 3/1/07 was initiated 6 months after her arrival at the facility and was incomplete. No treatment program was developed from the assessment. R8's Comprehensive Care Plan under Physical and Psychosocial Needs list 2 problems for R8; Urinating on the floor (dated 9/8/06) and poor personal hygiene (dated 9/8/06). No discharge care plan was found. The urination and hygiene had never been updated since initiated. Only the dates changed on a quarterly. 4 of 4 days of the survey, R8 was observed in the facility. The resident was clean and neat. She did not smell of urine. R8's room did not smell of urine. R8's roommate did not complain of the resident urinating on the floor. During a Daily Status meeting, E3 was interviewed about R8's care plan and community skills training. E3 stated that when the resident was a new admit (8/25/06), there was a problem with her urinating on the floor and hygiene. She no longer has that problem. Because the resident never asked to go out in the community, E3 never assessed her community skills or worked on improving what community skills that the resident had. E3 stated that R8 was "Isolative and stayed in her room when new to the facility." 4 of 4 days of the survey, R8 attended day programs; visited with residents in the patio area and front room. R8 started attending a day program, 3/5/07. Six months after her arrival at the facility. The program addresses her depression, poor decision making skills and anxiety. Because the facility failed at admission	F 406		

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F 406	Continued From page 31 to address R8's poor decision making skills, R8 was put at risk in a relationship with a violent resident (R12). This relationship resulted in R8 being physically abused (1/27/07) by R12. 3. R12 has a diagnosis of Schizoaffective, Major Depression, Cocaine Abuse and Alcohol Dependency. R12's preadmission screening states that the resident has low stress tolerance, easily frustrated; suicidal gesture or attempts; and placement issues. During the first 30 days of R12's stay at the facility his physically and verbally abusive behavior manifested itself. The facility never addressed any of the R8's behavioral problems. R8's behavioral problem escalated over time resulting in the resident physically abusing two residents (R8, R13) and one Staff member (E7, CNA), 1/27/07. 4. R7 is a 41 year old with diagnoses that include Depression, Bipolar Disorder and Acute Anxiety Disorder. Medications include Lexapro, Xanax and Trazadone. Review of R7's most recent MDS (Minimum Data Set) of 03/12/2007 score R7 as a "1" or modified independence for cognitive status and independent in all ADLs. During initial tour of the facility on 05/07/2007, R7 was observed sitting in his room. When asked by the surveyor if he attended an outside program, R7 responded, "no." When asked by the surveyor why he was at the facility, R7 responded: "I got divorced and needed a place to stay." R7 Per E1(Administrator), R7 left the facility on a 2 day pass on 05/07/2007 to help R7's girlfriend with a personal problem.	F 406		

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F 406	Continued From page 32 On 05/10/2007 at 8:30 AM, R7 was observed sitting on the facility's smoking patio smoking. R7 was also observed throughout most of the day, out on the smoking patio, smoking. 5. R11 is a 53 year with diagnoses that include Major Depression and Schizoaffective. Medications include Zoloft, Risperdal, Trazodone and Lorazepam. Review of R11's most recent MDS dated 02/21/2007, scores R11 as a "1" or modified independence for cognitive status and independent in all ADLs. During the initial tour of the facility on 05/07/2007, R11 was observed sitting on her bed watching television. R11 informed the surveyor, that she did not attend program, because all they did was color and do puzzles. R11 stated she preferred to stay in her room and watch religious theme television programs. R11 stated she was at the facility because she had no place to live. 6. On 5/08/2007 from 12:45pm and 1:20pm, the surveyor observed 15 residents attending a psychosocial program, given by an outside group. Among the residents were in attendance was R22 with a language barrier; R11 high functioning; R1, R5, & R8 low functioning; R1, R11, R24 younger residents (under 55 years old) and R5, R14, & R22 older residents (over 55 years old). The surveyor reviewed the out service's contract with the facility. The service agreement specified	F 406		

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F 406	Continued From page 33 the following:" will provide psychosocial groups, based on profile of residents, including age groups, levels of functioning strength and risk..... On 5/09/2007 between 11:46am and 12:47pm, the surveyors met with 2 representatives from the outside program services (Z3 & Z4) The surveyor asked why was all the residents in the facility assigned to the one group? Z3 stated there were some individual sessions. However, the facility only had one time period for a group to be conducted. The immediate jeopardy was removed on 5/10/2007. However, the severity remains at the second level. The surveyor confirmed the facility took the following actions to removal the Immediate Jeopardy: -All resident's diagnosis were reviewed and assessed as related to implementation and evaluation of the requirements of Sub Part S. Appropriate staff will continue this practice with new admissions to maintain compliance with the regulation. Each resident identified in needed of programing has an individualize program. Completed by 5/15/2007 to monitored for compliance by social service. -Residents most at risk for elopement (residents that smoke, but do not have community access) were identified. -Residents at risk will have their photos taken and placed in the medication room and the break room. -Facility will have a staff member assigned to monitor the front and back doors for 24 hours a day until the electric monitoring device system is installed and electric monitoring device safety devices have been applied to all residents who	F 406		

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F 406	Continued From page 34 do not have community access. This will start by 7pm on 5/09/2007. -Any resident who does not have community access will not be allowed out of the building without an escort. -This procedure will remain in effect until the electric monitoring device system has been installed. Estimated installation date is Friday, May 11, 2007.	F 406		
F 458 SS=B	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 observations, the facility failed to ensure that resident rooms meet the minimum required square footage of 80 square feet in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Findings include: 1. Resident room 11, a 3 bed room, was measured to provide 66 square feet per resident bed. 2. Resident room 12, a 3 bed room, was measured to provide 74 square feet per resident bed.	F 458		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 35 300.1210a) 300.1210b)3) 300.1210b)6) 300.1220b)2) 300.3240a) 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. Restorative measures shall include at a minimum the following procedures: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 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. 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	F9999		

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F9999	Continued From page 36 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 status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 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 observation, interview and record review the facility failed to: 1. adequately supervise 1 of 10 sampled residents (R9) and one resident outside the sample (R12). 2. provide adequate interventions to prevent R9 from eloping from the facility on 3 separate	F9999		

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F9999	Continued From page 37 occasions (4/19/07, 5/5/07, and 5/6/07). 3. provide staff to adequately supervise 25 of 26 residents left in the facility on 5/5/07 between 3:30pm and 4:42pm, while staff members searched the community for R9. 4. monitor R12's consumption of alcohol in the facility. R12 after consumption of alcohol physically abused two residents (R8, R13) and one staff member (E7). Due to the facility's inability to supervise residents: -One cognitively impaired resident (R9),eloped 3 times. -Two residents (R8 & R13) were injured. -Twenty-five residents were left without qualified nursing personnel to supervise them. The facility has 10 residents identified with behavioral symptoms. In addition, the facility has 12 residents independent and 14 residents dependent on staff assistance for bathing; 18 residents independent and 8 residents dependent on staff assistance for dressing; 23 residents independent and 3 residents dependent on staff for transferring; 23 residents independent and 3 residents dependent on staff for toilet use; and 25 residents independent and 1 resident dependent on staff for eating. Findings Include: 1. Per record review, R9 had eloped from the facility 4/19/07, 5/5/07 and 5/6/07. R9 had walked 3.25 miles to the home of (Z2) each elopement and was returned to the facility by Z2. After R9's first elopement, 4/19/07, R9's Elopement assessment was updated from a score of 6 to 8,	F9999		

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F9999	Continued From page 38 making the resident at risk for elopement. -On all 3 elopement incidents, R9 walked away from the facility from the back patio where residents smoke. On 5/07/2007, the surveyor observed the facility's back patio is not fenced in and residents who smoke were not being monitored continuously while smoking. -R9 has an elopement care plan dated 4/3/07 stating that the resident has no community access. R9 was not to leave the facility without an escort (staff, family). Staff was to closely monitor resident when he sits outside and follow the facility's Elopement Policy when resident is missing. E10 (RN), who was the nurse on duty when R9 eloped Saturday, 5/5/07, was interviewed 5/7/07 at approximately 2:56pm. E10 stated that she observed R9 at 3:00pm. R9 went out of the building to smoke on the back patio. At 3:30pm, E10 started looking for R9 and could not find the resident. E10 went out of the building with a CNA/nurse aide (E11) to search for the resident. E10 thought a second CNA (E7) was still in the building monitoring the remaining residents. She later found out that E7 had signed in for the second shift, but had left the building to get a hair cut without telling E10. The remaining residents were left in the building with only the Cook (E9). E10 reported the police were called when she returned to the facility. On 5/10/2007 the surveyor, with the assistance of Z6 (state police),obtained information from the local police department regarding emergency calls from the facility. According to the local police department's recorded calls, on 5/05/2007 at 1642 hour (4:42pm) a call from facility came to the police emergency call system. At that time,	F9999		

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F9999	Continued From page 39 there was a reported missing person. E9 was interviewed, 5/9/07 at approximately 4:06pm. E9 stated that Saturday, 5/5/07, he was not aware that R9 had eloped from the building. "I take my break on the back patio around 3:00pm before I start preparing dinner. R9 was on the patio smoking when I was out there, breaking. He was acting like his usual self. I left him on the patio when after break. I did not know he had eloped Saturday. I did not know that I was the only one in the building with the residents at 3:30pm." E9 further stated that he knew about the elopement, Sunday 5/6/07, because E12 (LPN/nurse) came and got him to see if he could talk R9 back in the building. He couldn't get R9 to come back and R9 continued to walk away. E7 was interviewed, 5/9/07 at approximately 4:28pm. E7 stated that he worked 5/5/07 and saw R9 when he signed in at 3:00pm. E7 subsequently left the building without informing E10. He found out that R9 had eloped upon his return to the facility at or about 4:30pm. On 5/9/07, E7 was discharged from his job because he jeopardized the safety of the residents when he left the building. The facility's Elopement Policy States that everyone except the nurse on duty is to go out and search for a missing resident. On 5/5/07, the nurse on duty, E10, left the building to search for a missing resident. Per record review R9's updated elopement assessment stated R9 did not have community access. The resident could only go out of the facility with staff or family. R9's record did not contain a physician order for permission for	F9999		

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	14E669	A. BUILDING _____ B. WING _____	05/16/2007

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F9999	Continued From page 40 access to community or permission for access to community. On 5/7/07, E3 (Activity Director/ CNA Supervisor/Social Service Director/ Psychiatric Rehabilitative Coordinator) was interviewed and asked why R9 never had community access. E3 stated that she never assessed him for community access because R9 never asked to go out in the community. On 5/9/07, E13 (nurse aide), who is a direct care personnel, was interviewed and asked about R9's cognitive ability and community skills. E13 stated that R9 was not able to function in the community. "R9 would say to me, 'Here's a dollar. Buy me a candy bar,' and would be handing me a five dollar bill." On 5/9/07, during a telephone interview, Z2 was asked about the elopements; how the resident arrived at his house and his community skills. Z2 stated that all 3 times that the resident eloped, he walked 3.25 miles to his house. Z2 complained about the condition of the resident when he arrived. "He always had on clothes that smelled. He needed a bath. I complained to the facility about it." Z2 further stated that he was completely surprised that R9 knew how to get to his house because he had no community skills. His father took him everywhere. "Yes, he probably had a few dollars in his pocket. I didn't check, but he wouldn't know what to do with it. He does not know how to get on a bus." 2. On 5/10/07 at approximately 12:15pm, R13 was interviewed concerning an incident dated 1/27/07. R13 stated that he and R12 were in R8's room talking together, when R12 asked R8 to do	F9999		

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F9999	Continued From page 41 something. He did not remember exactly what R12 asked R8 to do. R12 did not like R8's answer and slapped the resident in the face. (R8's left eye was scratched causing bruising.) R12 then turned his anger to R13. R12 tried to turn R13 over in his wheelchair. R13 grabbed R12 around the waist in order to stop from hitting the floor, head first. The noise could be heard out in the hallway and finally brought the staff to the scene. E7 (CNA) was one of the staff members that responded. R13 got back in his wheelchair and left the room. R12 followed and tried to hit the resident in the hallway between resident rooms 2 and 3. R13 wheeled himself into his room and R12 tried to follow. E7 tried to bar R12 from the door of room 2. R12 hit E7 trying to get to R13. R13 was asked if there was any alcohol involved? R13 admitted that he and R12 were "friends" before the incident and had been drinking in the facility. R13 stated the R8 had not had any alcohol. R13 was asked about how R12 obtained the alcohol. The resident stated that there is a store around the corner where he buys it. Per record review, the police were called and R12 was transferred to the hospital. R12's clinical record shows that the resident had been escalating in behavior without intervention for over a month. 12/3/07 at 12:50am, R12 left the facility without signing out. Police and Physician were notified. R12's Elopement assessment was not updated. 12/5/06, R12's wife complained to the facility about harassing phone calls from R12. 12/31/06 at 12:00am, R12 was found in R8's room. Staff asked resident to return to his room. The resident became angry and verbally abusive. Staff noticed alcohol on the resident's breath. Staff went to call the police, when R12 blocked the front office door in order to	F9999		

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F9999	Continued From page 42 stop staff from calling the police. R12 eventually left without signing out and the police were called. R12 has a care plan dated 11/27/06, that instructs staff to monitor his relationship with a female resident (R8) and call the police when the resident becomes too aggressive to handle. R8 had complained to staff about feeling "uncomfortable" around R12 (Social Service note, 12/21/06). (A) 300.4090c) Section 300.4090 Personnel for Providing Services to Persons with Serious Mental Illness for Facilities Subject to Subpart S c) Psychiatric Rehabilitation Services Coordinator 1) A Psychiatric Rehabilitation Services Coordinator (PRSC) shall be an occupational therapist or possess a bachelor's degree in a human services field (including but not limited to: sociology, special education, rehabilitation counseling or psychology) and have a minimum of one year of supervised experience in mental health or human services. 2) An individual who is employed at a licensed nursing home in a capacity similar to that of a Psychiatric Rehabilitation Services Coordinator on January 1, 2002 and who has at least five years of experience in that capacity may petition the Department for approval to continue to act in that role even if the individual does not possess a bachelor's degree in human services. The Department will consider	F9999		

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F9999	Continued From page 43 information submitted in accordance with subsection (h) of this Section in deciding whether to grant approval. The Department may revoke approval if the individual fails to continue to meet professional standards or to complete required training. 3) Each resident admitted to the facility shall have a PRSC to act as a case manager. The PRSC will be identified as the staff member to whom the resident primarily relates for the coordination of service. 4) The responsibilities of the PRSC are: A) To provide the resident with a stable therapeutic relationship; B) To orient the resident to the facility; C) To review and assist the resident in understanding the treatment plan and program schedule; D) To prepare and assist the resident with active participation in the treatment plan review; E) To provide and/or coordinate the delivery of the psychiatric rehabilitation services programs; and F) To monitor the resident in the areas of self-directed care and for overall compliance with the treatment plan. This requirement is not met as evidenced by : Based on record review and interview the facility to have a qualified person serve as a PRSC to	F9999		

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F9999	Continued From page 44 appropriate assess, provide a treatment plan and coordinate services for 3 of 10 sampled residents (R7, R8, R9) and 2 residents outside the sample (R11 & R12) identified as needing Subpart S services. Findings include: 1. R8 has a diagnosis of Major Depression and Unspecified Psychosis. R8's PASARR screening indicates that the resident needs specialized mental health rehabilitatives services. The PASARR completed 10/23/06 states, "The plan would be for the client to become stabilized and return home within 6 months." Per record review, R8's Specific Level of Functioning Assessment dated 3/1/07 was initiated 6 months after her arrival at the facility and was incomplete. No treatment program was developed from the assessment. R8's Comprehensive Care Plan under Physical and Psychosocial Needs list 2 problems for R8; Urinating on the floor (dated 9/8/06) and poor personal hygiene (dated 9/8/06). No discharge care plan was found. The urination and hygiene had never been updated since initiated. Only the dates changed on a quarterly. Four of 4 days of the survey, R8 was observed in the facility. The resident was clean and neat. She did not smell of urine. R8's room did not smell of urine. R8's roommate did not complain of the resident urinating on the floor. During a Daily Status meeting, E3 was interviewed about R8's care plan and community skills training. E3 stated that when the resident was a new admit (8/25/06), there was a problem with her urinating on the floor and hygiene. She no longer has that problem. Because the resident never asked to go	F9999		

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F9999	Continued From page 45 out in the community, E3 never assessed her community skills or worked on improving what community skills the resident had. E3 stated that R8 was "Isolative and stayed in her room when new to the facility." Four of 4 days of the survey, R8 attended day programs, and visited with residents in the patio area and front room. R8 started attending a day program, 3/5/07, six months after her arrival at the facility. The program addresses her depression, poor decision making skills and anxiety. Because the facility failed at admission to address R8's poor decision making skills, R8 was put at risk in a relationship with a violent resident (R12). This relationship resulted in R8 being physically abused (1/27/07) by R12. 2. R12 has a diagnosis of Schizoaffective, Major Depression, Cocaine Abuse and Alcohol Dependency. R12's preadmission screening states that the resident has low stress tolerance, easily frustrated, suicidal gesture or attempts, and placement issues. During the first 30 days of R12's stay at the facility his physically and verbally abusive behavior manifested itself. The facility never addressed any of the R8's behavioral problems. R8's behavioral problem escalated over time resulting in the resident physically abusing two residents (R8, R13) and one Staff member (E7, CNA), 1/27/07. 3. R7 is a 41 year old with diagnoses that include Depression, Bipolar Disorder and Acute Anxiety Disorder. Medications include Lexapro, Xanax and Trazadone. Review of R7's most recent assessment of 03/12/2007 scores R7 as a "1" or modified independence for cognitive status and	F9999		

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F9999	Continued From page 46 independent in all ADLs. During initial tour of the facility on 05/07/2007, R7 was observed sitting in his room. When asked by the surveyor if he attended an outside program, R7 responded, "no." When asked by the surveyor why he was at the facility, R7 responded: "I got divorced and needed a place to stay." Per E1(Administrator), R7 left the facility on a 2 day pass on 05/07/2007 to help R7's girlfriend with a personal problem. On 05/10/2007 at 8:30 am, R7 was observed sitting on the facility's smoking patio smoking. R7 was also observed throughout most of the day, out on the smoking patio, smoking. 4. R11 is a 53 year old with diagnoses that include Major Depression and Schizoaffective. Medications include Zoloft, Risperdal, Trazodone and Lorazepam. Review of R11's most recent MDS dated 02/21/2007, scores R11 as a "1" or modified independence for cognitive status and independent in all ADLs. During the initial tour of the facility on 05/07/2007, R11 was observed sitting on her bed watching television. R11 informed the surveyor that she did not attend programs, because all they did was color and do puzzles. R11 stated she preferred to stay in her room and watch religious theme television programs. R11 stated she was at the facility because she had no place to live. 5. Per record review, R9 has a diagnosis of Schizophrenia and Depression. The resident's Preadmission Screening and Annual Resident	F9999		

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F9999	Continued From page 47 Review (PASARR) indicates that R9 needed specialized mental health Rehabilitative services. The needed services listed in the PASARR screening were the following: -Medication Management -Daily Supervision -Structured Environment -Development of Personal Support Network -Assistance with Self - Maintenance & Community Living Activities. On three separate occasions (4/19/07, 5/5/07,5/6/07), R9 was allowed to elope from the facility. The facility's patio area where residents smoke and sit outside is not fenced. This area is not continuously monitored by staff. R9 eloped from the patio due to lack of supervision. Per interview with Z2 (cousin of R9) 5/9/07, R9 did not have any community skills because his father took him everywhere. The resident was put at risk for harm when allowed to elope. R9 was not assessed and a treatment program developed for the resident which would have included a structured environment. R9 did not attend a day program, and the facility has no in house programing. Examples of the individualized programing that the facility failed to provide R9 are grief counseling when his father died, and self maintenance and community skills. Per interview with E3 (Activity Director/ CNA Supervisor/ Social Service Director/ Psychiatric Rehabilitative Service Coordinator) 5/7/07, R9 never received community skills training because the resident never asked and his Physician never checked a box on his Physician's order saying the resident could go out into the community.	F9999		

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F9999	Continued From page 48 6. The surveyor reviewed E3's (PRSC/social service)'s employee file. E3's file indicated E3's background qualified her to be a nurse aide. On 5/9/2007 E3 was questioned by the surveyor regarding her qualification as a PRSC. E3 told the surveyor she had petitioned the state to be a qualified PRSC and she had received a letter. The surveyor found the letter for the state agency among E3's personnel documentation dated in the year 2005. The letter indicated she was eligible for a PRSC, after the completion of an approved program. In addition, the letter stated E3 was responsible for filing evidence of the completion of the program with the state. E3 was asked for this evidence. The surveyor was told there was no documentation to be presented. (A)	F9999		