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EAST PEORIA GARDENS HLTHCR CTR	1910 SPRINGFIELD ROAD EAST PEORIA, IL 61611

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F 514	Continued From page 128 Review of the nurses notes reveal no documentation of this deterioration. The last 2 entries in the nursing notes of 04/09/07 and 04/10/07 both show "no s/sx (signs or symptoms) of distress noted". Review of the weekly skin reports for 3/20/07, 3/28/07 and 4/03/07 also reveal no documentation of skin checks or monitoring of these areas. 4. R9's MAR (Medication Administration Record) shows accuchecks which are ordered QID (four times daily) are not documented as done. The March 2007 MAR has blanks for the 8AM check on 3/13/07, the noon check on 3/12, 13, 16, 17, 18 and 19/07, blanks for the 4PM check on 3/18/03 and for the 8PM check, blank for the 3/15/07 check. Also, the MAR is blank for four albuterol nebulizer treatments, all at the noon treatment order time, as well as random blanks for other ordered treatments. 5. R9 has a reference to intake and output being a special treatment on the MDS. The nursing notes do not routinely show documentation of intake and output. The CNA's interviewed state they report the output to the licensed nurses to chart in the nurses notes. There was no uniformity to documenting intake and output. 6. R27 is a 53 year old male admitted from a Mental Health Center on 9/18/06. R27 has diagnoses including Paranoid Schizophrenia and Chronic MI(mental illness). R27 has had multiple incidents of behavior outbursts of verbal and physical aggression towards residents and staff. R27's care plan addresses a problem of "violence (maladaptive behavior with anger)" with "hostile	F 514		

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F 514	Continued From page 129 verbalization, hostile actions, strikes out" listed as manifested by. The nurses notes document incidents of being verbally and physically abusive on 2/10/07, with no incident to explain further. Also, nurses notes document incidents of aggressiveness, being violent on 3/5/07, 3/8/07 and 4/4/07 with no incident reports.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)2)3)6) 300.1220b)2)3)7) 300.2040b)e) 300.3240a) 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) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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	F9999		

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F9999	Continued From page 130 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 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. 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. 7) Coordinating the care and services provided to residents in the nursing facility.	F9999		

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F9999	Continued From page 131 Section 300.2040 Diet Orders b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered. e) A therapeutic diet means a diet ordered by the physician as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet). Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements were not met as evidenced by the following: Based on record reviews, interviews and observations, the facility failed to provide services necessary to avoid physical harm, mental anguish, or mental illness when they neglected to provide cardio pulmonary resuscitation; neglected to monitor worsening necrosis, neglected to monitor a resident in the dining room, and neglected to monitor a resident with a head injury. Four of 17 sampled residents were affected by these failures (R41, R17, R18, and R9). These failures resulted in: R41 expired without cardiopulmonary resuscitation being offered; R9 developed gangrene in his left great	F9999		

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F9999	Continued From page 132 toe; R18 choked and subsequently expired and R17 expired from injuries related to a fall in the facility. Additionally the facility failed to collect and analyze data related to the number, types and frequency of falls to identify trends and patterns and perform root-cause analysis. Further, the facility did not develop and implement corrective actions to address the falls occurring in the facility for R17 and R18. Findings include: 1. R41 was a 51 year old male with multiple diagnoses including A-Fib(Atrial fibrillation), COPD(Chronic obstructive pulmonary disease) and sleep apnea. R41's many medication orders include Coumadin 2 mg four times per week, and Coumadin 1mg three times per week. Per medical record review R41 was admitted to the facility on the evening of 03/31/07 for skilled nursing care with primary diagnoses of "(increased potassium) +8.4; EKG (changes)" and end stage renal disease. The face sheet on this admission shows R41 as "Full code per facility" and "self" referring to being own guardian. R41 also had orders including dialysis "M-W-F-" (Monday, Wednesday and Friday), oxygen at 2 liters per nasal cannula at all times and up as tolerated. Nursing notes show documentation at 1:00 AM on 04/01/07, R1 was found on the floor, and had a hematoma. Additional information listed under an addendum in the nursing notes reads "res(resident) yell for help, nurse and CNA(certified nurse aide)" ... "found on floor blood noted to be coming from res's head, suggesting head injuries." "CNA ran to get some towels," "nurse call 911 and doctor." The neuro(neurologist) consult at the hospital	F9999		

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listed R41 was admitted with "traumatic subarachnoid hemorrhage." The record from the hospital also showed R41 was transfused with two units of blood and two units of fresh frozen plasma and vitamin K. This would be needed due to the large amount of blood loss from the subarachnoid hemorrhage. The coumadin R41 was on would have contributed to the blood loss due to blood thinning and slow clotting of the blood. R41's laboratory reports show protime listed as 18.6(normal is 11.1-13.4), and INR listed as 1.8(normal is 1.1), showing R41's blood was thinner than normal.

R41 was readmitted to the facility from the hospital the evening of 04/03/07 "via cab" ..."no complaints of pain or discomfort. Pt(patient) short of breath. Needs oxygen at night," documented by E32. The hospital transfer record shows a discharge diagnosis of "4/1 subarachnoid hemorrhage/occipital laceration." The discharge record also shows R41 "refused dialysis" today.

The hand written physician orders of 04/03/07 show the code status left blank, so the facility still has the original code status of full code. A written physician order for code status could not be found in the medical record.

Vital signs were documented as being taken each shift from readmission on the evening of 04/03/07. The vital signs were within normal limits and showed no reason for nursing concern until the day shift of 04/04/07 when R41's blood pressure was 80/49 and pulse was 46, documented by E9. E9 documents the O2 sats(oxygen saturation) as 98(meaning 98%). There is no documentation of E9 contacting the physician regarding these low vital signs. E2 then

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documents in the nursing notes R41 was refusing dialysis and the physician was notified of this, although there are no new orders or plan of care by the physician. The evening shift shows the vital signs returned to within normal limits with "no C/O(complaint of) pain" and "resident continues on 15 min(checks)."

The night shift of 4/4 to 4/5/07 has E31 documenting a blood pressure of 44/24, pulse 64 and temperature of 96.2 ... "patient is resting with eyes closed. Does not respond to verbal or tactile stimuli." ... "Patient in no apparent discomfort" ... "O2 per N/C continuous. Skin cool to touch." Then at 1:40 AM, E31 documents "staff noted patient was not breathing. Nurse notified. Patient without breath sounds-negative for all pulses" .... "Patient expired."

Interviews with nursing staff and physician:
E31, LPN on duty night of R41's death: E31 was interviewed per phone on 4/12/07 at 3:10 PM, stating "I know that was low (referring to the blood pressure of 44/24), but I reviewed what I was told" ... "he (R41) stopped dialysis and death was imminent." When asked what it was he reviewed, he replied E32 told him during report at change of shifts R41 had refused dialysis, and E32 told E31 that R41 "was hospice." E31 did say there was nothing in writing that he could remember in regards to R41 being on hospice or a DNR (do not resuscitate). E31 did say if E31 had known R41 had continued with dialysis, E31 would have sent R41 (referring to sending R41 to the hospital with these low vital signs).

Z3, physician was interviewed per phone on 04/12/07 at 11:00 AM and did say it would have been "reasonable to send (R41) back to the

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F9999	Continued From page 135 hospital" due to the low blood pressure of 44/24. Z3 added R41 "could have been" ... staff "needed to send to hospital." Z3 was asked and explained the internal defibrillator R41 had implanted had nothing to do with (the heart stopping). The internal defibrillator "is there to spot times when the heart rate is too fast or irregular." Z3 explained this internal defibrillator does not take the place of CPR (cardiopulmonary resuscitation) when needed. E2, DON was interviewed in regards to R41's code status and the night R41 expired. When asked if the face sheet is what staff go by for code status, E2 said "yes ... (R41 was) a full code status, no form stating otherwise." E2 verified R41 was readmitted on the second shift on 4/3/07; it is protocol for every fifteen minute checks for all new admissions (or readmission) for the first 72 hours. When asked if E2 knew why CPR was not started, E2 replied "no ... he is a full code," adding "yes" E2 "would have expected full code, CPR to be done." When asked if E2 had talked with E31 in regards to this, E2 replied E31 no longer worked there and would not answer her calls. E32, RN on the evening shift of 04/04/07, reporting to E31 when he came on duty was interviewed at the facility on 04/13/07 at approximately 2:00 PM. E31 was asked what she knew about R41's CPR and hospice status and resultant death, replying she did not know what he was for sure (referring to code status). (Note, this interview took place at the nurses station with an enormous amount of noise from alarms, staff and residents making loud noises and we were talking very loudly to understand each other).	F9999		

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F9999	Continued From page 136 E10, CNA on night shifts was interviewed at 5:25 AM on 4/13/07 at the facility. E10 explained she was familiar with R41 as R41 had lived at this facility prior. ("Knew him from before when he lived here" .... "he came into some money, bought a trailer and lived on his own for a while" ... "hearsay is he had a couple of heart attacks." E10 was present the night R41 fell, had found him on the floor, "he was trying to get up so he could go smoke." "We got him out of here quick." E10 was on duty the night R41 expired, adding "we (herself, E12 and E31) kept an eye on him"..."his vitals were low." E10 added her routine is to come on duty, "walk around at 10:00 PM and look at all her residents." E10 said she was unable to hear a blood pressure on him, so she had E12 (CNA) try. E12 "had to close the door so she could hear" the blood pressure, and "he wouldn't respond. We rotated and stayed with him." "We were all under the impression he was hospice ... no thought of doing CPR due to thinking he was hospice" ... "because he told us he was hospice." E34, CNA on the night shift on 04/04 through 04/05/07 was interviewed at the facility at 5:50 AM on 4/13/07. E34 was on duty the night R41 expired. E34 added "I was in there," "we thought he was hospice ... the nurse said he was hospice" ... "that means no resuscitation." R41 "would have been sent to the hospital if he wasn't hospice." E9, LPN was interviewed regarding R41 at 5:20 AM on 4/13/07. E9 stated R41 told people at the facility "he was hospice, he was back and forth with dialysis." E9 explained it was her understanding if he continued with dialysis he could not go on hospice; if he quit dialysis, he	F9999		

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could go on hospice. R41 had not been evaluated and accepted for hospice. E9 stated she had "tried everything to find out what was going on" with R41. E9 had asked E1 and E2, "there was nothing in the chart," a call to the doctor was made, E9 stated adamantly, "he was not hospice." The doctor had said he had refused dialysis, "he was not hospice."
E9 added "we do 15 minute checks for the first 72 hours on all new admits."

2. R9, a 54 year old male resident admitted 12/28/2006 with multiple diagnoses, including IDDM(insulin dependent diabetes mellitus), history of smoking, history of drinking, chronic renal failure, hypertension, bipolar, chronic obstructive pulmonary disease, etc. R9 is listed as "self" for emergency contacts, then a friend. R9 is own guardian. A copy of the history and physical of R9's hospital stay in March, 2007, shows R9 had a consult due to peripheral vascular disease and osteomyelitis. The consultant dictated on 3/23/07, in reference to R9 "there are some dry necrotic changes over the first toes of both feet. I cannot feel pulses in either foot. There is no obvious cellulitis or infection, though." The consultant physician recommended "I would not recommend any further intervention at this time." ... "If the foot were to deteriorate, then I think probably a primary amputation would serve him best."

The resident assessment-data collection form for R9's readmission on 3/28/07 shows a diagram of the toes being circled and comments read "Rt and Lt toe necrotic. Right side of the toe has multiple scabs."

On Saturday, 4/14/07, E42(RN who works every

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other weekend) was preparing the paperwork for R9 to go to the hospital due to "black" toe. E42 had seen R9's toe and questioned the aides in regards to this. E14(CNA) was interviewed at 11:50 AM when putting R9 to bed to prepare him for transport. E14 said she had been telling the nursing staff R9's toes were looking worse. Both feet were observed with E14 pointing out R9's left great toes was totally black and drying, but the area at the joint of the foot was red, swollen and E14 said R9 had let her know this area was more sensitive. R9 denied it being sensitive when asked at this time. The right sock was removed and the right great toe was also turning black under the toe nail and to the outside of the toe. E14 said she had reported this worsening toe to different nurses.

Review of the nurses notes reveal no documentation of this deterioration. The last 2 entries in the nursing notes of 04/09/07 and 04/10/07 both show "no s/sx(signs or symptoms) of distress noted." Review of the weekly skin reports for 3/20/07, 3/28/07 and 4/03/07 also reveal no documentation of skin checks or monitoring of these areas.

The MDS and care plan shows nothing in regards to care or monitoring needed for R9's feet, even with a diagnosis of peripheral vascular disease on readmission of 3/28/07 and known necrotic areas on both feet.

On 4/18/07, R9's readmission forms were reviewed. The admission form to the hospital on 04/14/07 shows an admitting diagnosis of gangrene left great toe. This first consult dictated on admission also shows Z3 wanted this resident to "stay in the hospital and have the surgeons

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F9999	Continued From page 139 reevaluate" R9. The other consults show "there is a dry gangrene to the first toe on the left foot," adding "since the toe is dry, one can still probably favor nonoperative intervention without any amputation." The resident assessment and data collection completed on return to the facility on 4/17/07 shows a diagram with more drawings of scabs, blackness and redness on feet, left hand and left hip. 3. Nursing notes for R18 dated 4-9-07 at 9:08 AM state "845am resident at dining room table noticed resident to be unresponsive in full arrest placed on floor cpr uninitiated by 2 nurses calls placed to 911 and to family and physician also notified of condition and that 911 had been called. 85 a. amt on scene and took over care. cpr still in progress. 905am amt exited with resident cpr still in progress." A late entry at 11:22 a.m. states at 845am when resident was found unresponsive unconscious choking protocol was done, cpr with finger sweep, suction was also used." The facility's investigation into the incident states "7:30 am breakfast served at facility, 8:00 am Ate 100% of breakfast without difficulty. 8:47am Sitting at table in dining room, tray was not in front of resident. Table was being cleared by kitchen staff. (R18) was talking to kitchen staff while they were clearing the tables...(E14)cna noticed resident was unresponsive and looked blue, she yelled for help. Nurse (E9) went to the dining room, resident had no signs of choking was not gagging or gasping for breath.. (E9) did a finger sweep and protocol for choking, did not find any food in his mouth...8:55 am EMT arrived	F9999		

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F9999	Continued From page 140 on scene and took charge of cpr, 11:30 am Notified by hospital that family had decided to remove all life support from resident and he passed away at 11:14 am." The "Prehospital Patient Care Report" dated 4-9-07 written by the responding paramedics states "Called to (nursing facility) for a 72 year old male in full arrest. Upon ALS(Advanced Life Support) arrival found patient lying on the floor with CPR(cardiopulmonary resuscitation) in progress. Staff stated patient was eating breakfast and slumped forward at the table. Staff stated that patient was pulseless and breathless prior to moving him onto the floor and starting CPR. Upon exam patient pulseless and breathless, patient had a lot of food in his airway...CPR was continued via ALS provider. ET(endotracheal tube) placement was attempted without success. Patient received an oral airway....Patient transported without incident to (local hospital) and released in care of ED(emergency department) staff." The preliminary forensic pathology report dated 4-10-07 list cause of death as "asphyxia due to choking and aspiration of food." This was verified during interview with Z5, County Coroner on 4-13-07 at 12:55 PM. On 4-18-07, Z6, paramedic stated he responded to a 911 call at the facility on 4-9-07. When he arrived, R18 was already on the floor with CPR in progress. Z6 stated there was parts of a donut on the floor and also on R18's clothing. Z6 stated he noticed air was not going in as R18 was being bagged. An endotracheal tube placement was attempted without success. Z6 proceeded to suction donut material from R18 filling up his two and a half to three feet of suction tubing. Z6 was then able to	F9999		

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F9999	Continued From page 141 establish an oral airway. During interview on 4-11-07 at 11:45 AM, E14, Certified Nursing Assistant stated on 4-9-07 about 8:45 AM, she and another CNA were assisting residents out of the dining room after breakfast. When E14 reentered the dining room she approached R18 who was leaning over in his wheelchair. E14 noted R18's color was gray and he was unresponsive with drainage coming from his nose and mouth. E14 also noted a silver dollar sized piece of chewed donut on R18's cushioned lap restraint. E14 yelled for help and nursing staff responded initiating CPR. E14 related R18's diet order was mechanical soft with regular liquids. Staff assisted R18 with tray set up but R18 was able to eat by himself. E14 was not aware of any eating program or any special precautions to watch for other than R18's tendency to lean to one side and need to be repositioned. R18 did not eat at a feeder table and his swallowing was not monitored. E14 indicated there were two or three CNA's working in the dining room that morning while nursing staff was in and out passing medication. There were times when no one was in the dining room while taking residents out of the dining room after breakfast. R18 had a breakfast of cereal, donut, eggs with water, coffee, juice and maybe milk and had eaten all of his meal without incident. R18's physician order sheet for 4-07 shows R18 to be a 72 year old with diagnoses including schizophrenia, obsessive/compulsive disorder, depression, gastroesophageal reflux disease and tardive-dyskinesia. R18's current diet order reads "mechanical soft, thin liquids, no corn or raw vegetables, sauce or gravies on all dry foods."	F9999		

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F9999	Continued From page 142 R18's current Minimum Data Set (MDS) dated 3-23-07 shows R18 needs "supervision, setup help only" with meals, has a mechanical altered diet and "does not have or does not use dentures." R18's speech therapy "restorative program re-assessment eating/swallowing" note dated 3-7-07 states the following; "Resident will decrease risk for aspiration/choking by participating in a safe swallow protocol...nursing to ensure the following: Resident to receive mechanical soft diet with thin liquids. No regular corn, rice or raw vegetable. Provide alternative soft vegetable or potatoes in place of these food items. Butter, sauces, gravies on all dry foods. Nursing to provide assistance from nursing staff for feedings and tray prep. Resident to remain at current dining room placement for meals. Encourage resident to drink frequently during the meals, provide small bites/sips. Tell resident to clear throat and swallow if resident voice sounds gurgly." On 4-12-07 at 1:00 PM, Z4, Speech Therapist stated she re-evaluated R18 in early March 2007 related to his swallowing difficulties. Z4 confirmed R18 was still at risk for choking/aspiration and continued to need the above listed precautions. Z4 stated R18 was to sit at a feeder table and be monitored by staff to ensure his throat was being cleared adequately. Z4 confirmed a dry cake donut should not have been part of his diet. R18's care plan last updated 3-22-07 was reviewed. Care plan interventions listed for eating include in part, "resident has had a speech evaluation and is found to be safe with a	F9999		

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mechanically altered diet and thin liquids. He doesn't take food that he hasn't been served and is monitored by staff, encourage resident to eat slowly and monitor during each meal, report to nurse if there is any change in resident's eating ability, is non compliant with wearing his dentures and not eating with others with same diet, resident has some/all of his teeth missing and chooses not to wear dentures." This care plan was printed per request on 4-11-07 by facility staff and was not accessible to direct care staff. The care plan accessible to staff found in a designated binder plus the "CNA Assignment Card" located in another binder state in part "encourage resident to eat slowly and monitor during each meal, report to the nurse if there is any change in the resident's eating ability." None of the care plans provided contain all the special instructions developed by speech therapy to help prevent R18 from choking/aspirating.

During interview on 4-12-07 at 9:10 AM, E38, CNA working at the facility for the last 14 years, stated on the morning of 4-9-07, she was working the 100 hall taking residents from the dining room after breakfast to their rooms. E38 and E14, CNA were walking back from the 100 hallway when they noticed R18 leaning to one side in his wheelchair at the dining room table. R18 appeared gray in color.

E38 stated she was in charge of meal intake book that morning and knew R18 had consumed most of his eggs, cereal, coffee, soda and a cake donut. R18 did not have a history of "dunking" his donuts in coffee or milk. E38 stated R18 needed assistance with set up of his meal tray but could eat independently. R18 was not good about consuming liquids. E38 related R18 did

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F9999	Continued From page 144 not have a specific program for eating or any special instructions for monitoring at mealtime that she was aware of nor did she know R18 was to have gravy or sauces on all dry foods. R18 did not sit at a "feeder table" with staff supervision. When asked if she thought there were enough staff working in the dining room to provide adequate supervision for the residents, E38 replied no. On 4-12-07 at 10:00 AM, E47, Dietary Manager stated on the morning of 4-9-07, R18 was served eggs, hot and cold cereal, juice and a cake donut. At about 8:20 AM, R18 had finished all of his breakfast except some of his cold cereal. R18 was in no distress. When asked about R18's diet order, E47 stated R18 was to receive a mechanical soft diet, no added salt, with no raw vegetables, apples, oranges or rice. E47 stated residents diets are listed on their "diet card" as well as any additional instructions which were listed on the back of the card. E47 did not remember any additional information except what she listed above. R18's dietary card had already been thrown away. E47 stated she was aware R47 was getting a donut for breakfast and verified it was not soaked nor did it have any sauce or gravy on it. On 4-11-07 at 11:20 AM, E9, Licensed Practical Nurse (LPN) stated on the morning of 4-9-07 around 8:30 AM she was doing medication pass when she was called to the front dining room. E9 checked R18 finding no pulse and no respirations. R18 was placed on the floor and his head tilted back, performed the look, listen and feel and again found no pulse and no respirations. A finger sweep was performed. CPR was then initiated. E9 stated R18 ate	F9999		

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F9999	Continued From page 145	F9999		

independently with a diet of mechanical soft with thin liquids. E9 was aware of no specific instructions relating to R18 being monitored at mealtime per speech therapy recommendations.

4. R17's physician's order sheet dated 3/27/09 notes that R17 was admitted to the facility on 11/02/06. Diagnoses on this face sheet include Cerebral Vascular Accident, Urinary Tract Incontinence, Hypotension Orthostatic, Muscle Weakness, Parkinson's, and Alzheimer's disease among others.

Nursing note dated 4/07/07 at 1:19 a.m. document that R17 "did not appear to be breathing...did not have a pulse, no blood pressure, no respirations, and no apical pulse...called coroner and notified of death." Z11, Coroner stated on 4/16/07 at 8:50 a.m. that an autopsy was done. The cause of death was "brain trauma due to subdural hematoma due to an unwitnessed fall." Z11 continued that R17 "bled out in the brain."

Nursing notes for R17 document at least 10 falls from 2/10/06 though 3/27/07. Four of these 10 falls required hospitalization for at least emergency room treatment.

Fall #1--Nursing notes dated 2/10/06 document that at 4:15 p.m. "CNA(Certified Nursing Assistant) reported hearing something fall. Notice(d) res(resident) on floor. Skin pale. Oxygen applied at 2 L (liters) / NC(nasal cannula). Pulse OX 95%. Slowly responding to verbal and touch stimuli. B/P(Blood pressure) 180/100..." The resident according to these notes was transferred to a local hospital for emergency room evaluation . Upon R17's return,

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F9999	Continued From page 146 it is documented that "abrasion to left parietal/occipital area of scalp on the left...diagnosis was fall with minor head injury..." Fall #2--Nursing notes dated 2/11/06 state "res was standing at ns (nursing station) using phone when she just fell over onto floor onto right side. Nurse present at nursing station when incident occurred and resident did not hit head... TIME OF INCIDENT: 2:15 PM evening shift change ...Vitals: blood pressure 124/70 pulse 84 , respirations 20.... " Nursing note on the same date at 7:11 p.m. documents that "resident continues to ambulate self with unsteady gait. Have encouraged resident not to ambulate by self numerous times with out resident remembering. no change in mentation noted. Neuro checks with in normal limits. Small bump noted on back of head from prior fall. Denies headache, dizziness, or pain. Denies seeing spots or having periods of blackness before eyes. Only report from resident is feeling "fuzzy" in her head sometimes....will continue to observe." Fall #3--Nursing notes dated 6/8/06 show at 2:26 p.m. "resident reported falling out of bed this am. Date of incident: 06/08/06 shift change NOC (night) to AM...no apparent injury noted...up ambulating with walker. Gait steady...Vitals...pulse 60, respirations 20, blood pressure 130/60." Fall #4--Nursing notes dated 6/14/06 read "Blood pressure 102/56, dropped to 80/45 15 minutes. Pulse 48...comments At 0935 (9:35 a.m.) resident was found laying on her back in her hall outside her room with her walker next to her.	F9999		

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F9999	Continued From page 147 She stated my morning meds make me dizzy. I fell and hit my head. Small hematoma noted on right side of back of head, no bleeding noted. Moves all extremities with normal limits. No other injury noted. Skin felt cool and clammy. (Blood sugar) is 159....resident alert and conscious. Assisted to standing position...incontinent of loose yellow stool...asked to call Doctor because of her Lamictal being increased and see what he wants to do...send to Emergency Room for evaluation...". Nursing note dated 6/19/06 documents that R17 was readmitted to the facility after hospitalization for the fall. Consultation report from the acute care hospital dated 6/17/06 documents that "this is an 80 year old lady ...who presented...after sustaining a fall. The patient has no clear reminiscence of events. A computerized tomography scan ...revealed a presence of ill defined sphenoid bone fracture and the presence of extensive pneumocephalus...we will make sure that the patient does not have any active cerebrospinal fluid leaking in the next few days which could predispose her to the development of meningitis." Discharge summary report dated 6/19/06 notes that "The episode was unwitnessed, but she reportedly did not have any loss of consciousness. She has had multiple falls recently that she claims are due to feeling lightheaded and little unsteady. The patient does admit that whenever she has been taking her Lamictal that she does seem to be more lightheaded and dizzy. While hospitalized, she was found to have a urinary tract infection...Initially the resident was somewhat hypotensive, but this did improve with IV	F9999		

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F9999	Continued From page 148 fluids...In consultation with (attending physician), she will be tapered off her Lamictal unless a clear indication for it becomes available..." Fall #5--Nursing notes of 7/23/06 at 9:16 .am. show that R17 fell at 8:25 a.m. in the hallway. Note reads that "walking with walker and fell to knees with chin landing on the walker. INJURY: bruising bilateral knees are red...possible cause: none obvious. Denied felling dizzy...vitals blood pressure 142/90...ACTIONS: continue to observe Fall #6--Nursing notes dated 9/23/06 at 4:21 a.m. document that R17 was "found on the floor" on 9/22/06 at 3:30 p.m. "Resident stated 'trying to stand up and couldn't and slid down from my bed to the floor'" No apparent injury noted in the nurse's note. Blood pressure was noted at 158/62. Fall #7--"INCIDENT TYPE: Resident witness by another resident slowly lying herself on the floor. Date of incident:10/16/06. Time of incident: 5 p.m...." Subsequent nursing note on 10/17/06 at 12:41 a.m. documents that "resident found on floor on stomach. Another resident stated I watched her slowly get on hand and knees and lay on her belly. Resident stated I did not hit my head or get hurt. I felt dizzy and had to lie down..." Fall #8--"INCIDENT TYPE: fall witnessed at nurses station. DATE OF INCIDENT: 10/31/06. TIME OF INCIDENT 2:30 p.m....MENTAL STATE: confused, disoriented at time: ACTIVITY AT THE TIME: walking in the hall with walker...blood pressure 89/48..." Nursing notes continue that resident was sent to the emergency room and admitted to the hospital with diagnoses	F9999		

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F9999	Continued From page 149 of "Hypotension and Bradycardia." Fall #9--Nursing notes dated 3/5/07 document that R17 was "found on the floor" at 1:20 p.m. in her bathroom. Possible cause was listed as slipped on the floor. Nursing noted dated 3/5/07 at 5:25 a.m. document that R17 remained on antibiotics for urinary tract infection. Fall #10--Nursing notes of 3/27/07 with time of entry as 6:47 a.m. document that R17 fell in resident room "transferring". Injury is listed as laceration. Possible cause is stated as "none obvious". According to this note, a report was faxed to the physician. Actions are listed as "continue to observe". Teaching done is stated as "resident advised to use call light to get help when needed to use the bathroom". Investigation reports were requested for all of the above falls. Information provided in response to this request were computerized "fall risk screening" which did not analyze each fall's circumstances to establish a possible root cause. Causal factors are not listed each entry for the falls and when it was listed was stated as "rolled out of bed." These screenings simply listed generic statements regarding the resident such as "may need device but walks with walker" or "able to communicate". There is no documented investigation or analysis of R17's overall medical condition, physical abilities, medication side affects, usual and customary routine which may affect her fall status. Despite the reference from R17's 6/14/06 fall that R17 complained of dizziness after taking her morning medications and that her Lamictal was being discontinued, no analysis is documented of this potential cause for falls. No investigation is documented regarding	F9999		

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hypotension affecting her fall status. No approaches are listed on any of the screenings provided to guide direct care staff in preventing future falls for R17.

Care plan dated 3/21/07 lists problem as: Potential for injury related to Trauma falls. Approaches listed are: Monitor for orthostatic hypotension (but does not instruct when and how often to take blood pressure). Observe, record and report all unsafe conditions and situations. Anticipate fall times. Observe for functional decline due to psychotropic use. Instruct on safety, Assess change in level of consciousness. Bed in low position. Call light in reach. Check comfort level every 4 hours, toilet before and after meals and at hour of sleep. No approach is individualized or based on in-depth analysis of the falls.

Current physician orders dated 3/5/07 document that R17 was again given Lamictal 100 milligrams tablets, two in the morning and one in the afternoon. There is no documentation in nursing notes or in the clinical record regarding any monitoring of possible side affects of this medication.

E3, Assistant Director of Nursing on 4/14/07 at 11:40 a.m. stated that she had been put in charge of "keeping up with incidents/accidents" since she started at the facility in late February 2007. E3 indicated that prior to that "she had nothing to go by--not much was in place". When asked regarding R17, E3 stated that she was not aware of investigations done prior to February and was unable to provide any additional information for these falls.

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F9999	Continued From page 151 Z10, relative of R17, stated on 4/12/07 at 9:45 AM that Z10 received a phone call from nursing home staff at 6:24 a.m. on 3/27/07. According to Z10, she was told that R17 had fallen, was "fine," and did not need to go to the hospital. Z10 came to the facility later this same date at 10:50 AM. Z10 stated that R17 was in the shower at the time Z10 arrived. Z10 stated that R17 was noted to have "an open gaping wound on her forehead and a knot the size of a tennis ball on her head." Z10 stated during this interview that she told an unidentified Certified Nurse Aide that Z10 wanted R17 sent to the hospital. The CNA relayed this message to the nurse, who according to Z10 responded that "if you want her to go to the hospital, you can take her." Z10 persisted in her request that R17 be sent to the hospital and emergency transport was arranged. Emergency Room records for 3/27/07 document as "Take Home Instructions for the Patient" that R17 "suffered a minor head injury...You should see your doctor or go to the emergency room at once if any of the following symptoms develop over the next few days: Severe headaches not helped by pain medicine Mental confusion, restlessness, or personality changes Loss of balance or trouble with movement or coordination. The instructions continue "Avoid using aspirin or alcohol; take acetaminophen (Tylenol) as needed for headache or other pain. Watch for signs of developing head injury." Medication administration records for R17 dated March 2007 and physician orders dated March	F9999		

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F9999	Continued From page 152 2007 both include aspirin 81mg. documented as ordered and given daily to R17 from March 27 until 4/7/07 when R17 expired. Interview with E33(Registered Nurse) on 4/14/07 at 10:45 AM verified that aspirin was on both the Medication Administration Record and on the physician's order despite the instructions for R17 to avoid using aspirin after her head injury. When asked if she had verified the instructions for no aspirin with the physician when R17 came back to the facility, E33 replied no, stating that the resident came back during shift change and things were hectic. E33 was questioned regarding the actual time of fall. E33 stated that the fall occurred sometime around 4 AM the morning of March 27th. E33 remembered some bruising of R17's forehead, but did not remember any swelling, stating that neuro checks had been implemented at the time of the fall. Nursing note dated 3/27/07 with time as 9:08 PM documents that "resident remains on fall vitals with laceration on right eye dubond (Durabond) remains. No complaints or pain noted or voiced. Knot remains to upper right eye..." Limited nursing notes are documented for R17 from 3/28/07 to 4/3/07. The only nursing note documented on 3/29/07 notes at 2:15 p.m. that "Resident is on FVS(fall vital signs) with bruising to her right eye and a laceration that is healing without infection. Blood pressure 112/60; Pulse 76; Temperature 96.9 and Respiratory Rate 18. The only nursing note on 3/30/07 is timed 2:09 PM states "Resident alert and oriented seen by Eye Dr. Follow up recommended..." There are no nursing notes documented for 3/31/07, 4/1/07, or	F9999		

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F9999	Continued From page 153 4/2/07. During interview with Z12, Ombudsman on 4/11/07 at 10:00 AM, Z12 related that on 4/3/07 she visited the facility. Z12 noticed R17 siting in the dining room, holding her head in her hands. R17 told Z12 that "I must have fallen." R17 complained of having a bad headache to Z12. Z12 attempted to talk with E2, Director of Nursing at this time, but was met with a closed door. Z12 then went to the nurse's station and talked with the nurse(E22) telling her of R17's complaint of headache. E22 told Z12 that R17 was "due for a Tylenol at 11. I'll make sure she is ok." Review of the prn(as needed) medication records for this date do not document R17 receiving any Tylenol after Z12's report of pain. Z12 continued during this same interview to state that Z12 returned to her office, but was still upset over R17's condition, her complaint of headache, physical signs of pain, and what seemed to be lack of concern in the facility for R17's condition. Z12 stated that R17 had yellow bruised areas to the right side of her head extending from lower cheek area up to her forehead. Z12 returned to the facility on 4/06/07, this time accompanied by another ombudsman and their supervisor. R17 was found again in the dining room. R17 told Z12 that she was "having double vision and that her head still hurt." Z12 again relayed this information to facility staff, this time talking with E1 Administrator and E2, Director of Nursing. According to Z12 when the Director of Nursing was told that Z12 was concerned with R17's continued complaint of headache and now the double vision, E2 became curt with the Ombudsman, telling her that "I have an eye	F9999		

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F9999	Continued From page 154 appointment scheduled." The only nursing note documented on 4/3/07 relates to a pressure ulcer risk assessment. There are no notes for 4/4/07, except for a late entry made by the Director of Nursing which references the eye appointment and "addressed residents complaint to ombudsman regarding complaint of headache asked resident if she had told any of the nurses about headache she stated no reminded resident to let nurses know if she doesn't feel well." The single note documented on 4/6/07 lists R17's monthly weight. The next note on 4/7/07 at 12:40 AM documents that "resident does not appear to be breathing...did not have a pulse, no blood pressure, no respirations, and an apical pulse..." Facility policy for Neurological checkpoints, monitoring include statement that reads; Rule: Notify Physician. Notify the resident's physician in any instance of changes in level of consciousness. Then monitor neurological checkpoints closely. Rule: Report Changes. Report significant changes in neurological response to the physician immediately. Review of the Neurological Assessment check sheet indicates that facility recorded vital signs and neuro checks up until 3/29/07 second shift at which time they were discontinued. Facility did not implement any monitoring of vital signs or neuro checks after twice being alerted by Z12 that R17 was complaining of headaches and double vision. 5. R18's face sheet states he is a 72 year old with diagnoses including schizophrenia, obsessive/compulsive disorder, depression and	F9999		

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F9999	Continued From page 155 tardive-dyskinsia. R18's physician order sheet for April 2007 has an order initiated 2-16-07 stating "may wear self releasing belt in wheelchair for safety and trunk balance improvement, lap restraint per patient falling out of wheelchair, waiting for (cushioned lap restraint) R18's current MDS dated 3-23-07 shows R18 is dependent on staff assistance with propelling wheelchair and transfers. This MDS shows R18 had more that one fall in the last 180 days. Nursing notes dated 12-16-06 at 6:51am state "at 0555 resident was in main dining room in wheelchair, he was trying to reach a cup off the push cart when he leaned over too far falling out and hitting his right cheek on push cart...resident again five minutes later tried moving his way away from the table with wheels locked and leaned over too far trying to move wheelchair, falling out again..." Nursing notes dated 1-31-07 at 0500 am state "resident fell on the floor from his wheelchair in TV room at AM landing on his right side, has small skin abrasion on right elbow..." On 2-3-07 at 3:47 p.m., nursing notes state "patient fell out of wheelchair has small laceration to nose, sent to hospital for evaluation." On 2-8-07 at 6:09 pm, nursing notes state "resident leaned too far forward in wheelchair. Fell on floor to knees and leaned forward to floor." On 3-14-07 on "day shift" R18 slid from his wheelchair sustaining a laceration to the bridge of his nose. On 3-3-07 at 3:23 pm nursing notes state "fell out of wheelchair in back hallway." Nursing notes dated 3-4-07 at 2:32 state "found on floor in room fell out of wheelchair on to floor..." The facility's policy entitled "Accidents and	F9999		

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Incidents" dated 6-1-04 states the following: "It is the responsibility of the DON/Designee to investigate and ensure appropriate completion, notification, and follow-up on all Accidents and Incidents...It is the responsibility of the Incident Review/QA Team to review incidents on a weekly basis...The care plan coordinator/MDS coordinator will be notified so that appropriate adjustments can be made with care planning interventions as necessary."

R18's current care plan was last updated 3-22-07. The newest intervention related to fall prevention is dated 12-26-06 and states "make sure he is wearing a self release restraint belt when up in his wheelchair/night am, pm." There are no other new interventions listed on this care plan.

On 4-14-07 at 11:35 am, E3, Assistant Director of Nursing stated she has been put in charge of the "fall program" when she started at the facility in late February. E3 stated there were no past procedures for her to follow, as it was "hit and miss." Now E3 states she keeps a log of all falls but "has not gotten to" the point of analyzing past history of falls for trends and root causes. E3 states at the time of the incident, nursing staff are to complete the incident report including any new interventions they may have at that point. The next morning, department heads have a meeting and discuss incidents and then a weekly fall meeting is held to further discuss falls. Any new interventions or therapy involvement should be discussed at these times.

Investigation reports were provided by the facility for one the fall incidents on 12-16-06 and the falls on 2-3-07 and 2-8-07. Only one these

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F9999	Continued From page 157 investigation contains any interventions to prevent further falls and it reads, "reminded to sit back in wheelchair and ask for assist." Periodically the record contains "fall risk screening-history of falls" but again does not determine causative factors with related new interventions. (A) 300.1210a) 300.1220b)2)3)7) 300.1410a) 300.3240a) 300.4000a)b)1)A)C)I) 300.4000b)2)A)B)C)D) 300.4000b)3)A 300.4000c) 300.4010a)b)c) 300.4030a) 300.4090f)A)B)C)D)E)F)G)H) 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. Section 300.1220 Supervision of Nursing Services	F9999		

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F9999	Continued From page 158 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. 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. 7) Coordinating the care and services provided to residents in the nursing facility. Section 300.1410 Activity Program a) The facility shall provide an ongoing program of activities to meet the interests and preferences and the physical, mental and psychosocial well-being of each resident, in accordance with the resident's comprehensive assessment. The activities shall be coordinated with other services and programs to make use of both community and facility resources and to benefit the residents.	F9999		

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F9999	Continued From page 159 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Section 300.4000 Applicability of Subpart S a) Beginning July 1, 2002, a licensed SNF or ICF providing services to persons with serious mental illness shall meet the requirements of this Subpart S. Applicability of this Subpart S shall not affect a facility's compliance with the remainder of this Part. b) For the purposes of this Subpart, "serious mental illness" is defined as the presence of a major disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric Association, 1400 K Street NW, Washington, DC 20005), excluding alcohol and substance abuse, Alzheimer's disease, and other forms of dementia based upon organic or physical disorders. A serious mental illness is determined by all of the following three areas: 1) Diagnoses that constitute a serious mental illness are: A) Schizophrenia; C) Schizo-affective disorder; I) Major depression, recurrent 2) In addition, the individual must be 18 years of age or older and be substantially functionally limited due to mental illness in at least two of the following areas: A) Self-maintenance; B) Social functioning; C) Community living activities; D) Work-related skills	F9999		

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F9999	Continued From page 160 3) Finally, the disability must be of an extended duration expected to be present for at least a year, which results in a substantial limitation in major life activities. These individuals will typically also have one of the following characteristics: A) Have experienced two or more psychiatric hospitalizations c) This Subpart applies to persons who are transferred to a facility for 120 or fewer days for a medical reason directly related to the person's diagnosis of serious mental illness, such as medication management. Section 300.4010 Comprehensive Assessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) The facility shall establish an Interdisciplinary Team (IDT) for each resident. The IDT is a group of persons that represents those professions, disciplines, or service areas that are relevant to identifying an individual's strengths and needs, and that designs a program to meet those needs. The IDT includes, at a minimum, the resident; the resident's guardian; a Psychiatric Rehabilitation Services Coordinator (PRSC); the resident's primary service providers, including an RN or an LPN with responsibility for the medical needs of the individual; a psychiatrist; a social worker; an activity professional; and other appropriate professionals and care givers as determined by the resident's needs. The resident or his or her guardian may also invite other individuals to meet with the IDT and participate in the process of identifying the resident's strengths and needs. b) The IDT must identify the individual's needs by performing a comprehensive assessment as	F9999		

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F9999	Continued From page 161 needed to supplement any preliminary evaluation conducted prior to admission to the facility. The assessment shall be coordinated by a PRSC. c) A comprehensive assessment must be completed by the IDT no later than 14 days after admission to the facility. Reports from the pre-admission screening assessment or assessments conducted to meet other requirements may be used as part of the comprehensive assessment if the assessment reflects the current condition of the individual and was completed no more than 90 days prior to admission. Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) On admission, information received from the admission source (e.g., resident, family, preadmission screening (PAS) agent) shall be used to develop an interim treatment plan. In developing an individual's interim treatment plan (IITP), the facility shall review the PAS/MH assessments and "Notice of Determination" and consider the use of this information in developing the interim treatment plan. The IITP shall focus on those behaviors and needs requiring attention prior to development of the individualized treatment plan (ITP). Each IITP shall be based on physician's orders and shall include diagnosis, allergies and other pertinent medical information. The following information shall also be considered, as appropriate, to allow for the identification and provision of appropriate services until a final plan is developed. Section 300.4090 Personnel for Providing Services to Persons with Serious Mental Illness	F9999		

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F9999	Continued From page 162 for Facilities Subject to Subpart S f) Psychiatric Rehabilitation Services Aides 2) If a facility does not employ PRSAs to provide psychiatric rehabilitation program services, the following minimum training shall be provided to certified nursing assistants (CNAs) within 30 days after the CNA's first day of employment: A) Understanding the impact of serious mental illness; B) Understanding the role of psychiatric rehabilitation, including how to manage psychiatric disabilities and countering stigma and discrimination; C) Confidentiality; D) Preventative strategies for managing aggression and crisis intervention; E) Goals and function of case management; F) Appropriate verbal and physical interaction; G) Communication skills between staff and residents; and H) Basic psychiatric rehabilitation techniques and service delivery. These Requirements were not met as evidenced by the following: Based on interviews, observations, and record reviews the facility failed to provide mental health programming for 11 of 51 residents identified as "seriously mentally ill." Two of 51 residents are identified as "mentally retarded" but not provided any programming. Of the 41 residents on the facility's Subpart S list only 16 residents are involved in programs. Programming in place does not meet the needs of all the residents identified. The facility failed to provide enough trained staff to consistently implement programming for identified individuals. These	F9999		

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factors combined resulted in a non-structured environment leaving all residents at risk for increased behaviors or becoming victims of behaviors.

Findings include:

1. Observations made on 4/10/07 (first day of survey) noted no specific programming taking place for residents assessed as "seriously mentally ill." Interview with E19, Licensed Counselor on 4/11/07 at 11:54 AM stated that the facility was unable to carry out the scheduled programming for that day because of the survey process.

On 4/10/07 the facility provided a list of 41 residents identified as "Subpart S" or "seriously mentally ill." Of the 41 residents only 16 are involved in programming required for Subpart S.

Review of the facility's schedule of programming only includes 3 programs: 1) Substance Abuse for 10 residents, 2) Symptom Management for 7 residents, and 3) Communications for 17 residents.

These 3 programs combined to only provide four and 1/2 hours of programming each week per resident if a resident was involved in all 3 programs. Further review of the program documents that only 1 resident is involved in all 3 programs. The majority of residents are involved in two programs which equals three hours per week.

Admission logs December of 2006 through April of 2007 document ?? newly admitted residents that meet Subpart S requirements. Interviews

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F9999	Continued From page 164 with the following staff members E6, E7, E10, E12 and E26 all CNA's (Certified Nurse Aides) stated that they received no specific training regarding the care of mentally ill residents. E8, Restorative Aide, E13 LPN (Licensed Practical Nurse) and E25, Housekeeper stated that they did not receive any training as well. E11, E14, E15, and E38 all CNA's stated that they just recently received CPI (Crisis Prevention Intervention) training the beginning of April of 2007. Interview with E38, CNA on 4/12/07 at 9:10 AM stated that she has worked at the facility for 14 years. E38 stated that she thought the CPI training was not that helpful and she was still concerned for the safety of the elderly residents with the increase of mentally ill residents. On 4-10-07 at 7:55 p.m., R48 stated he had "concerns about the new members in the facility from the mental health places." R48 related he "gets scared" at times because of their behaviors. R48 reported that last night someone was throwing things and he was hit but not hurt. Staff told R48 he was to "overlook it." On 4-10-07 at 855 p.m., R53 stated she sometimes has concerns about her safety. Some of the residents have mental illnesses and yell and scream a lot, pushing each other around and attacking staff and each other. 2. Screens showed need SMI (Severe Mental Illness) services for 13 residents - (R40, R46, R1, R5, R36, R48, R54, R28, R55, R56, R58, R23, R52). Screens showing need DD services for 2 residents - (R47, R59) E1 (Administrator) and E30 (Corporate Consultant) were interviewed on 4/12/07 at 2:10	F9999		

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F9999	Continued From page 165 PM. E30 was the primary speaker during this interview. E30 stated in 2/2006 the facility hired E43 (Licensed Clinical Social Worker/LCSW). E30 stated E43 was "to get the programs set up. It didn't work." E30 stated E43 worked until 9/2006 when she was "termed" (terminated). E30 stated the facility hired E44 (Doctorate level psychology degree) to formulate and run the programs. E30 stated E44 worked from 10/2006 until 11/2006 when E44 was "termed" as "he didn't work out." E1 and E30 confirmed there was no Director of Clinical Services from 11/2006 until 2/2007 when E19 (LCSW) was hired as Director of Clinical Services. E30 was asked what type of staffing had been added to accommodate the influx of SMI residents (approximately 30 over 3 months). E30 stated, "In 8/2006 23 hours every two weeks was added to the facility for the services of myself and E46 Masters level social worker (MSW/LCSW)." E30 stated,"Sometimes we are here more." On 9/13/06 the facility increased CNA (Certified Nursing Assistant) hours 40 hours every two weeks. E45 (Psych Tech) was also hired in 9/2006. On 1/11/07 the census increased so the hours for psych techs was increased by 48 hours every two weeks and E20 (Psych Tech) became full-time. On 2/15/07 the facility approved 80 hours every two weeks for a treatment nurse and dietary hours were increased by 23 hours every two weeks." E30 also stated, "One of the CNA's (Certified Nursing Assistants) was working as a PRSA (Psycho-Social Rehab Aid) and doing some programming when (E44) was here (11/2006) and before (E19) was hired (2/2007)." This left no Clinical Leadership staff at the facility from 11/2006 until 2/2007.	F9999		

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	146073	A. BUILDING _____ B. WING _____	04/25/2007

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F9999	Continued From page 166 E30 was questioned if the lack of clinical leadership staff to run programs for the SMI prompted the facility to decrease the admission of SMI residents to the facility. E30 stated the facility "did not back off admitting residents" but they decided to "push CPI (crisis prevention intervention)." E30 stated at the time (9/2006 to 3/2007), the CPI programs were being offered in Chicago and 5 staff were trained at that time. The facility has offered CPI in Peoria since late 3/2007. E30 stated, "Approximately 14 staff members from the facility have been trained in CPI up to this date. We can't do the entire staff like a snap. We want the staff who went (to CPI) to give cues to other staff." E30 stated no other inservice training had been offered to the CNA's who deal directly with the SMI population regarding the needs of this type of population. E30 stated E5 (Corporate Consultant) had inserviced licensed nursing staff in psychiatric medications such as if a resident is experiencing hallucinations whether they should give Haldol or Ativan and the corporate/administrative staff try to "model approaches." The facility Inservice Training Log shows licensed staff were given an inservice on 3/30/07 regarding psychiatric behaviors and psychoactive medications. This shows licensed staff were instructed on medication usage when a resident displayed negative behaviors but not instructed in non-pharmaceutical interventions to be utilized to de-escalate residents before medicating. No other facility Inservice Training Log was provided by the facility regarding training to direct	F9999		

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F9999	Continued From page 167 care staff, licensed staff or ancillary staff for December 2006 thru 4/10/07 when this survey was initiated. R51 was initially admitted to the facility on 3/5/07 from an inpatient psychiatric hospital with diagnoses including: Schizo-affective disorder, Antisocial behavior, multiple psychiatric admissions and history of self abusive behaviors. On 3/19/07, R51 was sent to a local hospital for evaluation after cuting herself on the left forearm with a coat hanger and stating she "wants to kill everyone and cannot stand to be here another minute-it's too static." R51 was readmitted on 3/27/07 after a psychiatric stay in the local hospital. On 3/31/07 R51 was sent to the hospital with transfer referral form noting "extreme violent behavior, repeated banging head on wall, combative, verbally abusive." The facility requested the police come to the facility and assist staff as R51's was unable to be controlled by facility staff. Thirteen current residents were identified in OBRA initial screening as requiring Mental Health Services prior to admission. These 13 residents did not appear on the active Subpart S list supplied by the facility. R46's screening was completed on 1/19/06 and noted to require nursing services "for 120 days convalescent stay only." OBRA (Ombudsman Reconciliation Act) Initial screen completed on 10/06/05, Part II "Reasonable Basis to Suspect a Developmental Disability notes "Yes" to the following: 1) Individual has been formally diagnosed with related condition (Neuropsychological exam review and Psychological assessment review); 3) The	F9999		

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F9999	Continued From page 168 individual has received special education and/or day program services; 5) There are other indicators of mental retardation of developmental disability. Part III "Reasonable Basis to Suspect A Mental Illness" notes "Yes" to the following: 3) The individual has a history of outpatient mental health services. Part IV notes MHPAS (Mental health preadmission screen) as positive. Part V notes: Although an item was marked "yes".....he was admitted for Rehabilitation (for 120 days) he will be returning home within 120 days. This is dated 1/31/06 (approximately 434 days). The facility was unable to provide any documentation that R46 is or has received mental health or development disability services since he has been a resident at the facility. The facility was unable to state why the resident was still at the facility when discharge was initially planned within 120 days. The facility was unable to provide information why R46 is not on the Subpart S list of residents. R52's OBRA screen dated 5/3/1989 Part I "Based upon all information and data available to me for this person, there is a reasonable basis for suspecting: 1) The individual has the diagnosis indicated above: Severe Mental Illness. This is the only part of the screen the facility was able to produce for R52. The facility was unable to explain why R52 was not on the current list of SMI or produce a new screen showing her medical needs would now outweigh her psychiatric needs. R1's OBRA Initial Screen dated 9/1/2006, Part III "Reasonable Basis to Suspect a Mental Illness" notes "Yes" to the following: 1) The individual has been formally diagnosed with a mental illness verified by a DSM-IV (Diagnostic	F9999		

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F9999	Continued From page 169 Statisticians Manual fourth edition) classification code which substantially impairs the person's cognitive, emotional and/or behavioral functioning, excluding organic disorders/dementia, developmental disabilities and alcohol/substance abuse; 2) The individual has a history of psychiatric hospitalization; 3) The individual has a history of outpatient mental health services. The Determination Screen from MHPAS agent marked "Yes" to "Does require facility level of care per section 520.00 of the PAS/MH (Preadmission Screen/Mental Health) Manual." The history of Antisocial/Maladaptive/Risk Behaviors provided to the facility by the PAS/MH screen states "Was on probation last year but thinks it's resolved. History of 3 felony convictions. General behaviors to wife (hits her around). Married/Divorced 16 times (state record). Has verbally threatened (community) staff in the past. Frequent suicidal ideation often preempts inpatient admission. 1983 - Went to wife's workplace with machete and tried to kill her (resulting in) attempted murder convictions." R1 currently resides in the same room as his wife. The facility was unable to explain why R1 is not on the current list of SMI residents and not receiving services. R5's OBRA Initial Screen dated 12/14/2006 part III "Reasonable Basis to Suspect a Mental Illness" notes "Yes" to the following: 1) The individual has been formally diagnosed with mental illness verified by a DSM-IV classification which substantially impairs the person's cognitive, emotional and/or behavioral functioning, excluding organic disorders/dementia, developmental disabilities, and alcohol/substance abuse; 2) The individual	F9999		