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	145970	A. BUILDING _____ B. WING _____	C 10/16/2009

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SOUTH SHORE NUR & REHAB CENTER	2649 EAST 75TH ST CHICAGO, IL 60649

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F9999	Continued From page 13 LICENSURE VIOLATIONS 300.1210a) 300.1220b)2) 300.1220b)3) 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 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	F9999		

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F9999	Continued From page 14 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. These Regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to supervise 1 resident (R3) with Dementia from hitting 2 residents in a sample of 6. R3 has multiple incidents of hitting a family member, the staff, and a resident prior to hitting R2 on the left eye on 10/11/09. R2 sustained persistent redness and irritation of the left sclera which resulted in her transfer to the Emergency Room for evaluation. This failure also has a potential to affect other residents nearby R3, as staff were not aware that without provocation, R3 has assaulted his wife, a staff member, and another resident (R1) prior to 10/11/09. Findings include : R3 has diagnoses of Cerebrovascular Dementia, Diabetes Mellitus, and Hypertension. R3 was initially admitted to the facility on 7/31/09. The following were R3's documented aggressive and abusive behaviors noted in his Progress Notes : a) On 7/31/09 at 10:26 PM, R3 was standing over his roommate, confused and disoriented. R3 told his roommate, "You are in my house, get out."	F9999		

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F9999	Continued From page 15 When nurse tried to redirect R3, he became agitated and aggressive and redirection was unsuccessful. R3 was brought to the nurses station and transferred to room 321. b) On 8/15/09 at 10:15 PM, R3 became combative to staff and daughter while his daughter was visiting; 1:1 intervention provided. c) On 8/19/09 at 7:11 PM, according to an activity aide, R3 got out of his wheelchair while in the dining room, struck another resident (R1) and used profanities. d) On 8/20/09 at 11:18 AM, R3 continued to get out of his wheelchair, walked around with unsteady gait, and was argumentative with other residents. e) On 8/21/09 at 2:15 PM, R3 hit E10 (Social worker) on the forehead and was unreceptive to redirection. f)On 8/21/09 at 2:32 PM, while at the dining room, R3 stood up from his wheelchair, swore at staff, and grabbed E11 (Nurse) by the collar swearing. Combative with staff and other residents. PRN attempt unsuccessful. g)On 8/21/09 at 2:52 PM, R3 continued to be agitated and fought with staff and other residents. h) On 8/21/09 at 7:16 PM, R3 was agitated while waiting for ambulance; spoke vulgarities to staff and other residents, and cannot keep quiet. Removed from the area, and intervention was documented as partially effective. i) 8/27/09 at 8:02 PM, R3 was physically	F9999		

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F9999	Continued From page 16 aggressive towards other residents and was pushing them. j) 9/4/09 at 3:30 PM, R3 was verbally abusive to staff. R3 was counseled but with poor insight and could not remember behavior. Unreceptive to intervention and redirection. k) 9/4/09, R3 was confused, verbally abusive to staff and other residents at times. l) 9/7/09 at 8:00 AM, R3 was charted as confused and with combative behavior. m) On 9/17/09 at 5:15 PM, R3 was agitated, verbally abusive, used profanities, and was noted in another resident's room. n) 9/26/09 at 12:04 AM, confused as to rooming arrangement requires constant supervision. o) On 10/10/09 at 6:47 PM, R3 was physically abusive to E12 (nurse) while E12 was connecting R3's Gastrostomy tube. Kicked E12 and balled fist attempting to hit R12 and refused blood sugar check. p) On 10/11/09 at 8:30 PM, R3 struck R2 on the left eye causing redness and transfer to the Emergency Room for evaluation. When E10 (Social Worker) was interviewed on 10/13/09 at 3:10 PM, E10 said that when she first met R3 on 8/21/09, she was coming out of the 3rd floor elevator and saw R3 behind the nurses station. E10 said that R3 was smiling at her and motioning to her to come to him. E10 continued that when she got behind the 3rd floor nurse's station, without warning and without getting	F9999		

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F9999	Continued From page 17 provoked, R3 punched her on the forehead causing her to fall on the floor while her eyeglasses flew. E10 said that R3 also attacked his wife and pulled his wife's hair before, and that R3 is also verbally abusive to other residents. E10 added that R3's attacks were random and unprovoked. Review of R3's nurses notes showed that on 8/19/09 at 7:11 PM, an activity aide said to E9 that R3 got out of his wheelchair in the dining room, and struck another resident and used profanities. During 10/13/09 interview at 3:45 PM, E9 (2nd floor nurse) confirmed that indeed, on that day, an activity aide called E9 during dinner time that R3 hit R1. E9 continued that she saw R3 standing from his chair, and being verbally abusive towards R1. E9 said that R3 was saying that he hit R1 because R1 hit him first. E9 said that R1 explained that he did not do anything, and that R1 is alert and oriented x3. Furthermore, E9 mentioned that the activity aide saw what happened, and said that R3's attack on R1 was unprovoked. According to E18 (3rd floor nurse aide) during 10/13/09 interview, she personally had seen R3 chase his wife around the dining room and pull her hair. E18 also added that she heard that R3 had a physical altercation with another resident. Although E18 said she hasn't seen his behavior, another aide warned her that R3 is verbally and physically aggressive towards the nurse aide. E5 also said on 10/14/09 that R3 tried to hit other nurse aides. Similarly, E4 (nurse) said that she heard from nurse aides that R3 would sometimes swing at staff. E13 also mentioned in a 10/15/09 interview that R3 is very confused and would	F9999		

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F9999	Continued From page 18 swing at anyone near him without any reason. E8 (nurse aid) also recalled that while R3 was still on the 2nd floor, R3 threatened to beat her up one time, and while she was picking up another resident's tray, R3 again stood up from his chair and tried to hit her. E8 added that on the 3rd floor, R3 also threatened to knock E8 out when she tried to get him up from bed. E3 said during 10/13/09 interview, that she heard that R3 would raise his fist to staff and other residents, and actually saw him lash out at his wife. Per R3's assessment dated 9/21/09, R3 has a moderate cognitive impairment in daily decision-making skills. R3 was also coded as 1/1 in wandering which means that R3 exhibits wandering behavior that occurred 1-3 days in a 7 day period during the assessment, and that this wandering behavior is not easily altered. Furthermore, this assessment indicated that R3 is verbally abusive and resists care in 1-3 days in a 7 day period during the assessment. Review of R3's Nurses notes for the following dates confirms above coding in the assessment that indeed R3 has wandering behaviors: a) 8/1/09 at 9:50 AM, R3 was noted as had took off his clothes and wandered in and out of other residents' rooms. b) 8/4/09 1:36 PM, R3 was charted as wandering from room to room since admission, and exhibiting socially inappropriate behavior such as disrobing. The nurses notes indicated that somewhat R3 was unreceptive to redirection and intervention.	F9999		

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F9999	Continued From page 19 c) 9/17/09 at 5:15 PM, R3 was charted as agitated, verbally abusive, and was noted in another room. d) 9/19/09 at 6:57 PM, R3 was noted as using the wheelchair to move around the unit. e) 9/26/09 at 12:04 AM, R3 was noted as with unsteady gait, confused as to room arrangement and requires constant supervision. During 10/13/09 interview at 2:20 PM, E7 (7-3 nurse) said that she also saw R3 in another resident's room, trying to get to bed. E7 said that R3 is confused. E8 (7-3 Nurse Aide) also said on 10/13/09 that she saw R3 several times going in other residents' rooms and would get in arguments with other residents because R3 thinks it is his room. E10 also said during 10/13/09 interview at 3:10 PM, that she heard R3 wanders to other residents' rooms. Despite the documented wandering behaviors to other residents' room and actual observation by staff, this information was not disseminated to other staff, most of them direct care providers for R3. Similarly, despite R3's documented and observed physical aggression and physical assault on staff, family member, and another resident, R3's nurses and Nurses Aides on the 3rd floor were not made aware of these behaviors. As a result, staff were not monitoring R3's wandering into rooms nor did staff had provide other residents around R3 with a safety space to prevent R3 from hitting them even without provocation.	F9999		

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F9999	Continued From page 20 E17 (Care Plan Coordinator) said on 10/15/09 at 2:30 PM, that although she is the care plan coordinator, she was not made aware of R3's wandering behavior and R3 being found in other residents' rooms. E17 added that she was aware of R3 hitting E10, but did not have knowledge that R3 hit R1 in the past. E14 (Rehab Aide/ 3-11 CNA) also denied being informed that R3 wanders inside other residents' rooms, and said she was not made aware at all that R3 had physically assaulted staff, a family member, and another resident. During 10/14/09 interview at 1:45 PM, E4 (3-11 nurse) also denied knowledge of R3's wandering inside other residents' rooms or of R3's swinging his fist at other residents or hitting another resident. When interviewed on 10/13/09 at 3:30 PM, E3 denied that she was informed that R3 is a wanderer or that he goes inside rooms, other than his own. E3 also has no knowledge of R3 actually physically assaulting a staff or another resident. E5 indicated as well that although she knows that R3 tried to get up and walk on his own even if he is not supposed to, no staff told her that R3 wanders in other residents' rooms. E5 also denied that staff told her that R3 had hit another resident. E6 also said that no staff told her that R3 wanders in other resident's room during 10/14/09 interview. E9 (3-11 nurse) also said that she was not made aware that R3 goes inside other residents' rooms, although she saw R3 roll his wheelchair in the hallways.. Per staffing schedule and per facility, E4 was R3's nurse on 10/11/09 and E5 was his Nurse aide during that shift. E3, E14, E6 and E13 were staff working on the 3rd floor on 10/11/09. During above interviews, E4, E5, E3, and E14 were all not aware of R3's wandering behavior, nor were	F9999		

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they aware that R3 had physically assaulted staff, family member, and another resident in the past. E6 was not aware of R3's wandering behavior and E14 was not aware that R3 had actually struck a staff, family, and a resident.

Per facility's Incident report dated 10/11/09, at 8:00 PM, R2 stated that she was hit in the eye by another resident.

When R2 was interviewed on 10/15/09 at 2:00 PM, R2 said that on 10/11/09, she was sitting on a chair inside her room, with her back turned away from the door. R2 continued that she did not hear R3 enter her room but that, when R2 stood up and turned around, without saying a word, R3 hit her on her left eye. R2 said she recognized R3 because he used to sit in the Dining Room during meal time and she saw him there.

On 10/15/09 at 2:00 PM, R3's left eye was noted as with reddened sclera and lacrimation. R2 said that her left eye vision was more blurry compared to the unaffected right eye. R3 was alert and oriented x3 at this time.

According to E6, while she was coming in the hallway at around 7:00 PM, she heard R2 yell for help and saw R3 come out from R2's room (room 333). E6 added that R2 said that R3 slapped her. E6 said that R3 was walking when she saw him.

Review of R3's Physician Order Sheet (POS) indicated that R3 is suppose to have a chair alarm. When E6 was asked if she heard a chair alarm during the time she saw R3 come out of room 333, E6 said that R3 was not in his wheelchair and she did not hear any triggered

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F9999	Continued From page 22 alarm from the 3rd floor dining room. E6 said she last saw R3 having dinner at the dining room. E6 added that dinner time was probably between 5:30 PM to 6:30 PM. When E13 was asked on 10/15/09, E13 said that R3 had his chair alarm connected to him during dinner time. E13 confirmed that he also did not see when R3 left the Dining Room and said that he did not hear his alarm triggered as well. E13 said that it was around 6:00 PM to 6:30 PM when R3 said that someone hit her in the face. At that time, E13 explained that he thought that E3 and E4 were just outside the Dining room, while he and E6 and another Nurse Aide were in the Dining Room picking up trays and taking residents out. Per E3 during 10/16/09 interview at 1:40 PM, she did not hear R3's chair alarm triggered before or during the time R2 yelled that another resident hit her in the face. E3 said that she remembered seeing a chair alarm connected to R3 during dinner. E3 added that she was at the 3rd floor nurses station just next to the Dining Room at this time. Per E15 during interview on 10/15/09, R3 was able to remove his alarm clip thus it usually is not triggered when he stands up, so staff are not alerted. Despite this, R3's chair alarm was continuously used on R3, even if he was able to remove it rendering it ineffective in alerting staff when he stands up and starts to wander. E5 (Nurse Aide) said on 10/14/09 that she was inside room 331 with another resident when she heard the nurse page the supervisor. E5 said that the last time she saw R3 was when he was	F9999		

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F9999	Continued From page 23 eating dinner in the Dining room around 6:30 - 7:00 PM. E4 (nurse assigned to R3) said during 10/14/09 interview that she was not on the 3rd floor when the altercation between R3 and R2 occurred. She said that when she went back to the floor, E3 told her of the incident. E4 said that she last saw R3 in the dining room sitting on a chair, and he was finished with his dinner already. E4 did not say what time it was. According to E3 during 10/13/09 interview, she last saw R3 at dinner time around 6:30 PM. E6, on the otherhand, said that she last saw R3 during dinner time which is between 5:30 to 6:30 PM. She also said that during this time, everybody is putting residents back to bed and that no one is in the dining room. Review of R3's care plan which was initiated on 8/6/09 showed no indication that R3's wandering behavior is being addressed, nor his behavior of physically assaulting staff, family, and another resident to ensure safety of other residents around him, who are within his easy reach. During meal time, R3 sits at a square table with R4, 5, and 6, all of them within his easy reach. When E17 was interviewed on 10/15/09 at 2:30 PM, E17 denied knowing that R3 wanders into other residents' rooms nor has knowledge that R3 hit R1 in the past. E17 explained that that is the reason why there was no care plan addressing R3's wandering behavior. E17 said that if she knew R3 wanders inside other residents' rooms or assaulted another resident, a family, and staff, she would evaluate his being a	F9999		

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safety risk to himself and to other residents. E17 added that had he known this prior to 10/11/09 incident, she would have focused his care plan on ensuring that R3 is supervised and prevented from going in other residents' rooms. E17 said further that normally a care plan is generated and communicated to staff on the floor so they are aware. The care plans are kept in a folder in the unit per E17, and are also available and accessible in the computer for the nurses and nurses aides.

Similarly, when E10 was asked, E10 said that she would make sure that R3 is monitored at all times and other residents should be positioned not too close to R3. E19 (Social Worker) also said that if she knew that R3 wanders into other residents' rooms, she would have recommended that he is monitored and engaged in activity at all times, to keep him occupied and prevent him from wandering. E19 said she did not have any intervention for R3 because R3 is no longer in the facility.

E13 also expressed during 10/15/09 interview that if he knew that R3 hit and assaulted staff and another resident, he would have focused more of his attention to watch R3 closely. E13 said that other residents are not safe near R3 if he has a behavior of hitting people. E13 said he dines at the same table near other residents easily within his reach.

During 10/15/09 interview, E14 also said that if she knew R3 has a behavior of hitting other people without provocation, she would not feel comfortable having R3 sit in the dining table with other residents who are seated within his reach. E14 added that no one also told her to closely

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F9999	Continued From page 25 supervise R3 to prevent him from wandering into other rooms. (A)	F9999		