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F 520	Continued From page 88 documented fall 7/03/2010 at 1pm, Resident found on the floor, in room. Resident sent out to hospital. Resident was alert-disoriented. Resident was last seen propelling self through out facility in her wheelchair. Intervention included the use of a pad alarm to wheelchair. The surveyor did not see any evidence of the interdisciplinary team to review this resident's care plan to determine how effective any of the previous intervention to prevent R21 from fall a fourth time. The care plan was not reviewed at the time of R21's falls. The care plan reviews were at 3/21, 3/22, 4/07 and 6/10/2010. According to the facility's policy for fall prevention program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R21. 13.) R22 has a diagnosis of a stroke and mental retardation with an unsteady gait. R22's minimum data set dated 2/14/2010 indicated R22 had a fall within the past 30 days. Incidents reports and fall investigations documented the following: -3/16/2010 at 6:40pm, unwitnessed fall in the dining area on the floor. Resident called for help. The investigation does not include any cause or possible factors contributing to R22's fall. -4/01/2010 at 9:12pm, computerized fall documented a fall on 4/01/2010 at 4:15pm while in the dining room. Resident found lying on left side. The investigation does not include any cause or possible factors contributing to R22's fall. R22's 3/06, 6/16/2010 care plan reviews had no change in interventions. On 9/07/2010 at	F 520		

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F 520	Continued From page 89 10:15am, initial tour of the facility, the surveyor observed the dining area in questioned was located directly across the unit's nurse station. According to the facility's policy for fall prevention program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R22. 14.) On review of the facility's incident reports the surveyor noted the following concerning R24: -6/21/2010 at 9:55am, computerized documented fall on 6/21/2010 at 9am, resident had a fall outside the facility. Resident sustained a brusing/skin tear. Resident stated she slipped when she was rising from chair. The resident reported the fall to the nurse. First aid was applied to right elbow and right knee. The intervention was that resident would let staff know her where about. No investigation surrounding the fall was done.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b)6) 300.1220b)2)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to	F9999		

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F9999	Continued From page 90 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. 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 2-107 of the Act)	F9999		

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F9999	Continued From page 91 These Regulations were not met as evidenced by: Based observation interview and record review the facility failed to adequately supervise residents, evaluate the circumstances and/or the reason of falls, implement planned interventions, or follow the facility's fall policy to prevent falls; for 5 of 16 sampled residents (R4, R5, R6, R12, R13) and 7 supplementary residents (R17, R20, R21, R22, R23, R24, R27) to avoid falls with the risk of injury. In addition, the facility failed to eliminate environmental hazards within the facility's interior and exterior areas, areas used by all the ambulatory residents.The facility failed put in place safety mechanisms to ensure falls are avoided for the residents. As a result of the above facility's failures R5, R13, R17, R23 and R27 had injuries after falling. R5 and R17 had a fall directly related to one of the facility's environmental hazards that existed at the time of the survey. R6, R12, R13 and R24 had a fall unwitnessed by a facility staff member, on the exterior of the facility. R3, R4, R5, R12, R17 and R23 had a fall or falls unwitnessed by a facility staff member. R27 has a history of substance abuse and suspected alcohol usage. R27 was granted a community pass, and reported to have had 3 falls resulting in injuries, in which no facility interventions were put in place to prevent further falls or adequate supervision. Findings include: 1. On 9/07/2010 at 12:30pm, R5 reported he had	F9999		

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recent falls in the facility. R5 claimed he fell in the men's shower room while the floor was wet. R5 told the surveyor the floor in the shower room is wet all the time. R5 hurt his left leg and it swelled up and just recently went down to normal.

The incidents reports had three incidents involving R5 as follows:
-3/08/2010 at 5:45pm, resident observed on floor, in the room. Resident was ambulating at the time. R5 stated he attempted to turn off the light and lost his balance. R5 fell onto the floor on his buttock. Intervention taken: Body check/assessment done immediately-no injuries noted. MD (medical doctor) notified of incident-new orders received. Family notified. Safety re-eduction done.
-3/09/2010 at 7:20pm, resident observed on floor, in the room. Noted with hematoma to left side of head. Apparently lost balance and hit head in process. Intervention taken: body check/assessment done immediately, neuro check performed immediately and resident sent to emergency room(ER) for medical evaluation.
-3/12/2010 at 5:00am in the bathroom, Patient stated that he bumped his left leg into the metal demarcation (unknown object) in the residents' bathroom. Patient has two open areas on the left left and the area appear swollen. Intervention taken for prevention: First aid given. Railings checked by maintenance in Unit 1 bedroom. No rough edges noted. Safety teachings reinforced.

None of the facility's investigations for the above incidents address the cause of R5's fall and injury. The investigations did not go beyond the resident's statement to the staff. The care plan did not reflect any adjustment in the resident's monitoring or supervision. Also no care plan

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F9999	Continued From page 93 intervention were changed. On 9/09/2010 at 11:00am, the surveyor asked E2 (Director of Nursing) in the presence of E3 (Nurse Consultant), why type of safety education was given to R5 after the fall on 3/08 and 3/12/2010. E2 was unable to tell the surveyor. 2. On 9/07/2010 one of the surveyor approached R13 to inquire about a bandage attached to his head. R13 told the surveyor he fell while outside. According to R13's record, R13 had a history of left hip fracture, and seizure disorder The computerized incident report dated 9/01/2010, documented R13 had a fall incident at 9am on 9/01/2010, while outside. R13 was in a chair (wheelchair) at the time. R13 was noted to have a laceration to the left forehead, and transferred to the ER. The incident was not witnessed by any staff member. The hospital emergency room record stated R13 had a head injury. "The skull and/or brain were affected" The investigation conducted by the facility consist of R13`s statement at the time of the incident. According to one part of the investigation, the wheelchair was locked during the incident. R13 leaned and fell out the chair. Another part of the documented investigation documented R13 stated that he was in the wheelchair when the rubber part of the small wheel came completely off. Wheelchair leaned sideways and resident had fall.	F9999		

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F9999	Continued From page 94 On 9/09/2010 at 4:18pm, the surveyor met with R13 to discuss the incident. R13 told the surveyor he was being pushed by another resident, going across the street. While being pushed over pot holes and bumps one of the rubber wheels came off. The chair tilted, he leaned and fell to the ground. E12 was in R13's room at the time, R13 told the surveyor E12 replaced the wheel. E12 confirmed he replaced the wheel on R13's wheelchair. The surveyor reviewed R13's care plan dated 8/10/2010 which had added to the goal of resident will not sustain a fall-related injury the following interventions, 9/01/2010 resident will inform staff regarding any repairs needed to wheelchair. Encourage resident to allow staff to assist with cleaning and maintenance of wheelchair. Encourage resident to ask for assistance. None of these intervention address how R13's wheelchair became in disrepair, nor what regular maintenance including monitoring the staff will do to prevent it from happening again. 3. R17 is is a 51 year old resident with diagnoses including dizziness and orthostatic hypertension. Review of the Incident Accident log for 2010 shows R17 had 2 fall incidents. On 3/9/10 while ambulating in the dining room, R17 lost her balance and fell. R17 complained of pain to her left ankle. On 3/10/10 R17 was noted with bruising to the left ankle. R17 was sent to the hospital for evaluation and returned in the evening with a diagnosis of fracture of left fibula. R17 required a	F9999		

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F9999	Continued From page 95 leg cast. On 6/18/10 a 6:15am, R17 slipped in the shower. R17 complained of lower back pain. An Xray ordered for the lumbar spine was negative for fractures. On 9/13/10 E2 (director of nursing) stated, "she (R17) entered the shower area without supervision. The staff didn't know she was in the shower." The quarterly MDS (minimum data set) dated 8/17/10 shows R17 scored 2 in cognitive skills for daily decision making which indicates moderately impaired - decisions poor; cues/supervision required. In walking and personal hygiene/bathing, R17 scored 1/2 which indicates supervision/setup help only. On 9/14/10 at 2:10pm, R17 was interviewed in her room. Surveyor asked R17 had she had any falls within the last 6 months. R17 stated, "I fell in the dining room in March. I broke my ankle. I just slipped. I got the cast off April 27th. About 3 months ago, I felt dizzy and I slipped in the shower. No one was in there. I managed to get up and I told staff. I didn't bump my head but I did hurt my back. It was sore for a while." R17 was not noted wearing an orange wrist band during the time of this interview. 4. R27 is a 55 year old resident with a history of alcohol abuse and diagnosis of Schizophrenia. According to an incident report, on 1/05/2010 at 10:20pm, R27 returned to the facility from a community pass with a bloody face. He stated he	F9999		

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F9999	Continued From page 96 fell three times. R27 was noted with the smell of alcohol on his breath. R27 was sent out to the ER and returned after receiving 5 sutures above his left eyebrow. There was no investigation beyond the resident's statement. No confirmation on the use of alcohol. No intervention regarding inappropriate behavior while on pass. The intervention included counseling on alcohol abuse. The resident's care plan during the time period does not reflect the resident was in a rehabilitative program addressing alcohol abuse with mental illness. On 9/14/2010 at 4:15pm, the surveyor interviewed E9 (social service director) about the intervention taken post R27's 2/02/2010 incident. E9 stated R27 still has a community pass privileged. Now he is on a level two, where he can go out with a staff member or a family member. The surveyor asked about the program R27 was attending. R27 was not listed among the residents attending the outside MISA (mental illness substance abuse) program, offered by the facility. E9 told the surveyor R27 was evaluated last Thursday (9/09/20100 and would attend by tomorrow (9/15/2010). The facility's resident behavior management and outside pass program stated the inappropriate and unacceptable behaviors including but not limited to : using non-prescribed drugs or alcohol: will result in immediate pass suspension. 5. R23 has diagnosis of cerebral palsy and grand-mal seizures. R23 had the following fall incidents: -1/22/2010 at 4:34pm, computerized documented fall at 1:00pm, in the corridor. R23 was wearing slippers. However, the handwritten incident report	F9999		

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F9999	Continued From page 97 documented 1/22/2010 at 8:45am, the fall incident in the corridor. -1/22/2010 at 3:20pm, handwritten fell by nursing station. The intervention was increased supervision. No investigation to determine any one of the record falls. -1/29/2010 at 9:30am in the television room. Resident was observed laying on the floor on the right side. Intervention use of chair alarm when out of bed and pad alarm while in bed. -2/18/2010 at 3:45pm, unwitnessed fall by staff. However, another resident told staff resident started to get up and fell backward and hit his head. The incident took place in the dayroom. No investigation of the cause nor the factor surrounding the fall was noted. No change in the care plan interventions. No documentation of the use of the chair alarm going off to alert staff members of R23's movement. -8/12/2010 at 9:59pm, computerized documented a fall on 8/12/2010 at 6:30pm, in the hall. R23 sustained a bruise noted to the right side lower back. R23 observed getting up from a chair and ambulated pass the nursing station and fell. No change in the care plan interventions. No documentation of the use of the chair alarm and it going off to alert staff members of R23's movement and staff intervention at the time. The surveyor did not see any evidence of the interdisciplinary team reviewing this resident's care plan to determine how effective any of the previous interventions were to prevent R23 from falling a fifth time. R23's care plan had multiple dates from 4/06/2009, 7/03/09, 9/28/09. 12/09, 3/28 and 6/20/2010. The care plan was not reviewed at the time of R23's falls. According to the facility's policy for fall prevention	F9999		

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F9999	Continued From page 98 program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R23. 6. On 9/07/2010 between 10:00am and 2:40pm the surveyor observed R6 ambulating outside the facility's building in the park lot and sitting areas. On 8/07/2010 at 2:40pm, interviewed the resident in the lounge located in Unit 1. R6 had an orange wrist band on one of wrist. R6 told the surveyor he was in a shelter care facility prior to his admission to the facility three years ago. R6 told the surveyor he was hit by a car and woke up at the facility. On 9/08/2010 at 9:40am, 11:20am, and 3:35pm, R6 was observed ambulating outside the facility around the front of the building and parking lot area. R6 was not engaged in any activity with any resident and no staff was present in the area. On 9/09/2010 during an interview with E2 (Director of Nurses), the surveyor was told that the leaf on any resident's room door or head of bed, and the presensce of an orange wrist band, meant that resident was high risk for fall. This was initiated in July 2010. R6 had the following computerized incident report with accompanying investigation: -4/24/2010 10:14pm, Fall incident at 4:45pm, outside. Observed on ground by peer, who notified staff. - 5/07/2010 12:50pm, Fall incident date	F9999		

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F9999	Continued From page 99 4/24/2010 at 10:14pm. The resident was located outside the facility at the time. R6 reported he tripped. The surveyor could not determined if these two dates were two separated reported fall incident or the same one. On 9/09/2010 E2 confirmed the documentation above both refer to the incident on 4/24/2010 and it occurred at 4:45pm, but was charted at 10:14pm. The management follow up to incident had no investigation beyond the incident report. There is no interview of the witness, a peer. There was no investigation done to determine the cause and/or the factors that cause R6 go fall. The intervention was to monitor on unit and grounds. This intervention was not observed implemented on 9/07 and 9/08/2010, while R6 ambulated outside without visual supervision from staff. 7. R12 is a 53 year old resident admitted to the facility on 7/28/2010. R12 has diagnoses including but not limited to dementia and seizures disorder. R12 had a physician order initially dated 7/28/2010 for chair alarm when up in chair for safety. The surveyor did not note any discontinue orders for this chair alarm in place up to the current physician's order for September 2010. On 9/07/2010 at 4:35pm, R12 was positioned in a geriatric chair in the Unit 2 television viewing area. R12 was placed in the lowest reclining position of the chair. E19 (certified nurse aide), who was in the area at the time, told the surveyor R12 was in the chair like that because he tries to get up.	F9999		

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F9999	Continued From page 100 On 9/09/2010 at 10:46am, the surveyor observed R12 in the Unit 2's television viewing area, in the geriatric chair. R12 was making several attempts to sit up in the chair. R12 told the surveyor he wanted to sit up. On 9/09/2010 at 12:00pm, E20 (nurse aide), who was taking care of R12, was questioned about the use of a chair alarm. E20 stated she was not aware of the use of an alarm. E20 told the surveyor she had taken care of R12 before this day. R12 had the following documented fall incidents: -7/29/2010 at 10:27pm, unwitnessed in room, resident was found on the floor. Protective device in use: pad alarm secondary to risk for fall. The investigation consists of the resident's statement: He was getting out of bed to go to the bathroom. Interventions stated put in place: assessed for injury and pain. Redirected to use call light for assistance and not try to get out of bed by himself. Pad alarm in place. Orange band/leaf to identify risk for falls. -Computerize incident 8/17/2010 documented 7:41am, at 4:30am while making rounds, resident observed on floor. Resident in a sitting position. Resident stated he was trying to got to toilet without assistance. Interventions stated put in place: assessed for injury and pain. Redirected to use call light for assistance and not try to get out of bed by himself. Pad alarm in place. Orange band/leaf to identify risk for falls. Both investigations had the same information. No change in any interventions. Nothing about staff member being alerted to the pad alarm, if it was applied. Nothing about toileting the resident.	F9999		

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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
F9999	Continued From page 101 During the survey, the surveyor noted the use of incontinent pads/briefs in use for R12. The facility's policy for fall prevention program stated: Residents at risk of falling will be assisted with toileting needs in accordance with voiding patterns identified during the assessment process and as addressed on the plan of care. This was not implemented for R12. Care plan dated 8/02/2010 had problem with poor balance and goal to be free from a fall related injury and problem of history of seizure and goal of not experience any injury from seizure activity through 11/02/2010. No falls were noted as a problem in the the care plan. 8. R4 was observed on 09/7/10 at 11:30 am sitting in chair in the dining room. R4 was alert and answered simple questions. R4 is an 89 year old female with diagnosis Hypothyroidism, Alzheimer, Pacemaker, Insomnia Expressive Aphasia, Frontal Sinusitis, Orthostatic Hypertension, Cardio Syncope and Sinuitis. The Minimum Data Sets dated 04/20/10 and 06/18/10 denoted: Section B: (4). Cognitive Skill for Daily Decisions-Making was score 2 moderate impaired - decision poor, cues/supervision required. Section J (4). Accidents fells in past 30 days and fell in past 31 - 180 days. Fall incident and accident reports denoted: 04/07/10 at 5:00 pm Called by resident that patient (R4) fell. Pt was walking around. Resident fell in Television room on knee.	F9999		

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	145947	A. BUILDING _____ B. WING _____	09/21/2010

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F9999	Continued From page 102 04/20/10 at 9:50 am fell in dinning room. She was ambulating. Alert and disoriented normal for resident. Pupil response, pupils equal and reactive to light equal. Move all extremities. Blood pressure 198/132. Physician notified Z7 ordered received transfer to nearest emergency room. Resident noted with high blood pressure, lethargic, no apparent injury noted. 05/09/10 2:45 pm Resident observed on floor in dining room on unit 2. Resident unable to explain. No witness to fall. Re-educate on importance of waiting for assist from staff. 08/08/10 1:22 pm Fall observed on floor in television area. Resident was observed sitting on couch in television room. Resident was lying on side on floor. Resident fell and hit her head on the floor. Vital signs taken and transferred to emergency room. She will be going to Z1 hospital. Alert but confused. The fall risk assessment dated 04/20/10 at 1:30 pm denoted Resident is not at risk for falls. There was no assessment or reassessment for resident after each fall. The fall care plan intervention and approaches were not updated or revised to prevent resident from further falls. 9. R20 with a history of a stroke had the following fall incidents: -2/06/2010 at 7am, observed resident in sitting position in bathroom. Interventions instructed to wear shoes at all time. No investigation of why R20 fell and any how the fact of having no shoes, contributed to the fall. -computerized documentation 6/24/2010 at 8:30am, a fall in the bathroom. However, the	F9999		

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F9999	Continued From page 103 written investigation stated resident was found of floor, in the hallway. There was no investigation to determine why the resident fell and no change intervention. 10. R21 has a diagnosis of dementia with behavior disturbance and a history of seizure. R21 had the following fall incidents: -3/21/2010 at 4:39am computerize documented fall incident 3/21/2010 at 2:00am. R21 was walking without shoes on on the side walk of building. No investigation and no change in interventions. Post fall R21 instructed on safe use of assistive device. Safe transfer techniques. Use of call light . Resident exited back door and exit alarm sound. The report documented R21 was alert but confused. Cognitively impaired. Unable to interview. -3/22/2010 9:45pm, resident found in room on floor. The investigation did not go beyond the incident report. The intervention were Complete body assessment. Safety teaching reinforced. Mat at bedside. Bed in lowest position. Medication for agitation as needed Increase superversion when resident is anxious or agitated state. Medication review by DON (Director of Nurses). No conclusion to the investigation. No indication R21 had a behavior before the fall. -On 4/07/2010 at 10:43pm, computerized documented fall 4/07/2010 at 3:45pm in the resident's room. Resident found on flooring on her stomach. Intervention - reeducated to safety issues. Staff to initiated every 15 minute checks after R21's return to the facility. The reason for R21's fall was not investigated for proper care planning of interventions. -On 7/03/2010 at 2:51pm, computerized	F9999		

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F9999	Continued From page 104 documented fall 7/03/2010 at 1:00pm. Resident found on the floor, in room. Resident sent out to hospital. Resident was alert-disoriented. Resident was last seen propelling self throughout facility in her wheelchair. Intervention included the use of a pad alarm to wheelchair. The surveyor did not see any evidence of the interdisciplinary team reviewing this resident's care plan to determine how effective any of the previous intervention were to prevent R21 from falling a fourth time. The care plan was not reviewed at the time of R21's falls. The care plan reviews were at 3/21, 3/22, 4/07 and 6/10/2010. According to the facility's policy for fall prevention program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R21. 11. R22 has a diagnosis of a stroke and mental retardation with an unsteady gait. R22's minimum data set dated 2/14/2010 indicated R22 had a fall within the past 30 days. Incidents reports and fall investigations documented the following: -3/16/2010 at 6:40pm, unwitnessed fall in the dining area on the floor. Resident called for help. The investigation does not include any cause or possible factors contributing to R22's fall. -4/01/2010 at 9:12pm, computerized fall documented a fall on 4/01/2010 at 4:15pm while in the dining room. Resident found lying on left side. The investigation does not include any cause or possible factors contributing to R22's fall. R22's 3/06, 6/16/2010 care plan reviews had no change in interventions.	F9999		

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F9999	Continued From page 105 On 9/07/2010 at 10:15am, initial tour of the facility, the surveyor observed the dining area in questioned was located directly across the unit's nurse station. According to the facility's policy for fall prevention program: The care plan incorporates addressing each fall and interventions are changed with each fall, as appropriate. Immediate change in interventions that were unsuccessful. This was not implemented for R22. 12. On review of the facility's incident reports the surveyor noted the following concerning R24: -6/21/2010 at 9:55am, computerized documented fall on 6/21/2010 at 9:00am. Resident had a fall outside the facility. Resident sustained a brusing/skin tear. Resident stated she slipped when she was rising from chair. The resident reported the fall to the nurse. First aid was applied to right elbow and right knee. The intervention was that resident would let staff know her whereabouts. No investigation surrounding the fall. 13. On 9/07/2010 at 9:35am, the survey team entered the facility. While ambulating to the front entrance of the facility, the surveyor's shoe fell with in a crack of the sidewalk and the surveyor lost balance but did not fall. The surveyor observed residents from the facility's Unit 1 ambulating and wheeling themselves out the entrance onto the sidewalk and parking lot. The cracks in the sidewalk pavements, created a tripping hazard for residents. At 11:45am and 4:00pm, the surveyor observed unnamed residents (and R6) ambulating within	F9999		

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F9999	Continued From page 106 the facility's parking lot. This parking lot had a large pot hole with unlevel surfaces, creating a tripping hazard for residents. On 9/08/2010 between 10:05am and 11:15pm, the surveyor conducted an environmental tour of the facility, while accompanied by E12 (Maintenance Director) and E13 (Housekeeping Director). The surveyor noted the facility has four community bathing/shower areas available for all residents. The unit 2 men's shower room had a wet floor. E13 commented a resident just got out the shower, and the housekeeper would mop it up. The surveyor noted no non-slip surface in the shower stall, and the floor directly outside the shower curtain. There was no rug nor any other method for absorbing the excessive water from the shower. The unit 2 women's shower room had no non-slip surface in and directly outside the shower curtain. Each Unit 2 shower room had a shower stall that was leveled with the room's floor. However, the unit 1 women's and men's shower rooms had a tub/shower combination. The tub did not have a complete non slip surface inside the tub. The top of the tub was at least 1 1/2 feet above the floor level. This required residents to step into and out of the tub. The grab bar was attached to the left side of the tub, facing the faucet of the the tub. While testing the water temperatures in the Unit 1 men's shower/bath, the surveyor noted an excessive amount of water pooling over the floor outside the tub. This also, created a tripping hazard for the residents. (A)	F9999		

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F9999	Continued From page 107 300.4030a)1)2)3) 300.4030b) 300.4030c) 300.4030d)1)2)3)4) 300.4030e)1)2)3)4) 300.4030f) 300.4030g)1)2) 300.4030h) 300.4030l)1)5)6) 300.4030n) 300.4030o) 300.3040p) 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: 1) Known risk factors (e.g., wandering, safety issues, aggressive behavior, suicide,	F9999		

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F9999	Continued From page 108 self-mutilation, possible victimization by others); 2) Observable resident medical/psychiatric conditions that may require additional immediate assessment or consultation; 3) Therapeutic involvement that might be of interest to the resident, be recommended based on referral information, aid in orientation or provide meaningful data for further professional assessment; and b) An ITP shall be developed within seven days after completion of the comprehensive assessment. c) The plan for each resident shall state specific goals that are developed by the IDT. The resident's major needs shall be prioritized, and approaches or programs shall be developed with specific goals, to address the higher prioritized needs. If a lower priority need is not being addressed through a specific goal or program, a statement shall be made as to why it is not being addressed or how the need will be otherwise addressed. d) The ITP shall contain objectives to reach each of the individual's goals in the plan. Each objective shall: 1) Be developed by the IDT; 2) Be based on the results obtained from the assessment process; 3) Be stated in measurable terms and identify specific performance measures to assess; and 4) Be developed with a projected completion or review date (month, day, year). e) Services designed to implement the objectives in the resident's ITP shall specify: 1) Specific approaches or steps to meet the	F9999		

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F9999	Continued From page 109 objective; 2) Planned skills training, skill generalization technique, incentive/behavior therapy, or other interventions to accomplish the objectives, including the frequency (number of times per week, per day, etc.), quantity (in number of minutes, hours, etc.) and duration (period of time, i.e., over the next 6 months) and the support necessary for the resident to participate; 3) The evaluation criteria and time periods to be used in monitoring the expected results of the intervention; and 4) Identification of the staff responsible for implementing each specific intervention. f) Whenever possible, residents shall be offered some choice among rehabilitation interventions that will address specific ITP objectives using techniques suited to individual needs. g) ITP Documentation: 1) Significant events that are related to the resident's ITP, and assessments that contribute to an overall understanding of his/her ongoing level and quality of functioning, shall be documented. 2) The resident's response to the ITP and progress toward goals shall be documented in progress notes. h) The ITP shall be reviewed by the IDT quarterly and in response to significant changes in the resident's symptoms, behavior or functioning; sustained lack of progress; the resident's refusal to participate or cooperate with the treatment plan; the resident's potential readiness for discharge and actual planned discharge; or the resident's achievement of the goals in the treatment plan.	F9999		

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F9999	Continued From page 110 l) The ITP shall be based upon each resident's assessed functioning level, appropriate to age, and shall include structured group or individual psychiatric rehabilitation services interventions or skills training activities, as appropriate, in the following areas: 1) Self-maintenance; 5) Symptom management skills; and 6) Substance abuse management. n) Residents' attendance in therapeutic programs shall be recorded. o) The PRSC shall assess the reason for the failure to attend whenever a resident fails to attend at least 50 percent of any programs included in his or her ITP over a 30 day period. Within 14 days after noting this failure, the PRSC shall document why the resident's attendance was less than 50 percent and that the resident's attendance is, at the time of the documentation, more than 50 percent, or the PRSC shall conduct an IDT meeting. This IDT meeting shall result in a change in components of the resident's treatment plan or shall indicate why a change is not needed. p) The PRSC is responsible for coordinating staff in the delivery of psychiatric rehabilitation services programs, oversight of data collection, and the review of the resident's performance. 2) At least quarterly, the PRSC shall record the resident's response to treatment in the clinical record. These Regulations were not met as evidenced by:	F9999		

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F9999	Continued From page 111 Based on observation, interview and record review the facility failed to ensure residents with SMI (serious mental illness) receive mental health rehabilitative services, failed to coordinate services with an outside resource provider, and failed to adequately address the residents' refusal of specialized rehabilitative services. This applies to 4 of 16 residents inside the sample (R5, R6, R13, R14), and 1 supplementary resident (R27) who have a SMI (serious mental illness) diagnosis and a history of inappropriate behaviors. Findings include: 1. R14 is a 53 year old resident with diagnoses including bipolar disorder. R14 has documented history of explosive and aggressive verbal behavior toward staff and other residents. The social services notes and nurse's notes document the following: -1/6/10: R14 refuses to come to some structured activities because he says the noise level upsets him. When he does participate, he is very passive. The quarterly review indicates R14 at times is isolative, withdrawn , has difficulty in expressing himself, can be resistant to care by refusing to eat his meals, experiences low frustration tolerance and will become verbally abusive to staff and clients. -1/18/10: R14 was witnessed as having a physical altercation with another resident in a wheelchair. 14 was frustrated that he could not get the other resident to move out of his way and pushed his wheelchair into the other resident. As R14 was being redirected he became frustrated	F9999		

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F9999	Continued From page 112 and left. -4/7/10: E9 (social service) visited R14 to discuss recent escalation in anxiety regarding the condition of the bathroom on his wing or the way in which the bathroom tissue is hung on the roll. R14 has become verbally abusive towards staff stating, "you need a new position because you are ignorant." -4/16/20: (nurses note): was verbally aggressive, likes to degrade other residents. -5/10/10: (Client) R14 approached about his failure to attend skills training groups. R14 states, this he has no desire to interact with certain peers in the group. -6/9/10: Client (R14) approached multiple times about scheduled group meetings, continues to refuse treatment due to lack of motivation. Client verbally stated that group meetings are a waste of his time and he chooses not to interact with certain peers. Client has shown no progress toward care plan objective. -7/13/10: Client has improved socially since last evaluation. He makes anxious complaints regarding others at times due to his inability to cope in new situations. He has continually refused to attend skills training classes. -7/23/10 (nurse's note): resident has been refusing to take his Lithium, states he does not need it. Lab called, Lithium level critical low. MD (medical doctor) paged. This information was endorsed to the next shift. However there is no documentation to show if the MD answered the page or how this concern was addressed.	F9999		

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F9999	Continued From page 113 -8/11/10: Behavior: Client states that he is having difficulties with other residents. He states they are speaking to him in a "negative way, i.e.. cursing at him" or that another resident has rammed his wheelchair when in fact the incident was an accident. -8/16/10: (nurse's note) Writer was rendering medical services to another male resident when when resident (R14) came to nursing station demanding that I make the other resident leave so that he could receive something for pain. Writer then explained to him that once I was done, I would take care of him. Resident (R14) then became upset and angry and said he called 911 and told them he was being threatened. Writer asked why he called the police, R14 stated, "I wanted him away from the desk so I could get some medication." R14 was redirected to his room. -9/2/10: Client has made several complaints towards a peer. He has began to antagonize his peer and then makes comments to the staff the "he is threatening me." The client is experiencing increased agitation in the last few days. 1:27pm: Writer, administrator, fellow peer and client meet today to discuss an ongoing conflict between them. The client stated, "his very presence irritates me" within the meeting and began to call his peer a "cotton picker" and stated, "I want to provoke him in order for him to hit me and he will be sent out." His doctor will be contacted. On 9/2/10, R14 was sent out to the hospital for a psychological evaluation.	F9999		

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F9999	Continued From page 114 R14 has constantly informed staff that he does not want to participate in group skills training. It has been identified that R14 does not like or do well in a group setting. The facility has not shown evidence of a documented plan for development of a behavior modification program or what was done to decrease incidents of inappropriate behavior by R14 or how R14 will be encouraged and rewarded for consistently participating in 1:1 programing. 2. R27 is a 55 year old resident with a history of alcohol abuse and diagnosis of Schizophrenia. According to an incident report, on 1/05/2010 at 10:20pm, R27 returned to the facility from a community pass with a bloody face. He stated he fell three times. R27 was noted with the smell of alcohol on his breath. R27 was sent out to the ER (emergency room) and returned after receiving 5 sutures above his left eyebrow. There was no investigation beyond the resident's statement, no confirmation on the use of alcohol, and no intervention regarding inappropriate behavior while on pass. The intervention included counseled on alcohol abuse. The resident's care plan during the time period does not reflect the resident was in a rehabilitative program addressing alcohol abuse with mental illness. On 9/14/2010 at 4:15pm, the surveyor interviewed E9 (Social Service Director) about the intervention taken post R27's 2/02/2010 incident. E9 stated R27 still has a community pass privilege. Now he is on a level two, where he can go out with a staff member or a family member. The surveyor asked about the program R27 was attending. R27 was not listed among the residents attending the outside MISA (mental illness substance abuse) program offered by the	F9999		

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	145947	A. BUILDING _____ B. WING _____	09/21/2010

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F9999	Continued From page 115 facility. E9 told the surveyor R27 was evaluated last Thursday (9/09/2010) and would attend by tomorrow (9/15/2010). 3. R13 is a 55 year old resident with a diagnosis of psychosis due to substance abuse and mental illness. On 9/09/2010 at 4:18pm, R13 confirmed he attends any day program. According to the facility's list of residents attending a substance abuse program for the mental illness, R13 is not listed. On 9/09/2010 at 11:10am E9 (Social Service Director) reported E9 communicates with R13's day program via phone or fax about the day to day issues. The surveyor asked about the specific identified problems the day program was currently working with R13 to achieve. E9 began reading various not measurable goals for the resident. The surveyor asked what programs or interventions the facility is doing to help R13 meet the goals. E9 initially stated R13 was attending a skills training program, but later stated he was not, because he had a head trauma. In addition, E9 stated R13 had graduated from the MISA group provided by the outside provider, and was no longer attending the program. The surveyor asked how does the facility monitor R13 for possible relapse. E9 stated, if substance abusive behavior is suspected, then a urine/blood screening is done. R13's comprehensive care plan dated 6/28/2010 had an identified problem with substance abuse. The goal for this problem is the resident will comply with intake procedures for a substance abuse treatment program and increased group attendance . The resident's attendance at the day	F9999		

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F9999	Continued From page 116 program/behavior center was added on 9/09/2010 after the surveyor's concerns were identified. 4. R6 is a 54 years old resident. R6 has a diagnosis of schizoaffective disorder, depression and alcohol dependence. On 9/07/2010 between 2:40pm and 3:30pm the surveyor observed R6 ambulating from outside the building throughout Unit 1. R6 was listed to attended the facility in-house psychosocial skill program. On 9/07/2020 at 2:40pm, the surveyor interviewed R6. R6 stated he desired to leave the facility and go to a shelter care facility. R6 told the surveyor he is not attending any type of group activities. When the surveyor asked about the attendance to the MISA (mental ill substance abuse) group, R6 stated he was not going to stop drinking (alcohol). As a response to the surveyor observations of R6 not attended listed psychosocial groups, the facility presented the following: -social service documentation dated 7/06/2010 of R6's refusal of complying with mental health rehabilitative program. -statements of resident's right to refuse skill training dated: 8/03, 8/10, and 8/20 /2010: signed by R6. However, R6's comprehensive care plan did not address these refusals. In addition, E9(Social Service Director) did not present any evidence this resident was referred to the psychiatrist or psychologist for further interventions. 5. R5 is a 74 year old paroled resident, admitted to the facility on 11/25/2009. R5 has a diagnosis	F9999		

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F9999	Continued From page 117 of depression and has an order for Lorazepam 0.5mg (milligram) every 4 hours as needed for agitation. On 9/07 and 9/08/2010 during the morning and afternoon hours, the surveyor noted R5 in the room without staff or resident interactions. The surveyor on 9/07/2010 at 12:30pm noted R5 eating in the room alone without any stimulant to the environment, for example the use of a radio or television playing. R5 stated he prefers not to attend group activities, prefers TV watching in room. R5 commented what could a 74 years old male do. When surveyor asked about regular meetings with facility's staff, resident stated 2 weeks ago he met with E9, but nothing on a regular basis. R5 expressed his desire to live in a less restricted environmental since he believes he could be more independent. On 9/09/2010 at 4:38pm, the surveyor was presented with information from E1 (Administrator) related to questions and concerns not answered by E9 earlier. The documents received included: -A comprehensive care plan dated 12/01/2010 noting R5's isolative behavior and refusal with the goal of resident to meet with social service as tolerated. - Social service progress note dated 9/09/2010 discussing the resident's desire for discharge to another facility. -1 statement dated 7/13/2010 regarding R5's right to refuse skills training. The evidenced presented does not demonstrate the facility investigating R5's refusal for services and any adjusting or changing interventions to address R5's refusal. E9 (Social Service Director)	F9999		

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F9999	Continued From page 118 did not present any evidence this resident was referred to the psychiatrist or psychologist for further interventions. (B) Section 300.625 Identified Offenders f) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall immediately fax the resident's name and criminal history information to the Department. (Section 2-201.5(c) of the Act) g) If identified offenders are residents of a facility, the facility shall comply with all of the following requirements: 4) If the identified offender is on probation, parole, or mandatory supervised release, the facility shall contact the resident's probation or parole officer, acknowledge the terms of release, update contact information with the probation or parole office, and maintain updated contact information in the resident's record. The record must also include the resident's criminal history record. j) For current residents who are identified offenders, the facility shall review the security measures listed in the Criminal History Analysis Report provided by the Department. l) The facility shall incorporate the Criminal History Analysis Report into the identified offender's care plan. (Section 2-201.6(f) of the Act)	F9999		

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F9999	Continued From page 119 These Regulations were not met as evidenced by: Based on record review and interview, the facility failed to contact the Department regarding the admission of 3 of 3 residents (R5, R28, R34) who are identified offenders, and failed to obtain a harm risk assessment for each resident. In addition, the facility failed to maintain updated contact information for the parole officer for 1 of 16 sampled residents (R5). Findings include: 1. R5 was admitted to the facility on 11/25/2009. R5 is a 74 year old resident on parole for a felony offense. On 9/15/2010 at 2:45pm, the surveyor interviewed Z9 (parole officer) regarding R5's parole. Z9 told the surveyor he became R5's parole officer as July 29,2010. The previous parole officer (Z10) is on medical leave. Z9 stated R5 is allowed to leave the facility and must not be involved in any crime as a condition of his parole. R5's medical record does not have updated information regarding his parole officer (with direct number for contact) and his department of correction identification number. 2. The facility present the survey team with 3 residents who were identified with a felony criminal offense through a criminal background check. R5, R28, and R34 had no evidence that the state agency department for offenders, was informed of each resident's admission. The state agency's risk assessments were not completed	F9999		