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F 323	Continued From page 15 activity. This will be audit by ADM &DON will monitor along with the IDT to ensure a Care plan is established for said behaviors. What approaches will work based on dementia care best practices as identified by the Alzheimer association. 6) A weekly QA meetings to evaluate the behavioral track and trending,the outcomes of all care plans and the continued review of education, policy&procedure for addition improvement and the preventing of further occurrence the follow will be apart of this QA Medical Director & Our NEW Psychiatric Medical Director,Administrator DON , LCSW. IDT, Charge Nurse. This will be done for the next 6 months .	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	F9999		

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F9999	Continued From page 16 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall 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 resident care plan. 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. d) Pursuant to subsection (a), 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 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 300.3240 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	F9999		

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by:

Based on interview and record review the facility failed to ensure the supervision and safety of 1 resident (R1). R1 is identified with advanced dementia, aggressive disorder, history of verbal outburst, wandering, and impaired cognition. The facility also failed to develop a plan of care to ensure supervision and monitoring of 1 of 3 residents (R2). R2 is identified with dementia, and a noted history of aggressive behavior. These failures resulted in a physical altercation between R1 and R2 on 2/12/2012. R1 required emergency hospitalization, and was admitted to the hospital with a cerebral hemorrhage, right sided ventricular hemorrhage, and fracture of the right maxillary antrum and right orbital. R1 expired on 2/14/2012 from these injuries.

Findings include:

The facility's initial resident abuse report form dated 2/12/12 9:00pm indicates that R1 and R2 were walking in the hallway when the nurse heard yelling in the hallway. The report indicates that the nurse responded to the yelling, and found R1 on the floor with R2 standing next to him. R1 was noted with injuries to the right eye, and right forearm.

The facility's final investigation report indicates that on 2/12/12 at approximately 9:30pm the nurse heard a yell and a sound coming from the hallway. The report indicates that R1 was observed on the floor in the hallway, and that R2 was standing next to R1 in the hallway. The report indicates that R1 was assessed with an abrasion with bleeding over the eye. The report

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indicates that there were no eyewitnesses to the incident. The report also indicates that neither R1 nor R2 had any prior issues with physical aggression/violence toward each other.

On 2/15/11 at 1:00pm E1 (administrator/Abuse coordinator) said that she was notified by phone on Sunday 2/12/2012 around 9:10pm that R1 and R2 were involved in an incident. E1 said that she was told that there were no eyewitnesses to the incident, and that R1 was found on the floor with a laceration. E1 said that she was familiar with both residents and that she was unaware of either R1 or R2 having a history of aggressive behavior. E1 said that she was told that R2 was observed just standing near R1, with no weapon or nothing in his hands. E1 said that both R1 and R2 were oriented to name only. E1 said that R1 was found on the floor facility staff. E1 said there was no indication that R1 was struck by R2.

According to the clinical record R2 was admitted to the facility with a diagnosis with Dementia/Alzheimer. According to R2's clinical record dated 4/21/2011, R2 was involved in another altercation with another co-resident (R8). According to the social service notes dated 4/21/2011 6:03pm, R2 was noted being pushed by R8 in the dining room, and that R2 in turn pushed R8 onto the floor. The note also indicates that R2's plan of care will be updated. According to R2's current comprehensive plan of care there are no interventions/approaches noted addressing R2's altercation and act of physical aggression toward R8. According to the clinical record there was no aggression risk assessment done or presented to survey team on 2/17/2012 when the incident was brought the facility's

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attention.

On 2/16/2012, E2 (Director of Nursing) said that she is familiar with both R1 and R2. E2 said that R1 has displayed behaviors of constant wandering, verbal outburst, and signs of forgetfulness. E2 said that she does not know if R1 was able to protect himself from others knowing his history of verbal outburst, and aggressive disorder. Staffing for 2/12/2012 at the time of the incident was discussed with E2, and E2 said normal staffing for the 3rd floor pavilion was (1) nurse, and (2) certified nurse aides. E2 said that one of the two cna's should have been in the dining room monitoring residents in that location, and the other cna should have been monitoring residents that are known to wander throughout the nursing unit. E2 identified both R1 and R2 with behaviors of wandering the nursing unit. E2 said that the cna not in the dining room usually sits in a chair near the doorway of the dining room to monitor and supervise residents wandering the unit. E2 was told that E4 (nurse) was sitting at the nurse station, and that E5 (certified nurse aide) was inside the dining room monitoring residents. E2 said that E6 (certified nurse aide) should have been seated near the dining room supervising/monitoring residents wandering the hallways. E2 said that she was aware of R1's behavior of verbal outburst, and wandering. E2 said "that is why we have cna seated in the hallway to monitor."

On 2/16/2012 at 9:45am E4 (nurse) said that she was working the 3rd floor pavilion on the 3:00pm to 11:30pm shift on 2/12/2012. E4 said prior to the incident between R1 and R2, there were no unusual occurrences. E4 said around 8:40pm R1

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was up wandering the nursing unit, and that R2 was standing between rooms 354 and 355. E4 indicated that she was seated at the nurse station, and that she heard R2 raise his voice. E4 said that she could not tell what R2 said, however E4 said that she got up to go and investigate R2's yelling, and said that she heard a loud noise. E4 said that as she rounded the corner R1 was lying on the floor on his right side and blood was on the floor. E4 said that she immediately called 911, and for all nurses to come to the third floor stat. E4 said she was quickly assisted by the other nurses and assessed R1 with a laceration over the right eye with moderate amount of bleeding. E4 said that R1's right eye was swollen. E4 said she and the other nurses applied first aide. E4 said that R2 was standing there but wandered off into another room. E4 said that E11 (social service), also came to the 3rd floor pavilion and took R2 to his own room and provide 1:1 supervision. E4 said that R1 initially was un-responsive. E4 said that when she asked R2 what happened R2 said that he did not know. E4 said that R1 was noted for having behaviors of wandering around the nursing unit, E4 also said that R1 would have verbal outbursts of cursing at other residents/staff when walking by. E4 said that she was unaware of R1 or R2 ever being involved in any other physical altercations. E4 said there were three staff members working the nursing unit on 2/12/12 (E4, E5 and E6). E4 said around the time of the incident there should have been one certified nurse aide in the dining room monitoring residents as they watched television, and another certified nurse aide sitting near the doorway of the dining room to monitor and supervise residents wandering the hallways. E4 said the certified nurse aides are responsible for

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monitoring all residents regardless of their assignments. E4 said that E5 was stationed inside of the dining room, and E6 was assigned to sit in the hallway to monitor residents wandering around the nursing units. E4 said she did not recall seeing E6 sitting in the hallway the evening of 2/12/2012. E4 said that E6 should have been sitting in a position to see the entire hallway and able to see the section of hallway where R1 and R2 were involved in the altercation on 2//12/2012.

On 2/22/2012 at 4:00pm via telephone E4 said that she was unaware of R2 being involved in other altercation, however E4 said that she has heard things regarding R2. E4 said that she was unaware of any unusual behaviors displayed by R2. E4 said that behaviors and interventions are located and reviewed on residents' plan of care. E4 said that if a behavior is not noted on the plan of care she would not be aware of it. E4 said that there was no supervision or monitoring in place for R1 or R2. E4 said that after finding R1 on the floor she yelled for help and paged all nurses to the third floor pavilion stat. E4 said that the (3) nurses from the 1st and 2nd floor arrived to the 3rd floor at the same time E5 and E6 arrived, both of which were working on the 3rd floor pavilion.

On 2/16/2012 at 3:30pm, E5 (certified nurse aide), said that on 2/12/2012 between 8:00pm and 9:00pm, she was assigned to the dining room to monitor residents that were in there. E5 said there were about 3 residents in the dining room. E5 said that she heard E4 call for help and she went into the hallway and observed R1 lying on the floor not moving, unconscious with blood coming from his head. E5 said that R2 was in the

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hallway pacing back and forth next to R1. E5 said that there was nothing noted in R2's hand, and no blood noted on R2's hand. E5 said that both R1 and R2 has a history of wandering the nursing unit. E5 said that she has witnessed R2 getting agitated but not aggressive. E5 said that E6 was sitting in a chair in the doorway of the dining room facing inside the dining room. E5 said that E6 should be facing the hallway to monitor residents known for wandering the nursing unit. E5 said that R1 has a history of wandering the nursing unit, and verbal outburst (cursing at staff/residents). E5 said that she could not recall R1 and R2 being involved in any other physical altercations. E5 said she was not aware of any supervision or monitoring in place for R and R2. E5 said that she was told by E4 that R2 hit R1 in the face.

On 2/15/2012 at 2:30pm, E6 said that she was working on the 3rd floor pavilion. E6 said around 7:00pm to 8:00pm said she was seated near the dining room and was monitoring residents inside the dining room and monitoring the hallways. E6 said that she was facing the dining room at the time of the incident between R1 and R2. E6 also said that she was not assigned to R1 and R2, and said that she was monitoring her assigned residents. E6 said that she heard E4 hollering her name, E6 said that she got up and saw R1 lying on the floor face down. E6 said that she observed blood on the floor "lots of Blood" coming from R1's head. E6 said that she did not hear or see anything prior to E4 calling her name. E6 showed the surveyor exactly where she was seated at the time of the incident. The seat was in direct line and direct view of the incident. However E6 denied seeing R1 and R2, or hearing

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F9999	Continued From page 23 a verbal or physical altercation between R1 and R2 prior to E4 calling her name. On 2/17/2012 at 3:25pm E7 (Nurse) said that she has never witnessed R2 display any behavior of aggression, however E7 said that she has heard that R2 could be aggressive. E7 said that R1 has a history of wandering the nursing unit, and could be touchy feeling. E7 said that R1's touching could at times be inappropriate. E7 said that E4 said that she heard R2 hit R1 and then got up and found R1 lying on the floor bleeding. E7 said that normal staffing for the 3rd floor pavilion is (1) nurse and (2) cna's. E7 said that (1) cna is assigned to be in the dining room and the other cna is assigned to sit and monitor wandering residents in the hallway. E7 said that R2 was escorted off the nursing unit by E11 after the incident. E7 said that she asked R2 what happened and said that R2 was very emotional and looked as if he wanted to cry. E7 said that R2 was displaying a remorseful disposition. E7 said this was side of R2 that she never witnessed before. On 2/17/12 at 2:30pm E11 (Social Service) said that he heard a page from E4 to come to the 3rd floor pavilion stat. E11 said that when he arrived to the 3rd floor, R1 was on the floor being attended to by nursing staff. E11 said that R2 was standing in the hallway gesturing his shoulders upward motion. E11 said that he redirected R2 to a room and asked R2 what happened, and said that R2 said that we (R1/R2) had some issues over some water bottles. E11 said that he was told by the local police department that R1 was punched in the face by R2. E11 said that he petitioned R2 out for a	F9999		

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psychiatric evaluation. E11 said that he completed the petition to discharge R2 involuntarily due to his aggression on R1.

According to the social service progress note dated 2/12/2012 10:10pm E11 indicated that R2 was assessed to be alert and oriented to name only, and could not recall any reason for him being upset. The note indicates that R2 said "we had a skirmish." The note indicates that R2 was disoriented. The note also indicates that do to the physical nature of the incident R2 will be sent to the hospital for evaluation.

The petition for involuntary admission was completed by E11 and signed by E4, E6, and E11. The petition indicates that both R1 and R2 were walking down the hall, and R2 punched R1 in the face. The petition denotes that this aggression was unprovoked and due to R2's diagnosis and confusion at times R2 provides a safety risk to himself and others.

On 2/22/12 via telephone at 10:45am E18 (nurse) said that it is normal staffing on the 3rd floor pavilion (1) nurse and (2) certified nurse aides, and at times an activity aide. However E18 said that (1) cna should monitor the dining room, while the other cna sits in a chair near the dining room and monitors the hallway for wandering residents along with the nurse which should also be monitoring the hallway for wandering residents. E18 said the cna seated near the dining room should be able to view the length of hallway. E18 also said that R1 has a history of wandering and verbal outburst toward co-peers/staff.

On 2/17/12 at 3:00pm E8 (Social Service

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Director), said that R2 had no known history of abnormal behaviors, and that R1 had a history of wandering and talking to people. E8 said that he was not aware of any physical altercations involving R2. However E8 said that he recalls R1 brushing up against someone a few weeks ago. E8 said that brushing up against someone is not a physical altercation. However E8 said that when residents are involved in a physical altercation the resident plan of care is reviewed and new interventions/approaches are implemented.

Both current plans and progress notes for R1 and R2 were reviewed with E8. R2's social service progress notes were reviewed with E8 dated 1/14/2011 and denote that R2 was observed displaying inappropriate behavior toward another resident, R2 is noted was following another residents around, and laying down next to resident. R2 was also noted as trying to enter another resident room. The note indicates that R2's care plan will updated. Social service note dated 4/21/2011 indicates that R2 was pushed by R8, and in turn R2 pushed R8 onto the floor. Again the note indicates that R2's plan of care will be updated. According to R2's current plan of care R2 has no plan to monitor/supervise R2's behavior of wandering into other residents' rooms, no plan to monitor/supervise R2's inappropriate behavior with other residents, and no plan monitor/supervise R2's history of aggression toward other residents until after R2's incident dated 2/12/12 with R1. According to R1's current plan of care problem dated 12/11/2011 indicated R1 was involved in a physical altercation, in which R1 slapped another resident in the chest area, according to the plan of care there were no approaches to monitor/supervise

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R1 for acts of aggression, there were no approaches/interventions for staff to monitor/supervise R1 for behavior of wandering the nursing unit. The current plan of care failed to indicate a plan to monitor/supervise R1 for verbal outburst to include cursing at co-peers.

On 2/28/2012 at 8:45am, E1 (Administrator) said that the facility did not have a policy or plan to address coping with physically aggressive behavior.

On 2/22/12 via telephone Z3 said that he was notified by a male member from facility staff that R1 was involved in an incident on 2/12/2012 and that R1 sustained a cut over his right eye . Z3 was unable to recall the name. Z3 said 20 minutes later the same male staff member called him back and said that R1 was severely injured and needed to go to the hospital for evaluation. Z1 said that on 2/13/12 1:00am he was notified by the hospital of the proposed treatment plan, and then at 3:30am the hospital informed Z3 of R1's condition indicating that R1 was brain dead. Z3 said that R1 subsequently expired 2/14/2012 related to the sustained injuries. Z3 also said that he was told by local police that the incident was between R1 and R2 was ruled a homicide due to the nature of the injury was not due to a fall, but was due to a blow to the head.

According to the hospital record history of present illness R1 was an 80 year old male with diagnosis of dementia (has gotten worse in last 2 years). R1 was sent to the hospital for evaluation status post battery by another resident. R1's CT scan impression 1). Indicated right parietal and right frontal parenchymal hematoma with smaller

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F9999	Continued From page 27 contusions in the left frontal region. Diffuse subarachnoid hemorrhage and large intraventricular hemorrhage also noted. 2). Effacement of sulci, especially on the right, about 12mm midline shift to the let, subfalcine and pending right to left uncal herniation, entrapment of the left temporal horn with enlarged left lateral ventricle, and about 6 mm inferior displacement of cerebellar tonsils through the foramen magnum. 3). Right maxillary sinus anterior and posterior wall comminuted fractures as as the right orbital floor fracture. Protosis on the right with right hemifacial soft tissue swelling/hematoma. 4). External drainage catheter in the right middle cranial fossa. (A)	F9999		