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F 441	Continued From page 49	F 441		
F9999	. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1220b)3) 300.3240a) 300.3240f) Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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	F9999		

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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. (A, B) (Section 2-107 of the Act)

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to protect residents from sexual abuse for three of four residents (R13, R27 and R28) reviewed for sexual abuse allegations in the sample of 15. This failure resulted in R11 inappropriately touching R13's, R27's and R28's breasts.

Findings include:

R11's Physician's Order Sheet (POS) dated November 2012 documented he had the following

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partial diagnoses: Psychosis/Agitation, Schizo-Affective, Bipolar Type 2, Dementia with Alzheimer's , Depression and Behavior Disorder.

R11's Nurse's Note dated 2/24/12 at 9:30 AM documented "Res having inappropriate behaviors. Res ambulated c (with) assist of w/c (wheelchair) up to this nurse c (with) back to res. Res then took his fingers and touched nurse's buttocks. When nurse turned around he grabbed the nurse's hand when she attempted to stop him. Nurse informed res that behavior is inappropriate . Res then looked @ nurse c (with) aggression et (and) said 'I know it is.' Nurse then informed SSD (Social Service Director) . (Z2, Psychiatrist) to see res this am et (and) will inform MD of increase in aggressive et (and) sexual behavior. Haloperidol 2 mg give et seem to (not) be effective."

On 2/24/12, Z2, Psychiatrist, saw R11 and documented the following progress note: "Reviewed note - Nurse did verbal warning but documentation not enough to support use of Haloperidol - Discussed with (E12, SSD) - chart- flow of events, how it happened including verbal redirection and behavior modification. Will (decrease) dose of PRN (as needed) Haldol. Will adjust meds to address sexually inappropriate behavior. If it fails will consider psychiatric hospitalization. Meds reviewed. Education."

R11's Behavior Monitoring Record dated February 2012 documented his targeted behaviors as "Sexually Inappropriate Behavior - Attempts to grab/grope at staff. Disrobes in public." The Behavior Monitoring Record documented the following interventions to

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F9999	Continued From page 52 address this behavior: I) Use Name to Capture Attention J) Redirect to Activity of Interest or Social Service K) Explain that it is not appropriate behavior L) Approach at later time and give time of return. In addition, the Behavior Monitoring Record documented another targeted behavior as "Verbally Aggressive - Sexually Inappropriate Comments 'Play with me, I wanna f--k you, or suck my penis.' " The Behavior Monitoring Record documented the following interventions to address this targeted behavior: "I) Explain that he should not talk to others that way. K) Remove from point of anger/interest. L) Redirect to Activities of Social Services. M) Use name to capture attention." Both Behavior Monitoring Records documented he grabbed at another resident and made sexual comments towards a resident. This incident was not documented in his nurse's notes. The Behavior tracking documented throughout the month of February 2012 that R11 made many sexually inappropriate comments, pulled out his penis and showed his penis to staff and residents and groped and grabbed staff while doing care. R11's Nurse's Note dated 3/14/12 documented "5:30 PM Resident in the dining room, came behind another female resident placed his hands on her shoulders. Redirected resident. Haldol 0.5 mg give po for aggression. Staff closely monitoring every 15 minutes." R11's Nurse's note at 6:30 PM (one hour after the initial incident) documented "Resident found in a resident's (R28) (female room) had his hands on her breast. Staff redirected him. Placed him by nurse's station." R11 was sent to the hospital and admitted for sexual aggression. On 3/26/12, upon return from the hospital, R11's Care Plan	F9999		

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F9999	Continued From page 53 and Behavior Tracking Monitoring Records were not revised to implement new non-pharmaceutical interventions to address his sexually inappropriate behaviors. R28 could not be interviewed regarding this incident due to her cognitive impairment R11's Behavior Monitoring Record dated April 2012 documented he had five episodes of pulling out his penis in public and 12 episodes of sexually inappropriate comments towards staff such as asking staff if "they want to touch it?", and "want to s--k it?" Although R11 continued to have these sexually inappropriate behaviors, R11's Care Plan and Behavior Monitoring Record was not revised with new non-pharmaceutical interventions to address his sexually inappropriate behaviors. R11's Behavior Monitoring Record dated May 2012 documented he had an episode of sexually inappropriate behavior in another resident room on 5/21/12. There was no documentation in R11's nurse's note regarding this incident. There was no investigation regarding this incident. R11's Social Service Progress Review, dated 5/31/12 documented "(R11) wanders around the facility and sometimes into to other residents rooms but can be redirected easily. He can become easily distracted at times as well." The Progress Review documented "(R11) has shown some problems with inappropriate behavior and making sexually inappropriate comments. He sometimes attempts to grab or grope at staff during care. He can usually be easily directed. He does wander around the facility most times. Behavior tracking in place and (Z2) monitors his	F9999		

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F9999	Continued From page 54 medications." This Review did not document R11's history of being sexually aggressive towards other residents. R11's Care Plan, revised on 6/1/12 documented "I am restless, I have socially inappropriate behaviors . I am on an antipsychotic. My goal is to have agitation and depression controlled on the lowest dose possible with ASE (any side effects). 1.) The Social Service Director will complete a social assessment upon admission, quarterly, and prn, implement appropriate interventions, and update care plan accordingly. 2) Advance directives: I am a DNR. 3) 1:1 as needed." Although multiple interventions regarding medications adjustments had been discontinued on the care plan, it did not address any non-pharmaceutical behavioral interventions to address R11's sexually inappropriate behaviors. R11's Minimum Data Set (MDS), dated 8/14/12 documented he wanders daily which significantly intrudes on the privacy or activities of others and has behavioral symptoms not directed towards others. R11's Care Plan was revised on 8/14/12 and documented "Resident has behaviors that others may find disruptive/socially inappropriate. Others may seek reprisal against this Resident. Behavior exhibited-inappropriate sexual statements and inappropriate sexual touching." Interventions to address these behaviors were "Determine if behavior is stimulated by certain activities, noise levels, persons involved, time of day. Intervene as needed as soon as behavior is noted to ensure safety of residents and others. Gain attention of Resident by using name. Talk	F9999		

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F9999	Continued From page 55 with resident in calm manner. Redirect to area where others will not be distracted. Staff to move between Resident and any dangers. Take to quiet location and divert from distracting stimuli. Discuss behavior with resident; watch for behavioral clues to understand. Help resident to understand why behavior is socially inappropriate/disruptive." The Behavior care plan documented "Resident has inappropriate behavior, such as resisting care and making sexual approaches and statements to staff and other residents.: Interventions to address these behaviors documented "Initiate Behavior Monitoring program to attempt to identify patterns, precursors, and causes of behavior and to attempt to understand the meaning of the behavior. Introduce self upon contact, make eye contact, approach from front, explain all procedures prior to beginning, seek resident input/reassurance with all cares. During periods of inappropriate behavior, use a consistent, calm, firm approach. use resident's name to help divert inappropriate behavior. Provide reality orientation as tolerated. Reviewed abnormal behaviors with IDT. Establish and maintain trust. Encourage family input as needed to assist win identifying issues of concerns." R11's Nurse's Note dated 9/27/12 documented "Res allegedly touched a resident (R27) in a sexually inappropriate manner around her breasts. Res approached et questioned r/t (related to) allegation. Res did not answer @ (at) first questioning. After repeating question, res states 'Hey baby. I want to f--k you.' 1:1 done speaking that behavior is inappropriate, resident smiled. Res placed in room et toileted. DON Made aware." This incident occurred in the dining	F9999		

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room. R11 was sent to the hospital and admitted to hospital for aggressive behaviors. R27 could not be interviewed regarding this incident due to her cognitive impairment.

R11's Hospital History and Physical dated 9/28/12 documented "76-year-old male admitted to the Behavioral Health Unit yesterday in transfer from (facility). He is transferred for sexually inappropriate behaviors. This is his third or fourth hospitalization in this unit for the same problems. Most recent hospitalization was March 2012. He has been touching other female residents on the breasts and other sexually inappropriate statements to them and to the staff."

R11 was readmitted to the facility on 10/2/12. The facility did not revise R11's Care Plan or Behavior Monitoring Record with new interventions to address his sexual aggression.

R11's Nurse's Note dated 11/6/12 at 4:30 "It was reported to this nurse that Res had been sexually aggressive toward a female res. (R13) Touching her breasts - genitals etc. Call out to (Z2, Psychiatrist)." R11 was transferred to the hospital.

On 11/15/12, at 9:25 AM, an interview was conducted with R13. She did not recall this incident.

On 11/16/12 at 1:25 PM an interview was conducted with E12, SSD. E12 stated R11 had a history of making sexually inappropriate comments to staff, "pulling out his friend in the hallway and dining room." E12 stated R11 had dementia. He stated R11's sexual inappropriate

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behaviors were always directed towards females although there was no particular female he would target. E12 stated R11's wandered the hallways and sometimes into other residents rooms. E12 stated this wandering behavior was daily. E12 stated if R11 was sexually inappropriate staff would remove him form the situation, redirect, attempt to reorientate, and send him to the hospital if necessary. E12 stated R11 had medication changes which would improve his behaviors, but then R11 would get use to the medications, and his behaviors would return.

On 11/16/12 at 2:50 PM, an interview was conducted with E2, Director of Nurse's (DON). E2 stated she was the facility's Abuse Coordinator. E2 stated that with regards to R11's behavior, staff would always separate the residents after an incident would occurred. E2 stated R11 was always sent to the Behavioral Health Unit for a psychiatric evaluation. E2 stated R11 was placed on 15 minutes checks and staff would keep a close eye on him. When questioned where the 15 minute checks were documented E2 stated "I don't know if they documented it anywhere." When questioned why no new non-pharmaceutical interventions were implemented after R11 became sexually aggressive towards residents, E12 stated "I don't know."

The facility's Abuse Prevention Program, revised 11/11/11 documented "Resident Assessment. As part of the resident social history assessment,staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will

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identify any problems, goals, and approaches, which would reduce the changes of mistreatment, neglect, and abuse of these residents. Staff will continue to monitor the goals and approaches on a regular basis."

(B)

300.690a)
300.1210a)
300.1210b)
300.1210d)6)
300.3240a)

Section 300.690 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

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 resident's comprehensive assessment, which

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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. (A, B) (Section 2-107 of the Act)

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F9999	Continued From page 60 These requirments are not met as evidenced by: Based on observation, record review, and interview, the facility failed to investigate and implement progressive interventions to prevent falls for one of 4 residents (R10) reviewed for falls in the sample of 15; and failed to identify and assess for potential hazards and entrapments risk for two of four residents (R12, R15) reviewed for restraints in the sample of 15. This failure resulted in R10's fall on 7/27/12 resulting in a fractured right hip. Findings include: 1. R10 was admitted to the facility on 6/27/12, with diagnoses from August 2012 Physician's Order Sheet (POS) of: Congestive Heart Failure, Alzheimer's Dementia, Bi-Polar, Depression, Hypothyroidism, Agitation, Altered Mental Status. The facility's Fall Tracking and Skin Tear/Bruise Tracking Reports documented falls and/or skin tears on 7/2, 7/3, 7/12, 7/12, 7/17, 7/19, 7/27, and 8/3/12. The fall on 7/27/12 resulted in a fractured hip. R10's first fall was documented in Nursing Notes 7/2/12 at 7 AM, "Res noted on floor in room. Res. L. side laying with head in contact with floor.....Res. c/o (complaining of) generalized pain. M.D. notified.....". On 11/16/12, E2, Director of Nursing (DON), was asked to provide incident report and investigation of this incident. E2 stated she could not find the incident report. On 11/27/12, the facility faxed a report with a QA review dated 7/4/12 which stated	F9999		

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(in part) "Labs done revealing increase in disease process....increase in muscle weakness.....increase in confusion. Labs done 8/8/12."
There is no explanation how the 8/8 labs could have been done on 7/4/12. There are no new intervention to prevent falls in the future.

On 7/12/12 at 9 AM, R10's Nursing Notes documented, "Res. noted ambulating in hallway. Observed walking into wall and going down to floor....". E2 stated she could not find the incident report for this incident on 11/16/12. On 11/27/12, the facility faxed an incident report with QA review dated 7/14/12 which documented (in part), "Increasing confusion et (and) muscle weakness for progressive disease process. Family considering hospice. Admitted to Hospice.....8/22/12.". There is no explanation about the discrepancy in dates - 7/14/12 to 8/22/12. There are no new interventions to prevent future falls.

On 7/27/12 at 13:15 (1:30 PM), Nursing Notes documented R10 was on the floor by the Nurses Station, lying on his left side. He had a small skin tear on his left elbow. No new interventions are documented to prevent future falls on the incident report or Nursing Notes.

On 7/27/12 at 5:30 PM, Nursing Notes documented, "Resident noted in hallway on 200 hall floor. Laying on left side. Blood noted from left brow area and left elbow. Resident was walking with wife and fell. 911 called....Ambulance arrived....left on stretcher."

R10 was sent to the hospital. Hospital History

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F9999	Continued From page 62 and Physical dated 7/27/12 documented a hip fracture. X-ray results of the right hip: Mildly displaced fracture of the right greater trochanter. R10's Minimum Data Set (MDS) is dated 7/9/12, and R10's ADL (Activities of Daily Living) assessments document he needs extensive assistance of two or more staff for bed mobility, transfers, ambulation in room and hall, and toilet use. His balance is assessed as NOT steady, only able to stabalize with staff assistance with impaired range of motion in both upper and lower extremities. R10's Nursing Notes document R10 ambulated without assistance of staff on numerous occassions, even after recommendations of need for increased assistance. On 6/29/12, E15, Physical Therapy Assistant, documented in Nursing Notes, "Nurse reports to this Therapist resident needs increased assist with ADLs. Recommend OT (Occupational Therapy) orders." On 6/30/12 at 13:30 PM, "....Ambulated independently"......On 7/1/12 at 13:45 PM. "........Res up, ambulated independently, gait steady....." . On 7/2/12 at 7:00 AM, "Res noted on floor in room....". On 7/5/12 at 10:20 AM, "...Res up ambulating independently...", on 7/7/12 at 3:00 AM, "Up this morning..... Roaming hallway....", On 7/12/12 9:00 AM, "Res noted ambulating in hallway. Observed walking into wall and going down to floor." On 7/13/12 at 3 AM, "Resident up ambulating in room.....". On 7/19/12 at 3 AM, "......Up ambulating in hallway......." The facility could not provide R10's	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145981	A. BUILDING ______ B. WING ______	11/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 63	F9999		

comprehensive Care Plan for review to see if his Care Plan was reviewed and revised following each fall. On 11/16/12, at 10:30 AM, E2, DON, stated, "I don't know what happened to his Care Plan. I can't find it anywhere."

2. R15's POS dated 11/1 thru 11/30/12 documented she had a diagnosis of Dementia. R15's Physician's Order dated 8/29/12 documented "May use (wheeled enclosed ambulation device)."

On 11/15/12 at 2:00 PM, R15 was sitting at the nurse's desk in an enclosed ambulation device.

R15's Minimum Data Set (MDS) dated 10/17/12 documented he had a trunk restraint which was used daily. The MDS documented she had short and long-term memory loss and had severely impaired cognitive skills for daily decision making. The Care Area Assessment (CAA) Summary dated 10/17/12 documented "Uses (wheeled enclosed ambulation device) for mobility. May be considered restraint as resident is unable to release bar to open (wheeled enclosed ambulation device)."

There was no documentation in R15's medical record regarding if the facility had assessed the risks versus benefits or medical reason for R15's enclosed ambulation device.

R15's Nurse's Note dated 8/30/12 documented "5 AM - Another resident reported to this nurse that this resident was on the floor. Found resident in (wheeled enclosed ambulation device) on hands and knees the belt remained in place. Resident unable to say what happened."

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F9999	Continued From page 64	F9999		

Continued From page 64

R15's Investigation Report for Falls dated 8/30/12 documented "What do you believe caused the fall? Resident leans forward until she is bending over while walking in (wheeled enclosed ambulation device)." There was no documentation in the section regarding what new interventions were implemented to prevent any further falls.

The Quality Care Reporting Form dated 8/30/12 documented in the Root Cause with Recommendations section "Risk of injury still (lower) (with) (wheeled enclosed ambulation device). Monitor closely while in (wheeled enclosed ambulation device.)"

R15's Nurse's Note dated 9/9/12 at 6:30 PM documented "Resident noted sitting on floor inside (wheeled enclosed ambulation device). Skin (check) completed. 0 injuries" There was no documented investigation of this fall. There were no new documented interventions implemented to address R15 falling while in the wheeled enclosed ambulation device.

On 11/16/12 at 9:20 AM, E2 was interviewed regarding R15 falling in her wheeled enclosed ambulation device. E2 stated Hospice brought in an enclosed ambulation device which was too big and she was able to fall inside it.

(B)

Illinois Administrative Code 300
Section 300.1230 Direct Care Staffing
k) Effective September 12, 2012, a minimum of

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F9999	Continued From page 65 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. These Requirements are NOT MET as evidenced by: Based on interview and record review, the facility failed to provide adequate Registered Nurse (RN) staff to meet the needs of the residents for 14 of 14 days reviewed for staffing. Findings include: 1. The Facility's census for 10/31/12 through 11/13/12 provided by E1, Administrator, in a hand written document on 11/16/12, documents an average daily census of 10 residents requiring skilled care and 51 residents requiring intermediate care. A signed written statement from E1, Administrator, and E2, Director of Nurses (DON), dated 11/16/12, documents the staffing ratio used for each shift as 45% on day shift, 35% on evening shift, and 20% on night shift. The Facility's Schedule Sheets for 10/31/12 through 11/13/12 were reviewed. The calculations for Minimum Total Direct Care Hours, Minimum Required Hours for Licensed Nurse time, Minimum Required Hours for Registered Nurses (RN), and Additional Direct Care Hours were compared to the Actual Hours worked for Saturday 11/3/12 and Wednesday 11/7/12. Shortages as follows:	F9999		

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F9999	Continued From page 66 On 11/3/12 the facility was short one Full Time Equivalent (FTE) RN On 11/7/12 the facility was short one FTE RN Further review of the Nurse's Schedule for 10/31/12 through 11/13/12 documented no RN's scheduled (short two FTE RN's) for: 10/31/12, 11/1/12, 11/2/12, 11/4/12, 11/5/12, 11/6/12, 11/8/12, 11/9/12, 11/11/12, 11/12/12 and 11/13/12. On 11/10/12 the facility was short one FTE RN. 2. In an interview on 11/16/12 at 9:05 AM, E2 stated, "We are actively searching for RN's. We have an ad in the paper. My RN just resigned effective 11/19/12." 3. In an interview on 11/16/12 at 10:15 AM, E1 stated, " I know there is a problem with our RN coverage, but it is beyond our control. We had two RN's, but one was fired for insubordination. Now the other has turned in her resignation. We are trying to hire RN's." (B)	F9999		