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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of	S9999		

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S9999	Continued From page 1 notification. 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. 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 300.1220 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	S9999		

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

These Requirements are not met as evidenced by:

A. Based on observation, interview, and record review the facility failed to supervise a resident (R12) with a history of recent suicide attempts by not conducting 15 minute checks as ordered and failed to place R12 on 1:1 supervision when she expressed thoughts of suicide. The facility failed to remove items she planned to use in a suicide attempt (trash bags, and shoe laces) from her room which R12 had talked about using or had used in previous attempts. These failures resulted in R12 attempting suicide with her shoe laces and call cord around her neck on 6/22/14. This applies to one of five residents (R12) reviewed for safety related to suicide risk in the sample of 19.
R12's Pre-Admission Screening (PAS) Assessment Summary Information on 11/23/13 shows R12 has a diagnoses including Bipolar. The PAS states,"R12 with long history of suicidal

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ideations and attempts...Age 50 R12 reports ongoing suicide ideations with numerous attempts: cut self, strangle with shoe strings, and bag over head. R12 would likely benefit from continued groups to gain coping skills and symptoms management.
The Pre-Admission Screening Mental Health Level II Notice of Determination dated 11/23/13 shows R12 requires special services: "Professional Observation (MD/RN) for medication monitoring, adjustment and/or stabilization, Instrumental Activities of Daily Living training/reinforcement, Mental Health Rehabilitation activities, Illness self management, and Community re-integration activities."
R12 was admitted to a psychiatric Hospital from 4/9/14-4/29/14 for inpatient treatment due to the severity of her suicidal and self-destructive thoughts. The Medical History and Physical Examination form from the psychiatric Hospital on 4/9/14 states,"R12 is depressed and suicidal. R12 put a cord aroundr neck to kill herself and later changed her mind. R12 has a history of physical and sexual abuse at the age of 10. R12 has auditory and visual hallucinations ... R12 hears devil 's voice...R12 suffers from...Post Traumatic Stress Disorder
The My Safety Crisis Plan sent with R12 on discharge from the psychiatric hospital on 4/29/14 shows R12's Triggers and Stressors include: "any kind of sexual abuse reference, slamming doors, raised voices, conflict, feeling ignored, feeling invisible, people coming up behind me, unpredicted changes." R12's warning signs include: sleeping too much, getting angry over little things, eating too much, and withdrawing. Other plans on the My Crisis Plan Sheet included guidance on coping skills and People to call and Reminders. This sheet was marked as copy for patient. This form was discovered in the thinned

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portion of R12's record, stored in the basement, not readily available to the resident or staff. On 9/22/14 at 4:00PM, E2 (Director of Nursing) said this should be incorporated into her care plan.
On 6/12/14 the Social Services Notes by E3 (Social Service Director) states,"...R12 shows signs and symptoms of depression. R12 tends to appear and feel depressed daily has had thoughts of suicide, has sleep disturbances, and lacks energy at times ...R12 has had three psych hospitalizations for suicidal ideation since admission, currently stable."
On 6/12/14 the Screening Assessment for Evaluating Self-Harm/Suicide Risk shows R12 has a score 10. A score of 6-15 is at moderate risk. The Risk Screening Assessment for Indicators of Aggressive, Harmful and/or Inappropriate Behaviors 6/12/14 shows R12 has a score of 6 (a score of 0-10 is at minimal/low risk). The Screening Assessment to Determine the Presentation of Abuse and/or Neglect Factors 6/12/14 shows R12 has a score of 4 (a score of 4 or more represents a high risk).
The Psychiatric Consultation progress note dated 6/16/14 said, R12 with recent suicide ideation and plan in place. R12's plan is to place a plastic bag around her neck. The trigger is relieved by removing the pillow case bag from the pillow. There are significant symptoms of depression and mood changes. R12 needs more psychotherapy.
On 6/20/14 Z6 (Psychiatrist) stated,"R12 reports chronic suicidal thought. R12 reports 2 days ago she had thoughts to wrap her panty hose around her neck. R12 then hid her panty hose. R12 reported last night she hid her Trazadone (Anti-psychotic medication) in her closet with the plan to save her meds and take them on Monday night. 15 minute checks at night ...and increase Lithium dose."

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The Nurse's Notes dated 6/20/14 said, R12 has been storing Trazadone in her closet. R12 said, she had a plan to take all her medications at once one night. Fifteen minute checks ordered and watch R12 take medications.
On 6/20/14 the Social Service Notes by E3 states, "Z6 (Psychiatrist) called the facility and spoke with nurse stating that during visit R12 stated that she was not taking Trazadone. R12 was saving pills to hurt herself. A Room check was done and two pills were found.
Z6(Psychiartist) placed R12 on 15minute checks."
On 6/20/14 the Screening Assessment for Evaluating Self-Harm/Suicide Risk shows a score of 13. A score of 6-15 is at moderate risk.
E3(SSD) wrote on the Screening Assessment, R12 was reassessed on this date related to making a suicide statement. E3 felt that resident was not a threat to herself.
For 6/22/14 (Saturday) there was no documentation of 15 minute checks for R12.
On 6/22/14 at 5:55 PM, An Incident and Accident Report states, "R12 wrapped shoe strings and call light around her neck and R12 ' s face was turning blue. All ties and cords cut and removed. R12 kept pulse during whole process ....911 called, Director of Nursing on site, Medical Doctor notified, family called, sent to Emergency room per protocol."
The Nurses Note dated 6/22/14 states,"Certified Nursing Assistant to answer R12's call light and then yelled out loudly multiple times " Help!!!" I ran to R12's room and observed shoelaces and call light cord all tied around her neck and R12 ' s facial color was beginning to turn blue. I immediately used my medical scissors and cut all ties around her neck and also removed call light cord. R12's color returned to pink immediately and she let out a deep gasp..I asked R12 why did

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you decide to do this? R12 stated," I ' m done." ...What are you done with? R12 stated, "Life"... How long have you been feeling this way? R12 states, "3 days" I asked her did you tell anyone about how you were feeling? R12 states," Yes, the doctor and he only said, he would increase my medication ...."
The Social Services Note dated 6/27/14 by E3(SSD) states," R12 was readmitted on this date from Rockford Memorial Hospital Behavioral Health Unit ...To ensure R12's safety the following actions have been put in place. R12 will be on 15 minute checks for first 24 hours on 6/28 and 6/29 R12 will be on 30 minute checks. On 6/30 ...R12 will be on 1 hour checks for 90 days. R12's call light has been removed ...R12 also has had all laces removed from shoes...no plastic bags ...all precautions have been care planned ...R12 will be encouraged to attend group in facility ...."
The 1 Hour Care Sheet for R12 from 6/30/14 - 9/16/14 shows no documentation for 9 days. 7 Care Sheets are completed hourly, and remaining sheets are not documented hourly.
On 9/18/14 at 11:00AM, E22 (Medical Records) said, these are the only hourly care sheet records he was able to find.
The Care Plan dated through June 2014 shows R12 has a history of suicide attempt as well as suicidal ideation. In the past two years she has had more than 50 attempts with most recent choking herself with shoe laces and call light cord around her neck on 6/22/14. R12 has a diagnoses of Major Depression recurrent and Bipolar Disorder. R12's Care plan states," In the event that R12 exhibits behavior of thoughts or attempts to harmself, R12 is to placed on one to one, psychiatrist and Medical Doctor to be notified resident will be monitored till discharged to hospital." R12's Care Plan was not revised to include removing plastic bags and shoelaces,

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supervision checks, and attend group.
On 9/17/14 at 11:45 AM, there were four pairs of shoes with shoelaces underneath R12's bed.
On 9/17/14 at 2:00 PM, there were two garbage cans with trash bags in R12's room.
On 9/22/14 at 3:05 PM, a garbage bag was in R12's bathroom and a garbage bag was near her roommate's bed.
On 9/22/14 at 4:10 PM, E19 (Housekeeping Supervisor) stated,"I took the bags out of her room. I didn't know they weren't supposed to be in there. I will pass that on to my housekeepers."
On 9/17/14 at 2:00 PM, E3 (SSD) stated, "R12 comes to me when she has feelings or issues ....There has been no gap in time where she doesn't come and see me ...I do one to one meetings with R12 as needed ....All staff are aware what should not be in her room garbage bags, shoe laces, and call light ...I don ' t have groups running right now. They stopped in July."
On 9/18/14 at 9:00 AM, R12 said, Groups have not been offered for about 2 months. I think the groups helped me when we had them.
On 9/18/14 at 9:25 AM, E23(Licensed Practical Nurse) said, R12's behaviors are managed well when she is kept busy. Isolation increases her triggers.
The Physician Order Sheet dated through September 2014 shows R12 has diagnosis including Psychosis and Depression.
The facility's undated policy titled Policy and Procedure for Handling Self Harm Behavior that was in place, shows that this policy emphasizes proactive intervention, promoting enhanced physical and psychosocial well-being. This facility protocol recognizes impending self harm behavior and instructs staff in management techniques to ensure the safety of each resident.
The Policy and Procedure for Handling Self Harm Behavior under section II describes what the

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facility is to do when a resident threatens or attempts to self harm. Under Verbal Threat and plan, in the event a resident makes a negative statement (indicating) self harm and voices a plan: a) the resident will be immediately placed on one to one supervision, b) The nurse in charge will immediately contact the Administrator, Director of Nursing and the Social Service director, c) the nurse in charge will contact the physician for (an) order for a psych evaluation, d) If an order cannot be obtained from the physician, the resident will be sent out on petition with 911, and e) (the) responsible Party will be notified of the event and facility policy.

B. Based on observation, interview and record review the facility failed to ensure residents safety by not revising approaches for a resident who had 12 falls in the past 9 months (1 fall resulting in a hip fracture), failed to conduct neurochecks after a resident fell twice and hit his head, failed to lock the treatment cart and failed to keep chemicals in locked storage. This applies to 2 of 3 residents (R5, R17) reviewed for safety in the sample of 19. The Findings Include:
1. R5's September 2014 Physician Order Sheets shows R5 has a diagnoses including Osteoporosis, Weakness and Hip Fracture. R5's History and Physical from a previous hospitalization on 4/2/14 states, R5 has a history of recurrent hip dislocations ...R5 reported that she was trying to get out of bed alone and fell. The Minimum Data Set assessment of 6/20/14 shows R5 transfers with a two person assist. On 9/16/14 at 1:20 PM, R5 stood up by herself attempting to transfer from her wheelchair to her bed. R5 held on to her side table and bed for assistance. E10(Licensed Practical Nurse) was at the bedside and did not assist R5 with her transfer. The chair alarm did not alarm.

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S9999	Continued From page 9 On 9/17/14 at 9:41 AM, R5 stood up from her wheelchair by herself. The chair alarm did not alarm. On 9/16/14 at 1:05 PM, E10 (Licensed Practical Nurse) said, R5 transfers with 1 staff assist and has a chair/bed alarm. R5's Care Plan dated through April 014 shows R5 had a fall that resulted in a hip replacement. It shows staff to assist with all transfers. R5 is not to transfer to/from wheelchair or toilet without staff. R5's Care Plan was last revised on 3/28/14. R5 has had 8 falls since then. The bed/chair alarm was not in the Care Plan. The Fall Risk Assessments dated July with no year documented shows R5 has a score 12. A score of 10 or more represents a high risk for falls. 3. The February 2014 Physician's Order Sheet showed R17 was admitted to the facility on 2/5/14 with diagnoses to include: Dementia, Diabetes Mellitus, End-Stage Renal Disease, Chronic Obstructive Pulmonary Disease and Hypertension. The Minimum Data Set (MDS) of 2/19/14 assessed R17 as severely impaired for decision making and needing limited assistance of 1 staff for transferring. R17 was assessed as being unsteady for balance during transfers. R17 required 1-2 staff for all ADL's (Activities of Daily Living) except eating. The fall risk assessment completed 2/5/14 showed R17 was at high risk for falls. R17's nurse's notes document the following: "On 2/12/14 at 10:15pm, "Resident alert to self. Transferred self to/from wheelchair without	S9999		

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supervision is reminded by staff that he should request assist due to safety."
"On 2/21 at 10:30pm, "Resident alert to self. Self propels wheelchair able to transfer self but needs reminders to request assist for safety."
"On 3/12 (10:20pm), Resident needs reminders not to get out of bed or up from chair without assist."

The care plan initiated 2/25/14 showed R17 has cognitive/function or Dementia related to impaired thought processes. The falls care plan is dated 2/25/14 and showed R17 is at risk due to deconditioning. Approaches include: Anticipate the resident's needs. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible.

The care plan was revised on 3/7/14 to include: the pad alarm in bed/recliner and while in wheelchair, check functioning with every transfer and ensure it is on and active prior to leaving the room.
The nurse's note show R17 had no alarm in place on 3/4/14 (POA wants the resident to have an alarm like he had in the hospital).

The nurse's notes on 3/4/14 (6:10am) describe , R17 was witnessed by staff transferring from wheel chair to recliner and fell. Resident stated he fell and hit the back of his head on the wall. The nurse's notes at 5:00pm document MD and POA were not notified of the fall that occurred at 6:10am.

The "Head Chart" form is used to monitor patients vital signs, pupils, and level of conciousness after head injuries/unwitnessed falls for 72 hours. R17's Head Chart documented

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the time of the incident was 6:10am on 3/4/14. The head chart was incomplete and only done 6 of 21 times in a 72 hour period: at 6:25am, 6:40am, 6:55am, 10:10pm and on 3/5 at 6:10am and 2:10pm. E2's name was in the area as completeing the assessment but there was no documentation of vitals shown on 3/4 from 6:55am to 2:10pm. There was no documentation of vitals/nerochecks on 3/5/14 at 2:10pm to 3/6/14 at 6:10am (72 hour monitoring) Comments on the fall checklist described R17 fell backwards, with just socks on, transferring self to wheelchair. On 9/24/14 at 10:00am, E2 was asked why R17's head chart form for 3/4/14 was incomplete. E2 stated, "I honestly don't know why there were gaps in the neurochecks."

R17's nurse's note on 3/5/14 (8:00am), Sat in wheel chair all night, refused to sit in recliner and elevate edematous legs. No alarm present, 30 min checks by staff all night.
(9:20pm) Resident in room in wheel chair next to the bed, attempted to stand without locking wheelchair, resident in stocking feet. When resident stood, started to slide, which alerted nurse and CNA, but staff could not get to resident. He slipped and landed on butt next to bed. Assisted off floor per 2 and into recliner. Post-Fall investigation report dated 3/5/14 showed alarm was not attached to the resident.

The nurse's note for R17 on 3/6/14 (3rd shift) showed, Vital signs taken. Alert with confusion. Up in recliner at times during the night, complained of headache. PRN Tylenol given. R17 blew nose and large amount of blood was in tissue. Alarm in place. Will monitor.
(1st shift)- Resident alert but to self only, refused dialysis said, "I'm not feeling well." Gave Tylenol for headache and Ativan but resident still

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refused dialysis. Dialysis informed nurse that stat labs to be drawn for Hemoglobin. Results back and Hemoglobin 5.6. Received orders to send resident to ER for eval and treatment with transfusion. Resident returned from hospital on 3/10/14.

The Physical Therapy note dated 3/11/14 showed R17 is a fall risk occasional impulsive as to transfers, decreased safety awareness, required cues for redirection and safety. Ambulation: Unable to perform at this time due to decreased endurance, strength and activity tolerance.

R17's nurse's note 3/15/14 (12:20am) Client heard falling on to the floor, alarm did not sound. Client on back and wheel chair had fallen on the side. Bed/chair alarm was on resident's chair. CNA last seen resident in his chair at midnight with alarm attached. To ER as resident stated he hit the back of his head. 1:05am left for ER. Late entry on 3/15/14 at 5:00am documented R17's vital signs were taken but no other assessment was done. Reason for fall, R17 was getting up to get his cell phone. CNA and nurse assisted resident to his bed to await ambulance. The incident report of the same date documented R17 had a bump on the back of his head the size of a fifty cent piece. The chair alarm did not sound on 3/15 to alert staff before R17 fell and sustained a subdural hematoma. There was no initial neurocheck sheet completed after R17 complained of hitting his head.

On 9/24/14 at 10am E2 said [on 3/15/14] R17 fell and was sent out and suffered a hematoma. The previous Director of Nursing was the nurse in charge covering a call off when it happened. [The procedure when someone falls] an incident report is done, resident is reassessed and vitals

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are taken for 72 hours, neurochecks are done and the fall investigation tool is filled out by the CNA and nurse for proper interventions.

R17's History & Physical of 3/15/14 showed, "CT scan of the head was done which showed some old and possible subdural hemorrhage." R17 was admitted to the Intensive Care Unit (ICU).

The Coroner's Report dated 4/7/14 described the details of the incident, On 3/15/14 at 12:36am the ambulance company received a call from the nursing home stating that R17 had fallen. At 12:52am the ambulance arrive at the nursing home and found R17 sitting in a chair in his room with a bump to the back of his head. He seemed confused and the nurse stated that this was normal and also he falls alot. R17 was able to stand and get on their cot. At the ER, R17 was given a CT scan of the head which showed a subdural hematoma. He was admitted to ICU. More CT's of the head were done and showed his subdural hematoma had worsened. His mental status did not change after a few days and he was seen by the palliative care team. On 4/1/14 the family opted to send R17 to another facility. He remained on comfort care and his condition did not improve. R17 expired on 4/7/15 at 12:50am. The cause of death was Subdural Hemorrhage, secondary to a Fall.

4. On 9/15, 9/16, and 9/17/14 the soiled utility room on the 2nd floor was unlocked. The door's lock mechanism was covered over by masking tape. The room contained bulk cleaning supply containers such as disinfectant, toilet bowl cleaner and floor cleaner. The containers posted warning labels, "Harmful if Swallowed", "May Cause Eye Irritation" and "Keep Out Of Reach Of Children." On 9/18/14 (Housekeeping

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S9999	Continued From page 14 Supervisor) said the lock was broken (A) 300.610a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999		

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S9999	Continued From page 15 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 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) These Requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain residents nutritional status by not identifying causes for a 20 pound weight loss in one month for a resident who receives all their nutrition through a feeding tube. This failure resulted in R7 experiencing a 20 pound weight loss in one month and developing an open wound while being solely tube fed. This applies to 1 of 2 residents (R7) reviewed for	S9999		

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tube feeding in the sample of 19.
The findings include:
On 9/15/14 at 11:20 AM, R7 had Fibersource HN 1.2 tube feeding being administered at 50ml (milliliters) per hour with a pump.
R7's MDS dated 5/31/14 showed that she is totally dependent on staff for activities of daily living and that she is at risk for pressure ulcers.
On 5/22/14, R7's Braden scale-for predicting pressure sore risk was 7 (severe risk).
R7's care plan for tube feeding initiated on 6/4/14 shows an intervention of: RD (registered dietitian) to evaluate quarterly and as needed (PRN). Monitor caloric intake, and estimate needs. Make recommendations for changes to tube feeding as needed.
The facility's undated tube-feeding policy states, " The dietician will complete a comprehensive nutritional assessment determining the appropriateness of the tube feeding order. The dietitian may make a recommendation to the physician to consider changing the tube-feeding if indicated. The dietitian will reassess the tube-fed resident's needs on a monthly basis. The facility's undated nutritional assessment policy states, " A comprehensive nutritional assessment is completed by the appropriate health professional within 14 days of admission. This includes information on the resident's nutrition status and requirements. Nutrition needs are reassessed quarterly and annually unless there is a change of condition which pertains to the resident's nutritional status.
R7's admission physician's order sheet dated 5/22/14 shows an order for NPO (nothing by mouth) and an order for Isosource HN 1.2 at 50ml per hour continuously. R7 has been on Isosource or Fibersource (calorie equivalents) at 50ml/hour since admission. R7's complete metabolic panel done on 6/4/14 shows a glucose

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S9999	Continued From page 17 of 152mg/dL (normal 70-102) and an albumin (blood protein) of 2.8 g/dL (normal 3.4-5.0). R7's July weight that was documented on the facility's weights list report was 165 lbs. R7's August weight that was documented on the facility's monthly weights and vitals 2014 form was 145 lbs. R7 had a 20 pound weight loss in 1 month. R7's resident admission nursing assessment dated 5/22/14 showed R7 had no pressure ulcers. The facility's wound spreadsheet dated 7/29/14 showed a facility acquired wound to the right buttock measuring 2.6 cm x 2.6 cm x .1 cm open wound with 50% granulation tissue and light serous drainage. R7's medical records were reviewed and no dietitian notes were found. On 9/16/14 at 8:50 AM, E2 (director of nursing-DON) stated, " There has not been a registered dietitian here since February." (B) 300.4000a) 300.4000g) 300.4010a) 300.4010b) 300.4010d) 300.4020a) 300.4030k) 300.4040a)4) 300.4080 Section 300.4000 Applicability of Subpart S a) Beginning July 1, 2002, a licensed SNF or ICF providing services to persons with serious mental	S9999		

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S9999	Continued From page 18 illness shall meet the requirements of this Subpart S. g) Facilities providing services to persons with serious mental illness in accordance with Subpart S shall also comply with Subparts A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and R of this Part. In case of a conflict between those Subparts and Subpart S, the more stringent requirement applies. Section 300.4010 Comprehensive Assessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) The facility shall establish an Interdisciplinary Team (IDT) for each resident. The IDT is a group of persons that represents those professions, disciplines, or service areas that are relevant to identifying an individual's strengths and needs, and that designs a program to meet those needs. The IDT includes, at a minimum, the resident; the resident's guardian; a Psychiatric Rehabilitation Services Coordinator (PRSC); the resident's primary service providers, including an RN or an LPN with responsibility for the medical needs of the individual; a psychiatrist; a social worker; an activity professional; and other appropriate professionals and care givers as determined by the resident's needs. The resident or his or her guardian may also invite other individuals to meet with the IDT and participate in the process of identifying the resident's strengths and needs. b) The IDT must identify the individual's needs by performing a comprehensive assessment as needed to supplement any preliminary evaluation conducted prior to admission to the facility. The	S9999		

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assessment shall be coordinated by a PRSC.

d) Based on the results of all assessments, the PRSD or PRSC shall develop a narrative statement for the IDT review that summarizes findings regarding the resident's strengths and limitations; indicates the resident's expressed interests, expectations, and apparent level of motivation for psychiatric rehabilitation; and prioritizes needs for skill development related to improved functioning and increased independence.

Section 300.4020 Reassessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

a) At least every three months, the PRSC shall document review of the resident's progress, assessments and treatment plans. If needed, the PRSC shall inform the appropriate IDT members of the change in resident's condition. The appropriate IDT member will reassess the individual and update the resident's assessment, assuring the continued accuracy of the assessment.

Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

k) The resident's treating psychiatrist shall review and approve the resident's treatment plan as developed by the IDT. The date of this review and approval shall be entered on the resident's treatment plan and be signed by the attending psychiatrist.

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S9999	Continued From page 20 Section 300.4040 General Requirements for Facilities Subject to Subpart S a) The psychiatric rehabilitation services program of the facility shall provide the following services as needed by facility residents under Subpart S: 4) Psychiatric rehabilitation services addressing major domains of functioning and skills development: self-maintenance, social and community living, occupational preparedness, symptom management, and substance abuse avoidance; Section 300.4080 Community Based Rehabilitation Programs for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S Community-based (off-site) rehabilitation programs shall be used as an adjunct to the facility program where their use will assist in community reintegration or in the development of relationships with the agency that will be providing services to the individuals after discharge. The facility shall develop and maintain working relationships and written agreements with community agencies that provide psychiatric rehabilitation services. Appropriate records shall be maintained for residents receiving psychiatric rehabilitation services from outside agencies. These records shall show the appropriateness of the program for the individual, the ITP objectives addressed, the interventions being utilized, the resident's response to the program, the responsible community agency staff, and any other pertinent observations. These Requirements are not met as evidenced	S9999		

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S9999	Continued From page 21 by: A). Based on Interview and Record Review the facility failed to provide services to persons with a serious mental illness (SMI) in accordance with Subpart S and comply with all of the subparts. This applies to 2 of 13 residents (R5 & R12) reviewed for Subpart S in the sample of 19 and 11 residents (R29, R30, R39, R40, R41, R42, R43, R44, R45, R46, & R47) in the supplemental sample. The findings include: On 9/16/14 at 10:45am E3 (Social Service Director - SSD) stated, "Dementia, Mental Retardation, Developmental Disabilities and Traumatic Brain Injuries are disqualifying diagnoses for Subpart S (Serious Mental Illness). The 13 residents (R5, R12, R29, R30, R39, R40, R41, R42, R43, R44, R45, R46, & R47) on the list are eligible for Subpart S services." During a confidential interview on 9/18/14, the person stated, "Nothing is being done for Subpart S. There aren't any groups being done and there wasn't any documentation on these people until yesterday." On 9/18/14 at 3:50pm, E22 (Corporate Administrator) stated, "There isn't anything in place for Subpart S. The entire thing is out of compliance. I have been telling them that for a long time. I know it was written here 1 year ago on a survey that I helped them with and it was 300.3240a) then. B). Based on Interview and Record Review the facility failed to have an interdisciplinary team that identifies the individual's needs by performing comprehensive assessments and structured assessments of each resident's interests and	S9999		

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expectations regarding psychiatric rehabilitation. This applies to 1 resident (R43) that was reviewed for Comprehensive Assessments under Subpart S Guidelines in the supplemental sample.
The findings include:
The Department of Human Service (DHS) Assessment Summary for R43 dated 10/12/11 showed,"Schizoaffective Disorder and Personality Disorder; R43 rambling off topic at times. R43 is able to be redirected. R43 appears to have some religious preoccupation. History of delusions is noted. R43 requires prompts/cues from staff for med taking and cleaning. R43 will require ongoing psych services to maintain his current stability. R43 has been placed in a nursing facility in the past for the same issue and once stabilized he was able to return to community living."
The DHS/Mental Health Level II Notice of Determination dated 3/20/13 for R43 showed the following special services are needed, "Professional observation (Medical Doctor/Registered Nurse) for medication monitoring, adjustment and/or stabilization, Instrumental Activities of daily Living Training/Reinforcement, Mental Health Rehabilitation activities, Aggression/Anger Management, Illness Self Management, Incentive Program to improve participation in treatments and Community Re-integration activities."
R43 did not have a structured assessment of his interests and expectations regarding psychiatric rehabilitation.
R43 does not have an initial or annual assessment of his Level of Functioning/Skills.
On 9/18/14 at 3:50pm, E22 (Corporate Administrator) stated, "There isn't anything in place for Subpart S. The entire thing is out of compliance. I have been telling them that for a long time. I know it was written here 1 year ago

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on a survey that I helped them with and it was out then."
On 9/17/14 at 10:55am, E3 (Social Services Director - SSD) stated, "There isn't an interdisciplinary team for Subpart S right now. Comprehensive Assessments should be done at admission (the initial one) and then annually. There are not any rehabilitation interventions right now. The rehab I have been doing is 1:1 with some of them. The Level of Functioning Assessment is done at admission and then annually or with a significant change."

C). Based on Interview and Record Review the facility failed to ensure residents that qualify for Subparts S Services have quarterly reviews of their progress, assessments and treatment plans. The facility failed to have annual psychiatric, psychosocial, skills assessments or a narrative summary for residents when a complete reassessment is not needed.

This applies to 1 of 13 residents (R5) reviewed for Subpart S in the sample of 19 and 5 residents (R39, R40, R43, R45 & R46) in the supplemental sample.
The findings include:

On 9/18/14 at 3:50pm, E22 (Corporate Administrator) stated, "There isn't anything in place for Subpart S. The entire thing is out of compliance. I have been telling them that for a long time. I know it was written here one year ago on a survey that I helped them with and it was out then."
R5, R39, R40 & R43, do not have Level of Functioning/Skills Assessments.
The last Annual Psychiatric Note/Evaluation for R46 was in June 20013. The last Annual

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Psychiatric Note/Evaluation for R5 was in August 2013.
The last Psychosocial Assessment for R42 was dated 6/20/12. R43 does not have a Psychosocial Assessment and his Determination of Need Screening dated 10/7/11 showed he was admitted to the facility on 10/11/11. R39 does not have a Psychosocial Assessment and her Determination of Need Screening dated 3/7/13 showed she was admitted to the facility on 3/7/13.
On 9/17/14 at 10:55am, E3 (Social Services Director - SSD) stated, "There isn't an interdisciplinary team for Subpart S right now. Comprehensive Assessments should be done at admission (the initial one) and then annually. The Level of Functioning Assessment is done at admission and then annually or with a significant change."
On 9/24/14 at 8:55AM, E1 Administrator and E2 (Director of Nursing) verified that a psychiatrist has not seen residents in the building since November 2013. An agreement was signed with Z 7 on 7/31/14 but he has not been in the building since. They also confirmed that there has been no dietitian in the building between 2/11/4 and 9/23/14. There is an unsigned contract for a consultant dietitian dated 1/1/2014.

D). Based on Record Review and Interview the facility failed to have the psychiatrist review, approve and sign the treatment plan for residents that qualify for Subpart S. The facility failed to have the date of this approval entered on the resident ' s treatment plan.

This applies to 2 of 13 residents (R5 & R12) reviewed for Subpart S in the sample of 19 and 9 residents (R30, R39, R40, R41, R42, R43, R44, R45, & R47) in the supplemental sample.

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The findings include:

1. On 9/16/14 at 10:45am E3 (Social Service Director - SSD) stated, "The 13 residents (R5, R12, R29,R30, R39, R40, R41, R42, R43, R44, R45, R46, & R47) on the list are eligible for Subpart S services."
During a confidential interview on 9/18/14, the person stated, "Nothing is being done for Subpart S. There aren't any groups being done and there wasn't any documentation on these people until yesterday."
On 9/18/14 at 3:50pm, E22 (Corporate Administrator) stated, "There isn't anything in place for Subpart S. The entire thing is out of compliance. I have been telling them that for a long time. I know it was written here 1 year ago on a survey that I helped them with and it was out then."
There weren't any treatment plans in place for residents with a serious mental illness, that qualify for Subpart S, that showed the psychiatrist reviewed, approved and signed a treatment plan.
On 9/24/14 at 8:55AM, E1 Administrator and E2 (Director of Nursing) verified that a psychiatrist has not seen residents in the building since November 2013. An agreement was signed with Z 7 on 7/31/14 but he has not been in the building since.
R12's Care Plan dated 6/30/14 showed, "R12 has a history of a suicide attempt at another facility as well as suicidal ideation. In the past two years she has had more than 50 attempts with the most recent attempt of choking herself with a shoe lace and call light cord around her neck which occurred on 6/22/14. R12 has a diagnosis of major depression, recurrent and Bipolar Disorder. R12 returned from the hospital with the following behavioral plan in place: 15 minute checks the

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first 24 hours; 30 minute checks until 6/30/14 then followed by hourly checks for the next 90 days; no call light for 90 days. R12 will be using a whistle. No shoes with laces or laces for the next 90 days and no trash bags in the room for 90 days. A Re evaluation will be done to determine stability and safety in 90 days from 6/27/14."
2. The Care Plan dated 4/30/14 for R5 showed, "R5 is at risk for abuse and at risk for abusive type behavior related to a diagnosis of Depressive Disorder. R5 has the potential to be verbally aggressive related to mental/emotional illness, ineffective coping skills and poor impulse control. " The Care Plan Meeting notes dated 7/2/14 for R5 showed her power of attorney was asking for groups to help with R5's behaviors of anxiety as part of her treatment.
3. R47's Care Plan dated 12/26/13 showed, "R47 has a history of violence and aggressive behavior towards others. R47 has a history of alcohol and drug use. R47 has a self harm which occurred in his teen years. R47 has a criminal history and is considered an identified offender by Illinois Department of Public Health (IDPH). R47 has a long criminal history involving drug possession and unlawful possession of a firearm as well as domestic battery. Currently R47 is on probation until 2015 for the most current arrest of unlawful possession of a firearm. R47 ' s symptoms and problems are manifested drug and alcohol use, manipulation, confabulation, poor impulse control and poor anger/frustration control. R47 has a diagnosis of a serious mental illness, Bipolar I disorder."
4. R30's Care Plan dated 3/18/14 showed, "R30's symptoms an problems are manifested by manipulation, confabulation, poor impulse control, poor anger and frustration control. R30 has a diagnosis of a serious mental illness - Bipolar Disorder. R30 has deficits in the following areas:

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social functioning, community living and symptom/medication management. R30 is/has the potential to be physically aggressive/threatening related to Bipolar Disorder." The Care Plan dated 7/1/14 for R39 showed, "R39 is at risk for abuse and at risk for abusive type behavior related to her diagnosis of Schizoaffective Disorder, Bipolar Disorder and Depression; R39 has a past history of self harm which includes suicidal ideation. R40's Care Plan dated 12/9/13 showed, "R40 is at risk for potential abuse and is at risk of abusive type behavior due to her diagnosis of Schizophrenia." R41's Care Plan dated 12/9/13 showed he has a history of criminal behavior, alcohol use and a diagnosis of Schizophrenia. The Care Plan dated 9/3/14 for R42 showed, "R42 has a history of a suicide attempt in which he jumped off a bridge and landed on the railroad tracks and suffered multiple fractures. R42 is at risk for abuse/neglect and has potential for abusive type behavior related to his diagnosis of Major depression." R43 has a Care Plan dated 12/13/13 that shows he has a diagnosis of Schizophrenia and problems with delusional fears, being manipulated easily by other residents and leaving the building without permission. R44's Care Plan dated 6/3/14 showed, "R44 is at risk for abuse and at risk for abusive type behavior related to a diagnosis of Bipolar Disorder. R44 has both auditory and tactile hallucinations. At times the hallucinations, especially auditory will tell her to hurt herself and she has difficulty coping with them. R44 was recently hospitalized for them and has been hospitalized in the past for suicidal thoughts." R45's Care Plan dated 6/4/14 showed he has a diagnosis of Schizophrenia, history of substance use, physical aggression, poor impulse control, anger and past criminal history. R46's Care Plan dated 11/27/13 showed he has

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S9999	Continued From page 28 Schizophrenia and Bipolar Disorder. E). Based on Interview and Record Review the facility failed to provide psychiatric rehabilitation services and related programs to residents with a serious mental illness (SMI) in accordance with Subpart S. This applies to 2 of 13 residents (R5 & R12) reviewed for Subpart S in the sample of 19 and 11 residents (R29, R30, R39, R40, R41, R42, R43, R44, R45, R46, & R47) in the supplemental sample. The findings include: On 9/16/14 at 10:45am E3 (Social Service Director - SSD) stated, "The 13 residents (R5, R12, R29, R30, R39, R40, R41, R42, R43, R44, R45, R46, & R47) on the list are eligible for Subpart S services." The Department of Human Service (DHS) Assessment Summary Information dated 3/11/13 for R5 showed, "Schizoaffective Disorder, and Obsessive-Compulsive Disorder. R5 is pleasant and cooperative. R5 seems somewhat guarded in her answers at times. R5 denies any current psych symptoms and none were obvious at this time. R5 admits to voices in her past but denies any for years. R5 expressed interest in returning to a group home when therapy is completed. Recommend supervised living arrangement. R5 to benefit from continued medication management and could benefit from ongoing skills training/education." The Psychiatric Evaluation and Follow Up form dated 11/7/13 for R29 showed she has Diagnoses of Schizophrenia and Paranoia. The Psychiatric Evaluation and Follow Up form dated 11/18/13 for R30 showed a Diagnosis of Bipolar Affective Disorder.	S9999		

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The OBRA-I Initial Screen dated 6/30/05 for R39 showed Diagnoses including Depressed Mood, Suicidal Ideation, Auditory Hallucinations and Anxiety. The Pre-admission Screen (PAS) Mental Health (MH) Level II Notice of Determination dated 11/23/13 for R39 showed the following special services that are needed: "Instrumental Activities of Daily Living training/reinforcement, Illness Self Management, Incentive Program to improve/participation in treatments, and Community re-integration activities."
The inpatient hospital Psychiatric Evaluation for R41 dated 9/9/14 showed, "Anxiety, Mania, Behavioral Changes, Change in Personality and irritability." The PAS/MH dated 3/13/13 for R41 showed the following special services that are needed: "Mental Health Rehabilitation Activities, Illness Self Management and Community re-integration activities. "
The DHS Assessment Summary dated 1/24/13 for R42 showed Diagnoses including Major Depressive Disorder, recurrent, severe without psychotic features. The PAS/MH Level II Notice of Determination dated 1/24/13 for R42 showed the following special services that are needed: "Mental Health Rehabilitation Activities, Incentive Program to improve participation in treatments and Community re-integration activities."
The DHS Assessment Summary for R43 dated 10/12/11 showed Diagnoses including Schizoaffective Disorder and Personality Disorder. The PAS/MH Level II Notice of Determination dated 3/20/13 for R43 showed the following special services are needed, "Instrumental Activities of Daily Living training/reinforcement, Mental Health Rehabilitation Activities, Aggression/Anger Management, Illness Self Management, Incentive Program to improve participation in treatments and Community Re-integration activities."

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The Psychiatric Evaluation and Follow Up form dated 7/7/14 for R44 showed Diagnoses including Bipolar Disorder, Depression, Mania and Personality Disorder.
The DHS Assessment Summary for R46 dated 8/6/12 showed a diagnosis of Schizoaffective Disorder. The PAS/MH Level II Notice of Determination dated 8/16/12 for R46 showed the following special services that are needed: " Instrumental Activities of Daily Living training/reinforcement, Incentive Program to improve/participation in treatments, and Community re-integration activities."
The DHS Assessment Summary Information dated 6/12/13 for R47 showed Diagnoses including Major Depressive Disorder with recurrent, severe psychotic features. The PAS/MH Level II Notice of Determination dated 6/12/13 for R47 showed the following special services that are needed: "Instrumental Activities of Daily Living training/reinforcement, Mental Health Rehabilitation Activities, Aggression/Anger Management, Illness Self Management, Incentive Program to improve/participation in treatments, Community re-integration activities and Substance use/abuse management."
On 9/18/14 at 3:50pm, E22 (Corporate Administrator) stated, "There isn't anything in place for Subpart S. The entire thing is out of compliance. I have been telling them that for a long time. I know it was written here 1 year ago on a survey that I helped them with and it was out then."
On 9/17/14 at 10:55am, E3 stated, "We don't have any psychiatric rehabilitation groups. There are not any rehabilitation interventions in place. The only rehab I have been doing is some 1:1 with residents. The Level of Functioning Assessments for (Subpart S) residents is done initially at admission and can be updated once on

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the same form. When the next annual or significant change minimum data set is done the level of functioning assessment form is redone. As far as the Subpart S groups, there were only 5 people that would attend them anyway." E3 stated the 5 people that attended previous groups would benefit from psychiatric rehabilitation groups if they were provided.
During a confidential interview on 9/18/14, the person stated, Nothing is being done for Subpart S. There aren't any groups being done and there wasn't any documentation on these people until yesterday. E3 is not doing 1:1's with residents."

F). The findings include:
1. The DHS Assessment Summary Information dated 6/12/13 for R47 showed Diagnoses including Major Depressive Disorder with recurrent, severe psychotic features. The PAS/MH Level II Notice of Determination dated 6/12/13 for R47 showed the following special services that are needed: "Community re-integration activities and Substance use/abuse management.
2. The PAS/MH Level II Notice of Determination dated 1/24/13 for R42 showed community re-integration activities are needed for this resident.
3. The PAS/MH Level II Notice of Determination dated 3/20/13 for R43 showed the following special services are needed, "Community Re-integration activities. "
4. The PAS/MH Level II Notice of Determination dated 8/16/12 for R46 showed the following special services that are needed: "Community re-integration activities."
On 9/17/14 at 10:55am, E3 stated, " The only person that goes out to groups in the community is R12. We don ' t have any outside community

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S9999	Continued From page 32 based programs coming to the facility for Subpart S residents. " On 9/18/14 at 3:50pm, E22 (Corporate Administrator) stated, " There isn ' t anything in place for Subpart S. The entire thing is out of compliance. I have been telling them that for a long time. I know it was written here 1 year ago on a survey that I helped them with and it was out then. " (B)	S9999		

Imposed

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A

1. Corrective Action Taken for Residents Affected By Deficient Practice

In addition to the steps outlined on pages 8-9 of the Statement of Deficiencies, the facility has taken the following steps for R12:

a. All facility staff including nursing, social services, housekeeping, maintenance, and office staff have been inserviced on the facility policy for Handling Self Harm Behavior with an emphasis on the need for proactive inteivenlion and the promotion of physical and psychosocial wellbeing.

b. The care plan for R 12 has been reviewed and revised as needed to incorporate as needed the My Safety Crisis Plan that came with R 12 when she was discharged from the hospital. The resident has been reassessed as part of this care plan review. The care plan has been revised to include R 12's triggers, stressors, warning signs, guidance on coping skills, people to call, interventions and approaches. Nursing staff who care for R 12were inserviced on the resident's revised care plan and on the need to follow the care plan. The DON, Care Plan Coordinator and medical records staff were inserviced on the need to include the crises planning information from the hospital or the resident's doctor in the resident's care plan and further on the need to ensure that nursing staffare fully inserviced on the care plan.

c. All plastic bags and shoe laces have been removed from the resident's room. Nursing, housekeeping and maintenance staff have been inserviced on the need to ensure that these items are not allowed in the resident's room and on their obligation to immediately report and remove the presence of any of these items.

d. Nursing staff have been inserviced on the steps that are required to be taken whenever R 12 threatens or attempts self-harm as set forth in the facility Self Harm Behavior policy and on the need to follow those steps.

e. The results of the Psychiatric consultation for R 12 have been reviewed and incorporated as needed into the resident's care plan. Nursing staff have been inserviced on the revised care plan.

f. Pursuant to the recommendation of the Psychiatrist, the resident is

receiving ongoing psychotherapy treatments.

g. Nursing staff who administer medication to the resident have been inserviced on the requirement that they must observe the resident as she takes medication to ensure that the medication is swallowed and is not kept for later use. This approach and intervention has been included in the resident's care plan. Nursing staff were inserviced on the revised care plan as well as the resident's stated goal of keeping Trazadone pills to take in bulk for a suicide attempt.

h. Nursing staff have been inserviced on the requirement that where periodic checks are required to monitor resident safety, those checks must occur and be documented.

i. The DON and nursing staff have been inserviced on the requirement in the Handling Self Harm Behavior policy for a reassessment of a resident on return from a psych evaluation to the facility with the care plan to be revised as needed. That has been completed for R 12.

j. R 12 is no longer a resident at the facility.

2. Identification of Other Residents Having The Potential To Be Affected By Same Deficient Practice

The facility has identified five residents who are considered high risk for suicide or self-harm.
Each of these residents has been assessed for suicide risk. In addition, the facility has confirmed that the following steps have been taken for each of these residents:

a. Each resident has been reassessed and a full care plan review has taken place. As part of the care plan review, the facility has confirmed that any crises planning information or psychiatric orders are incorporated in the care plan and are being followed. Care plans have been revised to include information on triggers, stressors, warning signs, guidance of coping skills, people to call, interventions and approaches.

b. Nursing staff have been inserviced on the revised care plans and on the need to follow those care plans including the steps to be taken whenever a resident threatens or attempts self-harm or exhibits warning signs.

c. The facility has confirmed that any recommendations for ongoing psychotherapy are being followed.

d. Nursing staff who administer medication have been inserviced on the need to ensure that residents who are at risk of suicide are observed to verify that medication is taken and swallowed.

e. Nursing staff have been inserviced on the need to follow and document safety checks.

f. The facility has verified that each of these residents have been reassessed as required following readmission after a psych evaluation. Imposed

g. Each resident who has been identified as being at risk for self-harm will be reassessed on a quarterly basis or more often as needed.

h. Nursing staff have been inserviced on how to identify warning signs and possible triggers for self-harm or suicide.

3. Measures Taken To Assure That Deficiency Does Not Reoccur

Inservices on the facility Self Harm policy will be given monthly for three months and thereafter on a quarterly basis or more often as needed. The DON will on an ongoing as needed basis monitor the care and documentation of each resident at risk for self-harm to verify that each such resident has been assessed, that the care plan reflects the resident's current condition, approaches and interventions, that nursing staff are following each such resident's care plan, that reassessments are taking place as required upon readmission from the hospital or following a psych evaluation, that nursing staff are reporting and documenting changes in each resident's behavior with proper follow up occurring as required, and that all steps to ensure each resident's safety are being followed as required by each resident's care plan. The DON and QA Committee will document that this ongoing monitoring is occurring and that resident care is being provided as required by facility policy.

4. Quality Assurance

Inservices on the facility Self Harm policy will be given monthly for three months and thereafter on a quarterly basis or more often as needed. The DON will on an ongoing as needed basis monitor the care and documentation of each resident at risk for self-harm to verify that each such resident has been assessed, that the care plan reflects the resident's current condition, approaches and interventions, that nursing staff are following each such resident's care plan, that reassessments are taking place as required upon readmission from the hospital or following a psych evaluation, that nursing staff are reporting and documenting changes in each resident's behavior with proper follow up occurring as required, and that all steps to ensure each resident's safety are being followed as required by each resident's care plan. The DON and QA Committee will document that this ongoing monitoring is occurring and that resident care is being provided as required by facility policy.

B.

1. Corrective Action Taken For Residents Affected By Deficient Practice

R 5 has been reassessed for falls. The resident's care plan has been revised to include additional interventions and approaches for fall prevention in light of the resident's assessment. The resident's bed alarm has been checked and is properly working. Nursing staff have been inserviced on R 5's revised care plan and fall prevention program as well as how to properly use a bed alarm.

The noted treatment cart on the second floor is locked when not in use or when it is not in direct view of a nurse. Nursing staff have been inserviced on the need to keep treatment carts

locked when not in use or when not in direct view of a nurse.

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R 17 is no longer a resident at the facility.

The soiled utility room on the second floor is locked and the masking tape has been removed from the lock mechanism. Nursing staff, housekeeping, and maintenance have been inserviced on the requirement that the soiled utility room must be kept locked when not in use by a staff member because of the presence of items that are potentially harmful to residents.

2. Identification of Other Residents Having The Potential To Be Affected By Same Deficient Practice

The facility has reviewed each resident who is at risk of falls to verify that each resident has been properly assessed for fall prevention with a care plan that includes appropriate approaches and interventions to prevent further falls. The facility has inserviced nursing staff on the need to ensure that bed and chair alarms are in place and are properly functioning. All bed and chair alarms have been tested and are in working order. The facility has verified that for all falls that have occurred within the last three months, each resident's doctor and POA were notified of the fall and that documentation of the notification is in the resident's chart. The facility has reviewed head charts for each instance of head injury for the last three months to verify that the head charts were properly completed and that the required checks on the resident's condition and vitals were taken and documented. The facility has inspected each medication cart and the doors to the soiled utility room to verify that they are locked when not in use.

3. Measures Taken To Ensure Deficiency Does Not Reoccur

Nursing staff have been inserviced on the requirement that for each fall, an investigation of the fall must be conducted and documented and that the fall must be reported in writing to the DON. The DON and Care Plan Coordinator have been inserviced on the need to reassess each resident following a fall and to review and revise the care plan as needed for fall prevention intervention and approaches. Nursing staff will be inserviced on the revised care plans. Nursing staff have been inserviced on the proper use of and the need to test bed and chair alarms. The DON, Administrator, Charge Nurses and QA Committee will during regular rounds ensure that the doors to the soiled utility room are locked when not in use and that medication carts are locked when not in use or in direct view of a nurse. Nursing staff have been inserviced on the proper steps to follow after a head injury including the need to complete head charts and document post fall checks on the resident and vitals taken from the resident.

4. Quality Assurance

Nursing staff have been inserviced on the requirement that for each fall, an investigation of the fall must be conducted and documented and that the fall must be reported in writing to the DON. The DON and Care Plan Coordinator have been inserviced on the need to reassess each resident following a fall and to review and revise the care plan as needed for fall prevention intervention and approaches. Nursing staff will be inserviced on the revised care plans. Nursing staff have been inserviced on the proper use of and the need to test bed and chair alarms. The DON, Administrator, Charge Nurses and

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QA Committee will doing regular rounds ensure that the doors to the soiled utility room are locked when not in use and that medication carts are locked when not in use or in direct view of a nurse. Nursing staff have been inserviced on the proper steps to follow after a head injury including the need to complete head charts and document post fall checks on the resident and vitals taken from the resident

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F 000	INITIAL COMMENTS Annual Licensure and Certification. Licensure Survey for Subpart S: SMI Complaint Investigation #1414215/IL#72177 - F323 cited An extended survey was conducted.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, and record review the facility failed to supervise a resident (R12) with a history of recent suicide attempts by not conducting 15 minute checks as ordered and failed to place R12 on 1:1 supervision when she expressed thoughts of suicide. The facility failed to remove items she planned to use in a suicide attempt (trash bags, and shoe laces) from her room which R12 had talked about using or had used in previous attempts. These failures resulted in R12 attempting suicide with her shoe laces and call cord around her neck on 6/22/14. As a result of this failure an Immediate Jeopardy was identified. The Immediate Jeopardy began on 6/12/2014	F 323		

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 /s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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F 323	Continued From page 1 when R12 expressed suicidal thoughts. On 9/22/14 at 2:30PM, E1 (Administrator) was informed of the Immediate Jeopardy. The immediacy was removed on 9/22/14 at 6:15PM, when all residents at risk for suicide were reassessed and the policy regarding residents at risk for suicide was revised and was presented to staff. The facility remains out of compliance at a level 2 as staff on all shifts had not been in-serviced on the new policy and procedure. This applies to one of five residents (R12) reviewed for safety related to suicide risk in the sample of 19. The findings include: R12's Pre-Admission Screening (PAS) Assessment Summary Information on 11/23/13 shows R12 has a diagnoses including Bipolar. The PAS states,"R12 with long history of suicidal ideations and attempts...Age 50 R12 reports ongoing suicide ideations with numerous attempts: cut self, strangle with shoe strings, and bag over head. R12 would likely benefit from continued groups to gain coping skills and symptoms management. The Pre-Admission Screening Mental Health Level II Notice of Determination dated 11/23/13 shows R12 requires special services: "Professional Observation (MD/RN) for medication monitoring, adjustment and/or stabilization, Instrumental Activities of Daily Living training/reinforcement, Mental Health Rehabilitation activities, Illness self management, and Community re-integration activities." R12 was admitted to a psychiatric Hospital from 4/9/14-4/29/14 for inpatient treatment due to the severity of her suicidal and self-destructive thoughts. The Medical History and Physical Examination form from the psychiatric Hospital on 4/9/14 states,"R12 is depressed and suicidal.	F 323		

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F 323	Continued From page 2 R12 put a cord around her neck to kill herself and later changed her mind. R12 has a history of physical and sexual abuse at the age of 10. R12 has auditory and visual hallucinations ... R12 hears devil 's voice...R12 suffers from...Post Traumatic Stress Disorder." The My Safety Crisis Plan sent with R1 on discharge from the psychiatric hospital on 4/29/14 shows R12 ' s Triggers and Stressors include: "any kind of sexual abuse reference, slamming doors, raised voices, conflict, being feeling ignored, feeling invisible, people coming up behind me, unpredicted changes. "R12's warning signs include: sleeping too much, getting angry over little things, eating too much, and withdrawing. Things I like to do:"Walking nature trails, reading, playing games on kindle, bingo and devotionals." The Screening Assessment for Evaluating Self-Harm/Suicide Risk dated 3/14/14 shows R12 has a score of 14(a score of 6-15 represents a moderate risk). The 3/14/14 Risk Screening Assessment for Indicators of Aggressive, Harmful and/or Inappropriate Behaviors shows R12 has a score 8. (a score of 0-10 shows a minimal/low risk). The Screening Assessment to Determine the Presentation of Abuse and/or Neglect Factors 3/14/14 shows R12 has a score of 5 (a score of 4 or more represents high risk). On 6/12/14 the Social Services Notes by E3 (Social Service Director) states,"...R12 shows signs and symptoms of depression. R12 tends to appear and feel depressed daily has had thoughts of suicide, has sleep disturbances, and lacks energy at times ...R12 has had three psych hospitalizations for suicidal ideation since admission, currently stable." On 6/12/14 the Screening Assessment for Evaluating Self-Harm/Suicide Risk shows R12	F 323		

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F 323	Continued From page 3 has a score 10. A score of 6-15 is at moderate risk. The Risk Screening Assessment for Indicators of Aggressive, Harmful and/or Inappropriate Behaviors 6/12/14 shows R12 has a score of 6 (a score of 0-10 is at minimal/low risk). The Screening Assessment to Determine the Presentation of Abuse and/or Neglect Factors 6/12/14 shows R12 has a score of 4 (a score of 4 or more represents a high risk). The Psychiatric Consultation progress note dated 6/16/14 said, R12 with recent suicide ideation and plan in place. R12's plan is to place a plastic bag around her neck. The trigger is relieved by removing the pillow case bag from the pillow. There are significant symptoms of depression and mood changes. R12 needs more psychotherapy. On 6/20/14 Z6 (Psychiatrist) stated,"R12 reports chronic suicidal thought. R12 reports 2 days ago she had thoughts to wrap her panty hose around her neck. R12 then hid her panty hose. R12 reported last night she hid her Trazadone (Anti-psychotic medication) in her closet with the plan to save her meds and take them on Monday night. 15 minute checks at night ...and increase Lithium dose." The Nurse's Notes dated 6/20/14 said, R12 has been storing Trazadone in her closet. R12 said, she had a plan to take all her medications at once one night. Fifteen minute checks ordered and watch R12 take medications. On 6/20/14 the Social Service Notes by E3 states, "Z6 (Psychiatrist) called the facility and spoke with nurse stating that during visit R12 stated that she was not taking Trazadone. R12 was saving pills to hurt herself. A Room check was done and two pills were found. Z6(Psychiartist) placed R12 on 15minute checks."	F 323		

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F 323	Continued From page 4 On 6/20/14 the Screening Assessment for Evaluating Self-Harm/Suicide Risk shows a score of 13. A score of 6-15 is at moderate risk. E3(SSD) wrote on the Screening Assessment, R12 was reassessed on this date related to making a suicide statement. E3 felt that resident was not a threat to herself. For 6/22/14 (Saturday) there was no documentation of 15 minute checks for R12. On 6/22/14 at 5:55 PM, An Incident and Accident Report states, "R12 wrapped shoe strings and call light around her neck and R12 ' s face was turning blue. All ties and cords cut and removed. R12 kept pulse during whole process ....911 called, Director of Nursing on site, Medical Doctor notified, family called, sent to Emergency room per protocol." The Nurses Note dated 6/22/14 states,"Certified Nursing Assistant to answer R12's call light and then yelled out loudly multiple times " Help!!!" I ran to R12's room and observed shoelaces and call light cord all tied around her neck and R12 ' s facial color was beginning to turn blue. I immediately used my medical scissors and cut all ties around her neck and also removed call light cord. R12's color returned to pink immediately and she let out a deep gasp..I asked R12 why did you decide to do this? R12 stated," I ' m done." ...What are you done with? R12 stated, "Life"... How long have you been feeling this way? R12 states, "3 days" I asked her did you tell anyone about how you were feeling? R12 states," Yes, the doctor and he only said, he would increase my medication ...." The Social Services Note dated 6/27/14 by E3(SSD) states," R12 was readmitted on this date from Rockford Memorial Hospital Behavioral Health Unit ...To ensure R12's safety the following actions have been put in place. R12 will be on 15	F 323		

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minute checks for first 24 hours on 6/28 and 6/29 R12 will be on 30 minute checks. On 6/30 ...R12 will be on 1 hour checks for 90 days. R12's call light has been removed ...R12 also has had all laces removed from shoes...no plastic bags ...all precautions have been care planned ...R12 will be encouraged to attend group in facility ...."
The 1 Hour Care Sheet for R12 from 6/30/14 - 9/16/14 shows no documentation for 9 days. 7 Care Sheets are completed hourly, and remaining sheets are not documented hourly.
On 9/18/14 at 11:00AM, E22 (Medical Records) said, these are the only hourly care sheet records he was able to find.
The Care Plan dated through June 2014 shows R12 has a history of suicide attempt as well as suicidal ideation. In the past two years she has had more than 50 attempts with most recent choking herself with shoe laces and call light cord around her neck on 6/22/14. R12 has a diagnoses of Major Depression recurrent and Bipolar Disorder. R12's Care plan states," In the event that R12 exhibits behavior of thoughts or attempts to harmself, R12 is to placed on one to one, psychiatrist and Medical Doctor to be notified resident will be monitored till discharged to hospital." R12's Care Plan was not revised to include removing plastic bags and shoelaces, supervision checks, and attend group.
On 9/17/14 at 11:45 AM, there were four pairs of shoes with shoelaces underneath R12's bed.
On 9/17/14 at 2:00 PM, there were two garbage cans with trash bags in R12's room.
On 9/22/14 at 3:05 PM, a garbage bag was in R12's bathroom and a garbage bag was near her roommate's bed.
On 9/22/14 at 4:10 PM, E19 (Housekeeping Supervisor) stated,"I took the bags out of her room. I didn't know they weren't supposed to be

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in there. I will pass that on to my housekeepers."
On 9/17/14 at 2:00 PM, E3 (SSD) stated, "R12 comes to me when she has feelings or issues ....There has been no gap in time where she doesn't come and see me ...I do one to one meetings with R12 as needed ....All staff are aware what should not be in her room garbage bags, shoe laces, and call light ...I don ' t have groups running right now. They stopped in July."
On 9/18/14 at 9:00 AM, R12 said, Groups have not been offered for about 2 months. I think the groups helped me when we had them.
On 9/18/14 at 9:25 AM, E23(Licensed Practical Nurse) said, R12's behaviors are managed well when she is kept busy. Isolation increases her triggers.
The Physician Order Sheet dated through September 2014 shows R12 has diagnosis including Psychosis and Depression.
Based on observation, interview and record review the surveyor confirmed the facility took the following actions to remove the immediacy:
1. Corrective Action taken for Residents displaying self Harm behaviors:
The resident at risk will be assessed for warning signs and triggers. The staff will use the best of their knowledge to remove or prevent any triggers that would cause the resident to decide to harm themselves. This will be done suing the new Suicide Risk Assessment. The facility has five residents who could be considered high risk. These five residents had the Suicide Risk assessment done on 9/22/14.
2. Identification of other residents that have potential to be affected by the same deficient conduct:
All other residents that have the potential to be affected by the conduct will have quarterly assessments done. These will also be done on

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an as needed basis. Nursing staff will be in-serviced on how to identify different warning signs and possible triggers. The Director of Nursing, Social Service and administrator will implement this tool effective 9/22/14. All residents that were admitted previous to this date will be assessed using this tool within 30 days from this date.

3. Measures taken to prevent deficient conduct from reoccurring:

The Suicide Risk assessment will be done upon admission by the social service department. The nursing staff will then use this assessment to determine possible triggers for each resident. These assessments will be assessed weekly by the Director of Nursing and social service representative. The Director of Nursing will also assess any 15 minute check forms every Monday through Friday. At the time of any occurrence the Director of Nursing, administrator and Social Services rep will be notified immediately so that the proper action can be taken beginning 9/22/14.

4. Quality Assurance

The Social Service representative, Director of Nursing, and administrator will give in-services monthly for the next three months on the suicide risk assessment tool and how to take proper suicide precautions for a resident at risk. At this time an initial in-service will be given at the beginning of every shift before the employees take care of the residents until we hit 100% of staff in-serviced. This training will include review of the policy and procedure for handling self harm behavior, Asta care healthcare center ' s contract for safety and the initiation of the blue triangle to alert staff that the resident is at high risk for suicide.

B. Based on observation, interview and record review the facility failed to ensure residents safety

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by not revising approaches for a resident who had 12 falls in the past 9 months (1 fall resulting in a hip fracture), failed to conduct neurochecks after a resident fell twice and hit his head, failed to lock the treatment cart and failed to keep chemicals in locked storage. This applies to 2 of 3 residents (R5, R17) reviewed for safety in the sample of 19. The Findings Include:

1. R5's September 2014 Physician Order Sheets shows R5 has a diagnoses including Osteoporosis, Weakness and Hip Fracture. R5's History and Physical from a previous hospitalization on 4/2/14 states, R5 has a history of recurrent hip dislocations ...R5 reported that she was trying to get out of bed alone and fell.

The Minimum Data Set assessment of 6/20/14 shows R5 transfers with a two person assist.

On 9/16/14 at 1:20 PM, R5 stood up by herself attempting to transfer from her wheelchair to her bed. R5 held on to her side table and bed for assistance. E10(Licensed Practical Nurse) was at the bedside and did not assist R5 with her transfer. The chair alarm did not alarm.

On 9/17/14 at 9:41 AM, R5 stood up from her wheelchair by herself. The chair alarm did not alarm.

On 9/16/14 at 1:05 PM, E10 (Licensed Practical Nurse) said, R5 transfers with 1 staff assist and has a chair/bed alarm.

R5's Care Plan dated through April 014 shows R5 had a fall that resulted in a hip replacement. It shows staff to assist with all transfers. R5 is not to transfer to/from wheelchair or toilet without staff.

R5's Care Plan was last revised on 3/28/14. R5 has had 8 falls since then. The bed/chair alarm was not in the Care Plan.

The Fall Risk Assessments dated July with no year documented shows R5 has a score 12. A score of 10 or more represents a high risk for

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falls.

2. On 9/15/2014 at 11:30 AM, one of the two treatment carts on the second floor was unlocked and unsupervised. The treatment cart was located at the end of long hall around the corner from the nurse ' s station. The treatment carts were not in direct view from the nurse ' s station. The treatment cart contained prescription ointments, ointments for skin/perineal care, fingernail clippers, razors, iodine, dressings, gauze, and wound cleansers.
On 9/18/2014 at 8:35 AM, E23 (Licensed Practical Nurse-LPN) stated, " (The treatment cart) should be locked at all times except when in use " .
An allegation of abuse on 11/21/2013 showed R41 opened the medication cart while E6 was a few feet away helping another resident.
The facility ' s policy on Medication Administration (No Date) shows, the medication cart should always be locked unless it is in direct view of the unit nurse.

3. The February 2014 Physician's Order Sheet showed R17 was admitted to the facility on 2/5/14 with diagnoses to include: Dementia, Diabetes Mellitus, End-Stage Renal Disease, Chronic Obstructive Pulmonary Disease and Hypertension.

The Minimum Data Set (MDS) of 2/19/14 assessed R17 as severely impaired for decision making and needing limited assistance of 1 staff for transferring. R17 was assessed as being

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F 323	Continued From page 10 unsteady for balance during transfers. R17 required 1-2 staff for all ADL's (Activities of Daily Living) except eating. The fall risk assessment completed 2/5/14 showed R17 was at high risk for falls. R17's nurse's notes document the following: "On 2/12/14 at 10:15pm, "Resident alert to self. Transferred self to/from wheelchair without supervision is reminded by staff that he should request assist due to safety." "On 2/21 at 10:30pm, "Resident alert to self. Self propels wheelchair able to transfer self but needs reminders to request assist for safety." "On 3/12 (10:20pm), Resident needs reminders not to get out of bed or up from chair without assist." The care plan initiated 2/25/14 showed R17 has cognitive/function or Dementia related to impaired thought processes. The falls care plan is dated 2/25/14 and showed R17 is at risk due to deconditioning. Approaches include: Anticipate the resident's needs. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. The care plan was revised on 3/7/14 to include: the pad alarm in bed/recliner and while in wheelchair, check functioning with every transfer and ensure it is on and active prior to leaving the room. The nurse's note show R17 had no alarm in place on 3/4/14 (POA wants the resident to have an alarm like he had in the hospital).	F 323		

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The nurse's notes on 3/4/14 (6:10am) describe , R17 was witnessed by staff transferring from wheel chair to recliner and fell. Resident stated he fell and hit the back of his head on the wall. The nurse's notes at 5:00pm document MD and POA were not notified of the fall that occurred at 6:10am.

The "Head Chart" form is used to monitor patients vital signs, pupils, and level of conciousness after head injuries/unwitnessed falls for 72 hours. R17's Head Chart documented the time of the incident was 6:10am on 3/4/14. The head chart was incomplete and only done 6 of 21 times in a 72 hour period: at 6:25am, 6:40am, 6:55am, 10:10pm and on 3/5 at 6:10am and 2:10pm. E2's name was in the area as completeing the assessment but there was no documentation of vitals shown on 3/4 from 6:55am to 2:10pm. There was no documentation of vitals/nerochecks on 3/5/14 at 2:10pm to 3/6/14 at 6:10am (72 hour monitoring) Comments on the fall checklist described R17 fell backwards, with just socks on, transferring self to wheelchair. On 9/24/14 at 10:00am, E2 was asked why R17's head chart form for 3/4/14 was incomplete. E2 stated, "I honestly don't know why there were gaps in the neurochecks."

R17's nurse's note on 3/5/14 (8:00am), Sat in wheel chair all night, refused to sit in recliner and elevate edematous legs. No alarm present, 30 min checks by staff all night.
(9:20pm) Resident in room in wheel chair next to the bed, attempted to stand without locking wheelchair, resident in stocking feet. When resident stood, started to slide, which alerted nurse and CNA, but staff could not get to resident. He slipped and landed on butt next to

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bed. Assisted off floor per 2 and into recliner. Post-Fall investigation report dated 3/5/14 showed alarm was not attached to the resident.

The nurse's note for R17 on 3/6/14 (3rd shift) showed, Vital signs taken. Alert with confusion. Up in recliner at times during the night, complained of headache. PRN Tylenol given. R17 blew nose and large amount of blood was in tissue. Alarm in place. Will monitor.

(1st shift)- Resident alert but to self only, refused dialysis said, "I'm not feeling well." Gave Tylenol for headache and Ativan but resident still refused dialysis. Dialysis informed nurse that stat labs to be drawn for Hemoglobin. Results back and Hemoglobin 5.6. Received orders to send resident to ER for eval and treatment with transfusion. Resident returned from hospital on 3/10/14.

The Physical Therapy note dated 3/11/14 showed R17 is a fall risk occasional impulsive as to transfers, decreased safety awareness, required cues for redirection and safety. Ambulation: Unable to perform at this time due to decreased endurance, strength and activity tolerance.

R17's nurse's note 3/15/14 (12:20am) Client heard falling on to the floor, alarm did not sound. Client on back and wheel chair had fallen on the side. Bed/chair alarm was on resident's chair. CNA last seen resident in his chair at midnight with alarm attached. To ER as resident stated he hit the back of his head. 1:05am left for ER. Late entry on 3/15/14 at 5:00am documented R17's vital signs were taken but no other assessment was done. Reason for fall, R17 was getting up to get his cell phone. CNA and nurse assisted resident to his bed to await ambulance. The

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incident report of the same date documented R17 had a bump on the back of his head the size of a fifty cent piece. The chair alarm did not sound on 3/15 to alert staff before R17 fell and sustained a subdural hematoma. There was no initial neurocheck sheet completed after R17 complained of hitting his head.

On 9/24/14 at 10am E2 said [on 3/15/14] R17 fell and was sent out and suffered a hematoma. The previous Director of Nursing was the nurse in charge covering a call off when it happened. [The procedure when someone falls] an incident report is done, resident is reassessed and vitals are taken for 72 hours, neurochecks are done and the fall investigation tool is filled out by the CNA and nurse for proper interventions.

R17's History & Physical of 3/15/14 showed, "CT scan of the head was done which showed some old and possible subdural hemorrhage." R17 was admitted to the Intensive Care Unit (ICU).

The Coroner's Report dated 4/7/14 described the details of the incident, On 3/15/14 at 12:36am the ambulance company received a call from the nursing home stating that R17 had fallen. At 12:52am the ambulance arrive at the nursing home and found R17 sitting in a chair in his room with a bump to the back of his head. He seemed confused and the nurse stated that this was normal and also he falls alot. R17 was able to stand and get on their cot. At the ER, R17 was given a CT scan of the head which showed a subdural hematoma. He was admitted to ICU. More CT's of the head were done and showed his subdural hematoma had worsened. His mental status did not change after a few days and he was seen by the palliative care team. On 4/1/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145818	A. BUILDING _____ B. WING _____	C 09/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK RIVER HEALTH CARE	707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103

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F 323	Continued From page 14 the family opted to send R17 to another facility. He remained on comfort care and his condition did not improve. R17 expired on 4/7/15 at 12:50am. The cause of death was Subdural Hemorrhage, secondary to a Fall. 4. On 9/15, 9/16, and 9/17/14 the soiled utility room on the 2nd floor was unlocked. The door's lock mechanism was covered over by masking tape. The room contained bulk cleaning supply containers such as disinfectant, toilet bowl cleaner and floor cleaner. The containers posted warning labels, "Harmful if Swallowed", "May Cause Eye Irritation" and "Keep Out Of Reach Of Children." On 9/18/14 (Housekeeping Supervisor) said the lock was broken	F 323		