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	IL6001986	A. BUILDING: _____ B. WING _____	10/19/2017

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GRANITE NURSING & REHABILITATION	3500 CENTURY DRIVE GRANITE CITY, IL 62040

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S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation 1746025/IL97409	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 3) 300.1210b) 300.1210d)6) 300.1220)b)3) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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	S9999	Attachment A Statement of Licensure Violations	

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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 and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on record review, observation and interview, the facility failed to supervise and implement fall interventions for one of seven residents (R14) reviewed for falls in the sample of 17. This failure resulted in R14 falling and

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sustaining a fracture of the left femoral neck and a left distal radial metaphyseal fracture.

Findings include:

R14's Physician Order Sheet (POS), dated 10/01/17, documents R14 has in part a diagnoses of Osteoarthritis and Pain.

R14's MDS, dated 08/14/17, documents R2's balance is not stable, only able to stabilize with staff assistance for moving from seated to standing position, walking, turning around, moving on and off the toilet, and surface to surface transfers. R14's MDS documents a (BIMS) score of 4, which represents severely impaired with cognition.

R14's Care Plan, dated 03/06/16, documents R14 is at risk for falls related to weakness, mobility impairment, and the use of psychotropic medication. The Care Plan documents on 01/3/17, R14 had a fall without injuries with interventions of neurological checks, check for proper footwear. The Care Plan also documents another fall on 01/04/17 without injury. Her interventions are bed and wheelchair alarms, and a rubber, non-slip pad in her wheelchair. R14's Care Plan also documents a fall on 05/05/17 with injuries. The interventions are bilateral floor mats and tab alarm to her wheel chair. R14's Care Plan, dated 05/23/17, documents R14 needs the assistance of one staff for transfers.

R14's Resident Incident Report, dated 05/05/17 at 9:55 AM, documents R14 was found on the floor yelling in pain. R14 stated she was trying to get into her wheelchair, and it rolled back because she forgot to lock her brakes. R14 stated she turned off her alarm, because it was

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too loud.

An untitled letter regarding R14, dated 05/09/17, written by Z4, former Director of Nursing (DON), documents on 05/05/17 at 9:55 AM, R14 was found lying on her side left side on the floor in her room next to her bed. It also documents R14 was sent out to the local hospital and diagnosed with a left radial and femoral fracture.

R14's X-ray Report, dated 05/05/17, documents a fracture of the left femoral neck and a left distal radial metaphyseal fracture with comminution.

The facility Departmental Notes, dated 05/15/17, documents R4 arrived back to the facility via local ambulance. R14 had a brace to her left arm, with noted bruising to her fingers. R14 had staples and a dressing intact to her left hip. R14's pedal pulses were present. R14 had pain rated as 9 out of ten, and Tylenol was given.

On 10/12/17 at 8:30 AM, R14 wheeled herself into the bathroom and toileted herself. R14 then wheeled herself to the bed and transferred herself into bed. R14's bed alarm then sounded. R14 stood up, hanging onto her wheel chair, and moved her bed alarm down to her feet. The bed alarm wasn't sounding. E19, Licensed Practical Nurse (LPN), who was in the room and witnessed the transfer, told R14, "No, you have to sit on it." E19 moved the bed up to where R14 could sit on it. R14 then got herself into the bed, sitting on the pressure pad alarm.

E2, DON, on 10/13/17 at 9:00 AM, stated, "We are trying to beef up our rounds for Nurses and Certified Nursing Assistants."

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S9999	Continued From page 4 (A) (Violation 2 of 3) 300.610a) 300.1210b) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	S9999		

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S9999	Continued From page 5 resident. (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 provide supervision to prevent resident to resident altercations and implement interventions after incident occurred for 1 of 1 resident (R9) in the sample of 17 and 1 resident (R24) in the supplemental sample. This failure resulted in R24 inappropriately touching R9 causing her to be fearful during the hour long incident and experiencing nightmares related to the incident. Findings include: R24's Physician Order Sheet (POS), dated 9/7/17, documents a diagnosis in part of anxiety disorder and other intellectual disabilities. R24's Minimum Data Set (MDS), dated 9/7/17, documents behavior not exhibited for other behavioral symptoms directed toward others. R24's MDS also documents no conditions that are related to ID/DD (intellectual disability/developmental disability) status. R24's Social History/Psychosocial Assessment, dated 9/7/17, documents, in part, "prior psychiatric treatment/concerns: developmentally disabled." Mental Health Diagnosis/History: anxiety. Behaviors (Y/N): "N" Physical Aggression." R24's OBRA-1 Initial Screen Identification of Individuals for Whom There is a Reasonable Basis to Suspect a Developmental Disability or a Mental Illness, dated 9/6/17, documents in part "intellectual disability; other indicators of mental	S9999		

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illness."

R24's Instant Care Plan, dated 9/7/17, documents, in part, "inappropriate touching another resident." The intervention documented is "15 minute location monitoring, behavior tracking."

R24's Behavior/Intervention Monthly Flow Record, dated 10/2017, documents tracking behaviors of "pushing wheel chair into others, disruptive, s/s (signs and symptoms) of aggression." There is no documentation of behavior tracking of R24 touching others inappropriately.

On 10/10/17 at 1:10 PM, E18, Physical Therapy Aide (PTA), informed another surveyor to be careful of R24 due to his inappropriate touching, because R24 was attempting to touch the surveyor's arm. E18 stated R24 has the behavior of grabbing a person's arm and touching further up the arm until R24 was told to stop. R24 was propelling self about the hall without supervision.

On 10/12/17 at 10:00 AM, while interviewing E19, Licensed Practical Nurse (LPN) at the Nurse's station, R24 propelled himself to the Nurses Station and grabbed the surveyor's left arm multiple times. R24 continued to massage surveyor's left arm, moving upward until the surveyor intervened. R24 had no staff around, except E19 who was being interviewed. E19 did not intervene or redirect R24. R24 laughed inappropriately as he was massaging the surveyor's left arm.

On 10/12/17 at 1:10 PM, R24 was propelling himself in the hall towards the Nurses Station without supervision.

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R24's Behavior/Intervention Monthly Flow Record, dated 10/2017, documents tracking behaviors of pushing wheel chair into others, disruptive, s/s of aggression.

R9's Abuse Investigation Statement, dated 10/05/17, documents, in part, R24 came into R9's room and inappropriately touched her. R9's Abuse Statement documented "Resident (R9) stated she was doing crossword puzzles around 6:30 PM when (R24) came into her room and continued to get closer to her. R9's statement documents "Resident (R24) said he wanted to watch TV, and resident (R9) replied there was nothing to watch at the time. Resident (R9) stated soon after, (R24) placed his hand on her stomach and began rubbing and would not stop. Resident (R9) then shouted, 'No!' (R24) stopped, and 'I screamed or something.'" The Statement documented "Resident (R9) stated a while later, 'a nurse or something' came in and asked (R24), 'What are you doing?' and took (R24) to his room. ED (Executive Director, E1) asked resident (R9) if she had called for help." The Statement documents "Resident (R9) replied that she did not, because she was afraid of what (R24) would have done to her." Resident (R9) stated she has had traumatic experiences in her life, one almost near death experience where she was beaten. SSD (Social Service Director, SDD, E14) asked resident (R9) if the door was open. Resident (R9) and R9 replied that it is always open because she was "claustrophobic." ED (E1) asked resident (R9) if she felt like (R24) abused her. Resident (R9) replied, "No kidding! He told me to shh!" The Statement documented "ED (E1) asked resident (R9) how long (R24) was in her room. Resident (R9) replied, "at least an hour or more."

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The Facility Investigative Report, dated 10/6/17, documents, "On 10/6/17 at approximately 8:50 am (R9) reported to staff last night, (R24) came into her room and touched her abdomen. (R9) stated she thought (R24) was going to touch her private areas, so she distracted (R24) by turning on the computer and showing religious information." The Investigative Report documented "Upon completion of the investigation the facility substantiated the altercation did occur."

On 10/13/17 at 11:13 AM, R9 stated when R24 came in her room and touched her, "I was floored! I thought 'What the heck?' I was scared. I was so upset, I was really scared. I thought, 'What do I do?'"

On 10/13/2017 at 4:00 PM, Z7, Clinical Operations Nurse, reported R24 was placed on 1:1 observation on 10/12/2017 after the Daily Status Meeting at 4:00 PM, when it was brought to their attention that R24 propels himself around the facility without supervision. This was six days after this incident occurred. E1 was present and was in agreement with Z7.

On 10/17/17 at 11:25 AM, Z7 stated, "(E1) can administratively put someone on 1:1 anytime he wants. We don't document anything when someone is put 1:1." Z7 also reported the facility does not have a policy for 1:1 monitoring. Z7 also stated, "You know, I talked to her just to find out everything that happened. And she's fine." Z7 reported R9 doesn't have any issues with the incident.

On 10/17/17 at 11:20 AM, R9 stated in part, "When (R24) came in my room and touched my abdomen, I was scared at first. My mind went

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blank. I was flabbergasted, and I couldn't think. I was afraid to tell him to get out. I don't know what he is capable of. I turned on my computer to get his mind on something else. But he (R24) just continued rubbing, and he tried to touch my private area. He hasn't touched me since then, but now there's people with him now. I've started having nightmares. I've had 3 nightmares since this."

R9's MDS, dated 10/2/17, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R9 is cognitively intact.

R9's Care Plan, dated 9/25/17, documents a diagnosis of depression and requires the use of psychotropic medication.

R9's Social History/Psychosocial Assessment, dated 10/9/17, documents provoking factors for mood/behavior as being touched in an unwanted manner.

R24's Resident Location Monitoring form, dated 10/7/17 at 6:00 PM, through 10/10/17 at 1:00 PM fails to document that observations were completed on 10/9/17 from 12:00 AM till 6:00 AM, and from 2:00 PM till 6:00 PM. On 10/10/17, the form fails to document observations were completed from 2:00 PM till 6:00 PM.

On 10/17/17 at 10:37 AM, E14, Social Services Designee (SSD), stated the SSD is educating R24 on inappropriate touching by 1:1 visits 3 times per week and educating on personal space. E14 also stated, "He answers using yes and no and sign language, but I don't know sign language."

On 10/17/17 at 1:40 PM, Z6, Physician, reported

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he is aware of the incident that occurred on 10/5/17 with R9 and R24. Z6 stated, "I think they (the facility) need to do good screening and assessing, and if you want to admit that type of person, you need to be prepared to provide the care he needs. I think he (R24) needs 24 hour 1:1."

On 10/17/17 at 2:08 PM, E21, Care Plan/MDS Coordinator stated, "Here's the new MDS for (R24), I had him marked wrong. That's my fault, but I fixed it."

The facility's undated Abuse Policy documents, "Policy: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteer and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual." The policy continues, "Section C) Sexual Abuse: This includes, but is not limited to sexual harassment, sexual coercion or sexual assault or non-consensual sexual contact of any type with a resident." The Policy continued, "Protection: #3. It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment. Care will be monitored so that the resident's

(B)

Section 300.3060A4 Nursing Unit-resolved no longer applies

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(Violation 3 of 3)

Section 300.241OJ3 Nursing Unit

J) For each bed there shall be furnished: 3) An individual towel rack.

This requirement is NOT Met as evidence by:

Findings include:

Based on interview and observation the Facility failed to ensure each resident was provided with a towel rack per bed for residents reviewed for towel racks.

This has the potential to affect all 83 residents living in the facility.

Findings include:

On 10/10/17 from 3:30 PM - 4:11 PM each resident's room and all bathrooms on the east and west wings were inspected and no room contained any towel rack for the residents. While each bathroom contained at least one handrail no room contained a towel rack.

On 10/10/17 at 4:12 PM, in Room 229 in the bathroom sink a washcloth was sitting on the sink. Room 229 shares a bathroom with Room 227.

On 10/10/17 at 4:18 AM, R19 stated "I never know where to put my washcloth."

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S9999	Continued From page 12 On 10/12/17 at 8:40 AM, E6, Linen staff, was handing out washcloths and towels in the east hall. On 10/10/17 at 4:15 PM, E4, Maintenance Director, stated "We have never had any towel racks. It's been like that since I have been here. We have never had any towel racks." On 10/12/17 at 8:40 AM, E5, Housekeeper Supervisor, stated there was no towel racks in the room. There is a designated linen staff that passes out linen 3-4 times a day. When staff uses the linen (dirty linen) they place them in the dirty linen closet. The linen staff checks the rooms multiple times a day and empties the dirty linen and takes them to laundry. E1 stated there were no policy on hand towels that he was aware of. The Resident Census and Conditions of Residents and CMS 672, dated 10/10/17 documents that the facility has 83 residents living in the facility. (AW) Section 300.3060B2 Nursing Unit b) Resident Bedroom 2) Maximum room capacity shall be four residents. Beds shall be at least three feet apart, and no more than three beds deep from an outside wall. There shall be a minimum of ten feet between walls or a wall and any built in	S9999		

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GRANITE NURSING & REHABILITATION	3500 CENTURY DRIVE GRANITE CITY, IL 62040

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 furniture or storage space. This requirement is NOT Met as evidence by: Findings include: On 10/11/17 at 4:01 PM, behind the nurses' station, R20's Special care unit room is on the West Wing with one bedroom and one bathroom. The room is not in a square shape and the back wall measures 9 feet by 8 inches in width and measures less than ten feet between the walls. The room does not have a room number on the outside of the door and documents SPCW on the wall. On 10/11/17 at 4:45 PM, R21's Special care unit room is on the East Wing with one bedroom and one bathroom. The room is not in a square shape and the back wall measures 9 feet by 8 inches in width and measures less than ten feet apart between the walls. R21 is on a vent and is unable to communicate. The room does not have a room number on the outside of the door and documents SPCE on the wall. On 10/11/17 at 4:32 PM, E4, Maintenance Supervisor, stated yes both of the rooms are the same and because of the shape of the room the wall is not ten feet between the walls. On 10/12/17 at 10:02 AM, E1, Administrator, stated "there is no policy on walls less than 10 feet apart." (WAIVER APPROVED)	S9999		