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EDWARDSVILLE NURSING & REHABILITATION CENTER	401 ST MARY DRIVE EDWARDSVILLE, IL 62025

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There was no tracking for the certified nurses's assistant to ensure that they receive 12 hours of in service annually.

On 6/16/06, the facility's Nurse Aide Roster was reviewed. 10 CNAs have been employed by the facility for longer than one year.

On 6/16/06, at 11:00 a.m., during an interview with E3, Assistant Director of Nurse's, E3 said she was responsible for tracking the CNAs in-service hours. E3 said she had not been completing tracking because she had multiple duties in the facility. E3 noted she would be developing a new system to track the CNAs and would be developing a calendar of in-service training, although there was no program as of yet .

F9999 FINAL OBSERVATIONS F9999

Licensure Violations

300.1210a)
300.1210b)6)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care
a) The facility must 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 assessment and plan of care. 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.

b) General nursing care shall include at a

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minimum the following and shall be practiced on a 24-hour, seven day a week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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

Based on observation, record review and interview the Facility failed to monitor, supervise, and implement their policy "Suicidal Precautions," for 1 (R12) of 2 sampled residents who made suicidal statements. This neglect resulted in R12 attempting to commit suicide with superficial lacerations made to each side of the neck and hospitalization after the attempt was made.

The findings include:

R12 was admitted to the facility on 1/12/06 with diagnoses, in part, of major depressive disorder, dementia, and suicidal ideations. R12 was assessed on the 1/18/06 and 4/7/06 Minimum Data Set as having modified independence with cognitive skills, independent with ambulation with mood and behavior indicators present.

The nurses notes by E29, Licensed Nurse, dated 3/26/06 at 7:15 PM noted that another resident approached E29 and stated R12 had said he was going to "break his tea glass and cut his wrist with them." At 7:25 PM the nurses notes states

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that R12 was asked if he had said that "he was going to break his tea glass and cut his wrist he said yes he had said that." E29 documented that R12 "promised he wouldn't' hurt himself." At 7:45 PM the physician was paged and returned the call at 7:53 PM and ordered "1 hour suicide watch."

On 3/31/06 at 11:30 PM, R12 complained of feeling depressed as documented in the nurses notes. The nurses notes documented that R12 stated "my mind isn't working well" Asked res. if he wanted to hurt himself? states "doesn't want to be in the world any more. Notified Z2, (physician), verbal orders/telephone send res to ER for phyc. evaluation." The nurses notes state the ambulance was called at 12:00 AM for transfer to hospital. The next nurses note on 3/31/06 at 1215 states "Found lying in bed with 2 small superficial lacerations to each side of neck. When asked what happened stated "I'd be better off dead" When asked if he had tried to harm himself did not respond. Broken glass lying on night stand." R12 was sent to the hospital at 1225.

The History and Physical dated 3/31/06 identifies the chief complaint as "Suicidal ideation with self-inflicted scratches to the neck." It states R12 " wanted to hurt himself." The history and physical identifies R12 had previous psychiatric admissions with a history of trying to hurt himself in the past. R12 was admitted to the closed psych unit and was kept until he was "no longer a danger to himself or others."

R12 returned to the facility on 4/7/06. On 4/9/06 at 5:15 AM, according to the nurses notes, R12

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brought two glass bottles to staff that he stated were in his trash can. Staff checked R12's room for any other glass objects and none were found.

On 5/21/06 at 4:30 PM, R12 approached staff and stated he was very upset. According to the nurses notes R12 stated "I think you need to call my doctor they're going to have to handcuff me" "I've had 3 mental breakdowns in my life and I'm about to have another, you have to get me out of here or I'm going to kill myself." Pt taken to his room all sharp objects removed from his room. Pt. helped. Said he didn't want to eat, he was going to lie down and try to calm down." R12 was sent to the hospital at 5:45 PM. The "Daily Supervision Checklist" documents hourly checks on R12 until 3:00 PM. There is no documentation that the Suicidal Precaution" Policy was implemented. R12 was readmitted on 5/31/06.

On 6/13/06 at 9:30 AM R12 made the statement to staff and surveyor that he "needed to be in a mental hospital." In an interview with E30, Licensed Practical Nurse for R12's hall, E30 stated on 6/14/06 at 9:35 AM that R12 was on one hour monitoring with the documentation in the monitoring book. E30 showed the surveyor the book with R12's whereabouts monitored every hour. E30 stated that staff watch where he is. Observation of R12 on 6/13/06 from 3:00 PM until 4:05 PM noted that he was in his room with the door shut. One hour documentation was documented for 1, 2, 3 and 4 PM for R12 on the "Daily Supervision Checklist." It was documented that R12 was in his room.

On 6/15/06, E1, Administrator, stated R12 had

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F9999	Continued From page 78 been giving his personal items away and stated he didn't deserve them. E1 stated R12 had been put on 1:1 observation per the policy at this time and the physician called. Orders were received to send R12 to the hospital. The care plan dated 2/1/06 through 5/1/06 states as a problem "Resident has a dx of suicidal ideations" with the goal to "not make any negative statements or voice thoughts of hurting self/suicide." The approaches include: "monitor resident for changes in mood; give medication as prescribed by physician; 1:1 visits as needed by social service; include resident in facility activities and programs; give res. tasks to increase feelings of self worth." The care plan dated 3/31/06 through 6/31/06 identifies a problem of "Resident gave self a superficial wound on the neck with broken piece of glass. There has been no observed hx of self mutilation or suicidal thoughts since admit to this facility. Res is currently taking Zoloft 50 mg daily Risperdal 0.25 mg TID." The goal is to "control resident suicidal ideations at current time." The approaches are to "send resident off-site for a psych eval; will take suicidal precautions upon readmit; evaluate psych eval land reassess resident for most appropriate placement; 1:1 with social services daily upon return." The care plan dated 4/20/06 through 7/20/06 states "Res has suicidal ideations" with the expected outcome of "will not make any negative statements or voice thoughts of hurting self/ suicide." The interventions include: "doc changes in mood; meds as ordered; 1:1 visits; 15 minute checks as needed; include res in facility	F9999		

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activities and pgms; give res tasks to inc feelings of self worth; p/s pgm as needed."

The care plans made for R12 after the 3/31/06 suicidal actions do not identify the specific response staff are to make should R12 make suicidal statements or actions. According to the facility policy and procedure "Suicidal Precautions," staff were not monitoring R12 every 15 minutes per the care plan as documented on the "Daily Supervision Checklist" dated 4/27/06 to 6/13/06.

The policy and procedure "Suicidal Precautions," with no date, states "The facility should provide for the safety, protection, and well being of all residents who have demonstrated thought words or actions of suicidal tendencies." It further states "When a resident is observed by a staff member to exhibit verbally and/or physically suicidal tendencies the following measures should be taken in an effort to prevent an attempt or further attempt by the resident from harming his/herself:

1. The resident is not to be left unattended until resident's intent is evaluated. The staff person observing the resident that exhibits verbal and/or physical suicidal tendencies should notify by call light the licensed nurse in charge and/or another staff member if the charge nurse is the one to find the resident.
2. The licensed nurse in charge should assign a staff member to remain with the resident so he/she is visible to a staff member at all times until the situation can be e valuated and precautions can be implemented.
3. The licensed nurse should evaluate the immediacy of the resident's intent and contact

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F9999	Continued From page 80 Social Services Director to complete the Suicidal Questionnaire to gather date for evaluation of the situation." Interview with E1, Administrator, on 6/14/06 at 11 :10 AM confirmed that the policy and procedure " Suicidal Precautions" was not followed for R12 for the 3/31/06 incident. In an interview with E24, Social Service Director, on 6/13/06 at 10:30 AM he stated that R12 was a very quiet person and had not voiced any complaints prior to the incident. E24 stated that he had not been called to do a "Suicidal Questionnaire" after R12 made verbal suicidal statements. E24 stated he did not think he was in the building at the time it happened. E24 stated he would be notified and would assess the situation and make sure there was no sharp or harmful objects in R12's room. E24 stated he met with R12 one on one and was working on trying to increase R12's self worth. The Social Service notes dated 3/27/06 identified R12 was noticed to be less involved in activities and reduced social interaction. R12 stated at that time he was tired and his roommate was keeping him up at night. (A)	F9999		