PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	COMPLETED		
		146114	B. WIN	1G _			7/ <b>2011</b>	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COI 1010 SOUTH LOGAN STREET LENA, IL 61048			,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	TS	F	000				
	Incident Report In 54226	vestigation of 8/17/11 /IL						
F 224 SS=J	483.13(c) PROHIE	survey was conducted. IT NEGLECT/MISAPPROPRIAT	F2	224			9/28/11	
	policies and proced mistreatment, negl	evelop and implement written dures that prohibit ect, and abuse of residents on of resident property.						
	by: Based on interview neglected to have to staff intervention suicidal ideation or facility also neglect procedure in place disposable razors.	NT is not met as evidenced w and record review the facility a policy and procedure related as when a resident expresses threats of self harm. The ted to have a policy and for the storage/use of These failures contributed to wrists with a modified a 8/17/11.						
	8/31/11. The Imme 7/25/11 at 7:30 PM	pardy was identified on ediate Jeopardy began on I when R1 scratched his hand and expressed a desire to die.						
	the facility remains level two. Addition and evaluate the e	cy was removed on 8/31/11 out of compliance at a severity al time is needed to monitor ffectiveness of the training and aff and the policy and						
_ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following 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 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146114	B. WI	NG _		C 09/07/2011	
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048	1 03/01	72011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	This applies to 1 of for depression and The findings included R1's Nurse's Notes state, "Nurse entereresident's left hand happened. Resider live for, I want to die resident very depreskin tear and applied complaints of discobit to cheer up. Med Requested Tylenol Attorney) aware. A left message x 3. N Z3."  On 8/29/11 at 10:30 Coordinator) stated and he didn't remeranything. So I put he described 72 hour rinterviews at randor hour period. E3 was monitoring was parresidents with suicidiust what I do. There know. I just take it a here about 1 year." R1's cognitive statu "He had the start of status varied. He whappens when you	ntation.  35 residents (R1) reviewed self harm in a sample of 35.	F	224			
	uementia was settii	ig in but seemed okay will it.					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		146114	B. WIN	IG _			C <b>7/2011</b>
	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET LENA, IL 61048		1/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 224	E3 was asked what position. E3 stated, and some college. I1 x a month." R1's was seen by Z2 (Sc 8/12/11. E3 stated, call her. I don't beli incident) on 7/25/11. The Nurse's Notes resident in bathroor multiple cut marks to covered with blood. go." Immediately go bleeding. Received (Hospital) for psych Wife and POA notif. On 8/29/11 at 1:00 they had a policy resuicidal ideations as storage/use of disportant dideations as storage/use of disportant dideations. This procedures for resident in the procedure in the procedur	her qualifications were for her "I have a high school diploma I have a consultant that comes medical record shows that R1 ocial Work Consultant) on "If I have any concerns I can eve I called her after (the ."  dated 8/17/11 state, "Found m sitting in wheelchair with to bilateral wrists. Floor Made statement, "Just let me of another nurse to assist with order to transfer resident to eval and possible admission. ied."  PM, the facility was asked if garding residents that elicit and a policy regarding the osable razors. E1 ied, "Common Sense."  d a copy of an undated policy or Handling Behavioral policy does not address dents who inflict self harm or al ideations.  PM, E1 confirmed that the re a policy regarding the osable razors.	F2	224			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G	С	
		146114	B. WING _			7/2011
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET ENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	observation, intervisurveyor confirmed following actions to  1. On 8/17/11 at 5:0 completed an in horesident personal it concern to resident  2. From 8/18/11 thr being completed daresidents.  3. No safety razors effective 8/18/11. A change.  4. On 8/18/11 Inser -(A new) Policy and Harm Behavior was staff by (Z2) Co-Policy and Procewhen Shaving was 8/18/11.  - Psychotropic Me-Mood Changes/  5. On admission eafor negative behavior MDS Data collection first 72 hours. New alarm and checked the first 72 hour per statements/suicidal immediately place residents.	intervention. Through aw and record review the that the facility took the remove the Immediacy:  O PM all nursing staff use audit to remove any ems that could be a safety s.  ough present, QA audits are allowed in the facility are allowed in the facility. If families were notified of the vicing was done as follows: and Procedure for Handling Self is initiated and inserviced to insultant on 8/18/11. Edure for Safety of Residents initiated and inserviced on eds/Hot Rack MD Notification  ach resident will be assessed ors and suicidal ideations. In tool will be completed in the residents will have safety on every 15 minutes during riod. If there are any negative ideations staff will per policy resident on 1:1's and notify, Administrator and physician	F 224			

Facility ID: IL6005292

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL	.DIN	3	١ ,	
		146114	B. WIN	G_			7/2011
	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
LENA LI	/ING CENTER				ENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	Continued From pa	ge 4	F 2	24			
	discussed to ensure interventions are imbeen completed. The will be placed on how ensure proper docubehavior. All reside referred to the in how weekly.	plemented, care planning has ne resident with the behavior of rack charting for 72 hours to imentation/monitoring of the nts with behaviors will be ouse psychologist who visits					
		ventions will be added to the n book for staff to review and					
	neglected to have a to staff interventions suicidal ideation or facility also neglecte	and record review the facility a policy and procedure related s when a resident expresses threats of self harm. The ed to have a policy and for the storage/use of					
	which began on 7/2	I in an Immediate Jeopardy 5/11 at 7:30 PM when R1 causing a skin tear and to die.					
	The Immediate Jeo 8/31/11.	pardy was identified on					
	the facility remains level two. Additiona and evaluate the ef	cy was removed on 8/31/11 out of compliance at a severity al time is needed to monitor fectiveness of the training and aff and the policy and ntation.					

Facility ID: IL6005292

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146114	B. WI	NG _			7/ <b>2011</b>
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048	1 03/01	72011
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	This applies to 1 of for depression and R1's Nurse's Notes state, "Nurse entereresident's left hand. happened. Resider live for, I want to die resident very depreskin tear and applied complaints of discobit to cheer up. Med Requested Tylenol Attorney) aware. A left message x 3. N Z3."  On 8/29/11 at 10:30 Coordinator) stated and he didn't remeranything. So I put he described 72 hour rinterviews at randor hour period. E3 was monitoring was parresidents with suicidiust what I do. There know. I just take it a here about 1 year."  The Nurse's Notes resident in bathroor multiple cut marks to covered with blood. go." Immediately go bleeding. Received	35 residents (R1) reviewed self harm in a sample of 35.  dated 7/25/11 at 7:30 PM ed room found skin tear on Asked resident what he stated, "I have nothing to e. I scratched myself." ssed and tearful. Cleansed ed steri strips. 1.5 cm long. No mfort. Sat with resident for a dication given without difficulty. to help relax. POA (Power of tempted to call on-call doctor, o return call. Fax written for 0 AM, E3 (Life Enrichment, "I talked to him the next day mber a thing. He denied saying im on 72 hour monitoring "E3 monitoring as resident in times throughout the 72 s asked if the 72 hour to f the facility policy related to dal ideation. E3 stated, "It is e may be a policy, I don't as it comes. I've only been dated 8/17/11 state, "Found in sitting in wheelchair with to bilateral wrists. Floor Made statement, "Just let me of another nurse to assist with order to transfer resident to eval and possible admission.	F:	224			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		146114	B. WING _		09/07	7/2011
	ROVIDER OR SUPPLIER  /ING CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET LENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	they had a policy resuicidal ideations a storage/use of disp (Administrator) repl  The facility provided entitled: Protocol for Emergencies. This procedures for resident who express suicid  On 8/29/11 at 3:00 facility does not have storage/use of disp  On 8/31/11 at 9:30 Administrator was reported and lack of facility in observation, intervisurveyor confirmed following actions to  1. On 8/17/11 at 5:00 completed an in hor resident personal it concern to resident  2. From 8/18/11 throbeing completed daresidents.  3. No safety razors effective 8/18/11. A	PM, the facility was asked if garding residents that elicit and a policy regarding the osable razors. E1 ied, "Common Sense."  d a copy of an undated policy or Handling Behavioral policy does not address dents who inflict self harm or al ideations.  PM, E1 confirmed that the rea policy regarding the osable razors.  AM, E1, the facility notified of the Immediate R1's self- injurious behaviors intervention. Through ew and record review the that the facility took the remove the Immediacy:  D0 PM all nursing staff use audit to remove any ems that could be a safety	F 224			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		146114	B. WIN				C <b>7/2011</b>
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET LENA, IL 61048	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	- Policy and Proce Behavior was initiat (Z2) Const Policy and Proce when Shaving was 8/18/11 Psychotropic Me - Mood Changes/ 5. On admission ea for negative behavior MDS Data collectio first 72 hours. New alarm and checked the first 72 hour per statements/suicidal immediately place r Director of Nursing, for referral for psyclosussed to ensure interventions are imbeen completed. The will be placed on he ensure proper docubenavior. All reside referred to the in howekly.  7. All behavior interstaff communication sign off on. 483.20(g) - (j) ASSE	vicing was done as follows: dure for Handling Self Harm ed and inserviced to staff by ultant on 8/18/11. edure for Safety of Residents initiated and inserviced on eds/Hot Rack MD Notification  ch resident will be assessed ors and suicidal ideations. In tool will be completed in the residents will have safety on every 15 minutes during riod. If there are any negative ideations staff will per policy esident on 1:1's and notify Administrator and physician in eval.  Ining meeting, behaviors will be es that appropriate uplemented, care planning has he resident with the behavior of rack charting for 72 hours to mentation/monitoring of the ents with behaviors will be ouse psychologist who visits  Ventions will be added to the in book for staff to review and  ESSMENT		224			9/28/11
SS=D	ACCURACY/COOF	RDINATION/CERTIFIED					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUI	LDING	·		c
		146114	B. WIN	IG _			7/2011
	ROVIDER OR SUPPLIER			10	EET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET ENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	The assessment m resident's status.  A registered nurse each assessment w participation of heat A registered nurse assessment is come Each individual who assessment must state portion of the attemporation of the attempo	must conduct or coordinate with the appropriate the professionals.  must sign and certify that the pleted.  completes a portion of the ign and certify the accuracy of ssessment.  d Medicaid, an individual who gly certifies a material and resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a not is subject to a civil money than \$5,000 for each  ent does not constitute a statement.  NT is not met as evidenced or and record review the facility to a resident assessment as a resident's condition.  35 residents (R1) reviewed for	F 2	278			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION  G	COMPLETED		
		146114	B. WIN	IG _			7/ <b>2011</b>
	PROVIDER OR SUPPLIER			10	EET ADDRESS, CITY, STATE, ZIP CODE D10 SOUTH LOGAN STREET ENA, IL 61048		.,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	The findings included The Behavior Track states, "(R1) stated to live (for)." Resided Skin tear noted to live self. Sat with resided On 8/29/11 at 10:40 (7/25/11) I asked hir cut myself." I looked see anything in his cut himself with. The were long so I cut the confused and deprehim it was okay. I to the confused and deprehim it was okay. I to the confused and the head of the confused and the section labeled directed at others (for as hitting, or scratch R1 had no behavior the Social Service state, (R1) has not	king Sheet dated 7/25/11  , "I want to die, I have nothing ent very depressed and tearful. eft hand- resident scratched ent for a bit to cheer up."  O AM, E4(LPN) stated, "(On m what happened. He said, "I d through his room and didn't drawers that he could have en I noticed his fingernails hem. He is normally a little essed. I comforted him- told old him he was just here for e was going to go home."  disciplinary Progress Notes as the following note written by the Coordinator, "Spoke with ms/complaints at this time. Esident regarding incident that and in which resident stated, we for, I want to die. I Resident denied making at has a diagnosis of dementia and in change was made"  A Set (MDS) of 7/29/11 under "Behavioral symptoms not e.g. physical symptoms such hing self)" documents that	F2	278			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146114	B. WIN	G			C <b>7/2011</b>
	ROVIDER OR SUPPLIER			10	EET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET ENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	Review of R1's med that as of 8/17/11 R not address his stal live for nor his histo On 8/17/11 R1 atte	room I have no concerns	F 2	78			
F 319 SS=J	Based on the comp resident, the facility who displays menta difficulty receives a services to correct	C FOR SOCIAL DIFFICULTIES  rehensive assessment of a must ensure that a resident of a psychosocial adjustment oppopriate treatment and the assessed problem.	F3	19			9/28/11
	failed to ensure that who expressed a latesire to die receive to assist with his addiffe circumstances. In Immediate Jeop 8/31/11. The Immediate Jeop 8/31/11 at 7:30 PM	and record review the facility to a newly admitted resident ck of interest in life and a ged psychosocial interventions justment to a change in his. This failure resulted in R1 with a disposable razor on ardy was identified on diate Jeopardy began on when R1 scratched his hand expressed a desire to die and nothing to live for.					
	While the immediad	cy was removed on 8/31/11					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUII	LDING	·		c
		146114	B. WIN	G			7/2011
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 319	the facility remains level two. Additional and evaluate the effection of the stap procedure implemed. This applies to 1 of for depression and of 35.  The findings included The Physician's Order 8/2011 shows that I on 7/23/11 with diagent Prosthetic Fracture Joint and Mild Dem that R1 is ordered to (Antidepressant) 30.  The Minimum Data has a Cognitive Scolin and Mild Dem that R1 is ordered to (Antidepressant) 30.  The Minimum Data has a Cognitive Scolin pairment.)  The Nurse's Notes state, "Nurse entereresident's left hand, happened. Resident very depression tear and applied complaints of discobit to cheer up. Med Requested Tylenol Attorney) aware. A	out of compliance at a severity al time is needed to monitor fectiveness of the training and off and the policy and ntation.  35 residents (R1) reviewed suicidal ideation in a sample  e:  der Sheet (POS) dated R1 was admitted to the facility gnoses including Peri Around Prosthetic Left Hip entia. The POS also shows to take Remeron	FS	319			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		440444	A. BUI B. WIN		G	С	
NAME OF F		146114				09/07	7/2011
	ROVIDER OR SUPPLIER VING CENTER			10	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET ENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 319	On 8/29/11 at 10:30 Coordinator) stated and he didn't remer anything. So I put h described 72 hour r interviews at randor hour period. E3 wa monitoring was part residents with suicidiust what I do. There know. I just take it a here about 1 year." R1's cognitive statu "He had the start of status varied. He whappens when you dementia was settir E3 was asked what position. E3 stated, and some college. If 1 x a month." R1's was seen by Z2 (So 8/12/11. E3 stated, call her. I don't beli incident) on 7/25/11 E3's Interdisciplinar 7/26/11 at 11:00 AN No concerns/compl addressed resident occurred last night a have nothing to live myself." Resident d Resident has diagnidifficulty with short to The Social Service	D AM, E3 (Life Enrichment, "I talked to him the next day of the a thing. He denied saying im on 72 hour monitoring "E3 monitoring as resident of the facility policy related to dal ideation. E3 stated, "It is e may be a policy, I don't as it comes. I've only been E3 was asked to describe s on admission. E3 stated, dementia. His cognitive fould say, 'That is what get old.' He knew his fing in but seemed okay with it." Ther qualifications were for her "I have a high school diploma I have a consultant that comes medical record shows that R1 focial Work Consultant) on "If I have any concerns I can eve I called her after (the I."  They Progress Note dated of the states, "Spoke with resident aints at this time. Writer regarding incident that and in which resident stated, "I for, I want to die. I scratched enied making statements. osis of Dementia and has	F	319			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUI	LDIN	G		
		146114	B. WIN	1G	<del></del>		7/2011
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 319	therapies following is alert and oriented and forgetfulness. It past events and a pevents. He is able to known and can undothers, although no has not exhibited at to contend with and room."  On 8/29/11 at 12:00 depressed- he coul really bothered by the disnown and he is getting really helped a lot."  On 8/30/11 at 2:45 audit charts, assist provide inservice are was asked what he resident expressed expectation is that the first of there is a major is need me. I've made have called me beforthat is was an oversident expression So R1 scored a 0 (no same document statements on 7/26 symptoms of depreno signs and symptoms are successful as a size of the symptoms of depreno signs and symptoms and symptoms are size of the symptoms	ge 13 a fall and a fractured hip. He dix 1-2 with some confusion He has good memory recall of proor memory recall of present to make his wants and needs derstand and respond to the generally appropriately. He may mood or behavior problems of takes his meal in the dining of PM, Z1 stated, "He was very don't remember things. He was that. He watched 2 brothers ementia. He was really sease. He is in the hospitaling counseling there. It has a desire to die. Z2 stated, "My the resident would be if a a desire to die. Z2 stated, "My the resident would be sent out. It has be them aware of that and they be them aware of that and they be them aware of that and they be them aware was thinking."  Cale dated 7/26/11 shows that signs of depression). This area, "Resident made negative with some of depression. States he making any statements. Will	F	319			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL	DING		، ا	С
		146114	B. WING			09/07/2011	
	ROVIDER OR SUPPLIER  /ING CENTER		;	1010 5	ADDRESS, CITY, STATE, ZIP CODE SOUTH LOGAN STREET A, IL 61048		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 319	monitor."  R1's careplan dated has a history of self and/or behavior. TI Poor impulse control hopelessness; little The approaches/ in negative statements made resident will be services for 72 hours.	d 7/26/11 states, "The resident f-harmful ideation (thoughts) his appears to be related to: ol, Feelings of helplessness, hope that life will improve." terventions include: "If s made or self harm threats be monitored by social rs., (Physician) notified of or. and If self harm occurs	F3	19			
	Administrator was r Jeopardy related to and lack of facility in observation, intervie surveyor confirmed following actions to 1. On 8/17/11 at 5:0 completed an in hor resident personal it concern to resident 2. From 8/18/11 thr being completed da residents. 3. No safety razors	AM, E1, the facility notified of the Immediate R1's self- injurious behaviors ntervention. Through ew and record review the that the facility took the remove the Immediacy:  O PM all nursing staff use audit to remove any ems that could be a safety s.  ough present, QA audits are allowed in the facility II families were notified of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		146114	B. WIN			C <b>09/07/2011</b>	
	ROVIDER OR SUPPLIER		•	10	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET ENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 319	-(A new) Policy and Harm Behavior was staff by (Z2) Consultance Policy and Proceed when Shaving was 8/18/11.  - Psychotropic Means and Changes/  5. On admission ear for negative behavior MDS Data collection first 72 hours. New alarm and checked the first 72 hour per statements/suicidal immediately place or Director of Nursing, for referral for psychological for policy of the placed on how the placed on ho	vicing was done as follows: d Procedure for Handling Self initiated and inserviced to ultant on 8/18/11. edure for Safety of Residents initiated and inserviced on eds/Hot Rack MD Notification  ch resident will be assessed ors and suicidal ideations. In tool will be completed in the residents will have safety on every 15 minutes during riod. If there are any negative ideations staff will per policy resident on 1:1's and notify Administrator and physician in eval.	F	319			
F 323 SS=J	483.25(h) FREE OF HAZARDS/SUPER		F:	323			9/28/11

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED	
		A. BUILDI	ING		С
	146114	B. WING			7/2011
			1010 SOUTH LOGAN STREET	Ē	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
environment remair as is possible; and	ns as free of accident hazards each resident receives	F 320	3		
by: Based on interview failed to supervise a depression, self-injustatements indicating the resident from at The facility failed to not have access to causing injury. On 8 bathroom with laces	and record review the facility a resident with a history of urious behavior and ng a desire to die to prevent tempting to commit suicide ensure that the resident did sharp objects capable of 8/17/11 R1 was found in his rations to both wrists, blood				
which began on 7/2 scratched his hand expressed a desire The Immediate Jeo	25/11 at 7:30 PM when R1 causing a skin tear and to die.				
the facility remains level two. Additiona and evaluate the ef education of the sta procedure impleme	out of compliance at a severity al time is needed to monitor fectiveness of the training and aff and the policy and intation.				
	Continued From parenvironment remains as is possible; and adequate supervision prevent accidents.  This REQUIREMENT by: Based on interview failed to supervise a depression, self-injustatements indicating the resident from any the facility failed to not have access to causing injury. On 8 bathroom with laced pooled on the floor razor.  These failures result which began on 7/2 scratched his hand expressed a desire.  The Immediate Jeon 8/31/11.  While the immediate Jeon 8/31/11.  While the immediate Jeon 8/31/11.	PROVIDER OR SUPPLIER  VING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16 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:  Based on interview and record review the facility failed to supervise a resident with a history of depression, self-injurious behavior and statements indicating a desire to die to prevent the resident from attempting to commit suicide The facility failed to ensure that the resident did not have access to sharp objects capable of causing injury. On 8/17/11 R1 was found in his bathroom with lacerations to both wrists, blood pooled on the floor and a self modified disposable razor.  These failures resulted in an Immediate Jeopardy which began on 7/25/11 at 7:30 PM when R1 scratched his hand causing a skin tear and expressed a desire to die.  The Immediate Jeopardy was identified on	PROVIDER OR SUPPLIER    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG	This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to supervise a resident with a history of depression, self-injurious behavior and statements indicating a desire to die to prevent the resident from and a self modified disposable razor.  These failures resulted in an Immediate Jeopardy which began on 7/25/11 at 7:30 PM when R1 scratched his hand causing a skin tear and expressed a desire to die.  The Immediate Jeopardy was identified on 8/31/11.  While the immediacy was removed on 8/31/11.  While the immediacy was removed on 6/31/11 the facility remains out of compliance at a severity level two. Additional time is needed to monitor and evaluate the effectiveness of the training and education of the staff and the policy and procedure implementation.	This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to supervise a resident with a history of depression, self-injurious behavior and statements indicating a desire to die to prevent the resident from attempting to commit sucide The facility failed to nesure that the resident did not have access to sharp objects capable of causing injury. On 81/71/11 R1 was found in his bathroom with lacerations to both wrists, blood pooled on the floor and a self modified disposable razor.  These failures resulted in an Immediate Jeopardy which began on 77/25/11 at 7:30 PM when R1 scratched his hand causing a skin tear and expressed a desire to die.  The Immediate Jeopardy was identified on 8/31/11.  While the immediacy was removed on 8/31/11 the facility remains out of compliance at a severity level two. Additional time is needed to monitor and evaluate the effectiveness of the training and education of the staff and the policy and procedure implementation.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION  IG	COMPLETED		
		146114	B. WIN	IG_			; 7/ <b>2011</b>	
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET LENA, IL 61048			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	8/2011 shows that I Peri Prosthetic Frace Hip Joint and Mild I shows that R1 is on (Antidepressant) 30 The Minimum Data has a Cognitive Scolinpairment.)  The Nurse's Notes state, "Nurse entereresident's left hand happened. Resident live for, I want to die resident very depreskin tear and applied complaints of discobit to cheer up. Med Requested Tylenol Attorney) aware. A left message x 3. N Z3."  The Behavior Track states, "Resident states,	sample of 35. e: der Sheet (POS) dated R1 has diagnoses including cture Around Prosthetic Left Dementia. The POS also dered to take Remeron	F3	323				
		O AM, E4(LPN) stated, "(On m what happened. He said, "I						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		4.4644.4	B. WING		C	
NAME OF F	ROVIDER OR SUPPLIER	146114	1		09/07	7/2011
	VING CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET LENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	cut myself." I looked see anything in his cut himself with. The were long so I cut the confused and deprehim it was okay. I to therapy and then he was asked if she pure monitoring in place stated, "No, we did guess we should he facility policy was if to die. E4 stated, "The checks or sit in there.  The (Facility) Intered dated 7/26/11 show E3 (life enrichment resident, No concer Writer addressed recocurred last night. "I have nothing to list statements, resider and has difficulty with was notified, medic (Remeron increase will monitor residen reassess for depressame document should be a history of self and/or behavior. The Poor impulse control.	ge 18 d through his room and didn't drawers that he could have en I noticed his fingernails hem. He is normally a little essed. I comforted him- told old him he was just here for e was going to go home." E4 at any special precautions or for R1 after this incident. E4 n't do 15 minute checks, I ave." E4 was asked what the a resident expressed a desire hey like us to do 15 minute re with the resident."  isciplinary Progress Notes as the following note written by coordinator), "Spoke with rns/complaints at this time. esident regarding incident that and in which resident stated,, ve for, I want to die. I Resident denied making at has a diagnosis of dementia ith short term recall. Doctor ation change was made d from 15 mg to 30 mg), writer t for next 72 hours and esion and self harm." The ows that E3 checked on R1 on 8 at 10:30 AM and 7/29 at  d 7/26/11 states, "The resident f-harmful ideation (thoughts) his appears to be related to: ol, Feelings of helplessness, hope that life will improve."	F 323			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. B			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146114	B. WIN	۱G _		C <b>09/07/2011</b>	
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048	00,0	72011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	warranted conduct remove: Any sharp (razor blades, razor nails, screwdriver, sharm occurs reside for evaluation."  On 8/29/11 at 12:15 had what I call "Sur confused at night."  The Nurse's Notes resident in bathroor multiple cut marks to covered with blood. go." Immediately go bleeding. Received (Hospital) for psych Wife and POA notif  On 8/29/11 at 11:30 going my medicatio room was shut. (E8 the last room at the during the incident of the start of the sta	terventions include: "As a room check/search and objects or similar contraband os, knives, scissors, hammer, screws, needles"and "If self int will be sent to the hospital of PM, E9 (LPN) stated, "He indowners" and he got more of the hospital of the hospi	F	323	,		
	the bathroom door was in the wheelchaback to me. I saw be where he was bleed his wrists. I put cold went down the hall me. (R1) seemed fi get depressed in the	get it open all the way because was against it. I got in and R1 air (in the bathroom) with his alood on the floor. I asked R1 ding from and he showed me I compresses of them and I and brought (E9) back with ne earlier in the day. He would be evening."					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		146114	B. WI	۱G _		C <b>09/07/2011</b>	
	PROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET LENA, IL 61048	1 00/01	72011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	I got to the room, E wrists. He was sittir were puddles of blo softball size. There told E8 to get E1 (A CNA to get housek applying pressure a anymore. R1 had takind of tented them the floor. I saw a lokicked it with my for saw that it was a rarazor) without the h snapped the handle plastic shield to expweren't supposed to cuts on his right writhe right wrist. The and less superficial himself deeper. It c E9 was asked when razor from. E9 state them in the day bef of them in a ziplock because he couldn' apologizing. Sorry hasked if she was av 7/25/11. E9 stated, that." E9 was asker regarding someone stated, "Nothing like before. I would not someone says they we need to tell the pthrough the room to be dangerous."	ge 20 8 had placed wet cloths on his ag in the wheelchair and there and all over the floor- about were splatters of blood too. It dministrator) and I told the deeping. By this time I was and he was not bleeding afken pieces of toilet paper and over the puddles of blood on any blue thing on the floor. I not and then picked it up and zor blade- like a (disposable andle, just the blade. R1 had a coff and the bottom of the blue are the blade. R1 said, "You of find me." He had superficial at and then a bigger gash on deft wrist had a gash on it too cuts. Thank God he didn't cut ould have been a lot worse." There were maybe 3 or 4 bag. He said he did it to get a hold of her. He kept are put us through this." E9 was ware of the incident from a "I don't know anything about d what the facility policy was a expressing a desire to die. E9 this has ever happened for the Administrator. If are going to hurt themselves are going to hurt themselves are going to hurt themselves are remove anything that might at 11:00 AM, E5, E6 and E7	F;	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		146114	B. WIN	NG			7/2011
	PROVIDER OR SUPPLIER			10	EET ADDRESS, CITY, STATE, ZIP CODE D10 SOUTH LOGAN STREET ENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	(CNAs) were asked incident on 7/25/11 monitoring of R1 ar regarding the use/s E5 stated, "They (ranursing closet. Supput in sharps contastated, "Razors are residents, put in the shower room. I donincident on 7/25/11 any extra monitorin always had razors i cream. He would shup at the sink and conever cut himself. A happened (incident razors in the wash I bathroom. You had were on the bottom incident on 7/25/11 monitoring of (R1). know about the reswhen we come in."  On 8/29/11 at 12:55 brought the razors is saying, I need to shorought in razors, s I did not bring them to him had some to  On 8/30/11 at 2:45 policy that alert resismeone told me to and didn't tell anyor	If if they were aware of R1's, if they did any additional and what the facility policy is storage of disposable razors. Fazors azors) are stored in the posed to be locked. Then we iner in the shower room." E6 to be kept away from a sharps container in the 't know anything about the. We were never told to do g of (R1)" E7 stated, "(R1) in his room and shaving have himself. I would set him check on him. He did okay, he about 1 week before this on 8/17/11) there were 2 or 3 basin on the sink in his did to dig for them because they. I was never told of the was never told of the was never did any increased. If there is anything we need to idents then the nurse tells us for PM, Z1 stated, "They in- one of the CNAs. He kept have, I need to shave so they having cream and after lotion. in. The man in the bed next oo."	F	323			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION  G	COMPLETED		
		146114	B. WIN	IG _			<i>5</i> 7/ <b>2011</b>
	PROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET .ENA, IL 61048		.,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	8/17/11 states, "Parright hip pain. State to handle so he too wrists."  The facility docume Department Visit dathe Physician's Asswhat he did was "rejust got frustrated, I kind of balled up to so he cut his wrists states, "The patient lacerations with a forequiring closure."  The Addendum to Edated 8/17/11 and of states, "(R1) had mhave been secondathese horizontal lace that either might had chronic pain or frustevaluated by Crisis admission."  The Hospital Psychem 8/17/11 states, "The he cut his wrists. He arrival to the emerging dealing with the pais spoke to the patien seek attention. The of dementia. Admin when found in the bemeant to be caught that he knew deep	tient reports knee pain and is that it was too much for him is a razor blade to his bilateral ent entitled Emergency ated 8/17/11 and dictated by istant states, "(R1) states ally stupid." he states that he had an altercation, everything gether and got him frustrated, "This same document has multiple superficial ew of them deeper than others emergency Department Visit dictated by the ER physician and the entitle stories which might ery to his dementia but he had be reations across both wrists are been frustration with his tration with his wife. He was and deemed appropriate for an ency room that he was tired of an in his legs. By the time I the patient stated he did it to patient does have a mild case instrator stated that the patient bathroom, stated he was not the has been tearful all night.	F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		146114	B. WING		C 09/07/2011	
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	"(R1's )memory recis poor and immedigoals are to get a hisome coping skills:  The Psychiatric Adristates, "(R1) reports of pleasure in things	ge 23  This same document states, all for remote is good, recent ate is fair." and " Treatment old of his depression, get so that he will feel better."  mission Note dated 8/17/11 s depression, anhedonia (lack s that should bring pleasure), decreased appetite and	F 323			
	Jeopardy related to and lack of facility in observation, intervie surveyor confirmed following actions to 1. On 8/17/11 at 5:0	notified of the Immediate R1's self- injurious behaviors intervention. Through ew and record review the that the facility took the remove the Immediacy:				
		use audit to remove any ems that could be a safety s.				
		ough present, QA audits are aily to ensure the safety of the				
		are allowed in the facility Il families were notified of the				
	4. On 8/18/11 Inser	vicing was done as follows:				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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		146114	B. WING _		09/0	7/2011
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET ENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	- Policy and Proce Behavior was initiat (Z2) Consi - Policy and Proce when Shaving was 8/18/11 Psychotropic Me - Mood Changes/ 5. On admission eafor negative behavid MDS Data collectio first 72 hours. New alarm and checked the first 72 hour perstatements/suicidal immediately place in Director of Nursing for referral for psychological for policy of the placed on how t	edure for Handling Self Harm ed and inserviced to staff by altant on 8/18/11.  edure for Safety of Residents initiated and inserviced on eds/Hot Rack MD Notification  ach resident will be assessed ors and suicidal ideations. In tool will be completed in the residents will have safety on every 15 minutes during riod. If there are any negative ideations staff will per policy resident on 1:1's and notify. Administrator and physician in eval.  Ining meeting, behaviors will be a that appropriate in the resident with the behavior of rack charting for 72 hours to imentation/monitoring of the ints with behaviors will be ouse psychologist who visits in book for staff to review and in incomplete in the property of the interest will be added to the in book for staff to review and incomplete.	F 323			
i						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION  G	COMPLE	TED
		146114	B. WIN	IG _			C <b>7/2011</b>
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET .ENA, IL 61048	09/07/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	a) The facility shall procedures, govern the facility which sh Resident Care Polic least the administrathe medical advisor representatives of representatives of resident the Act and all These written policity operating the facility least annually by the written, signed and meeting.  Section 300.1210 Conversion and Person b) The facility shall and services to attapracticable physical well-being of the reseach resident's complan. Adequate and care and personal coresident to meet the care needs of the resident of the resident to meet the care needs of the resident and the care needs of the resident to meet the care needs of the resident	ATIONS  esident Care Policies  have written policies and ling all services provided by all be formulated by a cy Committee consisting of at lator, the advisory physician or ray committee and line and line of the promulgated thereunder. The shall be followed in lay and shall be reviewed at its committee, as evidenced by dated minutes of such a  General Requirements for	F99	999			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN		С	
		146114	B. WING _			7/2011
	PROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET .ENA, IL 61048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	agent of a facility shresident. (Section 2) These regulations was a seed on interview neglected to have a to staff interventions suicidal ideation or facility also neglected procedure in placed disposable razors. R1 lacerating his was disposable razor on This applies to 1 of for depression and The findings included R1's Nurse's Notes state, "Nurse entereresident's left hand. happened. Resident very depreskin tear and applied complaints of discobit to cheer up. Med Requested Tylenol Attorney) aware. A left message x 3. N Z3."	ee, administrator, employee or nall not abuse or neglect a -107 of the Act)  vere not met as evidenced by:  and record review the facility policy and procedure related swhen a resident expresses threats of self harm. The ed to have a policy and for the storage/use of These failures contributed to rists with a modified a 8/17/11.  35 residents (R1) reviewed self harm in a sample of 35.	F9999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		TIPLE CONSTRUCTION  NG	(X3) DATE SU COMPLE	TED
		146114	B. WI	NG _			7/ <b>2011</b>
	ROVIDER OR SUPPLIER		-		REET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048	09/01	7/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Coordinator) stated and he didn't remer anything, so I put hi described 72-hour rinterviews at randor 72-hour period. E3 72-hour monitoring related to residents stated, "It is just wh I don't know. I just the been here about 1 y E3's Interdisciplinar 7/26/11 at 11:00 AN No concerns/compladdressed resident occurred last night have nothing to live myself." Resident d Resident has diagn difficulty with short of the Nurse's Notes resident in bathroor multiple cut marks to covered with blood. go." Immediately go bleeding. Received (Hospital) for psych Wife and POA notifical of the Nurse's Notes resident in bathroor multiple cut marks to covered with blood. go." Immediately go bleeding. Received (Hospital) for psych Wife and POA notifical of the Nurse's Notes resident in bathroor multiple cut marks to covered with blood. go." Immediately go bleeding. Received (Hospital) for psych Wife and POA notifical of the Nurse's Notes resident in bathroor multiple cut marks to covered with blood. go." Immediately go bleeding. Received (Hospital) for psych Wife and POA notifical of the Nurse's Notes resident in bathroor multiple cut marks to covered with blood. go." Immediately go bleeding. Received (Hospital) for psych Wife and POA notifical of the Nurse's Notes resident in bathroor multiple cut marks to covered with blood. go." Immediately go bleeding. Received (Hospital) for psych Wife and POA notifical of the Nurse's Notes resident in bathroor multiple cut marks to covered with blood. go." Immediately go bleeding. Received (Hospital) for psych with the Nurse's Notes resident in bathroor multiple cut marks to covered with blood. go." Immediately go bleeding. Received (Hospital) for psych with the Nurse's Notes resident to could have the Nurse's	mber a thing. He denied saying m on 72-hour monitoring." E3 monitoring as resident m times throughout the was asked whether the was part of the facility policy with suicidal ideation. E3 at I do. There may be a policy, ake it as it comes. I've only year."  Ty Progress Note dated that states, "Spoke with resident aints at this time. Writer regarding incident that and in which resident stated, "I for, I want to die. I scratched enied making statements. osis of Dementia and has term recall."  dated 8/17/11 state, "Found m sitting in wheelchair with to bilateral wrists. Floor Made statement, "Just let me of another nurse to assist with order to transfer resident to eval and possible admission.	F99	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SU COMPLE	TED
		146114	B. WIN	۱G _			C <b>7/2011</b>
	ROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET ENA, IL 61048	33.0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	back to me. I saw be where he was bleed his wrists. I put cold went down the hall me. (R1) seemed fi get depressed in the On 8/29/11 at 12:15 I got to the room, E wrists. He was sittin were puddles of blo softball size. There told E8 to get E1 (A CNA to get houseke applying pressure a anymore. R1 had takind of tented them the floor. I saw a lokicked it with my for saw that it was a rarazor) without the h snapped the handle plastic shield to experient supposed to cuts on his right writhe right wrist. The and less superficial himself deeper. It can be superficial himself deeper. It can be supposed to them in the day before them in the day before them in the day before them in a ziplock because he couldn' apologizing. Sorry hasked if she was av 7/25/11. E9 stated,	air (in the bathroom) with his lood on the floor. I asked R1 ding from and he showed me I compresses of them and I and brought (E9) back with ne earlier in the day. He would	F99	999			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION  NG	COMPLETED	
		146114	B. WIN	1G _		09/07	
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048	<b>09/07/2011</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	stated, "Nothing like before. I would notify someone says they we need to tell the purchased to the purchased to tell the purchased to the purchased to tell the purchased to the purchased to tell the purchased to the purchased to tell the pur	expressing a desire to die. E9 et his has ever happened fy the Administrator. If are going to hurt themselves berson in charge and go remove anything that might  at 11:00 AM, E5, E6 and E7 If they were aware of R1's if they did any additional id what the facility policy is torage of disposable razors. fazors) are stored in the posed to be locked. Then we mer in the shower room." E6 to be kept away from e sharps container in the the though the were never told to do g of (R1)." E7 stated, "(R1) in his room and shaving have himself. I would set him wheck on him. He did okay, he about 1 week before this on 8/17/11) there were 2 or 3 pasin on the sink in his I to dig for them because they I was never told of the We never did any increased If there is anything we need to dents then the nurse tells us on, SPM, Z1 (R1's spouse) stated, fazors in- one of the CNAs. He to shave, I need to shave so ons, shaving cream and after	F99	999			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146114	B. WI	NG		C <b>09/07/2011</b>	
	PROVIDER OR SUPPLIER VING CENTER			10	EET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET ENA, IL 61048	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	lotion. I did not brir bed next to him had On 8/30/11 at 2:45 consultant) stated, residents can have R1's wife brought the Emergency Row 8/17/11 states, "Parright hip pain. State to handle so he too wrists."  The facility docume Department Visit do the Physician's Asswhat he did was "rejust got frustrated, I kind of balled up to so he cut his wrists states, "The patient lacerations with a forequiring closure."  The Addendum to Edated 8/17/11 and of states, "(R1) had me have been secondated these horizontal lace that either might had chronic pain or frus evaluated by Crisis admission."	ig them in. The man in the	F9	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	TED
		146114	B. WI	NG _			C <b>7/2011</b>
	ROVIDER OR SUPPLIER		<u> </u>	1	REET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048	1 03/01	172011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	arrival to the emerg dealing with the pair spoke to the patient seek attention. the possible that he knew deep going to find him. I about what he did." "(R1's) memory recis poor and immedia goals are to get a hisome coping skills of the Psychiatric Adristates, "(R1) reports of pleasure in things decreased energy, insomnia."  On 8/29/11 at 12:00 depressed- he could really bothered by the and a sister with Defrustrated by the disnow and he is gettir really helped a lot."  On 8/30/11 at 2:45 audit charts, assist provide inservice ar was asked what he resident expressed expectation is that the lifthere is a major is need me. I've made	ge 31 ency room that he was tired of n in his legs. By the time I to the patient stated he did it to patient does have a mild case histrator stated that the patient eathroom, stated he was not at He stated to me hours later down inside someone was the has been tearful all night. This same document states, all for remote is good, recent at is fair." and "Treatment old of his depression, get so that he will feel better."  mission Note dated 8/17/11 and depression, anhedonia (lack is that should bring pleasure), decreased appetite and  DPM, Z1 stated, "He was very don't remember things. He was not. He was really sease. He is in the hospital and counseling there. It has  PM, Z2 stated, "My role is to with dealing with issues and and education for the staff." Z2 or expectation would be if a a desire to die. Z2 stated, "My he resident would be sent out. See them aware of that and they be them aware of that and they one. I think what happened is	F99	999			

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		146114	B. WI	NG _			C <b>7/2011</b>
	PROVIDER OR SUPPLIER		•	1	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH LOGAN STREET LENA, IL 61048	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	that is was an overs don't know what the R1's Depression So R1 scored a 0 (no same document stastatements on 7/26. symptoms of depreno signs and symptodoesn't remember monitor."  R1's careplan dated has a history of self and/or behavior. TI Poor impulse control hopelessness; little The approaches/int negative statements made resident will be services for 72 hou changes in behavior resident will be sent evaluation."  On 8/29/11 at 1:00 whether they had a elicit suicidal ideatic storage/use of disport of the facility provided entitled: Protocol for Emergencies. This procedures for reside who express suicidal on 8/29/11 at 3:00.	sight on the facility's part. I e nurse was thinking."  cale dated 7/26/11 shows that signs of depression). This ates, "Resident made negative /11. Reassessed for signs and ssion. Resident assessed with oms of depression. States he making any statements. Will  d 7/26/11 states, "The resident finamful ideation (thoughts) his appears to be related to: of, Feelings of helplessness, hope that life will improve." erventions include: "If is made or self harm threats be monitored by social ris., (Physician) notified of ris. and If self harm occurs it to the hospital for  PM, the facility was asked policy regarding residents that ons and a policy regarding the osable razors.  d a copy of an undated policy remaining Behavioral policy does not address dents who inflict self harm or	F99	999			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER  LENA LIVING CENTER  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048  STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048  CO OSS-REFERENCED TO THE APPROPRIATE DEFICIENCES OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE	(X3) DATE SI COMPLE	PLE CONSTRUCTION  G	A. BUILI	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IT OF DEFICIENCIES OF CORRECTION	
NAME OF PROVIDER OR SUPPLIER  LENA LIVING CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  1010 SOUTH LOGAN STREET  LENA, IL 61048  (X4) ID PREFIX FAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  1010 SOUTH LOGAN STREET  LENA, IL 61048  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO COSS-REFERENCED TO THE APPROPRIATE			B. WINC	146114		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE		010 SOUTH LOGAN STREET				
DLI IGILINGT)	SHOULD BE	(EACH CORRECTIVE ACTION SHO	PREFIX	MUST BE PRECEDED BY FULL	(EACH DEFICIENCY	PREFIX
Continued From page 33 storage/use of disposable razors.  (A)			F999	osable razors.	·	F9999