STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146114	A. BUILDING _____ B. WING _____	C 09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENA LIVING CENTER	**1010 SOUTH LOGAN STREET LENA, IL 61048**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Incident Report Investigation of 8/17/11 /IL 54226 A partial extended survey was conducted.	F 000		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility neglected to have a policy and procedure related to staff interventions when a resident expresses suicidal ideation or threats of self harm. The facility also neglected to have a policy and procedure in place for the storage/use of disposable razors. These failures contributed to R1 lacerating his wrists with a modified disposable razor on 8/17/11. An Immediate Jeopardy was identified on 8/31/11. The Immediate Jeopardy began on 7/25/11 at 7:30 PM when R1 scratched his hand causing a skin tear and expressed a desire to die. 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	F 224		9/28/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 1 procedure implementation. This applies to 1 of 35 residents (R1) reviewed for depression and self harm in a sample of 35. The findings include: R1's Nurse's Notes dated 7/25/11 at 7:30 PM state, "Nurse entered room found skin tear on resident's left hand. Asked resident what happened. Resident stated, "I have nothing to live for, I want to die. I scratched myself." resident very depressed and tearful. Cleansed skin tear and applied steri strips. 1.5 cm long. No complaints of discomfort. Sat with resident for a bit to cheer up. Medication given without difficulty. Requested Tylenol to help relax. POA (Power of Attorney) aware. Attempted to call on-call doctor, left message x 3. No return call. Fax written for Z3." On 8/29/11 at 10:30 AM, E3 (Life Enrichment Coordinator) stated, "I talked to him the next day and he didn't remember a thing. He denied saying anything. So I put him on 72 hour monitoring " E3 described 72 hour monitoring as resident interviews at random times throughout the 72 hour period. E3 was asked if the 72 hour monitoring was part of the facility policy related to residents with suicidal ideation. E3 stated, "It is just what I do. There may be a policy, I don't know. I just take it as it comes. I've only been here about 1 year." E3 was asked to describe R1's cognitive status on admission. E3 stated, "He had the start of dementia. His cognitive status varied. He would say, 'That is what happens when you get old.' He knew his dementia was setting in but seemed okay with it."	F 224		

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F 224	Continued From page 2	F 224		

E3 was asked what her qualifications were for her position. E3 stated, "I have a high school diploma and some college. I have a consultant that comes 1 x a month." R1's medical record shows that R1 was seen by Z2 (Social Work Consultant) on 8/12/11. E3 stated, "If I have any concerns I can call her. I don't believe I called her after (the incident) on 7/25/11."

The Nurse's Notes dated 8/17/11 state, "Found resident in bathroom sitting in wheelchair with multiple cut marks to bilateral wrists. Floor covered with blood. Made statement, "Just let me go." Immediately got another nurse to assist with bleeding. Received order to transfer resident to (Hospital) for psych eval and possible admission. Wife and POA notified."

On 8/29/11 at 1:00 PM, the facility was asked if they had a policy regarding residents that elicit suicidal ideations and a policy regarding the storage/use of disposable razors. E1 (Administrator) replied, "Common Sense."

The facility provided a copy of an undated policy entitled : Protocol for Handling Behavioral Emergencies. This policy does not address procedures for residents who inflict self harm or who express suicidal ideations.

On 8/29/11 at 3:00 PM, E1 confirmed that the facility does not have a policy regarding the storage/use of disposable razors.

On 8/31/11 at 9:30 AM, E1, the facility Administrator was notified of the Immediate Jeopardy related to R1's self- injurious behaviors

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F 224	Continued From page 3 and lack of facility intervention. Through observation, interview and record review the surveyor confirmed that the facility took the following actions to remove the Immediacy: 1. On 8/17/11 at 5:00 PM all nursing staff completed an in house audit to remove any resident personal items that could be a safety concern to residents. 2. From 8/18/11 through present, QA audits are being completed daily to ensure the safety of the residents. 3. No safety razors are allowed in the facility effective 8/18/11. All families were notified of the change. 4. On 8/18/11 Inservicing was done as follows: -(A new) Policy and Procedure for Handling Self Harm Behavior was initiated and inserviced to staff by (Z2) Consultant on 8/18/11. - Policy and Procedure for Safety of Residents when Shaving was initiated and inserviced on 8/18/11. - Psychotropic Meds/Hot Rack - Mood Changes/ MD Notification 5. On admission each resident will be assessed for negative behaviors and suicidal ideations. MDS Data collection tool will be completed in the first 72 hours. New residents will have safety alarm and checked on every 15 minutes during the first 72 hour period. If there are any negative statements/suicidal ideations staff will per policy immediately place resident on 1:1's and notify Director of Nursing, Administrator and physician for referral for psych eval.	F 224		

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F 224	Continued From page 4 6. Each day in morning meeting, behaviors will be discussed to ensure that appropriate interventions are implemented, care planning has been completed. The resident with the behavior will be placed on hot rack charting for 72 hours to ensure proper documentation/monitoring of the behavior. All residents with behaviors will be referred to the in house psychologist who visits weekly. 7. All behavior interventions will be added to the staff communication book for staff to review and sign off on. Based on interview and record review the facility neglected to have a policy and procedure related to staff interventions when a resident expresses suicidal ideation or threats of self harm. The facility also neglected to have a policy and procedure in place for the storage/use of disposable razors. This failure 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 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.	F 224		

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F 224	Continued From page 5 This applies to 1 of 35 residents (R1) reviewed for depression and self harm in a sample of 35. R1's Nurse's Notes dated 7/25/11 at 7:30 PM state, "Nurse entered room found skin tear on resident's left hand. Asked resident what happened. Resident stated, "I have nothing to live for, I want to die. I scratched myself." resident very depressed and tearful. Cleansed skin tear and applied steri strips. 1.5 cm long. No complaints of discomfort. Sat with resident for a bit to cheer up. Medication given without difficulty. Requested Tylenol to help relax. POA (Power of Attorney) aware. Attempted to call on-call doctor, left message x 3. No return call. Fax written for Z3." On 8/29/11 at 10:30 AM, E3 (Life Enrichment Coordinator) stated, "I talked to him the next day and he didn't remember a thing. He denied saying anything. So I put him on 72 hour monitoring " E3 described 72 hour monitoring as resident interviews at random times throughout the 72 hour period. E3 was asked if the 72 hour monitoring was part of the facility policy related to residents with suicidal ideation. E3 stated, "It is just what I do. There may be a policy, I don't know. I just take it as it comes. I've only been here about 1 year." The Nurse's Notes dated 8/17/11 state, "Found resident in bathroom sitting in wheelchair with multiple cut marks to bilateral wrists. Floor covered with blood. Made statement, "Just let me go." Immediately got another nurse to assist with bleeding. Received order to transfer resident to (Hospital) for psych eval and possible admission. Wife and POA notified."	F 224		

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F 224	Continued From page 6 On 8/29/11 at 1:00 PM, the facility was asked if they had a policy regarding residents that elicit suicidal ideations and a policy regarding the storage/use of disposable razors. E1 (Administrator) replied, "Common Sense." The facility provided a copy of an undated policy entitled : Protocol for Handling Behavioral Emergencies. This policy does not address procedures for residents who inflict self harm or who express suicidal ideations. On 8/29/11 at 3:00 PM, E1 confirmed that the facility does not have a policy regarding the storage/use of disposable razors. On 8/31/11 at 9:30 AM, E1, the facility Administrator was notified of the Immediate Jeopardy related to R1's self- injurious behaviors and lack of facility intervention. Through observation, interview and record review the surveyor confirmed that the facility took the following actions to remove the Immediacy: 1. On 8/17/11 at 5:00 PM all nursing staff completed an in house audit to remove any resident personal items that could be a safety concern to residents. 2. From 8/18/11 through present, QA audits are being completed daily to ensure the safety of the residents. 3. No safety razors are allowed in the facility effective 8/18/11. All families were notified of the change.	F 224		

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F 224	Continued From page 7 4. On 8/18/11 Inservicing was done as follows: - Policy and Procedure for Handling Self Harm Behavior was initiated and inserviced to staff by (Z2) Consultant on 8/18/11. - Policy and Procedure for Safety of Residents when Shaving was initiated and inserviced on 8/18/11. - Psychotropic Meds/Hot Rack - Mood Changes/ MD Notification 5. On admission each resident will be assessed for negative behaviors and suicidal ideations. MDS Data collection tool will be completed in the first 72 hours. New residents will have safety alarm and checked on every 15 minutes during the first 72 hour period. If there are any negative statements/suicidal ideations staff will per policy immediately place resident on 1:1's and notify Director of Nursing, Administrator and physician for referral for psych eval. 6. Each day in morning meeting, behaviors will be discussed to ensure that appropriate interventions are implemented, care planning has been completed. The resident with the behavior will be placed on hot rack charting for 72 hours to ensure proper documentation/monitoring of the behavior. All residents with behaviors will be referred to the in house psychologist who visits weekly. 7. All behavior interventions will be added to the staff communication book for staff to review and sign off on.	F 224		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		9/28/11

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F 278	Continued From page 8 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that a resident assessment accurately describes a resident's condition. This applies to 1 of 35 residents (R1) reviewed for assessment in a sample of 35.	F 278		

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F 278	Continued From page 9	F 278		

The findings include:
The Behavior Tracking Sheet dated 7/25/11 states, "(R1) stated, "I want to die, I have nothing to live (for)." Resident very depressed and tearful. Skin tear noted to left hand- resident scratched self. Sat with resident for a bit to cheer up."

On 8/29/11 at 10:40 AM, E4(LPN) stated, "(On 7/25/11) I asked him what happened. He said, "I cut myself." I looked through his room and didn't see anything in his drawers that he could have cut himself with. Then I noticed his fingernails were long so I cut them. He is normally a little confused and depressed. I comforted him- told him it was okay. I told him he was just here for therapy and then he was going to go home."

The (Facility) Interdisciplinary Progress Notes dated 7/26/11 shows the following note written by E3 (Life Enrichment Coordinator), "Spoke with resident, No concerns/complaints at this time. Writer addressed resident regarding incident that occurred last night and in which resident stated,, "I have nothing to live for, I want to die. I scratched myself." Resident denied making statements, resident has a diagnosis of dementia and has difficulty with short term recall. Doctor was notified, medication change was made..."

R1's Minimum Data Set (MDS) of 7/29/11 under the section labeled "Behavioral symptoms not directed at others (e.g. physical symptoms such as hitting, or scratching self....)" documents that R1 had no behaviors.

The Social Service Progress Notes dated 7/29/11 state, (R1) has not exhibited any mood or behavior problems to contend with and takes his

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F 278	Continued From page 10 meals in the dining room.... I have no concerns regarding his care at this time." Review of R1's medical record on 8/29/11 shows that as of 8/17/11 R1's MDS assessment does not address his statement of having nothing to live for nor his history of self injurious behavior. On 8/17/11 R1 attempted suicide by lacerating both of his wrists with a modified disposable razor.	F 278		
F 319 SS=J	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that a newly admitted resident who expressed a lack of interest in life and a desire to die received psychosocial interventions to assist with his adjustment to a change in his life circumstances. This failure resulted in R1 lacerating his wrists with a disposable razor on 8/17/11. An Immediate Jeopardy was identified on 8/31/11. The Immediate Jeopardy began on 7/25/11 at 7:30 PM when R1 scratched his hand causing a skin tear, expressed a desire to die and stated that he had nothing to live for. While the immediacy was removed on 8/31/11	F 319		9/28/11

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F 319	Continued From page 11	F 319		

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 applies to 1 of 35 residents (R1) reviewed for depression and suicidal ideation in a sample of 35.

The findings include:

The Physician's Order Sheet (POS) dated 8/2011 shows that R1 was admitted to the facility on 7/23/11 with diagnoses including Peri Prosthetic Fracture Around Prosthetic Left Hip Joint and Mild Dementia. The POS also shows that R1 is ordered to take Remeron (Antidepressant) 30 mg Every Night.

The Minimum Data Set of 7/29/11 shows that R1 has a Cognitive Score of 10 (Moderate Impairment.)

The Nurse's Notes dated 7/25/11 at 7:30 PM state, "Nurse entered room found skin tear on resident's left hand. Asked resident what happened. Resident stated, 'I have nothing to live for, I want to die. I scratched myself.'. Resident very depressed and tearful. Cleansed skin tear and applied steri strips. 1.5 cm long. No complaints of discomfort. Sat with resident for a bit to cheer up. Medication given without difficulty. Requested Tylenol to help relax. POA (Power of Attorney) aware. Attempted to call on-call doctor, left message x 3. No return call. Fax written for Z3."

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F 319	Continued From page 12 On 8/29/11 at 10:30 AM, E3 (Life Enrichment Coordinator) stated, "I talked to him the next day and he didn't remember a thing. He denied saying anything. So I put him on 72 hour monitoring " E3 described 72 hour monitoring as resident interviews at random times throughout the 72 hour period. E3 was asked if the 72 hour monitoring was part of the facility policy related to residents with suicidal ideation. E3 stated, "It is just what I do. There may be a policy, I don't know. I just take it as it comes. I've only been here about 1 year." E3 was asked to describe R1's cognitive status on admission. E3 stated, "He had the start of dementia. His cognitive status varied. He would say, 'That is what happens when you get old.' He knew his dementia was setting in but seemed okay with it." E3 was asked what her qualifications were for her position. E3 stated, "I have a high school diploma and some college. I have a consultant that comes 1 x a month." R1's medical record shows that R1 was seen by Z2 (Social Work Consultant) on 8/12/11. E3 stated, "If I have any concerns I can call her. I don't believe I called her after (the incident) on 7/25/11." E3's Interdisciplinary Progress Note dated 7/26/11 at 11:00 AM states, "Spoke with resident. No concerns/complaints at this time. Writer addressed resident regarding incident that occurred last night and in which resident stated, "I have nothing to live for, I want to die. I scratched myself." Resident denied making statements. Resident has diagnosis of Dementia and has difficulty with short term recall." The Social Service Progress Notes dated 7/29/11 state, "(R1) was admitted from (hospital) for	F 319		

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F 319	Continued From page 13	F 319		

therapies following a fall and a fractured hip. He is alert and oriented x 1-2 with some confusion and forgetfulness. He has good memory recall of past events and a poor memory recall of present events. He is able to make his wants and needs known and can understand and respond to others, although not generally appropriately. He has not exhibited any mood or behavior problems to contend with and takes his meal in the dining room."

On 8/29/11 at 12:00 PM, Z1 stated, "He was very depressed- he couldn't remember things. He was really bothered by that. He watched 2 brothers and a sister with Dementia. He was really frustrated by the disease. He is in the hospital now and he is getting counseling there. It has really helped a lot."

On 8/30/11 at 2:45 PM, Z2 stated, "My role is to audit charts, assist with dealing with issues and provide inservice and education for the staff." Z2 was asked what her expectation would be if a resident expressed a desire to die. Z2 stated, "My expectation is that the resident would be sent out. If there is a major issue I am available if they need me. I've made them aware of that and they have called me before. I think what happened is that is was an oversight on the facility's part. I don't know what the nurse was thinking."

R1's Depression Scale dated 7/26/11 shows that R1 scored a 0 (no signs of depression). This same document states, "Resident made negative statements on 7/26/11. Reassessed for signs and symptoms of depression. Resident assessed with no signs and symptoms of depression. States he doesn't remember making any statements. Will

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LENA LIVING CENTER	**1010 SOUTH LOGAN STREET LENA, IL 61048**

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F 319	Continued From page 14 monitor." R1's careplan dated 7/26/11 states, "The resident has a history of self-harmful ideation (thoughts) and/or behavior. This appears to be related to: Poor impulse control, Feelings of helplessness, hopelessness; little hope that life will improve." The approaches/ interventions include: "If negative statements made or self harm threats made resident will be monitored by social services for 72 hours., (Physician) notified of changes in behavior. and If self harm occurs resident will be sent to the hospital for evaluation." On 8/31/11 at 9:30 AM, E1, the facility Administrator was notified of the Immediate Jeopardy related to R1's self- injurious behaviors and lack of facility intervention. Through observation, interview and record review the surveyor confirmed that the facility took the following actions to remove the Immediacy: 1. On 8/17/11 at 5:00 PM all nursing staff completed an in house audit to remove any resident personal items that could be a safety concern to residents. 2. From 8/18/11 through present, QA audits are being completed daily to ensure the safety of the residents. 3. No safety razors are allowed in the facility effective 8/18/11. All families were notified of the change.	F 319		

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F 319	Continued From page 15 4. On 8/18/11 Inservicing was done as follows: -(A new) Policy and Procedure for Handling Self Harm Behavior was initiated and inserviced to staff by (Z2) Consultant on 8/18/11. - Policy and Procedure for Safety of Residents when Shaving was initiated and inserviced on 8/18/11. - Psychotropic Meds/Hot Rack - Mood Changes/ MD Notification 5. On admission each resident will be assessed for negative behaviors and suicidal ideations. MDS Data collection tool will be completed in the first 72 hours. New residents will have safety alarm and checked on every 15 minutes during the first 72 hour period. If there are any negative statements/suicidal ideations staff will per policy immediately place resident on 1:1's and notify Director of Nursing, Administrator and physician for referral for psych eval. 6. Each day in morning meeting, behaviors will be discussed to ensure that appropriate interventions are implemented, care planning has been completed. The resident with the behavior will be placed on hot rack charting for 72 hours to ensure proper documentation/monitoring of the behavior. All residents with behaviors will be referred to the in house psychologist who visits weekly. 7. All behavior interventions will be added to the staff communication book for staff to review and sign off on.	F 319		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		9/28/11

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F 323	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 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. This applies to 1 of 35 residents (R1) reviewed	F 323		

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F 323	Continued From page 17 for depression in a sample of 35. The findings include: The Physician's Order Sheet (POS) dated 8/2011 shows that R1 has diagnoses including Peri Prosthetic Fracture Around Prosthetic Left Hip Joint and Mild Dementia. The POS also shows that R1 is ordered to take Remeron (Antidepressant) 30 mg Every Night. The Minimum Data Set of 7/29/11 shows that R1 has a Cognitive Score of 10 (Moderate Impairment.) The Nurse's Notes dated 7/25/11 at 7:30 PM state, "Nurse entered room found skin tear on resident's left hand. Asked resident what happened. Resident stated, "I have nothing to live for, I want to die. I scratched myself." resident very depressed and tearful. Cleansed skin tear and applied steri strips. 1.5 cm long. No complaints of discomfort. Sat with resident for a bit to cheer up. Medication given without difficulty. Requested Tylenol to help relax. POA (Power of Attorney) aware. Attempted to call on-call doctor, left message x 3. No return call. Fax written for Z3." The Behavior Tracking Sheet dated 7/25/11 states, "Resident stated, "I want to die, I have nothing to live with." Resident very depressed and tearful. Skin tear noted to left hand- resident scratched self. Sat with resident for a bit to cheer up." On 8/29/11 at 10:40 AM, E4(LPN) stated, "(On 7/25/11) I asked him what happened. He said, "I	F 323		

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cut myself." I looked through his room and didn't see anything in his drawers that he could have cut himself with. Then I noticed his fingernails were long so I cut them. He is normally a little confused and depressed. I comforted him- told him it was okay. I told him he was just here for therapy and then he was going to go home." E4 was asked if she put any special precautions or monitoring in place for R1 after this incident. E4 stated, "No, we didn't do 15 minute checks, I guess we should have." E4 was asked what the facility policy was if a resident expressed a desire to die. E4 stated, "They like us to do 15 minute checks or sit in there with the resident."

The (Facility) Interdisciplinary Progress Notes dated 7/26/11 shows the following note written by E3 (life enrichment coordinator), "Spoke with resident, No concerns/complaints at this time. Writer addressed resident regarding incident that occurred last night and in which resident stated,, "I have nothing to live for, I want to die. I scratched myself." Resident denied making statements, resident has a diagnosis of dementia and has difficulty with short term recall. Doctor was notified, medication change was made (Remeron increased from 15 mg to 30 mg), writer will monitor resident for next 72 hours and reassess for depression and self harm." The same document shows that E3 checked on R1 on 7/27 (untimed), 7/28 at 10:30 AM and 7/29 at 10:30 AM.

R1's careplan dated 7/26/11 states, "The resident has a history of self-harmful ideation (thoughts) and/or behavior. This appears to be related to: Poor impulse control, Feelings of helplessness, hopelessness; little hope that life will improve."

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F 323	Continued From page 19 The approaches/ interventions include: "As warranted conduct a room check/search and remove: Any sharp objects or similar contraband (razor blades, razors, knives, scissors, hammer, nails, screwdriver, screws, needles"and "If self harm occurs resident will be sent to the hospital for evaluation." On 8/29/11 at 12:15 PM, E9 (LPN) stated, "He had what I call "Sundowners" and he got more confused at night." The Nurse's Notes dated 8/17/11 state, "Found resident in bathroom sitting in wheelchair with multiple cut marks to bilateral wrists. Floor covered with blood. Made statement, "Just let me go." Immediately got another nurse to assist with bleeding. Received order to transfer resident to (Hospital) for psych eval and possible admission. Wife and POA notified." On 8/29/11 at 11:30 AM, E8 (RN) stated, "I was going my medication pass and the door to R1's room was shut. (E8 confirmed that R's room was the last room at the end of the hall just as it was during the incident on 7/25/11) I opened the door but I couldn't get it open all the way because the bathroom door was against it. I got in and R1 was in the wheelchair (in the bathroom) with his back to me. I saw blood on the floor. I asked R1 where he was bleeding from and he showed me his wrists. I put cold compresses of them and I went down the hall and brought (E9) back with me. (R1) seemed fine earlier in the day. He would get depressed in the evening." On 8/29/11 at 12:15 PM, E9 (LPN) stated, "When	F 323		

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I got to the room, E8 had placed wet cloths on his wrists. He was sitting in the wheelchair and there were puddles of blood all over the floor- about softball size. There were splatters of blood too. I told E8 to get E1 (Administrator) and I told the CNA to get housekeeping. By this time I was applying pressure and he was not bleeding anymore. R1 had taken pieces of toilet paper and kind of tented them over the puddles of blood on the floor. I saw a long blue thing on the floor. I kicked it with my foot and then picked it up and saw that it was a razor blade- like a (disposable razor) without the handle, just the blade. R1 had snapped the handle off and the bottom of the blue plastic shield to expose the blade. R1 said, "You weren't supposed to find me." He had superficial cuts on his right wrist and then a bigger gash on the right wrist. The left wrist had a gash on it too and less superficial cuts. Thank God he didn't cut himself deeper. It could have been a lot worse." E9 was asked where R1 could have gotten the razor from. E9 stated, "He told us his wife brought them in the day before. There were maybe 3 or 4 of them in a ziplock bag. He said he did it because he couldn't get a hold of her. He kept apologizing. Sorry he put us through this." E9 was asked if she was aware of the incident from 7/25/11. E9 stated, "I don't know anything about that." E9 was asked what the facility policy was regarding someone expressing a desire to die. E9 stated, "Nothing like this has ever happened before. I would notify the Administrator. If someone says they are going to hurt themselves we need to tell the person in charge and go through the room to remove anything that might be dangerous."

On 8/29/11 starting at 11:00 AM, E5, E6 and E7

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(CNAs) were asked if they were aware of R1's incident on 7/25/11, if they did any additional monitoring of R1 and what the facility policy is regarding the use/ storage of disposable razors. E5 stated, "They (razors) are stored in the nursing closet. Supposed to be locked. Then we put in sharps container in the shower room." E6 stated, "Razors are to be kept away from residents, put in the sharps container in the shower room. I don't know anything about the incident on 7/25/11. We were never told to do any extra monitoring of (R1)" E7 stated, "(R1) always had razors in his room and shaving cream. He would shave himself. I would set him up at the sink and check on him. He did okay, he never cut himself. About 1 week before this happened (incident on 8/17/11) there were 2 or 3 razors in the wash basin on the sink in his bathroom. You had to dig for them because they were on the bottom. I was never told of the incident on 7/25/11. We never did any increased monitoring of (R1). If there is anything we need to know about the residents then the nurse tells us when we come in."

On 8/29/11 at 12:55 PM, Z1 stated, "They brought the razors in- one of the CNAs. He kept saying, I need to shave, I need to shave so they brought in razors, shaving cream and after lotion. I did not bring them in. The man in the bed next to him had some too."

On 8/30/11 at 2:45 PM, Z2 stated, "It is the facility policy that alert residents can have razors. Someone told me that R1's wife brought them in and didn't tell anyone."

The Emergency Room Summary Report dated

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8/17/11 states, "Patient reports knee pain and right hip pain. States that it was too much for him to handle so he took a razor blade to his bilateral wrists."

The facility document entitled Emergency Department Visit dated 8/17/11 and dictated by the Physician's Assistant states, "(R1) states what he did was "really stupid." he states that he just got frustrated, had an altercation, everything kind of balled up together and got him frustrated, so he cut his wrists." This same document states, "The patient has multiple superficial lacerations with a few of them deeper than others requiring closure."

The Addendum to Emergency Department Visit dated 8/17/11 and dictated by the ER physician states, "(R1) had multiple stories which might have been secondary to his dementia but he had these horizontal lacerations across both wrists that either might have been frustration with his chronic pain or frustration with his wife. He was evaluated by Crisis and deemed appropriate for admission."

The Hospital Psychosocial Assessment dated 8/17/11 states, "The patient is not quite sure why he cut his wrists. He stated first to the nurse upon arrival to the emergency room that he was tired of dealing with the pain in his legs. By the time I spoke to the patient, the patient stated he did it to seek attention. the patient does have a mild case of dementia. Administrator stated that the patient when found in the bathroom, stated he was not meant to be caught. He stated to me hours later that he knew deep down inside someone was going to find him. He has been tearful all night

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F 323	Continued From page 23 about what he did." This same document states, "(R1's)memory recall for remote is good, recent is poor and immediate is fair." and " Treatment goals are to get a hold of his depression, get some coping skills so that he will feel better." The Psychiatric Admission Note dated 8/17/11 states, "(R1) reports depression, anhedonia (lack of pleasure in things that should bring pleasure), decreased energy, decreased appetite and insomnia." On 8/31/11 at 9:30 AM, E1, the facility Administrator was notified of the Immediate Jeopardy related to R1's self- injurious behaviors and lack of facility intervention. Through observation, interview and record review the surveyor confirmed that the facility took the following actions to remove the Immediacy: 1. On 8/17/11 at 5:00 PM all nursing staff completed an in house audit to remove any resident personal items that could be a safety concern to residents. 2. From 8/18/11 through present, QA audits are being completed daily to ensure the safety of the residents. 3. No safety razors are allowed in the facility effective 8/18/11. All families were notified of the change. 4. On 8/18/11 Inservicing was done as follows:	F 323		

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F 323	Continued From page 24 - Policy and Procedure for Handling Self Harm Behavior was initiated and inserviced to staff by (Z2) Consultant on 8/18/11. - Policy and Procedure for Safety of Residents when Shaving was initiated and inserviced on 8/18/11. - Psychotropic Meds/Hot Rack - Mood Changes/ MD Notification 5. On admission each resident will be assessed for negative behaviors and suicidal ideations. MDS Data collection tool will be completed in the first 72 hours. New residents will have safety alarm and checked on every 15 minutes during the first 72 hour period. If there are any negative statements/suicidal ideations staff will per policy immediately place resident on 1:1's and notify Director of Nursing, Administrator and physician for referral for psych eval. 6. Each day in morning meeting, behaviors will be discussed to ensure that appropriate interventions are implemented, care planning has been completed. The resident with the behavior will be placed on hot rack charting for 72 hours to ensure proper documentation/monitoring of the behavior. All residents with behaviors will be referred to the in house psychologist who visits weekly. 7. All behavior interventions will be added to the staff communication book for staff to review and sign off on.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 25 LICENSURE VIOLATIONS 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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. Restorative measures shall include, at a minimum, the following procedures:	F9999		

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F9999	Continued From page 26 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 regulations were not met as evidenced by: Based on interview and record review the facility neglected to have a policy and procedure related to staff interventions when a resident expresses suicidal ideation or threats of self harm. The facility also neglected to have a policy and procedure in place for the storage/use of disposable razors. These failures contributed to R1 lacerating his wrists with a modified disposable razor on 8/17/11. This applies to 1 of 35 residents (R1) reviewed for depression and self harm in a sample of 35. The findings include: R1's Nurse's Notes dated 7/25/11 at 7:30 PM state, "Nurse entered room found skin tear on resident's left hand. Asked resident what happened. Resident stated, "I have nothing to live for, I want to die. I scratched myself." resident very depressed and tearful. Cleansed skin tear and applied steri strips. 1.5 cm long. No complaints of discomfort. Sat with resident for a bit to cheer up. Medication given without difficulty. Requested Tylenol to help relax. POA (Power of Attorney) aware. Attempted to call on-call doctor, left message x 3. No return call. Fax written for Z3." On 8/29/11 at 10:30 AM, E3 (Life Enrichment	F9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENA LIVING CENTER	**1010 SOUTH LOGAN STREET LENA, IL 61048**

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Coordinator) stated, "I talked to him the next day and he didn't remember a thing. He denied saying anything, so I put him on 72-hour monitoring." E3 described 72-hour monitoring as resident interviews at random times throughout the 72-hour period. E3 was asked whether the 72-hour monitoring was part of the facility policy related to residents with suicidal ideation. E3 stated, "It is just what I do. There may be a policy, I don't know. I just take it as it comes. I've only been here about 1 year."

E3's Interdisciplinary Progress Note dated 7/26/11 at 11:00 AM states, "Spoke with resident. No concerns/complaints at this time. Writer addressed resident regarding incident that occurred last night and in which resident stated, "I have nothing to live for, I want to die. I scratched myself." Resident denied making statements. Resident has diagnosis of Dementia and has difficulty with short term recall."

The Nurse's Notes dated 8/17/11 state, "Found resident in bathroom sitting in wheelchair with multiple cut marks to bilateral wrists. Floor covered with blood. Made statement, "Just let me go." Immediately got another nurse to assist with bleeding. Received order to transfer resident to (Hospital) for psych eval and possible admission. Wife and POA notified."

On 8/29/11 at 11:30 AM, E8 (RN) stated, "I was doing my medication pass and the door to R1's room was shut. (E8 confirmed that R1's room was the last room at the end of the hall just as it was during the incident on 7/25/11) I opened the door but I couldn't get it open all the way because the bathroom door was against it. I got in and R1

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was in the wheelchair (in the bathroom) with his back to me. I saw blood on the floor. I asked R1 where he was bleeding from and he showed me his wrists. I put cold compresses of them and I went down the hall and brought (E9) back with me. (R1) seemed fine earlier in the day. He would get depressed in the evening."

On 8/29/11 at 12:15 PM, E9 (LPN) stated, "When I got to the room, E8 had placed wet cloths on his wrists. He was sitting in the wheelchair and there were puddles of blood all over the floor- about softball size. There were splatters of blood too. I told E8 to get E1 (Administrator) and I told the CNA to get housekeeping. By this time I was applying pressure and he was not bleeding anymore. R1 had taken pieces of toilet paper and kind of tented them over the puddles of blood on the floor. I saw a long blue thing on the floor. I kicked it with my foot and then picked it up and saw that it was a razor blade - like a (disposable razor) without the handle, just the blade. R1 had snapped the handle off and the bottom of the blue plastic shield to expose the blade. R1 said, 'You weren't supposed to find me.' He had superficial cuts on his right wrist and then a bigger gash on the right wrist. The left wrist had a gash on it too and less superficial cuts. Thank God he didn't cut himself deeper. It could have been a lot worse." E9 was asked from where R1 could have gotten the razor. E9 stated, "He told us his wife brought them in the day before. There were maybe 3 or 4 of them in a ziplock bag. He said he did it because he couldn't get a hold of her. He kept apologizing. Sorry he put us through this." E9 was asked if she was aware of the incident from 7/25/11. E9 stated, "I don't know anything about that." E9 was asked what the facility policy was

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regarding someone expressing a desire to die. E9 stated, "Nothing like this has ever happened before. I would notify the Administrator. If someone says they are going to hurt themselves we need to tell the person in charge and go through the room to remove anything that might be dangerous."

On 8/29/11 starting at 11:00 AM, E5, E6 and E7 (CNAs) were asked if they were aware of R1's incident on 7/25/11, if they did any additional monitoring of R1 and what the facility policy is regarding the use/storage of disposable razors. E5 stated, "They (razors) are stored in the nursing closet. Supposed to be locked. Then we put in sharps container in the shower room." E6 stated, "Razors are to be kept away from residents, put in the sharps container in the shower room. I don't know anything about the incident on 7/25/11. We were never told to do any extra monitoring of (R1)." E7 stated, "(R1) always had razors in his room and shaving cream. He would shave himself. I would set him up at the sink and check on him. He did okay, he never cut himself. About 1 week before this happened (incident on 8/17/11) there were 2 or 3 razors in the wash basin on the sink in his bathroom. You had to dig for them because they were on the bottom. I was never told of the incident on 7/25/11. We never did any increased monitoring of (R1). If there is anything we need to know about the residents then the nurse tells us when we come in."

On 8/29/11 at 12:55 PM, Z1 (R1's spouse) stated, "They brought the razors in- one of the CNAs. He kept saying, I need to shave, I need to shave so they brought in razors, shaving cream and after

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lotion. I did not bring them in. The man in the bed next to him had some too."

On 8/30/11 at 2:45 PM, Z2 (social work consultant) stated, "It is the facility policy that alert residents can have razors. Someone told me that R1's wife brought them in and didn't tell anyone."

The Emergency Room Summary Report dated 8/17/11 states, "Patient reports knee pain and right hip pain. States that it was too much for him to handle so he took a razor blade to his bilateral wrists."

The facility document entitled Emergency Department Visit dated 8/17/11 and dictated by the Physician's Assistant states, "(R1) states what he did was "really stupid." he states that he just got frustrated, had an altercation, everything kind of balled up together and got him frustrated, so he cut his wrists." This same document states, "The patient has multiple superficial lacerations with a few of them deeper than others requiring closure."

The Addendum to Emergency Department Visit dated 8/17/11 and dictated by the ER physician states, "(R1) had multiple stories which might have been secondary to his dementia but he had these horizontal lacerations across both wrists that either might have been frustration with his chronic pain or frustration with his wife. He was evaluated by Crisis and deemed appropriate for admission."

The Hospital Psychosocial Assessment dated 8/17/11 states, "The patient is not quite sure why he cut his wrists. He stated first to the nurse upon

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arrival to the emergency room that he was tired of dealing with the pain in his legs. By the time I spoke to the patient, the patient stated he did it to seek attention. the patient does have a mild case of dementia. Administrator stated that the patient when found in the bathroom, stated he was not meant to be caught. He stated to me hours later that he knew deep down inside someone was going to find him. He has been tearful all night about what he did." This same document states, "(R1's) memory recall for remote is good, recent is poor and immediate is fair." and "Treatment goals are to get a hold of his depression, get some coping skills so that he will feel better."

The Psychiatric Admission Note dated 8/17/11 states, "(R1) reports depression, anhedonia (lack of pleasure in things that should bring pleasure), decreased energy, decreased appetite and insomnia."

On 8/29/11 at 12:00 PM, Z1 stated, "He was very depressed- he couldn't remember things. He was really bothered by that. He watched 2 brothers and a sister with Dementia. He was really frustrated by the disease. He is in the hospital now and he is getting counseling there. It has really helped a lot."

On 8/30/11 at 2:45 PM, Z2 stated, "My role is to audit charts, assist with dealing with issues and provide inservice and education for the staff." Z2 was asked what her expectation would be if a resident expressed a desire to die. Z2 stated, "My expectation is that the resident would be sent out. If there is a major issue I am available if they need me. I've made them aware of that and they have called me before. I think what happened is

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that is was an oversight on the facility's part. I don't know what the nurse was thinking."

R1's Depression Scale dated 7/26/11 shows that R1 scored a 0 (no signs of depression). This same document states, "Resident made negative statements on 7/26/11. Reassessed for signs and symptoms of depression. Resident assessed with no signs and symptoms of depression. States he doesn't remember making any statements. Will monitor."

R1's careplan dated 7/26/11 states, "The resident has a history of self-harmful ideation (thoughts) and/or behavior. This appears to be related to: Poor impulse control, Feelings of helplessness, hopelessness; little hope that life will improve." The approaches/interventions include: "If negative statements made or self harm threats made resident will be monitored by social services for 72 hours., (Physician) notified of changes in behavior. and If self harm occurs resident will be sent to the hospital for evaluation."

On 8/29/11 at 1:00 PM, the facility was asked whether they had a policy regarding residents that elicit suicidal ideations and a policy regarding the storage/use of disposable razors.

The facility provided a copy of an undated policy entitled: Protocol for Handling Behavioral Emergencies. This policy does not address procedures for residents who inflict self harm or who express suicidal ideations.

On 8/29/11 at 3:00 PM, E1 confirmed that the facility does not have a policy regarding the

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F9999	Continued From page 33 storage/use of disposable razors. (A)	F9999		