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	14E242	A. BUILDING _____ B. WING _____	C 09/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS Incident of 8/24/11/ IL 54254 A partial extended survey was conducted.	F 000		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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:	F 278		9/22/11

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

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Based on record review and interview, the facility failed to ensure residents have an accurate assessment conducted and coordinated with a Registered Nurse (R.N.) and each individual who completes a portion of the assessment has signed and a R.N. has certified the assessments are accurate and complete. This is for one of six residents identified with suicidal ideations (R1)

Findings include:

A review of R1's clinical record indicates on 7/19 and 7/22/11 the facility has requested for authorization for Antipsychotic medication of Risperidone M -tab ODT and Risperidone for R1. In an Interview with E11 who completed the form dated 7/22/11 she states she was not sure why the medication is changed on 7/22/11 and she was not aware of the indication for use.

Item #2 on the form HFS 168 (N-3-11) is blank for indication of use for the antipsychotic medication for 7/19/11 and 7/22/11. These dates are in the assessment period for psychotropic drug use.

The clinical record also documents on 7/16/11 that R1's medication for Lexapro is changed to Celexa. There is no indication for use of the medication identified.

The summary CAA Summary does not show where the facility identifies risk factors, complications and/or any referral for these care areas.

On 8/26/11, the Minimal Data Set (MDS) and Care Area Assessment summary (CAA) for R1

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F 278	Continued From page 2 identified concerns for falls, cognitive lose and psychotropic drug use for R1. The summary dated 7/24/11 as completed (no signature) was requested for review from (E6) Director/LPN. E6 states she was not aware of what a CAA is and none was presented during survey. Interview with (E2) Psychiatric Rehabilitation Services Director (PRSD), E3 Activity Director (E8) Psychiatric Rehabilitation Services Counselor (PRSC) who state, they are responsible for activities and Mental Health portions of the MDS. They were not aware of CAA's and had not signed for the assessment areas they complete. (E1) Administrator and E6 state, the previous Director of Nursing has been terminated from the facility over two weeks earlier and there is no Registered Nurse at the time of the survey to sign and certify the assessments.	F 278		
F 309 SS=K	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to: - To identify residents with history of suicide	F 309		9/16/11

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F 309	Continued From page 3 ideation - Provide services in mental health for residents with history of suicide ideation, - Conduct a comprehensive assessment and care plan for residents with this background. These failures have the potential to affect R3, R4, R5, R6 and R7 who have history of suicidal ideations and did affect R1 who hung himself in his closet on 8/24/11 resulting in his death. An immediate jeopardy was identified on 8/26/11 at 5:30pm. It began on 8/24/11 the immediacy was removed on 9/2/11 at 2:30 p.m. The facility remains out of compliance at severity level 2 due to the need to evaluate the implementation of the removal plan. Findings include: R1 a 22 year old male was admitted to this facility on 7/11/11 with diagnosis including Bipolar disorder Schizoaffective disorder, manic type, psychotic. R1's medication administration record indicates he takes Celexa 20 mg, Lorazepam 0.5 mg three times a day and Risperidone 1 mg three times a day. An incident report dated 8/24/11 stated R1 was found at 8:40pm in his room hanging by neck in the closet with a belt. R1 died at hospital. The actions taken were CPR initiated 911 called, resident transported to hospital, medical director and psychiatrist were contacted. A review of R1's clinical record an Antipsychotic Medication for long Term Care Residents Prior Authorization Request form completed by (E11)	F 309		

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LPN on 7/22/11.

This form requested Risperidone 1 mg three times a day.
The form states to check all symptoms present in this patient. Areas checked for R1 are delusions, negative symptoms and fatigue/loss of energy, distractibility, hallucinations and depressed mood. Suicidal ideation (handwritten) is listed. Feelings of worthlessness/inappropriate guilt, flight of ideas, severely impaired mental status with history on non-compliance.
This same form was completed on 7/19/11 by staff requesting Risperidone indicate depressed mood and suicidal ideations are present.

A statement written by staff (E4) RN dated 8/24/11 indicates R1 was at the nursing station at 7:30pm using the phone. R1 became upset, the conversation escalated, R1 became agitated and swearing and slammed the phone down. E4 writes she went to R1's room and talked for 5 to 10 minutes. E4 gave R1 a hug and asked if he was OK, he said he was. He stated he was feeling better and went back into his room.

Later at 8:40 p.m. (R2), the roommate of (R1) reported to (E9) CNA R1 was in his closet.

R1 was hanging from the clothes bar with his belt around his neck. 911 was called, E4 writes she took R1's belt off his neck and laid him on the floor. Then ran to get mouth valve and ran back to begin CPR, which was continued until EMS arrived. E9's statement reports the same situation as E4.

R1's admission Minimum Data Set (MDS) was

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completed on 7/24/11. The areas triggered for an assessment are cognitive loss/ dementia, falls and psychotropic drug use. There was no assessment for falls. There was no assessment for psychotropic drug use and cognitive loss reads, refers to psych social history dated 7/11/11.

R1's record did not contain any care plan when reviewed the morning of 8/26/11. When asked, E6 (Director of Nursing /LPN) said R1 would have a quarterly care plan which is not due yet. Then E6 presented a computerized care plan that was printed on 8/26/11. The dates on the care plan are from 8/25 to 8/25/11.

There are five items listed as problems with the onset date as 8/25/11. E6 said maybe there is a hand written care plan. The surveyor followed E6 to care plan office. E6 attempted to close the office door in order to find hand written care plans for R1. There were none found.

E6 then said maybe the counselors has a care plan. E6 was accompanied to the office where (E2) Psychiatric Rehabilitation Services Director (PRSD), (E8) Psychiatric Rehabilitation Service Counselor (PRSC) and (Z3) Social Service Consultant were present. E8 was R1's counselor and said there were no hand written care plans. The care plans are in the computer.

E2 showed R1's room (17 bed 2) the morning of 8/26/11. R 1's possessions were still in the room. There were cloths, shoes, books and in the bedside table drawer. There were several documents. One of the documents was guidelines for group homes. Per interview with

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(E5) administrator on 8/30/11, staff was helping R1 with required paperwork to apply to live in a group home.

There were papers titled family background, residence history, financial status, health and wellness and patient health questionnaire-symptoms checklist. The health and wellness form asks, "have you experienced in the last year?" Some items checked by R1 were, increased stress level, depressed mood, excessive worry/ anxiety and thoughts of self-harm.

The questionnaire about symptoms asks, "over the last 2 weeks have you been bothered by the following problems?" Thoughts that you would be better off dead or of hurting yourself in some way is checked for several days.

A questionnaire found in the drawer of R1 dated 8/13/11 contains items about emotions, moods, thoughts and behaviors. To circle Yes or No - During the past 2 weeks, did you think you would be better off dead?" Is circled yes. "Did you have thoughts of suicide, even though you would not really do it?" This is circled yes. "Did you seriously consider talking your own life?" This is circled yes."Did you think about a specific way of taking your life?" This is circled yes.

On 8/26/11 at 12:30pm, the (E1) administrator and (E2) PRSD were asked to present a list of residents with suicide ideation or history of suicide ideation. The list was not forthcoming.

Surveyors asked E2, E8 and Z3 for the list of residents with suicide ideations or history of

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suicide ideations. All stated the facility does not have any residents they are aware of with suicide ideation or history of suicide ideation.

At 2:00pm on 8/26/11, resident's records were reviewed at random and five residents were found with a history or diagnosis of suicide ideation.

R4's record was reviewed and found to have bipolar, depression and suicide ideation as his diagnosis on the physicians order sheet. R4 was admitted to the facility on 8/12/11. In his record a copy of a history and physical from the hospital dated 8/8/11 stated he was admitted after a four day binge unable to control his drinking with suicidal ideation which persisted even during the interview. Although somewhat reduced in intensity. R4's record contained an assessment by E10 PRSC dated 8/24/11, which states R4 does have a history of a previous attempt or attempts of suicide. Comments on this form indicate R4 is at greater than moderate risk for self-harm. Resident requires a plan for assessment of self-harm. R4 had a universal progress note dated 8/12/11 with care plan notes written on top of the page. This page included diagnosis history of suicidal statements communication group, symptom management group daily meeting (1:1) to monitor behavior. The approach is to praise for all efforts. R4 did not have an MDS or Care plan for review on 8/26/11 at 5:00pm.

R5 observed during survey on 8/29/11, appears angry, agitated and saying statements of " being killed." E6 heard this statement. Stated that is what R5 says. R5 is noted to walk the facility at

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a fast pace and has very little interaction with staff or other residents.

A review of R5's admission record R5 admitted 6/2/2009 and has a diagnosis of Paranoid Schizophrenia. From record review, a 5/11/11 involuntary admission to hospital was noted. It states R5 was more depressed since her boyfriend was convicted and stating she would rather die with her boyfriend. R5 lost 20 lbs in one month.

From record review and interview with (E2) Psychiatric Rehabilitation Services Director (PRSD), an assessment for R5's suicidal ideations or a plan of care to address these concerns is not developed.

The 6/29/11 plan of care presented to the surveyor does not address R5's behaviors of weight lose, not eating, depressions or thoughts and words of dying

R6 observed during the survey on 8/29/11, R6 appears to have flat affect, disheveled, hair unkempt. During interview, R6 states she did not like the doctors and staff. Stating the doctor is not adjusting her medication that was causing her gain weight.

A review of R6's clinical record notes a Psychiatric Evaluation dated 8/25/08, R6 states" two years ago I took all my pills" R6 suffers from depression and insists "I only tried to kill myself once."
I an interview with E2 on 8/29/11, E2 was asked if facility has assessed R6 for risk or self-harm. E2 states none was available.

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R3 was observed during survey on 8/29/11, R3 was noted to be disheveled and unkempt. R3 appeared to be anxious with flight of ideas. R3 speech is pressured and difficult to understand. R3 spoke of the FBI and CIA coming to get him.

In a review of the clinical record, two petitions for emergency admission to hospital are noted for R3. On 10/28/09, R3 states he tried to choke and cut self with cell phone cord. Reddish marks were noted around his neck and on right wrist. On 12/27/10, R3 reported he felt suicidal and homicidal.

E2 was interviewed for R3's assessment for risk / harm. None was available. A review of the plan of care dated 6/30/11 does not identify R3 to have a history of suicidal ideations.

R7 observed on 8/26/11 during survey, R7 entered the conference room and grabbed a pot of coffee that was on the table. R7 proceeded to drink the entire pot of coffee. R7 spilled liquid while pouring coffee into cup. E6 (Director of Nursing /LPN) was made aware of this situation E6 stated he likes coffee. R7 is observed to be loud and has flight of ideas with labile affect.

In a review of R7's clinical record a Petition for emergency admission dated 1/15/11 was noted. The petition reads, R7 states, wants to commit suicide."I can not take it any more it is in my gut, I don't know if I will run away or what. I feel like I'm being bullied by the staff and residents and I can not take anymore."

E2 was asked for risk harm assessment for R7.

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F 309	Continued From page 10 E2 has none. In a review of the 3/11/11 plan of care for R7, the plan does not address the history of suicide ideations. Removal Plan RESIDENT IDENTIFIED Resident was found hanged in his room. Resident was under psychiatrist Care and was receiving medication prescribed by the psychiatrist. While at Facility, resident did not express suicidal ideation or make any such attempts. Resident had no prior history of suicidal ideation or attempts before entering the facility. IDENTIFYING OTHER RESIDENTS AT RISK An audit of all residents who have either expressed suicidal ideation or made any such attempt has been completed. This was completed on August 29, 2011. All such residents will be reassessed and their care plans updated with related interventions. PREVENTION OF FUTURE OCCURRENCES Staff was inserviced on the following: 1. Facility policy regarding 'Handling Behavioral Emergencies'; 2. Facility policy on 'Suicide Prevention Policy and Procedure': 21 staff members inserviced, staff that has not completed the training will not be able to start their next work assignment until they complete the inservice training. COMPLETION: September 2, 2011	F 309		

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F 309	Continued From page 11 List will be maintained at nurses' station of residents who have either expressed suicidal ideation or made any attempts at suicide. PRSC's, Certified Nurse's Aides and Nurses to review the list so as to remain familiar which resident's names are on it. List will be updated as indicated. COMPLETED: September 2, 2011 PRSC schedules have been revised to provide for 24-hour coverage to expand their availability for intervention and assessment. COMPLETED: August 29, 2011 Care plans will be reviewed and updated so as to reflect side effects of medications for appropriate medication monitoring. COMPLETED: August 31, 2011 All resident criminal background checks will be reviewed to identify criminal offenders. Where appropriate, interventions for behavior consistent with the criminal history will be updated. COMPLETED: September 2, 2011 MONITORING: 1. Inservice of staff regarding residents with suicidal ideation or past suicidal attempts will be conducted quarterly by Administrator to ensure the proper monitoring of such residents. 2. Resident charts will be audited monthly by DON to ensure that medication side effects are care planned with appropriate interventions. 3. Resident charts for those with criminal backgrounds will be audited biweekly by Psycho-Social Consultant to	F 309		

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F 309	Continued From page 12 ensure that appropriate behavior interventions are included. 4. Progress will be monitored quarterly in Q.A. Meeting to ensure compliance with regulations.	F 309		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to designate a Registered Nurse (RN) to serve as Director of Nursing on a full time basis. This failure has the potential to affect all 64 residents in the facility. Findings include: On 8/26/11 at 11:30am, E6 said she is the Director of Nursing (DON). The Facility Data Sheet given to the facility to fill out in the morning of 8/26/11 was returned listing E6 as the Director of Nursing (DON). Review of E6's personal file	F 354		9/23/11

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F 354	Continued From page 13 includes certificates indicating she is a Licensed Practical Nurse (LPN). E6 stated at 5:35pm in the conference room on 8/26/11 the facility does not have to have an RN as DON because of the low number of beds. The facility has 70 intermediate beds according to Illinois Department of Public Health (IDPH) record. IDPH has no record of granting a waiver for E6 to serve as DON, and the schedule for August September 2011 indicate that 4 RN's are on duty at the facility.	F 354		
F 406 SS=G	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to: - Ensure the Psychiatric Rehabilitation Services Director (PRSD) and all staff is aware of residents who have or have history of high-risk behaviors. - Ensure the PRSD is made aware of residents who are refusing programming and that documentation and evaluations are available for the refusal. - Ensure on admission an initial plan of care is	F 406		9/22/11

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F 406	Continued From page 14 developed and implemented - Ensure changes in resident's conditions are assessed and plans of care are developed and implemented, - Ensure the Level Of Functions (LOF) assessments indicate the priority level for programs to be initiated and which level of the skills programs the resident is to be started. - Ensure programs are initiated in a timely manner. - Ensure the plans of care are specific to the assessed residents needs and the care plan goals and interventions are measurable. - Ensure residents and family (if applicable) are actively involved in the development of skills programs and the care plan process. - Ensure there are 24 hours continuous support, supervision and therapeutic interventions to provide crisis services. And - Ensure psychoactive medication monitoring, services and evaluations are available These failures resulted in R1 committing suicide and facility not aware of other residents who have suicidal ideations For six of six residents identified with suicidal ideations R1, R3. R4, R5, R6, R7 in the sample of 10. This has the potential to affect all 36 residents identified with Severe Mental Illness. Findings include: The facility currently have identified 36 residents with programming for Severe Mental Illness (SMI) In an interview, E2 (PSRD) said and record	F 406		

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review confirms he works Monday through Friday . The facility currently has one full time counselor who works Monday thru Friday and one part time counselor who works Tues, Wednesday and Saturday. A review of the schedule for skills group available is Symptom management, Coping Skills and Communication skills. Symptom management starts at 9:30am and Communication Skills end at 11:30a.m. No groups are available on Sundays.

On 7/11/11, R1 a 22 year old male was admitted to this facility with diagnosis including Bipolar disorder Schizoaffective disorder, manic type, psychotic.

The Antipsychotic Medication for Long- Term Care Residents Prior Authorization Request Form was completed by (E11) LPN on 7/22/11.
This form states to check all symptoms present in this patient. Areas checked are delusions, negative symptoms, fatigue/loss of energy, distractibility, hallucinations, depressed mood with (suicidal ideation handwritten), feelings of worthlessness/inappropriate guilt, flight of ideas. (Severely impaired mental status with history of non-compliance is handwritten.)

E11 during interview on 8/29/11 states, she entered the information and signed the form. E11 states she was not sure were she got the information that was handwritten.

Another staff nurse completed this same form on 7/19/11 indicates: depressed mood and suicidal ideations (handwritten) are present.

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F 406	Continued From page 16 A review of the facility's Screening Assessment to Determine the Presentation of Abuse and /or Neglect Factors completed on 7/26/11 by(E10) PSRC scores R1 at a (1) low = 0-1. This score is incorrect. Point #1 for history of abuse on this form states a (NO) for R1. A review of the 6/29/11 hospital record Psychiatric Evaluation notes R1 has a history of sexual abuse as child, verbal abuse from parents and pornography addiction. Point #2 on the form states (NO) for R1 for history of obsessions. The 6/29/11 Psychiatric Evaluation and facility's 7/27/11 psychosocial history noted R1 has sexual addition and compulsive masturbating. Point #5 states (NO) for R1's history of Depression. Point #6 for history of inappropriate behavior list (NO).6/29/11, R1 admits addiction to pornography. The addition of these three other factor place R1 at (4) High= 4+ The Level Of Function (LOF) assessment for R1 is dated 7/26/11 as completed. The summary of this assessment indicates R1 was in agreement for long-term care placement and to keep R1 active in peer community. R1 is to develop healthy relationships and work on coping skills and community living. The skills assessment does not list which group has the highest priority. The summary does not address why it would take a month to begin R1 into groups. From interview with E2 on 8/26/11, R1 was to start the coping skills group on 8/29/11.	F 406		

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E2 states R1 did not want to stay at the facility and from interview with (Z1) Psychiatric on 8/29/11 states, on 8/12/11 he had long talk with R1 who voiced he did not want to stay in the nursing home. R1 wanted to go stay with his father. Z1 recommended a group home placement for R1.
R1 committed suicide on 8/24/11.

Statement written by staff (E4) RN dated 8/24/11 indicates R1 was at the nursing station at 7:30 p.m. using the phone. R1 became upset. The conversation escalated. R1 became agitated and swearing and slammed the phone down. E4 writes she went to R1's room and talked for 5 to 10 minutes. E4 gave R1 a hug and asked if he was OK, he said he was. He stated he was feeling better and went back into his room.

Later at 8:40 p.m. (R2), the roommate of R1 reported to (E9) CNA R1 was in his closet.

R1 was hanging from the clothes bar with his belt around his neck.

From record review, R1's admission Minimum Data Set (MDS) was completed on 7/24/11. The areas triggered for an assessment were cognitive loss/ dementia, falls and psychotropic drug use. There was no assessment for falls. There was no assessment for psychotropic drug use, and cognitive loss reads refers to psych social history dated 7/11/11.

R1's record did not contain any care plan when reviewed the morning of 8/26/11. When asked (E6) Director of Nursing /LPN said, R1 would

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have a quarterly care plan, which is not due yet. Then E6 presented a computerized care plan that was printed on 8/26/11. The dates on the care plan are from 8/25 to 8/25/11. There were five items listed as problems with the onset date as 8/25/11. E6 said maybe there is a hand written care plan. Surveyors followed E6. She attempted to close the office door. No hand written care plans were found. E6 then said that maybe the counselors have a care plan. Surveyors accompanied E6 to the office where (E2) Social Service/ PSRD, (E8) PRSC and (Z3) Social Service Consultant were present.

E8 was R1's counselor and said there were no hand written care plans, the care plans are in the computer.

E2 showed the surveyors R1's room (17 bed 2) the morning of 8/26/11. R 1's possessions were still in the room. There were cloths, shoes, books and in the bedside table drawer. There were several documents. One of the documents was guidelines for group homes. Per interview with (E5) administrator on 8/30/11, staff was helping R1 with required paperwork to apply to live in a group home. There were papers titled family background, residence history, financial status, health and wellness and patient health questionnaire- symptoms checklist. The health and wellness form asks, "have you experienced in the last year?" Some of the items checked were: increased stress level, depressed mood, excessive worry/ anxiety and thoughts of self-harm. The questionnaire about symptoms asks, "over the last two weeks have you been bothered by the following problems?" Thoughts that you would be better off dead or of hurting

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F 406	Continued From page 19 yourself in some way is checked several days A questionnaire found in the drawer of R1 dated 8/13/11 contains items about emotions, moods, thoughts and behaviors. Circle Yes or No - During the past two weeks "Did you think that you would be better off dead?" (Yes) is circled. "Did you have thoughts of suicide, even though you would not really do it?", is circled (yes). "Did you seriously consider talking your own life?", is circled (yes). "Did you think about a specific way of taking your life?", is circled (yes.) Interview with E2 as to who was assisting R1 in completing the form for the group home. E2 states all the counselors had not seen the paperwork. On 8/26/11 at 12:30 p.m., the facility staff was asked to present a list of residents with suicide ideation or history of suicide ideation. The list was not forthcoming. The surveyors asked E2, E8 and Z3 for the list of residents with this condition. All stated the facility does not have any residents they are aware of with suicide ideation or history of suicide ideation. At 2:00 p.m. on 8/26/11, surveyors reviewed resident records at random and found five residents R3, R4, R5, R6 and R7 with history or diagnosis of suicide ideation. R4's record was reviewed by surveyor and found to have bipolar, depression and suicide ideation as his diagnosis on the physicians order sheet. R4 was admitted to the facility on 8/12/11. In his record a copy of a history and physical from the hospital dated 8/8/11 states, R4 was admitted	F 406		

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F 406	Continued From page 20 after a four day binge, unable to control his drinking with suicidal ideation which persisted even during the interview although somewhat reduced in intensity. R4's record contained an assessment by E10 PRSC dated 8/24/11, which states R4 does have a history of a previous attempt or attempts of suicide. Comments on this form indicate R4 is at greater than moderate risk for self-harm and requires a plan for assessment of self-harm. R4 had a universal progress note dated 8/12/11 with care plan notes written on top of the page. This page included diagnosis history of suicidal statements. Communication group, symptom management group daily meeting (1:1) to monitor behavior. Approach praise for all efforts. R4 did not have an MDS or Care plan for review on 8/26/11 at 5:00 p.m. R5 observed during survey on 8/29/11, appears angry, agitated and saying statements of " being killed." E6 heard this statement. Stated that is what R5 says. R5 noted to walk the facility at a fast pace and has very little interaction with staff or other residents. A review of R5's admission record R5 admitted 6/2/2009 and has a diagnosis of Paranoid Schizophrenia. The Pre Admission Screening / Mental Health (PAS/MH)level II dated 6/9/2009 states R5 requires special services: medication monitoring activities of daily living training, illness management and community re-integration activities. The 6/16/11 Level Of Function (LOF) summary	F 406		

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notes R5 wanders hall and refuses to take medication. She speaks of staff poisoning her and of her boyfriend. The mental health concerns identified in the LOF are not elaborated. The summary does not tell which areas the Psychiatric Rehabilitation Services Coordinator (PRSC); has placed as high priority and what level of skill training is appropriate for R5.

From record review, a 5/11/11 involuntary admission to hospital was noted. It states R5 was more depressed since her boyfriend was convicted and stating she would rather die with her boyfriend. R5 lost 20 lbs in one month.

From record review and interview with (E2) Psychiatric Rehabilitation Services Director (PRSD), an assessment for R5's suicidal ideations or a plan of care to address these concerns is not developed.

The 6/29/11 plan of care presented to the surveyor does not address R5's behaviors of weight lose, not eating, depressions or thoughts and words of dying.

R6 was observed during the survey on 8/29/11, R6 appears to have flat affect, disheveled, hair unkempt. During interview, R6 states she did not like the doctors and staff. Stating the doctor is not adjusting her medication that was causing her gain weight. R6 states she wants to change doctors to get medications evaluated to help her lose weight. R6 states she use to go to groups but she stopped because the groups are boring and they talk about the same thing all the time. R6 is noted to have boxes of an over the counter weight reduction meals at bedside. R6 states the

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facility dietary only has her on a diabetic diet. R6 states no one is helping her with her weight reduction goal.

A review of R6's clinical record notes a Psychiatric Evaluation dated 8/25/08, R6 states" two years ago I took all my pills" R6 suffers from depression and insist "I only tried to kill myself once."

In an interview with E2 on 8/29/11 if facility, E2 said if R6 has been assessed for risk or self-harm none was available. The last group note for R6 was 1/13/11 as presented by E2.

A review of the 6/16/11 plan of care for R6 does not address R6's not attending programs or the concerns with R6 weight loss goals.

R3 was observed during survey on 8/29/11, R3 was noted to be disheveled and unkempt. R3 appeared to be anxious with flight of ideas. R3 speech is pressured and difficult to understand. R3 spoke of the FBI and CIA coming to get him.

A review of the clinical record two petitions for emergency admission to hospital is noted for R3. On 10/28/09, R3 states he tried to choke and cut self with cell phone cord. Reddish marks noted around neck and on right wrist. On 12/27/10, R3 reported he felt suicidal and homicidal.

Interviewed E2 for R3 ' s assessment for risk / harm none was available. A review of the plan of care dated 6/30/11 does not identify R3 to have a history of suicidal ideations.

R7 observed on 8/26/11 during survey, R7

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F 406	Continued From page 23 entered the conference room and grabbed a pot of coffee that was on the table. R7 proceeded to drink the entire pot of coffee. R7 spilled liquid while pouring coffee into cup. E6 (Director of Nursing /LPN) was made aware of this situation E6 stated he likes coffee. R7 is observed to be loud and has flight of ideas with labile affect. On 9/1 and 9/2/11 the outside temperature was above 80 degrees. R7 was observed to seat outside in direct sunlight for over 30 minutes on two occasions. R7 had been sweating and clothing was wet with sweat. Asked (E11) nurse and (E8) PRSC who is to monitor R7 by surveyor. E8 stated the facility has to keep an eye on him; he likes to sit in the sun. In a review of R7's clinical record, a Petition for emergency admission dated 1/15/11 was noted. The petition reads, R7 states, wants to commit suicide. " I can not take it any more it is in my gut, I don't know if I will run away or what. I feel like I ' m being bullied by the staff and residents and I can not take anymore." Asked E2 for risk harm assessment for R7. E2 has none. A review of the 3/11/11 plan of care for R7, the plan does not address the history of suicide ideations.	F 406		
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		9/22/11

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F 514	Continued From page 24 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation,record review and interview the facility failed to have readily accessible the plan of care and Minimal Data Sets are accessible to staff who must perform assessments for activities, Psychsocial and Dietary For 10 of 10 residents requested for review of care plans, Minimal Data Sets (MDS) and Care Areas Assessments (CAA's) This has the potential to affect all 61 residents in the facility. Findings include: During survey conducted 8/26/11,E6 (Director of Nursing /LPN) is identified as the resource person to obtain care plans and Minimal Data Sets for residents in the facility. E6 was noted to have books her office that read care plans how ever, would not allow surveyor to review stating the plans of care were not in the books. E6 states the plan of care are in the computer and had to be accessed by her. R1's initial plan of care and plan of care from minimal Data Sets are requested. An initial plan of care is not received and a plan of care dated 8/25/11 for goals is presented. R1 committed suicide on 8/24/11. E6 states that is day the plan of care is printed. The surveyor also	F 514		

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F 514	Continued From page 25 requested plans of care for R2 through R10. None of these plans of care had the print date as the onset date. R3's plan of care had the print date in the upper right hand corner of the care plan submitted to surveyor. Interview with E2,E3 and E8 on 8/31/11 in activity room all state they are unable to access the plan of care unless E6 has open her completer and password. Inter view with (E11) LPN if she knew how to obtain a plan of care states, she knew nothing about the care plans. E6 asked for the Care Areas Assessments(CAA) for R1 through R10. from annual Minimal Data Sets E6 states she had no idea what surveyor are asking for. None of the residents CAA's were received. E6 states the pervious Director of Nursing had taken all the information with her when she left the facility two weeks ago. E6 showed surveyors a room with file cabinets that contained MDS's and care plans however none are current.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.610b) 300.1210a) 300.1210b) 300.1210c) 300.3240a) 300.4010a) 300.4010b) 300.4010c)1)B)2)A)-G)3)A)-F)4)5)6)7)A)-C) 300.4010d)1)-3) 300.4020a)3) 300.4030a) 300.4030b) 300.4030c)	F9999		

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F9999	Continued From page 26 300.4030d) 300.4030e) 300.4030f) 300.4030g) 300.4030h) 300.4030i) 300.4030j) 300.4030k) 300.4030l) 300.4030m) 300.4030n) 300.4030o) 300.4030p) 300.4040a) 300.4040b) 300.4040c) 300.4040d) 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. b) All the information contained in the policies shall be available to the public, staff, residents and for review by Department personnel.	F9999		

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F9999	Continued From page 27 Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	F9999		

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F9999	Continued From page 28 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) Section 300.4010 Comprehensive Assessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) The facility shall establish an Interdisciplinary Team (IDT) for each resident. The IDT is a group of persons that represents those professions, disciplines, or service areas that are relevant toidentifying an individual's strengths and needs, and that designs a program to meet those needs. The IDT includes, at a minimum, the resident; the resident's guardian; a Psychiatric Rehabilitation Services Coordinator (PRSC); the resident's primary service providers, including an RN or an LPN with responsibility for the medical needs of the individual; a psychiatrist; a social worker; an activity professional; and other appropriate professionals and care givers as determined bythe resident's needs. The resident or his or her guardian may also invite other individuals to meet with the IDT and participate in the process of identifying the resident's strengths and needs. b) The IDT must identify the individual's needs by performing a comprehensive assessment as needed to supplement any preliminary evaluation conducted prior to admission to the facility. The assessment shall be coordinated by a PRSC. c) A comprehensive assessment must be completed by the IDT no later than 14 days after admission to the facility. Reports from the pre-admission screening assessment or	F9999		

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F9999	Continued From page 29 assessments conducted to meet other requirements may be used as part of the comprehensive assessment if the assessment reflects the current condition of the individual and was completed no more than 90 days prior to admission. The assessment shall include at least the following: 1) A psychiatric evaluation completed by a board certified or board eligible psychiatrist or, if countersigned by a board certified or board eligible psychiatrist, the evaluation may be completed by a person who is a certified psychiatric nurse, a nurse with a Bachelor of Science in Nursing (BSN) and two years of experience serving individuals with serious mental illness, or a registered nurse with five years of experience serving individuals with serious mental illness; a licensed clinical social worker; a physician; a licensed psychologist; or a licensed clinical professional counselor (LCPC) under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]. The psychiatric evaluation shall include: B) Comprehensive mental status examination, which includes: a statement of assets and deficits, a description of intellectual functioning, memory functioning, orientation, affect, suicidal/homicidal ideation, response to reality testing, and current attitudes and overt behaviors. 2) Psychosocial assessment performed by the Psychiatric Rehabilitation Services Director (PRSD), a social worker, an occupational therapist, an LCPC, or the PRSC if reviewed and countersigned by the PRSD. The assessment shall cover the following points: A) Identifying information (including resident's name, age, race, religion, date of admission; name of individuals giving information);	F9999		

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F9999	Continued From page 30 B) Reason for admission (including specific problems and how long the problems have existed in their current state; contributing factors to exacerbation of problems; most recent psychiatric treatment and effects; goals of nursing facility as articulated by referral source); C) History of mental illness, treatment, and care (including age of onset; private and public hospital inpatient episodes; community mental health care; prior nursing facility placement; specific treatments and effects); D) Personal history (including current marital status; marital history including name, occupation, and age of current and previous spouses; name, age, sex and occupation of children, if any; status of significant personal relationships with individuals (past and present); work history of individual including all known past professions and/or jobs); E) Residential history (including, for the last two years, the types of housing (e.g., family, public housing, apartment, room, or community agency), relationship to other occupants, the total number of known moves; factors known to have contributed to past housing loss; the highest level of residential independence attained, approximate date and length; any patterns of persistent residential instability or homelessness); F) Family history (including information regarding individual's parents and siblings; any significant family illnesses, especially psychiatric illnesses; history of traumatic or significant loss including where, when and effect on individual); and G) Developmental history (including early life history, place of birth, where raised and by whom and with whom; school history; and history regarding friends, hobbies, interests, social	F9999		

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F9999	Continued From page 31 activities and interactions). 3) A skills assessment performed by a social worker, occupational therapist, or PRSD or PRSC with training in skills assessment. The skills assessment shall include an evaluation of the resident's strengths, an assessment of the resident's levels of functioning, including but not limited to the following areas: A) Self-maintenance (including basic activities of daily living such as hygiene, dressing, grooming, maintenance of personal space, care of belongings, diet and nutrition, and personal safety); B) Social skills (including communication, peer group involvement, friendship, family interaction, male/female relationship, and conflict avoidance and resolution); C) Community living skills (including use of telephone, transportation and community navigation, avoidance of common dangers, shopping, money management, homemaking (cleaning, laundry, meal preparation), and use of community resources); D) Occupational skills (including basic academic skills; job seeking and retention skills; ability to initiate and schedule activities; promptness and regular attendance; ability to accept, understand and carry out instructions; ability to complete an application; and interview skills); E) Symptom management skills (including symptom monitoring and coping strategies; stress identification and management; impulse control; medication management and self-medication capability; relapse prevention); and F) Substance abuse management (including recovery, relapse prevention and harm reduction). 4) Oral screening completed by a dentist or	F9999		

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registered nurse.
5) Discharge plan as required by Section 300.4060 of this Part.
6) Other assessments recommended by the IDT or required elsewhere in this Part, or as ordered by the resident's physician or psychiatrist to clarify diagnoses or to identify concomitant motivational, cognitive, affective, or physical deficits that could have an impact on rehabilitation efforts and outcomes, as indicated by the individual's needs.
7) A structured assessment of resident interests and expectations regarding psychiatric rehabilitation conducted by the PRSC or PRSD with each resident. The assessment shall include at a minimum:
A) Resident's identification of personal strengths, goals, needs, and resources;
B) Skill development and problem areas for which the resident expresses an interest in setting goals and participating in psychiatric rehabilitation programming;
C) Resident's beliefs and confidence regarding his/her capacity to develop increased skills and independence.

d) Based on the results of all assessments, the PRSD or PRSC shall develop a narrative statement for the IDT review that summarizes findings regarding the resident's strengths and limitations; indicates the resident's expressed interests, expectations, and apparent level of motivation for psychiatric rehabilitation; and prioritizes needs for skill development related to improved functioning and increased independence. The IDT's assessment of overall rehabilitation focus for the resident will also be identified as one of the following levels:
1) Basic skills training and supports with

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F9999	Continued From page 33 opportunities for community integration; 2) Intensive skills training and supports with an increasing focus on community integration; or 3) Advanced skills training and supports with active linkage and use of community services in preparation for expected discharge within six months Section 300.4020 Reassessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) At least every three months, the PRSC shall document review of the resident's progress, assessments and treatment plans. If needed, the PRSC shall inform the appropriate IDT members of the change in resident's condition. The appropriate IDT member will reassess the individual and update the resident's assessment, assuring the continued accuracy of the assessment. 3) Skills assessment update, including an assessment of resident levels of functioning and reassessment of rehabilitation potential (an evaluation of the individual's strengths, potentials, environmental opportunities and ability to achieve or likelihood of achieving maximum functioning); and a narrative statement of the individual's strengths and potential as they directly relate to the individual's functional limitations with recommendations for treatment and/or services, and the potential of the individual to function more independently. A complete reassessment shall be required if changes in the resident's functional level make the current assessment inapplicable. If a complete reassessment is not required, the update must include a narrative summary of the reevaluated	F9999		

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F9999	Continued From page 34 assessment; Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) On admission, information received from the admission source (e.g., resident, family, preadmission screening (PAS) agent) shall be used to develop an interim treatment plan. In developing an individual's interim treatment plan (IITP), the facility shall review the PAS/MH assessments and "Notice of Determination" and consider the use of this information in developing the interim treatment plan. The IITP shall focus on those behaviors and needs requiring attention prior to development of the individualized treatment plan (ITP). Each IITP shall be based on physician's orders and shall include diagnosis, allergies and other pertinent medical information. The following information shall also be considered, as appropriate, to allow for the identification and provision of appropriate services until a final plan is developed: 1) Known risk factors (e.g., wandering, safety issues, aggressive behavior, suicide, self-mutilation, possible victimization by others); 2) Observable resident medical/psychiatric conditions that may require additional immediate assessment or consultation; 3) Therapeutic involvement that might be of interest to the resident, be recommended based on referral information, aid in orientation or provide meaningful data for further professional assessment; and 4) Other known factors having an impact on the resident's condition (e.g., family involvement,	F9999		

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F9999	Continued From page 35 social interaction patterns, cooperation with treatment planning b) An ITP shall be developed within seven days after completion of the comprehensive assessment. c) The plan for each resident shall state specific goals that are developed by the IDT. The resident's major needs shall be prioritized, and approaches or programs shall be developed with specific goals, to address the higher prioritized needs. If a lower priority need is not being addressed through a specific goal or program, a statement shall be made as to why it is not being addressed or how the need will be otherwise addressed. d) The ITP shall contain objectives to reach each of the individual's goals in the plan. Each objective shall: 1) Be developed by the IDT; 2) Be based on the results obtained from the assessment process; 3) Be stated in measurable terms and identify specific performance measures to assess; and 4) Be developed with a projected completion or review date (month, day, year). e) Services designed to implement the objectives in the resident's ITP shall specify: 1) Specific approaches or steps to meet the objective; 2) Planned skills training, skill generalization technique, incentive/behavior therapy, or other interventions to accomplish the objectives, including the frequency (number of times per week, per day, etc.), quantity (in number of	F9999		

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minutes, hours, etc.) and duration (period of time, i.e., over the next 6 months) and the support necessary for the resident to participate;
3) The evaluation criteria and time periods to be used in monitoring the expected results of the intervention; and
4) Identification of the staff responsible for implementing each specific intervention.

f) Whenever possible, residents shall be offered some choice among rehabilitation interventions that will address specific ITP objectives using techniques suited to individual needs.

g) ITP Documentation:
1) Significant events that are related to the resident's ITP, and assessments that contribute to an overall understanding of his/her ongoing level and quality of functioning, shall be documented.
2) The resident's response to the ITP and progress toward goals shall be documented in progress notes.

h) The ITP shall be reviewed by the IDT quarterly and in response to significant changes in the resident's symptoms, behavior or functioning; sustained lack of progress; the resident's refusal to participate or cooperate with the treatment plan; the resident's potential readiness for discharge and actual planned discharge; or the resident's achievement of the goals in the treatment plan.

i) The resident's individual treatment plan shall be signed by all members of the IDT participating in its development, including the resident or the resident's legal guardian.

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F9999	Continued From page 37 j) If the resident refuses to attend the IDT meeting or refuses to sign the treatment plan, the PRSC shall meet with the resident to review and discuss the treatment plan as soon as possible, not to exceed 96 hours after the treatment plan review. Evidence of this meeting shall be documented in the resident's record. k) The resident's treating psychiatrist shall review and approve the resident's treatment plan as developed by the IDT. The date of this review and approval shall be entered on the resident's treatment plan and be signed by the attending psychiatrist. l) The ITP shall be based upon each resident's assessed functioning level, appropriate to age, and shall include structured group or individual psychiatric rehabilitation services interventions orskills training activities, as appropriate, in the following areas: 1) Self-maintenance; 2) Social skills; 3) Community living skills; 4) Occupational skills; 5) Symptom management skills; and 6) Substance abuse management. m) Activity interventions for individual residents shall be part of, but not used to replace, psychiatric rehabilitation programming and should provide for using skills in new situations. Activity programs shall comply with Section 300.1410 of this Part. n) Residents' attendance in therapeutic programs shall be recorded.	F9999		

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F9999	Continued From page 38 o) The PRSC shall assess the reason for the failure to attend whenever a resident fails to attend at least 50 percent of any programs included in his or her ITP over a 30 day period. Within 14 days after noting this failure, the PRSC shall document why the resident's attendance was less than 50 percent and that the resident's attendance is, at the time of the documentation, more than 50 percent, or the PRSC shall conduct an IDT meeting. This IDT meeting shall result in a change in components of the resident's treatment plan or shall indicate why a change is not needed. p) The PRSC is responsible for coordinating staff in the delivery of psychiatric rehabilitation services programs, oversight of data collection, and the review of the resident's performance. 1) At least quarterly, and prior to the treatment plan reviews, the PRSC shall meet with the resident to review and discuss the resident's current treatment plan, progress toward achieving the objectives, and obstacles inhibiting progress. Based upon this review, the PRSC, in consultation with the appropriate IDT members, shall revise the resident's ITP as needed. The revised treatment plan shall be submitted to the appropriate IDT members for review, approval and signature. 2) At least quarterly, the PRSC shall record the resident's response to treatment in the clinical record. Section 300.4040 General Requirements for Facilities Subject to Subpart S a) The psychiatric rehabilitation services program of the facility shall provide the following services	F9999		

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as needed by facility residents under Subpart S:
1) 24 hours of continuous supervision, support and therapeutic interventions;
2) Psychotropic medication administration, monitoring, and self-administration;
3) Case management services and discharge preparation and training;
4) Psychiatric rehabilitation services addressing major domains of functioning and skills development: self-maintenance, social and community living, occupational preparedness, symptom management, and substance abuse avoidance;
5) Crisis services; and
6) Personal care assistance.

b) The psychiatric rehabilitation services programs in the facility shall be designed to improve or maintain the resident's level of functioning and independence.

c) The facility's psychiatric rehabilitation program shall have the following overall goals:
1) Encourage the engagement of each resident in his/her recovery and rehabilitation;
2) Increase acquisition, performance, and retention of skills to enhance independence and promote community integration;
3) Support the progressive assumption of as much personal responsibility, self-management, and self-determination as each resident can manage;
4) Broaden the use of living, coping, and occupational skills to new environments with an ultimate goal of discharge to a more independent living arrangement, as appropriate;
5) Decrease psychotic, self-injurious, antisocial, and aggressive behaviors;

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F9999	Continued From page 40 6) Decrease the impact of cognitive deficits as an impediment to learning new skills; and 7) Foster the human dignity, personal worth, and quality of life of each resident. d) The psychiatric rehabilitation program shall provide education and training to maximize residents' capacities for self-management of psychotropic medications and utilization of other supportive mental health services, such as cooperation with prescribed treatment regimen, self-medication, recognition of early symptoms of relapse, and interactive effects with other drugs and alcohol. These Regulations were not met as evidenced by: Based on observation, record review and interview the facility failed to: - Ensure the Psychiatric Rehabilitation Services Director (PRSD) and all staff is aware of residents who have or have history of high-risk behaviors. - Ensure the PRSD is made aware of residents who are refusing programming and that documentation and evaluations are available for the refusal. - Ensure on admission an initial plan of care is developed and implemented - Ensure changes in residents' conditions are assessed and plans of care are developed and implemented, - Ensure the Level Of Functions (LOF) assessments indicate the priority level for programs to be initiated and which level of the skills programs the resident is to be started. - Ensure programs are initiated in a timely	F9999		

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manner.
- Ensure the plans of care are specific to the assessed residents needs and that the care plan goals and interventions are measurable.
- Ensure residents and family (if applicable) are actively involved in the development of skills programs and the care plan process.
- Ensure there are 24 hours continuous support, supervision and therapeutic interventions to provide crisis services.
- Ensure psychoactive medication monitoring, services and evaluations are available

These failures resulted in R1 committing suicide and facility not aware of other residents who have suicidal ideations (R3. R4, R5, R6, R7). This has the potential to affect all 36 residents identified with Severe Mental Illness.

Findings include:

The facility currently has identified 36 residents with programming for Severe Mental Illness (SMI) Interview with E2 (PSRD) and record review shows he works Monday thru Friday. The facility currently has one full time counselor who works Monday through Friday and one part time counselor who works Tuesday, Wednesday and Saturday. A review of the schedule for skills group available is Symptom Management, Coping Skills and Communication Skills. Symptom management starts at 9:30am and Communication Skills ends at 11:30a.m. No groups are available on Sundays.

On 7/11/11, R1, a 22 year old male was admitted to this facility with diagnosis including Bipolar disorder Schizoaffective disorder, manic type,

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SHELTERING OAK	P O BOX 367 ISLAND LAKE, IL 60042

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psychotic.

The Antipsychotic Medication for Long-Term Care Residents Prior Authorization Request Form completed by (E11) LPN on 7/22/11 for R1 was reviewed. This form states to check all symptoms present in this patient. Areas checked are delusions, negative symptoms, fatigue/loss of energy, distractibility, hallucinations, depressed mood with (suicidal ideation handwritten), feelings of worthlessness/inappropriate quilt, flight of ideas. (Severely impaired mental status with history of non-compliance is handwritten.) E11 during interview on 8/29/11 stated she entered the information and signed the form. E11 states she was not sure where she got the information that was handwritten.

Another staff nurse completed this same form on 7/19/11 and depressed mood and suicidal ideations (handwritten) are present.

A review of the facility's Screening Assessment to Determine the Presentation of Abuse and/or Neglect Factors completed on 7/26/11 by E10 (PSRC) scores R1 at a (1) low = 0-1. This score is incorrect.

Point #1 for history of abuse on this form states a (NO) for R1. A review of the 6/29/11 hospital record Psychiatric Evaluation notes R1 has a history of sexual abuse as a child, verbal abuse from parents and pornography addiction. Point #2 on the form states (NO) for R1 for history of obsessions. The 6/29/11 Psychiatric Evaluation and facility's 7/27/11 psychosocial history noted R1 states has sexual addition and compulsive masturbating. Point #5 states (NO) for R1's

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history of Depression. Point #6 for history of inappropriate behavior lists (NO). 6/29/11, R1 admits addiction to pornography. The addition of these three other factor place R1 at (4) High= 4+.

The Level Of Function (LOF) assessment for R1 is dated 7/26/11 as completed. The summary of this assessment indicates R1 was in agreement for long-term care placement and to keep R1 active in peer community. Develop healthy relationships and work on coping skills and community living.

The skills assessment does not list which group has the highest priority. The summary does not address why it would take a month to begin R1 into groups. From interview with E2 on 8/26/11, R1 was to start the coping skills group on 8/29/11. E2 stated R1 did not want to stay at the facility and from interview with (Z1) Psychiatric on 8/29/11 stated, on 8/12/11 he had long talk with R1 who voiced he did not want to stay in the nursing home. R1 wanted to go stay with his father. Z1 recommended a group home placement for R1. R1 committed suicide on 8/24/11.

Statement written by E4 (RN) dated 8/24/11 indicates that R1 was at the nursing station at 7:30 p.m. using the phone. R1 became upset, the conversation escalated, R1 became agitated and swearing and slammed the phone down. E4 writes that she went to R1's room and talked for 5 to10 minutes. E4 gave R1 a hug and asked if he was OK. He said he was. He stated he was feeling better and went back into his room.

Later at 8:40 p.m. (R2), the roommate of R1

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reported to (E9) CNA that R1 was in his closet. R1 was hanging from the clothes bar with his belt around his neck.

From record review, R1's admission Minimum Data Set (MDS) was completed on 7/24/11. The areas triggered for an assessment were cognitive loss/dementia, falls, and psychotropic drug use. There was no assessment for falls, there was no assessment for psychotropic drug use, and cognitive loss reads refers to psych social history dated 7/11/11.

R1's record did not contain any care plan when reviewed the morning of 8/26/11. When asked about the lack of a care plan, E6 (Director of Nursing/LPN) said that R1 would have a quarterly care plan which is not due yet. Then E6 presented a computerized care plan that was printed on 8/26/11. The dates on the care plan are from 8/25 to 8/25/11. There were five items listed as problems with the onset date as 8/25/11. E6 said maybe there is a handwritten care plan. Surveyors followed E6; she attempted to close the office door. No handwritten care plans were found. E6 then said that maybe the counselors have a care plan. Surveyors accompanied E6 to the office where (E2) Social Service/ PSRD, (E8) PRSC and (Z3) Social Service Consultant were present.

E8 was R1's counselor and said that there were no handwritten care plans, the care plans are in the computer.

E2 showed surveyors R1's room (17 bed 2) the morning of 8/26/11. R1's possessions were still in the room. There were clothes, shoes, books and

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in the bedside table drawer several documents. One of the documents was guidelines for group homes. Per interview with (E5) administrator on 8/30/11, staff was helping R1 with required paperwork to apply to live in a group home. There were papers titled family background, residence history, financial status, health and wellness, and patient health questionnaire- symptoms checklist. The health and wellness form ask whether you experienced certain feelings in the last year. Some of the items checked were increased stress level, depressed mood, excessive worry/anxiety and thoughts of self-harm. The questionnaire about symptoms asks over the last 2 weeks have you been bothered by the following problems. Thoughts that you would be better off dead or of hurting yourself in some way is checked several days.

A questionnaire found in the drawer of R1 dated 8/13/11 contains items about emotions, moods, thoughts and behaviors. Circle Yes or No - During the past 2 weeks. Did you think that you would be better off dead? (Yes) is circled, did you have thoughts of suicide, even though you would not really do it? Is circled (yes), did you seriously consider talking your own life? Is circled (yes), did you think about a specific way of taking your life? Is circled (yes.) E2 as to who was assisting R1 in completing the form for the group home was interviewed. E2 stated all the counselors that R1 had had not seen the paperwork.

On 8/26/11 at 12:30 p.m., the facility staff was asked to present a list of residents with suicide ideation or history of suicide ideation. The list was not forthcoming. Surveyors asked E2, E8 and Z3 for the list of residents with this condition. All

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stated that the facility does not have any residents that they are aware of with suicide ideation or history of suicide ideation.

At 2:00 p.m. on 8/26/11, surveyors reviewed resident records at random and found five residents R3, R4, R5, R6 and R7 with history or diagnosis of suicide ideation.

R4's record was reviewed by surveyor and found to have bipolar, depression and suicide ideation as his diagnosis on the physicians order sheet. R4 was admitted to the facility on 8/12/11. In his record a copy of a history and physical from the hospital dated 8/8/11 states R4 was admitted after a 4 day binge, unable to control his drinking with suicidal ideation which persisted even during the interview although somewhat reduced in intensity.

R4's record contained an assessment by E10 PRSC dated 8/24/11, which states that R4 does have a history of a previous attempt or attempts of suicide. Comments on this form indicate that R4 is at greater than moderate risk for self-harm. Resident requires a plan for assessment of self-harm. R4 had a universal progress note dated 8/12/11 with care plan notes written on top of the page. This page included diagnosis history of suicidal statements. Communication group, symptom management group daily meeting (1:1) to monitor behavior. Approach: praise for all efforts. R4 did not have an MDS or Care plan for review on 8/26/11 at 5:00 p.m.

R5 observed during survey on 8/29/11, appears angry, agitated and saying statements of "being killed." E6 heard this statement and stated that is

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what R5 says. R5 was noted to walk the facility at a fast pace and had very little interaction with staff or other residents.

A review of R5's admission record showed R5 was admitted 6/2/09 and has a diagnosis of Paranoid Schizophrenia.

The Pre Admission Screening/Mental Health (PAS/MH) level II dated 6/9/09 states R5 requires special services: medication monitoring, activities of daily living training, illness management and community re-integration activities.

The 6/16/11 Level Of Function (LOF) summary notes R5 wanders hall and refuses to take medication. Speaks of staff poisoning her and of her boyfriend. The mental health concerns identified in the LOF are not elaborated. The summary does not tell which areas the Psychiatric Rehabilitation Services Coordinator (PRSC) has placed as high priority and what level of skill training is appropriate for R5.

From record review, a 5/11/11 involuntary admission to hospital was noted. It states R5 was more depressed since herboyfriend was convicted and stating she would rather die with her boyfriend. 30 shots and 30 cigarettes. R5 lost 20 lbs in one month.

From record review and interview with E2 (Psychiatric Rehabilitation Services Director/PRSD), an assessment for R5's suicidal ideations or a plan of care to address these concerns is not developed. The 6/29/11 plan of care presented to surveyor does not address

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F9999	Continued From page 48 R5's behaviors of weight lose, not eating, depression or thoughts and words of dying. R6 was observed during the survey on 8/29/11. R6 appears to have flat affect, disheveled hair, unkempt. During interview, R6 stated she did not like the doctors and staff, stating the doctor is not adjusting her medication that was causing her to gain weight. R6 stated she wants to change doctors to get medications evaluated to help her lose weight. R6 stated she used to go to groups but stopped because the groups are boring and they talk about the same thing all the time. R6 is noted to have boxes of over the counter weight reduction meals at bedside. R6 stated the facility dietary only has her on a diabetic diet. R6 stated that no one is helping her with her weight reduction goal. A review of R6's clinical record noted a Psychiatric Evaluation dated 8/25/08 in which R6 stated, "two years ago I took all my pills." R6 suffers from depression and insists "I only tried to kill myself once." E2 was intrerviewed on 8/29/11 and asked whether the facility has assessed R6 for risk of self-harm. E2 stated none was available. The last group note for R6 was 1/13/11 as presented by E2. A review of the 6/16/11 plan of care for R6 does not address R6's not attending programs or the concerns with R6's weight lose goals. R3 was observed during survey on 8/29/11. R3 was noted to be disheveled and unkempt. R3 appeared to be anxious with flight of ideas. R3's speech is pressured and difficult to understand. R3 spoke of the FBI and CIA coming to get him.	F9999		

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A review of the clinical record showed two petitions for emergency admission to the hospital for R3. On 10/28/09, R3 stated he tried to chock and cut self with cell phone cord. Reddish marks noted around neck and on right wrist. On 12/27/10, R3 reported he felt suicidal and homicidal.

E2 was interviewed for R3's assessment for risk/harm and none was available. A review of the plan of care dated 6/30/11 does not identify R3 to have a history of suicidal ideations.

R7 was observed on 8/26/11 during survey. R7 entered the conference room and grabbed a pot of coffee that was on the table. R7 proceeded to drink the entire pot of coffee. R7 spilled liquid while pouring coffee into cup. E6 (Director of Nursing /LPN) was made aware of this situation. E6 stated he likes coffee. R7 was observed to be loud and has flight of ideas with labile affect. On 9/1 and 9/2/11, the outside temperature was above 80 degrees. R7 was observed to sit outside in direct sunlight for over 30 minutes on two occasions. R7 was sweating and his clothing was wet with sweat. E11 nurse and E8 PRSC were asked who is to monitor R7. E8 stated the facility has to keep an eye on him; he likes to sit in the sun.

During a review of R7's clinical, a Petition for emergency admission dated 1/15/11 was noted. The petition reads, R7 states, wants to commit suicide. "I can not take it any more it is in my gut, I don't know if I will run away or what. I feel like I'm being bullied by the staff and residents and I can not take anymore."

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F9999	Continued From page 50 E2 was asked for risk harm assessment for R7. E2 had none. A review of the 3/11/11 plan of care for R7 showed the plan does not address the history of suicide ideations. (A)	F9999		