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BROOKSIDE MANOR	**1740 WEST MCCORD CENTRALIA, IL 62801**

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F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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	F9999		

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F9999	Continued From page 37 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	F9999		

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These requirments are not met as evidenced by:

Based on record review and interview, the facility failed to assess, monitor, and implement interventions for suicidal ideations for 2 of 3 residents (R1, R2) reviewed with a history of suicide attempts in the sample of 6. This failure resulted in R1 leaving the facility unnoticed after a recent hospitalization for suicidal ideations, walking 2.6 miles to the railroad tracks and laying down on the tracks in front of an oncoming train. R1 was apprehended by police and taken to a psychiatric unit for treatment.

The findings include:

1. R1 was admitted to the facility on 1/26/12 with diagnoses, in part, of schizo-affective disorder, depression, history of suicide attempts, and psychogenic polydipsia. The hospital history and physical dated 1/19/12 documented R1 was "a poor historian secondary to mental illness and may be some degree of mental retardation." The history and physical documented R1 as "alert and oriented x 2, to person and place, not time." R1 had been residing in a group home prior to hospitalization.

The "Psychotropic Medication Quarterly Evaluation" dated 2/8/12 and 5/8/12 documented R1 was receiving Zyprexa 15 milligrams (mg) daily and Wellbutrin 150 mg twice a day for diagnosis of "depression, suicidal." The evaluation documented the reason for the medication was "c/o (complaint of) depression." Both evaluations documented "no change noted" with use of the medication.

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The "PAS/MH (Pre-Admission Screen/Mental Health) dated 1/23/12 along with an assessment summary information, PAS/MH Notice of Determination, Psychiatric Assessment, History and Physical, Hospital Discharge Summary, Current Medications and other pertinent Documentation was sent to the facility on admission. R1 was determined to be eligible for nursing home placement. The "assessment summary information" dated 1/23/12 documented R1 was unable to stay at a group home due to water intoxication, mental health symptoms and activities of daily living decompensation. The assessment documented R1 was hospitalized on 5/17/08 for suicide attempt of stabbing himself in the abdomen.

The Minimum Data Set (MDS) dated 5/8/12 under Section D for Mood assessed R1 as not having any symptoms of "Thoughts better off dead/hurting self." The "Elopement Risk Assessment" dated 1/26/12 documented R1 at risk for elopement with a score of 10. The review dates of 3/8/12 and 5/8/12 as "No Risk" were documented. E2, Director of Nursing, stated in an interview on 5/29/12 at 11:15 AM that there were no other assessments done regarding the elopement or suicidal ideations.

In an interview with E1, Administrator, on 5/24/12 at 9:50 AM, E1 stated staff called him on 5/20/12 at 2:30 PM, told him they could not find R1, and police were called. At 4:00 PM they called him, said they had found R1 by the railroad tracks, and he was waiting for a train so he could stand in front of the train. E1 stated R1 was taken to the hospital. E1 confirmed R1 could not leave the

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facility on his own and had "escaped." E1 stated R1 had a history of problems with ideations to commit suicide but there had been no statements made regarding suicide since he was admitted on 1/26/12.

In an interview with E4, Social Service Director (SSD), on 5/24/12 at 10:30 AM she stated R1 had been hospitalized 6 weeks ago for suicidal ideations. According to the hospital history and physical, R1 was admitted to the hospital on 3/26/12. E4 stated R1 had come to her, said he was having suicidal thoughts, and wanted to die. E4 stated she asked R1 if he had a plan and he told her he was going to "find railroad tracks, lay on it and let the train decapitate him." E4 stated R1's physician, Z5, was notified, and R1 was admitted to the hospital for 5 days. E4 stated there were no special instructions sent back with R1 when he returned to the Facility after hospitalization, and there were no signs or symptoms that R1 was plotting to end his life. E4 said upon admission to the Facility on 1/26/12, both R1 and his family told her that R1 had attempted to kill himself by stabbing himself in the stomach 7 times. R1 missed hitting any vital organs.

The "Social History" dated 2/8/12 and the "Social Service Progress Notes" dated 1/26/12 through 5/8/12 do not address the history of suicide attempts or the 3/26/12 hospitalization for suicidal ideations. E4 confirmed on 5/29/12 at 10:30 AM there was no other social service documentation. E4 stated on 5/30/12 at 10:45 AM that R1 was attending a mental health community resource center in town for skills, retraining and counseling. E4 stated R1 was hoping to go back

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home or to the group home. E4 stated staff at the mental health resource center did not mention anything to her about suicidal ideations and were surprised when she called them on Tuesday to inform them R1 was hospitalized. E4 stated R1 did see a counselor at the community resource center. E4 stated she never got any progress notes from the mental health center but had gotten the treatment plan. E4 stated the plan was not integrated with the regular Care Plan.

The community resource center "MH (mental health) Individual Treatment and Recovery Plan-Outpatient" dated 2/29/12 documented the goal for R1 as "Client will attend counseling and PSR services in order to learn independent living skills such as personal safety, cooking/nutrition, recreation/leisure, household tasks and self care in order to return to his prior living situation." Objectives to meet the goal included attending individual counseling sessions to discuss depressive thoughts and anxiety one time a month; learn coping skills for depression and anxiety 1 time per month; learn safety, cooking, leisure and self care tasks; and, learn about his medications. There was no documentation regarding suicidal ideations.

The History and Physical dated 3/28/12 by Z4, Psychiatrist, documented the reason for R1's hospitalization was "The patient was having suicidal thoughts of wanting to be decapitated by a train." Z4 documented R1 tried to hang himself in May, 2009 and when this was not successful he tried to stab himself in the abdomen with a butcher knife. Z4 documented R1's sodium level was low in the emergency room on 3/26/12 and when this was stabilized R1 felt better. R1's

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sodium level was 117 with normal 137-145. Medication changes were made. Z4 documented the long term treatment goal was to explore placement options and link him with appropriate services in the community.

Z6, Nurse for Z4, stated in an interview on 6/11/12 at 1:25 PM that if R1 was suicidal they would not have discharged him. Z6 stated hospital discharge instructions for R1 were to follow up with Z2, Psychiatrist and Z5, attending Physician at the facility, after discharge. Z6 stated it was up to the facility to put monitoring in place as needed.

The hospital "Transfer Summary" dated 3/26/12 documented the final diagnoses for R1, in part, as Hyponatremia due to oral fluid intake, depression, schizophrenia, and suicidal ideation on admission. There were no instructions for monitoring/supervision.

The hospital "Progress Note" dated 3/28/12 by Z2, Psychiatrist, documented R1 was denying "paranoia and hallucinations and suicidality." Z2 documented "Insight and judgement appear to be improved, although he is still fearful of the idea of return to (facility) and what it may mean in terms of his depression and suicidality."

The hospital "Nursing Home Transfer Form" dated 4/2/12 did not identify any instructions regarding the suicidal ideations on re-admission to the facility.

In an interview with E2 on 5/29/12 at 11:15 AM, E2 stated she was not aware of R1's prior suicide attempts when he was admitted to the facility and

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found out later. E2 stated she had talked to R1's Power of Attorney and he had never said anything about R1's suicide attempts. E2 stated she was not present for on 3/26/12 when he voiced suicidal ideations. E2 was not aware any information or instructions regarding suicide being sent back from the hospital. E2 stated R1's biggest concern was his water intoxication and they were working on keeping his fluid intake under control. E2 confirmed R1 was not on 15 minute checks nor were there any changes made to his care plan after the 3/26/12 hospitalization for suicidal ideations. E2 stated R1 never made any attempts to leave the facility and was not sure why R1 was assessed for high risk of elopement on the 1/26/12 "Elopement Risk Assessment." E2 had written on the assessment on 3/8/12 and 5/8/12 "No Risk" although R1 had no changes in the score.

The Care Plan for R1 dated 1/27/12 documented the "Problem" as "Resident has attempted suicide in the past." The "Goal" was identified as "Residents emotional crisis will be identified and controlled so resident will remain free from injury." The "Approaches" were documented as "Psychological evaluation as needed. Transfer to hospital for any attempts or verbalized attempts of injury to self ASAP. Evaluation and one-one supervision will be maintained 24 hours per day until crisis is declined or psychological services are obtained. Give medications as ordered. Notify MD as needed. Document any and all verbalizations or attempts." The dates of 4/12/12 and 5/8/12 as review dates were documented on the Care Plan with no updates after the 3/26/12 statements to E4 and hospitalization.

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Other Care Plan "Problem"(s) identified were Fall risk, "Potential for adverse effects of antidepressants R/T (related to) depression and mild MR (mental retardation)," "Drinking excess amounts of fluids R/T psychogenic polydipsia," "Rejects care at times R/T mental/emotional illness," "Prefers own routine," "Smoking," and "COPD (chronic obstructive pulmonary disease)."

In an interview with E6, Cook, on 5/24/12 at 1:25 PM, she stated she saw R1 on 5/20/12 around 1:15 PM walking in front of a large department store near the road and called the facility. The department store is set back off the main road almost 1/2 mile from the facility. E6 stated she called the facility and told them she saw R1, but did not follow or talk to him.

In an interview with E5, Licensed Practical Nurse (LPN), on 5/24/12 at 10:15 AM, she stated she saw R1 on 5/20/12 at lunch and gave him a cigarette around noon for smoke break. E5 stated R1 went in back of the facility to smoke and was not supervised. E5 stated residents are not supervised when they are outside smoking, and there had not been any problems before this. E5 stated she missed R1 at 2:00 to 2:30 PM. E5 stated R1 stayed in his room a lot. E5 stated the last time she saw R1 was around 1:00 PM out back. E5 confirmed R1 was not allowed to leave the facility unattended. E5 stated she was not aware of R1's history of wanting to commit suicide until E4 informed her that day after he was missing. There were no specific instructions to monitor R1. E5 stated she was not sure where R1 was from 1:00 PM until about 3:00 PM. E5 did state the cook had called to say she had seen him at the department store. E5 stated staff did

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go to the department store but could not find him. E5 stated she called the police at about 3:00 PM. E5 stated Z5 was at the facility at 3:00 PM. E5 stated the police found R1 at the train station and took him to the hospital. E5 stated she went to the hospital and signed an "Intent to Harm" form so he could be admitted.

The nurses notes dated 5/20/12 at 3:00 PM documented "Noted res (resident) not in facility not in for snack. Rec'd (received) phone call from kitchen worker that res seen in (department store). Called (family) per SSD (social service director) call (local police department) (with) description, (Z5) here (and) aware (local police Department officer Z1) here."

In an interview with E7, Certified Nurse Aide (CNA), on 5/29/12 at 10:45 AM she stated R1 had not said he was going to leave or commit suicide nor was there any specific instructions to monitor R1. E7 stated on 5/20/12 R1 went out back of the facility to smoke and then Dietary staff called to say he was at a large department store. E7 stated another staff went to look for him at the department store, but did not see him and came back. E7 stated they continued to look up and down the road to see if they could see R1. E7 stated E5 called E4, SSD, at home and E4 went to look for him. E7 stated when residents say they want to leave they are put on 15 minute checks but R1 was not on 15 minute checks. E7 stated she was not aware of any suicide attempts. E7 stated she went home at 3:00 PM.

In an interview with E3, CNA, on 5/24/12 at 1:15 PM, E3 stated she worked on a daily basis with R1. E3 stated there were no specific precautions

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for R1 except they had to monitor R1 when he shaved due to suicide attempts. E3 stated she did not check on R1 a lot as he stayed to himself in his room most of the day. E3 stated she had not heard about the other attempts at suicide and was shocked when E5 told the police on 5/20/12 R1 had attempted to kill himself on more than one occasion. E3 stated the police came to the facility around 2:45 PM.

In an interview with E4 on 5/24/12 at 10:30 AM she stated facility staff called her at home at 3:00 PM on 5/20/12 to tell her they could not find R1. E4 stated she went to the shopping center and park and could not find R1. E4 stated the police were called around 3:00 PM to 3:30 PM. E4 stated she told the police that R1 had a history of suicide and that 6 weeks prior to 5/20/12 he had been hospitalized for planning suicide. E4 confirmed that R1 was not on any special precautions or 15 minute checks when he was readmitted from the hospital on 4/2/12 for suicidal ideations and there had been no indicators of suicide. E4 confirmed R1 was in back of the facility, outside, smoking with no staff present. E4 stated when the hospital called to say the police had R1 there she went to the hospital. E4 stated the police found R1 in the middle of town at the train station. E4 stated it would have taken R1 about an hour to get there as he was not the fastest walker. E4 stated she talked to R1 at the emergency room and he was very angry. E4 stated R1 told her at the hospital if they let him out he would try to commit suicide "again and again." E4 stated R1 told her he didn't want to live anymore and he was a "useless, worthless, piece of s..t". E4 stated R1 told her he was planning on laying on the railroad tracks to kill

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himself.

Z5, attending Physician for R1, stated in a telephone interveiw on 6/14/12 at 9:00 AM that he was at the facility on 5/20/12 and had asked to see R1. That was when E5 noticed R1 was not there. Another staff said they had seen R1 at the department store and E5 stated "why didn't you grab him?" Z5 stated he told R1 to call the police, but she called E1 first. Z5 stated staff should have called police right away. Z5 stated the staff did not realize R1 was gone.

Z5 stated they had called him on 3/26/12 and told him that R1 was suicidal and he was admitted to the hospital. Z5 stated that facility staff had not told him that R1 had a plan to lay on the railroad tracks. Z5 stated he was aware of R1's previous suicide attempts from the history received.

Z5 stated R1 went outside on 5/20/12 to the back of the facility to smoke and disappeared. Z5 stated the staff would not have noticed he was missing because the facility is "too open." Z5 stated R1 should not have been out unsupervised and "should not allow (R1) to go anywhere unsupervised." Z5 stated R1 was a "slow type" person. Z5 stated R1 should not have been out back to smoke unsupervised and stated "No, wouldn't trust him. Could go out in front of (a) car." Z5 stated with R1's history he should not have been allowed to go out unsupervised. Z5 stated that the facility is too open for a person like R1 and it would be hard for anyone to notice if he was there or not. Z5 stated the facility did not have enough supervision and they did not notice he was missing until there was a problem. Z5 stated R1 could hang himself. Z5 stated the

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emergency room had called him to say R1 was there and had been found at the railroad tracks. Z5 stated R1 was under the care of the psychiatrist at the hospital.

E2 stated on 5/29/12 at 11:15 AM that she was not notified of the incident until the next day and staff had not called her. E2 confirmed that staff should have called police "immediately" as soon as R1 was discovered missing. E2 stated "apparently not" when asked if R1 was capable of being out of the building unsupervised.

The facility policy and procedure for "Wandering/Missing Resident" dated "4/97" states "If for any reason a resident leaves the grounds without signing out on a temporary release form or notifying the charge nurse, the following procedures will be in effect. 1. Alert charge nurse and all shift personnel to search the facility and grounds. 2. If the resident is unaccounted for after a thorough search of the building and grounds, the following will be immediately notified and documentation of such notification made in the residents medical record: A. Director of Nursing and Executive Director B. Police C. Family and/or legal representative D. Attending Physician."

The police report dated 5/20/12 at 2:55 PM documented the "nursing home advised that this subject has walked away from the facility." The officer took a description of R1. Z1, Police Officer, stated on 5/24/12 at 3:20 PM that they had received a call at 2:55 PM that R1 was missing. Z1 stated at 4:04 PM the railroad staff called to say that R1 had put his head on the railroad tracks but they got the train stopped in

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	14E124	A. BUILDING _____ B. WING _____	C 06/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE MANOR	**1740 WEST MCCORD CENTRALIA, IL 62801**

(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
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time. Z1 stated R1 was picked up at the train station and taken to the emergency room.

The police report dated 5/20/12 at 4:04 PM documented railroad personnel called to report "subject had put his head on the train tracks and train did get stopped in time. He went back into the depo. WM (white male) white and blue shirt jeans 20's light skinned." R1 was named as the subject. The police report documented the train master was notified R1 was in custody and the train master stated "the train was doing about 15 mph (miles per hour) and when the crew saw the man put his head on the tracks, they got the train stopped in time and the man took off to the train depo." R1 was taken to the hospital.

The facility "Incident/Accident Report" dated 5/20/12 documented the physician and the family of R1 was notified at 3:00 PM of R1 leaving the facility without notification. The police were not notified until 2:55 PM.

The hospital emergency room report dated 5/20/12 documented the chief complaint was "Laid head across railroad tracks." The emergency room "Suicide Risk Assessment" identified R1 as high risk for suicide. The emergency room notes documented R1 had 6 suicide attempts which included stabbing himself and hanging. R1 was transferred to another hospital psychiatric unit on 5/21/12 according to the history and physical. R1's sodium level was 133 in the emergency room.

The hospital "History and Physical" dated 5/21/12 documented the "Chief Complaint" as "Yesterday I laid my head on the railroad tracks." R1 was

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admitted due to "ongoing suicidal ideation and intent." The history and physical documented "Attempts to harm himself included stabbing, and hanging as well as another effort at breaking his neck."

2. R2 has diagnoses, in part, of vascular dementia with depression, history of stroke with right sided weakness, coronary artery disease, and chronic obstructive pulmonary disease. The Care Plan dated 3/3/12 does not address any suicidal attempts or ideation.

In an interveiw with E2, DON, on 5/29/12 at 11:15 AM, she stated R2 had left the facility several times. E2 stated R2 is his own person and can leave if he wants. E2 stated R2 had never said he was going to kill himself. E2 confirmed that E4, Social Service Director, had had to drive a four wheeler around looking for R2 after he went looking for mushrooms.

In a telephone interveiw on 6/11/12 at 9:05 AM, Z3, Physician, stated R2 should be supervised when smoking if he was leaving the facility. Z3 stated R2 had "No business going (out) by himself." Z3 stated R2 has dementia, psychiatric issues and a left sided weakness due to a stroke.

Z2, Psychiatrist, stated in a telephone interveiw on 6/11/12 at 10:25 AM, that R2 "shouldn't be out on his own." Z2 stated R2 has medical problems as well as a stroke with very little insight into his limitations.

E7, CNA, stated on 5/29/12 at 10:45 AM that R2 had left a couple of times. E7 stated R2 was not suppose to go out by himself and was on 15

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minute checks. E3, CNA, confirmed on 5/24/12 at 1:15 PM that R2 had left the facility at least three times and had to be brought back by a four wheeler when he ran out into the woods.

E4, SSD, stated in an interview on 5/24/12 at 3:00 PM, that R2 had left the facility unattended "maybe 3 times." E4 confirmed that R2 had walked off into traffic and was found by police throwing signs into traffic in front of a large state operations facility. E4 also stated R2 had run off into the woods in back of the facility and they could not find him. E4 stated R2 would not be able to take care of himself in the woods. E4 stated R2 was a "good three miles" away from the facility, in the middle of a plowed field looking for mushrooms. E4 stated she had to go and get her four wheeler to look for him. E4 stated R2 had not said anything to her about killing himself.

The hospital history and physical dated 2/23/12 by Z4, Psychiatrist, documented the chief complaint for R2 on admission was "I tried to commit suicide." The history and physical documented that R2 became angry at the nursing home staff due to smoking rules and told the staff he planned to "kill himself by walking out into traffic." R2 stated in the emergency room that he "had nothing to live for." R2 had left the facility. E1, Administrator, confirmed on 5/29/12 at 12:10 PM that there is no incident report nor was it reported to the Department.

The only police report obtained was for 3/3/12 which stated R2 had walked away from the nursing home and was refusing to come back. The history and physical dated 3/3/12 documented R2 became upset with staff and

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started walking down the road. The report states R2 "is not capable of taking care of himself. Police were called and he was picked up and transported to the emergency room and admitted." The report documented R2 was threatening bodily harm. E1, Administrator, confirmed on 5/29/12 at 12:10 PM that there are no incident reports nor any of the incidents reported to the Department.

The history and physical dated 3/20/12 documented the reason for hospitalization was "The patient had left the nursing facility and was wandering along the roadside." The report states R2 became angry with staff and told staff he planned to "kill himself by walking out into traffic." E1, Administrator, confirmed on 5/29/12 at 12:10 PM that there is no incident report nor was it reported to the Department.

E5, LPN, stated in an interview on 5/24/12 at 2:00 PM that R2 had left on 5/23/12 and she had called police. E5 stated R2 was out back smoking and jumped over the fence. E5 stated she had not filled out an incident report. E5 stated R2 had threatened to walk out in traffic before.

E1, Administrator, stated in an interview on 5/29/12 at 12:10 PM that there was no reason the incident reports were not done or reported to the Department, it had just not been done.

(A)