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RED BUD REGIONAL CARE	**350 WEST SOUTH 1ST STREET RED BUD, IL 62278**

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F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	Annual Certification Survey 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

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by:
Based on record review and interview the facility failed to promptly notify the physician regarding a suicide attempt for one of one resident (R7) reviewed for suicidal risks in the sample of 19.

Findings include:

R7's Record of Admission documents that R7 was admitted to the facility on 6/6/12. R7's February, 2015 Physician's Orders document diagnoses that include Dementia and Depression.

R7's Nurses Notes documents, in part, on 2/16/15 at 1:00 AM , "CNA (Certified Nurse Aide) (E9), found resident (R7) with a Nebulizer Cord wrapped around the resident's (R7's) neck two times and told (E9) to 'finish it'. Resident (R7) was then placed on 15 minute checks at this time. Resident (R7) in bed and resting with oxygen on, after CNA (E9) assisted him."

On 2/19/15 at 9:30 AM, E3, Assistant Director of Nursing (ADON), handed this surveyor a typed paper documenting a phone interview that E3 had with E9. This typed paper, dated 2/18/15, documents in part, "CNA (E9) was responding to alarm sounding in (R7's) room when she noted (R7) sitting on the side of the bed with feet on the floor. (R7) was noted to be undressed. CNA (E9) questioned (R7) what he was doing? CNA (E9) noted nebulizer tubing wrapped around (R7's) neck. (R7) said "finish it". CNA (E9) said finish what? And (R7) states choke me. CNA (E9) kind of thought (R7) was joking and said no we don't do that. CNA (E9) immediately removed the tubing, cleaned (R7) up, got him dressed and offered for (R7) to come and sit with her at nurses' station and R7 stated, no. CNA (E9)

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proceeded to ask (R7) if he would like something to eat or drink as she could get that for him and he stated, "Damn it, no I want to go to bed". CNA (E9) put (R7) back to bed per his request and removed nebulizer and tubing out of reach and exited room to notify nurse of incident. Upon notifying nurse, nurse recommended CNA (E9) to initiate 15 minute checks and notify her of any further incidents. ADON (E3) did question CNA (E9) if on this occasion she truly believed and was concerned for (R7's) safety due to nebulizer tubing being around his neck. CNA (E9) said no I don't believe so, maybe with a call light cord but not that tubing. CNA (E9) did continue the 15 minute checks per nurse recommendation and resident rested throughout shift with no further distress noted."

On 2/17/15 at 3:51 PM, Z1, R7's Physician, stated that her office received a fax from the Facility regarding R7's suicide attempt on 2/16/15 at 10:40 AM and that she was initially informed of R7's suicide attempt when she reviewed the fax on 2/16/15 at 11:29 AM. On 2/17/15 at 10:00 AM, Z3, R7's Power of Attorney (POA), stated that he could not recall the exact time that he received the phone call from the facility to inform him of R7's suicide attempt, but Z3 thought he may have received the call about 7:00 AM or 8:00 AM on 2/16/15.

On 2/18/15 at 10:30 AM, E1, Administrator, and E3 stated that they were not called regarding R7's suicide attempt, but were notified when they came to work on 2/16/15 at approximately 7:00 AM or 8:00 AM.

The Facility's Change in a Resident's Condition or Status Policy and Procedure, dated 11/14/13,

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F 157	Continued From page 3 documents "Policy: The Facility shall promptly notify the resident, his or her Attending Physician, and representative (POA) of changes in the resident's medical/mental condition and/or status (eg., changes in level of care, billing/payments, resident rights, etc.)". "Policy Interpretation and Implementation: "Protocol for notifying the Attending Physician of changes in the Resident's Medical/Mental Condition. The Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: d. A significant change in the resident's physical/emotional/ mental condition." The Facility's Suicide Risk Assessment and Interventions Policy and Procedure, dated 7/1/13, documents, "Procedure: A. If staff suspects a resident may harm him or herself, Administrator, Director of Nursing or designee on call will be notified." On 2/20/15 at 9:25 AM, E1 and E3 stated that R7's Physician, POA, and the Administrator should have been contacted immediately when R7 wrapped the nebulizer tubing around his neck.	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280		

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physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to update the Care Plan for depression/suicide attempt and provide specific, individualized interventions for 1 of 11 residents (R7) reviewed for Care Plans in the sample of 19.

Findings include:

R7's Record of Admission documents that R7 was admitted to the Facility on 6/6/12. R7's February 2015 Physician's Orders document that R7 has diagnoses that include Dementia and Depression.

R7's Nurses Notes documents, in part at 2/16/15 at 1:00 AM, "CNA (Certified Nurse Aide) (E9), found resident (R7) with a Nebulizer Cord wrapped around the resident's (R7's) neck two times and told CNA (E9), to 'finish it'. Resident (R7) was then placed on 15 minute checks at this time. Resident (R7) in bed and resting with oxygen on after CNA (E9) assisted him."

On 2/17/15 at 11:50 AM, E13, CNA, stated that R7 takes his oxygen tubing off himself, that the

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staff is checking R7 every 15 minutes due to suicide precautions and that R7 does not have a roommate due to R7 being on contact precautions related to being diagnosed with Clostridium Difficile.

R7's Social Service Medicare Progress Note, dated 12/3/14, documents, "Continues to have negative statements, as evidenced by, 'What's the use.' 'Just let me die.' Resident at times refuses oxygen treatment. Resident feels bad about self."

R7's Social Service 1:1 Visit forms have a start date of 9/27/13 with Reason for Visits: Depression/Negative statements such as thoughts that he would be better off dead. R7's Social Service 1:1 Visit Note, dated 8/15/14, documents "Resident has been feeling his family and wife do not care about him". R7's Social Service 1:1 Visit Note, dated 9/30/14, documents, "He wants to be with his wife, so he acts out." R7's Social Service 1:1 Visit Note, dated 12/31/14, documents, "Resident has not been happy with his life. Has voiced not wanting to live here anymore. He misses his wife and wishes he could move."

R7's 2/1/15 to 2/16/15 Behavior Tracking for the behavior of "Negative Statements - It doesn't matter anyway, It's no use, Etc.", it is documented that R7 voiced negative statements 2 times a day, for 8 days on day shift and that R7 voiced negative statements one day on night shift.

R7's 1/21/15 at 5:00 PM Nurses Notes document in part, "Resident (R7) had a tearful episode during med pass, 'What if I don't want my meds

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F 280	Continued From page 6 (medications)? If I take my meds I won't Croak, so why should I when everyone is against me?' Nurse (E16, Licensed Practical Nurse) asked resident (R7) what was bothering him, he stated he hasn't been able to talk to his wife. When asked if he wanted to call his wife, he said, no." On 2/17/15 at 2:50 PM, E3, Assistant Director of Nursing (ADON), stated that R7 has never wanted to live at the facility and that R7 always wants to go home. E3 went on to say that R7 misses his wife, but when R7 does talk to his wife, they argue and then he gets mad. At this same time, E3 said that R7 prefers to sit alone in his room and not be bothered. R7's Care Plan documents a problem of Depression that was initiated on 6/26/12 and last updated on 2/9/15. R7's Care Plan for Depression does not identify any problems regarding R7's wife, noncompliance with taking medications, or R7's adjustment issues to living at the facility. This Care Plan for Depression does not include any individualized interventions regarding these problem areas. Also, this same Care Plan is not updated regarding R7's suicide attempt on 2/16/15 or R7's 15 minute checks by staff which were initiated on 2/16/15. On 2/20/15 at 9:35 AM, E3 stated that R7's Care Plan should have been reviewed and revised to include R7's recent suicide attempt along with R7's 15 minute checks. E3 went on to say that R7's Care Plan for Depression should include specific and individualized interventions.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 7 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the Facility failed to provide complete incontinent care for one of six residents (R8) reviewed for incontinent care in the sample of 19. Findings include: The Physician's Order Sheet (POS) for R8 for 2/2015 documents a diagnosis, in part, of VRE (Vancomycin Resistant Staphylococcus Enterococcus) of the Urine. The Minimum Data Set (MDS) dated 2/13/2015, documents R8 is incontinent of urine, and requires extensive assistance of staff for all activities of daily living and personal hygiene. On 2/17/2015 at 10:20 AM, E6, Registered Nurse (RN) reported R8 was on contact isolation for VRE in the urine. Personal protective equipment (PPE) for R8 was located outside R8's room. On 2/17/2015, at 1:15 PM. E7 and E8, Certified Nurses Aides (CNA) gowned, gloved and transferred R8 from the wheelchair to the bedside commode using a gait belt. R8's incontinent brief was heavily soiled with urine and was removed by E8. R8's pants were wet with urine. E7 removed R8's pants and shoes while he was seated on the commode. After R8 was finished on the commode, E7 and E8 assisted him to stand. E7	F 312		

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F 312	Continued From page 8 held onto R8's right arm and the gait belt to steady him. E8 used her left arm to hold the gait belt. E8 used her right gloved hand to cleanse R8's rectal area with disposable wipes, 3 times. E8 failed to cleanse R8's buttocks. Without changing gloves, E8 switched hands, holding the gait belt with her right hand, then used the left hand to cleanse R8's inner thighs. E8 used the left hand to wipe around R8's penis, but did not pull back the foreskin to cleanse the head or the shaft of the penis or cleanse R8's scrotum. The Facility's policy and procedure, revised 2/16/2011, entitled, 'Incontinent Care' documents, in part, "For uncircumcised males, retract the foreskin, wash the tip of penis, and then return the foreskin over the tip of penis. If the foreskin is not returned, circulation can be affected which could lead to tissue damage. Using a circular motion, gently wash penis by lifting it and cleaning from the tip downward. Wash and rinse the scrotum."	F 312		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314		

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Based on observation, record review and interview, the Facility failed to accurately assess and provide effective pressure relieving interventions to prevent the development of pressure ulcers for one of four residents (R2) reviewed for pressure ulcers in the sample of 19.

Findings include:

R2's Minimum Data Set (MDS) dated 1/14/2015 documents R2 is at risk for the development of pressure ulcers and requires extensive assistance with bed mobility. R2's Braden Scale, dated 1/15/2015, documents R2 is a moderate risk (Score of 14)for the development of skin breakdown.

On 2/17/2015 at 10:30 AM, E6, Registered Nurse (RN) reported R2 is receiving hospice services, and has a poor oral intake since the development of an upper respiratory infection. R2 was lying on her back with the head of the bed elevated to 30 degrees. R2 was receiving oxygen via a nasal cannula, with tubing wrapped around both ears. There was no padding around the tubing that came into contact with R2's ears and head. R2's heels were directly on the mattress.

On 2/17/2015 at 11:47 AM, 12:05 PM, 12:37 PM, 1:00 PM, 1:15 PM, 1:30 PM, 2:30 PM and 3:15 PM, R2 was in bed lying on the right side with her heels directly resting on the mattress. R2 was receiving oxygen via a nasal cannula. The head of the bed was elevated 30 degrees. R2 was lying on an alternating air loss mattress. R2 was very thin.

The Pressure Ulcer Report, dated 2/17/2015 documents R2 developed two, facility acquired

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pressure ulcers on 2/16/2015. The Stage II pressure ulcer on the coccyx is documented on the Report as measuring 4.5 cm (centimeter) X 1.8 cm. The Stage II pressure ulcer on the right inferior buttock is documented on the Report as measuring 0.8 cm X 0.5 cm.

On 2/18/2015 at 9: 25 AM, R2 was lying on her right side wearing the nasal cannula. A pillow was behind R2's back and a pillow was between her knees. R2's heels were directly on the mattress.

On 2/18/2015 at 10:10 AM, E14, RN entered R2's room to do treatments and a skin assessment for R2. When asked how R2 developed pressure ulcers, E14 reported, "(R2) has breakdown from being in bed for awhile. She is turned and repositioned every 2 hours." E14 reported R2 had an abrasion behind her right ear from the oxygen tubing, and was receiving triple antibiotic ointment daily to aid in healing. E14 reported R2 is supposed to have some padding for the tubing, but she did not know where is was. E14 reported R2 is turned and positioned from side to side due to the pressure ulcers on her coccyx and right buttock. During the skin assessment at this time, R2 had a open area to her coccyx with yellow slough, and 2 open areas coated with yellow slough to her right buttock. R2 had a dark brown area covered with eschar on her head behind the right ear lobe, exactly where the oxygen tubing was rubbing. The skin behind R2's left ear where the oxygen tubing rested was red, but blanchable. R2's heels were without socks and resting directly on the mattress. The right heel was red and mushy. A small brown area was noted to R2's right heel. R2 had no dressings to the open areas or wound behind her right ear. E14 applied a barrier cream to the open area to R2's coccyx

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and right buttock. E14 reported R2 is not being seen by a special wound consultant.

On 2/18/2015 at 11:50 AM, R2 was positioned on the left side with the right heel directly on the mattress. R2's left heel was floated on a folded blanket. R2's oxygen tubing had no padding in place around her ears. At that time, E8 reported R2 is turned and repositioned every two hours.

On 2/18/2015 at 12:46 PM, R2 was lying on her back with the head of her bed elevated 30 degrees. R2's heels were resting directly on the mattress. There was no padding around R2's oxygen tubing.

On 2/19/2015 at 9:00 AM, R2 was lying on the right side with her feet
lying directly on the mattress.

On 2/19/2014 at 1:40 PM, E2, Director of Nursing (DON) reported she identified the three, Stage II pressure ulcers to R2's perineal area on 2/16/2015. E2 reported the open areas are due to "maceration from moisture." E2 reported R2 is being repositioned very 2 hours. E2 reported she did not measure the wound behind R2's right ear.

The Facility's Wound Risk Assessment/Prevention/Management policy and procedure, revised 3/2012, documents, in part, "Moderate to High Risk (14 or less per Braden Scale Assessment). Keep skin clean, dry and free of body wastes, perspiration and wound drainage. Reposition at a minimum every 2 hours. Inspect skin daily for signs and symptoms of breakdown. Head of bed is to be kept flat or elevated less than 30 degrees, unless medically contraindicated.

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F 314	Continued From page 12 Stage 2: Partial thickness skin loss involving epidermis, dermis or both (e. g. (for example), abrasion, blister or shallow crater). May present as a shallow crater with a pink red wound bed, without slough. Unstageable full thickness tissue loss in which the base of the ulcer is covered with slough and/or eschar in the wound bed. Suspected Deep Tissue Injury: The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. When eschar is present, a pressure ulcer cannot be accurately staged until the eschar is removed."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the Facility failed to perform catheter care for one of one residents (R9) reviewed for catheter care in the sample of 19. Findings Include: R9's Physician Order Sheet (POS), dated	F 315		

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02/05/15, documents indwelling catheter care to be done every shift. The POS, dated 02/05/15, documents R9's diagnoses as neurogenic bladder and obstructive uropathy.

R9's 02/2015 Treatment Record documents that indwelling catheter care was not completed on day shift for the following dates 2/4, 2/5, 2/7-2/9, 2/11-2/13 and 2/15-2/18/15. R9's 01/2015 Treatment Record documents indwelling catheter care was not completed on the day shift for the following dates 01/08, 01/22, and 01/29/15. R9's 12/2014 Treatment Record documents indwelling catheter care was was not completed on the day shift for 12/31/15. The evening shift did not complete catheter care on 12/10/15. The night shift did not complete catheter care on 12/13 and 12/22/14.

The Urinalysis, dated 01/19/15, documents R9 was treated for a urinary tract infection (UTI) with Clindamycin 300 milligrams (mg) by mouth three times daily. The Urinalysis, dated 12/15/14, documents R9 was treated for a UTI with Macrobid 100 mg twice daily for ten days. The Urinalysis, dated 12/31/14, documents R9 was treated for a UTI with Macrobid 100 mg twice daily for ten days.

On 02/18/15 at 3:10 PM , R9 stated, "They are not doing the cleaning of my catheter every shift". On 02/19/15 at 12:00 PM, R9 stated, "She told me to tell you she does it (indwelling catheter care) every morning.

On 02/19/15 at 1:00 PM, E18, Certified Nursing Assistant (CNA), stated, "I do his catheter care every morning when I get him up." On 02/20/15 at 8:45 AM, E17, Licensed Practical Nurse (LPN),

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F 315	Continued From page 14 stated, "I just forgot to mark the treatment record, but he was given catheter care on my shift." The Facility's Prevention of Catheter Associated Urinary Tract Infection Policy, dated March 2014, documents all personnel who provide catheter care shall practice aseptic technique. The policy does not address the frequency of catheter care.	F 315		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Facility failed to provide a psychological and/or psychiatric evaluation for one of one resident (R7) reviewed for suicidal risk/depression in the sample of 19. Findings include: R7's Record of Admission documents that R7 was admitted to the facility on 6/6/12. R7's February, 2015 Physician's Orders document diagnoses that include Dementia and Depression and that R7 receives Elavil 50 milligrams (mg) at 5:00 PM daily and Remeron 45 mg every night at bedtime. R7's Nurses Notes documents, in part, on 2/16/15 at 1:00 AM, "CNA (Certified Nurse Aide)	F 319		

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(E9) found resident (R7) with a Nebulizer Cord wrapped around the resident's (R7's) neck two times and told CNA (E9), to 'finish it'. Resident (R7) was then placed on 15 minute checks at this time. Resident (R7) in bed and resting with oxygen on after CNA (E9) assisted him."

On 2/19/15 at 9:30 AM, E3, Assistant Director of Nursing (ADON), handed this surveyor a typed paper documenting a phone interview that E3 had with E9. This typed paper, dated 2/18/15, documents, in part, "CNA (E9) was responding to alarm sounding in (R7's) room when she noted (R7) sitting on the side of the bed with feet on the floor. (R7) was noted to be undressed. CNA (E9) questioned (R7) what he was doing? CNA (E9) noted nebulizer tubing wrapped around (R7's) neck. (R7) said "finish it". CNA (E9) said finish what? And (R7) states choke me. CNA (E9) kind of thought (R7) was joking and said no we don't do that. CNA (E9) immediately removed the tubing, cleaned (R7) up, got him dressed and offered for (R7) to come and sit with her at nurses' station and (R7) stated, no. CNA (E9) proceeded to ask (R7) if he would like something to eat or drink as she could get that for him and he stated, "Damn it, no I want to go to bed". CNA (E9) put (R7) back to bed per his request and removed nebulizer and tubing out of reach and exited room to notify nurse of incident. Upon notifying nurse, nurse recommended CNA (E9) to initiate 15 minute checks and notify her of any further incidents. ADON (E3), did question CNA (E9) if on this occasion she truly believed and was concerned for (R7's) safety due to nebulizer tubing being around his neck. CNA (E9) said no I don't believe so, maybe with a call light cord but not that tubing. CNA (E9) did continue the 15 minute checks per nurse recommendation and

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resident rested throughout shift with no further distress noted."

On 2/17/15 at 11:45 AM, R7 was alone in his room, sitting in his wheelchair with his wheelchair alarm intact, eating cookies. At this same time, R7's oxygen tubing was laying on the floor in front of him and R7's nebulizer tubing was hanging off of side of his bedside table which was located approximately 10 inches to R7's right. On 2/17/15 at 11:50 AM, E13, CNA, stated that R7 takes his oxygen tubing off himself, that the staff is checking R7 every 15 minute due to suicide precautions and that R7 does not have a roommate due to R7 being on contact precautions related to being diagnosed with Clostridium Difficile.

On 2/18/15 at 10:00 AM and on 2/18/15 at 2:00 PM and on 2/19/15 at 11:00 AM, R7 was alone in his room, sitting in his wheelchair with his oxygen tubing, his nebulizer tubing and his call light within his reach. R7's room is located at the end of the hall.

R7's 9/23/14 Minimum Data Set (MDS), under Section D0200 "Resident Mood Interview", documents: 1). R7 as having little or no interest or pleasure in doing things 12 to 14 days over the last 2 weeks. 2). R7 as feeling down, depressed or hopeless 12 to 14 days over the last 2 weeks. 3). R7 as having trouble falling asleep or staying asleep, or sleeping too much 7 to 11 days over the last 2 weeks. 4). R7 as feeling bad about yourself - or that you are a failure or have let yourself or your family down 12 to 14 days over the last 2 weeks. 5). R7 has having trouble concentrating on things, such as reading the newspaper or watching television 12 to 14 days

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over the last 2 weeks. 6). R7 as moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual 12 to 14 days over the last 2 weeks. 7). R7 as having thoughts that you would be better off dead, or hurting yourself in some way 12 to 14 days over the last 2 weeks. A quote by R7 was added to this same MDS section stating, "Never hurt myself on purpose". A note was documented by E12, Social Service Director (SSD), to this same MDS section stating, "asked R7 what we could do to help him with his mood - response was, "Get my wife to come up here to stay with me".

R7's 11/29/14 Minimum Data Set (MDS), under Section D0200 "Resident Mood Interview", documents: 1). R7 as feeling down, depressed, or hopeless 7 to 11 days over the last 2 weeks. 2). R7 as feeling bad about yourself - or that you are a failure or have let yourself or your family down 7 to 11 days over the last 2 weeks.

R7's Social Service 1:1 Visit forms have a start date of 9/27/13 with Reason for Visits: Depression/Negative statements such as thoughts that he would be better off dead. R7's Social Service 1:1 Visit Note, dated 8/15/14, documents "Resident has been feeling his family and wife do not care about him." R7's Social Service 1:1 Visit Note, dated 9/30/14, documents, "He wants to be with his wife, so he acts out." R7's Social Service 1:1 Visit Note, dated 12/31/14, documents, "Resident has not been happy with his life. Has voiced not wanting to live here anymore. He misses his wife and wishes he could move."

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R7's Social Service Medicare Progress Note, dated 12/3/14, documents, "Continues to have negative statements, as evidenced by, 'What's the use.' 'Just let me die.' Resident at times refuses oxygen treatment. Resident feels bad about self."

R7's 2/1/15 to 2/16/15 Behavior Tracking for the behavior of "Negative Statements - It doesn't matter anyway, It's no use, Etc.", documents R7 voiced negative statements 2 times a day, for 8 days on day shift and R7 voiced negative statements one day on night shift.
R7's 1/21/15 at 5:00 PM Nurses Notes document in part, "Resident (R7) had a tearful episode during med pass, 'What if I don't want my meds? If I take my meds I won't Croak, so why should I when everyone is against me?' Nurse, (E16, LPN), asked resident (R7) what was bothering him, he stated he hasn't been able to talk to his wife. When asked if he wanted to call his wife, he said, no."

On 2/17/15 at 2:50 PM, E3 stated R7 has never wanted to live at the Facility and that R7 always wants to go home. E3 went on to say that R7 misses his wife but when R7 does talk to his wife, they argue and then he gets mad. E3 also said at this time that R7 prefers to sit alone in his room and not be bothered.

R7's medical record indicates R7's most recent visit by a physician was on 1/30/15 at 3:05 PM by Z2 (Physician for R7) as documented on R7's "Routine Follow Up Visit" form.

On 2/17/15 at 2:50 PM, E3 stated that in September 2012, R7 had approximately a 2 week hospital stay for a Psychiatric Evaluation due to

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F 319	Continued From page 19 making suicidal threats. E3 went on to say that R7 was much stronger in 2012 because R7 walked, was not severely cognitive impaired but that R7 is now weaker, in a wheelchair and is severely cognitive impaired. On 2/18/15 at 3:55 PM, E3 stated that the facility does not have a psychiatrist and that R7 has not had a psychological or a psychiatric evaluation since September 2012 On 2/19/15 at 3:15 PM, E3 verified that R7 should of had a psychiatric evaluation and that the facility now has a psychiatrist scheduled to come to the facility to assess R7.	F 319		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the Facility failed to follow their Policy and Procedure for Suicide Risk and implement the correct level of supervision for Suicide Risk, for one of one resident (R7) reviewed for Suicide Risk in the sample of 19. Findings include: R7's Record of Admission documents that R7	F 323		

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was admitted to the facility on 6/6/12. R7's February, 2015 Physician's Orders document diagnoses that include Dementia and Depression. This same Physician's Order documents that R7 receives Amitriptylin 50 milligrams (mg) at 5:00 PM daily for depression and Mirtazapine 45 mg every night at bedtime for depression. R7's Nurses Notes document on 2/10/15 at 10:30 PM that R7 was diagnosed with Clostridium Difficile and was placed on contact isolation. R7's 2/18/15 Minimum Data Set (MDS), Section C0500, documents that R7 has severe cognitive impairment.

R7's Nurses Notes documents in part at 2/16/15 at 1:00 AM that "CNA (Certified Nurse Aide) (E9) found resident (R7) with a Nebulizer Cord wrapped around the resident's (R7's) neck two times and then told CNA (E9), to 'finish it'. The resident (R7) was then placed on 15 minute checks at this time. The resident (R7) was then in bed and resting with oxygen on after CNA (E9) assisted him".

On 2/19/15 at 9:30 AM, E3, Assistant Director of Nursing (ADON), handed this surveyor a typed paper documenting a phone interview that E3 had with E9. This typed paper, dated 2/18/15, documents, in part, "CNA (E9) was responding to alarm sounding in (R7's) room when she noted (R7) siting on the side of the bed with feet on the floor. (R7) was noted to be undressed. CNA (E9) questioned (R7) what he was doing? CNA (E9) noted nebulizer tubing wrapped around (R7's) neck. (R7) said "finish it." CNA (E9) said finish what? And (R7) states choke me. CNA (E9) kind of thought (R7) was joking and said no we don't do that. CNA (E9) immediately removed the tubing, cleaned (R7) up, got him dressed and

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offered for (R7) to come and sit with her at nurses' station and (R7) stated, no. CNA (E9) proceeded to ask (R7) if he would like something to eat or drink as she could get that for him and he stated, "Damn it, no I want to go to bed". CNA (E9) put (R7) back to bed per his request and removed nebulizer and tubing out of reach and exited room to notify nurse of incident. Upon notifying nurse, nurse recommended CNA (E9) to initiate 15 minute checks and notify her of any further incidents. ADON (E3) did question CNA (E9) if on this occasion she truly believed and was concerned for (R7's) safety due to nebulizer tubing being around his neck. CNA (E9) said no I don't believe so, maybe with a call light cord but not that tubing. CNA (E9) did continue the 15 minute checks per nurse recommendation and resident rested throughout shift with no further distress noted."

On 2/17/15 at 11:45 AM, R7 was alone in his room, sitting in his wheelchair, with his wheelchair alarm intact, eating cookies. At this same time, R7's oxygen tubing was laying on the floor in front of him and R7's nebulizer tubing was hanging off of side of his bedside table which was located approximately 10 inches to R7's right.

On 2/17/15 at 11:50 AM, E13, CNA, stated that R7 takes his oxygen tubing off himself, that the staff is checking R7 every 15 minute due to suicide precautions and that R7 does not have a roommate due to R7 being on contact precautions related to being diagnosed with Clostridium Difficile.

On 2/18/15 at 10:00 AM and 2:00 PM and on 2/19/15 at 11:00 AM, R7 was alone in his room, sitting in his wheelchair with his oxygen tubing,

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his nebulizer tubing and his call light within his reach. R7's room is located at the end of the hall.

On 2/18/15 at 10:30 AM, E1, Administrator, and E3 stated that they were not called regarding R7's suicide attempt but were notified when they came to work on 2/16/15 at approximately 7:00 AM or 8:00 AM

The Facility's Suicide Risk Assessment and Interventions Policy and Procedure, dated 7/1/13, documents, "Procedure: A. If staff suspects a resident may harm him or herself, Administrator, Director of Nursing or designee on call will be notified."

The Facility's "Evaluation of Suicide Risk" was completed for R7 on 2/16/15 at 11:15 AM by E12, Activity Director, (AD). This Evaluation documents, Question Number 1: "This past week, have you had any thoughts that life is not worth living or that you'd be better off dead?" with R7's answer as "Yes". This same Evaluation documents, Question Number 2: "Do you have thoughts about hurting or even killing yourself?" with R7's answer as "Yeah, Just to get away from here". This same form documents that R7 was asked what he would do and R7 responded "that's what I don't know." This same "Evaluation of Suicide Risk" form documents the "Action Plan" for a resident that answers "yes" to questions 1 and 2 has scored 4 points indicating the facility should then enact the Suicide Policy.

The Facility's Suicide Policy and Procedure, titled "Suicide Risk Assessment and Interventions", dated 7/1/13, documents, "Score 4: Continue with "Close Observation" level of supervision and notify physician". This same Policy and Procedure

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documents on page 2, "Levels of Supervision, B. Close Observation, Resident is under direct observation at all times and observer must be able to respond to the resident rapidly. Ratio may be more than 1:1 as long as observer is able to attend to the immediate needs of one resident without sacrificing surveillance and attendance to the immediate needs of another resident(s). Observer must have direct line of sight to resident."

On 2/17/15 at 10:30 AM, E3 stated that R7's "Evaluation of Suicide Risk" was correctly scored at a "4," but according to the Facility's Policy and Procedure for "Suicide Risk Assessment and Interventions", dated 7/1/13, with R7 having a score of 4, R7 should have been put on "Close Observation and not "15 minute checks."

On 2/18/15 at 10:40 AM, E3 stated that E12, Activity Director (AD), does the "Evaluation of Suicide Risk" for the Facility when E10, Social Service Director (SSD), is not available. E3 went on to say that E12 has worked many years as the Facility's Social Service Director prior to being the facility's Activity Director.

On 2/19/15 at 11:40 AM, E10 stated that her Social Service training consisted of "on the job training for the last 3 years." On 2/19/15 at 11:50 AM, E12 stated that she has worked for 17 years as a Social Service Director at the Facility prior to becoming the Activity Director and that her training also consisted of "on the job training."

R7's 9/23/14 MDS, under Section D0200 "Resident Mood Interview," documents: 1.) R7 as having little or no interest or pleasure in doing things 12 to 14 days over the last 2 weeks. 2.)

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R7 as feeling down, depressed or hopeless 12 to 14 days over the last 2 weeks. 3.) R7 as having trouble falling asleep or staying asleep, or sleeping too much 7 to 11 days over the last 2 weeks. 4.) R7 as feeling bad about yourself - or that you are a failure or have let yourself or your family down 12 to 14 days over the last 2 weeks. 5.) R7 has having trouble concentrating on things, such as reading the newspaper or watching television 12 to 14 days over the last 2 weeks. 6.) R7 as moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual 12 to 14 days over the last 2 weeks. 7.) R7 as having thoughts that you would be better off dead, or hurting yourself in some way 12 to 14 days over the last 2 weeks. A quote by R7 was added to this same MDS section stating, "Never hurt myself on purpose". On 9/23/14, a note was documented by E12, SSD, to this same MDS section stating, "asked R7 what we could do to help him with his mood - response was, "Get my wife to come up here to stay with me."

R7's 11/29/14 MDS under Section D0200 "Resident Mood Interview," documents: 1.) R7 as feeling down, depressed, or hopeless 7 to 11 days over the last 2 weeks. 2.) R7 as feeling bad about yourself - or that you are a failure or have let yourself or your family down 7 to 11 days over the last 2 weeks.

R7's Social Service 1:1 Visit forms have a start date of 9/27/13 with Reason for Visits: Depression/Negative statements such as thoughts that he would be better off dead. R7's Social Service 1:1 Visit Note, dated 8/15/14, documents "Resident has been feeling his family

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and wife do not care about him," R7's Social Service 1:1 Visit Note, dated 9/30/14, documents, "He wants to be with his wife, so he acts out." R7's Social Service 1:1 Visit Note, dated 12/31/14, documents, "Resident has not been happy with his life. Has voiced not wanting to live here anymore. He misses his wife and wishes he could move."

R7's Social Service Medicare Progress Note, dated 12/3/14, documents, "Continues to have negative statements, as evidenced by, 'What's the use.' 'Just let me die.' Resident at times refuses oxygen treatment. Resident feels bad about self."

R7's 2/1/15 to 2/16/15 Behavior Tracking for the behavior of "Negative Statements - It doesn't matter anyway, It's no use, Etc.," it is documented that R7 voiced negative statements 2 times a day, for 8 days on day shift and that R7 voiced negative statements one day on night shift.

R7's Nurses Notes document in part on 1/21/15 at 5:00 PM, "Resident (R7) had a tearful episode during med pass, 'What if I don't want my meds? If I take my meds I won't Croak, so why should I when everyone is against me?' Nurse, (E16 LPN), asked resident (R7) what was bothering him, he stated he hasn't been able to talk to his wife. When asked if he wanted to call his wife, he said, no."

On 2/17/15 at 3:00 PM, E3 said that R7 has never wanted to live at the facility and that R7 misses his wife but when R7 does talk to his wife, they argue and then he gets mad. At this same time, E3 said that R7 prefers to sit alone in his

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F 323	Continued From page 26 room and not be bothered. On 2/17/15 at 2:50 PM, E3 stated that in September 2012, R7 had approximately a 2 week hospital stay for a Psychiatric Evaluation due to making suicidal threats. E3 went on to say that R7 was much stronger in 2012 because R7 walked, was not severely cognitive impaired but that now R7 is weaker, in a wheelchair and is severely cognitive impaired.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation record review and interview, the Facility failed to provide a rationale to support the use and a dosage increase of a antipsychotic medication for one of six residents (R12) reviewed for antipsychotic medication use in the sample of 19. Findings include: The Physician's Order Sheet (POS) for 1/2015 for R12 documents diagnoses, in part, as General Anxiety Disorder, Depression and Senile Psychosis. The Minimum Data Set (MDS) dated 1/16/2015 documents R12 is moderately impaired with cognition, resists care and has behaviors of yelling out. The Physician's Order (PO) from Z1, Physician, dated 1/09/2015 documents, in part, "Consult pharmacy re (about) taper Haldol (Haloperidol) 0.5 mg (milligram) po (by mouth)". The PO dated 1/11/2015 documents "D/C (discontinue) Haldol 0.5 MG PO prn (as needed) every HS (bedtime). Haldol 0.5 mg po daily at HS." The Patient Transfer Form for R12, dated 1/11/2015 documents, in part, "Resident (R12) has had multiple drug therapies for extreme anxiety with delusions, echolalia (repetitive speech patterns). She is now threatening to harm self if she doesn't go home in front of husband. Per husband, threw herself out of bed. States she will continue to try to hurt self. Send to ER (emergency room) for evaluation related to threats and attempts to harm self."	F 329		

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The Nurses Note, dated 1/11/2105 at 3:15 PM, documents R12 was sent to the local hospital via an ambulance. The Nurses Note, dated 1/12/2015 at 1:00 AM, documents R12 returned to the facility, was placed on 1:1 observation and continued to yell out with repetitive statements and chanting.

The PO for R12, dated 1/22/2015, documents "Send to ER to evaluate and treat per ambulance." The Patient Transfer Form, dated 1/22/2015, documents, in part, "G-tube (gastrostomy tube) not in place." The Nurses Note, dated 1/22/2015, documents R12 returned to the facility at 6:50 PM.
The Nurses Note, dated 1/25/2015, documents R12 was sent to the local hospital for problems with the G-tube and was admitted.

The Nurses Note, dated 1/28/2015 at 5:15 PM, documents R12 returned to the Facility. The PO, dated 1/28/2015, documents R12 was ordered the anti-psychotic medication of Haloperidol 5 mg by mouth at bedtime on readmission to the Facility by Z1. The Nurses Note, dated 1/28/2015 at 8:00 PM documents, in part, "Called (Z1) to verify meds (medications) list, Haldol increased to 5 mg every HS. (Z1) requests that list of meds be faxed to office."

The Chronological Record of Drug Regimen Review for 12/2014, 1/2015 and 2/2015 has no documentation from Z4, Pharmacist related to Haldol or a GDR (gradual dose reduction) or increase of Haldol for R12.

Z1's Physician Progress Notes, dated 12/30/2014 and 1/31/2015 has no documentation or rationale about the use of or the increase of the

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F 329	Continued From page 29 antipsychotic medication of Haldol for R12. On 2/19/2015, at 9:00 AM, R12 was sleeping in her wheelchair. On 2/19/2015 at 9:30 AM, R12 was awake in the wheelchair. R12 had poor eye contact, a flat affect and reported she felt anxious. At that time, Z6, family member was visiting. Z6 reported R12 had had problems with her medications and at times was over medicated. On 2/20/2015 at 9:15 AM, E3, Assistant Director of Nursing (ADON) reported the facility has had problems with Z1 related to the psychotropic medication use and dealing with the behaviors of R12. E3 reported Z1 has been very difficult to deal with and Z5, Medical Director has been involved with issues related to Z1, R12 and the appropriate treatments and placements for R12. E3 reported R12 has not been evaluated by a psychiatrist since residing at the facility for a correct psychiatric diagnosis to support the use of numerous psychotropic medications. The Facility's policy and procedure, dated 2/09/2012, entitled 'Psychopharmacological Medication' documents in part, "It is the policy of (the facility) to use Psychopharmacological medications only with appropriate assessment and adequate indication for use. Residents who receive antipsychotic medication due to associated psychotic and/or agitated behaviors will have documentation to support the use of medication. Gradual dose reduction will be implemented per regulation requirements unless clinically indicated. Any new psychopharmacological mediation order or dosage change will be maintained on the psychopharmacological tracking log."	F 329		

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F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the Facility failed to label, date and monitor food which prevents potential contamination. This has the potential to affect all 97 residents living in the Facility. Findings include: On the initial tour of the kitchen on 2/17/15 with the starting time of 10:03 AM, one 12 ounce box of lasagna noodles was observed in the dry storage area with an expiration date of 02/11/2015. In the freezer were three frozen, unidentified white meat products with no labels or dates present, also there was one full large nine pound box of cheese tortellini with an expiration date of October 2011. In another freezer there was a 5 pound bag of chicken tenders identified by E5, Head Cook, and a 4 inch deep pan of spaghetti present with a label indicating the expiration date of January 2015, and 2 dozen muffins in the refrigerator without any labels and dates. Also there was a clear bag of shredded chicken opened and 7 hamburger patties with no dates or labels; both were not closed properly, with the product being exposed to air. In a box	F 371		

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F 371	Continued From page 31 were 8 brown bags containing French fries, onion rings, and potatoes wedges opened with no labels or dates, and the package was not secured properly and the product was exposed to air. During the initial tour on 02/17/2015, with the starting time of 10:03 AM, E4, Director of Nutritional Services and E5, Head Cook, removed all items immediately and said they would be disposing of all of the products without labels, dates and all items that were expired. The Food & Nutrition Service Department Food Label Dating Guide posted on the freezer and refrigerators on 02/17/2015 at 10:28 AM, documents that labels are to be used for all opened stored products and filled out completely, listing the name of the product, date opened/and/or prepared and/or placed in the cooler or freezer, and to record the expiration date. The Resident Census and Conditions of Residents, CMS 672, dated 02/17/2105, documents the Facility has 97 residents living in the Facility.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	Continued From page 32 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the Facility failed to change soiled gloves to prevent the spread of infection for one of four residents (R8) reviewed for infection control in the sample of 19. Findings include: The Physician's Order Sheet (POS) for R8 for 2/2015 documents a diagnosis, in part, of VRE (Vancomycin Resistant Staphylococcus Enterococcus) of the Urine. The Minimum Data	F 441		

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Set (MDS) dated 2/13/2015, documents R8 is incontinent of urine, and requires extensive assistance of staff for all activities of daily living and personal hygiene.

On 2/17/2015 at 10:20 AM, E6, Registered Nurse (RN) reported R8 was on contact isolation for VRE in the urine. PPE (personal protective equipment) for R8 was located outside R8's room.

On 2/17/2015, at 1:15 PM. E7 and E8, Certified Nurses Aides (CNA) gowned and gloved and transferred R8 from the wheelchair to the bedside commode using a gait belt. R8's incontinent brief was heavily soiled with urine and was removed by E8. R8's pants were wet with urine. After R8 was finished on the commode, E7 and E8 assisted him to stand. E8 used her left arm to hold the gait belt. E8 used her right gloved hand to cleanse R8's rectal area with disposable wipes, 3 times. E8 failed to cleanse R8's buttocks. Without changing the soiled gloves, E8 switched hands, holding the gait belt with her right hand, then used the left hand to cleanse R8's inner thighs. E8 used the left hand to wipe around R8's penis, but did not pull back the foreskin to cleanse the head or the shaft of the penis or cleanse R8's scrotum. Without removing the soiled gloves, E8 scratched her nose with her left hand, touched R8's wheeled walker and gait belt before assisting E7 to transfer R8 to bed.

The Facility's policy and procedure, revised 3/2014 and entitled, 'Standard and Transmission Based Precautions' documents, in part, "Transmission based precautions are used for patients known or suspected to be infected or colonized with epidemiologically important

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F 441	Continued From page 34 pathogens that can be transmitted by airborne or droplet transmission or by contact with dry skin or contaminated surfaces. 1. Gloves must be worn when there is a reasonable likelihood of hand contact with blood or other body substances, mucous membranes or non-intact skin, when performing vascular access procedures, and when handling contaminated items or surfaces. 2. Gloves must be removed when the task is completed or before touching public areas that others may contact. 3. Gloves must be changed between patients/residents (before leaving the patient's room) and when moving from a contaminated to clean body site. Hands must be washed as soon as possible after gloves are removed."	F 441		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the Facility failed to ensure the Facility was free of pests and rodents. This has the potential to affect all 97 residents living in the Facility. Findings include: During the initial tour of the kitchen on 02/17/2015 at 10:03 AM, 30-40 mouse droppings were present under the dry storage rack in the corner and also present throughout the main wall storage unit with up to 70-80 mouse droppings	F 469		

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F 469	Continued From page 35 under the shelving unit. 2 mouse traps were observed and 2 glue traps containing over 25 dead phorid (Humpback) flies present on the glue strip. In the kitchen entrance doors to the outside there were gaps in the door greater than 3/16 of an inch on the bottom and sides of the door. On 02/17/2015 at 10:25 AM, phorid (Humpback) flies were present in the kitchen area flying around. One dead fly was observed frozen inside an ice cube in the ice machine. Above the kitchen hood were four lights covered in grease with 25-50 dead phorid flies stuck to each light fixture. Flies were also present flying around the kitchen. On 02/18/2015 at 11:30 AM, the phorid flies were also observed in the East Shower Room. 02/18/201 5 at 11:35 AM, the phorid flies were observed in the East Wing across from the nurses station and again in the Director of Nurses Office at 11:40 am. E4, Director of Nutritional Services, stated on 02/18/2015 at 10:33 AM, staff has only seen one small mouse present in the storage area. She stated she was aware of the flies and they were a nuisance but she thought they were just fruit flies. On 02/17/2015, the Pest control contract and records, dated 01/07/2015, did not identify or address the phorid flies or mice. The Resident Census and Conditions of Residents, CMS 672, dated 02/17/2105, documents that the Facility has 97 residents living in the Facility.	F 469		