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documented, length in cm = 3.5, width in cm=1.5, no odor is apparent, drainage consistency is thin, minimal drainage is present, color ids red-tinged. The wound was not present on admission. Wound base is visible, Red wound base=100% , Epithelial tissue type=100%, no itching or discomfort, condition is flat, color is bright red, no foreign bodies present, surrounding tissue is macerated, skin tissue temperature is warm to touch, margins are irregular, mucous membranes are moist, mucus membranes are pink, Skin turgor is fair, skin tear flap edges are open, site improvement noted , no recent changes were made to the treatment orders for this site. "

" 01/31/2012 Present on the coccyx is a denuded area... The following findings were documented, length in cm = 4, width in cm=2, no odor is apparent, no drainage is apparent, this wound was not present on admission, wound base is visible, red wound base=100% , epithelial tissue type =100%, no itching or discomfort, condition flat, color is red, no foreign bodies present, skin tissue temperature is warm to touch, margins are irregular, resident has no pain, skin turgor is fair, deterioration noted in site, risk factors; General comment: resident wound site worsening, red in color , no odor, no drainage noted. Wound nurse made aware. Calmoseptine treatment continues as ordered. "

" 02/07/2012 Present on the coccyx is a denuded area. The following findings were documented, length in cm = 3.5, width in cm=3.5, Depth in cm=0.2, no odor is apparent, drainage consistency is thin, minimal drainage is present, color is red tinged, this wound was not present on admission, General comments:

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F 314	Continued From page 40 Noted dark pink area around the edges, with mild pale yellow area in the center, would recommend the application of Santyl. Wound base is visible, red wound base= 70%, yellow wound base=30%, no foreign bodies present, surrounding tissue is normal. The affected area has an absence of hair, skin tissue temperature is consistent with surrounding tissue, and margins are irregular, resident has no pain, mucus membranes are moist, skin turgor is fair, deterioration noted in site. " " 02/14/2012 Present on the coccyx is a denuded area. The following findings were documented, length in cm = 3.2, width in cm=2, no odor is apparent, drainage consistency is thin, scant drainage is present, color is tan, Wound base is visible, pink wound base= 60%, red wound base =20%, yellow wound base=20%, Epithelial tissue type = 100%, no foreign bodies present, surrounding tissue is normal. Skin tissue temperature is consistent with surrounding tissue, margins are irregular, mucus membranes are moist, mucus membranes are pink, skin turgor is fair. " " 02/15/2012 Present on the coccyx is a denuded area. The following findings were documented, length in cm = 3.5, width in cm=2, depth in cm =0.5, no odor is apparent, drainage consistency is thin, minimal drainage is present, color is red-tinged, recent changes were made to the treatment orders for this site, This wound was not present on admission, General comments: The wound appears reddened with brown colored non-viable tissue, minimal drainage. Recommend applying 2 x 2 gauze saturated with Santyl deterioration noted in site. "	F 314		

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F 314	Continued From page 41 " 02/21/2012 Present on the coccyx is a denuded area. The following findings were documented, length in cm = 2.5, width in cm=2.0, Skin is not blanchable, drainage consistency is thin, scant drainage is present, color is red-tinged, This wound was not present on admission, General comments: sacral-coccyx ulcer treatment done as per order to sprinkle Polysporin powder and packaging done with 4x4 gauze with Polysporin powder Santyl ointment and secured with Tegaderm. Resident is also on Zinc Sulphate and Vitamin C for wound healing. " " 2/22/2012 - Present on the Coccyx is a DENUDED AREA. The following findings were documented; Length in cm = 3.5, Width in cm = 2.5, Depth in cm = 0.8, no odor is apparent, drainage consistency is thin, minimal drainage is present, color is red-tinged. Recent changes were made to the treatment orders for this site. This wound was not present on admission. General Comments: Noted [approximately] 10% of loose pale brown slough, with pale red wound base. Minimal serosangious drainage; mildly ecchymotic around the edges. Recommend application of 2 X 2 gauze saturated with Dakin ' s solution to fill the wound bed. Wound initially appeared as denuded area moisture contributing to the formation of the ulcer. Appearance now suggest the role pressure also involved leading to the current status of the wound. Wound base is visible, Red wound base = 90%, yellow wound base = 10%, Granulation tissue type = 90%, Slough tissue type = 10%. Recent changes were made to the treatment order for this site, antibiotics are not currently in use; pressure reducing or relieving device (s) are in place,	F 314		

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devices used on the bed surface, extremity device or shoe used, turning and repositioning program being implemented. Nutritional update, protein supplement administered, Vitamin C administered, Zinc administered, other nutritional programs in ensure plus. Risk Factors; Co-Morbidities, Decreased Mobility. "

" 2/22/2012 - Skin and Wound Update to Site- 352. Present on the Coccyx is a DENUDED AREA. The following findings were documented, General Comments: dietician made aware for the inclusion of Vitamin C and Zinc. "

" 2/28/12- Skin and Wound Update to Site -352, Condition changed (From: DENUDED AREA To: Pressure Area). Reason: wound appearance is chronic and has progressed to this stage suggests pressure was the [major] contributing factor in addition to [moisture], shear and friction. Present on the Coccyx is a Pressure Ulcer. The following findings were documented: Staging, Stage3, Length in cm = 2, Width in cm = 2, Depth in cm= 1, no odor is apparent; drainage consistency is thick, minimal drainage is present, color is red-tinged, color is serosanguinous. Recent changes were made to the treatment orders for this site. General Comments: Noted that the wound has progressed from Stage II to Stage III. Wound was identified as denuded area, which in fact was a Stage II ulcer, slowly progressed now to the current stage. Wound base is visible, Pink wound base = 10%, Red wound base = 40%, Black Brown Base = 50%; no foreign bodies present, surrounding tissue is macerated, surround tissue is hyper pigmented. Skin tissue temperature is consistent with surrounding tissue; margins are irregular; mucous membranes are moist. Skin Turgor is

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fair. Pressure reducing or relieving devices (s) are in place, devices used on the bed surface, turning and repositioning program being implemented. Nutritional update; protein supplement administered, Vitamin C administered, Zinc administered, other nutritional programs in ensure, Risk Factors: Co-Morbidities, Decreased Nutrition. "

" 2/29/2012 - Skin and wound update to Site- 352. Present on the Coccyx is a Pressure Ulcer. The following findings were documented: Staging, Stage 3, Length in cm = 2, Width in cm = 2, Depth in cm = 1; a faint odor is apparent, drainage consistency is thin, moderate drainage is present, color is serosanguineous. Recent changes were made to the treatment orders for this site. Wound base is visible; Red wound base = 60%, Black Brown base = 40%, Granulation tissue type = 50%; Slough tissue type = 50%. Surrounding tissue is macerated, surrounding tissue is firm, skin tissue temperature is consistent with surrounding tissue, margins are irregular. Mucous membranes are moist, mucous membranes are pink. Skin turgor is fair. Pressure reducing or relieving device(s) used on the bed surface, turning and repositioning program being implemented. Risk Factors: Co-Morbidities, Decreased Mobility, Decreased Nutrition, PUSH Tool 3.0; Total Score = 11. "

" 3/1/12 - Present on the Coccyx is a Pressure Ulcer. Unable to accurately stage- Slough and/or Eschar covered; no drainage is apparent. General Comments: Noted 70-80% dark brown; non-viable tissue noted on the wound bed. Wound had foul odor. Also noted with induration around the lateral edges. Discussed with [MD ' s

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F 314	Continued From page 44 name] about the current status of the wound condition. [MD ' s name] said he will come and see the wound. Saw the wound again with [MD ' s name]. Advised for a surgery consult for possible debridement. Wound base is visible, Red wound base = 20%, Black Brown base= 70%. Other color in wound base = 10%, surrounding tissue is indurated. Skin tissue temperature is consistent with surrounding tissue; margins are irregular, margins are thickened, mucous membranes are moist, mucous membranes are pink. Skin turgor is fair. Pressure reducing or relieving devices (s) are in place. " " 3/9/12-Present on Coccyx is a pressure ulcer. The following were documented, Staging, Stage 4, color is serosanugineous. Recent changes were made to the treatment orders for this site. This wound was not present on admission. Wound base us visible, Red wound base=90%m yellow wound base=10%, Granulation tissue type=90%, slough tissue type=10%, surrounding tissue is macerated ...Risk Factors: PUSH Tool 3.0, Total Score=12 ... " Nutrition According to the clinical record " December 30, 2011 at 1430 ...Vitamin C 500mg by mouth twice daily for wound healing x 14 days. Zinc Sulphate 220 mg by mouth daily for wound healing x 14 days was directed to be given on December 30, 2011. When the skin impairment was first observed there was no evidence that a nutritional assessment was conducted to determine if additional nutritional supplements were necessary to promote the healing of the impaired	F 314		

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F 314	Continued From page 45 skin for 45 days. After the assessment was done on December 30, 2011 the resident received the supplements for 14 days (December 31, 2011 - January 13, 2012) at this time the order stopped. A review of the Physician ' s Interim Orders revealed, " February 15, 2012 at 1710 ...Increase Ensure to TID [three times a day] (Provides 1050 Kcal, 39 g protein). Give Zinc Sulfate 220mg p.o. daily x 14 day(s) for wound. Give Vitamin C 500 mg p.o. daily for wound x 14 days ... " There was no evidence that the resident received additional supplementation between January 14, 2012 and February 16, 2012. The Dietitian ' s assessment on February 15, 2012 revealed the following, " ...Intervention #3, " Initiate Vitamin C and Zinc supplementation times 14 days for micronutrient repletion and to promote wound care. " A face-to-face interview was conducted with the Employee # 27on September 24, 2012 at11:26 AM. He/she stated, " We (dietitians) only follow pressure ulcers [Note: the facility characterized Resident#3 ' s wound as a denuded area]. When it was documented as a pressure ulcer I put interventions in place. " Physician Review A review of the medical record revealed that the attending physician made a visit on January 5, 2012. There was no evidence that physician	F 314	E. 1. Resident #3's wound was assessed. Resident received supplementation as per physician's order during the time frame mentioned 1/14/2012 through 2/16/2012. 2. All residents with wounds have been identified and are currently receiving appropriate supplementation. 3. All licensed staff have been in-serviced on obtaining additional supplementation for residents with wounds. 4. Monthly audits will be conducted by the Nurse Manager or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	1/14/12 11/9/12 11/9/12 Ongoing

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F 314	Continued From page 46 addressed the changes in condition to the Resident ' s coccyx in his/her review. A face-to-face interview was conducted with Employee # 4 on September 24, 2012 at approximately 4:45 PM. He/she stated, " The area was very superficial. There was no evidence for me to say it went beyond the dermal layer when it was first observed. It was a denuded area that is what was documented. I treated the area. [He/she] was on an air loss mattress. It was a Stage 2 when I was saying it was denuded. After one month I did not change the diagnosis. It was denuded until February [2012] when it became a Stage 3 and then a Stage 4. " Summary · According to the aforementioned quarterly and annual MDS and the Braden Scale the resident was at risk for pressure sores. · There was no evidence that facility staff administered the treatment to the coccyx as per the physician ' s order on November 25, 2011 (for one treatment), November 26, 27 and 28, 2011, and December 8 and 9, 2011. · According to the documentation on the TAR, February 16 thru 22 and 29, 2012 the resident received a treatment to cleanse Sacro-Coccyx ulcer with Normal Saline, sprinkle Polysporin powder; apply pack 2x2 gauze saturated with poly Santyl ointment, cover with 4x4 gauze;	F 314		

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F 314	Continued From page 47 secure with Tegadem. However, there is no corresponding physician ' s order to direct the care. · There was no evidence that the resident received additional nutritional supplementation for 30 days (January 14, 2012 and February 16, 2012). · A review of the medical record revealed that the attending physician made a visit on January 5, 2012. There was no evidence that physician addressed the changes in condition to the Resident ' s coccyx in his/her review. In conclusion there was no evidence that the facility consistently implemented interventions to promote wound healing for the altered skin integrity sustained by Resident #3. The resident sustained an alteration in the integrity of the skin of his/her coccyx, characterized by the facility as a " denuded area " that progressively declined over a period of three (3) months and greater. The site of the wound, the coccyx area, is located at a bony prominence at a pressure point; the resident was assessed as " always incontinent " of bowel and bladder according to the MDS and the facility ' s pressure ulcer risk assessment tool revealed that the resident was a " moderate " risk for pressure ulcers. The facility characterized the altered skin as a " denuded area " although the wound was assessed with depth on December 21, 2011 [of note: depth is not characteristic of denudation].	F 314	F. 1. Resident #3's wound was assessed and it was determined that the facility staff consistently provided necessary treatment and services to promote wound healing. 2. All residents with wounds have been identified. Facility is consistently implementing interventions to promote wound healing. 3. All licensed staff have ben in-serviced on consistent implementation of interventions to promote wound healing. 4. Monthly audits will be conducted by the wound nurse or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	9/24/12 11/9/12 11/9/12 Ongoing

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F 314	Continued From page 48 The dietician was not consulted for greater than 40 days after the wound was initially identified and was noted to have progressed as opposed to improved. The interventions recommended by the dietician for nutritional supplementation for micronutrient repletion and promotion of wound healing were followed for a period of 14 days and discontinued thereafter. The interventions related to nutritional supplementation was absent for a period of approximately 30-days wherein it was determined that the wound significantly deteriorated. There was no evidence the facility staff ensured that Resident #3, who had an alteration in skin integrity, classified by the facility as a " denuded " area to the coccyx, consistently received the necessary treatment and services to promote wound healing. The wound progressed over approximately 3 months to Stage 4 pressure ulcer. According to the Physician ' s Interim orders, dated March 4, 2012 the Resident #3 was transferred to [hospital] for sacral ulcer management. The record was reviewed on September 24, 2012. 2. Facility staff failed to consistently assess the status of skin impairment for Resident #16. Review of the " Progress Notes by Resident " notes dated May 5, 2012 11:23 AM revealed that Resident #16 was admitted to the facility with an alteration in skin integrity of the coccyx.	F 314		

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F 314	Continued From page 49 Review of the " Skin Condition Report with Images " sheet dated May 5, 2012 identified the skin alteration as Site 388 which indicated: "New (1st recording) ...cracked opened red areas in between buttocks 1x0.4cm and 2x0.5cm no drainage (no identification of the location on anatomical image)." Further review of the " Skin Condition Report with Images " sheets which identified the skin alteration as Site 388 dated May 9, 2012, May 22, 2012 and May 29, 2012 lacked information about the site in terms of progress of the wound, the description, measurments, or staging or the wound. Review of the " Progress Notes By Residents " dated May 11, 2012 and May 12, 2012 indicated that Baza ointment was applied to buttocks as per Dr. orders, however no measurements, staging or description of the wound was identified. Further review of the " Progress Notes By Residents " dated May 28, 2012 indicated that the resident was discharged to home ..., however no status of the wound was identified upon discharge. A face-to-face interview was conducted with Employee #4 on Septemberl 21, 2012 at approximately 3:00 PM. A query was made as to the progression of the wound of the coccyx area	F 314	2. 1. Resident #16 was discharged from the facility at the time of this observation. 2. All residents with skin impairments have been identified and have consistent assessments and progression of skin impairment in place. 3. All licensed staff have been in-serviced on consistent assessment and progression of skin impairment. 4. Monthly audits will be conducted by the Nurse Manager or designee. Results will be submitted to the DON for presentation at quarterly QI/QA meeting.	5/29/12 11/9/12 11/9/12 Ongoing

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in terms of description, measurements, staging and what was the status of the wound upon discharge. Employee #4 acknowledged that the " Skin Condition with Images " sheet lacked information about the status of the wound and indicated the wound had healed, that the skin was pink and measurements remained the same with healing.

Facility staff failed to consistently assess the characteristics and progression of the resident's skin impairment. The record was reviewed on September 21, 2012.

3. Facility staff failed to measure and consistently identify the status of skin impairment for Resident #289's right heel and right lateral malleolus.

Review of the "Progress Notes By Resident" notes dated April 25, 2012 revealed that the resident was admitted to the facility on April 25, 2012 at 21:35 with...right ankle open to be, cleansed with NS [Normal Saline] and bacitracin ointment applied BID [two times a day] x 21 days. Wound nurse to assess tomorrow.

Review of the "Progress Notes By Resident" dated April 25, 2012: 22:25 revealed an entry, upon assessment resident noted with a stage 2 pressure ulcer on the right ankle that measured 2cmx1cm. [he/she] also noted to have reddened area on [his/her] right heel that measured

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F 314	Continued From page 51 4.5cmx5cm. Right lateral ankle to be cleaned with NS and apply Bacitracin Ointment twice daily for 21 days ... Review of the "Skin Condition Report with Images" sheet dated April 25, 2012 identified Site 461, right lateral malleolus is a pressure ulcer. A second entry dated April 25, 2012 no time, Site 461 present on right lateral malleolus is a pressure ulcer. Staging, stage 2 length in cm [centimeters] 2, width in cm = 1, depth in cm = 0, no odor is apparent, no drainage is apparent, present on admissions... Review of the "Skin Condition Report with Images" sheet dated April 25, 2012 identified Site 488: present on right heel is a pressure ulcer. A second entry dated April 25, 2012 no time, site 488 present on as right heel is a pressure ulcer. Staging, stage1 length in cm = 4.5, width in cm = 5, skin non blanchable, no odor is apparent, no drainage is apparent ...present on admissions ... Review of the " Skin Condition with Images " dated April 26, 2012 indicated: Site 488 present on the right heel is a pressure ulcer, staging, stage 1 length in cm = 7, width in cm = 6, no odor is apparent, no drainage is apparent ...	F 314	3. 1. Resident #289 was discharged from the facility at the time of this observation. 2. All residents with skin impairment have been identified. There are measurements and consistent identification of the status of the skin impairment. 3. All licensed staff have been in-serviced on measuring and consistent identification of the status of skin impairment. 4. Monthly audits will be conducted by the wound nurse. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	5/29/12 11/9/12 11/9/12 Ongoing

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	095034	A. BUILDING _____ B. WING _____	09/25/2012

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F 314	Continued From page 52 Review of the " Skin Condition with Images " dated April 26, 2012 indicated: site 461 present on the right lateral malleolus is a pressure ulcer. No odor is apparent, drainage consistency is thin, scant drainage present, color is red-tinged, wound present on admissions, wound base visible: red wound base 50%, yellow wound base 50% slough tissue type 50%, epithelial type 50%, however there is no staging or measurement of the wound. Review of the " Physician ' s Order " sheet dated and signed by the physician on April 26, 2012 directed: Cleanse right ankle open area with NS, gently pad dry and apply bacitracin ointment BID x 21 days; POS bilateral heels boots to be worn while in bed for protection. A telephone order dated April 27, 2012 1605 [4:05] PM revealed: T.O/physician and Wound Nurse: Right ankle area: cleanse with NS apply thin layer of Silvadiene - cover with gauze and tape dressing bid x 14 days. D/C Bacitracin Ointment. Review of the " Progress Notes By Resident " dated April 28, 2012 indicated boots to prevent skin breakdown ... Review of the " Progress Notes By Resident " dated April 30, 2012 indicated admitted to unit...noted stage 2 pressure ulcer to right ankle and reddened area on his right heel ... however	F 314		

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F 314	Continued From page 53 there is no staging or measurement of the wound. Review of the " Progress Notes By Resident " dated May 2, 2012 indicated pain control, resident wound care done right ankle, scant yellowish drainage noted to old dressing no odor ... however there is no staging or measurement of the wound. Review of the " Progress Notes By Resident " dated May 6, 2012 indicated no pain...dsg [dressing] right heel and ankle areas, no drainage noted, right heel blister ruptured with skin lifted. Right ankle with granulation presenting, no silvadene applied to area. Wound Nurse to follow up in AM for assessment and advancement of treatment, however there is no staging or measurement of the wound. Review of the " Progress Notes By Resident " dated May 7, 2012 indicated, right heel, paint edges with betadine and leave it open to air. right ankle area; cleaned with NS, apply a thin layer or silvadene and cover with gauze and tape... however there is no staging or measurement of the wound. Review of the " Skin condition " form dated May 8, 2012 indicated, Site: 461 right malleous heel wound is healing slowly w/o [without] infection betadine tx [treatment] administered as ordered ... however there is no staging or measurement	F 314		

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F 314	Continued From page 54 of the wound. Review of the " Skin Condition " form dated May 8, 2012 indicated Site: 488 slowly healing without s/s [signs and symptoms] of infection betadine tx as ordered, however there is no staging or measurement of the wound. Review of the " Progress Notes By Resident " dated May 10, 2012 indicated wound care rendered to right ankle and heel ... however there is no staging or measurement of the wound. Review of the " Skin Condition " form dated May 15, 2012 indicated Site 461: skin site healed Review of the " Skin Condition " form dated May 15, 2012 indicated Site 488: skin site healed Review of the "Progress Notes By Resident " dated May 16, 2012 indicated treatment done to top right foot wound... Review of the "Progress Notes by Resident" dated May 17, 2012 Dietary: Pressure Ulcer healed. Per nursing skin is thin. d/c [discontinue] vit [Vitamin] C cont. [continue] current diet supplements. Review of the "Progress Notes by Resident" dated May 19, 2012 Tx. [treatment] to both	F 314		

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F 314	Continued From page 55 heels.. Review of the "Progress Notes by Resident" dated May 20, 2012 Tx done to right foot... Facility staff failed to consistently identify and measure Sites 461 and 488 after April 26, 2012, and failed to consistently stage the wound after April 30, 2012. There was no description of the wound noted upon discharge. On May 19, and 20, 2012 there was a notation which indicated that there was treatment to both heels whereby the "Skin Condition with Images" indicated that the right heel had healed on May 15, 2012, there was never a mention of a wound site to both heels which would have included the left heel or a status upon discharge. There was never a mention of a wound site to the top of the right foot or any previous treatments done to the top of the right foot including a status upon discharge. A face-to-face interview was conducted with Employee #3 and #4 on September 21, 2012 at approximately 2:30 PM. After review of the above he/she acknowledged the findings. Employee #4 acknowledged that consistent details involving the locations, staging and measuring of the wounds should have been identified up to the healing and upon discharge of the resident. The record was reviewed on september 21, 2012.	F 314		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES	F 319		

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F 319	Continued From page 56 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 record review and staff interview for one (1) of 33 sampled residents, it was determined that facility staff failed to ensure that Resident #376 who displayed mental and/or psychosocial adjustment difficulties received timely, appropriate treatment and services to correct the assessed problem. The findings include: According to the admission minimum data set dated June 20, 2012 Resident #376 Was coded as having physical, verbal, and other behavioral symptoms directed toward others in Section E0200 (Behavioral Symptoms). Section I (Active Diagnoses) the resident was coded for diagnoses which included: Hypertension, End Stage Renal Disease, Urinary Tract Infection (within the last 30 days), and Diabetes Mellitus. A review of progress notes for Resident #376 ' s included the following progress notes: July 14, 2012 at 23:12 ...call by the front desk secretary to go and see resident in [his/her] room because of [his/her] pain. He/she stated that	F 319	F319 483.25(f)(1) TX – SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES 1. Resident #376 was assessed. Interventions to address alleged suicidal ideation have been documented. 2. All residents who have verbalized suicidal ideation have been identified and timely documentation of assessments and interventions are in place. 3. All social services staff were in-serviced on timely documentation of assessments and interventions for suicidal ideations. 4. Monthly audits will be conducted by Social Services Manager or designee. Results will be reported at the quarterly QA/QI meeting.	10/1/12 9/28/12 9/28/12 Ongoing

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F 319	Continued From page 57	F 319		

resident has been calling that if [he/she] did not get relief from his/her pain, he/she is going to hurt him/herself. Upon getting to his/her room I observed [multiple] open areas on the resident ' s hip/thigh area with bright red blood. Skin tears measured about 0.7cm x 0.8cm some of them unmeasurable. [Primary Attending] made aware and family also made aware. Calmoseptine [ointment] to be applied [every] shift. Resident remains alert, confused and stable.

July 24, 2012 at 17:21 ...[Social worker] visited with resident in a quiet corner in the living room and resident expressed unhappiness at being in LTC (long term care) setting. [Social worker] explored ADL [activities of daily living] needs with resident, and resident asserted, " [he/she] can do everything for [him/herself] and doesn ' t need any help. " Resident stated [he/she] feels like he/she is " in prison " and " just look at these people. " Per resident his/her sleep and appetite have improved. He/she would prefer to be at home " doing everything [he/she] use to do " . Resident showed little insight about his/her current health status ...[Social Worker] reminded resident of the circumstances surrounding his/her admission (multiple intubations) and resident agreed he/she almost died-and said he/she sometimes " Wishes God would take [him/her]. " Resident denied [suicidal] and hallucinations or delusions. He/she quickly added that " suicide is a sin and God forgive me. " [Social worker] will share this with IDT [interdisciplinary team] and recommend psychiatric consult for depressive symptoms. "

July 31, 2012 at 11:09 ...[Social Worker] met

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F 319	Continued From page 58 with resident in his/her room after CNA (certified nurse aide) reported resident has been irritable. Resident said, " Get me outta here. " Social Worker discussed discharge planning resources and need for 24-hour care. Resident expressed firm belief that he/she was " walking and well " when he/she came into this place, " and now he/she keeps being told, " You ' re sick " and can ' t leave. [Social Worker] reviewed resident ' s rights and explored discharge options. Resident continues to believe that [facility name] and [hospital] staff wish to keep his/her here. He/she expressed anger, frustration and disbelief about his/her current health status. He/she said he/she wished he/she was dead but denied suicidality, stating " Suicide is a sin. " Resident did not respond to supportive counseling or redirection but did say he/she understood that someone would need to care for him/her at his/her home. [Social Worker] to share his/her thoughts of death with [nursing] and pastoral care. A review of Interdisciplinary Progress Notes dated August 15, 2012 [no time indicated] revealed, " Late entry note for tx [treatment] given August 13, 2012, Pt [patient] extremely agitated. c/o [complain of] pressure abdomen with pain LB [lower back]. Pt discussed wanting to commit suicide by throwing [his/herself] out of the 2nd flr (floor) window. [He/she] c/o being concerned about meds [medication] causing confusion. [He/she] says he/she asked for the meds to help decrease his/her anxiety but he/she regrets it. Pt said the doctors and nurses were trying to kill him/her because he/she did not	F 319		