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

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accept dialysis. She then said, " If they can treat me then why won ' t they send me somewhere where they can treat me. " Pt discussed main reasons for these emotions with me. His/her pain was [unable to read]. Encouraged Pt to try moist heat ...However when PT went to leave she stated, " Don ' t leave me alone he/she followed by stating you care about me won ' t you help me kill myself. Pt then fell asleep. Pts statements reported to social services upon RTW (return to work) by therapist today. Spoke further with [pastoral representative] and Employee # 23 who interviewed this therapist re: above. Pt seen by MD ... "

August 16, 2012 at 08:47 ...Resident was seen by Psych for suicidal thoughts and asking his/her therapist to assist him/her in executing his/her thoughts. According to rehabilitation [staff name] the resident told him/her that he/she wanted to kill him/herself by jumping through his/her window. He/she said the resident also asked him/her to please help him/her do so. Resident was seen last week by Psych, he/she did express suicidal thoughts and his/her high level of anxiety ... "

A telephone interview with Employee # 28 was conducted on October 10, 2012 at 3:17 PM. He/she stated, " It happened on August 13, 2012 around 6:00 PM, it was a scheduled therapy visit and I always did the treatment in the resident ' s room, but he/she was in distress. I wanted to calm him/her. He/she was screaming at the top

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of his/her voice, screaming like in labor and deliver and I wanted to get him/her out of pain. He/she complained of her back hurting. I informed the nurse came in and medicated the resident for pain. I spent a good amount a time calming him/her down. The resident was going on and on and the resident was agitated. I don ' t recall him/her saying that [that he/she wanted me to help her to kill him/herself]. I didn ' t have concerns when I left that day; it was an emotionally draining experience. I was not listening to him/her directly. It [the suicidal ideation] was an afterthought. I left the building and did not have concerns. He/she made a health care choice that was a terminal choice for him/her. When queried as to why the note wasn ' t written on the day of the incident. He/she stated, " It was late. I am a professor, a student and a mother. It [the resident ' s suicidal ideation] was not clear to me when I was working with the resident. It hit me when I was coming back to work [August 15, 2012]. It was not an atypical visit with this resident. I was focused on the resident ' s functional treatment. I wish I had come to a mental awareness sooner. Based on the residents physical ability he/she was no able to carry out the plan that he/she verbalized. This resident could not move or roll in bed."

When queried about would what would be your customary practice if someone verbalized a desire to harm themselves? He/she replied, " I would go to the nurse and let the nurse know. "When I came back to work I spoke with the social worker who told me to write down what happened so that he/she could follow up. "

A period of 2 days lapsed from the time the

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resident verbalized suicide ideations to the time the facility was notified.

There was no evidence that Employee #28 (physical therapist) act timely in conveying to the medical team, a resident's verbalization of suicidal ideation.

A review of the physician's progress notes revealed that the Primary physician saw the resident on June 16, July 10 and August 9, 2012. There was no documented evidence that the physician included the resident ' s psycho-social and behavioral concerns and suicidal thoughts.

A review of the Physician ' s Interim Orders revealed orders requesting a psychiatric consultation for Resident #376 on two occasions, July 20, 2012 and again on August 8, 2012. The psychiatric consult was conducted approximately 20 days following the initial request, on August 9, 2012.

A face-to-face interview was conducted on September 21, 2012 at 10:30 AM with Employee #13. He/she acknowledged that the psychiatric consult was not done until August 9, 2012 after the second order for the consult was written.

A face-to-face interview was conducted on September 21, 2012 at 4:45 PM with Employee # 23 (Social Worker). He/she stated, " I documented the incident the first time not the second time. I went in to talk to him/her and assess him/her again and he/she denied being

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F 319	Continued From page 62 suicidal. He/she said, " Suicide is a sin. " The resident exhibited mental and psychosocial difficulties compounded with suicidal ideation and there was no evidence that the facility acted with timeliness and/or implemented appropriate treatments to consistently address the concerns. The record was reviewed September 21, 2012.	F 319		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional 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 one (1) resident maintained acceptable parameters of nutritional status when it determined he/she sustained unplanned weight loss. Resident #376. The findings include:	F 325	F325 483.2(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE 1. Resident #376's weight was maintained within acceptable parameters of nutritional status at the time of this observation. The facility is unable to retrospectively reweigh resident. 2. All residents with weight variances have been identified and acceptable nutritional status is being maintained for those identified with unplanned weight loss. 3. All licensed nursing staff and registered dietitians have been in-serviced on obtaining reweights as specified by weight loss policy. 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.	9/21/12 11/9/12 11/9/12 Ongoing

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F 325	Continued From page 63 Facility staff failed to consistently monitor and follow up on weight variances for Resident #376. 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. According to the Attending note dated July 10, 2012 ...recently d/c (discharged) from [hospital] after treatment with volume overload, pitting edema-needing IV [intravenous] diuresis...refusing Hemodialysis -which [he/she] needs ... " A review of meal consumption records for the period of July - August 2012, although not comprehensive (some entries remained blank), revealed that the resident's appetite was 50% or less for a substantial number of meals. There were greater than 20 out of 30 days that a PM snack was "not available" as recorded on the meal consumption records. A review of the Resident ' s Weights revealed the following: June 14, 2012-166.3 pounds July 10, 2012-182.6 pounds July 19, 2012 -165.4 pounds August 6, 2012 -152.2 pounds August 9, 2012 - 146.0 pounds August 16, 2012-145.2 pounds	F 325		

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F 325	Continued From page 64 August 23, 2012-135.2 pounds August 30, 2012-129.6 pounds September 6, 2012-126.8 pounds September 13, 2012-126.6 pounds There was no evidence that weight variances were verified, such as the assessment of a re-weight. The dietary progress note dated 7/11/12 revealed, " Weight Gain/Loss Comments=...Question of accuracy of current wt (weight) given diagnoses and poor prognosis. Wt changes possibly related to fluid shifts given documentation of volume depletion...General dietary comments-...4) suggest re-weight. " On August 10, 2012, a Dietary consult was conducted secondary to weight loss. The resident's weight record reflected variances for greater than 30 days without evidence of consistent interventions by clinical staff and/or the medical team. A face-to-face interview was conducted on September 21, 2012 at 2:45 PM with Employee # 27. He/she acknowledged that the re-weight was not done. The record was reviewed on September 21, 2012.	F 325		
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	F 329		

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F 329	Continued From page 65 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. 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 administer insulin in accordance with the physician's orders for Resident # 154. The findings include: According to the facility ' s policy " Glucose Monitoring and Insulin Usage " Number: 1246, Effective May 2006-revised date August 1, 2009,	F 329		

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F 329	Continued From page 66 stipulated, " Policy Guidelines: ...Repeat finger stick in one hour if results are 400 or greater. Do not cover repeat finger stick with sliding scale if the blood glucose level is lower. Recheck in two hours if blood glucose is still greater than 400, don ' t give a second dose. Call physician if results are still 400 or greater. " According to the physician's Order Sheet last signed and dated by the physician on August 11, 2012 directed the following: Novolog solution,100 unit/ml: Inject 5 Units subcutaneous daily before meals at 07:30, 16:30for DM (Diabetes Mellitus), Document fingerstick: document results and Injection Site Location ...Special Instructions: Give 5 units only if blood sugar more than 350mg ... " A review of the " Blood Sugar Recordings " sheets revealed that on September 12, 2012 the resident ' s blood sugar value was " 423 " at 5:45 PM. According to the Medication Administration Record the resident was administered an additional 5 units of insulin in accordance with the physician's order. There was no evidence that facility staff notified the physician or the house supervisor or rechecked the blood sugar after administering an additional 5 units of insulin. There was no evidence in the clinical record that staff performed an additional assessment of the resident once he/she was aware of the elevated blood sugar level. A face-to-face interview was conducted on September 24, 2012 at approximately 10:40 AM	F 329	F329 483.25(1) DRUG REGIMEN IS FREE FROM UNESESSARY DRUGS 1. Resident #154 was assessed. Physician was notified for the next blood sugar reading greater than 400. 2. All residents with an order requiring administration of extra insulin have been identified. There are interventions in place to notify physician off blood sugar greater than 400. 3. All licensed staff have been in-serviced on facility glucose monitoring and insulin usage policy. 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.	11/3/12 11/9/12 11/9/12 Ongoing

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F 329	Continued From page 67 with the Employee # 9. He/she acknowledged that there was no documented evidence that the facility staff notified the physician and further assessed the resident once the staff member was aware of the elevated blood sugar level. The record was reviewed on September 24, 2012.	F 329		
F 371 SS=E	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 observations made on September 18, 2012 at approximately 9:30 AM and on September 21, 2012 at approximately11:15 AM, it was determined that the facility failed to prepare, distribute and serve food under sanitary conditions as evidenced by soiled cooking equipment such as two (2) of two (2) convection ovens and one (1) of one (1) gas stove, nine (9) of nine (9) size 1-3 hotel pans and ten of ten gourmet pans that were inappropriately stored , four (4) of nine (9) size 1-3 hotel pans, five (5) of ten gourmet pans and one (1) of three (3) full size hotel pans that were soiled, foods such as fried chicken and a pan of broccoli from the 5th. floor pantry that did not reach expected hot food	F 371	F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY 1. 1. The two convection ovens and gas stove were cleaned and sanitized. 2. All kitchen equipment was inspected and any concerns were corrected. 3. Staff were in-serviced on proper cleaning and sanitizing procedures for equipment. 4. Monthly audits will be done by the closing supervisor or designee. Results of the monitoring will be reported to the quarterly QA/QI meeting.	9/21/12 11/9/12 11/9/12 Ongoing

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F 371	Continued From page 68 temperatures and eight (8) of eight (8) cold cut sandwiches that were stored undated in the resident refrigerator on 5 east. The findings include: 1. Cooking equipment such a such as two (2) of two (2) convection ovens and one (1) of one (1) gas stove including the six (6) burners were soiled. 2. Nine (9) of nine (9) size 1-3 hotel pans and ten of ten gourmet pans were stored wet. 3. Four (4) of nine (9) size 1-3 hotel pans, five (5) of ten gourmet pans and one (1) of three (3) full size hotel pans were soiled. 4. Fried chicken temperature from the 5th. floor pantry was 97 degrees Fahrenheit (F) and a pan of broccolli tested at 122 degrees F. 5. Eight (8) of eight (8) cold cut sandwiches were stored undated in the resident refrigerator on 5 east. These observations were made in the presence of Employee #16 and/or Employee #18 who confirmed the findings.	F 371	2. 1. Pans were removed from storage and were properly cleaned, sanitized, air dried, and properly stored. 2. All remaining pans were inspected for proper sanitation and drying. 3. All kitchen staff were in-serviced on proper cleaning, sanitizing, air drying, and storage procedures of pots and pans. 4. Monthly audits will be done by the closing supervisor. Results of the monitoring will be reported quarterly at the QA/QI meeting. 3. 1. The broccoli and fried chicken in the 5th floor pantry was discarded. 2. All remaining broccoli and fried chicken temperatures were checked for proper hot food holding temperatures. 3. Staff were in-serviced on the proper procedures for taking food temperatures and documenting in	9/21/12 9/21/12 11/15/12 Ongoing 9/21/12 9/21/12
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total	F 386		

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F 386	Continued From page 69 program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 33 sampled residents it was determined that the physician failed to include skin impairment in the review of Resident #3's total program of care and the physician failed to include psycho-social, behavioral and suicidal ideations in the review of Resident #376's total program of care. The findings include: 1. The physician failed include significant changes as it relates to skin impairment in the total program of care for Resident #3. Skin Condition Report -Unhealed Daily Wound Assessment revealed: " 11/11/2011 Present on the Coccyx is a denuded area. The following findings were documented, length in cm=0.8, width in cm=0.5, no odor is present, no drainage is apparent, recent changes were made to the treatment	F 386	in the temperature logs. 4. Monthly audits will be done by the closing supervisor or designee. Results will be reported at the quarterly QA/QI meeting. 4. 1. Cold cut sandwiches stored on 5 east were discarded. 2. All refrigeration storage areas were inspected for compliance with proper labeling, dating, and storage of all food products. 3. Staff were in-serviced in proper labeling, dating, and storage of all food products. 4. Monthly audits will be done by the closing supervisor or designee. Results of the monitoring will be reported at the quarterly QA/QI meeting.	11/9/12 Ongoing 9/21/12 9/21/12 11/9/12 Ongoing

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F 386	Continued From page 70 orders for this site, no itching or discomfort, General comments: At 2020 reported by CNA resident noted open pink area on coccyx measuring 0.8cm x 0.5cm, [physician] notified and gave order to clean the area with bedside care foam and pat dry, apply Calmoseptine ointment twice daily x14 days. " " 11/15/2011 Present on the Coccyx is a denuded area: The following findings were documented, General comments: Resident denuded area on coccyx assessed this morning, area measures 0.5 x 0.5 appearance is pink, no drainage noted. Treatment continues to cleanse with bedside foam and apply Calmoseptine bid x14 days. " " 11/23/2011 Present on the Coccyx is a denuded area: The following findings were documented, Length 0.2 x width 0.2, skin is not blanchable, no odor is apparent, no drainage is apparent, This wound was not present on admission, wound baseline visible, pink wound base = 100%, granulation tissue type = 100%, no itching, or discomfort, condition is flat, color is pink, wound has no pattern -scattered, no foreign bodies , surrounding tissues is normal, The affected area has an absence of hair, skin tissue temperature is warm to touch, margins are regular, resident has no pain. Skin turgor is fair, General comments: Denuded area on coccyx healing well, site dry and pink in color, site improvement noted. " " 11/24/11 Present on the coccyx is a denuded area. The following findings were documented, PA, NP, MD were notified of the present status of site. No changes in site condition, no recent	F 386	F386 483.40(b) PHYSICIAN VISITS-REVIEW CARE/NOTES/ORDERS 1. Resident #3 was assessed by the physician, and changes in the resident's condition as it relates to skin impairment were included in the next physician progress note. 2. All residents with skin impairment have been identified, and it has been determined that physician progress notes contain description of significant change in condition as it relates to skin impairment. 3. All physicians were in–serviced on describing significant changes in residents condition as it relates to skin impairment in progress notes. 4. Random audits will be conducted by wound nurse or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	3/1/12 11/15/12 11/15/12 Ongoing

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F 386	Continued From page 71	F 386		

changes were made to the treatment orders for this site, antibiotics are not currently in use. General Comments: Open area on coccyx assessed, cleanse with bedside foam as ordered and Calmoseptine applied to site, no bleeding or odor at site. "

" 11/28/2011 Present on the coccyx is a denuded area. The following findings were documented Length in cm=0.5, width in cm=0.5, depth in cm= 0, no odor is apparent, no drainage is apparent recent changes were made to the treatment orders for this site, the wound was not present on admission, General comment: pale pink dry wound bed, also noted moist areas in the gluteal fold and in the periwound area, current applying Safgel ointment and covering with gauze and Tegaderm, change dressing daily14 days, wound base is visible, pink wound base = 100%, condition is flat, color pink, no foreign bodies present, surrounding tissue hyper pigmented, skin tissue temperature is consistent with surrounding tissue, margins are regular, mucus membranes are dry, mucus membranes are pink, skin turgor is fair, no change in site condition, recent changes were made to the treatment orders for this site, Antibiotics are not currently in use: pressure reducing or relieving devices are in place, devices used on the bed surface, extremity device or shoes used, turning and repositioning program being implemented. Nutrition update: protein supplemental administered other nutritional programs in Ensure. Risk factor: Decreased mobility, inactivity. "

" 11/29/2011 Present on the coccyx is a denuded area. The following findings were

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

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CARROLL MANOR NURSING & REHAB	725 BUCHANAN ST., NE WASHINGTON, DC 20017

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F 386	Continued From page 72 documented General comments: Residents Coccyx area assessed this morning is pink and dry and new treatment orders received to cleanse with bedside foam and apply Safgel daily, no pain at site. " " 12/07/2011 Present on the coccyx is a denuded area. The following findings were documented Length in cm=0.5, width in cm=0.5, depth in cm=0, no odor is apparent, no drainage is apparent, The wound was not present on admission, General comments: dark pink wound bed with very scant drainage, recommend applying Mepilex sacral border to the dressing, wound base is visible, pink wound base = 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 ... " " 12/13/2011 Present on the coccyx is a denuded area. The following findings were documented General comments: Sacral coccyx area assessed this shift and appearance pink and moist, treatment done as ordered with Mepilex sacral border, no drainage was noted, no odor " " 12/14/2011 Present on the coccyx is a denuded area: Length 0.5cm x width 0.5cm, skin is not blanchable, no drainage, wound base is visible, pink wound base = 100%. " " 12/21/2011 Present on the coccyx is a denuded area: Length 1cm x width 1cm, depth 0.1cm, drainage consistency is thin, scant drainage is present, color is clear, red area on the edges with pale pink area in the center,	F 386		

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F 386	Continued From page 73 wound base is visible, pink wound base = 15%, red wound base = 85%, surrounding tissue is moist, continue applying Mepilex sacral dressing. " " 12/27/2011 Present on the coccyx is a denuded area.: Length 0.5cm x width 0.3cm, depth 0cm, skin is blanchable, no odor, no drainage, red in color, is red and moist, treatment cleanse with bedside foam and with Mepilex sacral border every third day. " " 12/28/2011 Present on the coccyx is a denuded area.: Length 3cm x width 6cm, depth 0cm, drainage consistency is thin, scant drainage is present, color is clear, denuded superficial dark pink ... with irregular borders, wound base visible, red wound base = 100%, Apply Stomadhesive powder, Calmoseptine and baza clear as moisture barrier ointment, Nutrition: zinc and vitamin C, protein supplement. " " 01/06/2012 Present on the coccyx is a denuded area ...Length 2cm x width 4.5cm. depth 0cm, no drainage , wound base visible, red wound base = 100%, Epithelial tissue type =100%, wound red, margins are irregular, treatment no changes, continue pressure reducing or relieving devices, Nutrition zinc, vitamin C and protein supplement. " A review of the medical record revealed that the attending physician made a visit on January 5, 2012. However, there was no evidence that physician addressed the changes in condition to the Resident ' s coccyx in his/her review.	F 386		

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F 386	Continued From page 74 A face-to-face interview was conducted with Employee # 3 on September 25, 2012 at approximately 10:00 AM. He/she acknowledged that the physician did not include Resident #3's skin impairment in his/her findings. The record was reviewed September 24, 2012. 2. The physician failed to include mental/psychosocial concerns and suicidal ideation(s) exhibited by Resident #376 in the total program of care. 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 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]	F 386	2. 1. Resident #376 was assessed by the physician. Mental/Psychosocial concerns were included in the total program of care. Resident was not exhibiting any suicidal ideations at that time. 2. All residents with mental/psychosocial concerns have been identified, and it has been determined that the physician has included these concerns in the total program of care. 3. All physicians were in-serviced on including mental/psychosocial concerns in the total program of care. 4. Random audits will be conducted by social services staff or designee. Findings will be reported at the quarterly QA/QI meeting.	8/20/12 11/9/12 11/9/12 Ongoing

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F 386	Continued From page 75	F 386		

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 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

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F 386	Continued From page 76 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 accept dialysis. She then said, " If they can treat me then why won ' t they send me somewhere where they can treat me. " Pt discussed main reasons for these emotions with me. His/her pain was [unable to read]. Encouraged Pt to try moist heat ...However when PT went to leave she stated, " Don ' t leave me alone he/she followed by stating you care about me won ' t you help me kill myself. Pt then fell asleep. Pts statements reported to social services upon RTW (return to work) by therapist today. Spoke further with [pastoral representative] and Employee # 23 who interviewed this therapist re: above. Pt seen by MD ... "	F 386		

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F 386	Continued From page 77 August 16, 2012 at 08:47 ...Resident was seen by Psych for suicidal thoughts and asking his/her therapist to assist him/her in executing his/her thoughts. According to rehabilitation [staff name] the resident told him/her that he/she wanted to kill him/herself by jumping through his/her window. He/she said the resident also asked him/her to please help him/her do so. Resident was seen last week by Psych, he/she did express suicidal thoughts and his/her high level of anxiety... " A review of the physician's progress notes revealed that the Primary physician saw the resident on June 16, July 10 and August 9, 2012. There was no documented evidence that the physician included the resident ' s psycho-social, behavioral concerns and suicidal ideations in his/her review. A face-to-face interview was conducted on September 21, 2012 at 10:30 AM with Employee #13. He/she acknowledged the findings. The record was reviewed September 21, 2012.	F 386		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 463	F463 483.70(f) RESDIENT CALL SYSTEM – ROOM/TOILET/BATH 1. Call bells in all identified rooms were checked for proper operation and repaired as needed. 2. All call bells have been checked for proper operation.	9/21/12 11/9/12

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F 463	Continued From page 78 Based on observations made on on September 21, 2012 between 1:40 PM and 3:45 PM and observations made on September 21, 2012 at approximately 10:30 AM, it was determined that the facility failed to maintain call bells in working condition as evidenced by call bells that did not initiate an alarm when tested in three (3) of 63 residents rooms, call bells that were wrapped around the grab bar in three (3) of 63 residents rooms, one (1) call bell that was cracked in two of 63 residents rooms and one (1) call bell that could not be connected in one (1) of five (5) residents rooms on 5 East. The findings include: 1. Call bells did not initiate an alarm in rooms #215, #110 and #104 in three (3) of 63 residents rooms. 2. Call bells were wrapped around the grab bar and could not be activated in the bathroom of residents rooms #436, #401 and #101. 3. The call bell switch was cracked in room #101 and the reset button was cracked in room #102 in two (2) of 63 residents rooms. 4. Staff was unable to hook up the call bell in room #564 on 5 East (Hospital) due to a missing connector. Observations one (1), two (2) and three (3) were made in the presence of Employee #19 and	F 463	3. All staff have been in-serviced on proper protocol to report inoperable defective call bells or call bell cords wrapped around bars. 4. Random audits will be completed by maintenance staff. Results will be presented at the quarterly QA/QI meeting.	11/9/12 Ongoing