Amended on December 20, 2012

An investigation for complaint #30271 and #306497 was completed at Overton County Nursing Home on November 5, 6, and 26, 2012, through December 4, 2012. No deficiencies were cited related to complaint investigation #30271. The investigation determined the facility failed to prevent neglect by not following facility policies for resident change in condition to protect and prevent suicide attempts, failed to notify the physician of verbal statements of and plan for suicide, failed to provide Social Service counseling, failed to revise the care plan with interventions to prevent suicide attempts, failed to provide the necessary care and services to prevent attempted suicide, failed to provide Mental Health Services, failed to administer the facility to identify issues, develop and implement plans of corrective action to ensure the effectiveness of facility systems, for one resident (#1) of thirty-two residents reviewed. The facility's failure placed resident #1 at risk for suicide attempts and resulted in Immediate Jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death).

The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Conference Room on November 28, 2012, at 11:30 a.m.

A partial extended survey was conducted on December 4, 2012.

The Immediate Jeopardy was effective on 12-14-12.
February 25, 2012, through November 29, 2012, and was removed on November 30, 2012. An acceptable allegation of compliance, which removed the immediacy of the Jeopardy, was received and corrective actions were validated by the survey team on November 30, 2012.

Non-compliance continues at "D" and "E" levels for monitoring of corrective actions. The facility is required to submit a plan of correction.

Substandard Quality of Care was cited under F224 J, F250 J, F309 J, and F319 J.

F 157.483.10(b)(11) NOTIFY OF CHANGES
I/J. (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 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
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>X4</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEGAL IDENTIFYING INFORMATION)</th>
<th>X3</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>X2</th>
<th>DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>F 157</strong> Continued from page 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>12/04/2012</strong></td>
</tr>
</tbody>
</table>

**OVERTON COUNTY NURSING HOME**

<table>
<thead>
<tr>
<th>X4</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEGAL IDENTIFYING INFORMATION)</th>
<th>X3</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>X2</th>
<th>DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>F 157</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>12/04/2012</strong></td>
</tr>
</tbody>
</table>

2) On 11/29/12 & 11/30/12, the DON and Nursing Management assessed all other residents’ conditions for any reportable changes in status. No notification needed.

Beginning 12/29/12, monthly in-services will be conducted for 3 months by DON and Nursing Management with all RNs and LPNs on Notification of Physician and Family/POA concerning Resident Changes and Status. The December in-services are scheduled for 12/26/12, 12/27/12, & 12/28/12.

3) On 12/1/12, the DON implemented a process for monitoring of Notification of Physician related to suicidal resident. The monitoring includes: nurses notifying MD, DON, family/POA by phone when any resident is identified as suicidal. This will be recorded in the medical record in nursing notes & transfer forms. The DON will continue monitoring for 3 months and then the OAPI committee will evaluate if continued monitoring is needed.

On 12/1/12, DON and Nursing Management will review monthly suicidal transfers with individual nurse who identifies suicidal resident that was transferred. Discussion of review to include 1) Timely notification of MD, family/POA, and DON 2) Date and time of notification 3) Quality & pertinent documentation. This monitoring will continue for 3 months and then the OAPI committee will evaluate if continued monitoring is needed.

The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Conference Room on November 29, 2012, at 11:30 a.m.
The findings included:

Resident #1 was admitted to the facility from the local hospital on February 10, 2012, with diagnoses including Lack of Coordination; Status/Post Cerebrovascular Accident (CVA, or Stroke); Left-Side Hemiplegia secondary to CVA; History of Depression; Diabetes Mellitus Type II; and Coronary Artery Disease.

Medical record review of the hospital Discharge Summary dated February 10, 2012, revealed, (the resident was) "...significantly disabled...due to a cerebrovascular accident in...2003 which has left (resident) hemiplegic and very poorly coordinated..." and had a history of depression.

Medical record review of the Admission Orders dated February 10, 2012, revealed Xanax at 0.5 mg (used to treat anxiety and panic disorders) by mouth, daily in the morning; and 1 mg at HS (bedtime).

Medical record review of the Nursing Admission Assessment dated February 10, 2012, at 1:00 p.m., revealed the resident's cognition as oriented to person, place, time, and was alert. The resident was able to recall three named objects after five minutes, and was able to understand communication.

Medical record review of a Nurse's Note dated February 15, 2012, at 9:45 a.m., revealed the resident was beginning to exhibit confusion, "...thinks...is going home today...states (spouse) is getting out of the hospital...going home with (spouse)...will monitor."
Medical record review of a Social Service Progress Note dated February 24, 2012, at 1:35 p.m., revealed, "Family told SW (Social Worker) resident called the POA (Power-of-Attorney)...and (resident's spouse) late last night at 10:40 p.m. and made a delusional statement. (Resident) said...would send (resident's sibling) over to (resident's spouse's) home to run off a (spouse's visitor) according to...POA...also stated resident had a hx (history) of making statement(s) wanting to take pills to end (resident's) life...stated (resident) has made these statements to family 1-2 (one-to-two) yrs (years). SW talked to the DON (Director of Nursing) and (contracted Mental Health Service) referral being sent for counseling and Dr. (Physician) notified for medication and instruction. SW spoke to the resident...stated...was concerned about spouse but not thinking of hurting (resident's) self @ (at) this time. (Resident) thinks...spouse has... (someone else) Spouse just (recently) got out of hospital with heart by-pass (heart surgery). SW asked (resident) if (resident) had thoughts of how (resident) would hurt (resident's) self. Resident stated, 'I would use a knife because my family took my guns from me.' SW spoke to DON and nurse on unit. Resident to eat in dining room with plastic spoon and plastic knife for safety measure since (resident) made statement. (Physician) has ordered medications to address depression and anxiety. SW sent (contracted Mental Health Service) referral signed by (Physician) for counseling. SW will continue to monitor and will assist with any needs."

Interview with the SW on November 28, 2012, at 2:45 p.m., in the Conference Room, confirmed,
F 157. Continued From page 5

On February 24, 2012, staff (unable to recall who)
reported the resident had voiced suicidal
ideations. "After I had been told (resident) had
voiced suicidal ideations, I talked with (resident's)
POA...the resident had a history of suicidal
ideations...upon assessing the resident's history,
recent threats of suicide, and current suicidal
ideations with a plan, I want to the Administrator's
office; the DON was there. I talked with the
Administrator and DON; and reported the resident
had suicidal ideations, had a plan, and showed
signs and symptoms of suicide attempt. I feared
the resident would attempt to take or end
(resident's) life. I informed them (Administrator
and DON) the resident needed (local mental
health service) evaluation now. The DON stated,
"This is a safe place... (resident) was irrational,
and when irrational, will not attempt suicide..."
The SW confirmed the Administrator and DON
stated, "You don't understand; it is a safe place
here, and the resident attempting or committing
suicide is not going to happen here." Continued
interview with the SW confirmed plastic
silverware was the only precaution implemented.
When the surveyor asked if mental health
services were provided, the SW confirmed, "An
order was written for (contracted Mental Health
Service) to evaluate but I don't know if it was
done or not." When the surveyor asked if
supportive counseling had been done by the SW,
the SW confirmed, "No; I was waiting on
(contract Mental Health Service) to provide
counseling."

A second interview with the SW, in the presence
of the Administrator, on November 26, 2012, at
6:50 p.m. In the conference room confirmed on
February 24, 2012, the resident's POA informed
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 6</td>
<td>the SW of the resident's history of wanting to take pills to end the resident's life. The SW was told on February 24, 2012, by staff (names unrecalled) the resident had asked questions regarding ending life and/or end of life, including &quot;how to cut-off (resident's) air supply (SW placed hand around SW's throat and described an action of choking self); if insurance would pay if (resident) died.&quot; The SW assessed the resident after the reports on February 24, 2012, and determined the resident had a plan to kill (resident's) self with a knife. The SW reported the assessment and suicidal concerns to the Administrator and DON, on February 24, 2012. The SW confirmed, &quot;...The resident needed to be sent out to (local Mental Health Service provider) for an evaluation...I instructed the unit nurse to call the Physician and get orders for (contracted Mental Health Service) consult and medications for depression and anxiety. Dietary was notified to provide plastic silverware,&quot; The Administrator revealed to be unaware of the (resident's) threat to cut-off (resident's) air supply; the SW revealed, &quot;I thought I told the Administrator.&quot; The Administrator confirmed, &quot;The DON and I felt the (resident) to be in a safe environment and did not feel the resident needed to be sent out...we (Administrator and DON) felt the resident was not a threat of harm to (resident's) self...felt the resident was unable to attempt suicide. Both the SW and Administrator confirmed to be unaware of the resident's suicidal ideations voiced to the spouse on a phone call documented in the nurse's notes on February 25, 2012, at 8:59 p.m. Continued interview confirmed no Mental Health Service consult occurred as ordered on February 24, 2012, and the Physician was not immediately notified by the SW of the assessment and...</td>
<td>F 157</td>
<td>12/04/12</td>
<td></td>
</tr>
</tbody>
</table>
F 157 Continued From page 7

Concerns of suicide.

Medical record review of a Physician's Telephone Order dated February 24, 2012, revealed: 16:15 (3:15 p.m.) "...(contracted Mental Health Service) to eval (evaluate) and treat as indicated..."

Medical record review of a (contracted Mental Health Service) Physician's Order for Mental Health Services, dated February 24, 2012, (no time), revealed the resident was referred for psychotherapy only, with the reasons for the referral documented as the following:

1. Sad;
2. Agitation;
3. Delusions.

Continued review of the referral revealed no documentation of urgency (suicidal ideation) or crisis intervention ordered for this resident. Continued review revealed no documentation of a Mental Health Service evaluation or treatment.

Continued review revealed no documentation of a Mental Health Service evaluation or treatment.

Medical record review of an "Admit Note" dated February 25, 2012, (no time), documented by the Physician, revealed the resident was unable to care for (resident's) self, "particularly with (resident's) declining health." The note revealed the resident "has some delusional thought patterns about (resident's spouse) running off with somebody." The Physician's impression revealed the following:

1. CVA with left-sided hemiparesis;
2. CAD (Coronary Artery Disease) S/P (status post) CABG (Coronary Artery Bypass Graft-a type of surgery that improves blood flow to the heart) with...angina;
3. Type II diabetes mellitus currently on insulin
Continued From page 8

therapy;
4. Chronic atrial fibrillation;
5. Hyperlipidemia.

The Physician’s plan revealed “Continue as per orders at this time.” Continued review of the note revealed no documentation of the resident being at risk of suicide.

Medical record review of a Nurse’s Note dated February 25, 2012, at 9:59 p.m., revealed the resident was on the phone talking to the resident’s spouse, “... (the resident)... talking and getting emotional at (and) crying continuing to state ‘I’ll just end it now.’ (Resident) quickly changes tone and says sorry to (spouse)... This nurse (Licensed Practical Nurse (LPN) #1) spoke with... spouse et assured will keep close watch on Res (resident). Administered PRN Lunesa to help Res sleep. Res calm et polite to staff at this moment. Will cont (continue) to monitor...” Continued review revealed no documentation the physician was notified of the resident’s suicidal ideation.

Medical record review of a Nurse’s Note dated March 3, 2012, at 7:46 p.m., revealed, “This nurse (LPN #2) was coming down the hall and saw resident had a butter knife... trying to stab self in the chest. LPN #2 got knife away from resident... asked (resident) what (resident) was doing. Resident stated, ‘I just wanted to end this...’ LPN #2 notified the Physician on-call; orders were received to send to the (Hospital) Emergency Room (ER) for an evaluation. Continued review revealed the Emergency Medical Service (EMS) arrived at 8:00 p.m., and the resident was transferred from the nursing
Continued From page 9

home at 8:15 p.m.

Medical record review of a Patient Transfer Form dated March 3, 2012, (no time), revealed the resident tried to "stab self in the chest with a butter knife" as the reason for transfer (to the hospital from the nursing home).

Medical record review of an inpatient Mental Health Service Consultation report dated March 4, 2012, revealed, "...saw..." in the middle of the night (on March 3, 2012) from the nursing home after making a suicide gesture...was found sitting in a chair in the hallway with butter knife trying to stab..."self in the chest...they (nursing home staff) were able to get the knife away..." (resident) stated that (resident) was trying to end (resident's) life...sent to (hospital) for evaluation..." The resident was admitted to the hospital's inpatient mental health services program for treatment of diagnoses including depression and suicide gesture.

Review of facility policy, Change in Medical Condition of Residents, (no date) revealed, "...Purpose: To keep the physician...informed of the resident's medical condition...Standard: Notification of the physician...occurs...according to federal regulations, when there is a change in the resident's condition. Change in condition is identified as:...A change in the resident's physical, mental or psychosocial status (i.e., deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications)...need to alter a treatment (i.e., commence a new form of treatment)...

Interview with LPN #1 on November 26, 2012, at
F 157: Continued From page 10
12:17 p.m., in the Conference Room, confirmed, the entry in the nurse's note on February 25, 2012, at 9:59 p.m., was documented by LPN #1. LPN #1 confirmed on the evening of February 25, 2012, the resident called the spouse and was emotional; which ranged from crying and remorse, to anger, then back to crying and remorse. LPN #1 confirmed (resident) said, "I'll just end it now." LPN #1 confirmed, "There are just too many variables here for a resident to be safe if they are suicidal...While (resident) had mood swings and was emotional, I just didn't think (resident) would do something like that (attempt suicide)...and confirmed (LPN #1) failed to immediately or ever notify the Physician of the resident's mood swings, emotional status, and suicidal ideations.

Interview with LPN #2 on November 26, 2012, at 12:50 p.m., in the Conference Room, confirmed, on March 3, 2012, shortly after supper (dinner), LPN #2 was walking out from another resident's room, to the hallway, and observed resident #1 with a knife trying to stab (resident's) self in the chest with the knife. During this interview, while describing the attempt, LPN #2 demonstrated how the resident attempted to stab self in the chest, by hitting (LPN #2) self in the chest repeatedly with a fist above the right hand, and made a forceful thumping sound with each strike of the fist to the chest. "(Resident) was using a metal knife...like the ones that come on the residents' trays for meals. I think (resident) got it off of another resident's tray...I grabbed the knife...I asked 'What are you doing?...' (resident) said, 'I just want to end it...kill myself...finally got the knife from (resident)...(resident) had a tee-shirt and sweat shirt on...I pulled them up to make
F 157: Continued From page 11

I saw no wounds or lacerations... I directed a nearby CNA (Certified Nursing Assistant) to stay with the resident... called Physician, got an order to send to the ER for evaluation, and called the family..." LPN #2 confirmed to know of previous suicidal ideations with the resident, and confirmed, "I do not know what suicide precautions are... I have never been told... I had no idea..." (resident was not placed 1:1 (one staff person providing constant observation of one resident, within reach of that resident) until after the suicide attempt... we were just told to watch (resident) closer and give plastic silverware because of previous suicidal ideations..."

Interview with Physician on November 27, 2012, at 8:00 p.m., in the conference room confirmed the facility did not make the Physician aware of the resident's suicidal ideations, or any plan to commit suicide as documented by the SW on February 24, 2012, or on February 25, 2012. "If the facility had reported the resident to be significantly depressed to the point of suicidal ideations and/or intent with a plan, I would have ordered to send the resident out to the ER for an evaluation immediately."

A second interview with the DON on November 28, 2012, at 1:00 p.m., in the conference room confirmed the Physician was not immediately notified of the concerns of suicide.

Interview with the Administrator on November 28, 2012, at 7:35 p.m., in the conference room confirmed the resident was in a mental health crisis, as identified and reported on February 24, 2012. Continued interview confirmed the resident...
F 157. Continued From page 12

obtained a knife from another resident's tray, which the Administrator confirmed to be a stainless steel dinner knife. Continued interview with the Administrator confirmed the facility failed to follow its policy, Change In Medical Condition of Residents, and immediately notify the Physician of the concerns of suicide.

In summary, the facility failed to immediately notify the Physician when resident #1 had a change in condition; and after being made aware the resident had a history and current threat of suicide. The initial threat was reported to the DON on February 24, 2012, by the POA; and then to the Administrator and DON on February 24, 2012, by the SW. Physician orders were written on February 24, 2012, for the contracted Mental Health Service provider to evaluate and treat as indicated; the evaluation did not occur, and the resident was not treated in the nursing home or on an outpatient basis (until March 3, 2012). Due to the facility's failure to follow facility policies and notify the Physician of the resident in crisis, the resident remained in the facility, obtained a dinner knife from another resident's meal tray during supper and attempted suicide by repeatedly stabbing (resident's) self in the chest on March 3, 2012.

The Immediate Jeopardy was effective from February 25, 2012, through November 28, 2012, and was removed November 30, 2012. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyor through review of documents, staff interviews, and observations conducted onsite on November 30, 2012. The surveyor verified the
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>(X1) Provider/Supplier Identification Number</th>
<th>(X2) Multiple Construction</th>
</tr>
</thead>
<tbody>
<tr>
<td>445419</td>
<td>A. Building</td>
</tr>
<tr>
<td></td>
<td>B. Wing</td>
</tr>
</tbody>
</table>

#### Continued From page 13

- Allegation of compliance by:

  1. Reviewing the facility's in-services records to ensure all staff was educated regarding changes to and implementation of the facility's following policies:
     a. Change in Resident's Condition and Status;
     b. Suicide Threats;
     c. Care of a Suicidal Resident;
     d. Behavioral Management;
     e. Care Planning and Using the Care Plan.

  2. Conducting interviews with facility staff, to include fifteen of thirty-one nurses, three of nine environmental services, one of three maintenance, two of four activities, one of two social services, twenty-nine of fifty-two CNA's, ten of twenty-three dietary, seven of seventeen laundry and housekeeping, on staff to determine the level of comprehension gained through in-service education conducted regarding changes to and implementation of the facility's policies, "Change in Resident's Condition and Status: Suicide Threats; Care of a Suicidal Resident; Behavioral Management; Care Planning and Using the Care Plan," to ensure staff recognize and respond to the following:
     a. A resident making suicide threats or statements are immediately placed 1:1 for constant observation; staff will remain with the resident at all times until (1) the Physician orders the resident transferred for evaluation and admitted to a higher level of care, or (2) the Physician evaluates the resident and deems them safe;
     b. Warning signs of suicide;
     c. Statements and behaviors that may be a warning sign of suicide;
### Statement of Deficiencies and Plan of Correction

#### (x1) Provider/Supplier/IA Identification Number:

445419

#### (x2) Multiple Construction

<table>
<thead>
<tr>
<th>A. Building</th>
<th>B. Wing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### (x3) Date Survey Completed:

C

12/04/2012

---

#### Name of Provider or Supplier:

OVERTON COUNTY NURSING HOME

#### Street Address, City, State, Zip Code:

318 BILBREY STREET

LIVINGSTON, TN 38570

---

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>Identification Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 14</td>
</tr>
</tbody>
</table>

- d. Using probes for more information;
- e. Risk factors for suicide;
- f. Protective factors for suicide;
- g. Restricting access to lethal means and removal of any harmful objects;
- h. Residents at risk of suicide are communicated to all staff via the current Care Plan; Nursing 24-Hour Report; noted on the Medication Administration Record (MAR) and Treatment Administration Record (TAR);
- i. A newly identified resident at risk of suicide will result in a suicide watch, and an emergency department head meeting will be called for immediate discussion.

3. Reviewing the facility’s in-service records with the Social Worker ensuring responsibilities were reviewed.
   - a. A Suicidal Rating Scale has been added to the Social Services Assessment, to be completed on new admissions, quarterly, and with a significant change in condition;
   - b. Social Services is responsible for ensuring the referral source sees the resident and appropriate notes are in the medical record;
   - c. Supportive Counseling;
   - d. Bachelor of Social Work (BSW) Scope of Practice;
   - e. Responsibilities of Social Services;

4. Review of the facility’s contract with the Licensed Master of Social Work (LMSW) to ensure services are contracted to occur on a monthly basis beginning on November 30, 2012.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 15</td>
<td>F 157</td>
<td></td>
<td>12/04/2012</td>
</tr>
</tbody>
</table>

Continued From page 15.

To provide visits ensure oversight of the current SW and compliance with State and Federal Regulations, facility's policies, and Standards of Practice.

5. Reviewing of Suicide Risk Assessments on all residents in the facility. No residents were identified to have suicide risks.

6. Reviewing the new contract with a different Mental Health Services provider, who will be providing weekly services to the facility's residents, as identified and indicated.

7. Reviewing assessments and supportive counseling provided by a contracted BSW with Long Term Care experience. The assessments and supportive counseling was provided to all residents receiving services from a previous contracted Mental Health Services; and new admissions from the past two months were assessed and supportive counseling was provided.

8. An emergency Quality Assurance/Performance Improvement Committee Meeting was held on November 20, 2012, with the Medical Director, DON, Administrator, Consultant, Infection Control Nurse, and two other facility staff to include the Safety Leader.

Non-compliance continues at a "D" level for monitoring corrective actions. The facility is required to submit a plan of correction.

CO 30697

F 224 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN

F 224
The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

- Based on medical record review, review of facility policies, and interview, the facility failed to follow facility policies to provide the necessary services, and prevent neglect for one (1) resident of thirty-two residents reviewed. The facility's failure to follow policies, provide Mental Health Services, and prevent neglect resulted in one resident (1) attempting suicide by stabbing (resident's self) in the chest with a table knife, of thirty-two residents reviewed.

- The facility's failure to ensure policies were followed and interventions were implemented for a resident in crisis resulted in the resident obtaining a dinner knife, and attempting to stab (resident's self) in the chest. Resident #1's attempted suicide on March 3, 2012, required a transfer to the hospital emergency room and admission to a mental health unit for treatment. The facility's failure placed resident #1 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident).

#224 483.13(c) Prohibits Mistreatment/Neglect/Misappropriation of Funds

Resident #1

1) Resident #1 was discharged from facility on 3/3/12.

On 11/29/12, the DON & Administrator reviewed and revised the following policy and procedure:
- Change in Resident's Condition & Status, Care of a Suicidal Resident, Behavior Management, Care Planning, Using Care Plan, & Suicide Threats.

Attachment #12

On 11/29/12 & 11/30/12, mandatory in-services were conducted for all facility staff by Licensed Master Social Worker (LMSW) concerning Recognizing & Responding to the warning signs of suicide, Statements & Behaviors that may be a warning sign, Probes for more Information, Risk Factors for Suicide, Protective factors for Suicide, & Restricting Access to Lethal Means. Also in-services on revised policies: Change in Resident's Condition & Status, Care of a Suicidal Resident, Behavior Management, Care Planning, Using Care Plan, & Suicide Threats.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F224</td>
<td></td>
<td></td>
<td>Continued From page 17</td>
<td>F224</td>
<td></td>
<td></td>
<td>- Notify Director of Nursing Administrator, Physician, Family and/or POA immediately</td>
<td>12-14-12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Conference Room on November 29, 2012, at 11:30 a.m.</td>
<td></td>
<td></td>
<td></td>
<td>- 1:1 Constant Observation started immediately</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>F224 resulted in Substandard Quality of Care.</td>
<td></td>
<td></td>
<td></td>
<td>- Staff will remain with resident at all times until a physician deems them safe or removes 1:1 Observance or the resident is moved to higher level of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The findings included:</td>
<td></td>
<td></td>
<td></td>
<td>- Remove any harmful objects</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resident #1 was admitted to the facility from the local hospital on February 10, 2012, with diagnoses Including Lack of Coordination; Status/Post Cerebrovascular Accident (CVA, or Stroke); Left-Side Hemiplegia secondary to CVA; History of Depression; Diabetes Mellitus Type II; and Coronary Artery Disease.</td>
<td></td>
<td></td>
<td></td>
<td>Residents at Risk for suicide are communicated to all staff via:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medical record review of the hospital Discharge Summary dated February 10, 2012, revealed, (the resident was) &quot;...significantly disabled...due to a cerebrovascular accident in...2009 which has left (resident) hemiplegia and very poorly coordinated...&quot; and had a history of depression.</td>
<td></td>
<td></td>
<td></td>
<td>- Nursing 24 hour Report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medical record review of the Nursing Admission Assessment dated February 10, 2012, at 1:00 p.m., revealed the resident's cognition as oriented to person, place, time, and was alert. The resident was able to recall three named objects after five minutes, and was able to understand communication. The resident required assistance with all physical functioning: two people were required for bed mobility, transfers, toileting and bathing; one person was required for walking/locomotion, dressing, eating and personal hygiene. Eating required the supervised assistance of one person.</td>
<td></td>
<td></td>
<td></td>
<td>- Current Care Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Noted on the Medication Administration Record (MAR) and Treatment Administration Record (TAR)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Suicidal Resident will be communicated via weekly department head meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Suicidal Watch will be issued and emergency Department head meeting called</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Staff not attending mandatory In-services will not be allowed to work until they have attended the in-service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2) On 11/29/12, the DON, Supervisors, MDS RN conducted Suicide Risk Assessments on all residents within the facility [census 106]. No residents were identified to have suicide thoughts or behaviors.</td>
<td></td>
</tr>
</tbody>
</table>
**F 224** Continued From page 16

Medical record review of a Nurse's Note dated February 15, 2012, at 9:45 a.m., revealed the resident was beginning to exhibit confusion, "...thinks...is going home today...states (spouse) is getting out of the hospital...going home with (spouse)...will monitor."

Medical record review of the Social Service Progress Notes revealed no documentation the Social Worker (SW) assessed the resident's confusion and/or provided interventions to determine the cause of the resident's confusion on February 15, 2012, at 9:45 a.m.

Medical record review of a Social Service Progress Note dated February 24, 2012, at 1:35 p.m., revealed, "Family told SW (Social Worker) resident called the POA (Power-of-Attorney)...and (resident's spouse) late last night at 10:40 p.m. and made a delusional statement. (Resident said)...would send (resident's sibling) over to (resident's spouse's) home to run off a (spouse's visitor) according to...POA...also stated resident had a fix (history) of making statements wanting to take pills to end (resident's life)...stated (resident) has made these statements to family 1-2 (one-to-two) yrs (years). SW talked to the DON (Director of Nursing) and (contracted Mental Health Services) referral being sent for counseling and Dr. (Physician) notified for medication and instruction. SW spoke to the resident...stated...was concerned about spouse but not thinking of hurting (resident's self) at (at) this time. (Resident) thinks...spouse has... (someone else)...Spouse just (recently) got out of hospital with heart by-pass (heart surgery), SW asked (resident) if (resident) had thoughts of how (resident) would hurt (resident's self). Resident F 224 On 11/30/12, all residents with documented behaviors, receiving services from a previous contracted Mental Health Service, and new admissions from past 2 months were assessed and supportive counseling provided by a contracted BSW and LMSW with Long Term Care experience.

Effective 11/30/12, a Suicidal Rating Scale has been added to the Social Services Assessment for New Admissions and Quarterly assessments. [See Attached]

Beginning 11/30/12, a new contracted Mental Health Services will replace previous Mental Health Services and they will be providing weekly services to the facility. [See Attached]

Beginning 12/1/12, monthly in-services will be conducted for 3 months by facility's Mental Health Provider with all facility staff on Abuse, Neglect, Misappropriation of Funds, Care of Suicidal Resident, and Behavior Management. Staff not attending the above in-service will not be allowed to work until they have attended the in-service.

3) On 12/1/12, the DON & Nursing Management will monitor all referrals to Mental Health Services for Timely referrals, Date seen, Documentation on chart & Frequency of visits. This monitoring will continue for 6 months and then the OAPI committee will evaluate if continued monitoring is needed.

On 12/1/12, the Administrator assigned the responsibility for completing the Suicidal Rating
FE 224: "Continued From page 19" stated, "I would use a knife because my family took my guns from me." SW spoke to DON and nurse on unit. Resident to eat in dining room with plastic spoon and plastic knife for safety measure since (resident) made statement. (Physician) has ordered medications to address depression and anxiety. SW sent (contracted Mental Health Services) referral signed by (Physician) for counseling. SW will continue to monitor and will assist with any needs. Continued review of the SW notes revealed no further monitoring or assistance during the remainder of the resident's admission at the nursing home.

Medical record review of a Physician's Telephone Order dated February 24, 2012, revealed: 1515 (3:15 p.m.) "... (contracted Mental Health Services) to eva (evaluate) and treat as indicated..." Medical record review of a (contracted Mental Health Services) Physician's Order for Mental Health Services, dated February 24, 2012, revealed: the resident was referred for psychotherapy only, with the reasons for the referral documented as the following:
1. Sad;
2. Agitation;
3. Delusions.

Continued review of the referral revealed no documentation of urgency or crisis intervention ordered for this resident.

Medical record review of an "Admit Note" dated February 26, 2012, revealed that the Physician, reviewed the resident was unable to care for (resident's) self, "particularly with..."
F 224: Continued From page 20
(resident's) declining health." The note revealed the resident "has some delusional thought patterns about (resident's spouse) running off with somebody." The Physician's impression revealed the following:
1. CVA with left-sided hemiparesis;
2. CAD (Coronary Artery Disease) S/P (status post) CABG (Coronary Artery Bypass Graft)-a type of surgery that improves blood flow to the heart with...angina;
3. Type II diabetes mellitus currently on insulin therapy;
4. Chronic atrial fibrillation;
5. Hyperlipidemia.

The Physician's plan revealed "Continue as per orders at this time." Continued review of the note revealed no documentation of the resident being at risk of suicide.

Medical record review of a Nurse's Note dated February 25, 2012, at 9:38 p.m., revealed the resident was on the phone talking to the resident's spouse, "...[the resident)...talking and getting emotional et (and) crying continuously to state 'I'll just end it now.' (Resident) quickly changes tone at says sorry to (spouse)...This nurse (Licensed Practical Nurse (LPN) #1) spoke with...spouse and assured me to keep close watch on Res (resident). Administered PRN Lunesta to help Res sleep. Res calm ex pectile to staff at this moment. Will cont (continue) to monitor..."

Medical record review revealed no other interventions for the resident's threat of suicide.

Medical record review of a Nurse's Note dated March 3, 2012, at 7:43 p.m., revealed, "This nurse (LPN #2) was coming down the hall and..."
F 224: Continued From page 21

saw resident had a butter knife...trying to stab self in the chest. LPN #2 got knife away from resident...asked (resident) what (resident) was doing. Resident stated, "I just wanted to end this...". Continued review revealed a Certified Nursing Assistant (CNA) was assigned to stay with the resident. LPN #2 notified the Physician on-call; orders were received to send to the Hospital Emergency Room (ER) for an evaluation. The resident's POA was also notified. Continued review revealed the Emergency Medical Service (EMS) arrived at 8:00 a.m., and the resident was transferred from the nursing home at 9:15 p.m.

Medical record review of a Patient Transfer Form dated March 3, 2012, (no time), revealed the resident tried to "stab self in the chest with a butter knife" as the reason for transfer (to the hospital from the nursing home).

Medical record review of an Inpatient Psychiatric Consultation report dated March 4, 2012, revealed, "...sent over in the middle of the night (on March 3, 2012) from the nursing home after making a suicide gesture...was found sitting in a chair in the hallway with butter knife trying to stab...self in the chest...they (nursing home staff) were able to get the knife away... (resident) stated that (resident) was trying to end (resident) life...sent to (hospital) for evaluation...". The resident was admitted to the hospital's inpatient mental health services program for treatment of diagnoses including depression and suicide gesture.

Review of facility policy, Suicide Assessment and Intervention Practice, (no data) revealed,
**OVERTON COUNTY NURSING HOME**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
318 BILBREY STREET
LIVINGSTON, TN 38570

<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USD IDENTIFYING INFORMATION)</th>
</tr>
</thead>
</table>
| F 224 | Continued From page 22

"Purpose: To maintain safety of individual residents while receiving services in this facility... Standard: Residents who display characteristics of suicidal ideation will be evaluated for risk of self harm and intent to inflict self harm (does the resident have a plan?)...if intent is implied, then monitor for safety (keep resident within eyesight at all times) and notify MD (Physician) and resident’s family...Process: 1. Remove means of harming self or other from resident. 2. Assess resident for actual harm to self/others and follow up as indicated. 3. Resident will be kept within eyesight of staff at all times...until family arrives or resident is sent out of facility..."

Review of facility policy, Suicide Prevention, (no date) revealed, "...Identifying Potential for Suicide Attempt...a) Identify resident at high risk...place on suicide precautions...b) Designate staff to closely observe at all times..." Continued review revealed no policy for suicide precautions.

Interview with the Administrator and DON on November 26, 2012, at approximately 11:25 a.m., in the Conference Room, confirmed the resident did attempt suicide. The Administrator confirmed, "I felt like the suicide threats were threats only. I did not believe (resident) would attempt suicide, or could attempt suicide... (resident) obtained a regular stainless steel dinner knife and tried to stab (resident’s) self in the chest. I knew the resident from before, from a previous admission... I just did not believe (resident) would attempt suicide. I can’t recall the specific date of the initial threat, but yes, the SW reported the threat to me and the DON, That’s when we implemented the plastic silverware. We..."
Continued From page 23

(Administrator and DON) didn't put the resident on one-on-one (1:1) observations (one staff person providing constant observation of one resident, and within reach of that resident) because we felt the threat wasn't real." The DON confirmed the Administrator's statements were correct, and I have told multiple people, staff and the resident's siblings, the resident is in a safe place and nothing could happen. We (DON and Administrator) didn't implement 1:1 because we felt (resident) was safe and the threat was not real.

Interview with LPN #1 on November 26, 2012, at 12:17 p.m., in the Conference Room, confirmed, the entry in the nurse's note on February 25, 2012, at 9:59 p.m., was documented by LPN #1. LPN #1 confirmed on the evening of February 26, 2012, the resident called the spouse and was emotional; which ranged from crying and remorse, to anger, then back to crying and remorse. LPN #1 confirmed (resident) said, "I'll just end it now," and LPN #1 told the spouse (resident) would be watched closer. LPN #1 confirmed the resident did have periods of no observation, such as when the staff were providing care to other residents, and/or when staff were in the bathroom, or away from the particular area where the resident was positioned (nurse's station, hallway, and so on). "There are just too many variables here for a resident to be safe if they are suicidal...While (resident) had mood swings and was emotional, I just didn't think (resident) would do something like that (attempt suicide)..."

Interview with LPN #2 on November 26, 2012, at 12:50 p.m., in the Conference Room, confirmed
<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>(X1) Provider/Supplier/Unit Identification Number</th>
<th>(X2) Multiple Construction</th>
<th>(X3) Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overton County Nursing Home</td>
<td>456419</td>
<td>A. Building</td>
<td>C</td>
</tr>
<tr>
<td>Street Address, City, State, Zip Code</td>
<td>318 Bilberry Street</td>
<td>Livingston, TN 38570</td>
<td>12/04/2012</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>(X5) PREFIX</th>
<th>(X6) TAG</th>
<th>(X7) ID</th>
<th>(X8) PREFIX</th>
<th>(X9) TAG</th>
<th>(X10) Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>(X11) Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 224</td>
<td>Continued From page 24</td>
<td></td>
<td>F 224</td>
<td></td>
<td></td>
<td></td>
<td>12-14-12</td>
</tr>
</tbody>
</table>

F 224: On March 3, 2012, shortly after supper (dinner), LPN #2 was walking out from another resident's room, to the hallway, and observed resident #1 with a knife trying to stab (resident's) self in the chest with the knife. During this interview, while describing the attempt, LPN #2 demonstrated how the resident attempted to stab self in the chest, by hitting (LPN #2's) self in the chest repeatedly with a fistful right hand, and made a forceful thumping sound with each strike of the fist to the chest. "(Resident) was using a metal knife...like the ones that come on the residents' trays for meals... I think (resident) get it off another resident's tray...I grabbed the knife...I asked 'what are you doing?'... (resident) said, 'I just want to end it...kill myself...finally got the knife from (resident)... (resident) had a tee-shirt and sweatshirt on... I pulled them up to make sure... saw no wounds or lacerations... I directed a nearby CNA to stay with (resident)... called Physician, got an order to send to the ER for evaluation, and called the family..." LPN #2 confirmed to know of previous suicidal ideations with the resident, and confirmed, "I do not know what suicide precautions are... I have never been told... I had no idea... (resident) was not placed 1:1 until after the suicide attempt... we (staff) were just told to watch (resident) closer and give plastic silverware because of previous suicidal ideations." LPN #2 confirmed, "Watch closer meant to keep in common areas... a hallway or at nurse's station." LPN #2 confirmed there were times when other residents were being cared for and resident #1 was not being observed by any staff.

Interview with CNA #2 on November 27, 2012, at 8:45 p.m., in the conference room confirmed CNA.
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>ID</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 224</td>
<td>Continued from page 25</td>
<td>F 224</td>
<td></td>
</tr>
</tbody>
</table>

#2 worked on March 3, 2012, on the 2:00 p.m.-10:00 p.m. shift, and was assigned to the dining room for supper. "During dining room assignment, you assist, feed, and observe for choking and swallowing difficulties...you watch everybody (residents). During supper on March 3, 2012, there were seven residents with three tables in use in the dining room. Six residents were seated at two of the tables, with three per table; and one resident required to be fed, at the third table. I sat at the table with the one resident that had to be fed. There were two other CNAs (no longer employed at the facility), which had passed trays and were feeding residents on the hall...(LPN #2) was at the desk (Wing 4 nurse's station) charting. My focus was on the resident I was feeding (not resident #1). I was unable to continuously watch any one resident...(Resident #1) was seated at a table with two other residents. After supper, I transported (resident #1) to the nurse's station straight across the hall from the dining room on Wing 4, and then proceeded down the hall to pick up trays. The other two CNAs were in different rooms picking up trays, and (LPN #2) may have been on the hall somewhere answering a call light...As I came out from room number 56 (near the end of the hall), I looked up and heard (LPN #2) say, 'I need some help down here.' I ran to assist (LPN #2)...Resident #1 had a metal knife in (resident's) right hand...was repeatedly stabbing (resident's) chest with the knife and yelling, 'I'm going to kill myself...I'm going to kill myself.' (LPN #2) was struggling with (resident) to get the knife, as (resident) was going at it...stabbing at (resident's) chest...By the time I reached (LPN #2) and the resident, (LPN #2) had removed the knife from the resident. (LPN #2) asked me, 'Where did...
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| F 224 | Continued From page 26 | (resident) got this knife? I said, 'I don't know.' I thought about it, and I realized (resident #1) had gotten the knife from another resident seated at (resident #1)'s table during supper and I said, 'Oh, not (Resident #1) got the knife off of (random resident)'s tray,...I looked at (resident's) chest immediately...It had multiple red, dime-size areas but, no lacerations or stab wounds. (LPN #2) assigned me to stay 1:1 with (resident #1)...I stayed at (resident's) bedside until EMS (Emergency Medical Services), arrived. (Resident) previously made multiple statements...wanted to kill (resident's) self, and wanted to die." CNA #2 confirmed these statements were made prior to March 3, 2012, but, could not recall the dates, or date of onset, "I tried to encourage (resident) everyday...I just never dreamed (resident) would try to kill (resident's) self."

Interview with the SW on November 26, 2012, at 2:45 p.m. In the Conference Room, confirmed, on February 24, 2012, staff (unable to recall who) reported the resident had voiced suicidal ideations. "After I had been told (resident) had voiced suicidal ideations, I talked with (resident's) POA...the resident had a history of suicidal ideations...upon assessing the resident's history, recent threats of suicide, and current suicidal ideations with a plan, I went to the Administrator's office; the DON was there. I talked with the Administrator and DON; and reported the resident had suicidal ideations, had a plan, and showed signs and symptoms of suicide attempt. I feared the resident would attempt to take or end (resident's) life. I informed them (Administrator and DON) the resident needed (local mental health service) evaluation now. The DON stated,
P 224. Continued From page 27

"This is a safe place... (resident) was irrational, and when irrational, will not attempt suicide."
The SW confirmed the Administrator and DON stated, "You don't understand; it is a safe place here, and the resident attempting or committing suicide is not going to happen here." Continued interview with the SW confirmed plastic silverware was the only precaution implemented. When the surveyor asked if mental health services were provided, the SW confirmed, "An order was written for (contracted Mental Health Services) to evaluate but I don't know if it was done or not." When the surveyor asked if supportive counseling had been done by the SW, the SW confirmed, "No; I was waiting on (contracted Mental Health Services) to provide counseling." When the surveyor asked the SW who is responsible for arranging and tracking Psychiatric referrals, the SW replied, "I am."

Telephone interview on November 26, 2012, at approximately 3:30 p.m., with the (contracted Mental Health Service Provider's) Compliance Officer and Director of Business Development confirmed the Physician's Order for Mental Health Services, dated February 24, 2012, (no time) was received on February 24, 2012, via fax (facsimile). Continued interview confirmed the referral did not indicate a crisis situation (urgent, stat (immediately), or suicidal). "A clinician went to the facility to evaluate the resident on March 5, 2012; the resident was in the hospital and no treatment was provided."

A second interview with the SW, in the presence of the Administrator, on November 26, 2012, at 6:50 p.m., in the conference room confirmed on February 24, 2012, the resident's POA informed
F 224 Continued from page 28
the SW of the resident's history of wanting to take
pills to end the resident's life. The SW was told
on February 24, 2012, by staff (names
unrecalled) the resident had asked questions
regarding ending life and/or end of life, including
"how to cut-off (resident's) air supply (SW placed
hand around SW's throat and described an action
of choking self); if insurance would pay if
(resident) died." The SW assessed the resident
after the reports on February 24, 2012, and
determined the resident had a plan to kill
(resident's) self with a knife. The SW reported
the assessment and suicidal concerns to the
Administrator and DON on February 24, 2012.
The SW confirmed, "...The resident needed to be
sent out to (local mental health service) for a
psychiatric evaluation...I instructed the unit nurse
to call the Physician and get orders for
(contracted Mental Health Services) consult and
medications for depression and anxiety. Dietary
was notified to provide plastic silverware." The
Administrator revealed to be unaware of the
(resident's) threat to cut-off (resident's) air supply;
the SW revealed, "I thought I told the
Administrator." The Administrator confirmed,
"The DON and I felt the (resident) to be in a safe
environment and did not feel the resident needed
to be sent out...we (Administrator and DON) felt
the resident was not a threat of harm to
(resident's) self...felt the resident was unable to
attempt suicide. Both the SW and Administrator
confirmed to be unaware of the resident's suicidal
ideas voiced to the spouse on a phone call
documented in the nurse's notes on February 25,
2012, at 9:59 p.m. Continued interview confirmed
no psychiatric consult occurred as ordered on
February 24, 2012.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Overton County Nursing Home

**Address:** 218 Billaire Street, Livingston, TN 38570

**Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information):**

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
<th>Providers Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
</tr>
</thead>
</table>
| F 224     |     | Continued From page 29

Interview with CNA #1 on November 27, 2012, at 5:26 p.m., in the conference room confirmed to recall the resident talked about ending (resident's) life one night (unable to recall date). "I told (resident) not to talk like that...still had family and not to talk like that." CNA #1 confirmed to report the resident's threat to a nurse but could not recall when or who the nurse was.

Interview with Physician on November 27, 2012, at 6:00 p.m., in the conference room confirmed the facility did not make the Physician aware of the resident's depressed state, or any suicidal ideations, or any plan as documented by the SW on February 24, 2012, or on February 25, 2012. "If the facility had reported the resident to be significantly depressed or suicidal ideations and/or intent with a plan, I would have ordered to send the resident to the ER for an evaluation immediately. No medications were ordered on February 24, 2012, for depression or anxiety, or at any other time during the resident's admission at the nursing home. The Xanax was a previous medication...was taking prior to admission (to the nursing home). I was not aware the resident was required to use plastic silverware to prevent self-harm."

A second interview with the DON on November 28, 2012, at 1:00 p.m., in the conference room confirmed, the initial threat of suicide was reported to the DON by the POA on February 24, 2012, prior to meeting with the Administrator and SW about resident #1. "The POA and I were at the Wing 4 Nurse's Station; and we discussed the resident's anxiety and threats of suicidal ideation due to having to be admitted (to the nursing
Continued From page 30

home) on February 10, 2012, During this conversation, staff was present at the desk...I think it was a nurse, CNA, and possibly the SW...can't recall which nurse and CNA...I reassured the staff and the POA the resident was in a safe place and nothing could happen. The SW proceeded to assess the resident, and then met with me and the Administrator...SW reported to us (DON and Administrator) the resident had a history of wanting to end (resident's) life, cut off air supply (choke self), inquired about life insurance, and a plan to use a knife to kill (resident's) self...SW reported to us (DON and Administrator) the resident needed to be sent out for a psych (Mental Health Services) eval..."

Continued Interview confirmed the resident was not placed on 1:1 observation, and to "watch closer" did not mean the resident would be under constant supervision. The DON confirmed the Physician was not immediately notified of the SW's assessment or the concerns of suicide.

Interview with the SW on November 28, 2012, at 4:30 p.m., in the conference room confirmed, "...The resident voiced, wanted to die, how would kill...self, with a knife. (Resident) was depressed and suicidal...all of my bells and whistles...going off. The SW confirmed, "I strongly felt (resident) needed to go out for an eval." Continued Interview confirmed, the SW failed to ensure the following for the resident (#1);

- In crisis: failed to follow Social Services policies;
- Failed to in-service facility staff on related Social Services policies;
- Failed to provide medically-related social services and supportive counseling;
- Failed to review the resident's individual care plan regarding risk of suicide; and
- Failed to provide facility education on the...
F 224: Continued From page 31

Resident’s required plan of care regarding risk of suicide. “Most of the facility staff is unaware of what suicide precautions and precautions are. Oh, I know very well what they are and I know this (attempted suicide) was about to happen.”

Interview with the Administrator on November 28, 2012, at 7:35 p.m., in the conference room confirmed the facility’s neglect to follow policies, provide Mental Health Services, and lack of interventions, allowed the resident to obtain a dinner knife, and then carried out an attempted suicide (by stabbing self repeatedly in the chest) on March 3, 2012.

In summary, the facility neglected resident #1 after being made aware the resident had a history and current threat of suicide. The initial threat was reported to the DON on February 24, 2012, by the POA; and then to the Administrator and DON on February 24, 2012, by the SW. Physician orders were written on February 24, 2012, for the contracted Mental Health Services provider to evaluate and treat as indicated; the evaluation did not occur, and the resident was not treated in the nursing home or on an outpatient basis (until March 3, 2012). Due to the facility’s neglect of the resident in crisis, the failure to follow facility policies and implement interventions, the resident obtained a dinner knife from another resident’s meal tray during supper and attempted suicide by repeatedly stabbing (resident’s) self in the chest on March 3, 2012.

The Immediate Jeopardy was effective from February 25, 2012, through November 29, 2012, and was removed on November 30, 2012. An Acceptable Allegation of Compliance, which
F 224. Continued From page 32

1. Reviewing the facility's in-service records to ensure all staff were educated regarding changes to and implementation of the facility's following policies:
   a. Change in Resident's Condition and Status;
   b. Suicide Threats;
   c. Care of a Suicidal Resident;
   d. Behavioral Management;
   e. Care Planning and Using the Care Plan.

2. Conducting interviews with facility staff, to include fifteen of thirty-one nurses, three of nine environmental services, one of three maintenance, two of four activities, one of two social services, twenty-nine of fifty-two CNA's, ten of twenty-three dietary, seven of seventeen laundry and housekeeping, on staff to determine the level of comprehension gained through in-service education conducted regarding changes to and implementation of the facility's policies, "Change in Resident's Condition and Status; Suicide Threats; Care of a Suicidal Resident; Behavioral Management; Care Planning and Using the Care Plan," to ensure staff recognize and respond to the following:
   a. A resident making suicide threats or statements are immediately placed 1:1 for constant observation; staff will remain with the resident at all times until (1) the Physician orders the resident transferred for evaluation and admitted to a higher level of care, or (2) the
F 224. Continued From page 33

Physician evaluates the resident and deems them safe;

a. Warning signs of suicide;

b. Statements and behaviors that may be a warning sign of suicide;

c. Using probes for more information;

d. Risk factors for suicide;

e. Protective factors for suicide;

f. Restricting access to lethal means and removal of any harmful objects.

g. Residents at risk of suicide are communicated to all staff via the current Care Plan, Nursing 24-Hour Report, noted on the Medication Administration Record (MAR) and Treatment Administration Record (TAR);

h. Residents at risk of suicide are discussed weekly in the department head meetings.

1. A newly identified resident at risk of suicide will result in a suicide watch, and an emergency department head meeting will be called for immediate discussion.

2. Reviewing the facility's In-service records with the Social Worker ensuring responsibilities were reviewed and clarified, to include the following:

a. A Suicidal Rating Scale has been added to the Social Services Assessment, to be completed on new admissions, quarterly, and with a significant change in condition;

b. Social Services is responsible for ensuring the referral source sees the resident and responding/appropriate notes are in the medical record;

c. Supportive Counseling;

d. Bachelor of Social Work (BSW) Scope of Practice;

e. Responsibilities of Social Services;

F 224 | 3-14-12
4. Review of the facility’s contract with the Licensed Master of Social Work (LMSW) to ensure services are contracted to occur on a monthly basis beginning on November 30, 2012, to provide visits, ensure oversight of the current SW, and compliance with State and Federal Regulations, facility’s policies, and Standards of Practice.

5. Reviewing of Suicide Risk Assessments on all residents in the facility. No residents were identified to have suicide risks.

6. Reviewing the new contract with a different Mental Health Services provider, who will be providing weekly services to the facility’s residents, as identified and indicated.

7. Reviewing assessments and supportive counseling provided by a contracted BSW with Long Term Care experience. The assessments and supportive counseling was provided to all residents receiving services from a previous contracted Mental Health Services; and new admissions from the past two months were assessed and supportive counseling was provided.

8. An emergency Quality Assurance/Performance Improvement Committee Meeting was held on November 30, 2012, with the Medical Director, DON, Administrator, Consultant, Infection Control Nurse, and two other facility staff to include the Safety Leader.

Non-compliance continues at a “C” level for monitoring corrective actions. The facility is...
| ID | PREP FX | TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID | PREP FX | TAG | PROVIDERS PLAN OR CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY) | COMPLNCE DATE |
|---|---|---|---|---|---|---|---|---|---|
| F 224 | Continued From page 35 required to submit a plan of correction. | F 224 | F250 483.15(g)(1) Provision of medically necessary related social service | 12-14-12 |
| CO #30697 | F 250 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE | F 250 | Provision of medically necessary related social service | | |
| | The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. | | Resident #1 | | |
| | This REQUIREMENT is not met as evidenced by: | | J) On 11/30/12, the Administrator & RN Consultant reviewed with the Social Services employee her responsibilities, referral process, assessment requirement, supportive counseling as defined in BSW scope of practice, new policy for suicide rating scale, and federal regulation for social services. | | |
| | Based on medical record review, review of facility policies, observation, and interview, the facility failed to follow facility policies and provide medically-related social services for four (#1, #27, #16, #17) residents of thirty-two residents reviewed. The facility's failure to ensure policies were followed and medically-related social services were provided for a resident in crisis beginning on February 28, 2012, resulted in the resident obtaining a dinner knife, and attempting to stab (resident #1's) self in the chest. Resident #1's attempted suicide on March 3, 2012, required a transfer to the hospital emergency room and admission to a mental health unit for treatment. The facility's failure placed resident #1 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). | | Attachment #6 | |
| | The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the | | On 11/29/12 & 11/30/12, mandatory in-services were conducted by a Licensed Master Social Worker (LMSW) with all facility staff concerning Recognizing and Responding to the Warning Signs of Suicide, Statements & Behaviors that may be a warning sign, Probes for more information, Risk Factors for Suicide, Protective factors for suicide, & Restricting Access to Lethal Means. Also, in-services on revised policies Change in Resident's Condition & Status, Care of a Suicidal Resident, Behavior Management, Care Planning, Using Care Plan, & Suicide Threats. | | Attachment #7 | |
| | | | Effective 11/30/12, the Administrator contracted with LMSW to provide a monthly visit to ensure compliance with state & federal regulation, Standard of Practice, & review the BSW Documentation. | | |
**F 250** Continued From page 36

Conference Room on November 29, 2012, at 11:30 a.m.

F250 resulted in Substandard Quality of Care.

The findings included:

- Resident #1 was admitted to the facility from the local hospital on February 10, 2012, with diagnoses including Lack of Coordination; Status/Post Cerebrovascular Accident (CVA, or Stroke); Left-Side Hemiplegia secondary to CVA; History of Depression; Diabetes Mellitus Type II; and Coronary Artery Disease.

  Medical record review of the hospital Discharge Summary dated February 10, 2012, revealed, (the resident was) "...significantly disabled...due to a cerebrovascular accident in...2009 which has left (resident) hemiplegic and very poorly coordinated..." and had a history of depression.

  Medical record review of the Admission Orders dated February 10, 2012, revealed Xanax 0.5 mg (used to treat anxiety and panic disorders) by mouth, daily in the morning, and 1 mg at HS.

  Medical record review of the Nursing Admission Assessment dated February 10, 2012, at 1:00 p.m., revealed the resident's cognition as oriented to person, place, time, and was alert. The resident was able to recall three named objects after five minutes, and was able to understand communication.

  Medical record review of a Nurse's Note dated February 15, 2012, at 9:45 a.m., revealed the resident was beginning to exhibit confusion.

  On 12/10/12, the Administrator increased the working hours of LMSW to complete assessments on new admissions, Quarterly Assessments, & oversight of supportive counseling by social service staff.

  2) On 11/30/12, all residents with documented behaviors, receiving services from a previous contracted Mental Health Service, and new admissions from past 2 months were assessed and supportive counseling provided by a contracted BSW and LMSW with Long Term Care experience.

  Attachment #2

  On 11/29/12, the DON, Supervisors, MDS RN conducted Suicide Risk Assessments on all residents within the facility (census 105). No residents were identified to have suicide thoughts or behaviors.

  Attachment #3

  Effective 11/30/12, a Suicidal Rating Scale has been added to the Social Services Assessment for New Admissions and Quarterly assessments.

  Attachment #4

  Beginning 11/30/12, a new contracted Mental Health Services will replace previous Mental Health Services and they will be providing weekly services to the facility.
**OVERTON COUNTY NURSING HOME**

<table>
<thead>
<tr>
<th><strong>ID PREFIX TAG</strong></th>
<th><strong>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISD IDENTIFYING INFORMATION)</strong></th>
<th><strong>ID PREFIX TAG</strong></th>
<th><strong>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</strong></th>
<th><strong>COMPLETION DATE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>F 250</td>
<td>&quot;...thinks...is going home today...states (spouse) is getting out of the hospital...going home with (spouse)...will monitor.&quot;</td>
<td>F 250</td>
<td>3) On 12/5/12, the DON &amp; Nursing Management will monitor all referrals to Mental Health Services for Timely referrals, Date seen, Documentation on chart &amp; Frequency of visits. This monitoring will continue for 6 months &amp; then the QAPI committee will evaluate if continued monitoring is needed.</td>
<td>12-14-12</td>
</tr>
</tbody>
</table>

Medical record review of the Social Service Progress Notes revealed no documentation the Social Worker (SW) assessed the resident's confusion and/or provided interventions to determine the cause of the resident's confusion on February 15, 2012, at 9:45 a.m.

Medical record review of a Social Service Progress Note dated February 24, 2012, at 1:35 p.m., revealed, "Family told SW (Social Worker) resident called the POA (Power-of-Attorney)... and (resident's spouse) late last night at 10:40 p.m., and made a delusional statement. (Resident) said...would send (resident's sibling) over to (resident's spouse's) home to run off a (spouse's visitor) according to...POA...also stated resident had a hx (history) of making statements wanting to take pills to end (resident's) life...stated (resident) has made these statements to family 1-2 (one-to-two) yrs (years). SW talked to the DON (Director of Nursing) and (contracted Mental Health Service) referral being sent for counseling and Dr. (Physician #1) notified for medication and instruction. SW spoke to the resident...stated...was concerned about spouse but not thinking of hurting (resident's) self @ (at) this time. (Resident) thinks...spouse has... (someone else)...Spouse just (recently) got out of hospital with heart by-pass (heart surgery). SW asked (resident) if (resident) thought of how (resident) would hurt (resident's) self. Resident stated, 'I would use a knife because my family took my guns from me,' SW spoke to DON and nurse on unit. Resident to eat in dining room with..."
Continued From page 38
plastic spoon and plastic knife for safety measure since (resident) made statement. (Physician #1) has ordered medications to address depression and anxiety. SW sent (contracted Mental Health Service) referral signed by (Physician #1) for counseling. SW will continue to monitor and will assist with any needs. Continued review of the SW notes revealed no supportive counseling due to the resident's concerns of the spouse having someone else, history of suicidal ideation, or the plan to use a knife to hurt the resident's self. Continued review revealed no documentation of the SW providing any medically-related social services during the resident's admission at the nursing home.

Medical record review of a (contracted Mental Health Services) Physician's Order for Mental Health Services, dated February 24, 2012, (no time), revealed the resident was referred for psychotherapy only, with the reasons for the referral documented as the following:
1. Sed;
2. Agitation;
3. Delusions.

Continued review of the referral revealed no documentation of urgency or crisis intervention ordered for this resident.

Medical record review of an "Admit Note" dated February 25, 2012, (no time), documented by the Physician #1, revealed the resident was unable to care for (resident's) self, "particularly with (resident's) declining health." The note revealed the resident "has some delusional thought patterns about (resident's) spouse running off with somebody." The Physician's impression weekly visits X 3 months for counseling.

12/14/12 Documentation of visits will be recorded in the medical record.

On 11/30/12, the Administrator & RN Consultant reviewed with the Social Services employee her responsibilities, referral process, assessment requirement, supportive counseling as defined in BSW scope of practice, new policy for suicide rating scale, and federal regulation for social services.

On 11/30/12 & 11/30/12, mandatory in-services were conducted by a Licensed Master Social Worker (LMSW) with all facility staff concerning Behavior Management.

Effective 11/30/12, the Administrator contracted with LMSW to provide a monthly visit to ensure compliance with state & federal regulation, Standard of Practice, & review the BSW Documentation.

On 12/10/12, the Administrator increased the working hours of LMSW to complete assessments on new admissions, Quarterly Assessments, & oversight of supportive counseling by social service staff.

2) On 11/30/12, all residents with documented behaviors, receiving services from a previous contracted Mental Health Service, and new admissions from past 2 months were assessed and supportive counseling provided by a contracted BSW and LMSW with Long Term Care experience.

On 12/12/12, Geropsych Nurse Practitioner evaluated & assessed medications for needed changes.
F 250  Continued From pge 39

revealed the following:
1. CVA with left-sided hemiparesis;
2. CAD (Coronary Artery Disease) S/P (status post) CABG (Coronary Artery Bypass Graft—a type of surgery that improves blood flow to the heart) with...angina;
3. Type II diabetes mellitus currently on insulin therapy;
4. Chronic atrial fibrillation;
5. Hyperlipidemia.

The Physician's plan revealed "Continue as per orders at this time." Continued review of the note revealed no documentation of the resident being at risk of suicide, and/or collaboration with the SW.

Medical record review of a Nurse's Note dated February 25, 2012, at 9:59 p.m., revealed the resident was on the phone calling to the resident's spouse, "...(the resident)...talking and getting emotional at (and) crying continuing to state 'I'll just end it now.' (Resident) quickly changes tone et says sorry to (spouse)... This nurse (Licensed Practical Nurse (LPN) #1) spoke with...spouse at assured will keep close watch on Res (resident). Administered PRN Lunesta to help Res sleep. Res calm at polite to staff at this moment. Will cont (continue) to monitor..." Continued review revealed no documentation of the type of monitoring to be done or the frequency.

Medical record review of the Social Service Progress Notes revealed no documentation the SW assessed the resident's suicidal ideations and/or provided interventions to address the

F 250  Beginning 11/30/12, a new contracted Mental Health Services will replace previous Mental Health Services and they will be providing weekly services to the facility.

3) On 12/1/12, the LMSW will identify residents needing supportive counseling & will provide a list of those residents to the Administrator by 12/10/12. LMSW will provide the Administrator a monthly list of residents who have had a supportive counseling visit with a documented note by the end of each month for a period of 3 months.

4) Beginning 12/14/12, the Administrator will report to the QAPI Quarterly committee meetings the outcomes of the monitoring of supportive counseling and ultimately the Administrator will report to the Board quarterly. An emergency QAPI committee meeting was held on 11/30/12 with the Medical Director, DON, Administrator, RN Consultant, Infection Control Nurse and 2 other facility staff to include safety. A QAPI committee meeting was held on 12/14/12. A January meeting is scheduled for 1/17/13.
Continued From page 40

suicidal ideations.

Medical record review of a Nurse’s Note dated March 3, 2012, at 7:45 p.m., revealed, “This nurse (LPN #2) was coming down the hall and saw resident had a butter knife...trying to stab self in the chest. (LPN #2) got knife away from resident...asked (resident) what (resident) was doing. Resident stated, ‘I just wanted to end this...’” Continued review revealed a Certified Nursing Aide (CNA) was assigned to stay with the resident. LPN #2 notified the Physician on-call; orders were received to send to the (Hospital) Emergency Room (ER) for an evaluation. The resident's POA was also notified.

Continued review revealed the Emergency Medical Service (EMS) arrived at 8:00 p.m., and the resident was transferred from the nursing home at 8:15 p.m.

Medical record review of a Patient Transfer Form dated March 3, 2012, (no time), revealed the resident tried to “stab self in the chest with a butter knife” as the reason for transfer (to the hospital from the nursing home).

Medical record review of the Social Service Progress Notes revealed no documentation of the resident's attempted suicide on March 3, 2012, until March 6, 2012; which was two days after the resident was admitted to the hospital inpatient mental health services program for treatment of diagnoses including depression and suicide gesture.

Medical record review of an Inpatient Psychiatric Consultation report dated March 4, 2012, revealed, “...sent over in the middle of the night.

Residents #17 & #31

1) On 11/30/12, the Administrator & RN Consultant reviewed with the Social Services employee her responsibilities, referral process, assessment requirements, supporting Counsel as defined in BSW scope of practice, new policy for Suicide Rating Scale, and federal regulation for social services.

Effective 11/30/12, the Administrator contracted with LMSW to provide a monthly visit to ensure compliance with state & federal regulations, Standard of Practice, & review the BSW Documentation.

On 12/10/12, the Administrator increased the working hours of LMSW to complete assessments on new admissions, Quarterly Assessments, & oversight of supportive counseling by social service staff, and identifying psychosocial needs.

2) On 11/30/12, all residents with documented behaviors, receiving services from a previous contracted Mental Health Service, and new admissions from past 2 months were assessed and supportive counseling provided by a contracted BSW and LMSW with Long Term Care experience.

3) On 12/1/12, the LMSW will identify residents needing supportive counseling & will provide a list of those residents to the Administrator by 12/10/12. LMSW will provide the Administrator a monthly list of residents who have had a supportive counseling visit with a documented note by the end of each month for a period of 3 months.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
<th>MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>445419</td>
<td>A BUILDING</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
<th>DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>315 BILBRY STREET LIVINGSTON, TN 38570</td>
<td>12/04/2012</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F250</td>
<td></td>
<td></td>
<td>Continued from page 41</td>
<td>4) Beginning 12/14/12, the Administrator will report to the QAPI Quarterly committee. Meetings the outcomes of the monitoring of supportive counseling and ultimately the Administrator will report to the Board quarterly. An emergency QAPI committee meeting was held on 11/30/12 with the Medical Director, DON, Administrator, RN Consultant, Infection Control Nurse and 2 other facility staff to include safety. A QAPI committee meeting was held on 12/14/12. A January meeting is scheduled for 1/17/13.</td>
<td>12/14/12</td>
</tr>
</tbody>
</table>

Review of facility policy, Social Services, revised December 2008 revealed, "Our facility provides medically-related social services to ensure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being...1. The Social Services Staff is responsible for: a. Consultation with other departments regarding...planning...and prioritization of social services...Consultation to allied professional: health personnel regarding provisions for the emotional needs of the resident. 2. Medically-related social services is provided to maintain or improve each resident's ability to control everyday...mental and psychosocial needs (e.g., coping abilities...). 3. Factors that have a potentially negative effect on psychosocial functioning include...c. Problems in coping with grief...i.e. Presence of progressive, chronic disabling condition...g. Behavioral problems (i.e., confusion, anxiety, depressed mood...). 4. The social services department is responsible for...b. Identifying individual emotional needs; c. Assisting in providing corrective action for the resident's needs by developing and maintaining individualized care plan; d. Maintaining...
regular processes and follow-up notes indicating
the resident's response to the plan...i.e. making
supportive visits to the residents and performing
needed services...i.e. participating in
interdisciplinary staff conferences, providing
social services information to ensure treatment of
the...emotional needs of the resident as part of
the total care plan..."

Review of facility policy, Referrals, Social
Services, revised December 2006, revealed, "...1.
Social services shall coordinate resident
referrals...3. Social services will collaborate with
nursing staff or other pertinent disciplines to
arrange for services that have been ordered by
the physician...4. Social services will...ensure
adequate follow-up with appropriate
documentation from referral source..."

Interview with LPN #2 on November 26, 2012, at
12:50 p.m., in the Conference Room, confirmed
on March 3, 2012, shortly after supper (dinner),
LPN #2 was walking out from another resident's
room, to the hallway, and observed resident #1
with a knife trying to stab (resident's) self in the
chest with the knife. During this interview, while
describing the attempt, LPN #2 demonstrated
how the resident attempted to stab self in the
chest, by hitting (LPN #2's) self in the chest
repeatedly with a fist like right hand, and made a
forceful thumping sound with each strike of the
fist to the chest. "(Resident) was using a metal
knife...like the ones that come on the residents'
trays for meals, I think (resident) got it off of
another resident's tray...I grabbed the knife...I
asked 'what are you doing'...(resident) said, 'I
just want to end it...kill myself'...finally got the
knife from (resident)...(resident) had a tea-shirt
FO 250 Continued From page 43

and sweats shirt on...I pulled them up to make
sure...saw no wounds or lacerations...I directed a

nearby CNA to stay with (resident), called

Physician, got an order to send to the ER for
evaluation, and called the family..." LPN #2

confirmed to know of previous suicidal ideations

with the resident, and confirmed, "I do not know

what suicidal precautions are...I have never been
told...I had no idea... (resident) was not placed 1:1

until after the suicide attempt...we (staff) were just
told to watch (resident) closer and give plastic

silverware because of previous suicidal

ideations..." LPN #2 confirmed, "Watch closer

meant to keep in common areas...a hallway or at

nurse’s station..." LPN #2 confirmed there were
times when other residents were being cared for

and resident #1 was not being observed by any

staff.

Interview with CNA #2 on November 27, 2012, at

6:45 p.m., in the conference room confirmed CNA

#2 worked on March 3, 2012, on the 2:00

p.m.-10:00 p.m. shift; and was assigned to the
dining room for supper. "...After supper, I

transported (resident #1) to the nurse’s station

straight across the hall from the dining room on

Wing 4, and then proceeded down the hall to pick

up trays...As I came out from room number 85

(near the end of the hall), I looked up and heard

(LP N #2) say, ‘I need some help down here.’ I

ran to assist (LPN #2)...Resident #1 had a metal

knife in (residents) right hand...was repeatedly

stabbing (resident)’s chest with the knife and

yelling, ‘I’m going to kill myself...I’m going to kill

myself.’ (LPN #2) was struggling with (resident)
to get the knife, as (resident) was going at

it...stabbing at (resident)’s chest...By the time I

reached (LPN #2) and the resident, (LPN #2) had
OVERTON COUNTY NURSING HOME

<table>
<thead>
<tr>
<th>ID</th>
<th>PREMISES</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 250</td>
<td>Continued From page 44</td>
<td></td>
<td>removed the knife from the resident...I realized (resident #1) had gotten the knife from another resident seated at (resident #1's) table during supper and I said, 'Oh, no! (Resident #1) got the knife off of (random resident's) tray...I opened at (resident's) chest immediately...It had multiple red, dime-sized areas but no lacerations or stab wounds. (LPN #2) assigned me to stay 1:1 with (resident #1)...I stayed at (resident's) bedside until EMS (Emergency Medical Services), arrived. (Resident) previously made multiple statements...wanted to kill (resident's) self, and wanted to die.' CNA #2 confirmed these statements were made prior to March 5, 2012, but, could not recall the dates, or date of onset. &quot;I tried to encourage (resident) everyday...I just never dreamed (resident) would try to kill (resident's) self.&quot;</td>
<td>F 250</td>
<td></td>
<td></td>
<td></td>
<td>12-14-12</td>
</tr>
</tbody>
</table>

Interview with the SW on November 28, 2012, at 2:45 p.m., in the Conference Room, confirmed, on February 24, 2012, staff (unable to recall who) reported the resident had voiced suicidal ideations. "After had been told (resident) had voiced suicidal ideations, I talked with (resident's) POA...the resident had a history of suicidal ideations...upon assessing the resident's history, recent threats of suicide, and current suicidal ideations with a plan, I went to the Administrator's office; the DON was there. I talked with the Administrator and DON; and reported the resident had suicidal ideations, had a plan, and showed signs and symptoms of suicide attempt. I feared the resident would attempt to take or end (resident's) life. Continued interview with the SW confirmed plastic silverware was the only precaution implemented. When the surveyor asked if mental health services were provided,
**NAME OF PROVIDER OR SUPPLIER**
OVERTON COUNTY NURSING HOME

**STREET ADDRESS, CITY, STATE, ZIP CODE**
345 BILBREY STREET
LIVINGSTON, TN 38570

<table>
<thead>
<tr>
<th>ID</th>
<th>PREVIEW TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLIANCE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 250</td>
<td>Continued From page 45 the SW confirmed, &quot;An order was written for (contracted Mental Health Service) to evaluate but I don't know if it was done or not.&quot; When the surveyor asked if supportive counseling had been done by the SW, the SW confirmed, &quot;No, I was waiting on (contracted Mental Health Service) to provide counseling.&quot; When the surveyor asked the SW who is responsible for arranging and tracking Psychiatric referrals, the SW replied, &quot;I am.&quot; Telephone conference interview on November 26, 2012, at approximately 3:30 p.m., with the (contracted Mental Health Service's) Compliance Officer and Director of Business Development confirmed the Physician's Order for Mental Health Services, dated February 24, 2012, (no time), was received on February 24, 2012, via fax (facsimile). Continued interview confirmed the referral did not indicate a crisis situation (urgent, stat (immediately), or suicidal). &quot;A clinician went to the facility to evaluate the resident on March 5, 2012; the resident was in the hospital and no treatment was provided.&quot; A second interview with the SW, in the presence of the Administrator, on November 26, 2012, at 6:50 p.m., in the conference room confirmed on February 24, 2012, the resident's PIA informed the SW of the resident's history of wanting to take pills to end the resident's life. The SW was told on February 24, 2012, by staff (names unrecalled) the resident had asked questions regarding ending life and/or end of life, including &quot;how to cut-off (resident's) air supply (SW placed hand around SW's throat and described an action of choking self); if insurance would pay if (resident) died.&quot; The SW assessed the resident.</td>
<td>F 250</td>
<td>12-4-12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID TAG</td>
<td>PROVIDER-SUPPLIER/CLAUSION IDENTIFICATION NUMBERS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>445419</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

OVERTON COUNTY NURSING HOME

**STREET ADDRESS, CITY, STATE, ZIP CODE**

319 BILBREY STREET
LIVINGSTON, TN 38570

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 250</td>
<td>Continued From page 48</td>
</tr>
</tbody>
</table>

after the reports on February 24, 2012, and
determined the resident had a plan to kill
(resident's) self with a knife. The SW reported
the assessment and suicidal concerns to the
Administrator and DON, on February 24, 2012.
The SW confirmed, "...The resident needed to be
sent out to (local mental health service) for a
psychiatric evaluation....I instructed the unit nurse
to call the Physician and get orders for
(contracted Mental Health Service) consult and
medications for depression and anxiety.
Continued interview with the SW confirmed no
Mental Health Service consult occurred as
ordered on February 24, 2012.

Interview with Physician #1 on November 27,
2012, at 8:00 p.m., in the conference room
confirmed the facility did not make the Physician
aware of the resident's depressed state, or any
suicidal ideations, or any plan as documented by
the SW on February 24, 2012. "If the facility had
reported the resident to be significantly
depressed to the point of suicidal ideations and/or
intent with a plan, I would have ordered to send
the resident out to the ER for an evaluation
immediately,...I was not aware the resident was
required to use plastic silverware to prevent
self-harm."

A second interview with CNA #2 on November 27,
2012, at 10:15 p.m., in the conference room
confirmed "...I was never told or educated on
what to do when a resident threatened to harm
themselves or wished to die. Nobody ever told
me why (resident #1) had plastic silverware. I
never asked and I never really thought about
why...I'm doing the best I can...I had no idea what
to look for...I've not had psych (psychiatric)
Interview with the SW on November 28, 2012, at 4:30 p.m., in the conference room confirmed, "...The resident voiced... wanted to die...how would kill...self, with a knife. (Resident) was depressed and suicidal...all of my bills and whistles...going off. The SW confirmed, "I strongly felt (resident) needed to go out for an eval." Continued interview confirmed, the SW failed to ensure the following for the resident (#1) in crisis: failed to follow Social Services policies; failed to in-service facility staff on related Social Services policies; failed to follow-up on any orders for new medications or medication changes for the resident's depression and/or anxiety; failed to provide medically-related social services and supportive counseling; failed to revise the resident's individual care plan regarding risk of suicide; and failed to provide facility education on the resident's required plan of care regarding risk of suicide. "Most of the facility staff is unaware of what suicide prevention and precautions are. Oh, I know very well what they are and I know this (attempted suicide) was about to happen."

Interview with the Administrator on November 28, 2012, at 7:35 p.m., in the conference room, confirmed the SW failed to follow Social Services policies; and failed to ensure medically-related Social Services were provided to the resident (#1) in crisis. The facility's failure to ensure policies were followed and medically-related social services were provided for a resident (#1) in crisis beginning on February 24, 2012, resulted in the resident obtaining a dinner knife, and attempts to
<table>
<thead>
<tr>
<th>F 250</th>
<th>Continued From page 48</th>
</tr>
</thead>
<tbody>
<tr>
<td>stab (resident #1's) self in the chest.</td>
<td></td>
</tr>
</tbody>
</table>

Resident #27 was admitted to the facility March 24, 2012, with diagnoses including Depression, Anxiety, and Alzheimer's Disease.

Medical record review of a Quarterly Minimum Data Set (MDS) dated September 17, 2012, revealed the resident scored zero on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition; and exhibited feeling or appearing down, depressed, or hopeless nearly every day.

Medical record review of the Physician's Recapitulation Orders dated November 2012, revealed "...Alprazolam (Xanax-for anxiety), Tako 1 (one) tablet By MOUTH 3 (three) times daily AT 5:00 AM (a.m.); AT 1:00 PM (p.m.); AT 9:00 PM; Start Date: 07/30/2012 (July 30, 2012)...DX: INCREASED ANXIETY/ (and; or) CRYING." (Prior to the routine order dated July 30, 2012, the Alprazolam was ordered as needed).

Medical record review of the Nurse's Notes, revealed:
June 29, 2012, at 12:10 a.m. "...Resident crying, turning on light (call light). Xanax given..."
July 2, 2012, at 10:30 p.m. "...Res (resident) given Xanax dt (due to) anxiety up, crying..."
July 5, 2012, at 2:15 p.m. "...crying...Xanax...po (by mouth)..."
July 7, 2012, at 10:00 a.m. "...Res @ times has increased anxiety...Xanax...administered...cries easily..."
July 8, 2012, at 2:00 p.m. "...Res with increased anxiety crying uncontrollably...Xanax...for agitation..."
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Overton County Nursing Home  
**Street Address, City, State, Zip Code:** 318 Bilbrey Street, Livingston, TN 38570

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 250</td>
<td></td>
<td>Continued from page 49</td>
<td></td>
<td></td>
<td>12-14-12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>July 9, 2012, at 3:00 p.m. &quot;Res lying in bed rocking back &amp; forth crying. (Spouse) unable to redirect. This nurse admin. (administered). Xanax...Res less anxious when told medication would help (resident) to calm down...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>July 13, 2012, at 2:15 p.m. &quot;Res crying &amp; agitated says, 'Help me, Help me.' Xanax...admin...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>July 18, 2012, at 12:07 p.m. &quot;Res crying cont (continuously)...Xanax give (given)...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>July 20, 2012, at 11:20 p.m. &quot;Repeatedly turning on call light...Xanax...dit increased anxiety...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>July 30, 2012, at 10:32 a.m. &quot;Res in bad crying cont asking for 'help &amp; nurse' over &amp; over again...August 3, 2012, (no time). &quot;...Res cries a lot...&quot; September 6, 2012, at 9:40 a.m. &quot;...episodes of crying with Xanax...administered...&quot; September 20, 2012, at 8:00 a.m. &quot;Res in bad crying on &amp; off...&quot; October 4, 2012, at 8:40 a.m. &quot;...Res has episodes of crying at (and) stating 'Nurse, Nurse help me' repeatedly...&quot; October 18, 2012, (no time). &quot;...res verbal of wants and needs...&quot; November 7, 2012, at 8:00 a.m. &quot;Continues to cry @ times...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical record review of the Nurse's Monthly Summary dated July 3, 2012; August 3, 2012; September 1, 2012; October 2, 2012; and November 3, 2012; revealed the consistent presence of mood symptoms, which included &quot;Little interest or pleasure in doing things...Feeling or appearing down, depressed, or hopeless...Feeling tired or having little energy...Indicates that s/he (she or he) feels bad about self, is a failure, or has let family down...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID PREFIX</td>
<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX</td>
<td>TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
<tr>
<td>-----------</td>
<td>-----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-----</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| F 250     |     | Medical record review of the Physician's Progress notes revealed: August 30, 2012, (no time). "Pt (patient) is crying today..." October 30, 2012, (no time). "...is crying...continues to have crying spells." Medical record review of the Social Service Progress Notes, dated June 21, 2012, at 5:10 p.m., revealed "Annual Note:...Resident cries often according to...(spouse)..." Continued review revealed no documentation the SW provided supportive counseling or emotional support for depression and multiple episodes of anxiety and crying. Continued review revealed no documentation the SW collaborated with the Physician or any other facility staff to provide in-house or outside Mental Health Services. Observation of the resident and interview, on November 30, 2012, at 6:30 p.m., in the resident's room confirmed the resident was lying in bed, with the television on. During the beginning of the interview the resident began to cry. The surveyor asked the resident what was wrong and the resident answered, "I want to go home." The surveyor validated the resident missed being at home. The resident confirmed the validation, and continued to cry. Tears rolled from the resident's eyes, and down both sides of the face. The surveyor commented regarding the spouse's daily visits, and the resident confirmed, "Yes, but, (spouse) is only here a few hours during the day." Surveyor asked the resident what the resident enjoyed most when the spouse visited, and the resident confirmed, "Watching TV (television)." By this time during the interview, the

12-14-12
<table>
<thead>
<tr>
<th>X4</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PREPARED PLAN OF CORRECTION</th>
<th>COMPLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 250</td>
<td>Continued From page 81</td>
<td>F 250</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>resident's crying decreased, and then stopped.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>As the interview ended and the surveyor turned to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>leave the room, the resident began to cry again.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interview with the SW on November 26, 2012, at</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4:30 p.m., in the conference room confirmed the</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SW failed to follow Social Services policies; and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>failed to provide medically-related social services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and supportive counseling for resident #27.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resident #16 was admitted to the facility on April</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>19, 2012, with diagnoses including Depression,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anxiety, Psychosis, and Dementia.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical record review of a Quarterly Minimum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Set (MDS) dated October 27, 2012,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>revealed the resident scored zarp on the Brief</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interview for Mental Status (BIMS), indicating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>severely impaired cognition.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical record review of a (contracted)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychology Progress Note dated June 29, 2012,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>revealed, during the treatment session, the</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>resident exhibited sadness, hopelessness, and was</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>fearful. The resident's depression was ongoing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>with intermittent periods of anxiety but the</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>cognitive status wavered. The resident was</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>discharged from therapy services due to poor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>cognition; and &quot;...informed social service...of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>plan...&quot; Behavioral suggestions for staff:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;...consider soothing patient with a security</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>object...when the patient is fearful or</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>agitated...redirecting to calming...such as quiet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>music or comfort objects when...exhibits general</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| | agitation..."

Medical record review of the Nurses Notes and Daily Skilled Nurses Notes revealed:
Continued from page 52

July 31, 2012, at 1:00 a.m. “...was given...Alvan...anxiety and restlessness...”
August 2, 2012, (night shift). “...Anxious...”
August 4, 2012, at 2:15 a.m. “...Alvan was administered d/l anxiety and restlessness...”
August 5, 2012, at 6:20 a.m. “Resident was very anxious (anxious) at 4:30 AM...Alvan administered...”
August 8, 24, and 31, 2012, (night shift); August 9, 17, and 23, 2012, (day shift). “...Anxious...”
September 1, 3, and 5, 2012, (day shift). “...Anxious...”

September 7, 2012, at 9:20 AM “...Res states 'I want out of here'...depressed...”
September 8 and 14, 2012, (night shift). “...Anxious...”
September 9 and 12, 2012, (day shift). “...Anxious...”

Medical record review of the Social Service Progress Notes, dated July 9, 2012, through November 13, 2012, revealed no documentation the SW provided support or interventions to meet the psychosocial needs of the resident.

Interview with the SW on November 28, 2012, at 4:30 p.m., in the conference room confirmed the SW failed to follow Social Services policies; and failed to provide medically-related social services and supportive counseling for resident #18.

Resident #17 was admitted to the facility on August 18, 2011, with diagnoses including Depression, Right Above the Knee Amputee, and Peripheral Vascular Disease.

Medical record review of a Quarterly Minimum
Data Set (MDS) dated May 27, 2012, revealed the resident scored fifteen on the Brief Interview for Mental Status (BIMS), indicating the resident’s cognition was intact.

Medical record review of a Psychology Progress Note dated June 29, 2012, revealed the resident’s diagnosis included:

- Adjustment disorder with mixed disturbance of emotions and conduct...
- Depression, and
- Anxiety... symptoms presented are significant enough to interfere with the patient's psychosocial well-being...
- Chronic sad mood...
- With supportive reassurance, pt. slowly with brief gaps of silence...
- Verbalized feelings of sadness and worry...
- Pt. continues with s/s (signs and symptoms) of depression that are negatively impacting...
- Health status including lack of motivation, tearfulness, and general agitation toward issues (resident) cannot change...
- Based on current status, progress and need, counseling will continue for approximately 9-11 (nine to eleven) weeks...

Planned Session Frequency: 2-3mo (two-to-three sessions per month)...

Behavioral Suggestions to Staff:... consider providing positive support and understanding...” This session was the last session provided by the contracted Mental Health Service provider, and/or any Mental Health Service provider.

Medical record review of a Nurse's Note dated July 27, 2012, at 3:00 p.m., revealed “...not happy about going home next week... Staff reported that Res stated to them... was going to do everything... can do to make sure... won't have to leave... Staff stated while working with (resident), Res attempted to throw (resident’s) self backwards, so (resident) would fall but they...
Continued From page 54

were able to keep (resident) upright. Res was also trying to kick prosthetic leg off but was pulling all...weight...on...staff...

Medical record review of the Social Service Progress Notes revealed no documentation the SW provided assessment and/or interventions to address the resident's inability to cope with loss of function due to the amputation of the right leg; difficulty with prosthetic adjustment; the need for physical and emotional support; and difficulty with the planned discharge to home with the daughter. Continued review of the progress notes revealed the resident was discharged home (with daughter) on July 31, 2012.

Interview with the SW on November 28, 2012, at 4:30 p.m., in the conference room confirmed the SW failed to follow Social Services policies; and failed to provide medically-related social services and supportive counseling for resident #17.

Interview with the Administrator on November 28, 2012, at 7:35 p.m., in the conference room confirmed the SW failed to follow Social Services policies; and failed to provide medically-related social services and supportive counseling for residents #27, #16, and #17.

In summary, the facility failed to provide medically-related social services to resident #1 after being made aware the resident had a history and current threat of suicide. The initial threat was reported to the DON on February 24, 2012, by the POA; and then to the Administrator and DON on February 24, 2012, by the SW. Physician orders were written on February 24, 2012, for the contracted Mental Health Service
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID** | **PREFIX** | **TAG** | **SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | **ID** | **PREFIX** | **TAG** | **PROVIDERS PLAN OF CORRECTION** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | **COMPLETION DATE**

| F 250 | | | Continued From page 55 | | | | 12-14-12 |

The Immediate Jeopardy was effective from February 25, 2012, through November 29, 2012, and was removed on November 30, 2012. An Acceptable Allegation of Noncompliance, which removed the immediate jeopardy, was received and corrective actions were validated by the surveyed through review of documents, staff interviews, and observations conducted onsite on November 30, 2012. The surveyed verified the allegation of compliance by:

1. Reviewing the corrective action implemented for the SW.

2. Reviewing the facility's in-service records to ensure all staff were educated regarding changes.
### Statement of Deficiencies and Plan of Correction

#### (X) Providers/Suppliers:

<table>
<thead>
<tr>
<th>Identification Number</th>
<th>ID Prefix</th>
<th>Tag</th>
<th>Providers’ Plan of Correction (Each deficient action should be cross-referenced to the appropriate deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>446419</td>
<td>ID Prefix</td>
<td>Tag</td>
<td>Provider’s Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</td>
</tr>
</tbody>
</table>

#### Overton County Nursing Home

- **Name of Provider or Supplier:** Overton County Nursing Home
- **Address:** 318 Eubrey Street, Livingston, TN 38570

#### Summary Statement of Deficiencies

(F) 250 Continued from page 56

- To and implementation of the facility's following policies:
  - a. Change in Resident’s Condition and Status;
  - b. Suicide Threats;
  - c. Care of a Suicidal Resident;
  - d. Behavioral Management;
  - e. Care Planning and Using the Care Plan.

- 3. Conducting interviews with facility departments, to include fifteen of thirty-one nurses, three of nine environmental services, one of three maintenance, two of four activities, one of two social services, twenty-nine of fifty-two CNA’s, ten of twenty-three dietary, seven of seventeen laundry and housekeeping, on staff to determine the level of comprehension gained through in-service education conducted regarding changes to and implementation of the facility's policies, "Change in Resident’s Condition and Status; Suicide Threats; Care of a Suicidal Resident; Behavioral Management; Care Planning and Using the Care Plan;" to ensure staff recognizes and respond to the following:
  - a. A resident making suicide threats or statements are immediately placed 1:1 for constant observation; staff will remain with the resident at all times until (1) the Physician orders the resident transferred for evaluation and admitted to a higher level of care, or (2) the Physician evaluates the resident and deems them safe;
  - b. Warning signs of suicide;
  - c. Statements and behaviors that may be a warning sign of suicide;
  - d. Using probes for more information;
  - e. Risk factors for suicide;
  - f. Protective factors for suicide;
  - g. Restricting access to lethal means and
### F 250

Continued From page 57

- **g.** Residents at risk of suicide are communicated to all staff via the current Care Plan; Nursing 24-Hour Report; noted on the Medication Administration Record (MAR) and Treatment Administration Record (TAR);
- **h.** Residents at risk of suicide are discussed weekly in the department head meetings.
- **i.** A newly identified resident at risk of suicide will result in a suicide watch, and an emergency department head meeting will be called for immediate discussion.

4. Reviewing the facility's in-service records with the Social Worker ensuring responsibilities were reviewed and clarified, to include the following:
   - **a.** A Suicidal Rating Scale has been added to the Social Service Assessment; to be completed on new admissions, quarterly, and with a significant change in condition;
   - **b.** Social Services is responsible for ensuring the referral source sees the resident and responding/appropriate notes are in the medical record;
   - **c.** Supportive Counseling;
   - **d.** Bachelor of Social Work (BSW) Scope of Practice;
   - **e.** Responsibilities of Social Services;
   - **f.** Federal Regulations.

5. Review of the facility's contract with the Licensed Master of Social Work (LMSW) to ensure services are contracted to occur on a monthly basis beginning on November 30, 2012, to provide visits, ensure oversight of the current SW, and compliance with State and Federal Regulations, facility's policies, and Standards of Practice.
F 260 Continued From page 58

6. Reviewing of Suicide Risk Assessments on all residents in the facility. No residents were identified to have suicide risks.

7. Reviewing the new contract with a different Mental Health Service provider, who will be providing weekly services to the facility's residents, as identified and indicated.

8. Reviewing assessments and supportive counseling provided by a contracted BSW with Long Term Care experience. The assessments and supportive counseling was provided to all residents receiving services from a previous contracted Mental Health Service provider; and new admissions from the past two months were assessed and supportive counseling was provided.

9. An emergency Quality Assurance/Performance Improvement Committee Meeting was held on November 30, 2012, with the Medical Director, DON, Administrator, Consultant, Infection Control Nurse, and two other facility staff to include the Safety Leader.

Non-compliance continues at an "E" level for monitoring corrective actions. The facility is required to submit a plan of correction.

CO #30697

F 280 483.20(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
F 280 Continued From page 59

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 interdisciplin ary team, that includes the attending 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 medical record review, review of facility policies, and interview, the facility failed to follow facility policies and failed to revise the care plan with interventions to protect and prevent suicide attempts for one (#1) resident of thirty-two residents reviewed. The facility's failure to follow policies, and revise the care plan resulted in one resident (#1) attempting suicide by stabbing (resident's self) in the chest with a table knife, of thirty-two residents reviewed.

The facility's failure to ensure policies were followed and revise the care plan with interventions to prevent suicide attempts resulted in the resident obtaining a dinner knife and attempting to stab (resident's self) in the chest. Resident #1's attempted suicide on March 3.

Resident # 1

1) On 11/30/12, the Administrator & RN Consultant in-serviced the MDS staff on comprehensive care plan and updating the care plan. On 12/1/12, RN #2 was counseled by Administrator & RN Consultant in regard to altering care plan.

Attachment #4

2) On 12/4/12 - 12/5/12, care plans were reviewed by the DON and Nurse Management and were revised as needed. The DON communicated changes in the care plan by memo to all RNs, LPNs, and CNAs on 12/6/12.

3) The MDS staff will monitor all MDS assessments and care plans for appropriate data and interventions beginning 12/9/12. The DON will review four assessments and four care plans per month for correct data, appropriate and timely interventions. All suicidal resident care plans will be reviewed by the DON. This monitoring will be done for 6 months & then as needed to ensure compliance has been achieved.

Attachment #7
**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier Identification Number:** 445419

**Multiple Construction:**
A. Building
B. Wing

**Date Survey Completed:** 12/04/2012

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Providers Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F280</td>
<td>Continued from page 80</td>
<td>2012, required a transfer to the hospital emergency room and admission to a mental health unit for treatment. The facility's failure placed resident #1 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident).</td>
<td></td>
<td>12/04/2012</td>
</tr>
</tbody>
</table>

The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Conference Room on November 29, 2012, at 11:30 a.m.

The findings included:

- Resident #1 was admitted to the facility from the local hospital on February 10, 2012, with diagnoses including Lack of Coordination; Status/Post Cerebrovascular Accident (CVA, or Stroke); Left-Side Hemiplegia secondary to CVA; History of Depression; Diabetes Mellitus Type II; and Coronary Artery Disease.

Medical record review of the hospital Discharge Summary dated February 10, 2012, revealed, (the resident was) "...significantly disabled...due to a cerebrovascular accident...2003 which has left (resident) hemiplegic and very poorly coordinated..." and had a history of depression.

Medical record review of a Social Service Progress Note dated February 24, 2012, at 1:35 p.m., revealed, "Family told SW (Social Worker) resident called the POA (Power-of-Attorney)...and (resident's spouse) late last night at 10:40 p.m., and made a delusional statement. (Resident) said...would send (resident's sibling) over to..."
(resident's spouse's) home to run off a (spouse's visitor) according to...POA...also stated resident had a hx (history) of making statement(s) wanting to take pills to end (resident's) life...stated (resident) has made these statements to family 1-2 (one-two) yrs (years). SW talked to the DON (Director of Nursing) and (contracted Mental Health Service) referral being sent for counseling and Dr. (Physician) notified for medication and instruction. SW spoke to the resident...stated...was concerned about spouse but not thinking of hurting (resident's) self @ (at) this time. (Resident) thinks...spouse has... (someone else)...Spouse just (recently) get out of hospital with heart by-pass (heart surgery). SW asked (resident) if (resident) had thoughts of how (resident) would hurt (resident's) self. (Resident) stated, "I would use a knife because my family took my guns from me." SW spoke to DON and nurse on unit. Resident to eat in dining room with plastic spoon and plastic knife for safety measure since (resident) made statement. (Physician) has ordered medications to address depression and anxiety. SW sent (contracted Mental Health Service) referral signed by (Physician) for counseling. SW will continue to monitor and will assist with any needs."

Medical record review of an electronically printed Care Plan, revealed a handwritten entry: (Problem) "2-24-12, (February 24, 2012) Risk for harm to self AEB (as evidenced by HX (history) of statements of wanting to end life." (Goal) "No Harm to resident per self thru 5-13-12, (May 13, 2012)"

(Approaches) *Meds (medications) as ordered per MD (Medical Doctor); Psychiatric Services/Counseling (Mental Health Services..."
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 62</td>
<td>(Each deficiency must be preceded by full regulatory or JSC identifying information)</td>
<td>F 280</td>
<td></td>
<td></td>
<td>(Each corrective action should be cross-referenced to the appropriate deficiency)</td>
<td></td>
</tr>
</tbody>
</table>

F 280: Continued From page 62

and/or Counseling); Plastic utensils at meals for safety; Social Worker to monitor and assist c (with) needs. (emotional); Observe for possible adverse reactions to meds.

Medical record review of a Nurse’s Note dated February 25, 2012, at 9:59 p.m., revealed the resident was on the phone talking to the resident’s spouse, “... (the resident) talking and getting emotional (and) crying continuing to state 'I'll just end it now.' (Resident) quickly changes tone and says sorry to (spouse).... This nurse (Licensed Practical Nurse (LPN) #1) spoke with...spouse to assure will keep close watch on Res (resident). Administered PRN Lunesta to help Res sleep. Res calm at polite to staff at this moment. Will cont (continue) to monitor...

Continued review revealed no documentation of the type of monitoring to be done or the frequency, or revision to the care plan,

Medical record review of the Care Plan revealed no documentation the Care Plan was revised with interventions (approaches) to protect and prevent suicide attempts by the resident.

Medical record review of a Nurse’s Note dated March 3, 2012, at 7:45 p.m., revealed, "This nurse (LPN #2) was coming down the hall and saw resident had a butter knife... trying to stab self in the chest. (LPN #2) got knife away from resident... asked (resident) what (resident) was doing. Resident stated, ‘I just wanted to end this...’ continued review revealed a Certified Nursing Assistant (CNA) was assigned to stay with the resident. LPN #2 notified the Physician on-call; orders were received to send to the (Hospitl) Emergency Room (ER) for an
F 280. Continued From page 63

- Evaluation. The resident’s POA was also notified.
- Continued review revealed the Emergency Medical Service (EMS) arrived at 6:00 p.m., and the resident was transferred from the nursing home at 8:15 p.m.

- Medical record review of a Patient Transfer Form dated March 9, 2012, (no time), revealed the resident tried to "stab self in the chest with a butter knife" as the reason for transfer to the hospital from the nursing home.

- Medical record review of an inpatient Psychiatric Consultation report dated March 4, 2012, revealed, "...sent over in the middle of the night (on March 3, 2012) from the nursing home after making a suicide gesture...was found sitting in a chair in the hallway with butter knife trying to stab self in the chest...they (nursing home staff) were able to get the knife away..." (resident) stated that (resident) was trying to end (resident’s) life...sent to (hospital) for evaluation..." The resident was admitted to the hospital's inpatient mental health services program for treatment of diagnoses including depression and suicide gesture.

- Review of facility policy, Social Services, revised August 2006 revealed "...The care plan shall be used in developing the resident's daily care... 4. The social services department is responsible for:...b. Identifying individual...emotional needs; e...providing for the resident's needs by developing and maintaining individualized social care plans..."

- Review of facility policy, Care Plans—Comprehensive, revised April 2010
Telephone interview with Registered Nurse (RN) #1 on November 27, 2012, at approximately 10:50 a.m., revealed when the surveyor initiated the investigation on November 5, 2012, and requested the resident's record from medical records, RN #2 realized the surveyor would be reviewing the resident's care plan. On November 5, 2012, (unable to recall time), RN #2, realized the resident care plan had not been revised, called RN #1, and asked how to write a suicide precaution care plan. RN #1 revealed the care plan was not revised on February 24, 2012, as documented but, was falsely revised on November 5, 2012.

Interview with RN #2 on November 27, 2012, at 11:21 a.m., in the conference room confirmed, the surveyor had requested the chart when the complaint investigation was first initiated on November 5, 2012. "I looked at the chart before giving it to the surveyor and realized the care plan had not been updated (revised) for suicide precautions from when the resident threatened suicide on February 24, 2012...I documented the care plan update on November 5, 2012, to reflect a February 24, 2012, date, to prevent the surveyor from finding it had not been..."
F 280 Continued From page 65
updated..."

Interview with LPN #2 on November 25, 2012, at
12:50 p.m., in the conference room, confirmed on
March 3, 2012, shortly after supper (dinner), LPN
#2 was walking out from another resident's room,
to the hallway, and observed resident #1 with a
knife trying to stab (resident's) self in the chest
with the knife. During this interview, while
describing the attempt, LPN #2 demonstrated
how the resident attempted to stab self in the
chest, by hitting (LPN #2's) self in the chest
repeatedly with a fisted right hand, and made a
forceful thumping sound with each strike of the
fist to the chest. "(Resident) was using a metal
knife...like the ones that come on the residents'
trays for meals. I think (resident) got it off of
another resident's tray...I grabbed the knife...I
asked 'what are you doing?'...[resident] said, 'I
just want to end it...kill myself'...finally got the
knife from (resident)...(resident) had a tee-shirt
and sweat shirt on...I pulled them up to make
sure...saw no wounds or lacerations...I directed a
nearby CNA to stay with (resident)...called
Physician, got an order to send to the ER for
evaluation, and called the family..." LPN #2
confirmed to know of previous suicidal ideations
with the resident, and confirmed, "I do not know
what suicide precautions are...I have never been
told...I had no idea...[resident] was not placed 1:1
until after the suicide attempt...we (staff) were just
told to watch (resident) closer and give plastic
silverware because of previous suicidal
ideations..."

Interview with CNA #2 on November 27, 2012, at
8:45 p.m., in the conference room confirmed CNA
#2 worked on March 3, 2012, on the 200
F 280: Continued from page 66
p.m.-10:00 p.m. shift; and was assigned to the
dining room for supper. "...After supper, I
transported (resident #1) to the nurse's station
straight across the hall from the dining room on
Wing 4, and then proceeded down the hall to pick
up trays...As I came out from room number 65
(near the end of the hall), I looked up and heard
(LPN #2) say, 'I need some help down here.' I
ran to assist (LPN #2)...Resident #1 had a metal
knife in (resident's) right hand...was repeatedly
stabbing (resident's) chest with the knife and
yelling, 'I'm going to kill myself...I'm going to kill
myself.' (LPN #2) was struggling with (resident)
to get the knife, as (resident) was going at
it...stabbing at (resident's) chest...By the time I
reached (LPN #2) and the resident, (LPN #2) had
removed the knife from the resident...I realized
(resident #1) had gotten the knife from another
resident seated at (resident #1's) table during
supper and I said, 'Oh, no! (Resident #1) got the
knife off of (random resident's) tray...I looked at
(resident's) chest immediately...It had multiple
red, dime-size areas but, no lacerations or stab
wounds...I stayed at (resident's) bedside until
EMS (Emergency Medical Services), arrived.
(Resident) previously made multiple
statements...wanted to kill (resident's) self, and
wanted to die." CNA #2 confirmed these
statements were made prior to March 3, 2012,
but, could not recall the dates, or date of onset. "I
tried to encourage (resident) everyday...just
never dreamed (resident) would try to kill
(resident's) self..."
F 280: Continued from page 87
CNA #4, at 4:40 p.m.; CNA #7, at 4:50 p.m.; CNA #5, at 5:00 p.m.. The interviews confirmed no education was provided on the resident's care plan to protect and prevent suicide attempts.

A second interview with CNA #2 on November 27, 2012, at 10:15 p.m., in the conference room confirmed "...I was never told or educated on what to do when a resident threatened to harm themselves or wished to die. Nobody ever told me why (resident #1) had plastic silverware. I never asked and I never really thought about why...I'm doing the best I can...I had no idea what to look for...I've not had psych (psychiatric) training...I was never told what to do for (resident #1's) psychiatric or suicidal care."

Interview with the SW on November 28, 2012, at 4:30 p.m., in the conference room confirmed, "...The resident voiced...wanted to die...how would kill...self, with a knife. (Resident) was depressed and suicidal...all of my balls and whistles...going off. The SW confirmed, "I strongly felt (resident) needed to go out for an eval." Continued interview confirmed, the SW failed to ensure the following for the resident (fr): failed to follow Social Services policies; failed to revise the resident's individual care plan to protect and prevent suicide attempts; and failed to provide facility education on the resident's individual care plan to protect and prevent suicide attempts. "Most of the facility staff is unaware of what suicide prevention and precautions are. Oh, I know very well what they are and I know this (attempted suicide) was about to happen."

Interview with the Administrator on November 28,
F 280 Continued From page 68

2012, at 7:35 p.m., in the conference room confirmed the facility failed to follow Social Services and Care Plan policies, failed to revise the resident’s individual care plan to protect and prevent suicide attempts; and failed to provide facility education on the resident’s individual care plan to protect and prevent suicide attempts.

In summary, the facility failed to ensure the care plan was revised for resident #1, after being made aware the resident had a history and current threat of suicide. The initial threat was reported to the DON on February 24, 2012, by the POA; and then to the Administrator and DON on February 24, 2012, by the SW. The care plan was not revised until November 5, 2012, approximately months after the resident voiced suicide ideations (on February 24, 2012), and eight months after the resident was discharged due to a suicide attempt (on March 3, 2012).

The Immediate Jeopardy was effective from February 25, 2012, through November 29, 2012, and was removed on November 30, 2012. An Acceptable Allegation of Compliance, which removed the immediacy of the Jeopardy, was received and corrective actions were validated by the surveyor through review of documents, staff interviews, and observations conducted onsite on November 30, 2012. The surveyor verified the allegation of compliance by:

1. Reviewing the corrective action implemented for the SW and RN #2.

2. Reviewing the facility’s in-service records to ensure all staff were educated regarding changes to and implementation of the facility’s following
Continued From page 69 policies:

a. Change in Resident's Condition and Status;

b. Suicide Threats;

c. Care of a Suicidal Resident;

d. Behavioral Management;

e. Care Planning and Using the Care Plan.

3. Conducting interviews with facility departments, to include fifteen of thirty-one nurses, three of nine environmental services, one of three maintenance, two of four activities, one of two social services, twenty-nine of fifty-two CNA's, ten of twenty-three dietary, seven of seventeen laundry and housekeeping, on staff to determine the level of comprehension gained through in-service education conducted regarding changes to and implementation of the facility's policies, "Change in Resident's Condition and Status; Suicide Threats; Care of a Suicidal Resident; Behavioral Management; Care Planning and Using the Care Plan;" to ensure staff recognize and respond to the following:

a. A resident making suicide threats or statements are immediately placed 1:1 for constant observation; staff will remain with the resident at all times until (1) the Physician orders the resident transferred for evaluation and admitted to a higher level of care, or (2) the Physician evaluates the resident and deems them safe;

b. Warning signs of suicide;

c. Statements and behaviors that may be a warning sign of suicide;

d. Using probes for more information;

e. Risk factors for suicide;

f. Restricting access to lethal means and removal of any harmful objects.
Continued From page 70

g. Residents at risk of suicide are communicated to all staff via the current Care Plan; Nursing 24-Hour Report; noted on the Medication Administration Record (MAR) and Treatment Administration Record (TAR);

h. Residents at risk of suicide are discussed weekly in the department head meetings.

i. A newly identified resident at risk of suicide will result in a suicide watch, and an emergency department head meeting will be called for immediate discussion.

4. Reviewing the facility’s in-service records with the Social Worker ensuring responsibilities were reviewed and clarified, to include the following;

a. A Suicidal Rating Scale has been added to the Social Services Assessment, to be completed on new admissions, quarterly, and with a significant change in condition;

b. Social Services is responsible for ensuring the referral source sees the resident and corresponding/appropriate notes are in the medical record;

c. Supportive Counseling;

d. Bachelor of Social Work (BSW) Scope of Practice;

e. Responsibilities of Social Services;


5. Review of the facility’s contract with the Licensed Master of Social Work (LMSW) to ensure services are contracted to occur on a monthly basis beginning on November 30, 2012, to provide visits, ensure oversight of the current SW, and compliance with State and Federal Regulations, facility’s policies, and Standards of Practice.
6. Reviewing of Suicide Risk Assessments on all residents in the facility. No residents were identified to have suicide risks.

7. Reviewing the new contract with a different Mental Health Service provider, who will be providing weekly services to the facility's residents, as identified and indicated.

8. Reviewing assessments and supportive counseling provided by a contracted BSW with Long Term Care experience. The assessments and supportive counseling was provided to all residents receiving services from a previous contracted Mental Health Service provider; and new admissions from the past two months were assessed and supportive counseling was provided.

9. An emergency Quality Assurance/Performance Improvement Committee Meeting was held on November 30, 2012, with the Medical Director, DON, Administrator, Consultant, Infection Control Nurse, and two other facility staff to include the Safety Leader.

Non-compliance continues at a "D" level for monitoring corrective actions. The facility is required to submit a plan of correction.

CO #30697
F 308; 483.26 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.
<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>[(X)][(X)] Multiple Construction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ID) Provider/Supplier Identification Number</td>
<td>A Building: 445419</td>
</tr>
<tr>
<td>[(X)] Date Survey Completed</td>
<td>B. Wing</td>
</tr>
<tr>
<td>Name of Provider or Supplier</td>
<td></td>
</tr>
<tr>
<td>Overton County Nursing Home</td>
<td>Street Address: 318 Bilbrey St.</td>
</tr>
<tr>
<td>City, State, Zip Code</td>
<td>Livingston, TN 38570</td>
</tr>
<tr>
<td>[(X)] ID Prefix Tag</td>
<td>[(X)] ID Prefix Tag</td>
</tr>
<tr>
<td>Summary Statement of Deficiencies (each deficiency must be preceded by full regulatory or 120 identifying information)</td>
<td>Providers' Plan of Correction (each corrective action should be cross-referenced to the appropriate deficiency)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F 309 Continued from page 72</th>
<th>F 309</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309 Continued from page 72</td>
<td>F 309</td>
</tr>
<tr>
<td>309 488.25 Provide Care/Services for Highest Risk Patient</td>
<td>12-14-12</td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of facility policies, and interview, the facility failed to notify the physician of verbal statements of and plan for suicide, failed to prevent neglect by following facility policies for resident change in condition to protect and prevent suicide attempts, failed to provide Social Service counseling, failed to revise the care plan with interventions to prevent suicide attempts, and failed to provide Mental Health Services for one resident (#1), of thirty-two residents reviewed. The facility's failure resulted in one resident (#1) attempting suicide by stabbing (resident's self) in the chest with a table knife, of thirty-two residents reviewed. The facility failed to ensure policies were followed and Mental Health Services were provided for residents #27, #17, #18, and #31, who experienced mental and/or psychosocial difficulties.

The facility's failure to ensure policies were followed and interventions were implemented for a resident in crisis resulted in the resident obtaining a dinner knife, and attempted to stab (resident #1's) self in the chest. Resident #1's attempted suicide on March 3, 2012, required a transfer to the hospital emergency room and admission to a mental health unit for treatment. The facility's failure placed resident #1 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is effective 11/30/12, the Administrator contracted with LMSW to provide a monthly visit to ensure compliance with state & federal regulation. Included in Practice, & review the BSW Documentation. On 12/10/12, the Administrator increased the working hours of LMSW to complete assessments on new admissions, Quarterly Assessments, & oversight of supportive counseling by social service staff.
F 309 continued from page 73:

likely to cause, serious injury, harm, impairment, or death to a resident).

The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Conference Room on November 29, 2012, at 11:30 a.m.

F309 resulted in Substandard Quality of Care.

The findings included:

Resident #1 was admitted to the facility from the local hospital on February 10, 2012, with diagnoses including Lack of Coordination; Status/Post Cerebrovascular Accident (CVA, or Stroke); Left-Side Hemiplegia secondary to CVA; History of Depression; Diabetes Mellitus Type II; and Coronary Artery Disease.

Medical record review of the hospital Discharge Summary dated February 10, 2012, revealed, (the resident was) "...significantly disabled...due to a cerebrovascular accident in...2009 which has left (resident) hemiplegic and very poorly coordinated..." and had a history of depression.

Medical record review of the Admission Orders dated February 10, 2012, revealed Xanax at 0.5 mg (used to treat anxiety and panic disorders) by mouth, daily in the morning, and 1 mg at HS (bedtime).

Medical record review of the Nursing Admission Assessment dated February 10, 2012, at 1:00 p.m., revealed the resident's cognition as oriented to person, place, time, and was alert. The resident was able to recall three named objects.

2) On 11/30/12, all residents with documented behaviors, receiving services from a previous contracted Mental Health Service, and new admissions from past 2 months were assessed and supportive counseling provided by a contracted BSW and LMSW with Long Term Care experience.

On 11/29/12, the DON, Supervisors, MDS RN conducted Suicide Risk Assessments on all residents within the facility (census 106). No residents were identified to have suicide thoughts or behaviors.

Effective 11/30/12, a Suicidal Rating Scale has been added to the Social Services Assessment for New Admissions and Quarterly assessments.

Beginning 11/30/12, a new contracted Mental Health Services will replace previous Mental Health Services and they will be providing weekly services to the facility. (See Attached)

3) On 12/2/12, the DON & Nursing Management will monitor all referrals to Mental Health Services for Timely referrals. Date seen, Documentation on chart & Frequency of visits. This monitoring will continue for 6 months and then the CAPI committee will evaluate if continued monitoring is needed.

On 12/2/12, the Administrator assigned the responsibility for completing the Suicidal Rating
F 309 | Continued From page 74

- after five minutes, and was able to understand communication. The resident required assistance with all physical functions: two people were required for bed mobility, transfers, toileting and bathing; one person was required for walking/locomotion, dressing, eating and personal hygiene. Eating required the supervised assistance of one person.

- Medical record review of a Nurse's Note dated February 15, 2012, at 9:45 a.m., revealed the resident was beginning to exhibit confusion, "...thinks...is going home today...states (spouse) is getting out of the hospital...going home with (spouse)...will monitor..."

- Medical record review of a Social Service Progress Note dated February 24, 2012, at 1:36 p.m., revealed, "Family told SW (Social Worker) resident called the POA (Power-of-Attorney)...and (resident's spouse) last night at 10:45 p.m. and made a delusional statement. (Resident) said...would send (residents' stocking) over to (resident's spouse's) home to run off a (spouse's visitor) according to...POA...also stated resident had a hx (history) of making statement(s) wanting to take pills to end (resident's) life...stated (resident) has made these statements to family 1-2 (one-to-two) yrs (years). SW talked to the DON (Director of Nursing) and (contracted Mental Health Services) referral being sent for counseling and Dr. (Physician) notified for medication and instruction. SW spoke to the resident...stated...was concerned about spouse but not thinking of hurting (resident's self @ (at) this time. (Resident) thinks...spouse has... (someone else)...Spouse just (recently) got out of hospital with heart by-pass (heart surgery). SW

F 309 Scale on new admissions to the DGN. A list of Suicidal Ratings completed each month will be provided to the Administrator on the last day of the month. This monitoring will continue for 3 months.

- 4) Beginning 1/24/12, the DON will report to the QAPI Quarterly committee meetings the outcomes of the referral monitoring & completion of Suicidal Rating Scale on new admissions and ultimately the Administrator will report to the Board quarterly. An emergency QAPI committee meeting was held on 11/30/12 with the Medical Director, DON, Administrator, RN Consultant, Infection Control Nurse, and other facility staff to include safety. A QAPI committee meeting was held on 12/14/12. A January meeting is scheduled for 1/17/13.

Resident #27

- 1) On 12/3/12, the LMSW conducted a Supportive Counseling session & Documentation of her visit & assessment was placed in the medical record.

On 12/10/12, the LCSW from newly contracted Mental Health Services evaluated & scheduled weekly visits X 3 months for counseling. Documentation of visits will be recorded in the medical record.

On 11/30/12, the Administrator & RN Consultant reviewed with the Social Services employee her responsibilities, referral process, assessment requirements, supporting counsel as defined in SSW scope of practice, new policy for suicide rating scale, and federal regulation for social services.
On 11/29/12 & 11/30/12, mandatory in-services were conducted by a Licensed Master Social Worker (LMSW) with all facility staff concerning Behavior Management.

Effective 11/30/12, the Administrator contracted with LMSW to provide a monthly visit to ensure compliance with state & federal regulation, Standard of Practice, & review the BSW Documentation.

On 12/10/12, the Administrator Increased the working hours of LMSW to complete assessments on new admissions, Quarterly Assessments, & oversight of supportive counseling by social service staff.

2) On 11/30/12, all residents with documented behaviors, receiving services from a previous contracted Mental Health Service, and new admissions from past 2 months were assessed and supportive counseling provided by a contracted BSW and LMSW with Long Term Care experience.

On 12/12/12, Geropsych Nurse Practitioner evaluated & assessed medications for needed changes.

Beginning 11/30/12, a new contracted Mental Health Services will replace previous Mental Health Services and they will be providing weekly services to the facility.
Continued From page 76

3) On 12/1/12, the LMSW will identify residents needing supportive counseling & will provide a list of those residents to the Administrator by 12/10/12. LMSW will provide the Administrator a monthly list of residents who have had a supportive counseling visit with a documented note by the end of each month for a period of 3 months.

4) Beginning 12/14/12, the Administrator will report to the QAPI Quarterly committee meetings the outcomes of the monitoring of supportive counseling and ultimately the Administrator will report to the Board quarterly.

An emergency QAPI committee meeting was held on 11/30/12 with the Medical Director, DON, Administrator, RN Consultant, Infection Control Nurse and 2 other facility staff to include safety. A QAPI committee meeting was held on 12/14/12. A January meeting is scheduled for 1/17/13.

Residents #17 & #81

Resident #17 was discharged on 7/31/12.

1) On 12/11/12, LMSW conducted a supportive counseling visit and documentation of her visit & assessment was placed in the medical record.

On 11/30/12, the Administrator & RN Consultant reviewed with the Social Services employee her responsibilities, referral process, assessment requirements, Supporting Counsel as defined in the BSW scope of practice, new policy for Suicide Rating Scale, and federal regulation for social services.

Effective 11/30/12, the Administrator contracted with LMSW to provide a monthly visit to ensure...
F 309. Continued from page 77

Psychiatric referrals, the SW replied, "I am.

A second interview with the SW, in the presence of the Administrator, on November 28, 2012, at 6:50 p.m., in the conference room confirmed on February 24, 2012, the resident's POC informed the SW of the resident's history of wanting to take pills to end the resident's life. The SW was told on February 24, 2012, by staff (names unrecorded) the resident had asked questions regarding ending life and/or end of life, including "how to cut-off (resident's) air supply (SW placed hand around SW's throat and described an action of choking self); if insurance would pay if (resident) died." The SW assessed the resident the following day on February 24, 2012, and determined the resident had a plan to kill the (resident's) self with a knife. The SW reported the assessment and suicidal concerns to the Administrator and DON, on February 24, 2012. The SW confirmed, "...The resident needed to be sent to a local mental health service for a psychiatric evaluation,..." indicated the unit nurse to call the Physician and get orders for (contracted Mental Health Services) consult and medications for depression and anxiety. Dietary was notified to provide plastic silverware. "The Administrator revealed to be unaware of the (resident's) threat to cut-off (resident's) air supply, the SW revealed, "I thought I told the Administrator." The Administrator confirmed, "The DON and I felt the (resident) to be in a safe environment and did not feel the resident needed to be sent out...we (Administrator and DON) felt the resident was not a threat to harm to (resident's) self...felt the resident was unable to attempt suicide." Both the SW and Administrator confirmed to be unaware of the resident's suicidal

F 309. continued from page 77

compliance with state & federal regulation, standard of Practice, & review the BSW Documentation.

On 12/24/12, the Administrator increased the working hours of LMSW to complete assessments on new admissions, Quarterly Assessments, & oversight of supportive counseling by social service staff, and identifying psychosocial needs.

2) On 12/20/12, all residents with documented behaviors, receiving services from a previous contracted Mental Health Service, and new admissions from past 2 months were assessed and supportive counseling provided by a contracted GSW and LMSW with Long Term Care experience.

3) On 12/14/12, the LMSW will identify residents needing supportive counseling & will provide a list of those residents to the Administrator by 12/10/12. LMSW will provide the Administrator a monthly list of residents who have had a supportive counseling visit with a documented note by the end of each month for a period of 3 months.

4) Beginning 12/14/12, the Administrator will report to the OAPI Quarterly Committee meetings the outcomes of the monitoring of supportive counseling and ultimately the Administrator will report to the Board quarterly. An emergency OAPI committee meeting was held on 12/30/12 with the Medical Director, DON, Administrator, RN Consultant, Infection Control Nurse and 2 other facility staff to include safety. A OAPI committee meeting was held on 12/14/12. A January meeting is scheduled for 1/17/13.
F 309: Continued From page 78

Ideations voiced to the spouse on a phone call documented in the nurse's notes on February 25, 2012, at 9:59 p.m. Continued interview confirmed no psychiatric consult occurred as ordered on February 24, 2012.

Medical record review of an "Admit Note" dated February 25, 2012, (no time), documented by the Physician, revealed the resident was unable to care for (resident's) self, "particularly with (resident's) declining health." The note revealed the resident "has some delusional thoughts, patterns about (resident's spouse) running off with somebody." The Physician's impression revealed the following:
1. CVA with left-sided hemiparesis;
2. CAD (Coronary Artery Disease) S/P (status post) CABG (Coronary Artery Bypass Graft-a type of surgery that improves blood flow to the heart) with...angina;
3. Type II diabetes mellitus currently on insulin therapy;
4. Chronic atrial fibrillation;
5. Hyperlipidemia.

The Physician's plan revealed "Continue as per orders at this time." Continued review of the note revealed no documentation of the resident being depressed, treatment for depression, risk of suicide, and/or collaboration with the SW.

Medical record review of a Nurse's Note dated February 25, 2012, at 9:59 p.m., revealed the resident was on the phone talking to the resident's spouse, "...(the resident)...talking and getting emotional at (and) crying continuing to state "I'll just end it now." (Resident) quickly changes tone and says sorry to (spouse)...This
<table>
<thead>
<tr>
<th>F 309</th>
<th>Continued from page 79</th>
</tr>
</thead>
</table>

A nurse (Licensed Practical Nurse (LPN) #1) spoke with the spouse and assured them they would keep close watch on the resident. Administered PRN Lunesta to help the resident sleep. The nurse called to staff at this moment. Will cont (continue) to monitor...

Continued review revealed no documentation the physician was notified of the resident's suicidal ideation.

Medical record review of a Nurse's Note dated March 3, 2012, at 7:45 p.m., revealed, "This nurse (LPN #2) was coming down the hall and saw resident had a butter knife...trying to stab self in the chest. LPN #2 got knife away from resident...asked (resident) what (resident) was doing. Resident stated, 'I just wanted to end this'..." Continued review revealed a Certified Nursing Assistant (CNA) was assigned to stay with the resident. LPN #2 notified the Physician on-call; orders were received to send to the (Hospital) Emergency Room (ER) for an evaluation. The resident's PCP was also notified. Continued review revealed the Emergency Medical Service (EMS) arrived at 8:00 p.m., and the resident was transferred from the nursing home at 8:15 p.m.

Medical record review of a Patient Transfer Form dated March 3, 2012, (no time), revealed the resident tried to "stab self in the chest with a butter knife" as the reason for transfer (to the hospital from the nursing home).

Medical record review of a inpatient Psychiatric Consultation report dated March 4, 2012, revealed, "...sent over in the middle of the night (on March 3, 2012) from the nursing home after making a suicide gesture...was found sitting in a..."
F. 309. Continued From page 80
   chair in the hallway with butter knife trying to stab...self in the chest...they (nursing home staff) were able to get the knife away... (resident) stated that (resident) was trying to end (resident)'s life...sent to (hospital) for evaluation..." The resident was admitted to the hospital's inpatient mental health services program for treatment of diagnoses including depression and suicide gesture.

Review of facility policy, Change in Medical Condition of Residents, (no date) revealed, "...Purpose: To keep the physician...informed of the resident's medical condition...Standard: Notification of the physician...according to federal regulations, when there is a change in the resident's condition. Change in condition is identified as:...A change in the resident's physical, mental or psychosocial status (i.e., deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications)...need to alter a treatment (i.e., commence a new form of treatment)..."

Review of facility policy, Suicide Assessment and Intervention Practice, (no date) revealed, "Purpose: To maintain safety of individual residents while receiving services in this facility...Standard: Residents who display characteristics of suicidal ideation will be evaluated for risk of self harm and intent to inflict self harm (does the resident have a plan?)...If intent is implied, then monitor for safety (keep resident within eyesight at all times) and notify MD (Physician) and resident's family...Process: 1. Remove means of harming self or other from resident. 2. Assess resident for actual harm to self others and follow up as indicated. 3.
F 309. Continued From page 81

Resident will be kept within eyesight of staff at all times...until family arrives or resident is sent out of facility...

- Review of facility policy, Suicide Prevention, (no date) revealed, "...Identifying Potential for Suicide Attempt...a) Identify resident at high risk...place on suicide precautions...b) Designate staff to closely observe at all times..." Continued review revealed no policy for suicide precautions.

- Review of facility policy, Social Services, revised December 2008 revealed, "Our facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being..."

- Review of facility policy, Care Plans-Comprehensive, revised April 2010 revealed "...care plans are revised as information about the resident and the resident's change...

Interview with the Administrator and DON on November 26, 2012, at approximately 11:25 a.m., in the Conference Room, confirmed the resident did attempt suicide. The Administrator confirmed, "I felt like the suicide threats were threats only. I did not believe (resident) would attempt suicide, or could attempt suicide... (resident) obtained a regular stainless steel dinner knife and tried to stab (resident's) self in the chest. I just did not believe (resident) would attempt suicide. I can't recall the specific date of the initial threat but, yes, the SW reported the threat to me and the DON. That's when we implemented the plastic silverware. We (Administrator and DON) didn't
F 309: Continued From page 82

put the resident on one-on-one (1:1) observations. (one staff person providing constant observation of one resident, and within reach of that resident) because we felt the threat wasn’t real.” The DON confirmed the Administrator’s statements were correct, and "I have told multiple people, staff and the resident’s sibling, the resident is in a safe place and nothing could happen. We (DON and Administrator) didn’t implement 1:1 because we felt (resident) was safe and the threat was not real.”

Interview with LPN #1 on November 28, 2012, at 12:17 p.m., in the Conference Room, confirmed, the entry in the nurse’s notes on February 25, 2012, at 9:59 p.m., was documented by LPN #1. LPN #1 confirmed on the evening of February 25, 2012, the resident called the spouse and was emotional; which ranged from crying and remorse, to anger, then back to crying and remorse. LPN #1 confirmed (resident) said, “I just end it now,” and LPN #1 told the spouse the resident would be watched closer. LPN #1 confirmed the resident did have periods of no observation, such as when the staff were providing care to other residents, and/or when staff were in the bathroom, or away from the particular area where the resident was positioned (nurse’s station, hallway, and so on). “There are just too many variables here for a resident to be safe if they are suicidal...While (resident) had mood swings and was emotional, I just didn’t think (resident) would do something like that (attempt suicide).”

Interview with LPN #2 on November 28, 2012, at 12:50 p.m., in the Conference Room, confirmed on March 3, 2012, shortly after supper (dinner),
F 209: Continued From page 83

LPN #2 was walking out from another resident's room, to the hallway, and observed resident #1 with a knife trying to stab (resident's) self in the chest with the knife. During this interview, while describing the attempt, LPN #2 demonstrated how the resident attempted to stab self in the chest, by hitting (LPN #2's) self in the chest repeatedly with a fistled right hand, and made a forceful thumping sound with each strike of the fist to the chest. "(Resident) was using a metal knife...like the ones that come on the residents' trays for meals. I think (resident) got it off of another resident's tray...I grabbed the knife...I asked 'what are you doing?'... (resident) said, 'I just want to end it...kill myself'...finally got the knife from (resident)...(resident) had a tee-shirt and sweat shirt on...I pulled them up to make sure...saw no wounds or lacerations...I directed a nearby CNA to stay with (resident)...called Physician, got an order to send to the ER for evaluation, and called the family..." LPN #2 confirmed to know of previous suicidal ideations with the resident, and confirmed, "I do not know what suicide precautions are...I have never been told...I had no idea... (resident) was not placed 1:1 until after the suicide attempt...we (staff) were just told to watch (resident) closer and give plastic silverware because of previous suicidal ideations..." LPN #2 confirmed, "Watch closer meant to keep in common areas...a hallway or at nurse's station..." LPN #2 confirmed there were times when other residents were being cared for and resident #1 was not being observed by any staff.

Interview with CNA #2 on November 27, 2012, at 2:45 p.m., in the conference room confirmed CNA #2 worked on March 3, 2012, on the 2:00
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 34</td>
<td></td>
</tr>
</tbody>
</table>

p.m.-12:00 p.m. shift, and was assigned to the dining room for supper. "During dining room assignment, you assist, feed, and observe for choking and swallowing difficulties...you watch everybody (residents). During supper on March 3, 2012, there were seven residents with three tables in use in the dining room. Six residents were seated at two of the tables, with three per table; and one resident required to be fed, at the third table. I sat at the table with the one resident that had to be fed. There were two other CNAs (no longer employed at the facility), which had passed trays and were feeding residents on the hall...(LPN #2) was at the desk (Wing 4 nurse's station) charting. My focus was on the resident I was feeding (not resident #1). I was unable to continuously watch any one resident...(Resident #1) was seated at a table with two other residents. After supper, I transported (resident #1) to the nurse's station straight across the hall from the dining room on Wing 4, and then proceeded down the hall to pick up trays. The other two CNAs were in different rooms picking up trays, and (LPN #2) may have been on the hall somewhere answering a call light...As I came out from room number 85 (near the end of the hall), I looked up and heard (LPN #2) say, 'I need some help down here.' I ran to assist (LPN #2)...Resident #1 had a metal knife in (resident's) right hand...was repeatedly stabbing (resident's) chest with the knife and yelling, 'I'm going to kill myself...I'm going to kill myself.' (LPN #2) was struggling with (resident) to get the knife, as (resident) was going at it...stabbing at (resident's) chest...By the time I reached (LPN #2) and the resident, (LPN #2) had removed the knife from the resident. (LPN #2) asked me, 'Where did (resident) get this knife?' I said, 'I don't know.'
F 309: Continued from page 66

thought about it, and I realized (resident #1) had
gotten the knife from another resident seated at
(resident #1's) table during supper and I said,
"Oh, no! (Resident #1) got the knife off of (random
resident's) tray...I looked at (resident's) chest
immediately...it had multiple red, dime-size areas
but, no lacerations or stab wounds. (LPN #2)
assigned me to stay 1:1 with (resident #1)...I
stayed at (resident's) bedside until EMS
(Emergency Medical Services), arrived.
(Resident) previously made multiple
statements...wanted to kill (resident's) self, and
wanted to die." CNA #2 confirmed these
statements were made prior to March 3, 2012,
but, could not recall the dates, or date of onset. "I
tried to encourage (resident) everyday...I just
never dreamed (resident) would try to kill
(resident's) self."

Telephone interview with Registered Nurse (RN)
#1 on November 27, 2012, at approximately
10:50 a.m., revealed when the surveyor initiated
the investigation on November 6, 2012, and
requested the resident's record from medical
records, RN #2 realized the surveyor would be
reviewing the resident's care plan. On November
5, 2012, (unable to recall time), RN #2, realized
the resident care plan had not been revised,
called RN #1, and asked how to write a suicide
precaution care plan. RN #1 revealed the care
plan was not revised on February 24, 2012, as
documented but was revised on November 6,
2012.

Interview with RN #2 on November 27, 2012, at
11:21 a.m., in the conference room, confirmed,
the surveyor had requested the chart when the
complaint investigation was first initiated on
Continued From page 86

November 5, 2012. "...I looked at the chart before giving it to the surveyor and realized the care plan had not been updated (revised) for suicide precautions from when the resident threatened suicide on February 24, 2012...I documented the care plan update on November 5, 2012, to reflect a February 24, 2012, date, to prevent the surveyor from finding it had not been updated..."

Interviews were conducted in the conference room, on November 27, 2012, with LPN #1, at 3:10 p.m.; LPN #2, at 3:20 p.m.; CNA #3, at 3:50 p.m.; LPN #4, at 4:05 p.m.; LPN #3, at 4:30 p.m.; CNA #4, at 4:40 p.m.; CNA #7, at 4:50 p.m.; CNA #5, at 5:00 p.m. The interviews confirmed no education was provided on the resident's care plan to protect and prevent suicide attempts.

Telephone interview on November 26, 2012, at approximately 3:30 p.m., with the (contracted Mental Health Service Provider's) Compliance Officer and Director of Business Development confirmed the Physician's Order for Mental Health Services, dated February 24, 2012, (no time) was received on February 24, 2012, via fax (facsimile). Continued interview confirmed the referral did not indicate a crisis situation (urgent, stat (immediately), or suicidal). "A clinician went to the facility to evaluate the resident on March 6, 2012; the resident was in the hospital and no treatment was provided."

Interview with CNA #1 on November 27, 2012, at 5:25 p.m., in the conference room confirmed to recall the resident talked about ending (resident's) life one night (unable to recall date). "I told (resident) not to talk like that...still had
Continued From page 87

family and not to talk like that." CNA #1 confirmed to report the resident's threat to a nurse but could not recall when or who the nurse was.

Interview with Physician on November 27, 2012, at 6:00 p.m., in the conference room confirmed the facility did not make the Physician aware of the resident's depressed state, or any suicidal ideations, or any plan as documented by the SW on February 24, 2012, or on February 25, 2012. "If the facility had reported the resident to be significantly depressed to the point of suicidal ideations and/or intent with a plan, I would have ordered to send the resident out to the ER (Emergency Room) for an evaluation immediately. No medications were ordered on February 24, 2012, for depression or anxiety, or at any other time during the resident's admission at the nursing home. The Xanax was a previous medication...was taking prior to admission (to the nursing home). I was not aware the resident was required to use plastic silverware to prevent self-harm."

A second interview with CNA #2 on November 27, 2012, at 10:15 p.m., in the conference room confirmed "...I was never told or educated on what to do when a resident threatened to harm themselves or wished to die. Nobody ever told me why (resident #1) had plastic silverware. I never asked and I never really thought about why...I'm doing the best I can...I had no idea what to look for...I've not had psych (psychiatric) training...I was never told what to do for (resident #1's) psychiatric or suicidal care."

A second interview with the DON on November...
F 309  Continued From page 88

28, 2012, at 1:00 p.m., in the conference room confirmed, on February 24, 2012, prior to meeting with the Administrator and SW about resident 1, the DON talked with the resident’s POA while at the Wing 4 Nurse’s Station. “The POA and I discussed the resident’s anxiety and threats of suicidal ideation due to having to be admitted (to the nursing home) on February 10, 2012. During this conversation, staff was present at the desk...I think it was a nurse, CNA, and possibly the SW...can’t recall which nurse and CNA...I reassured the staff and the POA the resident was in a safe place and nothing could happen. The SW proceeded to assess the resident, and then met with me and the Administrator...SW reported to us (DON and Administrator) the resident had a history of wanting to end (resident’s) life, cut off air supply (choke self), inquired about life insurance, and a plan to use a knife to kill (resident’s) self...SW reported to us (DON and Administrator) the resident needed to be sent out for a psych (psychiatric) eval. Continued interview confirmed the resident was not placed on 1:1 observation, and to “watch closer” did not mean the resident would be under constant supervision. The DON confirmed the facility failed to follow policies and implement interventions to meet the psychiatric needs of the resident.

Interview with the SW on November 28, 2012, at 4:30 p.m., in the conference room confirmed, “The resident voiced...wanted to die...how would kill...self, with a knife. (Resident) was depressed and suicidal...all of my balls and whistles...going off. The SW confirmed, “I strongly felt (resident) needed to go out for an eval.” Continued interview confirmed, the SW...
F 309: Continued From page 89

failed to ensure the following for the resident (#1) in crisis: failed to follow Social Services policies; failed to review the resident's individual care plan to protect and prevent suicide attempts; and failed to provide facility education on the resident's individual care plan to protect and prevent suicide attempts. "Most of the facility staff is unaware of what suicide preventions and precautions are. Oh, I know very well what they are and I knew this (attempted suicide) was about to happen."

Resident #27 was admitted to the facility March 24, 2012, with diagnoses including Depression, Anxiety, and Alzheimer's Disease.

Medical record review of a Quarterly Minimum Data Set (MDS) dated September 17, 2012, revealed the resident scored zero on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition; and exhibited feeling or appearing down, depressed, or hopeless nearly every day.

Medical record review of the Physician's Recaptulation Orders dated November 2012, revealed "...Alprazolam (Xanax for anxiety). Take 1 (one) tablet by MOUTH 3 (three) times daily AT 5:00 AM (a.m.); AT 1:00 PM (p.m.); AT 5:00 PM; Start Date: 07/30/2012 (July 30, 2012)...DX: INCREASED ANXIETY/ (sudor or) CRYING." (Prior to the routine order dated July 30, 2012, the Alprazolam was ordered as needed).

Medical record review of the Nurse's Notes, revealed:
June 29, 2012, at 12:10 a.m. "...Resident crying, turning on light (call light). Xanax given."
<table>
<thead>
<tr>
<th>F 309</th>
<th>Continued From page 90</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2, 2012, at 10:30 p.m.</td>
<td>&quot;Res (resident) given Xanax dt (due to) anxiety up, crying...&quot;</td>
</tr>
<tr>
<td>July 6, 2012, at 2:16 p.m.</td>
<td>&quot;...crying...Xanax...po (by mouth)...&quot;</td>
</tr>
<tr>
<td>July 7, 2012, at 10:00 a.m.</td>
<td>&quot;...Res @ times has increased anxiety...Xanax...administered...crises easily...&quot;</td>
</tr>
<tr>
<td>July 8, 2012, at 2:00 p.m.</td>
<td>&quot;...Res with increased anxiety crying uncontrollably...Xanax...for agitation...&quot;</td>
</tr>
<tr>
<td>July 9, 2012, at 3:00 p.m.</td>
<td>&quot;Res lying in bed rocking back &amp; forth crying. (Spouse) unable to redirect. This nurse admin (administered)...Xanax...Res less anxious when told medication would help (resident) to calm down...&quot;</td>
</tr>
<tr>
<td>July 13, 2012, at 2:15 p.m.</td>
<td>&quot;Res crying &amp; agitated says, 'Help me. Help me.' Xanax...admin...&quot;</td>
</tr>
<tr>
<td>July 19, 2012, at 12:07 p.m.</td>
<td>&quot;Res crying cont (continuously)...Xanax give (given)...&quot;</td>
</tr>
<tr>
<td>July 20, 2012, at 11:20 p.m.</td>
<td>&quot;...repeatedly turning on cell light...Xanax...dt increased anxiety...&quot;</td>
</tr>
<tr>
<td>July 30, 2012, at 10:32 a.m.</td>
<td>&quot;...Res in bed crying cont asking for 'help &amp; nurse' over &amp; over again...&quot;</td>
</tr>
<tr>
<td>August 3, 2012, (no time.)</td>
<td>&quot;...Res cries a lot...&quot;</td>
</tr>
<tr>
<td>September 6, 2012, at 9:40 a.m.</td>
<td>&quot;...episodes of crying with Xanax...administered...&quot;</td>
</tr>
<tr>
<td>September 20, 2012, at 8:00 a.m.</td>
<td>&quot;Res in bed crying on &amp; off...&quot;</td>
</tr>
<tr>
<td>October 4, 2012, at 8:40 a.m.</td>
<td>&quot;...Res has episodes of crying at (and) stating 'Nurse, Nurse help me' repeatedly...&quot;</td>
</tr>
<tr>
<td>October 18, 2012, (no time.)</td>
<td>&quot;...Res verbal of wants and needs...&quot;</td>
</tr>
</tbody>
</table>
| November 7, 2012, at 9:00 a.m. | "Continues to cry @ times..."
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>(X1) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LCD identifying information)</th>
<th>(X1) ID Prefix Tag</th>
<th>Providers' Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>(X1) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 91 Medical record review of the Nurse's Monthly Summary dated July 3, 2012; August 3, 2012; September 1, 2012; October 2, 2012; and November 3, 2012; revealed the consistent presence of mood symptoms, which included &quot;Little interest or pleasure in doing things...Feeling or appearing down, depressed, or hopeless...Feeling tired or having little energy...Indicates that she (or he) feels bad about self, is a failure, or has let family down...&quot; Medical record review of the Physician's Progress notes revealed: August 30, 2012, (no time), &quot;Pt (patient) is crying today...&quot; October 30, 2012, (no time), &quot;...is crying...continues to have crying spells.&quot; Medical record review of the Social Service Progress Notes, dated June 21, 2012, at 5:10 p.m., revealed &quot;Annual Note...Resident cried often according to... (spouse)...&quot; Continued review revealed no documentation the SW provided supportive counseling or emotional support for depression and multiple episodes of anxiety and crying. Continued review revealed no documentation the SW collaborated with the Physician or any other facility staff to provide in-house or outside Mental Health Services. Medical record review of a Care Plan dated February 10, 2012, revealed &quot;...Resident has ineffective individual coping related to anxiety, depression...Also has frequent episodes of crying...Approaches: Consider...Mental Health Services consult and treatment if mood persists...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 308</td>
<td>Continued From page 92</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical record review revealed no documentation of mental or psychosocial services and/or treatment were provided.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observation of the resident and interview, on November 30, 2012, at 6:30 p.m., in the resident's room confirmed the resident was lying in bed, with the television on. During the beginning of the interview the resident began to cry. The surveyor asked the resident what was wrong and the resident answered, &quot;I want to go home.&quot; The surveyor validated the resident missed being at home. The resident confirmed the validation, and continued to cry. Tears rolled from the resident's eyes, and down both sides of the face. The surveyor commented regarding the spouse's daily visits, and the resident confirmed, &quot;Yes, but, (spouse) is only here a few hours during the day.&quot; Surveyor asked the resident what the resident enjoyed most when the spouse visited, and the resident confirmed, &quot;Watching TV (television).&quot; By this time during the interview, the resident's crying decreased, and then stopped. As the interview ended and the surveyor turned to leave the room, the resident began to cry again.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| F 309 | 12-14-12 |

Interview with the SW on November 29, 2012, at 4:30 p.m., in the conference room confirmed the SW failed to follow Social Services policies; and failed to provide medically-related social services and supportive counseling for resident #27.

Resident #17 was admitted to the facility on August 18, 2011, with diagnoses including Depression, Right Above-The-Knee Amputee, and Peripheral Vascular Disease.

Medical record review of a Quarterly Minimum
Data Set (MDS) dated May 27, 2012, revealed the resident scored fifteen on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact.

Medical record review of a (contracted) Psychology Progress Note dated June 29, 2012, revealed the resident's diagnoses included: "Adjustment disorder with mixed disturbance of emotions and conduct...Depression, and Anxiety...symptoms presented are significant enough to interfere with the patient's psychosocial well-being...Chronic sad mood...With supportive reassurance, pt. slowly with brief gaps of silence verbalized feelings of sadness and worry...PI continues with s/s (signs and symptoms) of depression that are progressively impacting...health status including lack of motivation, tearfulness, and general agitation toward issues (resident) cannot change...Based on current status, progress and need, counseling will continue for approximately 9-11 (nine to eleven) weeks...Planned Session Frequency: 2-3/mo (two-to-three sessions per month)...Behavioral Suggestions to Staff: consider providing positive support and understanding... This session was the last session provided by the contracted Mental Health Service provider, and/or any Mental Health Service provider.

Medical record review of a Nurse's Note dated July 27, 2012, at 3:00 p.m., revealed "...res not happy about going home next week. Staff reported that Res stated to them...was going to do everything...can do to make sure...won't have to leave...staff stated while working with (resident), Res attempted to throw (resident's) self backwards, so (resident) would fall but they...
F 309. Continued From page 94

were able to keep (resident) upright. Res was also trying to kick prosthetic leg off & he was putting all weight on staff..."

Medical record review of the Social Service Progress Notes revealed no documentation the SW provided assessment and/or interventions to address the resident's inability to cope with loss of function due to the amputation of the right leg; difficulty with prosthetic adjustment; the need for physical and emotional support; and difficulty with the planned discharge to home with the daughter. Continued review of the progress notes revealed the resident was discharged home (with daughter) on July 31, 2012.

Interview with the SW on November 29, 2012, at 4:30 p.m., in the conference room confirmed the SW failed to follow Social Services policies and failed to provide medically-related social services and supportive counseling for resident #17.

Resident #18 was admitted to the facility on October 30, 2006, with diagnoses including Depression, Psychotic Episodes, and Malignant Cancer of the Kidney.

Medical record review of a Quarterly Minimum Data Set (MDS) dated August 28, 2012, revealed the resident scored nine on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact.

Medical record review of a (contracted) Psychology Progress Note dated July 19, 2012, revealed the resident's diagnoses included "Major depressive disorder...moderate...oriented to person, place, time...symptoms presented are
F 309 Continued from page 95

significant enough to interfere with the patient’s psychosocial well-being...Obsessiveness...Sadness, Fearful...Verbalized increased anxiety...final session with this clinician and that (resident) desires to be followed by alternate clinician...Termination completed with this pt and...expresses to be followed by alternate clinician...Based on current status, progress and need, counseling will continue approximately 5-6 (five to six) weeks...Planned Session Frequency: 1-2/mo (one to two sessions per month). This session was the last session provided by the contracted Mental Health Service provider, and/or any Mental Health Service provider.

Interview with the SW on November 28, 2012, at 4:30 p.m., in the conference room confirmed the SW failed to follow Social Services policies; and failed to provide medically-related social services and supportive counseling for resident #18.

Resident #18 was admitted to the facility on July 2, 2009, with diagnoses including Explosive Personality, Behavioral Problems, Psychosis, Alzheimer’s Disease, and Dementia.

Medical record review of a Quarterly Minimum Data Set (MDS) dated September 22, 2012, revealed the resident scored fourteen on the Brief Interview for Mental Status (BIMS), indicating the resident’s cognition was intact.

Medical record review of a (contracted) Psychology Progress Note dated July 19, 2012, revealed the resident’s diagnoses included “Major depressive disorder...moderate...Oriented to person, place, time...symptoms presented are
F 309 Continued from page 98

significant enough to interfere with the patient’s psychosocial well-being...Verbal aggression...Sadness...Chronic worry...Irritability...Low frustration tolerance...Delusions...this will be the last session with this LCSW (Licensed Clinical Social Worker) and is receptive to follow up with alternate clinician. Participating in therapy sessions though has not yet reached maximum potential...continues with negative thinking and other s/s of depression that negatively impact psychosocial functioning. Termination completed with this pt and...is receptive to be followed by alternate clinician...Based on current status, progress and need, counseling will continue approximately 9-11 weeks...Planned Session Frequency: 1-2mo.

Medical record review of the Nurse's Monthly Summary dated August 12, 2012 and September 3, 2012, revealed the consistent presence of mood and behavior symptoms which included "...Mood: Little interest or pleasure in doing things...Behavior: Verbal behavioral symptoms toward others..." Continued review on October 10, 2012, revealed an increase of the number of mood symptoms but, behavior symptoms remained the same as the two prior months, which included "...Mood: Little interest or please in doing things; overeating; being short-tempered, easily annoyed...Behavior: Verbal behavioral symptoms toward others..." Continued review on November 8, 2012, revealed the mood symptoms remained unchanged but, behavioral symptoms increased, which included "...Mood: Little interest or please in doing things; overeating; being...short-tempered, easily annoyed...Behavior: Verbal behavioral symptoms toward others;
Medical record review revealed no documentation of mental or psychosocial services provided after July 19, 2012, psychiatric treatment session.

Telephone interview on November 29, 2012, at approximately 3:30 p.m., with the (contracted Mental Health Service provider’s) Compliance Officer and Director of Business Development confirmed the Mental Health Service provider services were no longer available to the facility due to inability to secure a clinician for the facility (location); the last two dates of service were June 29, 2012, and July 19, 2012.

Interview with the SW on November 28, 2012, at 4:30 p.m., in the conference room confirmed the SW failed to follow Social Services policies; and failed to provide medically-related social services and supportive counseling for resident #31.

Interview with the Administrator on November 28, 2012, at 7:35 p.m., in the conference room confirmed "We have not had Mental Health Services provider since June 2012...We’ve had a big problem with getting (psychiatric) (mental health services) In here...I’ll just go ahead and tell you, and be honest about it...we've not had anybody..." Continued interview with the Administrator confirmed resident #1 was in a mental health crisis, as identified and reported on February 24, 2012. Continued interview confirmed the resident obtained a knife from another resident’s tray, which the Administrator confirmed to be a stainless steel dinner knife. Continued interview with the Administrator confirmed the facility’s failure to follow policies,
F 309, Continued From page 98

failure to notify the Physician, failure to provide medically-related Social Services, failure to revise the care plan, failure to provide Mental Health Services, and failure to provide the necessary care and services to maintain the highest practicable mental and psychosocial well-being allowed the resident to obtain a dinner knife, and then carried out an attempted suicide (by stabbing self repeatedly in the chest) on March 3, 2012. Continued interview confirmed the facility failed to follow policies and failed to provide Mental Health Services for residents #27, #17, #18, and #31.

Interview with the Administrator on November 30, 2012, at 11:16 p.m., in the Administrator's Office confirmed "We now have a contract with a new (Mental Health Services provider)... I signed the new contract signed today."

In summary, the facility neglected resident #1 after being made aware the resident had a history and current threat of suicide. The initial threat was reported to the DON on February 24, 2012, by the PQA; and then to the Administrator and DON on February 24, 2012, by the SW. Physician orders were written on February 24, 2012, for the contracted Mental Health Services provider to evaluate and treat as indicated; the evaluation did not occur, and the resident was not treated in the nursing home or on an outpatient basis (until March 3, 2012). The Physician was not notified of the resident's suicidal ideation. Due to the facility's neglect of the resident in crisis, the failure to follow facility policies, failure to revise the care plan and implement interventions, and failure to provide the necessary care and services to maintain the highest practicable mental and...
psychosocial well-being, the resident obtained a
knife from another resident’s meal tray
during supper and attempted suicide by
repeatedly stabbing (resident’s) self in the chest
on March 8, 2012. Continued review revealed the
facility failed to follow Social Services policies,
and failed to provide Mental Health Services for
resident’s #27, #17, #18, and #21.

The Immediate Jeopardy was effective from
February 25, 2012, through November 29, 2012,
and was removed on November 30, 2012. An
Acceptable Allegation of Compliance, which
removed the immediacy of the Jeopardy, was
received and corrective actions were validated by
the surveyor through review of documents, staff
interviews, and observations conducted onsite on
November 30, 2012. The surveyor verified the
allegation of compliance by:

1. Reviewing the facility’s in-service records to
ensure all staff were educated regarding changes
to and implementation of the facility’s following
policies:
   a. Change in Resident’s Condition and Status;
   b. Suicide Threats;
   c. Care of a Suicidal Resident;
   d. Behavioral Management;
   e. Care Planning and Using the Care Plan.
2. Conducting interviews with facility staff to
include fifteen of thirty-one nurses, three of nine
environmental services, one of three
maintenance, two of four activities, one of two
social services, twenty-nine of fifty-two CNA’s, ten
of twenty-three dietary, seven of seventeen
laundry and housekeeping, on staff to determine
the level of comprehension gained through
F 309; Continued From page 100

In-service education conducted regarding changes to and implementation of the facility’s policies, “Change in Resident’s Condition and Status; Suicide Threats; Care of a Suicidal Resident; Behavioral Management; Care Planning and Using the Care Plan” to ensure staff recognize and respond to the following:

a. A resident making suicide threats or statements are immediately placed 1:1 for constant observation; staff will remain with the resident at all times until (1) the Physician orders the resident transferred for evaluation and admitted to a higher level of care, or (2) the Physician evaluates the resident and deems them safe;

b. Warning signs of suicide;

c. Statements and behaviors that may be a warning sign of suicide;

d. Using probes for more information;

e. Risk factors for suicide;

f. Protective factors for suicide;

g. Restricting access to lethal means and removal of harmful objects.

h. Residents at risk of suicide are communicated to all staff via the current Care Plan; Nursing 24-Hour Report; noted on the Medication Administration Record (MAR) and Treatment Administration Record (TAR);

i. Residents at risk of suicide are discussed weekly in the department head meetings.

j. A newly identified resident at risk of suicide will result in a suicide watch, and an emergency department head meeting will be called for immediate discussion.

3. Reviewing the facility’s in-service records with the Social Worker ensuring responsibilities were reviewed and clarified, to include the following:

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(24) ID NUMBER</th>
<th>(25) PROVIDER/SUPPLIER IDENTIFICATION NUMBER</th>
<th>(26) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>445449</td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

OVERTON COUNTY NURSING HOME

**STREET ADDRESS, CITY, STATE, ZIP CODE**

318 BILBREY STREET
LIVINGSTON, TN 38570

**SUMMARY STATEMENT OF DEFICIENCIES**

- Each deficiency must be preceded by full regulatory or LEC identifying information.

<table>
<thead>
<tr>
<th>ID NUMBER</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td></td>
</tr>
</tbody>
</table>

**PROVIDER'S PLAN OF CORRECTION**

- Each corrective action should be cross-referenced to the appropriate deficiency.

<table>
<thead>
<tr>
<th>ID NUMBER</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td></td>
</tr>
</tbody>
</table>

**COMPLETION DATE**

12/14/12

---

**Continued From page 101**

- A Suicidal Rating Scale has been added to the Social Services Assessment, to be completed on new admissions, quarterly, and with a significant change in condition;
- Social Services is responsible for ensuring the referral source sees the resident and responding/appropriate notes are in the medical record;
- Supportive Counseling;
- Bachelor of Social Work (BSW) Scope of Practice;
- Responsibilities of Social Services;
- Federal Regulations.

4. Review of the facility's contract with the Licensed Master of Social Work (LMSW) to ensure services are contracted to occur on a monthly basis beginning on November 30, 2012, to provide visits, ensure oversight of the current SW, and compliance with State and Federal Regulations, facility's policies, and Standards of Practice.

5. Reviewing of Suicide Risk Assessments on all residents in the facility. No residents were identified to have suicide risks.

6. Reviewing the new contract with a different Mental Health Services provider, who will be providing weekly services to the facility's residents, as identified and indicated.

7. Reviewing assessments and supportive counseling provided by a contracted BSW with Long Term Care experience. The assessments and supportive counseling was provided to all residents receiving services from a previous contracted Mental Health Services; and new
F 309: Continued From page 102
 admissions from the past two months were assessed and supportive counseling was provided.

8. An emergency Quality Assurance/Performance Improvement Committee Meeting was held on November 30, 2012, with the Medical Director, DON, Administrator, Consultant, Infection Control Nurse, and two other facility staff to include the Safety Leader.

Non-compliance continues at a "E1" level for monitoring corrective actions. The facility is required to submit a plan of correction.

CO #30697

F 319: 483.25(f)(1) TX/SVC FOR MENTAL/PSYCHO SOCIAL 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 medical record review, review of facility policies, observation, and interview, the facility failed to follow facility policies, and failed to provide Mental Health Services for five (#1, #27, #17, #18, #31) residents of thirty-two residents reviewed. The facility's failure to ensure policies were followed and Mental Health Services were provided for a resident in crisis beginning on February 24, 2012, resulted in the resident obtaining a dinner knife, and attempting to stab...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(O1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER
445419

(O2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(O3) DATE SURVEY COMPLETED
12/04/2012

NAME OF PROVIDER OR SUPPLIER
OVERTON COUNTY NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
310 BILBREY STREET
LIVINGSTON, TN 38570

(ID) ID PRECEDING TAG
(X4) ID PREFIX TAG
(SUMMARY STATEMENT OF DEFICIENCIES) (EACH DEFICIENCY MUST BE PREPARED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)

F 319: Continued From page 103
(resident #1's) self in the chest. Resident #1's attempted suicide on March 3, 2012, required a transfer to the hospital emergency room and admission to a mental health unit for treatment. The facility's failure placed resident #1 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The facility failed to ensure policies were followed and Mental Health Services were provided for residents #27, #17, #18, and #31, who experienced mental and/or psychosocial difficulties.

The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Conference Room on November 29, 2012, at 11:30 a.m.

F319 resulted in Substandard Quality of Care.

The findings included:

Resident #1 was admitted to the facility from the local hospital on February 10, 2012, with diagnoses including Lack of Coordination; Status/Post Cerebrovascular Accident (CVA, or Stroke); Left-Side Hemiplegia secondary to CVA; History of Depression; Diabetes Mellitus Type II; and Coronary Artery Disease.

Medical record review of the hospital Discharge Summary dated February 10, 2012, revealed, (the resident was) "...significantly disabled...due to a cerebrovascular accident in...2009 which has left (resident) hemiplegic and very poorly coordinated..." and had a history of depression.

for need of Mental Health Services by a contracted BSW & LMSW.

Beginning 11/30/12, a new contracted Mental Health Services provider will replace previous Mental Health Services and they will be providing weekly services to the facility.

3) On 12/1/12, the DON & Nursing Management will monitor all referrals to Mental Health Services for Timely referrals, Date seen, Documentation on chart & Frequency of visits. This monitoring will continue for 6 months and then the QAPI committee will evaluate if continued monitoring is needed.

4) Beginning 12/14/12, the DON will report to the QAPI Quarterly committee meetings the outcomes of the referral monitoring and Mental Health Documentation and ultimately the Administrator will report to the Board quarterly.

An emergency QAPI committee meeting was held on 11/30/12 with the Medical Director, DON, Administrator, RN Consultant, Infection Control Nurse and 2 other facility staff to include safety. A QAPI committee meeting was held on 12/14/12. A January meeting is scheduled for 1/17/13.
Continued from page 104

Medical record review of the Admission Orders dated February 10, 2012, revealed Xanax at 0.5 mg (used to treat anxiety and panic disorders) by mouth, daily in the morning, and 1 mg at HS (bedtime).

Medical record review of the Nursing Admission Assessment dated February 10, 2012, at 1:00 p.m., revealed the resident's cognition as oriented to person, place, time, and was alert. The resident was able to recall three named objects after five minutes, and was able to understand communication.

Medical record review of a Nurse's Note dated February 15, 2012, at 9:45 a.m., revealed the resident was beginning to exhibit confusion. "...thinks...is going home today...states (spouse) is getting out of the hospital...going home with (spouse)...will monitor."

Medical record review of a Social Service Progress Note dated February 24, 2012, at 1:36 p.m., revealed, "Family told SW (Social Worker) resident called the POA (Power-of-Attorney)...and (resident's spouse) late last night at 10:40 p.m. and made a delusional statement. (Resident) said...would send (resident's sibling) over to (resident's spouse's) home to run off a (spouse's visitor) according to...POA...also stated resident had a hx (history) of making statement(s) wanting to take pills to end (resident's) life...stated (resident) has made these statements to family 1-2 (one-to-two) yrs (years). SW talked to the DON (Director of Nursing) and (contracted Mental Health Services) referral being sent for counseling and Dr. (Physician) notified for medication and

Residents #27 & #31

1) On 12/3/12 (#27) & 12/11/12 (#31), the LMSW conducted a Counseling session & Documentation of her visit & assessment was placed in the medical record.

On 12/10/12, the LCSW from newly contracted Mental Health Services evaluated & scheduled weekly visits X 3 months for counseling. Documentation of visits will be recorded in chart.

On 11/30/12, the Administrator & RN Consultant reviewed with the Social Services employee her responsibilities for referral process to Mental Health Services.

Effective 11/30/12, the Administrator contracted with LMSW to provide a monthly visit to ensure compliance with state & federal regulation, Standard of Practice, & review the BSW Documentation.

2) On 11/30/12, all residents with documented behaviors, receiving services from a previous contracted Mental Health Service, and new admissions from past 2 months were assessed
F 319 Continued from page 105

Instruction. SW spoke to the resident...stated...was concerned about spouse but not thinking of hurting (resident's) self @ (st) this time. (Resident) thinks...spouse has... (someone else)...Spouse just (recently) got out of hospital with heart by-pass (heart surgery). SW asked (resident) if (resident) had thoughts of how (resident) would hurt (resident's) self. Resident stated, "I would use a knife because my family took my guns from me." SW spoke to DON and nurse on unit. Resident to eat in dining room with plastic spoon and plastic knife for safety measure since (resident) made statement. (Physician) has ordered medications to address depression and anxiety. SW sent (contracted Mental Health Service) referral signed by (Physician) for counseling. SW will continue to monitor and will assist with any needs. Continued review of the SW notes revealed no supportive counseling due to the resident's concerns of the spouse having someone else, history of suicidal ideations, or the plan to use a knife to hurt the resident's self.

Medical record review of a (contracted Mental Health Services) Physician's Order for Mental Health Services, dated February 24, 2012, (no time), revealed the resident was referred for psychotherapy only, with the reasons for the referral documented as the following:
1. Sad;
2. Agitation;
3. Delusions.

Continued review of the referral revealed no documentation of urgency or crisis intervention ordered for this resident.

Continued review revealed no documentation of a...
<table>
<thead>
<tr>
<th>F 319</th>
<th>Continued From page 106</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental Health Service evaluation or treatment. Continued review revealed no documentation of the SW providing any support or collaboration with the physician to get orders for additional referral(s) to evaluate and treat the resident's mental and psychosocial needs during the remainder of the resident's admission at the nursing home.</td>
</tr>
<tr>
<td></td>
<td>Medical record review of an 'Admit Note' dated February 25, 2012, (no time), documented by the Physician, revealed the resident was unable to care for (resident) self, particularly with (resident) declining health. The note revealed the resident &quot;has some delusional thought patterns about (resident) spouse running off with somebody.&quot; The Physician's plan revealed &quot;Continue as per orders at this time.&quot;</td>
</tr>
<tr>
<td></td>
<td>Medical record review of a Nurse's Note dated February 25, 2012, at 8:59 p.m., revealed the resident was on the phone talking to the resident's spouse, &quot;...(the resident)...talking and getting emotional at (and) crying continue to state 'I'm just end it now.' (Resident) quickly changes tone at says sorry to (spouse)...This nurse (Licensed Practical Nurse (LPN) #1) spoke with...spouse &amp; assured will keep close watch on (Resident). Administered PRN Lunesta to help (Resident) sleep. Res calm at polite to staff at this moment. Will cont (continue) to monitor...&quot;</td>
</tr>
<tr>
<td></td>
<td>Medical record review of the Social Service Progress Notes revealed no documentation the SW assessed and/or provided interventions to address the suicidal ideations.</td>
</tr>
<tr>
<td></td>
<td>Medical record review of a Nurse's Note dated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F 319</th>
<th>Residents #17 &amp; #18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1) On 11/30/12, the Administrator &amp; RN Consultant reviewed with the Social Services employee responsibilities for the referral process to Mental Health Services.</td>
</tr>
<tr>
<td></td>
<td>Effective 11/30/12, the Administrator contracted with LMSW to provide a monthly visit to ensure compliance with state &amp; federal regulation, Standard of Practice, &amp; review the BSW Documentation.</td>
</tr>
<tr>
<td></td>
<td>On 12/10/12, the Administrator increased the working hours of LMSW to complete assessments on new admissions. Quarterly Assessments, &amp; oversight of the referral process.</td>
</tr>
<tr>
<td></td>
<td>2) On 11/30/12, all residents with documented behaviors, receiving services from a previous contracted Mental Health Service, and new admissions from past 2 months were assessed for need of Mental Health Services by a contracted BSW &amp; LMSW.</td>
</tr>
<tr>
<td></td>
<td>Beginning 11/30/12, a new contracted Mental Health Services will replace previous Mental Health Services and they will be providing weekly services to the facility</td>
</tr>
<tr>
<td></td>
<td>3) On 12/1/12, the DON &amp; Nursing Management will monitor all referrals to Mental Health Services for Timely referrals, Date seen, Documentation on chart &amp; Frequency of visits. This monitoring will continue for 6 months and then the QAPI committee will evaluate if continued monitoring is needed.</td>
</tr>
</tbody>
</table>
March 3, 2012, at 7:45 p.m., revealed, "This nurse (LPN #2) was coming down the hall and saw resident had a butter knife...trying to stab self in the chest. (LPN #2) got knife away from resident...asked (resident) what (resident) was doing. Resident stated, 'I just wanted to end this...'" Continued review revealed a Certified Nursing Assistant (CNA) was assigned to stay with the resident. LPN #2 notified the Physician on-call; orders were received to send to the (Hospital) Emergency Room (ER) for an evaluation. The resident's POA was also notified. Continued review revealed the Emergency Medical Service (EMS) arrived at 8:00 p.m., and the resident was transferred from the nursing home at 8:16 p.m.

Medical record review of a Patient Transfer Form dated March 3, 2012, (no time), revealed the resident tried to "stab self in the chest with a butter knife" as the reason for transfer (to the hospital from the nursing home).

Medical record review of the Social Service Progress Notes revealed no documentation of the resident's attempted suicide on March 3, 2012, until March 5, 2012; which was two days after the resident was admitted to the hospital's inpatient Mental Health Services program for treatment of diagnoses including depression and suicide gesture.

Medical record review of an Inpatient Psychiatric Consultation report dated March 4, 2012, revealed, "..sent over in the middle of the night (on March 3, 2012) from the nursing home after making a suicide gesture...was found sitting in a chair in the hallway with butter knife trying to..."
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| F 319 | Continued From page 103 | stab...self in the chest...they (nursing home staff) were able to get the knife away... (resident) stated that (resident) was trying to end (resident's) life...sent to (hospital) for evaluation... The resident was admitted to the hospital's inpatient Mental Health Services program for treatment of diagnoses including depression and suicide gesture. Review of facility policy, Referrals, Social Services, revised December 2008, revealed, "...1. Social services shall coordinate resident referrals...3. Social services will collaborate with nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician...4. Social services will...ensure adequate follow-up with appropriate documentation from referral sources...5. Social service...will maintain a listing of referral agencies that...provide assistance or therapy to residents with special problems and/or needs..."
Interview with LPN #2 on November 26, 2012, at 12:50 p.m., in the Conference Room, confirmed on March 3, 2012, shortly after supper (dinner), LPN #2 was walking out from another resident's room, to the hallway, and observed resident #1 with a knife trying to stab (resident's) self in the chest with the knife. During this interview, while describing the attempt, LPN #2 demonstrated how the resident attempted to stab self in the chest, by hitting (LPN #2's) self in the chest repeatedly with a fistfull right hand, and made a forceful thumping sound with each strike of the fist to the chest. "(Resident) was using a metal knife...like the ones that come on the residents' trays for meals. I think (resident) got it off another resident's tray...I grabbed the knife..."
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 319</td>
<td>F 319</td>
<td></td>
<td>11-14-12</td>
</tr>
</tbody>
</table>

Interview with CNA #2 on November 27, 2012, at 8:45 p.m., in the conference room confirmed CNA #2 worked on March 3, 2012, on the 2:00 p.m.-10:00 p.m. shift, and was assigned to the dining room for supper. "...After supper, I transported (resident #1) to the nurse's station straight across the hall from the dining room on Wing 4, and then proceeded down the hall to pick up trays...As I came out from room number 85 (near the end of the hall), I looked up and heard (LPN #2) say, "I need some help down here." I ran to assist (LPN #2)... Resident #1 had a metal knife in (resident's) right hand...was repeatedly stabbing (resident's) chest with the knife and yelling, 'I'm going to kill myself...I'm going to kill myself.' (LPN #2) was struggling with (resident) to get the knife, as (resident) was going at it...stabbing at (resident's) chest...By the time I reached (LPN #2) and the resident, (LPN #2) had removed the knife from the resident...I realized (resident #1) had gotten the knife from another resident seated at (resident #1's) table during supper and I said, 'Oh, no! (Resident #1) got the knife off of (random resident's) tray...I looked at (resident's) chest immediately...It had multiple red, dime-size areas but, no lacerations or stab wounds. (LPN #2) assigned me to stay 1:1 with (resident #1)...I stayed at (resident's) bedside..."
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLT NTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 319</td>
<td>Continued From page 110 until EMS (Emergency Medical Services), arrived. (Resident) previously made multiple statements ...wanted to kill (resident's) self, and wanted to die.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Interview with the SW on November 26, 2012, at 2:45 p.m., in the Conference Room, confirmed on February 24, 2012, staff (unable to recall who) reported the resident had voiced suicidal ideas. "After I had been told (resident) had voiced suicidal ideas, I talked with (resident's) POA...the resident had a history of suicidal ideas...upon assessing the resident's history, recent threats of suicide, and current suicidal ideas with a plan, I went to the Administrator's office; the DON was there. I talked with the Administrator and DON; and reported the resident had suicidal ideas, had a plan, and showed signs and symptoms of suicide attempt. I feared the resident would attempt to take or end (resident's) life. Continued interview with the SW confirmed plastic sivloraw was the only precaution implemented. When the surveyor asked if Mental Health Services were provided, the SW confirmed, "An order was written for (contracted mental health) to evaluate but, I don't know if it was done or not." When the surveyor asked if supportive counseling had been done by the SW, the SW confirmed, "No; I was waiting on (contracted Mental Health Service) to provide counseling." When the surveyor asked the SW who is responsible for arranging and tracking psychiatric referrals, the SW replied, "I am."

Telephone interview on November 26, 2012, at approximately 3:30 p.m., with the (contracted Mental Health Service provider's) Compliance Officer and Director of Business Development...
Continued from page 111:

confirmed the Physician's Order for Mental Health Services, dated February 24, 2012, (no time), was received on February 24, 2012, via fax (Facsimile). Continued interview confirmed the referral did not indicate a crisis situation (urgent, stat (immediately), or suicidal). "A clinician went to the facility to evaluate the resident on March 6, 2012; the resident was in the hospital and no treatment was provided."

A second interview with the SW, in the presence of the Administrator, on November 26, 2012, at 6:50 p.m., in the conference room confirmed on February 24, 2012, the resident's POA informed the SW of the resident's history of wanting to take pills to end the resident's life. The SW was told on February 24, 2012, by staff (names unsealed) the resident had asked questions regarding ending life and/or end of life, including "how to cut-off (resident's) air supply (SW placed hand around SW's throat and described an action of choking self); if insurance would pay if (resident) died." The SW assessed the resident after the reports on February 24, 2012, and determined the resident had a plan to kill (resident's) self with a knife. The SW reported the assessment and suicidal concerns to the Administrator and DON, on February 24, 2012. The SW confirmed, "...The resident needed to be sent out to (local Mental Health Service provider) for a Mental Health Service evaluation...I instructed the unit nurse to call the Physician and get orders for (contracted Mental Health Service) consult and medications for depression and anxiety. Continued interview with the SW confirmed no psychiatric consult occurred as ordered on February 24, 2012."
Interview with Physician on November 27, 2012, at 6:00 p.m., in the conference room confirmed the facility did not make the Physician aware of the resident’s depressed state, or any suicidal ideations, or any plan as documented by the SW on February 24, 2012, or on February 25, 2012. “If the facility had reported the resident to be significantly depressed to the point of suicidal ideations and/or intent with a plan, I would have ordered to send the resident out to the ER for an evaluation immediately. No medications were ordered on February 24, 2012 for depression or anxiety, or at any other time during the resident’s admission at the nursing home. The Xanax was a previous medication...was taking prior to admission (to the nursing home). I was not aware the resident was required to use plastic silverware to prevent self-harm.” Continued interview confirmed the orders for Ambien, Lunesta, and Doxepin, were to treat insomnia.

Interview with the SW on November 28, 2012, at 4:30 p.m., in the conference room confirmed, “...The resident voiced...wanted to die...how would kill...self, with a knife. (Resident) was depressed and suicidal...all of my bells and whistles...going off. The SW confirmed, ‘I strongly felt (resident) needed to go out for an eval.’ Continued interview confirmed, the SW failed to ensure the policy, Referrals, Social Services, was followed and failed to ensure the psychiatric referral for evaluation and treatment was obtained for the resident (#1) in crisis.

Interview with the Administrator on November 28, 2012, at 7:35 p.m., in the conference room confirmed the resident was in a mental health crisis, as identified and reported on February 24,
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 319</td>
<td>Continued From page 113</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2012. Continued interview confirmed the resident obtained a knife from another resident's tray, which the Administrator confirmed to be a stainless steel dinner knife. Continued interview with the Administrator confirmed the SW failed to ensure the policy, Referrals, Social Services, was followed, and failed to ensure the Mental Health Services referral for evaluation and treatment was obtained for the resident (#1) in crisis. The facility's failure to ensure the policy, Referrals, Social Services, was followed, and failure to provide services and treatment for a resident (#1) in crisis beginning on February 24, 2012, resulted in the resident obtaining a dinner knife, and attempts to stab (resident #1)'s self in the chest.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resident #27 was admitted to the facility March 24, 2012, with diagnoses including Depression, Anxiety, and Alzheimer's Disease.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical record review of a Quarterly Minimum Data Set (MDS) dated September 17, 2012, revealed the resident scored zero on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition; and exhibited feeling or appearing down, depressed, or hopeless nearly every day.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical record review of the Physician's Recapitulation Orders dated November 2012, revealed &quot;...Alprazolam (Xanax-for anxiety). Take 1 (one) tablet by MOUTH 3 (three) times daily AT 5:00 AM (a.m.); AT 1:00 PM (p.m.); AT 8:00 PM; Start Date: 07/30/2012 (July 30, 2012)...DX: INCREASED ANXIETY (and; or) CRYING (Prior to the routine order dated July 30, 2012, the Alprazolam was ordered as needed).</td>
<td></td>
</tr>
</tbody>
</table>
F 319. Continued From page 114

Medical record review of the Nurse's Notes, revealed:

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 29, 2012, at 12:10 a.m.</td>
<td>&quot;...Resident crying, turning on light (call light), Xanax given.&quot;</td>
</tr>
<tr>
<td>July 2, 2012, at 10:30 p.m.</td>
<td>&quot;...Res (resident) given Xanax d/t (due to) anxiety up, crying.&quot;</td>
</tr>
<tr>
<td>July 5, 2012, at 2:15 p.m.</td>
<td>&quot;...crying, Xanax...po by mouth...&quot;</td>
</tr>
<tr>
<td>July 7, 2012, at 10:00 a.m.</td>
<td>&quot;...Res @ times has increased anxiety...Xanax...administered...cries easily...&quot;</td>
</tr>
<tr>
<td>July 8, 2012, at 2:00 p.m.</td>
<td>&quot;...Res with increased anxiety crying uncontrollably...Xanax...for agitation...&quot;</td>
</tr>
<tr>
<td>July 9, 2012, at 3:00 p.m.</td>
<td>&quot;Res lying in bed rocking back &amp; forth crying. (Spouse) unable to redirect. This nurse administered Xanax...Res less anxious when told medication would help (resident) to calm down...&quot;</td>
</tr>
<tr>
<td>July 13, 2012, at 2:15 p.m.</td>
<td>&quot;Res crying &amp; agitated says, 'Help me, Help me.' Xanax...admin...&quot;</td>
</tr>
<tr>
<td>July 19, 2012, at 12:07 p.m.</td>
<td>&quot;Res crying cont (continuously)...Xanax give (given)...&quot;</td>
</tr>
<tr>
<td>July 20, 2012, at 11:20 p.m.</td>
<td>&quot;repeatedly turning on call light...Xanax...d/t increased anxiety...&quot;</td>
</tr>
<tr>
<td>July 30, 2012, at 10:32 a.m.</td>
<td>&quot;...Res in bed crying cont asking for 'help &amp; nurse' over &amp; over again...&quot;</td>
</tr>
<tr>
<td>August 3, 2012, (no time).</td>
<td>&quot;...Res cries a lot...&quot;</td>
</tr>
<tr>
<td>September 6, 2012, at 9:40 a.m.</td>
<td>&quot;...episodes of crying with Xanax...administered...&quot;</td>
</tr>
<tr>
<td>September 20, 2012, at 8:00 a.m.</td>
<td>&quot;Res in bed crying on &amp; off...&quot;</td>
</tr>
<tr>
<td>October 4, 2012, at 8:40 a.m.</td>
<td>&quot;...Res has episodes of crying at (and) stating 'Nurse, Nurse help me' repeatedly...&quot;</td>
</tr>
<tr>
<td>October 18, 2012, (no time).</td>
<td>&quot;...res verbal of...&quot;</td>
</tr>
<tr>
<td>(X1) ID</td>
<td>PREFIX</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>F 319</td>
<td></td>
</tr>
</tbody>
</table>

F 319: Continued From page 115

wants and needs..."

November 7, 2012, at 9:00 a.m. "Continues to cry @ times..."

Medical record review of the Nurse's Monthly Summary dated July 3, 2012; August 3, 2012; September 1, 2012; October 2, 2012; and November 3, 2012; revealed the consistent presence of mood symptoms, which included "Little interest or pleasure in doing things...Feeling or appearing down, depressed, or hopeless...Feeling tired or having little energy...indicates that s/he (she or he) feels bad about self, is a failure, or has let family down..."

Medical record review of the Physician's Progress notes revealed:

August 30, 2012, (no time). "Pt (patient) is crying today..."

October 30, 2012, (no time). "...is crying...continues to have crying spells."
F 319 Continued From page 116

Medical record review revealed no documentation of mental or psychosocial services and/or treatment were provided.

Observation of the resident and interview, on November 30, 2012, at 6:30 p.m., in the resident's room confirmed the resident was lying in bed, with the television on. During the beginning of the interview the resident began to cry. The surveyor asked the resident what was wrong and the resident answered, "I want to go home." The surveyor validated the resident missed being at home. The resident confirmed the validation, and continued to cry. Tears rolled from the resident's eyes, and down both sides of the face. The surveyor commented regarding the spouse's daily visits, and the resident confirmed, "Yes, but, (spouse) is only here a few hours during the day." Surveyor asked the resident what the resident enjoyed most when the spouse visited, and the resident confirmed, "Watching TV (television)." By this time during the interview, the resident's crying decreased, and then stopped. As the interview ended and the surveyor turned to leave the room, the resident began to cry again.

Resident #17 was admitted to the facility on August 18, 2011, with diagnoses including Depression, Right Above-the-Knee Amputee, and Peripheral Vascular Disease.

Medical record review of a Quarterly Minimum Data Set (MDS) dated May 27, 2012, revealed the resident scored fifteen on the Airst Interview
**OVERTON COUNTY NURSING HOME**

<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 319</td>
<td>Continued From page 117</td>
<td>for Mental Status (BiMS), indicating the resident's cognition was intact.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical record review of a (contracted)
Psychology Progress Note dated June 29, 2012, revealed the resident's diagnosis included "Adjustment disorder with mixed disturbance of emotions and conduct...Depression, and Anxiety...symptoms presented are significant enough to interfere with the patient's psychosocial well-being...Chronic sad mood...With supportive reassurance, pt. slowly with brief gaps of silence verbalized feelings of sadness and worry...Pt continues with a/s (signs and symptoms) of depression that are negatively impacting...health status including lack of motivation, tearfulness, and general agitation toward issues (resident) cannot change...Based on current status, progress and need, counseling will continue for approximately 9-11 (nine to eleven) weeks...Planned Session Frequency: 2-3/mo (two-to-three sessions per month)...Behavioral Suggestions to Staff:...consider providing positive support and understanding..." This session was the last session provided by the contracted Mental Health Service provider, and/or any Mental Health Service provider.

Medical record review of a Nurse's Note dated July 27, 2012, at 3:00 p.m., revealed "...res not happy about going home next week. Staff reported that Res stated to them...was going to do everything...can do to make sure...won't have to leave...staff stated while working with (resident), Res attempted to throw (resident's)...self backwards, so (resident) would fall but they were able to keep (resident) upright. Res was also trying to kick prosthetic leg off at was putting..."
Continued from page 118

all...weight...on...staff..."

Medical record review of the Social Service Progress Notes revealed no documentation the SW provided assessment and/or interventions to address the resident's inability to cope with loss of function due to the amputation of the right leg; difficulty with prosthetic adjustment; the need for physical and emotional support; and difficulty with the planned discharge to home with the daughter. Continued review of the progress notes revealed the resident was discharged home (with daughter) on July 31, 2012.

Resident #18 was admitted to the facility on October 30, 2006, with diagnoses including Depression, Psychotic Episodes, and Malignant Cancer of the Kidney.

*Medical record review of a Quarterly Minimum Data Set (MDS) dated August 28, 2012, revealed the resident scored nine on the Brief Interview for Menti Status (BIMS), indicating the resident's cognition was intact.*

*Medical record review of a (contracted) Psychology Progress Note dated July 19, 2012, revealed the resident's diagnoses included "Major depressive disorder...moderate... Oriented to person, place, time...symptoms presented are significant enough to interfere with the patient's psychosocial well-being...Obsessiveness...Sadness, Fearful...Verbalized increased anxiety...final session with this clinician and that (resident) desires to be followed by alternate clinician...Termination completed with this pt and...expresses to be followed by alternate..."*
<table>
<thead>
<tr>
<th>DATE</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-24-12</td>
<td></td>
</tr>
</tbody>
</table>

**Summary Statement of Deficiencies**

**ID Number:** P 319

**Privileged Provider/Supplier ID Number:** 445419

**Monthly Construction**

**Building:** 1

**Wing:** 1

**Survey Completed:** C

**Address:** 318 Bilbrey Street

**City:** Livingston

**State:** TN

**Zip Code:** 38570

**Issue:** Continued from page 119

- Clinician...Based on current status, progress and need, counseling will continue approximately 5-6 (five to six) weeks...Planned Session Frequency: 1-2/mo (one to two sessions per month). This session was the last session provided by the contracted Mental Health Service provider, and/or any Mental Health Service provider.

- Resident #31 was admitted to the facility on July 2, 2009, with diagnoses including Explosive Personality, Behavioral Problems, Psychosis, Alzheimer's Disease, and Dementia.

- Medical record review of a Quarterly Minimum Data Set (MDS) dated September 22, 2012, revealed the resident scored fourteen on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact.

- Medical record review of a (contracted) Psychology Progress Note dated July 19, 2012, revealed the resident's diagnoses included "Major depressive disorder...moderate...Oriented to person, place, time...symptoms persists are significant enough to interfere with the patient's psychosocial well-being...Verbal aggression...Sadness...Chronic worry...Irritability...Low frustration tolerance...Delusions...this will be the last session with this LCSW (Licensed Clinical Social Worker) and is receptive to follow up with alternate clinician. Participating in therapy sessions though has not yet reached maximum potential...continues with negative thinking and other effects of depression that negatively impact...psychosocial functioning. Termination completed with this pt and...is receptive to be followed by alternate clinician...Based on current..."
OVERTON COUNTY NURSING HOME

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING

B. WING

IDENTIFICATION NUMBER:
445418

MULTIPLE CONSTRUCTION

DATE SURVEY COMPLETED:
12/04/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE:
318 BILBREY STREET
LIVINGSTON, TN 38570

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR FSC IDENTIFYING INFORMATION)

ID PREFIX TAG
F 319

ID PREFIX TAG
F 319

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE
12-14-12

Continued From page 120

status, progress and need, counseling will continue approximately 8-11 weeks. Planned Session Frequency: 1-2/mo.

Medical record review of the Nurse's Monthly Summary dated August 12, 2012 and September 3, 2012, revealed the consistent presence of mood and behavior symptoms which included...

...Mood: Little interest or pleasure in doing things. Behavior: Verbal behavioral symptoms toward others...

Continued review on October 10, 2012, revealed an increase of the number of mood symptoms but, behavior symptoms remained the same as the two prior months, which included ...

...Mood: Little interest or pleasure in doing things; overspending; being short-tempered, easily annoyed...

Behavior: Verbal behavioral symptoms toward others...

Continued review on November 8, 2012, revealed the mood symptoms remained unchanged but, behavioral symptoms increased, which included ...

...Mood: Little interest or pleasure in doing things; overspending; being short-tempered, easily annoyed ...

Behavior: Verbal behavioral symptoms toward others; rejects care...

Medical record review revealed no documentation of mental or psychosocial services provided after July 19, 2012, psychiatric treatment session.

Telephone interview on November 28, 2012, at approximately 3:30 p.m., with the (contracted Mental Health Services provider's) Compliance Officer and Director of Business Development confirmed the Mental Health Service provider services were no longer available to the facility due to inability to secure a clinician for the facility (location); the last two dates of service were June...
Continued From page 121

Interview with the SW on November 28, 2012, at
4:30 p.m., in the conference room confirmed the
SW failed to follow the policy, Referrals, Social
Services, and failed to provide Mental Health
Services for residents #27, #17, #18, and #31.

Interview with the Administrator on November 28,
2012, at 7:35 p.m., in the conference room
confirmed "We have not had Mental Health
Services provider since June 2012...We've had a
big problem with getting (psychiatric) (mental
health services) in here...I'll just go ahead and tell
you, and be honest about it...we've not had
anybody..." Continued interview with the
Administrator confirmed resident #1 was in a
mental health crisis, as identified and reported on
February 24, 2012. Continued interview
confirmed the resident obtained a knife from
another resident's tray, which the Administrator
confirmed to be a stainless steel dinner knife.

Continued interview with the Administrator
confirmed the facility's failure to follow policies,
 failure to notify the Physician, failure to provide
 medically-related Social Services, failure to revise
 the care plan, failure to provide Mental Health
 Services, and failure to provide the necessary
care and services to maintain the highest
predictable mental and psychosocial well-being
allowed the resident to obtain a dinner knife, and
then carried out an attempted suicide (by
stabbing self repeatedly in the chest) on March 3,
2012. Continued interview confirmed the facility
failed to follow policies and failed to provide
Mental Health Services for residents #27, #17,
#18, and #31.
Statement of Deficiencies and Plan of Correction

Name or Provider or Supplier: Overton County Nursing Home

Street Address, City, State, Zip Code: 316 BILBREY STREET LIVINGSTON, TN 38570

F-319 Continued From page 122

Interview with the Administrator on November 30, 2012, at 11:15 p.m., in the Administrator's Office confirmed: "We now have a contract with a new (Mental Health Services provider)... I signed the new contract signed today."

The immediate Jeopardy was effective from February 26, 2012, through November 29, 2012, and was removed on November 30, 2012. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyor through review of documents, staff interviews, and observations conducted onsite on November 30, 2012. The surveyor verified the allegation of compliance by:

1. Reviewing the corrective action implemented for the SW.

2. Reviewing the facility's in-service records to ensure all staff were educated regarding changes to and implementation of the facility's following policies:
   a. Change in Resident's Condition and Status;
   b. Suicide Threats;
   c. Care of a Suicidal Resident;
   d. Behavioral Management;
   e. Care Planning and Using the Care Plan.

3. Conducting interviews with facility departments, to include fifteen of thirty-one nurses, three of nine environmental services, one of three maintenance, two of four activities, one of two social services, twenty-nine of fifty-two CNAs, ten of twenty-three dietary, seven of seventeen laundry and housekeeping, on staff to determine the level of comprehension gained.
F 319: Continued from page 123

through in-service education conducted regarding changes to and implementation of the facility's
policies, "Change in Resident's Condition and Status; Suicide Threats; Care of a Suicidal
Resident; Behavioral Management; Care Planning and Using the Care Plan," to ensure
staff recognize and respond to the following:
a. A resident making suicide threats or
   statements are immediately placed 1:1 for
   constant observation; staff will remain with the
   resident at all times until (1) the Physician orders
   the resident transferred for evaluation and
   admitted to a higher level of care, or (2) the
   Physician evaluates the resident and deems them
   safe;
   b. Warning signs of suicide;
   c. Statements and behaviors that may be a
      warning sign of suicide;
   d. Using probes for more information;
   e. Risk factors for suicide;
   f. Restricting access to lethal means and
      removal of any harmful objects.

g. Residents at risk of suicide are communicated
to all staff via the current Care Plan; Nursing
24-Hour Report; noted on the Medication
Administration Record (MAR) and Treatment
Administration Record (TAR);

h. Residents at risk of suicide are discussed
weekly in the department head meetings;

i. A newly identified resident at risk of suicide will
result in a suicide watch, and an emergency
department head meeting will be called for
immediate discussion.

4. Reviewing the facility's in-service records with
the Social Worker ensuring responsibilities were
reviewed and clarified, to include the following:
Continued From page 124

5. Review of the facility's contract with the Licensed Master of Social Work (LMSW) to ensure services are contracted to occur on a monthly basis beginning on November 30, 2012, to provide visits, ensure oversight of the current SW, and compliance with State and Federal Regulations, facility's policies, and Standards of Practice.

6. Reviewing of Suicide Risk Assessments on all residents in the facility. No residents were identified to have suicide risks.

7. Reviewing the new contract with a different Mental Health Services provider, who will be providing weekly services to the facility’s residents, as identified and indicated.

8. Reviewing assessments and supportive counseling provided by a contracted BSW with Long Term Care experience. The assessments and supportive counseling was provided to all residents receiving services from a previous contracted Mental Health Services; and new
F 319, Continued From page 125

Admissions from the past two months were assessed and supportive counseling was provided.

9. An emergency Quality Assurance/Performance Improvement Committee Meeting was held on November 30, 2012, with the Medical Director, DON, Administrator, Consultant, Infection Control Nurse, and two other facility staff to include the Safety Leader.

Non-compliance continues at an "E" level for monitoring corrective actions. The facility is required to submit a plan of correction.

CO #30697

F 490 483.75 Effective Administration/Resident Well-Being

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, facility policy review and interview, the facility failed to be administered in a manner to ensure processes were in place to train and educate all staff on suicide prevention, failed to prevent neglect by following facility policies for resident change in condition to protect and prevent suicide attempts, failed to notify the physician of verbal statements of and plan for suicide, failed to provide Social Service counseling, failed to revise the care plan

Residents #1, #17, #18, #27, #31

1) On 11/29/12 & 11/30/12, the Administrator, Medical Director, and DON reviewed and approved all the new & revised policies and procedures.

On 11/29/12, 11/30/12, 12/1/12, 12/6/12-12/10/12, the Administrator was supportive & approved all in-services conducted by professionally trained nurses or Mental Health providers for:

- Recognizing & Responding to the Warning Signs of Suicide
- Statements & Behaviors that may be a Warning Sign
- Probes for more Information
- Risk Factors for Suicide
- Protective Factors for Suicide
- Restricting Access to Lethal Means
F 490. Continued From page 128

with interventions to prevent suicide attempts, failed to provide the necessary care and services to maintain the highest practicable mental and psychosocial well-being, for one resident (#1) in crisis of thirty-two residents reviewed; and failed to provide Mental Health Services for five residents (#1, #27, #17, #18, #31) of thirty-two residents reviewed.

The facility’s failure to be administered in a manner to attain or maintain the highest practicable physical, mental, and psychosocial well-being of a resident in crisis resulted in the resident obtaining a dinner knife, and attempting to stab (resident #1’s) self in the chest. Resident #1’s attempted suicide on March 3, 2012, required a transfer to the hospital emergency room and admission to a mental health unit for treatment. The facility’s failure placed resident #1 in Immediate Jeopardy (a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, or death to a resident).

The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Conference Room on November 29, 2012, at 11:30 a.m.

A partial extended survey was conducted on December 4, 2012.

The findings include:

Interview with the Administrator on November 30, 2012, at 9:00 a.m., in the Administrator’s Office confirmed the facility failed to provide in-service
F 490: Continued From page 127

training to staff after resident #1 made verbal threats of suicide on February 24, 2012, or after the resident attempted suicide on March 3, 2012; failed to prevent neglect by not following facility policies for resident change in condition to protect and prevent suicide attempts, failed to notify the physician of verbal statements of and plan for suicide, failed to provide Social Service counseling, failed to revise the care plan with interventions to prevent suicide attempts, failed to implement interventions in addition to plastic silverware, failed to provide the necessary care and services to maintain the highest practicable mental and psychosocial well-being, failed to provide Mental Health Services, failed to administer the facility in a manner to attain or maintain the highest practicable physical, mental, and psychosocial well-being, and failed to identify issues, develop and implement plans of corrective action to ensure the effectiveness of facility systems, for one resident (#1) of thirty-two residents reviewed. Continued interview confirmed the facility failed to ensure policies were followed and Mental Health Services were provided for residents #27, #17, #18, and #31, who experienced mental and/or psychosocial difficulties.

The facility’s failure placed resident #1 at risk for suicide attempts and resulted in immediate Jeopardy (a situation in which the provider’s noncompliance has caused or is likely to cause serious injury, harm, impelment, or death).

Refer to F187 J
Refer to F224 J Substandard Quality of Care
Refer to F250 J Substandard Quality of Care
Refer to F280 J

F 490: deficiencies & reporting of all findings to the QAPI committee and Governing Body.

4) Beginning 11/30/12, the Administrator will conduct timely QAPI meetings quarterly & will also conduct these meetings more often if needed to evaluate compliance with policies & procedures as well as monitoring tools established. The Administrator will report to the Governing Body concerning monitoring outcomes on a quarterly basis beginning 12/13/12. This will be ongoing.
F 490: Continued From page 128

Refer to F309 J Substandard Quality of Care
Refer to F319 J Substandard Quality of Care

The Immediate Jeopardy was effective from February 25, 2012, through November 29, 2012, and was removed on November 30, 2012. An Acceptable Allegation of Compliance, which removed the Immediate of the Jeopardy, was received and corrective actions were validated by the surveyor through review of documents, staff interviews, and observations conducted onsite on November 30, 2012. The surveyor verified the allegation of compliance by:

1. Reviewing the facility's in-service records to ensure all staff were educated regarding changes to and implementation of the facility's following policies:
   a. Change in Resident's Condition and Status;
   b. Suicide Threats;
   c. Care of a Suicidal Resident;
   d. Behavioral Management;
   e. Care Planning and Using the Care Plan.

2. Conducting interviews with facility staff to include fifteen of thirty-one nurses, three of nine environmental services, one of three maintenance, two of four activities, one of two social services, twenty-nine of fifty-two CNA's, ten of twenty-three dietary, seven of seventeen laundry and housekeeping, on staff to determine the level of comprehension gained through in-service education conducted regarding changes to and implementation of the facility's policies, "Change in Resident's Condition and Status; Suicide Threats; Care of a Suicidal Resident; Behavioral Management; Care Planning and Using the Care Plan," to ensure
F 490: Continued From page 129

- Staff recognize and respond to the following:
  a. A resident making suicide threats or statements are immediately placed 1:1 for constant observation; staff will remain with the resident at all times until (1) the Physician orders the resident transferred for evaluation and admitted to a higher level of care, or (2) the physician evaluates the resident and deems them safe;
  b. Warning signs of suicide;
  c. Statements and behaviors that may be a warning sign of suicide;
  d. Using probes for more information;
  e. Risk factors for suicide;
  f. Protective factors for suicide;
  g. Restricting access to lethal means and removal of any harmful objects;
  h. Residents at risk of suicide are communicated to all staff via the current Care Plan; Nursing 24-Hour Report; noted on the Medication Administration Record (MAR) and Treatment Administration Record (TAR);
  i. Residents at risk of suicide are discussed weekly in the department head meetings.
  j. A newly identified resident at risk of suicide will result in a suicide watch, and an emergency department head meeting will be called for immediate discussion.

3. Reviewing the facility's in-service records with the Social Worker ensuring responsibilities were reviewed and clarified, to include the following:
   a. A Suicide Rating Scale has been added to the Social Services Assessment, to be completed on new admissions, quarterly, and with a significant change in condition;
   b. Social Services is responsible for ensuring the referral source sees the resident and
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>Provider/Supplier Identification Number</th>
<th>Multiple Construction A. Building</th>
<th>C. Wing</th>
<th>Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>445419</td>
<td></td>
<td></td>
<td>12/04/2012</td>
</tr>
</tbody>
</table>

#### Name of Provider or Supplier

**Overton County Nursing Home**

#### Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Providers Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 490</td>
<td>Continued From page 130 responding/appropriate notes are in the medical record; c. Supportive Counseling; d. Bachelor of Social Work (BSW) Scope of Practice; e. Responsibilities of Social Services; f. Federal Regulations.</td>
<td>F 490</td>
<td></td>
<td>12-14-12</td>
</tr>
</tbody>
</table>

4. Review of the facility's contract with the Licensed Master of Social Work (LMSW) to ensure services are contracted to occur on a monthly basis beginning on November 30, 2012, to provide visits, ensure oversight of the current SW, and compliance with State and Federal Regulations, facility's policies, and Standards of Practice.

5. Reviewing of Suicide Risk Assessments on all residents in the facility. No residents were identified to have suicide risks.

6. Reviewing the new contract with a different Mental Health Services provider, who will be providing weekly services to the facility's residents, as identified and indicated.

7. Reviewing assessments and supportive counseling provided by a contracted BSW with Long Term Care experience. The assessments and supportive counseling was provided to all residents receiving services from a previous contracted Mental Health Services; and new admissions from the past two months were assessed and supportive counseling was provided.

8. An emergency Quality Assurance/Performance Improvement Committee
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 490</td>
<td>Continued From page 131</td>
<td>F 490: Continued From page 131</td>
</tr>
<tr>
<td></td>
<td>Meeting was held on November 30, 2012, with the Medical Director, DON, Administrator, Consultant, Infection Control Nurse, and two other facility staff to include the Safety Leader.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-compliance continues at &quot;E&quot; level for monitoring of corrective actions. The facility is required to submit a plan of correction.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 514</td>
<td>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</td>
<td>F 514: 483.75(l)(1) RES Records-Complete/Accurate/Accessible</td>
</tr>
<tr>
<td></td>
<td>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.</td>
<td>Res Records-Complete/Accurate/Accessible</td>
</tr>
<tr>
<td></td>
<td>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any predmission screening conducted by the State; and progress notes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policies, and interview, the facility failed to follow facility policies and maintain accurate records (care plan) for one (#1) resident of thirty-two residents reviewed. The facility's failure to follow policies, resulted in resident #1's care plan not being revised until November 5, 2012, which was approximately nine months after the resident</td>
<td></td>
</tr>
</tbody>
</table>

Attachment #13

On 12/1/12, the Administrator & RN Consultant conducted an In-service on comprehensive care planning & facility policy on accurate medical records.  

Attachment #14

2) On 12/4/12 - 12/6/12, DON & Nursing Management reviewed all care plans for accurately dated care plans.  

3) Beginning 12/9/12, the MDS staff will monitor care plans for appropriate date, data, & interventions for 3 months and then the QAPI committee will evaluate if continued monitoring is needed.
4) The DON will report the outcomes of care plan monitoring at the quarterly QAPI committee meetings and ultimately the Administrator will report to the Board quarterly. An emergency QAPI committee meeting was held on 11/30/12 with the Medical Director, DON, Administrator, RN Consultant, Infection Control Nurse and other facility staff to include safety. A QAPI committee meeting was held on 12/14/12. A January meeting is scheduled for 1/17/13.

Continued from page 132

made verbal statements of and plan for suicide (on February 24, 2012), and eight months after the resident was discharged due to a suicide attempt (on March 3, 2012).

The findings included:

Resident #1 was admitted to the facility from the local hospital on February 10, 2012, with diagnosis including Lack of Coordination; Status/Post Cerebrovascular Accident (CVA, or Stroke); Left-Side Hemiplegia secondary to CVA; History of Depression; Diabetes Mellitus Type II; and Coronary Artery Disease.

Medical record review of the hospital Discharge Summary dated February 10, 2012, revealed, (the resident was) "...significantly disabled...due to a cerebrovascular accident in...2009 which has left (residents) hemiplegic and very poorly coordinated... and had a history of depression.

Medical record review of a Social Service Progress Note dated February 24, 2012, at 1:36 p.m., revealed, "Family told SW (Social Worker) resident called the POA (Power-Of-Attorney)...and (residents spouse) late last night at 10:43 p.m. and made a delusional statement. (Resident) said...would send (residents sibling) over to (residents spouses) home to run off a (spouses visitor) according to...POA...also stated resident had a hx (history) of making statement(s) wanting to take pills to end (residents life)...ateled (residents) has made these statements to family 1-2 (one-to-two) yrs (years). SW talked to the DON (Director of Nursing) and (contracted Mental Health Services) referral being sent for counseling and Dr. (Physician) notified for medication and
F 514 Continued From page 133

Instruction. SW spoke to the resident...stated...was concerned about spouse but not thinking of hurting (resident's) self @ (at) this time. (Resident) thinks...spouse has... (someone else)...Spouse just (recently) got out of hospital with heart by-pass (heart surgery). SW asked (resident) if (resident) had thoughts of how (resident) would hurt (resident's) self. Resident stated, "I would use a knife because my family took my guns from me." SW spoke to DON and nurse on unit. Resident to eat in dining room with plastic spoon and plastic knife for safety measure since (resident) made statement. (Physician) has ordered medications to address depression and anxiety. SW sent (contracted Mental Health Service) referral signed by (Physician) for counseling. SW will continue to monitor and will assist with any needs."

Medical record review of an electronically printed Care Plan, revealed a handwritten entry:
(Problem) "2-24-12, (February 24, 2012) Risk for harm to self AEB (as evidenced by) HX (history) of statements of wanting to end life."
( Goal) "No Harm to resident per self thru 5-13-12, (May 13, 2012)"
(Approaches) "Med(s) (medications) as ordered per MD (Medical Doctor); Psychiatric Services/Counseling (Mental Health Services and/or Counseling); Plastic utensils at meals for safety. Social Worker to monitor and assist c (with) needs. (emotional); Observe for possible adverse reactions to med/s."

Medical record review of a Nurse's Note dated March 8, 2012, at 7:45 p.m., revealed, "This nurse (LPN #2) was coming down the hall and saw resident had a butter knife...trying to stab self..."
F 514: Continued From page 134

In the chest... (LPN #2) got knife away from resident... asked (resident) what (resident) was doing. Resident stated, 'I just wanted to end this..." Continued review revealed a Certified Nursing Assistant (CNA) was assigned to stay with the resident. LPN #2 notified the Physician on-call; orders were received to send to the (Hospital) Emergency Room (ER) for an evaluation. The resident's POA was also notified. Continued review revealed the Emergency Medical Service (EMS) arrived at 8:00 p.m., and the resident was transferred from the nursing home at 8:18 p.m.

Medical record review of a Patient Transfer Form dated March 3, 2012, (no time), revealed the resident tried to "stab self in the chest with a butter knife" as the reason for transfer (to the hospital from the nursing home).

Medical record review of an inpatient Psychiatric Consultation report dated March 4, 2012, revealed, "sent over in the middle of the night (on March 3, 2012) from the nursing home after making a suicide gesture... was found sitting in a chair in the hallway with butter knife trying to stab... self in the chest... they (nursing home staff) were able to get the knife away... (resident) stated that (resident) was trying to end (resident's) life... sent to (hospital) for evaluation... The resident was admitted to the hospital's inpatient mental health services program for treatment of diagnoses including depression and suicide gesture.

Review of facility policy, Care Plans, (no date) revealed "...g) When a new approach (intervention) or goal is identified, the entry should
Continued From page 135

be dated using the date the goal (and or)
approach is entered on the care plan."

Review of facility policy. Care
Plans-Comprehensive, revised April 2010
revealed "...care plans are revised as
information about the resident and the resident's
change...Revisions: The Care
Planning/Interdisciplinary Team is responsible
for...updating the care plans: a. When there
has been a significant change in the resident's
condition..."

Telephone interview with Registered Nurse (RN)
#1 on November 27, 2012, at approximately
10:50 a.m., revealed when the surveyor initiated
the investigation on November 6, 2012, and
requested the resident's record from medical
records; RN #2 realized the surveyor would be
reviewing the resident's care plan. On November
5, 2012, (unable to recall time), RN #2, realized
the resident's care plan had not been revised,
called RN #1, and asked how to write a suicide
precaution care plan. RN #1 revealed the care
plan was not revised on February 24, 2012, as
documented but, was revised on November 6,
2012.

Interview with RN #2 on November 27, 2012, at
11:21 a.m., in the conference room confirmed,
the surveyor had requested the resident's closed
medical record (a record that is inactive due to
the resident's discharge from the facility) when
the complaint investigation was first initiated on
November 6, 2012. "...I looked at the chart
before giving it to the surveyor and realized the
care plan had not been updated (revised) for
suicide precautions from when the resident
### Statement of Deficiencies and Plan of Correction

#### Provider/Supplier Identification Number:
- 445419

#### Name of Provider or Supplier:
- Overton County Nursing Home

#### Street Address, City, State, Zip Code:
- 315 Bilberry Street
- Livingston, TN 38570

#### Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information):

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Providers Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
</tr>
</thead>
</table>
| F 514         | Continued From page 136

threatened suicide on February 24, 2012...I documented the care plan update on November 2, 2012, to reflect a February 24, 2012, date, to prevent the surveyor from finding out it had not been updated...

Interview with the Administrator on November 28, 2012, at 7:35 p.m., in the conference room confirmed the resident was in a mental health crisis, as identified and reported on February 24, 2012; and on March 3, 2012, the resident obtained a dinner knife, and attempted to stab (resident #1's) self in the chest. Continued interview confirmed the resident was discharged on March 3, 2012, after the suicide attempt. The Administrator confirmed (RN #2's) documenting on the closed medical record resulted in the facility producing an inaccurate care plan for resident #1.

#### ID Prefix Tag: CO #30937
- F 516
  - Resident #1

A facility may not release information that is resident-identifiable to the public.

The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

The facility must safeguard clinical record information against loss, destruction, or unauthorized use.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 51G</td>
<td>Continued From page 137</td>
<td>F 516</td>
<td></td>
<td>12-14-12</td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

Based on review of facility policies and interview, the facility failed to follow facility policies and safeguard Protected Health Information (PHI) located in one resident's (#1) clinical record of thirty-two residents reviewed.

The findings included:

- Resident #1 was admitted to the facility from the local hospital on February 10, 2012, with diagnoses including Lack of Coordination; Status/Post Cerebrovascular Accident (CVA, or Stroke); Left-Side Hemiplegia secondary to CVA; History of Depression; Diabetes Mellitus Type II; and Coronary-Artery Disease.

Medical record review of a Social Service Progress Note dated February 24, 2012, at 1:35 p.m., revealed, "Family told SW (Social Worker) resident called the POA (Power-of-Attorney)...and (resident's spouse) late last night at 10:40 p.m. and made a delusional statement. (Resident) said...would send (resident's sibling) over to (resident's spouse's) home to run off a (spouse's visitor) according to...POA...also stated resident had a hx (history) of making statement(s) wanting to take pills to end (resident's) life...stated (resident) has made these statements to family 1-2 (one-to-two) yrs (years). SW talked to the DON (Director of Nursing) and (contracted Mental Health Service) referral being sent for counseling and Dr. (Physician) notified for medication and instruction. SW spoke to the resident...stated...was concerned about spouse but not thinking of hurting (resident's) self @ (all)"
F 516: Continued From page 138

this time. (Resident) thinks...spouse has...
(someone else)...Spouse just (recently) got out of
hospital with heart by-pass (heart surgery). SW
asked (resident) if (resident) had thoughts of how
(resident) would hurt (resident’s) self. Resident
stated, “I would use a knife because my family
took my guns from me.” SW spoke to DON and
nurse on unit. Resident to eat in dining room with
plastic spoon and plastic knife for safety measure
since (resident) made statement. (Physician) has
ordered medications to address depression and
anxiety. SW sent (contracted Mental Health
Service) referral signed by (Physician) for
counseling. SW will continue to monitor and will
assist with any needs."

Review of facility policy, Health Insurance
Portability and Accountability Act (HIPAA), (no
date) revealed, "...one may not...disclose PHI
(Protected Health Information) in any form to
anyone outside of the facility without first
obtaining written resident authorization...This
means you may not...discuss or present PHI from
a facility with or to anyone, including friends or
family, who was not directly involved in their care
at that facility..."

Telephone interview with Registered Nurse (RN)
#1 on November 27, 2012, at approximately
10:50 a.m., confirmed RN #1 made two copies of
an original Social Service Progress Note, and
dated sometime in February 2012. RN #1 was
unable to recall the specific date. Continued
interview confirmed RN #1 gave the copies to two
different people, one of which works in the
facility's Business Office.

Interview with family member #1 on November
**F 616** Continued From page 138

29, 2012, at 11:45 a.m., in the conference room confirmed sometime in March 2012, after (resident) had attempted suicide; RN #1 gave family member #1 a copy of a Social Service Progress Note about the resident being suicidal in February 2012. “I didn’t give or show the copy to anyone... I shredded it. This (resident) was my family... and I work here... I was scared to death and didn’t want anything to do with what was going on (RN #1 making copies of the resident’s record).”

Interview with RN #1 on November 30, 2012, at 1:00 p.m., in the conference room confirmed sometime after the resident’s attempted suicide on March 3, 2012, RN #1 made two copies of a Social Service Progress Note, dated in February 2012. RN #1 was unable to recall the specific date on the progress note but confirmed the documentation reflected the resident’s suicidal and depressed condition. Continued interview confirmed RN #1 gave one copy to family member #1 (who also works at the facility) and the other copy to family member #2, neither of which was the resident’s Power-of-Attorney or authorized to receive and/or review the copied document. RN #1 confirmed “I felt (resident) was being harmed by not getting the service (resident) needed. (Resident) needed a psychiatric (mental health) evaluation because (resident) was depressed and suicidal... (resident) actually had a plan of stabbing (resident) self with a knife... the Social Worker (SW) and I discussed this and realized (resident) was suicidal. The Administrator and Director of Nursing (DON) refused to send (resident) out, even though the SW told them (resident) was suicidal. This is the reason I made the copies... and gave them to the...
**F 516**: Continued from page 140

"family..." RN #1 confirmed copying the record was a failure to follow facility policies and safeguard the resident's Protected Health Information (PHI).

Interview with the Administrator on November 30, 2012, at 2:00 a.m., in the Administrator's Office confirmed the facility failed to follow facility policies and safeguard the resident's Protected Health Information (PHI).

**CO #30897**

**F 520**: 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committees with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 516</td>
<td></td>
<td></td>
<td>12-14-12</td>
</tr>
</tbody>
</table>
| F 520 483.75(o)(1) QAA Committee-Members/Meet | F 520 | Residents #1, #17, #18, #27, #32. 1) The DON & Administrator reviewed and revised the QAPI Plan and presented the Plan at the 11/30/12 QAPI meeting and developed a standardized agenda to ensure all topics are reviewed on a quarterly basis. Attachment #15  The DON & Administrator developed monitoring tools for referrals to Mental Health Services. Notification of Physician, HIPAA violation, care plans, and suicidal residents in facility. 2) On 12/3/12, the Administrator conducted a Department Head meeting to review new QAPI plan, agenda, and monitoring parameters. On 12/14/12, the Administrator developed Quality Improvement Objectives for 2013 to be presented at the December QAPI committee.
F 520 Continued From page 141

a basis for sanctions.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, facility policy review and interview, the facility failed to ensure an effective system was in place to train and educate staff on suicide prevention, failed to ensure an effective system to prevent neglect by following facility policies for resident change in condition to protect and prevent suicide attempts, failed to ensure an effective system to notify the physician of verbal statements of and plan for suicide, failed to ensure an effective system to provide Social Service counseling, failed to ensure an effective system to revise the care plan with interventions to prevent suicide attempts, and failed to ensure an effective system to provide the necessary care and services to maintain the highest practicable mental and psychosocial well-being, for one resident (#1) in crisis of thirty-two residents reviewed; and failed to ensure an effective system to provide Mental Health Services for five residents (#1, #27, #17, #18, #31) of thirty-two residents reviewed.

The facility's failure to ensure effective systems for a resident in crisis resulted in the resident obtaining a dinner knife, and attempted to stab (resident #1's) self in the chest. Resident #1's attempted suicide on March 3, 2012, and required a transfer to the hospital emergency room and admission to a mental health unit for treatment. The facility's failure placed resident #1 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has ceased, or is
F 520: Continued From page 142

likely to cause serious injury, harm, impairment, or death to a resident).

The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Conference Room on November 23, 2012, at 11:30 a.m.

A partial extended survey was conducted on December 4, 2012.

The findings included:

Interview with the Administrator on November 30, 2012, at 9:00 a.m., in the Administrator's Office confirmed the facility's Quality Assurance/Performance Improvement Committee had not addressed the facility's failure to prevent neglect by following facility policies for resident change in condition to protect and prevent suicide attempts, failure to notify the physician of verbal statements of and plan for suicide, failure to provide Social Service counseling. Failure to revise the care plan with interventions to prevent suicide attempts, failure to provide the necessary care and services to maintain the highest practicable mental and psychosocial well-being, failure to provide Mental Health Services, failure to administer the facility in a manner to identify issues and develop and implement plans of corrective action to ensure the effectiveness of facility systems, for one resident (#1) of thirty-two residents reviewed, and failure to provide Mental Health Services for five residents (#1, #27, #17, #18, #31) of thirty-two residents reviewed.

Refer to F187 J
Refer to F224 J Substandard Quality of Care
F 520: Continued From page 143
Refer to F250 J Substandard Quality of Care
Refer to F280 J
Refer to F309 J Substandard Quality of Care
Refer to F319 J Substandard Quality of Care
Refer to F493 J

The Immediate Jeopardy was effective from February 25, 2012, through November 29, 2012, and was removed on November 30, 2012. An Acceptable Allegation of Compliance, which removed the immediacy of the Jeopardy, was received and corrective actions were validated by the surveyor through review of documents, staff interviews, and observations conducted onsite on November 30, 2012. The surveyor verified the allegation of compliance by:

1. Reviewing the facility's in-service records to ensure all staff were educated regarding changes to and implementation of the facility's following policies:
   a. Change in Resident's Condition and Status;
   b. Suicide Threats;
   c. Care of a Suicidal Resident;
   d. Behavioral Management;
   e. Care Planning and Using the Care Plan.

2. Conducting interviews with facility staff, to include fifteen of thirty-one nurses, three of nine environmental services, one of three maintenance, two of four activities, one of two social services, twenty-nine of fifty-two CNA's, ten of twenty-three dietary, seven of seventeen laundry and housekeeping, on staff to determine the level of comprehension gained through in-service education conducted regarding changes to and implementation of the facility's policies, "Change in Resident's Condition and
Status; Suicide Threats; Care of a Suicidal Resident; Behavioral Management; Care Planning and Using the Care Plan; to ensure staff recognize and respond to the following:

a. A resident making suicide threats or statements are immediately placed 1:1 for constant observation; staff will remain with the resident at all times until (1) the Physician orders the resident transferred for evaluation and admitted to a higher level of care, or (2) the Physician evaluates the resident and deems them safe;

b. Warning signs of suicide;

c. Statements and behaviors that may be a warning sign of suicide;

d. Using probes for more information;

e. Risk factors for suicide;

f. Restricting access to lethal means and removal of any harmful objects.

g. Residents at risk of suicide are communicated to all staff via the current Care Plan; Nursing 24-Hour Report; noted on the Medication Administration Record (MAR) and Treatment Administration Record (TAR);

h. Residents at risk of suicide are discussed weekly in the department head meetings.

i. A newly identified resident at risk of suicide will result in a suicide watch, and an emergency department head meeting will be called for immediate discussion.

3. Reviewing the facility's in-service records with the Social Worker ensuring responsibilities were reviewed and clarified, to include the following:

a. A Suicide Rating Scale has been added to the Social Services Assessment, to be completed on new admissions, quarterly, and with a significant
<table>
<thead>
<tr>
<th>Tag</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 620</td>
<td>Continued From page 145</td>
</tr>
<tr>
<td></td>
<td>change in condition;</td>
</tr>
<tr>
<td></td>
<td>b. Social Services is responsible for ensuring the referral source sees the resident and responding/appropriate notes are in the medical record;</td>
</tr>
<tr>
<td></td>
<td>c. Supportive Counseling;</td>
</tr>
<tr>
<td></td>
<td>d. Bachelor of Social Work (BSW) Scope of Practice;</td>
</tr>
<tr>
<td></td>
<td>e. Responsibilities of Social Services;</td>
</tr>
<tr>
<td></td>
<td>4. Review of the facility’s contract with the Licensed Master of Social Work (LMSW) to ensure services are contracted to occur on a monthly basis beginning on November 30, 2012, to provide visits, ensure oversight of the current SW, and compliance with State and Federal Regulations, facility’s policies, and Standards of Practice.</td>
</tr>
<tr>
<td></td>
<td>5. Reviewing of Suicide Risk Assessments on all residents in the facility. No residents were identified to have suicide risks.</td>
</tr>
<tr>
<td></td>
<td>6. Reviewing the new contract with a different Mental Health Services provider, who will be providing weekly services to the facility’s residents, as identified and indicated.</td>
</tr>
<tr>
<td></td>
<td>7. Reviewing assessments and supportive counseling provided by a contracted BSW with Long Term Care experience. The assessments and supportive counseling was provided to all residents to support services from a previous contracted Mental Health Services; and new admissions from the past two months were assessed and supportive counseling was provided.</td>
</tr>
</tbody>
</table>
F 520: Continued From page 146

a. An emergency Quality Assurance/Performance Improvement Committee Meeting was held on November 30, 2012, with the Medical Director, DON, Administrator, Consultant, Infection Control Nurse, and two other facility staff to include the Safety Leader.

Non-compliance continues at "E" level for monitoring of corrective actions. The facility is required to submit a plan of correction.

CO #30697