DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
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STATE SURVEY REPORT

NAME OF FACILITY: Country Rest Home

DATE SURVEY COMPLETED: October 28, 2013

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced complaint visit was conducted at this facility on October 25, 2013 through October 28, 2013. The census on the first day of the survey was fifty-six (56). The deficiencies contained in this report are based on record review, staff interviews and review of other facility documentation as indicated. The survey sample totaled 11 records.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** **F319** **§483.25(f)(1)** **A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem.** Based on interview, record review,	

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	review of hospice agency's record, and review of the Division of Long Term Care Residents Protection Investigative documentation, it was determined that the facility failed to provide mental and psychosocial care and services to one (R1) out of 11 sampled residents. R1 committed suicide on 10/15/13 in his room at the facility. Findings include: R1 was admitted to the facility on 9/6/13 while receiving hospice in his home located in the same continuing care community. Review of the hospice agency's psychosocial comprehensive assessment dated 8/17/13 completed by E8, hospice social worker, documented that R1 was experiencing difficulty with coping, was anxious (experiencing worry, unease, or nervousness), isolated, and withdrawn. Nurse's Note dated 9/16/13 and timed 1:30 PM stated that R1 was visited by a lawyer and after this visit, R1 had more confusion and depression. There was lack of evidence for depression monitoring in the Nurse's Notes. Review of the attending physician's (E9) progress note dated 10/9/13 documented that R1 had diagnoses including bipolar disease and depression. Review of admission physician's order form dated 10/6/13 included one anti-anxiety medication, clonazepam 0.5 milligram by mouth four times a day, however, there were no additional pharmacological intervention for the treatment of depression or for bipolar disorder.	3201.1.2 F319 483.25(f)(1) All residents will have a Geriatric Depression Scale assessment completed within the first 24 hours of admission. This will include both admission and respite residents. If they score above 5, a "Comprehensive Assessment for Depression" will be completed. The Doctor will be informed of the results of both and the residents current medication regiment for depression will be reviewed with the Doctor for follow up plan of care. A behavior sheet will be started to include any behaviors related to depression. A care plan will be initiated for depression. Administration will notify nursing of any suicidal tendencies that they are aware of in all future admissions. If a resident has been identified as having mental health issues prior to their admission to CRH, CRH will request from their POA or the resident, the name of their mental health care provider. A copy will be requested of their latest visit and any follow ups. If a resident is noted to have a psychiatric issues after admission they will be referred to a local mental health care provider. We have a meeting scheduled with "LTC Psychological Services" on May 1, 2014 to consider using them as a health care provider for psychological services. A manual and forms have been ordered for the "Comprehensive Assessment for Depression." It has been requested that CRH have a copy of records for all hospice residents in the facility. These will be kept assessable for medical staff to review. All current resident charts have been reviewed by the D.O.N. to ensure that a Geriatric Depression Scale is on their chart. The DON will monitor that the depression assessment has been completed on all admissions and follow up as needed. These policies will be reviewed at a staff meeting scheduled for April 23rd.

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	Review of R1's admission assessment dated 10/10/13 completed at the nursing home contained a section titled depression scale which included fifteen questions from the short form of the Geriatric Depression Scale/GDS (a validated tool and based on the responses to the 15 questions, points were accumulated. A score of greater than five was suggestive of depression and should warrant a follow-up comprehensive assessment; a score of greater than or equal to 10 was almost always indicative of depression). Review of R1's responses led to a score of eight from the following questions and responses: - Have you dropped many of your activities and interest? Yes - Are you in good spirits most of the time? No - Do you feel helpless? Yes, somewhat - Do you prefer to stay at home, rather than going out and doing new things? Yes - Do you think it is wonderful the way you are now? No - Do you feel full of energy? No - Do you feel that your situation is hopeless? Yes, limited Although the above hospice assessment dated 8/17/13, physician's progress note dated 10/9/13, and nursing home's admission assessment dated 10/10/13 documented evidence that R1 was depressed, record review lacked evidence that the facility identified that R1's psychosocial problem of depression. This resulted in the failure to develop a plan of	Attachments: #1 Depression Assessment and Follow-up Policy #2 Geriatric Depression Scale - short form #3 Check off list for respite residents #4 Check off list for admissions #5 Hospice Policy

Provider's Signature Mark Yoder Jr. Title Administrator Date 4/29/14

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	care identifying psychosocial interventions that are pertinent to the needs of the dying resident such as treatment for depression, anxiety (normal reaction to stressors), and restlessness. Review of the Behavior Monitoring Flow Record from 10/1/13 through 10/15/13 revealed that the facility was utilizing this record to monitor the behavioral symptoms in which clonazepam was indicated. R1's behavioral symptoms being monitored included: 1) yelling instead of using call bell (one episode documented) 2) ringing bell for no reason (no episode documented) and 3) refusing activities of daily living (seven episode documented). In addition, on 10/6/13, inappropriate sexual comments were included when R1 had four episodes documented. Subsequently on 10/14/13, the facility developed a care plan for R1 related to depression-terminal illness, giving up home included goals that R1 will go to activities, feel comfortable here, interact well with staff, and able to express feelings. Approaches included monitor for falls; always approach resident calmly and unhurriedly; behavior sheet every shift; speak in calm, reassuring, unhurried manner; encourage to be involved in decision making of care as able; attempt to refocus to something positive when resident is depressed; encouraged to attend activities; encourage to express fears to staff, family; encourage to be involved with other alert residents; if resident becomes upset, change environment; one on one visit with activities; and when feeling down, try to refocus to something positive. Review of Nurse's Note dated 10/16/13	

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	documented a late entry by E5, Registered Nurse in which at approximately 10 PM on 10/15/2013, E5 heard a loud noise and E5 and E6, Certified Nurse's Aide ran down the hallway and opened the door to R1's room. E5 observed R1 lying face down on the floor with an open wound on the top of his head without pulse or respiration. A gun was found on the bed. Review of the Division's (Division of Long Term Care Residents Protection) Investigative files completed by Special Investigator, SI were reviewed which included an interview with E1, Administrator on 10/16/13. E1 verbalized that E1 was aware that R1 kept a number of guns in the house prior to admission to the facility. E1 stated R1 had told him on a number of times in conversations at R1's house, that when R1's time comes, R1 didn't want to linger. E1 stated either when R1 was admitted to the facility or about to be admitted, E1 talked to R1 about not committing suicide and that R1 stated he wouldn't. E1 stated E8, the hospice social worker was present during the conversation, but may not remember. Review of the written statement by E1 dated 10/16/13 documented that R1 mentioned on a number of occasions that he would know when it was time to check out, and R1 had no intention of living out his days as an invalid, hopeless and in pain. In addition, sometime around the time when R1 moved into the nursing home, which was 9/6/13, we had a three way conversation with R1, E8, and E1. E1 brought up the history of R1's determination to end his life rather than be out of control and unhappy with his life. At that time, E8 and E1 had a pointed conversation with R1 about suicide, and	

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	R1 stated and promised that R1 was not going to do that. Review of the written statement by E8 dated 10/16/13 documented that R1 was a private person and he was anxious when there were many people around. E8 stated in one of their conversations while R1 was living at home, R1 told E8 he had been under psychiatric care for many years. During a telephone interview with E8 on 10/28/13 at approximately 9:50 AM, E8 verbalized that E8 did not recall the above conversation in which R1 was asked about suicide and R1 stated and promised that R1 was not going to do that. Despite the fact that E1 was aware of R1's suicidal tendencies/ideations, record review lacked evidence of a referral for psychosocial services. An interview with E2, Director of Nursing, on 10/28/13, at approximately 1:30 PM, revealed that the facility did not have a policy and procedure for the above GDS assessment, thus, did not incorporate how the facility was to utilize the GDS information obtained to direct the plan of care for the resident. In addition, E2 verbalized that the facility did not have any hospice plans of care for R1 in the facility. E2 further verbalized that she was not aware of R1's suicidal tendencies/ideations and E2 confirmed that the facility did not coordinate any psychiatric evaluation. Following the onsite survey, the hospice agency was contacted by the surveyor and subsequently on 10/28/13 and 10/29/13, clinical records from the agency were	

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	forwarded to the surveyor since these records were not in the facility's records. Review of the hospice care plan dated 8/14/13 for altered emotional comfort related to R1's ineffective individual coping and transition in living arrangements. Goals included: 1) R1 will participate in decision making for the future and make choices related to current impending care. 2) R1 will report reduction or elimination of anxiety. Interventions included: 1) encourage R1/caregiver (E1, Administrator) to verbalize fears/concerns/frustrations/feeling 2) emphasize 24 hours availability of hospice care and support. 3) provide emotional support to R1/E1. 4) Encourage and support verbalization of fears/concerns. Review of the hospice social services notes by E8 revealed the following: -9/5/13 E8 visit with R1, after much discussion, R1 agreed to go to nursing home for "few days." E8 and R1 discussed his decline, he was more confused. R1 recognized he needs more help. R1 is not willing to commit to moving permanently, did not discuss long term Medicaid and the financial differences in his income, E1 and E4, Administrative Assistant, both aware and in agreement for R1 to move to the nursing home due to his decline and need for more care, E8 and E4 to assist R1 with the long term care Medicaid and move to a different facility due to his finances. E8 to assist with settling in. - 9/6/13 E8 spoke with E4, who will start the Medicaid process, E8 will visit next week after a few days to see how R1 is adjusting.	

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	- 9/9/13 E8 received phone call that R1 calling reporting "I want to go back home, they are holding me captive" E8 talked with E1, owner of cottage and nursing home who reported that E1 was not comfortable with R1 at his home without someone. R1 does not have the finances and does not currently understand what the financial undertaking for his care in long term care or at home. E1 to talk with R1 about staying here until financial things are in place. E8 will assist with support and validation for R1 and for nursing home staff as R1 acclimates to the facility. E8 to coordinate with staff and E1 with the care, comfort and process of R1 adjusting and planning on LTC. -9/16/13 E8 received message from hospice nurse that the lawyer visited R1 to do the Miller Trust to start the Medicaid process. E8 to do referral for LTC, coordinate with E1 and E4 at nursing home. - 9/19/13 E8 visit. Lawyer, E1 hired to do R1's Miller Trust to help R1 be eligible for Medicaid to move to another long term care facility. - 10/3/13 E8 visit. E1 frustrated at times with R1 due to financial obligations. He agrees it is better for R1 and staff he is in the nursing home, struggling with how to give him the care and discuss money. Starting the Medicaid process, R1 would like to stay at nursing home and is willing to pay his income and negotiate some for personal spending and will allow his income plus some spending money for R1. E8 to continue to coordinate with staff. R1 managing better in the facility, enjoying the peace and quiet of care. R1 is thinking	

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	about who he wants for his power of attorney, discussion around a lawyer for guardianship, continue with support and option for R1. - 10/7/13 E8 received a telephone call from R1 asking for a meeting with E1 and E8 to discuss living at nursing home or another facility. E8 to call E1 to arrange a visit this week. E8 to coordinate with nursing home staff to let R1 known when the meeting with E1 and E8 will be. -10/8/13 E8 telephone call to E1, meeting today, E1 has some concerns with some behaviors that is inappropriate with staff. E1 changed meeting to 10/9/13 in the afternoon. -10/10/13 Discussion of R1 staying and will store his things in a shed on the property, R1 to pay nursing home for monthly expenses, E1 frustrated but does feel responsible for him. Some discussion of having a lawyer as the one to be in charge of his Advanced Directive and Will, a mutual party. Continue to stay at nursing home, pay them and work out the details of his belongings. E4 to apply for payee of social security, R1 agreed so he can have access to his money when he is not able to make decision. E8 provided facilitation with E1 and R1. E8 and E1 informed R1 not to be disrespectful to the people that care for him and R1 was in agreement. R1 mental status not as sharp and could not stay as focused. . Review of the hospice interdisciplinary team notes dated 8/28/13, 9/11/3, 9/25/13, and 10/9/13 were reviewed which lacked evidence of R1's anxiety had been eliminated or was decreased. R1 was known to the facility, E1, and the	

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	hospice organization of displaying mental and psychosocial adjustment difficulties, however, there was a lack of evidence that the facility and the contracted services ensured that R1 received the appropriate treatment and services to correct the assessed problems. R1 committed suicide in his room on 10/15/13 in the facility. **F323** **§483.25(h)(1) The resident environment remains as free of accident hazards as is possible; and** **§483.25(h) (2)** **Each resident receives adequate supervision and assistance devices to prevent accidents.** Based on record review, interviews, and review of the Division of Long Term Care Residents Protection Investigative documentation, it was determined that for one (R1) resident out of 11 sampled residents, the facility failed to provide adequate supervision to prevent accidents. R1 had a history of receiving psychiatric care throughout his adulthood, was assessed as having difficulty coping with his terminal illness, and was known to have suicidal ideations/tendencies (thoughts about how to kill oneself). The facility failed to ensure that the environment was free of a hazard by failing to inspect R1's environment for hazard such as a weapon (gun) when the facility was aware of R1's suicidal ideations/tendencies and known history of gun possession. These failures resulted in R1 having access to two guns (one semi-automatic pistol which contained eight rounds which R1 used to commit suicide and a second pistol fully loaded five shot revolver which was found on the	F323 483.25 (h)(1) 483.25 (h)(2) Country Rest Home's policy/residents rights has been updated to include: -Requirements that ALL possessions must be noted on possession list. -ALL suspicious items/containers must be inspected. -NO fire arms are permitted in the facility. A policy for Inventory/Possession List was written and has been included in the check off list to be done at the time of admission/respite. All charts have been reviewed to ensure that a possession list is on file. The D.O.N. will review all future completed check off lists to ensure that possession lists have been completed. This will be reviewed at the staff meeting on April 23, 2014. Attachments #8 Section G of Guests Rights and Privileges given to all residents/family members on admission. #9 Policy for Inventory/Possession list.

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	bed) and placed other residents, facility staff, and visitors at risk for accident hazard. Findings include: R1 was admitted to the facility on 9/6/13 while receiving hospice (end of life services) in his home located in the same continuing care community. Review of the attending physician's (E9) progress note dated 10/9/13 documented R1 had diagnoses including bipolar disease (a condition in which a person has periods of depression and periods of being extremely happy or being cross or irritable) and depression (a serious illness in which the individual feels blue or sad and it interferes with daily life). Review of R1's admission assessment dated 10/10/13 contained information which suggested that R1 was experiencing depression and warranting comprehensive assessment and/or follow-up. Review of Nurse's Note dated 10/16/13, documented a late entry by E5, Registered Nurse, in which at approximately 10 PM, on 10/15/13, E5, was on the phone in the old section of the facility and heard a loud noise, like someone throwing a metal chair, E5 and E6, Certified Nurse's Aide ran down the hallway and opened the door to R1's. E5 observed R1 lying face down on the floor with a wound of unknown origin on the top of his head. R1 was without pulse or respiration. A gun was found on the bed. Review of the Division's Investigative files completed by Special Investigator, SI were reviewed which included an interview with E1, Administrator on 10/16/13. E1 verbalized that E1 was aware that R1 kept	

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	a number of guns in the house prior to the admission to the facility. E1 stated R1 had told him on number of times in conversations at R1's house, that when his time comes, he didn't want to linger. E1 stated either when R1 was admitted to the facility or about to be admitted, R1 talked to him about not committing suicide and that R1 stated he wouldn't. E1 stated E8, the hospice social worker was present during the conversation, but may not remember. During an interview on 10/16/13 S1 brought up the black bag/satchel and E1 stated it was not normal to search through resident's personal belongings, but looking back, maybe E1 should have. Despite the fact that E1 was aware of R1's suicidal tendencies/ideations, record review lacked evidence that the facility completed an inventory list of R1's belongings when R1 moved into the facility on 9/6/13. In addition, the facility failed to search R1's belongings to ensure hazards such as guns were not in R1's environment to ensure the safety of R1 and other residents. During an interview with E2, Director of Nursing, on 10/16/13, at 3 PM, SI was informed that E2 was told by E6, CNA after the incident that on the day that R1 came to the nursing home for his respite stay that the resident had a black bag that R1 put on a shelf in the closet in his room and told E6 not to touch it. E2 stated E6 assumed it contained personal items (sex toys because she had seen sex magazines sticking out of the top of it). E2 stated this might be how R1 brought the gun into the facility. During this interview, E2 was asked to provide a copy of R1's inventory sheet of the resident's	

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	belongings brought to the facility at admission. However after searching for it told the writer she could not find one and that apparently an inventory had not been completed R1 was known to the facility including E1 of having suicidal ideations/tendencies and R1 was known to have guns prior to moving into the nursing home. However, there was a lack of evidence that the facility ensured that the environment was free of an accident hazard by failing to inspect R1's environment for a hazard such as a weapon (gun). These failures resulted in R1 having access to two guns, one semi-automatic pistol which contained eight rounds which R1 used to commit suicide and a second pistol fully loaded five shot revolver which was found on the bed) and placed other residents, facility staff, and visitors at risk for accident hazards.	
3201.3.0 **3201.3.8**	**General Requirements** **Each facility shall provide, in writing, the refund and prepayment policy at the time of admission, and in the case of residents admitted while awaiting approval of third-party payment, an exact statement of responsibility in the event of retroactive denial. The facility shall notify residents, in writing, at least 30 days prior to a rate increase.** **This requirement is not met as evidenced by:** Based upon record review and interview, it was determined that the facility failed to provide in writing a refund and prepayment policy at the time of admission for one (R1) out of 11 sampled residents. Findings	3201.3.0 3201.3.8 A Country Rest Home Admission Agreement was implemented in December 2013 which details our payment and refund policy and any other financial responsibility. This agreement is signed by the resident or responsible party at time of admission and a copy is made for their records. The Administrative Assistant will monitor that an admission agreement is signed prior to billing the first month's invoice for all admissions. Attachment #7 Country Rest Home Admission Agreement

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	include: R1 was admitted to the facility on 9/6/13. Record review lacked evidence that R1 was provided in writing a refund and prepayment policy at the time of admission. Interview with E4, the facility's administrative assistant on 11/15/13 at approximately 11:15 AM confirmed that the facility failed to provide this to R1 at the time of admission.	
3201.3.9	**A facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract to provide for facility payment from the resident's income or resources. However, in doing so, the facility shall not require a third party to incur personal financial liability for the nursing facility expenses.** **This requirement is not met as evidenced by:** Based upon record review and interview, it was determined that the facility failed to have a contract signed for the facility's care at the time of admission for one (R1) out of 11 sampled residents. Findings include: R1 was admitted to the facility on 9/6/13. Record review lacked evidence that R1 signed a contract for the facility's care at the time of admission. During an interview with E4, the facility's administrative assistant on 11/15/13 at approximately 11:15 AM confirmed that the contract was verbal and the facility failed to have a contract signed by R1 at the time of admission.	3201.3.9 A Country Rest Home Admission Agreement was implemented in December 2013 which details our payment and refund policy and any other financial responsibility. This agreement is signed by the resident or responsible party at time of admission and a copy is made for their records. The Administrative Assistant will monitor that an admission agreement is signed prior to billing the first month's invoice for all admissions. Attachment #7 Country Rest Home Admission Agreement

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3201.6 **3201.6.3.5**	**Services to Residents** **Based on the physician's admission orders and the admission information for each resident, an interim individual nursing care plan shall be developed within 24 hours of admission pending the completion of a comprehensive resident assessment.** **This requirement is not met as evidenced by:** Based upon record review and interview, it was determined that the facility failed to develop an interim care plan for one (R1) out of 11 sampled residents who was identified as experiencing depression (a serious illness in which the individual feels blue or sad and it interferes with daily life). Findings include: Review of R1's hospice (services provided for end of life) agency's psychosocial comprehensive assessment dated 8/17/13 completed by E8, hospice social worker (while R1 lived in his home prior to admission to the facility on 9/6/13) documented that R1 was experiencing difficulty with coping, and was anxious (experiencing worry, unease, or nervousness, typically about an imminent event or something with an uncertain outcome, isolated, and withdrawn). R1's attending physician's (E9) progress note dated 10/9/13 documented R1 had diagnoses including bipolar disease (a condition in which a person has periods of depression and periods of being extremely happy or being cross or irritable) and depression (a serious illness in which the individual feels	3201.6 3201.6.3.5 An interim nursing care plan was completed on 9/7/13. The Hospice Psychosocial Comprehensive Assessment that was done while still at home and dated 8/17/13 was not made available to CRH until after his death. The social worker made no mention to the D.O.N. of his extensive psychosocial needs while he was a resident. To prevent these issues in the future, CRH has written a policy which requires that hospices provide us a copy of all Hospice residents records for our review and to care plan as indicated. Hospice Staff are requested to give a nurse to nurse report for any new residents coming into the facility. Hospice Social Workers and Nurses are requested to stop by the DON's office and give her a verbal summary of their visit or a written summary if she is not available. Any psychosocial issues that have been identified will be discussed during this summary conference. The D.O.N. will monitor that records are received from Hospice in a timely manner and will review these records and incorporate into the resident's plan of care in the future. Attachment #5 Hospice Policy #6 Interim Care Plan

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	blue or sad and it interferes with daily life). R1's nursing home admission assessment dated 10/10/13 contained a section titled depression scale which included fifteen questions from the short form of the Geriatric Depression Scale/GDS (a validated tool and based on the responses to the 15 questions, points were accumulated. A score of greater than five was suggestive of depression and should warrant a follow-up comprehensive assessment; a score of greater than or equal to 10 was almost always indicative of depression). Review of R1's responses lead to a score of eight, thus, suggestive of depression and warranting follow-up. Although the above hospice assessment dated 8/17/13, physician's progress note dated 10/9/13, and the nursing home admission assessment dated 10/10/13 documented that R1 was experiencing depression, record review lacked evidence that the facility identified R1's psychosocial problem of depression including R1's bipolar disorder. This resulted in the failure to develop an interim plan of care for identifying psychosocial interventions that are pertinent to the needs of the dying resident such as treatment for depression, anxiety (normal reaction to stressors), restlessness, or bereavement (period of grief and mourning after a death). An interview with E2, Director of Nursing on 10/28/13 at approximately 1:30 PM revealed that the facility did not have a policy and procedure for the use of the GDS assessment, thus, did not incorporate the intent of the validated tool to direct the plan of care for the residents. Thus, R1 had no follow-up with a	

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	comprehensive assessment for depression. E2 confirmed that there was no interim care plan for depression or bipolar disorder. E2 verbalized that the facility did not have any hospice plans of care for R1 in the facility for psychosocial functioning. **Records and Reports** **Inventory of resident's personal effects upon admission.** **This requirement is not met as evidenced by:** Based upon record review and interview, it was determined that the facility failed to ensure that an inventory of the resident's personal effects upon admission was completed for two (R1 and R3) out of 11 sampled residents. Findings include: 1. R1 was admitted to the facility on 9/6/13 while receiving hospice (end of life services). Review of the Division's Investigative Section's file revealed that on 10/16/13 at 3 PM, the Special Investigator, SI, interviewed E2, Director of Nursing. E2 was told by E6, Certified Nurse's Aide after the incident (on 10/15/13 in which R1 committed suicide using a gun) that on the day that R1 came to the nursing home for his respite stay that the resident had a black bag that R1 put on a shelf in the closet in his room and told E6 not to touch it. E2 stated E6 assumed it contained personal items (sex toys because she had seen sex magazines sticking out of the top of it). E2 stated this might be how R1 brought the gun into the facility. During this interview, E2 was asked to provide a copy of R1's inventory sheet of the resident's belongings brought to the facility	3201.9.0 3201.9.1.8 Country Rest Home's policy/residents rights has been updated to include: -Requirements that ALL possessions must be noted on possession list. -ALL suspicious items/containers must be inspected. -NO fire arms are permitted on the grounds or in the facility. A policy for Inventory/Possession List was written and has been included in the check off list to be done at the time of admission/respite. All charts have been reviewed to ensure that a possession list is on file. The D.O.N. will review all future completed check off lists to ensure that possession lists have been completed. This will be reviewed at the staff meeting on April 23, 2014. Attachments #8 Section G of Guests Rights and Privileges given to all residents/family members on admission. #9 Policy for Inventory/Possession list.
3201.9.0 3201.9.1.8		

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	on admission and after searching for it told SI that E2 could not find one and that apparently an inventory had not been completed. A subsequent interview with E2, on 10/28/13, at approximately 2 PM, revealed that the facility did not have evidence of R1's inventory of personal effects upon admission on 9/6/13. 2. R3 was admitted to the facility on 10/15/13 and record review lacked evidence of an inventory sheet of R3's belongings upon admission. An interview with E2, Director of Nursing, on 10/28/13, at approximately 2 PM, revealed that the facility did not have evidence of R3's inventory of personal effects upon R3's admission on 10/15/13.	
3201.9.1.11	**Special service notes, e.g., social services, activities, specialty consultations, physical therapy, dental, podiatry.** **This requirement is not met as evidenced by:** Based upon record review and interview, it was determined that the facility failed to ensure that the residents record contained current and accurate information for one (R1) out of 11 sampled residents. Findings include: R1 was admitted to the facility under respite services on 9/6/13 while receiving hospice (end of life service) in his home located in the same continuing care community. On 10/6/13, R1's placement was changed to long term care at this facility.	3201.9.1.11 CRH has written a policy which requires that hospices provide us a copy of all Hospice residents records for our review and to care plan as indicated. The D.O.N. will monitor that records are received from Hospice in a timely manner and will review these records and incorporate into the resident's plan of care in the future. Hospice Staff are requested to give a nurse to nurse report for any new residents coming into the facility. Hospice Social Workers and Nurses are requested to stop by the DON's office and give her a verbal summary of their visit or a written summary if she is not available. Any psychosocial issues that have been identified will be discussed during this summary conference. Attachment #5 Hospice Policy

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16 Del. C. Chap. 11	Record review lacked evidence of social services documentation by the hospice agency. An interview with E2 on 10/28/13 at approximately 2 PM confirmed the findings. **§ 1131 Definition** **(9) Neglect** **(a) Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals, and safety.** **This requirement is not met as evidenced by:** Based on record review, interviews, review of the Division of Long Term Care Residents Protection Investigative documentation, and review of other documentation as indicated it was determined that for one (R1) of 11 residents reviewed experienced neglect while residing in the facility. Neglect included failure to identify that R1 was experiencing depression (a serious illness in which the individual feels blue or sad and it interferes with daily life) which resulted in the failure to develop an interim plan of care; failure to coordinate and provide psychiatric care and services for R1 who verbalized suicidal ideation/tendencies (thoughts about how to kill oneself); failure to ensure R1's environment was free of hazard such as weapons (guns). Due to these multiple failures, R1 had access to two guns (one semi-automatic pistol which contained eight rounds which R1 used to commit suicide and second pistol fully loaded five shot revolver which was found on R1's bed after R1 committed suicide). Findings	16 Del. C. Chap. 11 1131 All residents will have a Geriatric Depression Scale assessment completed within the first 24 hours of admission. This will include both admission and respite residents. If they score above 5, a "Comprehensive Assessment for Depression" will be completed. The Doctor will be informed of the results of both and the residents current medication regiment for depression will be reviewed with the Doctor for follow up plan of care. A behavior sheet will be started to include any behaviors related to depression. A care plan will be initiated for depression. Administration will notify nursing of any suicidal tendencies that they are aware of in all future admissions. If a resident is noted to have a psychiatric issues after admission they will be referred to a local mental health care provider. We have a meeting scheduled with "LTC Psychological Services" on May 1, 2014 to consider using them as a health care provider for psychological services. All current resident charts have been reviewed by the D.O.N. to ensure that a Geriatric Depression Scale is on their chart. A manual and forms have been ordered for the "Comprehensive Assessment for Depression." The DON will monitor that the depression assessment has been completed on all admissions and follow up as needed. It has been requested that CRH have a copy of records for all hospice residents in the facility. These will be kept assessable for medical staff to review. These policies will be reviewed at a staff meeting scheduled for April 23rd.

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	include: 1a) Cross refer, 3201.1.2, F319 and F323. R1 was admitted to the nursing home on 9/6/13 with hospice services. Review of the hospice agency's psychosocial comprehensive assessment dated 8/17/13 completed by E8, hospice social worker, documented that R1 was experiencing difficulty with coping, was anxious (experiencing worry, unease, or nervousness), isolated, and withdrawn. In addition, review of the attending physician's progress note dated 10/9/13 documented R1 had diagnoses including bipolar disease (a condition in which a person has periods of depression and periods of being extremely happy or being cross or irritable) and depression (a serious illness in which the individual feel blue or sad and it interferes with daily life). The nursing home's admission assessment dated 10/10/13 in the nursing home contained a section titled depression scale which included fifteen questions from the short form of the Geriatric Depression Scale/GDS (a validated tool and based on the responses to the 15 questions, points are accumulated. A score of greater than five was suggestive of depression and should warrant a follow-up comprehensive assessment; a score of greater than or equal to 10 was almost always indicative of depression). Review of R1's responses led to a score of eight which would suggest that R1 was depressed and that comprehensive follow-up would have been warranted. Although the above hospice assessment dated 8/17/13, physician's progress note	Attachments: #1 Depression Assessment and Follow-up Policy #2 Geriatric Depression Scale - short form #3 Check off list for respite residents #4 Check off list for admissions #5 Hospice Policy

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	dated 10/9/13, and the nursing home's admission assessment dated 10/10/13 documented that R1 was experiencing psychosocial problems including depression, record review lacked evidence that the facility identified this problem. The facility failed to identify R1's multiple other psychosocial problems which included difficulty coping, and anxiety. This failure resulted in the lack of development of a plan of care and failure to coordinate and provide psychiatric care and services. An interview with E2, Director of Nursing, on 10/28/13, at approximately 11 AM confirmed that the facility did not identify that R1 was experiencing depression and failed to develop an interim care plan for depression or any follow-up comprehensive assessment of R1's depression. Review of the Division's Investigative files completed by Special Investigator, SI were reviewed which included an interview with E1, Administrator on 10/16/13. E1 verbalized that E1 was aware that R1 kept a number of guns in the house prior to the admission to the facility. E1 stated R1 had told him on a number of times in conversations at R1's house, that when R1's time comes, R1 didn't want to linger. E1 stated either when R1 was admitted to the facility or about to be admitted, E1 talked to R1 about not committing suicide and that R1 stated he wouldn't. E1 stated E8, the hospice social worker was present during the conversation, but may not remember. Despite that fact that R1 was known to the facility, E1, and the hospice organization with multiple psychosocial problems including suicidal ideations/tendencies, the	

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	facility neglected to coordinate services within the facility, between administrative staff, between providers (i.e. facility and the hospice agency) to ensure the provision of psychosocial services. R1 committed suicide on 10/15/13 in his room at the facility. 1b) Cross refer, 3201.1.2, F323. Review of R1's Nurse's Note dated 10/16/13 documented a late entry by E5, Registered Nurse, in which at approximately 10 PM on 10/15/2013, E5 heard a loud noise and E5 and E6, Certified Nurse's Aide ran down the hallway opened the door to R1's. E5 observed R1 lying face down on the floor next to his bed ...without pulse or respiration. A gun was found on the bed. 911 was called and police and an investigator from the Medical Examiner's office responded to the scene. Review of the Division of Long Term Care Residents Protection Investigative files completed by Special Investigator, SI, was reviewed which included an interview with E1, Administrator, on 10/16/13, revealed that R1 kept a number of guns in the house prior to the admission to the facility under respite care on 9/6/13. E1 stated R1 had told him on a number of times in conversations at R1's house, that when his time comes, he didn't want to linger. E1 stated either when R1 was admitted to the facility or about to be admitted, E1 talked to R1 about not committing suicide and that R1 stated he wouldn't. E1 stated E8, the hospice social worker was present during the conversation, but may not remember. SI during an interview on 10/16/13 brought up the black bag/satchel and E1 stated it was not normal to search	

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	through resident's personal belongings, but looking back, maybe E1 should have. Review of the written statement by E1 dated 10/16/13 documented that R1 mentioned on a number of occasions that he would know when it was time to check out, and R1 had no intention of living out his days as an invalid, hopeless and in pain. In addition, sometime around the time when R1 moved into the nursing home, which was 9/6/13, we had a three way conversation with R1, E8, and E1. E1 brought up the history of R1's determination to end his life rather than be out of control and unhappy with his life. At that time, E8 and E1 had a pointed conversation with R1 about suicide, and R1 stated and promised that R1 was not going to do that. During an interview with E2, Director of Nursing, on 10/16/13, at 3 PM, SI was informed that E2 was told by E6, Certified Nurse's Aide, after the incident that on the day that R1 came to the nursing home on 9/6/13, and that R1 had a black bag that R1 put on a shelf in the closet in his room and told E6 not to touch it. E2 stated E6 assumed it contained personal items (sex toys because she had seen sex magazines sticking out of the top of it). E2 stated this might be how R1 brought the gun into the facility. During this interview, E2 was asked to provide a copy of R1's inventory sheet of the resident's belongings brought to the facility on admission and after searching for it told SI she could not find one and that apparently an inventory had not been completed. Review of SI's documentation dated 10/18/2013 revealed that R1 shot himself using one semi-automatic pistol which	

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	contained eight rounds. There was a second pistol fully loaded five shot revolver which was found on the bed. Despite the fact that E1 was aware of R1's suicidal tendencies/ideations prior R1's admission to the facility on 9/6/13 and R1 was known to have owned guns, the facility failed to conduct a search of R1's environment to ensure hazards such as guns were not available. An interview with E2 on 10/28/13 at approximately 11 AM revealed that E2 was not aware of R1's suicidal tendencies/ideations. E2 confirmed that the facility neglected to coordinate services within the facility, between administrative staff, between providers (i.e. facility and the hospice agency) to ensure the provision of psychosocial services. Due to the multiple failures, R1, a resident with known access to guns prior to admission to the nursing home, with known history of psychiatric care with current diagnoses including bipolar disorder and depression, with suicidal tendencies/ideations had access to two guns. One, semi-automatic pistol which contained eight rounds which R1 used to commit suicide and a second pistol fully loaded five shot revolver which was found on the bed.	