Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint #1763184/IL94326 STATEMENT OF LICENSURE VIOLATIONS:	S 000		
S9999	Final Observations 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

These regulations are not met as evidenced by:

Based on record review and interview, the facility failed to assess, supervise and provide interventions to prevent self-harm of a resident (R1) with known suicide ideation. R1 is one of four residents reviewed for psychiatric behaviors in the sample of four. This failure resulted in R1's self-strangulation and death.

Findings include:

The Facility Face Sheet dated February 2017 for R1 documents the following diagnoses: Major Depression and Anxiety. This same Face Sheet documents an admission date of 2/3/2017.

R1's Physician Order Sheet (POS) dated February 2017 documents Cymbalta 30 milligrams (anti-depressant) every am(morning).

The Minimum Data Set (MDS) dated 02/9/17 documents R1 as being moderately cognitively impaired. The Mood and Behavior section of the MDS does not document R1 as having any delusions, hallucinations, behaviors or depression. There was no behavior tracking documentation made by the facility for R1. R1's Care Plan did not have documentation of goals or interventions addressing self-harm or negative statements about living or dying.

Review of R1's medical record is as follows:

On 2/6/17 Progress Notes document R1 having

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

delusions of R1 and R1 being tied up and held prisoner in their room. E13, Social Service Assistant documents on this same date that R1 has a psychiatric history, exhibits depression, anxiety and fear.

On 2/9/17 E14, Social Service Assistant documents in the Progress Notes R1 verbalizing that Orientals were taking R1 and tying R1 up.

On 2/13/17 Progress Notes By E14 document R1 appearing upset and stating R1 was being trapped in the basement and being held captive.

On 2/14/17, E15 Social Service Assistant documents per Progress Notes R1 is agitated in the lunchroom and hit another resident (unidentified) in the back of the head. E15 states when R1 was approached, R1 was referring to the war and started talking about how R1 wanted to kill more of them.

Progress Notes dated 2/16/17 at around 3:00 am, Certified Nursing Assistants (unidentified) reported to E16, Licensed Practical Nurse that R1 was yelling and banging on the wall that R1 wanted to die. There is no documentation of physician notification.

Progress Notes dated 2/16/17 document at 8:40 am E6, Registered Nurse went into R1's room and found R1 undressed down to R1's incontinence brief (resident previously up and dressed on the unit). R1 agreed to get back up and go to dining room to eat. E6 notified E9, Certified Nursing Assistant (CNA) to assist R1 in dressing and to take R1 to the dining room. E6 went in to R1's room at 8:45 am and found R1 holding a stretch band around R1's neck. R1 was unresponsive with no pulse. E7, Registered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

Nurse started Cardio Pulmonary Resuscitation and 911 was called. R1 was transported by Emergency Medical Technicians via ambulance at 9:10 am. A report titled "Coroner Summary Report" dated 2/16/17 documents Z4, Deputy Coroner being notified at approximately 9:59 am of R1's death in the Emergency Room.

On 5/30/17 at 1:05 pm, E9 CNA stated (on 2/16/17) E9 went to R1's room and found R1 in bed with the band wrapped around R1's neck and E9 removed the band from over R1's head/neck and ran to get the nurse. E9 stated that R1 had made statements several times about not wanting to live and that R1 just wanted to die. E9 stated this was reported to the nurses several times.

A statement taken on 2/16/17 written by E8, Certified Nursing Assistant documents the following events taking place on 2/15/17: E8 states that R1 was assisted to bed around 9:30 to 10:00 pm. When E8 entered R1's room R1 had an orange elastic band around R1's neck. E8 stated the band was taken away from R1 and put into the bottom drawer of R1's wardrobe. There is no documentation of physician notification. E8 was unable to be reached for interview.

On 5/31/17 at 9:35 am Z3, Family member of R1 stated Z3 and Z3's wife had told E2 about R1 trying to kill himself with a (elastic) cord the week before R1 was admitted to the facility. Z3 stated R1 was no longer safe at home alone.

On 5/30/17 at 1:20 pm E2, Assistant Administrator stated "The family lied to us, they didn't say anything about (R1) wanting to die or trying to killing (R1's self) on prescreening. Once we accepted (R1) they told us on admit day (2/3/17) that (R1) had been found the week

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

before with a cord wrapped around (R1's) neck and had stated (R1) wanted to die. It was too late we had to take (R1)."

On 5/30/17 at 4:00 pm E2 stated the facility should have gotten a psychiatric consult for R1 after being told about the cord around R1's neck on R1's day of admission.

On 5/30/17 at 1:45 pm E11, CNA stated that R1 made statements of wanting to die all the time. E11 stated "It was common knowledge that (R1) was unhappy and wanted to die."

On 5/30/17 at 1:50 pm E10, CNA stated E10 heard R1 verbalize that R1 wanted to die and he wanted to kill himself. E19 stated these statements were reported to the nurses.

On 5/31/17 at 12:00 pm E12 CNA stated E12 had heard and was aware of R1 wanting to die several times. E12 stated this was reported to the nurses each time.

On 5/30/17 at 2:00 pm, E5 Social Service/MSW stated that E5 was aware of R1's suicide ideations and acknowledges that E5 did not assess or talk with R1 about it.

R1's Care Plan did not have documentation of goals or interventions addressing self-harm or negative statements about wanting to die. There is no referral in R1's chart for a psychiatric or psychologist consult.

On 5/31/17 at 8:40 am Z2, Nurse Practitioner acknowledged that R1 had been having flashbacks of wartime and believed R1 was being held prisoner but did not recall being told of R1's self-harm statements. Z2 stated "Had I known

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

about these statements, I would have sent (R1) out for a psychiatric consult or to the emergency room.

On 5/31/17 at 10:25 am, Z1 Primary Care Physician stated the expectation of the facility would be when a resident, such as R1 is making comments of wanting to die or of self-harm, the facility would either send R1 out to the Emergency Room or get a psychiatric consult after notifying Z1. Z1 states the facility did not notify Z1 of R1's behaviors or suicidal ideations.

A report titled "State of Illinois Certificate of Death Worksheet" documents R1's time of death at 9:44 am on 2/16/17. The cause of death is documented as "Elastic Band Strangulation." The cause of the injury is documented as "Strangled Self with Elastic Resistance Band."

The facility policy titled "Suicide Threats" dated December 2007 documents the following: "After assessing the resident in more detail, the Nurse Supervisor/Charge Nurse shall notify the resident's Attending Physician and responsible party, and shall seek further direction from the physician. All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the residents behavior immediately. As, indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated. If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present. Staff shall document details of the situation objectively in the residents medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8 (AA) Section 300.690 b) Section 300.690 c) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These requirements were not met as evidenced by: Based on record review and interview, the facility failed to notify the Illinois Department of Public	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

Heath's Regional Offices of a serious incident of self-strangulation and subsequent death of a resident (R1). R1 is one of four residents reviewed for incidents in the sample of four.

Findings include:

The Facility Face Sheet dated February 2017 for R1 documents the following diagnoses: Major Depression and Anxiety. This same Face Sheet documents an admission date of 2/3/2017.

Progress Notes dated 2/16/17 document at 8:40 am E6, Registered Nurse went into R1's room and found R1 undressed down to R1's incontinence brief (resident previously up and dressed on the unit). R1 agreed to get back up and go to dining room to eat. E6 notified E9, Certified Nursing Assistant (CNA) to assist R1 in dressing and to take R1 to the dining room. E6 went in to R1's room at 8:45 am and found R1 holding a stretch band around R1's neck. R1 was unresponsive with no pulse. E7, Registered Nurse started Cardio Pulmonary Resuscitation and 911 was called. R1 was transported by Emergency Medical Technicians via ambulance at 9:10 am. A report titled "Coroner Summary Report" dated 2/16/17 documents Z4, Deputy Coroner being notified at approximately 9:59 am of R1's death in the Emergency Room.

The facility's initial Incident report dated 2/16/17 sent via facsimile to the Illinois Department of Public health on 2/16/17 documents that R1 was found unresponsive and a Certified Nursing Assistant alerted the Charge Nurse E6, Licensed Practical Nurse. Cardio-Pulmonary Resuscitation was started and 911 was called. R1 was transferred to the Hospital. There is no documentation in this initial incident report on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 06/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE URBANA, IL 61802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10 2/16/17 reporting that R1 was found with an elastic resistant band around R1's neck. On 2/22/17 a final incident report was sent via facsimile to the Illinois Department of Public Health documenting the following: "(R1) arrived at (the hospital) at 9:21 am. (R1) was in ventricular fibrillation arrest (Emergency Medical Service). (R1) was in pulseless ventricular tachycardia when (R1) arrived as (the hospital). (R1) received two shocks and three rounds of Epinephrine, additional 150 milligrams of Amiodarone and noted to be in pulseless electrical activity during the last two pulse checks. (R1) displayed agonal respirations. Family contacted and decided to terminate resuscitation efforts. Death was called at 9:44 am." This final incident report does not document that R1 was found with an elastic resistance band around R1's neck. On 5/30/17 at 2:00 pm E2, Assistant Administrator stated E2 believed the facility's Insurance Risk Management consultant was contacted about the above incident involving R1 and may have been advised not to report anything about the elastic resistant band being around R1's neck. A report titled "State of Illinois Certificate of Death Worksheet" documents R1's time of death at 9:44 am on 2/16/17. The cause of death is documented as "Elastic Band Strangulation." The cause of the injury is documented as "Strangled Self with Elastic Resistance Band." (C)	S9999		