STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06CH	A. BUILDING: _____ B. WING _____	C 09/11/2023

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CLEVELAND NURSING AND REHABILITATION CENTE	4036 HIGHWAY 8 EAST CLEVELAND, MS 38732

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M 000	Initial Comments The State Agency (SA) conducted an on site Complaint Investigations (CI) MS #22550 and CI MS #22325, from 8/22/23 - 8/28/23. After the SA review, the SA extended the survey on 9/7/23 through 9/11/23. During the investigation, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, State licensure requirements. An extended survey was completed, and the following deficiencies were cited for CI MS #22550: M0030 and M500 at an Immediate Jeopardy (IJ) level for Resident Rights related to Neglect and Administration. The investigation for CI MS #22325 for Misappropriation of Money, Infection Control and Quality of Care/Treatment determined the facility was in compliance with the requirements for participation in Medicare and Medicaid and no deficiencies were cited. The facility's failure to provide behavioral services and communicate to hospice staff for Resident #1 resulted in the suicide of Resident #1. The facility's failure to render the care and services necessary to provide for a hospice resident's behavioral and emotional health resulted in the ultimate death of Resident #1. The facility's failure to provide the care and services necessary for the behavioral and emotional health of a resident put all residents in the facility at risk for serious injury, serious harm, serious impairment, and possible death. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 8/9/23 when Resident #1 verbalized suicidal ideations on 8/8/23 and the Medical Doctor (MD) order for a psychiatric evaluation was discontinued on 8/9/23. Resident #1 committed suicide by hanging on 8/19/23.	M 000		

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M 000	Continued From page 1 After the SA review, the SA extended the survey on 9/7/23 through 9/11/23 and the situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) when began on 8/9/23 when the physician's order for a psychiatric evaluation for Resident #1 written on 8/9/23 was discontinued on 8/9/23. The SA notified the facility's Administrator of the IJ and SQC on 9/7/23 at 12:30 PM and provided the Administrator with the IJ templates. The IJ and SQC existed at: Rule 45.2.1 Administration M0030 Level IV Rule 45.17.2 Resident Rights M500 Level IV The facility submitted an acceptable Removal Plan on 9/8/23, in which they alleged all corrective actions to remove the IJ and SQC were completed on 9/7/23 and the IJ was removed on 9/8/23. The SA validated the Removal Plan on 9/11/23 and determined the IJ and SQC was removed on 9/8/23, prior to exit. Therefore, the scope and severity for Rule 45.2.1 Administration M0030 and Rule 45.17.2 Resident Rights M500 was lowered from a Level IV to a Level II while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility was licensed for 120 beds and the facility census was 115 on 8/22/23.	M 000		

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M 030	45.2.1 Administrator Administrator. The term "administrator" shall mean a person who is delegated the responsibility for the interpretation, implementation, and proper application of policies and programs established by the governing authority and are delegated responsibility for the establishment of safe and effective administrative management, control, and operation of the services provided. The administrator may be titled manager, superintendent, director, or otherwise. The administrator shall be duly licensed by the Mississippi State Board of Nursing Home Administrators. This Statute is not met as evidenced by: Level IV Based on record review, policy/procedure review and interviews, the facility failed to be administered effectively and efficiently to provide the mental health care for one (1) of seven (7), Resident #1, as evidenced by Resident #1 committed suicide by hanging on 8/19/23 using the remote control cord from his bed and using an exposed pipe on the ceiling in his room. During the admission process on 8/9/23, Resident #1 told the admitting nurse that he wanted to "jump off a bridge". During the 11:00 PM to 7:00 AM shift, on 8/ On 8/9/23, a Medical Doctor's (MD) order was written for a psychiatric (psych) evaluation. On 8/9/23, Resident #1 wanted to be admitted to hospice services. Another MD order was written on 8/9/23 to discontinue (D/C) the psych evaluation and resident was admitted to contract hospice services. He remained one-on-one observation through to 8/17/23 when he went to every hour	M 030	1. Resident #1 committed suicide on 8/19/2023. Facility failed to be administered effectively and efficiently to provide the mental health care for Resident #1. 2. All residents have the potential to be affected. 3. An in-service education on the Executive Director's (ED) job description was provided to the ED by the vice president to the ED on 8/21/2023, which included that the ED must provide oversight to provide the necessary care for residents who express suicidal ideation and for residents who have psychosocial needs that are not met. 4. The DON will conduct audits to ensure that residents with potential suicidal crisis are identified, receives the necessary psychiatric services starting 8/21/2023,	10/6/23

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M 030	Continued From page 3 observations. Resident #1 was observed by Licensed Practical Nurse (LPN) #1 at 7:15 AM lying in his bed with his eyes closed. LPN #1 took Resident #1's breakfast tray to his room at 8:30 AM and when the door was opened, Resident #1 was observed hanging from a pipe with the bed remote control cord wrapped around his neck. He was noted to be warm. LPN #1 yelled for help and LPN #2 responded. LPN #2 cut Resident #1 down and began doing sternal rubs with no response. Emergency Medical Services (EMS) were called as were hospice services. EMS arrived to the facility and found Resident #1 with no heart activity and he was pronounced dead at 9:00 AM. The facility's failure to be administered efficiently and effectively lead to the death of Resident #1 and placed other residents in a situation that was likely to cause serious injury, harm, impairment, or death. The State Agency (SA) investigated the death of Resident #1 on 8/22/23 through 8/28/23. After the SA Quality Assurance (QA) review, the SA extended the survey on 9/7/23 through 9/ 11/23 and the situation was determined to be an Immediate Jeopardy (IJ) which began on 8/9/23 when the physician's order for a psychiatric evaluation for Resident #1 written on 8/9/23 was discontinued on 8/9/23. The IJ existed at: Rule 45.2.1 Administration (M0030) Level IV The SA notified the notified the facility's Administrator of the IJ on 9/7/23 at 12:30 PM and provided the Administrator with the IJ template.	M 030	five times a week for eight weeks. Results of the audit will be forwarded to the Vice President to the ED, weekly times eight weeks starting 8/28/2023 to audit for accuracy and completeness and audits will be maintained in the ED office. The ED will forward the results of the audit to the Quality Assurance (QA) monthly, times three months starting 9/2023 for review and further recommendations.	

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M 030	Continued From page 4 The facility submitted an acceptable Removal Plan on 9/8/23, in which they alleged all corrective actions to remove the IJ were completed on 9/7/23 and the IJ was removed on 9/8/23. The SA validated the Removal Plan on 9/11/23 and determined the IJ was removed on 9/8/23, prior to exit. Therefore, the scope and severity of Rule 45.2.1 Administration M0030 was lowered from Level IV to Level II while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Record review of the facility's "Job Description" for the Administrator/Executive Director dated "8/2012" revealed "General Description The Executive Director leads and directs the overall operation of the Facility in accordance with resident needs, government regulations and Facility policies so as to maintain quality care for the residents while achieving the Facility's business objectives." The "Job Description" for the Executive Director revealed "Essential Duties 13. Demonstrates knowledge of all State Department of Health rules and regulations and provides adequate instruction regarding such rules and regulations to appropriate staff." The "Job Description" revealed "Standard Requirements 6. Immediately reports incidents of alleged resident abuse or neglect or alleged violations of resident' rights to appropriate authorities." Record review of Resident #1's Face Sheet revealed he was admitted on 8/8/23 to the facility with diagnoses which included Malignant	M 030		

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M 030	Continued From page 5 Neoplasm of Larynx, unspecified and Depression, unspecified. Record review of Resident #1's "Physician Orders" for "August 2023" revealed "Do Not Resuscitate (DNR)". Review of the handwritten "Physician Telephone Order" dated "8/9/23" read "psychiatric consult for evaluation/treatment" with no time that order was given. "Physician Telephone Order" dated "8/9/23" read "d/c (discontinue) psychiatric consult d/t (due to) admit to hospice" with no time that order was given. Review of a printed "Physician's Telephone Order" dated "8/9/23" with a time of "4:00 PM" read "Admit to hospice (proper name) related to diagnosis of malignant neoplasm of larynx." Record review of the "Departmental Notes" with a Category: "Nursing" dated 8/8/21 at 9:31 PM revealed, " ...Resident stated that he's scared of been in (being) in facility and in room by himself .... Please don't leave me alone, I'm scared ...Resident states he doesn't want to die here ...Resident not adjusting to new surroundings well. Resident hollering out loud ...Resident refuse to stay in his room due to he's scared of been (being) alone ...Stating that he wants to call him friend to pick him up so he can jump off bridge cause he's tired of living ..." He was placed one on one observation with staff after making that comment. Record review of the "Departmental Notes" with a Category: "Nursing" dated 8/9/21 at 7:21 AM revealed, " ...Resident constantly states he wants to die. He wrapped oxygen tubing around his neck ...Resident asked staff if he hit his head against the wall will go ahead and take him out ..." On 8/19/23 at 6:23 AM, Resident #1 ambulated to the nursing station and stated he had slipped. A laceration on his face and skin tear on his arm were cleaned.	M 030		

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Resident #1 was observed by Licensed Practical Nurse #1 at 7:15 AM lying in his bed with his eyes closed. LPN#1 took Resident #1's breakfast tray to his room at 8:30 AM and when the door was opened, Resident #1 was observed hanging from a pipe with the bed remote control cord wrapped around his neck. He was noted warm. LPN #1 yelled for help and LPN #2 responded. LPN #2 cut Resident #1 down using bandage scissors and began doing sternal rubs with no response. The facility called Emergency Medical Services (EMS) and hospice services. EMS arrived at the facility and found Resident #1 with no heart activity, and he was pronounced dead at 9:00 AM. Hospice contacted the coroner, and the body was released to the Medical Examiner.

Record review of the "Patient Care Report" by the Emergency Medical Services (EMS) that responded to the facility's call for assistance on 8/19/23 revealed that EMS received notification at "08:52 08/19/23" and were "at patient 08:59 08/19/23". The "NARRATIVE CHIEF COMPLAINT" revealed that EMS found Resident #1 "Unresponsive, apneic, and pulseless in bed covered up with blankets by staff. CPR not in progress. Staff states that patient is a DNR (Do Not Resuscitate) and wanted to confirm death by EMS, according to staff, patient was last seen alive 20-30 minutes ago". Resident #1 was found "unresponsive, apneic, and pulseless" with "airway patent", "breathing is absent", "skin is pale in color, warm to touch" and "pupils dilated". The "Narrative concludes with "DOA-no resuscitation, no transport, (name of county) coroner notified" and "patient's remains left with nursing staff awaiting coroner". The "Patient Care Report" revealed EMS "leave scene 09:11 8/19/23".

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Record Review of the "REPORT OF DEATH INVESTIGATION" revealed the death of Resident #1 was confirmed by EMS on "8-19-23 9:00", "Coroner notified 8-19-23 09:30" and "View of Body 8-19-23 10:05".
The report has the "Manner of Death" is "pending autopsy". The reports "Probable Cause of Death: 1. Pending Hanging/Strangulation".

Record Review of the "Reason for Assuming Medical Examiner Jurisdiction", undated with no time revealed "Suicide" with a check mark and "Medical History Cancer" has a check mark. The "Narrative Summary of Circumstances Surrounding Death" revealed "Called to (name of long term care facility) to find a 61 y/o W/M lying supine in bed with what appeared to be ligature marks to the front of his neck. The decedent body was cool to touch with no other obvious injuries. The decedent was taken to (Name of local hospital) to hold for autopsy. The cord used was also sent for evident with decedent." There is a diagram of a body with a line drawn across the neck.

Record review of the initial notification to the State Department of Health Licensure and Certification hotline regarding the suicide of Resident #1 on 8/19/23 revealed the facility reported an "attempted suicide" on "8/19/23" at "9:58 am".

Interview with the Administrator on 8/22/23 at 3:10 PM regarding reporting incidents to the State Agency (SA). The Administrator stated "I called and left a voicemail reporting a suicide attempt. He died a little after 9:00 AM. He was pronounced here by Emergency Medical Service (EMS). He was found around 8:30 AM and had a pulse. He was a DNR. They did call the

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ambulance and hospice right after he was found." She revealed she was told to report the incident as a "suicide attempt" by the facility's Regional Nurse Consultant.

Interview with the Administrator, 8/24/23 at 4:10 PM regarding the discontinued psychiatric evaluation order written by her on 8/9/23 revealed "He went on hospice. That is why the order was discontinued. Hospice won't pay for a psych eval. He (Resident #1) knew he had a psych evaluation ordered and was (one) 1 on 1 due to what he said about jumping off a bridge. We told him we were dc'ing the psych evaluation because hospice would provide for his needs. He said he understood.

Interview with the Administrator on 8/23/23 at 10:45 AM confirmed that she did not contact the Ombudsman regarding the suicide of Resident #1 until 8/23/23 at 11:00 AM.

Interview with the Administrator on 8/23/23 at 10:45 AM revealed "I didn't report it to the AG office" and that she didn't know she had to contact the AG office.

Interview with Attorney General Investigator on 8/24/23 at 10:37 AM revealed the AG office did not receive notification of this suicide from the facility. He stated it was the resident's sister that contacted the AG office on 8/21/23. He said the administrator said she didn't know she had to report to the AG office.

Interview with Resident #1's Responsible Party on 8/23/23 at 1:00 PM revealed that she called the police and sheriff department on 8/19/23 after her brother had committed suicide.

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Interview with the DON on 8/23/23 at 2:00 PM revealed "No, we didn't call the police after he died. The sheriff officer just showed up here around lunch. His body wasn't even here anymore. The medical examiner had picked him up earlier."

The facility provided the following Removal Plan:

Resident #1 was admitted on 08/08/2023. Resident #1 expressed that he wanted to sign up for hospice services on admission due to him being tired. He stated "I been suffering from throat cancer for seven years. I'm just tired". Resident #1 expressed that he wanted to call his friend so that he could jump off a bridge. On 08/09/2023, a psychiatric consult was ordered. The resident was admitted to hospice on 8/9/2023. The psychiatric consult was discontinued on 8/9/2023 by the physician after he elected hospice services. The facility failed to adequately meet Resident #1's mental health needs when the facility did not provide a psychiatric evaluation on 8/8/2023, after Resident # 1 stated that he wanted to jump off a bridge. The facility failed to ensure the Medical Director evaluated and acted on reported deficient practices related to Resident #1's actual suicide and failed to ensure that orders for the psychological evaluations were carried out as ordered. The facility failed to adequately meet Resident #1's mental health needs when the facility did not complete a status change PASRR when, on 8/8/23, Resident #1 verbalized suicidal ideations. The facility neglected to provide psychological interventions upon admission, on 8/8/23, to protect Resident #1, who expressed suicidal ideations and ultimately was found hanging in the facility on 8/19/23. The facility failed to accurately report an actual suicide for

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M 030	Continued From page 10 Resident #1 when he was found hanging from the pipes in the ceiling at 8:15 AM on 8/19/2023. The incident was reported as an attempted suicide to the department of licensure and certification (L&C) at 9:57 AM on 8/19/2023. The incident was not reported to the appropriate state agencies within the specific time frame, as required by federal guidance. The Administrator/Executive Director failed to ensure that Resident #1's psychological needs were addressed by a lack of immediate intervention and a lack of carrying out of a physician order for a psychological evaluation, which resulted in Resident #1's death. Interventions * The facility held an emergency meeting on 9/7/2023 at 1:00 PM, with the Quality Assurance team to discuss and implement removal plans for citations F600, F609, F644, F835, F841, related to Resident #1's suicide on 8/19/23. The Administrator/Executive Director, the DON/IP, the unit manager, the Medical Director, the activities director, the Vice President to the Administrator/Executive Director, social worker #1, and social worker #2 were in attendance. *On 9/7/2023, a new preadmission screening and resident review (PASRR) policy was created for the facility to coincide with federal and state guidelines. The policy was created by the Executive Director/Administrator of the facility and the governing body. *The facility implemented the policy for PASRR, to coincide with state and federal regulations. The policy was approved in the Emergency Quality and Assurance meeting held on 9/7/23, at 1:00 PM	M 030		

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*An in-service on neglect and abuse was provided to all staff on 9/7/2023, at 1:30 PM, by the Director of Nursing/Infection Preventionist (DON/IP). The information covered in the in-service included the definition of abuse and neglect, the different types of abuse and neglect, and what steps to take if abuse or neglect is witnessed or suspected.

*An in-service education on self reporting requirements was provided to the Administrator/Executive Director and the DON/IP to include reporting accurately to state agencies on 9/7/2023 at 2:00 PM, by the Vice President to the Administrator. The abuse and neglect policy was reviewed in the in-service which included the types of incidents that must be reported, the time frame in which to report, and the entities (Attorney General's Office, Licensure and Certification, Ombudsman) that must be reported to.

*An in-service education was provided with all licensed nurses by the DON on 9/7/2023 at 3:00 PM to review the policy on physician orders including, "The signature of the nurse receiving the order and the time of the order must appear."

*An in-service education was provided to social service on 9/7/2023, at 3:30 PM, by the Administrator/Executive Director, to include an increase in social visits for all residents with suicidal ideation to be seen by social service at least 3 times weekly, until they no longer have suicidal ideation.

*An in-service education on the Administrator's job description was provided to the Administrator/Executive Director to include that the Administrator must provide oversight to

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provide the necessary care for residents who express suicidal ideation and for residents who have psychosocial needs that are not met. This was completed 9/7/2023, at 4:00 PM, by the Vice President to the Administrator/Executive Director.

*An in-service education was provided on PASRR to Social Services on 8/23/2023, by the Administrator/Executive Director. Another PASRR in-service/education was completed on 9/7/23, at 4:30 PM by the Vice President to the Administrator, the DON/IP, Social Services, the Medical Director, and the Director of Admission. The information covered in the in-service included when to complete a new PASRR and the appropriate agency to send the completed forms to.

*An in-service education on the Medical Director Policy was provided to the Medical Director on 9/7/23, at 5:00 PM, by the Administrator/Executive Director. The information covered in the in-service included the role and responsibilities of the Medical Director and leading the continuity of care with nursing services to include physician orders with accurate times and dates.

*A one hundred percent audit was completed on 08/31/23, by the Administrator/Executive Director, of all current resident's PASRRs to ensure status change of assessment has been completed to include new diagnosis and to reflect that mood and behavior changes are included in the status change. Fifty-eight resident's status change forms were sent to the state mental health authority for a status change on 9/7/23 at 8:00 PM.

*A resident council meeting was completed by the activities director on 08/21/2023, at 2:30 PM. The

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residents were encouraged to express their feelings. An additional follow up resident counsel meeting was held on 9/5/2023 at 2:00 PM by the activities director. No negative effects reported from the residents.

*An education/in-service was provided to social service and nursing staff to immediately get psychiatric evaluation for residents with any new behaviors to include suicidal ideation. This was completed 08/21/2023, at 5:00 PM, by the Administrator/Executive Director and the DON/IP. A memo was placed at each nurses station to reflect the instructions of the in-service completed by 4:00 PM on 8/21/2023, by the DON/IP.

*Six residents with history of suicide ideation were seen per the psychiatric nurse practitioner, on 08/21/2023 and 08/22/2023. All residents denied suicidal ideations on evaluation per the psychiatric nurse practitioner.

*A phone meeting was held with the Administrator/Executive Director and the area Vice President of Sales for hospice on 08/23/2023, at 9:00 AM, concerning communication and collaboration between hospice and facility to provide better service for the residents receiving hospice care in the nursing facility. On 8/23/2023 a new system change included a hospice communication book was placed at each nurse's station for any change in condition to hospice residents.

*A grief counseling meeting was conducted by the hospice Chaplin on 08/23/2023, from 11:00 AM until 3:00 PM for the residents and staff.

*An in-service/education was provided to all the licensed nursing staff to notify hospice of all

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changes in condition, this will include condition changes such as, decline or improvement, medication changes, new orders of any type, and psychiatric needs and/or evaluations. All communication with hospice will be documented in the interdisciplinary notes and placed on hospice notification form (Form #1) in the hospice communication book. The in-service was completed by the DON/IP on 08/23/2023 by 5:30 PM.

*A second emergency Quality Assurance meeting held to discuss the new system implemented to communicate with hospice, the new hospice form #1, and communication book. This meeting was held on 08/23/2023 at 5:00 PM. In attendance were the Administrator/Executive Director, the DON/IP, the Unit Manager, Social Worker #1, Social Worker #2 and the Medical Director per phone.

*Any employee that has not been in-serviced will not be allowed to return to work until all in-services are completed.

*On 08/19/2023, the Emergency Medical Services were notified at 8:51 AM, along with hospice, the coroner, the Department of Health, and the resident's responsible party.

*The State Health Department was notified on 08/19/2023 at 9:57 AM, by the Executive Director/Administrator. The Attorney General's Office (AG) was notified on 08/23/2023 by the Executive Director/Administrator at 8:30 AM while at the facility investigating the incident.

*The Sheriff's Department was notified on 08/19/2023, at 1:00 PM, while at the facility investigating the incident by the Executive

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Director/Administrator. The Ombudsman was notified by phone on 08/23/2023, at 11:00 AM, by the Executive Director/Administrator.

*On 8/19/2023, at 12:30 PM, an emergency Quality Assurance meeting was held to discuss immediate interventions completed and interventions to be put in place related to Resident #'1s suicide. In attendance was the Director of Nursing/Infection Preventionist, the Executive Director/Administrator, the House Supervisor, Social Worker #1, Social Worker #2 and the Medical Director by phone.

*A trauma screening was performed on each resident in the facility. No issues were found. This was completed on 8/19/2023 between 10:00 AM and 12:00 PM, by social services.

*All staff was in-serviced on abuse, neglect, and suicide precautions starting at 10:00 AM on 8/19/2023, by the DON/IP.

*All care plans of residents with a history of suicidal ideation were updated to include the following interventions, residents that express feelings of harming themselves will be immediately placed on one on one and seen by the psychiatric nurse practitioner or a physician. If the psychiatric nurse practitioner or the physician are not available, then the resident will be sent to the emergency room for evaluation.

*These interventions were added to the plans of care of six residents on 8/19/2023 between 1:00 PM and 2:00 PM, by social services.

*100% audit of all beds to ensure bed remote secured to bed by social service, this was completed 08/19/2023, by 3:00 PM. There were

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two beds that required maintenance to secure the cord to the bed. The cords were secured immediately.

*For residents protection, all residents with a history of suicidal ideation were assessed for thoughts of self harm between the hours of 1:00 PM and 3:00 PM on 08/19/2023, by social services. No resident reported thoughts of self harm.

*An in-service was provided to social services to ensure that all residents with suicidal ideation will be seen by social service at least weekly, until they no longer have suicidal ideation. This in-service was completed by the DON/IP on 08/19/2023, at 5:00 PM.

*An in-service was completed with all staff by the DON/IP at 6:00 PM on 08/19/2023. Training included that all residents that express feelings of harming themselves will be immediately placed on one on one and seen by the psychiatric nurse practitioner or a physician. If the psychiatric nurse practitioner or the physician are not available, then the resident will be sent to the emergency room for evaluation.
Facility alleged compliance on 9/8/2023.

On 9/11/23, the State Agency (SA) validated the facility's Removal Plan by staff interviews, record reviews, and review of the in-service sign in sheets. The SA verified the facility had implemented the following measures to remove the IJ:

The SA validated through interviews and record review that the facility held an emergency meeting on 9/7/2023 at 1:00 PM, with the Quality

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Assurance team to discuss and implement removal plans for citations F600, F609, F644, F835, F841, related to Resident #1's suicide on 8/19/23. Interviews with the Administrator/Executive Director, the DON/IP, the unit manager, the Medical Director, the Vice President to the Administrator/Executive Director, social worker #1, and social worker #2 confirmed all were in attendance.

The SA validated through record review and interviews with the Administrator/Executive Director, Director of Nurses (DON), Social Worker #1, Social Worker #2 that on 9/7/2023, a new preadmission screening and resident review (PASRR) policy was created for the facility to coincide with federal and state guidelines. The policy was created by the Executive Director/Administrator of the facility and the governing body.

The SA validated through record review and interviews with the Administrator/Executive Director, DON, Social Worker #1, Social Worker #2, Medical Director, Unit Manager that the facility implemented the policy for PASRR, to coincide with state and federal regulations. The policy was approved in the Emergency Quality and Assurance meeting held on 9/7/23, at 1:00 PM.

The SA validated through record review and interviews with four Registered Nurses, five Licensed Practical Nurses, eight Certified Nurse Aides, one Laundry staff, three Housekeepers, two Social Workers, one Medical Director, one Administrator/Executive Director that an in-service on neglect and abuse was provided to all staff on 9/7/2023, at 1:30 PM, by the Director of Nursing/Infection Preventionist (DON/IP). The information covered in the in-service included the

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M 030	Continued From page 18 definition of abuse and neglect, the different types of abuse and neglect, and what steps to take if abuse or neglect is witnessed or suspected. The SA validated through record review and interviews with the Director of Nurses (DON) and Administrator/Executive Director that an in-service education on self reporting requirements was provided to the Administrator/Executive Director and the DON/IP to include reporting accurately to state agencies on 9/7/2023 at 2:00 PM, by the Vice President to the Administrator. The abuse and neglect policy was reviewed in the in-service which included the types of incidents that must be reported, the time frame in which to report, and the entities (Attorney General's Office, Licensure and Certification, Ombudsman) that must be reported to. The SA validated through record review and interviews with the Administrator/Executive Director, four RN's and five LPN's that an in-service education was provided with all licensed nurses by the DON on 9/7/2023 at 3:00 PM to review the policy on physician orders including, "The signature of the nurse receiving the order and the time of the order must appear." The SA validated through record review and interviews with two Social Workers and Administrator/Executive Director that an in-service education was provided to social service on 9/7/2023, at 3:30 PM, by the Administrator/Executive Director, to include an increase in social visits for all residents with suicidal ideation to be seen by social service at least 3 times weekly, until they no longer have suicidal ideation.	M 030		

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M 030	Continued From page 19 The SA validated through interview with the Administrator/Executive Director and record review that an in-service education on the Administrator's job description was provided to the Administrator/Executive Director to include that the Administrator must provide oversight to provide the necessary care for residents who express suicidal ideation and for residents who have psychosocial needs that are not met. This was completed 9/7/2023, at 4:00 PM, by the Vice President to the Administrator/Executive Director. The SA validated through record review and interviews with two Social Workers and the Administrator/Executive Director that an in-service education was provided on PASRR to Social Services on 8/23/2023, by the Administrator/Executive Director. Another PASRR in-service/education was completed on 9/7/23, at 4:30 PM by the Vice President to the Administrator, the DON/IP, Social Services, the Medical Director, and the Director of Admission. The information covered in the in-service included when to complete a new PASRR and the appropriate agency to send the completed forms to. The SA validated through record review and interviews with the Medical Director and Administrator/Executive Director that an in-service education on the Medical Director Policy was provided to the Medical Director on 9/7/23, at 5:00 PM, by the Administrator/Executive Director. The information covered in the in-service included the role and responsibilities of the Medical Director and leading the continuity of care with nursing services to include physician orders with accurate times and dates.	M 030		

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The SA validated by record review and interviews with the Administrator/Executive Director and two Social Workers that a one hundred percent audit was completed on 08/31/23, by the Administrator/Executive Director, of all current resident's PASRRs to ensure status change of assessment has been completed to include new diagnosis and to reflect that mood and behavior changes are included in the status change. Fifty-eight resident's status change forms were sent to the state mental health authority for a status change on 9/7/23 at 8:00 PM.

The SA validated through interviews with the Administrator, DON and SW #1 and record review a resident council meeting was completed by the activities director on 08/21/2023, at 2:30 PM. The residents were encouraged to express their feelings. An additional follow up resident counsel meeting was held on 9/5/2023 at 2:00 PM by the activities director. No negative effects reported from the residents.

The SA validated through interviews with five LPN's, one Activity Director, two Social Workers, one Director of Admissions, three RN's and five CNA's that an education/in-service was provided to social service and nursing staff to immediately get psychiatric evaluation for residents with any new behaviors to include suicidal ideation. This was completed 08/21/2023, at 5:00 PM, by the Administrator/Executive Director and the DON/IP. A memo was placed at each nurses station to reflect the instructions of the in-service completed by 4:00 PM on 8/21/2023, by the DON/IP.

The SA validated through interviews with the Administrator, DON and SW and record review that six residents with history of suicide ideation were seen per the psychiatric nurse practitioner,

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M 030	Continued From page 21 on 08/21/2023 and 08/22/2023. All residents denied suicidal ideations on evaluation per the psychiatric nurse practitioner. The SA validated through interviews with the Administrator and the Vice President of sales for hospice and record review that a phone meeting was held with the Administrator/Executive Director and the area Vice President of Sales for hospice on 08/23/2023, at 9:00 AM, concerning communication and collaboration between hospice and facility to provide better service for the residents receiving hospice care in the nursing facility. On 8/23/2023 a new system change included a hospice communication book was placed at each nurse's station for any change in condition to hospice residents. The SA validated through interviews with the Administrator, DON and SW and a record review that a grief counseling meeting was conducted by the hospice Chaplin on 08/23/2023, from 11:00 AM until 3:00 PM for the residents and staff. The SA validated through interviews with five LPN's, one Activity Director, two Social Workers, one Director of Admissions, three RN's and five CNA's an in-service/education was provided to all the licensed nursing staff to notify hospice of all changes in condition, this will include condition changes such as, decline or improvement, medication changes, new orders of any type, and psychiatric needs and/or evaluations. All communication with hospice will be documented in the interdisciplinary notes and placed on hospice notification form (Form #1) in the hospice communication book. The in-service was completed by the DON/IP on 08/23/2023 by 5:30 PM.	M 030		

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M 030	Continued From page 22 The SA validated through interviews with the Administrator, DON, Medical Director and SW and record review that a second emergency Quality Assurance meeting held to discuss the new system implemented to communicate with hospice, the new hospice form #1, and communication book. This meeting was held on 08/23/2023 at 5:00 PM. In attendance were the Administrator/Executive Director, the DON/IP, the Unit Manager, Social Worker #1, Social Worker #2 and the Medical Director per phone. Any employee that has not been in-serviced will not be allowed to return to work until all in-services are completed. The SA validated through interviews with the Administrator and DON and record review that on 08/19/2023, the Emergency Medical Services were notified at 8:51 AM, along with hospice, the coroner, the Department of Health, and the resident's responsible party. The SA validated through interviews with the Administrator and DON that The State Health Department was notified on 08/19/2023 at 9:57 AM, by the Executive Director/Administrator. The Attorney General's Office (AG) was notified on 08/23/2023 by the Executive Director/Administrator at 8:30 AM while at the facility investigating the incident. The SA validated through interview with the Administrator that the Sheriff's Department was notified on 08/19/2023, at 1:00 PM, while at the facility investigating the incident by the Executive Director/Administrator. The Ombudsman was notified by phone on 08/23/2023, at 11:00 AM, by the Executive Director/Administrator.	M 030		

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M 030	Continued From page 23 The SA validated through record review and interviews with the Administrator, DON, SW #1 and Medical Director that on 8/19/2023, at 12:30 PM, an emergency Quality Assurance meeting was held to discuss immediate interventions completed and interventions to be put in place related to Resident #'1s suicide. In attendance was the Director of Nursing/Infection Preventionist, the Executive Director/Administrator, the House Supervisor, Social Worker #1, Social Worker #2 and the Medical Director by phone. The SA validated through record review and interviews with the Administrator, DON and SW that a trauma screening was performed on each resident in the facility. No issues were found. This was completed on 8/19/2023 between 10:00 AM and 12:00 PM, by social services. The SA validated through record review and interviews with five LPN's, one Activity Director, two Social Workers, one Director of Admissions, three RN's and five CNA's that all staff was in-serviced on abuse, neglect, and suicide precautions starting at 10:00 AM on 8/19/2023, by the DON/IP. The SA validated through record review and interviews with the Administrator and DON that all care plans of residents with a history of suicidal ideation were updated to include the following interventions, residents that express feelings of harming themselves will be immediately placed on one on one and seen by the psychiatric nurse practitioner or a physician. If the psychiatric nurse practitioner or the physician are not available, then the resident will be sent to the emergency room for evaluation. These interventions were added to the plans of care of six residents on	M 030		

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M 030	Continued From page 24 8/19/2023 between 1:00 PM and 2:00 PM, by social services. The SA validated with record review and interviews with the Administrator and DON that 100% audit of all beds to ensure bed remote secured to bed by social service, this was completed 08/19/2023, by 3:00 PM. There were two beds that required maintenance to secure the cord to the bed. The cords were secured immediately. The SA validated through record review and interviews with the Administrator, DON and SW that for residents protection, all residents with a history of suicidal ideation were assessed for thoughts of self harm between the hours of 1:00 PM and 3:00 PM on 08/19/2023, by social services. No resident reported thoughts of self harm. The SA validated by record review and interviews with the Administrator, DON and SW that an in-service was provided to social services to ensure that all residents with suicidal ideation will be seen by social service at least weekly, until they no longer have suicidal ideation. This in-service was completed by the DON/IP on 08/19/2023, at 5:00 PM. The SA validated through record review and interviews with five LPN's, one Activity Director, two Social Workers, one Director of Admissions, three RN's and five CNA's that an in-service was completed with all staff by the DON/IP at 6:00 PM on 08/19/2023. Training included that all residents that express feelings of harming themselves will be immediately placed on one on one and seen by the psychiatric nurse practitioner or a physician. If the psychiatric nurse practitioner or	M 030		

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(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
M 030	Continued From page 25 the physician are not available, then the resident will be sent to the emergency room for evaluation.	M 030		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same	M 500		10/6/23

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M 500	Continued From page 26 standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the	M 500		

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M 500	Continued From page 27	M 500		

resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as

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M 500	Continued From page 28 documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level IV Based on record review, policy/procedure review and interviews, the facility neglected to identify a crisis of suicidal ideation of Resident #1 and neglected to provide the psychiatric services that were necessary to prevent death for one (1) of seven (7) residents sampled as evidenced by Resident #1 committed suicide by hanging on 8/19/23 using the remote-control cord from his bed and using an exposed pipe on the ceiling in his room. On 8/8/23, during the admission process	M 500	1. Resident #1 committed suicide on 8/19/2023. The facility neglected to identify a crisis of suicidal ideation of resident #1 and failed to provide psychiatric services that were necessary to prevent death of Resident #1. 2. All residents have the potential to be affected. 3. An in-service was provided to all staff on resident's right on 9/22/2023 by the staff development nurse. An in-service education was provided to social services	

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M 500	Continued From page 29 Resident #1 told the admitting nurse that he wanted to call a friend to pick him up and take him to "jump off a bridge". During the 11:00 PM to 7:00 AM shift, on 8/9/23, a Medical Doctor's (MD) order was written for a psychiatric (psych) evaluation. On 8/9/23, Resident #1 wanted to be admitted to hospice services. Another MD order was written on 8/9/23 to discontinue (D/C) the psych evaluation and resident was admitted to contract hospice services. He remained one-on-one observation through to 8/17/23 when he went to every hour observations. Resident #1 was observed by Licensed Practical Nurse (LPN) #1 at 7:15 AM lying in his bed with his eyes closed. LPN #1 took Resident #1's breakfast tray to his room at 8:30 AM and when the door was opened, Resident #1 was observed hanging from a pipe with the bed remote control cord wrapped around his neck. He was noted to be warm. LPN #1 yelled for help and LPN #2 responded. LPN #2 cut Resident #1 down and began doing sternal rubs with no response. Emergency Medical Services (EMS) were called as were hospice services. EMS arrived to the facility and found Resident #1 with no heart activity and he was pronounced dead at 9:00 AM. The facility's failure to provide a psychiatric evaluation for Resident #1 placed this resident in a situation that was likely to cause serious injury, harm, impairment, or death. The State Agency (SA) investigated the death of Resident #1 on 8/22/23 through 8/28/23. After SA review, the SA extended the survey on 9/7/23 through 9/11/23 and the situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) when began on 8/9/23 when the physician's order for a psychiatric evaluation for Resident #1 written on	M 500	and nursing staff to immediately get psychiatric evaluation for residents with any new behaviors to include suicidal ideation. This was completed 8/21/2023 by the Executive Director (ED). All residents with history of suicidal ideation were seen per the psychiatric nurse practitioner on 8/21/2023 and 8/22/2023. All staff was in-serviced on abuse, neglect, and suicide precautions, completed 8/19/2023 by the Director of Nursing (DON). All care plans of residents with a history of suicidal ideation were updated to include residents that express feelings of harming themselves will be immediately place on one-to-one monitoring and seen by the psychiatric nurse practitioner or a physician. If the psychiatric nurse practitioner or physician is not available, then the resident will be sent to the emergency room for evaluation. These interventions were added to the plans of care on 8/19/2023 by social services. A 100% audit of all beds to ensure bed remote secured to bed by social services was completed on 8/19/2023. For residents' protection, all residents with a history of suicidal ideation were assessed for thoughts of self harm on 8/19/23 by social services. An in-service was completed with all staff by the DON on 8/19/2023, which included all residents that express feelings of harming themselves will be immediately placed on one-to-one monitoring and seen by the psychiatric nurse practitioner or a physician. If the psychiatric nurse practitioner or the physician is not available, then the resident will be sent to the emergency room for evaluation. Also,	

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M 500	Continued From page 30 8/9/23 was discontinued on 8/9/23. The IJ and SQC existed at: 45.17.2 Resident Rights- M500- Level IV. The SA notified the facility's Administrator of the IJ and SQC on 9/7/23 at 12:30 PM and provided the Administrator with the IJ template. The facility submitted an acceptable Removal Plan on 9/8/23, in which they alleged all corrective actions to remove the IJ and SQC were completed on 9/7/23 and the IJ was removed on 9/8/23. The SA validated the Removal Plan on 9/11/23 and determined the IJ and SQC was removed on 9/8/23, prior to exit. Therefore, the scope and severity of (M500) was lowered to a Scope and Severity of Level II while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Record review of the facility's "Abuse Prevention" last dated "10/22" revealed "Definition: f) Neglect: A failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, mental anguish, emotional distress, or pain." Record review of the facility policy "Physician Orders" history 1/15 (A.15) revealed " ...Procedure ...4. The ...time of the order must appear ..." Record review of Resident #1's Face Sheet	M 500	a memo was placed at each nurses station to reflect the instructions of this in-service. 4. The Director of Nursing (DON) will monitor interdisciplinary notes and physician orders five times a week for eight weeks, starting 8/21/2023, to ensure that a psychiatric evaluation is ordered and completed. Results of the audit will be forwarded to the Executive Director (ED), weekly times eight weeks starting 8/28/2023 to audit for accuracy and completeness and the audits will be maintained in the ED office. The ED will forward results of the audit to the Quality Assurance (QA) committee monthly times three months starting 9/2023 for review and further recommendations.	

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revealed he was admitted on 8/8/23 to the facility with diagnoses which included Malignant Neoplasm of Larynx, unspecified, Restlessness and Agitation and Depression, unspecified.

Record review of Resident #1's "Physician Orders" for "August 2023" revealed Do Not Resuscitate (DNR). The orders also revealed a Handwritten "Physician Telephone Order" dated "8/9/23" read "psychiatric consult for evaluation/treatment" with no time that order was given. "Physician Telephone Order" dated "8/9/23" read "d/c (discontinue) psychiatric consult d/t (due to) admit to hospice" with no time that order was given. Record review revealed a printed "Physician's Telephone Order" dated "8/9/23" with a time of "4:00 PM" to "Admit to hospice (proper name) related to diagnosis of malignant neoplasm of larynx." Record review revealed there were no printed physician orders for a psychiatric consult on 8/8/23 or to d/c a psychiatric consult on 8/8/23.

Record review of the MD's (Medical Doctor) order to discontinue the psych evaluation written on 8/9/23 revealed the Administrator, a Registered Nurse, wrote the order to discontinue the psych. evaluation.

In an interview with Resident #1's Medical Doctor (MD) on 8/24/23 at 8:30 AM revealed that the psychiatric evaluation was discontinued "because hospice won't pay for psych."

Interview with the Administrator, 8/24/23 at 4:10 PM, regarding the discontinued psychiatric (psych) evaluation order on 8/9/23 revealed "He went on hospice. That is why the order was discontinued. Hospice won't pay for a psych eval. He knew he had a psych evaluation ordered and

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was 1 on 1 due to what he said about jumping off a bridge. We told him we were dc'ing (discontinuing) the psych evaluation because hospice would provide for his needs. He said he understood."

Interview with the Administrator on 9/7/23 at 10:45 AM revealed "LPN #3 did call me on 8/8/23 and let me know what Resident #1 said during the admission process. She stated she immediately put him one on one and got a psychiatric consult order from the Medical Director, who was the resident's primary physician. On 8/9/23, Resident #1 wanted to be admitted to hospice. He went on hospice on 8/9/23. Hospice isn't going to pay for consults, so the psychiatric consult was discontinued. If a resident is a Do Not Resuscitate (DNR) and on hospice or palliative care only, any consults will be discontinued."

Interview with the Social Worker (SW) #1 on 9/11/23 at 3:00 PM revealed that the facility will now do a telehealth psych eval if a resident expresses suicidal ideations and stated, "We've had that available for years, especially since Covid started."

Record review of the "Departmental Notes" with a Category: "Nursing" dated 8/8/21 at 9:31 PM revealed, " ...Resident stated that he's scared of been in (being) in facility and in room by himself .... Please don't leave me alone, I'm scared ...Resident states he doesn't want to die here ...Resident not adjusting to new surroundings well. Resident hollering out loud ...Resident refuse to stay in his room due to he's scared of been (being) alone ...Stating that he wants to call him friend to pick him up so he can jump off bridge cause he's tired of living ..." He was placed

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one on one observation with staff after making that comment. Record review of the "Departmental Notes" with a Category: "Nursing" dated 8/9/21 at 7:21 AM revealed, " ...Resident constantly states he wants to die. He wrapped oxygen tubing around his neck ...Resident asked staff if he hit his head against the wall will go ahead and take him out ..." On 8/19/23 at 6:23 AM, Resident #1 ambulated to the nursing station and stated he had slipped. A laceration on his face and skin tear on his arm were cleaned. Resident #1 was observed by Licensed Practical Nurse #1 at 7:15 AM lying in his bed with his eyes closed. LPN#1 took Resident #1's breakfast tray to his room at 8:30 AM and when the door was opened, Resident #1 was observed hanging from a pipe with the bed remote control cord wrapped around his neck. He was noted warm. LPN #1 yelled for help and LPN #2 responded. LPN #2 cut Resident #1 down using bandage scissors and began doing sternal rubs with no response. The facility called Emergency Medical Services (EMS) and hospice services. EMS arrived at the facility and found Resident #1 with no heart activity, and he was pronounced dead at 9:00 AM. Hospice contacted the coroner, and the body was released to the Medical Examiner.

In an interview with LPN #2 on 8/24/23 at 8:55 AM, revealed that he heard LPN #1 call for help and immediately went to help. He stated that Resident #1 and hanging from a pipe near the ceiling. He stated he cut the cord which was a bed control cord. The cord was removed from around the resident's neck. He stated the resident still felt warm and had a faint pulse for three (3) minutes. He did sternal rubs to see if the resident would respond and there was no response. He said that staff had called the EMS (emergency medical services) and they arrived. The EMS did

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an EKG and there was no heart activity. Hospice arrived and called the coroner and family.

During an interview with Certified Nursing Assistant (CNA) #1 on 8/24/23 at 9:20 AM, revealed that she saw Resident #1 on 8/19/23 "around 7:36 AM". She stated she was walking by his room and saw his door open. She saw him again lying in bed with his legs moving at 8:00 AM. She stated her assignment changed after 8:00 AM and she was no longer his assigned CNA. She stated that a little later she heard a nurse scream.

During an interview with LPN #1 on 8/24/23 at 9:58 AM, revealed that she was Resident #1's assigned nurse on 8/19/23 on the 7-3 shift. She first saw him at 7:15 AM on 8/19/23, he was lying in bed with his eyes closed. She went to his room at 8:30 AM to assist with his breakfast. She opened the room door and saw him hanging from an exposed pipe going across his ceiling. She attempted to get him down but was too short and yelled for help. LPN #2 came to help and had his bandage scissors in his pocket. He cut the cord and they laid the resident down. She stated that LPN #2 did sternal rubs. Staff called 911 for an ambulance and hospice. She stated LPN #2 stated he felt a faint pulse. She stated it appeared he stood on the wheelchair (w/c) to get to the pipe. His w/c was close to where he was hanging. She stated he was warm but unresponsive. She stated he had an order to Do Not Resuscitate (DNR) so Cardiopulmonary Resuscitation (CPR) was not started. She stated the Emergency Medical Services (EMS)'s ran an Electrocardiogram (EKG) and found no heart activity. The coroner was called by the hospice staff when they got here.

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The facility provided the following Removal Plan:

1. Resident #1 was admitted on 08/08/2023. Resident #1 expressed that he wanted to sign up for hospice services on admission due to him being tired. He stated "I been suffering from throat cancer for seven years. I'm just tired". Resident #1 expressed that he wanted to call his friend so that he could jump off a bridge. On 08/09/2023, a psychiatric consult was ordered. The resident was admitted to hospice on 8/9/2023. The psychiatric consult was discontinued on 8/9/2023 by the physician after he elected hospice services. The facility failed to adequately meet Resident #1's mental health needs when the facility did not provide a psychiatric evaluation on 8/8/2023, after Resident # 1 stated that he wanted to jump off a bridge. The facility failed to ensure the Medical Director evaluated and acted on reported deficient practices related to Resident #1's actual suicide and failed to ensure that orders for the psychological evaluations were carried out as ordered. The facility failed to adequately meet Resident #1's mental health needs when the facility did not complete a status change PASARR (Pre-Admission Screening and Resident Review) when, on 8/8/23, Resident #1 verbalized suicidal ideations. The facility neglected to provide psychological interventions upon admission, on 8/8/23, to protect Resident #1, who expressed suicidal ideations and ultimately was found hanging in the facility on 8/19/23. The facility failed to accurately report an actual suicide for Resident #1 when he was found hanging from the pipes in the ceiling at 8:15 AM on 8/19/2023. The incident was reported as an attempted suicide to the department of licensure and certification (L&C) at 9:57 AM on 8/19/2023. The incident was not reported to the appropriate state agencies

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within the specific time frame, as required by federal guidance. The Administrator/Executive Director failed to ensure that Resident #1's psychological needs were addressed by a lack of immediate intervention and a lack of carrying out of a physician order for a psychological evaluation, which resulted in Resident #1's death.

Immediate Interventions:
1. The facility held an emergency meeting on 9/7/2023 at 1:00 PM, with the Quality Assurance team to discuss and implement removal plans for citations F600, F609, F644, F835, F841, related to Resident #1's suicide on 8/19/23. The Administrator/Executive Director, the DON/IP, the unit manager, the Medical Director, the activities director, the Vice President to the Administrator/Executive Director, social worker #1, and social worker #2 were in attendance.

2. On 9/7/2023, a new preadmission screening and resident review (PASARR) policy was created for the facility to coincide with federal and state guidelines. The policy was created by the Executive Director/Administrator of the facility and the governing body.

3. The facility implemented the policy for PASARR, to coincide with state and federal regulations. The policy was approved in the Emergency Quality and Assurance meeting held on 9/7/23, at 1:00 PM.

4. An in-service on neglect and abuse was provided to all staff on 9/7/2023, at 1:30 PM, by the Director of Nursing/Infection Preventionist (DON/IP). The information covered in the in-service included the definition of abuse and neglect, the different types of abuse and neglect, and what steps to take if abuse or neglect is

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(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
M 500	Continued From page 37 witnessed or suspected. 5. An in-service education on self-reporting requirements was provided to the Administrator/Executive Director and the DON/IP to include reporting accurately to state agencies on 9/7/2023 at 2:00 PM, by the Vice President to the Administrator. The abuse and neglect policy was reviewed in the in-service which included the types of incidents that must be reported, the time frame in which to report, and the entities (Attorney General's Office, Licensure and Certification, Ombudsman) that must be reported to. 6. An in-service education was provided with all licensed nurses by the DON on 9/7/2023 at 3:00 PM to review the policy on physician orders including, "The signature of the nurse receiving the order and the time of the order must appear." 7. An in-service education was provided to social service on 9/7/2023, at 3:30 PM, by the Administrator/Executive Director, to include an increase in social visits for all residents with suicidal ideation to be seen by social service at least 3 times weekly, until they no longer have suicidal ideation. 8. An in-service education on the Administrator's job description was provided to the Administrator/Executive Director to include that the Administrator must provide oversight to provide the necessary care for residents who express suicidal ideation and for residents who have psychosocial needs that are not met. This was completed 9/7/2023, at 4:00 PM, by the Vice President to the Administrator/Executive Director. 9. An in-service education was provided on	M 500		

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M 500	Continued From page 38	M 500		

PASARR to Social Services on 8/23/2023, by the Administrator/Executive Director. Another PASARR in-service/education was completed on 9/7/23, at 4:30 PM by the Vice President to the Administrator, the DON/IP, Social Services, the Medical Director, and the Director of Admission. The information covered in the in-service included when to complete a new PASARR and the appropriate agency to send the completed forms to.

10. An in-service education on the Medical Director Policy was provided to the Medical Director on 9/7/23, at 5:00 PM, by the Administrator/Executive Director. The information covered in the in-service included the role and responsibilities of the Medical Director and leading the continuity of care with nursing services to include physician orders with accurate times and dates.

11. A one hundred percent audit was completed on 08/31/23, by the Administrator/Executive Director, of all current resident's PASARRs to ensure status change of assessment has been completed to include new diagnosis and to reflect that mood and behavior changes are included in the status change. Fifty-eight resident's status change forms were sent to the state mental health authority for a status change on 9/7/23 at 8:00 PM.

Interventions:

A resident council meeting was completed by the activities director on 08/21/2023, at 2:30 PM. The residents were encouraged to express their feelings. An additional follow up resident council meeting was held on 9/5/2023 at 2:00 PM by the activities director. No negative effects reported

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M 500	Continued From page 39	M 500		

from the residents.

An education/in-service was provided to social service and nursing staff to immediately get psychiatric evaluation for residents with any new behaviors to include suicidal ideation. This was completed 08/21/2023, at 5:00 PM, by the Administrator/Executive Director and the DON/IP. A memo was placed at each nurse's station to reflect the instructions of the in-service completed by 4:00 PM on 8/21/2023, by the DON/IP.

Six residents with history of suicide ideation were seen per the psychiatric nurse practitioner, on 08/21/2023 and 08/22/2023. All residents denied suicidal ideations on evaluation per the psychiatric nurse practitioner.

A phone meeting was held with the Administrator/Executive Director and the area Vice President of Sales for hospice on 08/23/2023, at 9:00 AM, concerning communication and collaboration between hospice and facility to provide better service for the residents receiving hospice care in the nursing facility. On 8/23/2023 a new system change included a hospice communication book was placed at each nurse's station for any change in condition to hospice residents.

A grief counseling meeting was conducted by the hospice Chaplin on 08/23/2023, from 11:00 AM until 3:00 PM for the residents and staff.

An in-service/education was provided to all the licensed nursing staff to notify hospice of all changes in condition, this will include condition changes such as, decline or improvement, medication changes, new orders of any type, and psychiatric needs and/or evaluations. All

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communication with hospice will be documented in the interdisciplinary notes and placed on hospice notification form (Form #1) in the hospice communication book. The in-service was completed by the DON/IP on 08/23/2023 by 5:30 PM.

A second emergency Quality Assurance meeting held to discuss the new system implemented to communicate with hospice, the new hospice form #1, and communication book. This meeting was held on 08/23/2023 at 5:00 PM. In attendance were the Administrator/Executive Director, the DON/IP, the Unit Manager, Social Worker #1, Social Worker #2 and the Medical Director per phone.

Any employee that has not been in-serviced will not be allowed to return to work until all in-services are completed.

Interventions:
On 08/19/2023, the Emergency Medical Services were notified at 8:51 AM, along with hospice, the coroner, the Department of Health, and the resident's responsible party.

The State Health Department was notified on 08/19/2023 at 9:57 AM, by the Executive Director/Administrator. The Attorney General's Office (AG) was notified on 08/23/2023 by the Executive Director/Administrator at 8:30 AM while at the facility investigating the incident.

The Sheriff's Department was notified on 08/19/2023, at 1:00 PM, while at the facility investigating the incident by the Executive Director/Administrator. The Ombudsman was notified by phone on 08/23/2023, at 11:00 AM, by the Executive Director/Administrator.

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M 500	Continued From page 41 On 8/19/2023, at 12:30 PM, an emergency Quality Assurance meeting was held to discuss immediate interventions completed and interventions to be put in place related to Resident #1's suicide. In attendance was the Director of Nursing/Infection Preventionist, the Executive Director/Administrator, the House Supervisor, Social Worker #1, Social Worker #2 and the Medical Director by phone. A trauma screening was performed on each resident in the facility. No issues were found. This was completed on 8/19/2023 between 10:00 AM and 12:00 PM, by social services. All staff was in-serviced on abuse, neglect, and suicide precautions starting at 10:00 AM on 8/19/2023, by the DON/IP. All care plans of residents with a history of suicidal ideation were updated to include the following interventions, residents that express feelings of harming themselves will be immediately placed on one on one and seen by the psychiatric nurse practitioner or a physician. If the psychiatric nurse practitioner or the physician are not available, then the resident will be sent to the emergency room for evaluation. These interventions were added to the plans of care of six residents on 8/19/2023 between 1:00 PM and 2:00 PM, by social services. 100% audit of all beds to ensure bed remote secured to bed by social service, this was completed 08/19/2023, by 3:00 PM. There were two beds that required maintenance to secure the cord to the bed. The cords were secured immediately.	M 500		

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M 500	Continued From page 42 For residents' protection, all residents with a history of suicidal ideation were assessed for thoughts of self-harm between the hours of 1:00 PM and 3:00 PM on 08/19/2023, by social services. No resident reported thoughts of self-harm. An in-service was provided to social services to ensure that all residents with suicidal ideation will be seen by social service at least weekly, until they no longer have suicidal ideation. This in-service was completed by the DON/IP on 08/19/2023, at 5:00 PM. An in-service was completed with all staff by the DON/IP at 6:00 PM on 08/19/2023. Training included that all residents that express feelings of harming themselves will be immediately placed on one on one and seen by the psychiatric nurse practitioner or a physician. If the psychiatric nurse practitioner or the physician are not available, then the resident will be sent to the emergency room for evaluation. Facility alleges compliance on 9/8/2023. On 9/11/23, the State Agency (SA) validated the facility's Removal Plan by staff interviews, record reviews, and review of the in-service sign in sheets. The SA verified the facility had implemented the following measures to remove the IJ: The SA validated through interviews and record review that the facility held an emergency meeting on 9/7/2023 at 1:00 PM, with the Quality Assurance team to discuss and implement removal plans for citations F600, F609, F644, F835, F841, related to Resident #1's suicide on 8/19/23. Interviews with the	M 500		

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M 500	Continued From page 43 Administrator/Executive Director, the DON/IP, the unit manager, the Medical Director, the Vice President to the Administrator/Executive Director, social worker #1, and social worker #2 confirmed all were in attendance. The SA validated through record review and interviews with the Administrator/Executive Director, Director of Nurses (DON), Social Worker #1, Social Worker #2 that on 9/7/2023, a new preadmission screening and resident review (PASARR) policy was created for the facility to coincide with federal and state guidelines. The policy was created by the Executive Director/Administrator of the facility and the governing body. The SA validated through record review and interviews with the Administrator/Executive Director, DON, Social Worker #1, Social Worker #2, Medical Director, Unit Manager that the facility implemented the policy for PASARR, to coincide with state and federal regulations. The policy was approved in the Emergency Quality and Assurance meeting held on 9/7/23, at 1:00 PM. The SA validated through record review and interviews with four Registered Nurses, five Licensed Practical Nurses, eight Certified Nurse Aides, one laundry staff, three Housekeepers, two Social Workers, one Medical Director, one Administrator/Executive Director that an in-service on neglect and abuse was provided to all staff on 9/7/2023, at 1:30 PM, by the Director of Nursing/Infection Preventionist (DON/IP). The information covered in the in-service included the definition of abuse and neglect, the different types of abuse and neglect, and what steps to take if abuse or neglect is witnessed or suspected.	M 500		

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M 500	Continued From page 44 The SA validated through record review and interviews with the Director of Nurses (DON) and Administrator/Executive Director that an in-service education on self-reporting requirements was provided to the Administrator/Executive Director and the DON/IP to include reporting accurately to state agencies on 9/7/2023 at 2:00 PM, by the Vice President to the Administrator. The abuse and neglect policy was reviewed in the in-service which included the types of incidents that must be reported, the time frame in which to report, and the entities (Attorney General's Office, Licensure and Certification, Ombudsman) that must be reported to. The SA validated through record review and interviews with the Administrator/Executive Director, four RN's and five LPN's that an in-service education was provided with all licensed nurses by the DON on 9/7/2023 at 3:00 PM to review the policy on physician orders including, "The signature of the nurse receiving the order and the time of the order must appear." The SA validated through record review and interviews with two Social Workers and Administrator/Executive Director that an in-service education was provided to social service on 9/7/2023, at 3:30 PM, by the Administrator/Executive Director, to include an increase in social visits for all residents with suicidal ideation to be seen by social service at least 3 times weekly, until they no longer have suicidal ideation. The SA validated through interview with the Administrator/Executive Director and record review that an in-service education on the Administrator's job description was provided to	M 500		

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the Administrator/Executive Director to include that the Administrator must provide oversight to provide the necessary care for residents who express suicidal ideation and for residents who have psychosocial needs that are not met. This was completed 9/7/2023, at 4:00 PM, by the Vice President to the Administrator/Executive Director.

The SA validated through record review and interviews with two Social Workers and the Administrator/Executive Director that an in-service education was provided on PASARR to Social Services on 8/23/2023, by the Administrator/Executive Director. Another PASARR in-service/education was completed on 9/7/23, at 4:30 PM by the Vice President to the Administrator, the DON/IP, Social Services, the Medical Director, and the Director of Admission. The information covered in the in-service included when to complete a new PASARR and the appropriate agency to send the completed forms to.

The SA validated through record review and interviews with the Medical Director and Administrator/Executive Director that an in-service education on the Medical Director Policy was provided to the Medical Director on 9/7/23, at 5:00 PM, by the Administrator/Executive Director. The information covered in the in-service included the role and responsibilities of the Medical Director and leading the continuity of care with nursing services to include physician orders with accurate times and dates.

The SA validated by record review and interviews with the Administrator/Executive Director and two Social Workers that a one hundred percent audit was completed on 08/31/23, by the

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M 500	Continued From page 46 Administrator/Executive Director, of all current resident's PASARRs to ensure status change of assessment has been completed to include new diagnosis and to reflect that mood and behavior changes are included in the status change. Fifty-eight resident's status change forms were sent to the state mental health authority for a status change on 9/7/23 at 8:00 PM. The SA validated through interviews with the Administrator, DON and SW #1 and record review a resident council meeting was completed by the activities director on 08/21/2023, at 2:30 PM. The residents were encouraged to express their feelings. An additional follow up resident council meeting was held on 9/5/2023 at 2:00 PM by the activities director. No negative effects reported from the residents. The SA validated through interviews with five LPN's, one Activity Director, two Social Workers, one Director of Admissions, three RN's and five CNA's that an education/in-service was provided to social service and nursing staff to immediately get psychiatric evaluation for residents with any new behaviors to include suicidal ideation. This was completed 08/21/2023, at 5:00 PM, by the Administrator/Executive Director and the DON/IP. A memo was placed at each nurse's station to reflect the instructions of the in-service completed by 4:00 PM on 8/21/2023, by the DON/IP. The SA validated through interviews with the Administrator, DON and SW and record review that six residents with history of suicide ideation were seen per the psychiatric nurse practitioner, on 08/21/2023 and 08/22/2023. All residents denied suicidal ideations on evaluation per the psychiatric nurse practitioner.	M 500		

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M 500	Continued From page 47 The SA validated through interviews with the Administrator and the Vice President of sales for hospice and record review that a phone meeting was held with the Administrator/Executive Director and the area Vice President of Sales for hospice on 08/23/2023, at 9:00 AM, concerning communication and collaboration between hospice and facility to provide better service for the residents receiving hospice care in the nursing facility. On 8/23/2023 a new system change included a hospice communication book was placed at each nurse's station for any change in condition to hospice residents. The SA validated through interviews with the Administrator, DON and SW and a record review that a grief counseling meeting was conducted by the hospice Chaplin on 08/23/2023, from 11:00 AM until 3:00 PM for the residents and staff. The SA validated through interviews with five LPN's, one Activity Director, two Social Workers, one Director of Admissions, three RN's and five CNA's an in-service/education was provided to all the licensed nursing staff to notify hospice of all changes in condition, this will include condition changes such as, decline or improvement, medication changes, new orders of any type, and psychiatric needs and/or evaluations. All communication with hospice will be documented in the interdisciplinary notes and placed on hospice notification form (Form #1) in the hospice communication book. The in-service was completed by the DON/IP on 08/23/2023 by 5:30 PM. The SA validated through interviews with the Administrator, DON, Medical Director and SW and record review that a second emergency Quality Assurance meeting held to discuss the	M 500		

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new system implemented to communicate with hospice, the new hospice form #1, and communication book. This meeting was held on 08/23/2023 at 5:00 PM. In attendance were the Administrator/Executive Director, the DON/IP, the Unit Manager, Social Worker #1, Social Worker #2 and the Medical Director per phone.

Any employee that has not been in-serviced will not be allowed to return to work until all in-services are completed.

The SA validated through interviews with the Administrator and DON and record review that on 08/19/2023, the Emergency Medical Services were notified at 8:51 AM, along with hospice, the coroner, the Department of Health, and the resident's responsible party.

The SA validated through interviews with the Administrator and DON that The State Health Department was notified on 08/19/2023 at 9:57 AM, by the Executive Director/Administrator. The Attorney General's Office (AG) was notified on 08/23/2023 by the Executive Director/Administrator at 8:30 AM while at the facility investigating the incident.

The SA validated through interview with the Administrator that the Sheriff's Department was notified on 08/19/2023, at 1:00 PM, while at the facility investigating the incident by the Executive Director/Administrator. The Ombudsman was notified by phone on 08/23/2023, at 11:00 AM, by the Executive Director/Administrator.

The SA validated through record review and interviews with the Administrator, DON, SW #1 and Medical Director that on 8/19/2023, at 12:30 PM, an emergency Quality Assurance meeting

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was held to discuss immediate interventions completed and interventions to be put in place related to Resident #1's suicide. In attendance was the Director of Nursing/Infection Preventionist, the Executive Director/Administrator, the House Supervisor, Social Worker #1, Social Worker #2 and the Medical Director by phone.

The SA validated through record review and interviews with the Administrator, DON and SW that a trauma screening was performed on each resident in the facility. No issues were found. This was completed on 8/19/2023 between 10:00 AM and 12:00 PM, by social services.

The SA validated through record review and interviews with five LPN's, one Activity Director, two Social Workers, one Director of Admissions, three RN's and five CNA's that all staff was in-serviced on abuse, neglect, and suicide precautions starting at 10:00 AM on 8/19/2023, by the DON/IP.

The SA validated through record review and interviews with the Administrator and DON that all care plans of residents with a history of suicidal ideation were updated to include the following interventions, residents that express feelings of harming themselves will be immediately placed on one on one and seen by the psychiatric nurse practitioner or a physician. If the psychiatric nurse practitioner or the physician are not available, then the resident will be sent to the emergency room for evaluation. These interventions were added to the plans of care of six residents on 8/19/2023 between 1:00 PM and 2:00 PM, by social services.

The SA validated with record review and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06CH	A. BUILDING: _____ B. WING _____	C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND NURSING AND REHABILITATION CENTE	4036 HIGHWAY 8 EAST CLEVELAND, MS 38732

(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
M 500	Continued From page 50	M 500		

interviews with the Administrator and DON that 100% audit of all beds to ensure bed remote secured to bed by social service, this was completed 08/19/2023, by 3:00 PM. There were two beds that required maintenance to secure the cord to the bed. The cords were secured immediately.

The SA validated through record review and interviews with the Administrator, DON and SW that for residents' protection, all residents with a history of suicidal ideation were assessed for thoughts of self-harm between the hours of 1:00 PM and 3:00 PM on 08/19/2023, by social services. No resident reported thoughts of self-harm.

The SA validated by record review and interviews with the Administrator, DON and SW that an in-service was provided to social services to ensure that all residents with suicidal ideation will be seen by social service at least weekly, until they no longer have suicidal ideation. This in-service was completed by the DON/IP on 08/19/2023, at 5:00 PM.

The SA validated through record review and interviews with five LPN's, one Activity Director, two Social Workers, one Director of Admissions, three RN's and five CNA's that an in-service was completed with all staff by the DON/IP at 6:00 PM on 08/19/2023. Training included that all residents that express feelings of harming themselves will be immediately placed on one on one and seen by the psychiatric nurse practitioner or a physician. If the psychiatric nurse practitioner or the physician are not available, then the resident will be sent to the emergency room for evaluation.