

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/05/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/11/2023
NAME OF PROVIDER OR SUPPLIER CLEVELAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE	
F 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 requirements for participation in Medicare and Medicaid. An extended survey was completed, and the following deficiencies were cited for CI MS #22550: F600, F609, F644, F740, F835, F841 and F849 at an Immediate Jeopardy (IJ) level for Neglect, Reporting, Preadmission Screening and Resident Review (PASARR), Behavioral Services, Administration, Medical Director and Hospice. The investigation for CI MS #22325 for Misappropriation of Money, Infection Control and Quality of Care/Treatment determined no deficiencies related to this complaint. 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 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, or 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 ideation to the facility on 8/8/23 and the facility discontinued a Medical	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/29/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Doctor (MD) order for a psychiatric evaluation on 8/9/23 and failed to provide any psychiatric services for the resident. Resident #1 committed suicide by hanging on 8/19/23. On 8/24/23 at 5:15 PM, the SA notified the facility Administrator and the Director of Nurses of the IJ and SQC and provided the facility with the IJ templates. IJ existed at: 42 CFR 483.40 Behavioral health services F740 S/S - J 42 CFR 483.70(o)(2)(ii)(D) Hospice Services F849 S/S - J 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) 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 the same day, 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 additional IJ templates. The IJ and SQC existed at: 42 CFR 483.12(a)(1) Freedom from Abuse, Neglect and Exploitation F600 - Scope/Severity (S/S) - J 42 CFR 483.12(c)(1) Reporting of Alleged Violations - F609 S/S- J	F 000			

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F 000	Continued From page 2 The IJ existed at: 42 CFR 483.20(e)(2) Coordination of PASARR and Assessments - F644 S/S - J 42 CFR 483.70 Administration F835-S/S - J 42 CFR 483.70(h)(2)(ii) Responsibilities of Medical Director - F841 - S/S - J 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 S/S for 42 CFR 483.12(a)(1) Freedom from Abuse, Neglect and Exploitation F600, 42 CFR 483.12(c)(1) Reporting of Alleged Violations F609, 42 CFR 483.20(e)(2) Coordination of PASARR and Assessments F644, 42 CFR 483.40 Behavioral health services F740, 42 CFR 483.70 Administration F835, 42 CFR 483.70(h)(2)(ii) Responsibilities of Medical Director F841, and 42 CFR 483.70(o)(2)(ii)(D) Hospice Services F849 was lowered from a "J" to a "D" 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.	F 000			
F 600 SS=J	Free from Abuse and Neglect	F 600		10/6/23	

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F 600	Continued From page 3 CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: 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 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 elected to be admitted to hospice services. Another MD order was written on 8/9/23 to discontinue (D/C) the	F 600	1. Resident #1 committed suicide on 8/19/2023. Facility neglected to identify a crisis of suicidal ideations of Resident #1 and neglected to provide the psychiatric services that were necessary to prevent the death of Resident #1. 2. All residents have the potential to be affected. 3. An in-service education was provided to social services 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		

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F 600	Continued From page 4 psych evaluation and resident was admitted to contract hospice services. An order was written on 8/8/23 with no time noted to place Resident #1 on one-on-one monitoring due to suicidal ideation. He remained on one-on-one observation through to 8/17/23 when the facility reduced the resident's supervision from one-on-one to every hour observation due to improved mood. 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 psychiatric services including a psych evaluation for Resident #1 placed this resident in a situation that likely led to death and placed other resident in a situation that could likely lead to serious injury, 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 8/9/23 was discontinued on 8/9/23. The IJ and SQC existed at:	F 600	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, 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		

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F 600	Continued From page 5 42 CFR 483.12 (a)(1) Freedom from Abuse, Neglect, Exploitation- F600 - Scope/Severity "J" and "SQC". 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 42 CFR 483.12 (a)(1) Freedom from Abuse, Neglect, Exploitation (F600) was lowered to a Scope and Severity of "D" 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 ..."	F 600	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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F 600	Continued From page 6 Policy/procedure review of the facility's policy/procedure for "Suicide Precautions", last revised "2/19" revealed " ...Procedure 8. Undertake emergency transfer of resident to appropriate treatment setting." Record review of Resident #1's Face Sheet 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 revealed no order for an emergency transfer of Resident #1 to an acute care facility. 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 documented that the 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.	F 600			

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F 600	Continued From page 7 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. 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." He also revealed that he didn't know the psychiatric evaluation had been discontinued until 8/22/23, which was three days after the suicide. 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 was one on one 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	F 600			

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F 600	Continued From page 8 hospice or palliative care only, any consults will be discontinued." The Administrator stated that the decision to send a resident for emergency care would depend on the resident and their specific situation. Interview with Licensed Practical Nurse (LPN)/admitting nurse/Unit Manager on 9/7/23 at 10:35 AM revealed, "It didn't cross my mind to send him out" for an emergency evaluation related to the suicidal ideation he had voiced. 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 his 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. Resident #1 was observed by Licensed Practical Nurse #1 at 7:15 AM lying in his bed with his eyes closed. LPN#1	F 600			

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F 600	Continued From page 9 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. 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 was 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 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, CNA #1 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	F 600			

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F 600	Continued From page 10 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. 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	F 600			

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F 600	Continued From page 11 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". 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. The facility provided the following Removal Plan:	F 600			

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F 600	Continued From page 12 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 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 within the specific time frame, as required by federal guidance. The Administrator/Executive	F 600			

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F 600	Continued From page 13 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 (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 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 *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	F 600			

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F 600	Continued From page 14 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 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.			F 600			

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F 600	Continued From page 15 *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. *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 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. *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	F 600			

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F 600	Continued From page 16 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 changes in condition, this will include condition changes such as, decline or improvement, medication changes, new orders of any type, and	F 600			

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F 600	Continued From page 17 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 Director/Administrator. The Ombudsman was notified by phone on 08/23/2023, at 11:00 AM, by	F 600			

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F 600	Continued From page 18 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 #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	F 600			

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F 600	Continued From page 19 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	F 600			

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F 600	Continued From page 20 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 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	F 600			

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F 600	Continued From page 21 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. 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	F 600			

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F 600	Continued From page 22 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 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	F 600			

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F 600	Continued From page 23 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 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. The SA validated 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	F 600			

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F 600	Continued From page 24 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. 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	F 600			

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F 600	Continued From page 25 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 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.	F 600			

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F 600	Continued From page 26 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 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	F 600			

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F 600	Continued From page 27 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 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.	F 600			

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F 600	Continued From page 28			F 600			
F 609 SS=J	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. Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all			F 609			10/6/23

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F 609	Continued From page 29 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, policy/procedure review and interviews, the facility failed to report an injury of unknown origin resulting in a serious bodily injury to law enforcement agencies after the death of one (1) of seven (7) residents sampled, Resident #1 as evidenced by Resident #1's suicide on 8/19/23. Resident #1 told the admitting nurse during the admission process on 8/8/23 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 on 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	F 609	1. Resident #1 committed suicide on 8/19/2023. The facility failed to report an injury of unknown origin resulting in a serious bodily injury to law enforcement agencies after the death of Resident #1. 2. All residents have the potential to be affected. 3. An in-service education on self-reporting requirements was provided to the Executive Director (ED) and the Director of Nursing (DON) to include accurately reporting to state agencies on 9/07/2023, by the Vice President. A staff in-service was initiated on 9/22/2023 for licensed nurses and department heads by the staff development nurse and the DON on ensuring that allegations of abuse and/or neglect are reported immediately to ensure that reporting to the state agencies occur within the two-hour time frame. 4. The DON will conduct incident and accident audits five times a week for six weeks to ensure any incidents requiring state agency notifications are reported timely beginning 8/21/2023. The DON will forward the results of the audits to the ED, weekly times eight weeks starting		

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F 609	Continued From page 30 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 made an initial notification to the State Department of Health Licensure and Certification hotline regarding Resident #1 on "8/19/23" at "9:58 am" that reported an "attempted suicide". Resident #1 was pronounced dead at the facility on 8/19/23 at 9:00 am. Resident #1's Resident Representative (RR) notified the local sheriff department and Attorney General's office of the suicide of Resident #1. The facility did not report to these agencies. The facility's failure to report after the suicide of Resident #1 delayed the investigation of his unusual death in the facility and placed 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 review by the SA, 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) which began on 8/9/23, when the facility failed to notify the local law enforcement and the State Attorney General Office of the suicide of Resident #1. The IJ and SQC existed at: 42 CFR 483.12(c)(1) Reporting of Alleged Violations - F609 Scope/Severity "J" The SA notified the facility's Administrator of the	F 609	8/28/2023 to ensure accuracy and completeness and the audits will be maintained in the ED office. The ED will forward the results to the Quality Assurance (QA) committee monthly starting 9/2023 times three months for review and further recommendations.		

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F 609	Continued From page 31 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 42 CFR 483.12(c)(1) Reporting of Alleged Violations - F609 was lowered to a "D" 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 policy/procedure for "Abuse Prevention" last dated "10/22" revealed "REPORTING: Alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including State Survey Agency, Adult Protective Services (APS) , and local law enforcement as required)." Record review of the initial notification to the State Department of Health Licensure and	F 609			

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F 609	Continued From page 32 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". An interview with the Administrator on 8/22/23 at 3:10 PM regarding reporting incidents to the State Agency (SA) revealed, "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 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 local Ombudsman on 8/22/23 at 2:30 PM, revealed she had not been contacted by the facility regarding a possible suicide. Interview with the Administrator on 8/23/23 at 10:45 AM, confirms that she did not contact the Ombudsman regarding the suicide of Resident #1. She revealed that the Attorney General (AG) Investigator had been at the facility earlier on 8/23/23 and interviewed two (2) staff members about Resident #1's suicide. She stated she had not contacted the Attorney General (AG) office about Resident #1's suicide and assumed the SA had. She revealed she did not know she should have contacted the AG office. Interview with Resident #1's Resident Representative (RR), 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.	F 609			

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F 609	Continued From page 33 Interview with the Director of Nurses (DON) on 8/23/23 at 2:00 PM, revealed that "No, we didn't call the police after he died. The sheriff officer showed up here around lunch. His body wasn't here anymore." Interview with the AG 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 the resident's sister 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. Record review by the State Agency (SA) of Resident #1's Face Sheet revealed he was admitted on 8/8/23 to the facility with diagnoses which included Malignant Neoplasm of Larynx, unspecified and Depression, unspecified. 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	F 609			

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F 609	Continued From page 34 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. 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.	F 609			

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F 609	Continued From page 35 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 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 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	F 609			

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F 609	Continued From page 36 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 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 *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	F 609			

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F 609	Continued From page 37 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 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 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. *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	F 609			

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F 609	Continued From page 38 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 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. *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. *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	F 609			

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F 609	Continued From page 39 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 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	F 609			

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F 609	Continued From page 40 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 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 #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.	F 609			

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F 609	Continued From page 41 *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. *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.	F 609			

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F 609	Continued From page 42 *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 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 (PASARR) policy was created for the facility to			F 609			

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F 609	Continued From page 43 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. 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	F 609			

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F 609	Continued From page 44 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 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	F 609			

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F 609	Continued From page 45 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 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.	F 609			

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F 609	Continued From page 46 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, 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	F 609			

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F 609	Continued From page 47 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 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.	F 609			

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F 609	Continued From page 48 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 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,	F 609			

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F 609	Continued From page 49 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 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	F 609			

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F 609	Continued From page 50 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.	F 609			
F 644 SS=J	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the	F 644		10/6/23	

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F 644	Continued From page 51 pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to coordinate a resident review with the Preadmission Screening and Resident Review (PASARR) program under Medicaid by not referring a resident that expressed suicidal ideations on admission for a significant change in status assessment for review by the State Designated Authority for one (1) of seven (7) residents sampled. Resident #1. During the admission process on 8/8/23, 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	F 644	1. Resident #1 committed suicide on 8/19/2023. The facility failed to coordinate a resident's review with the Preadmission Screening and Resident Review (PASRR) program under Medicaid by not referring a resident that expressed suicidal ideations on admission for a significant change in status assessment for review by the State Designated Authority for Resident #1. 2. All residents have the potential to be affected. 3. A new Preadmission Screening and Resident Review PASRR policy was created for the facility to coincide with federal and state guidelines. The policy was approved in the Emergency Quality and Assurance (QA) meeting held on 9/07/2023. A 100% audit was completed		

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F 644	Continued From page 52 contract hospice services. He remained on 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 at the facility and found Resident #1 with no heart activity, and he was pronounced dead at 9:00 AM. The facility's failure to submit a significant change in status assessment for review by the State Designated Authority to ensure Resident #1 received the care and services in the most appropriate setting for his needs after he expressed suicidal ideations on admission and during the next shift placed this resident and 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 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) 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 and the facility failed to refer the resident to the State Designated Authority for evaluation.	F 644	on 8/31/2023 by the Executive Director (ED) of all current resident's PASRR to ensure status change of assessment has been completed to include new diagnosis and to reflect that mood and behavior changes are included in status change. All status changes will be sent to the State Designated Authority. An in-service education was provided on PASRR to social services on 8/23/2023 by the ED. Another PASRR in-service education was completed on 9/07/2023 by the Vice President to the ED, the Director of Nursing (DON), Social Services, the Medical Director, and the Director of Admissions. 4. Social services will audit interdisciplinary team notes five times a week for eight weeks starting 8/21/2023 for behavioral changes to ensure PASRR is up-to-date and significant change completed as warranted. Results of the audit will be forwarded 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 results of the audit to the QA committee monthly times three months, starting 9/2023 for review and further recommendations.		

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F 644	Continued From page 53 The IJ existed at: 42 CFR 483.20(e)(2) Coordination of PASARR and Assessments - F644 Scope/Severity "J" 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. The facility submitted an acceptable Removal Plan on 9/8/23, in which they alleged all corrective actions to remove the IJ was 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 42 CFR 483.20(e)(2) Coordination of PASARR and Assessments (F644) was lowered to a Scope and Severity of "D" 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: The Administrator provided a statement on a facility letter head revealing the facility had no policy or procedure addressing the process of completing a PASARR significant change in status assessment. An interview with the Administrator on 8/23/23 at 4:10 PM revealed the facility did not do a change of status PASARR for Resident #1 after he had expressed suicidal ideations. She stated, "We don't have a specific policy or procedure for doing the PASARR".	F 644			

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F 644	Continued From page 54 Record review of the Screening Questionnaire dated 8/7/23 revealed19. In the last 3 days, has (formal first name of Resident #1) had any of the following problems...e. Displayed self-injurious behavior? The response is "Present but not exhibited in last 3 days" ... 31. Does (formal first name of Resident #1) have any history of mental illness? Mental illness includes any concerns about emotional wellness that interfere with quality of life or daily functioning. This includes depression, anxiety, psychosis, loss of interest in daily activities, etc. The response is checked "Yes." Record review of the State Designated Authority's response to the facility Level 1, admission Pre-Admission Screening (PAS), dated 8/8/23 at 12:48 PM revealed, Resident #1 was appropriate for nursing facility placement. Record review of Resident #1's Face Sheet revealed he was admitted on 8/8/23 to the facility with diagnoses which included Malignant Neoplasm of Larynx, Restlessness and Agitation, unspecified and Depression, unspecified. Record review of Resident #1's PASARR information revealed that there was not a change of status form completed and sent to the State Designated Authority for a reassessment after Resident #1 made suicidal ideation statements on 8/8/23 during his admission to the facility. An interview with the Administrator on 8/28/23 at 10:50 AM revealed the Social Worker was responsible for completing the change of status assessment form for the PASARR. An interview with the Social Worker on 8/28/23 at 10:58 AM confirmed she did not submit a change	F 644			

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F 644	Continued From page 55 in status PASARR for Resident #1. The Social Worker stated, "Because he (Resident #1) was on hospice, my understanding was I didn't have to submit a change in status form to send to the proper State Designated Authority (proper name)." An interview with a staff member at the State Designated Authority on 8/28/23 at 11:10 AM revealed that if a resident is voicing suicidal ideations a change of status assessment should be done, even if the resident was admitted to Hospice. She stated that the two (2) incidents are separate. The regulations are giving guidance that states a change of status assessment does not have to be completed anytime a resident is admitted to Hospice if that is the only change in care. 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	F 644			

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F 644	Continued From page 56 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. 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	F 644			

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F 644	Continued From page 57 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 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 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	F 644			

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F 644	Continued From page 58 #1, and social worker #2 were in attendance. *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 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 *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	F 644			

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F 644	Continued From page 59 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 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 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. *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	F 644			

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F 644	Continued From page 60 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 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. *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. *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.	F 644			

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F 644	Continued From page 61 *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 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.	F 644			

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F 644	Continued From page 62 *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 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 #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.	F 644			

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F 644	Continued From page 63 *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. *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.	F 644			

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F 644	Continued From page 64 *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 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 (PASARR) policy was created for the facility to coincide with federal and state guidelines. The	F 644			

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F 644	Continued From page 65 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. 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	F 644			

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F 644	Continued From page 66 (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 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	F 644			

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F 644	Continued From page 67 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 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	F 644			

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F 644	Continued From page 68 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, 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	F 644			

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F 644	Continued From page 69 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 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.	F 644			

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F 644	Continued From page 70 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 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	F 644			

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F 644	Continued From page 71 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 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	F 644			

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F 644	Continued From page 72 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.	F 644			
F 740 SS=J	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and	F 740		10/6/23	

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F 740	Continued From page 73 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on policy and procedure review, record review, and staff interviews, the facility failed to provide behavioral health services to address a resident's needs as evidenced by failure to act upon Resident #1's verbalized suicidal ideations which resulted in Resident #1's suicide in the facility for one (1) of seven (7) residents sampled. During the admission process on 8/8/23, Resident #1 expressed suicidal thoughts when he told the admitting nurse that he wanted to call a friend to pick him up and take him to "jump off a bridge". On 8/9/23, the facility obtained an physician order for a psychiatric evaluation. On the same day 8/9/23, the facility obtained a physician order for hospice services and obtained a second physician order to discontinue the psychiatric evaluation. The facility did not notify hospice services of the order for a psychiatric evaluation or the order to D/C (discontinue) the psychiatric evaluation. Record review revealed a physician order dated 8/8/23, with no time noted, to place Resident #1 on one-on-one monitoring due to suicidal ideation. Resident #1 remained on one-on-one observation through to 8/17/23 when the facility obtained an order for every hour observations due to improved mood. On 8/19/23, Resident #1 was observed by	F 740	1. Resident #1 committed suicide on 8/19/2023. Facility failed to provide behavioral health services to address a resident's needs upon verbalization of suicidal ideations. 2. All residents have the potential to be affected. 3. An education/in-service was provided to social services 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) and Director of Nursing (DON). All residents with a history of suicidal ideation were seen per the psychiatric nurse practitioner on 8/21/2023 and 8/22/2023. All care plans of residents with a history of suicidal ideation were updated to include residents who 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		

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F 740	Continued From page 74 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 she opened the door, LPN #1 observed Resident #1 was hanging from an exposed ceiling 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 using bandage scissors and performed sternal rubs with no response. Emergency Medical Services (EMS) were called as were hospice services. EMS arrived at 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 and other residents in a situation that lead to Resident #1's death and was likely to cause serious injury, harm, impairment, or death of other residents. The situation was determined to be an Immediate Jeopardy (IJ) which began on 8/9/23 when the facility failed to notify hospice of the physician's order for the psychiatric evaluation and discontinuation of the order. The State Agency (SA) investigated the death of Resident #1 on 8/22/23 through 8/28/23. After review by the SA, the SA extended the survey from 9/7/23 through 9/11/23. The State Agency identified Immediate Jeopardy at: CFR 483.40 Behavioral health services (F740)-Scope and Severity of "J".	F 740	evaluation. These interventions were added to the plans of care on 8/19/2023 by social services. All residents with a history of suicidal ideation were assessed for thoughts of self harm on 8/19/2023 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 services at least weekly, until they no longer have suicidal ideation. This in-service was completed by the DON on 8/19/2023. 4. The Director of Nursing (DON) will conduct audits of interdisciplinary team notes five times a week for eight weeks, starting 8/21/2023, to ensure that residents with potential suicide crisis are identified and receives the necessary psychiatric services. 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 will be maintained in the ED office. The ED will forward results of the audit to the Quality Assurance (QA) committee monthly starting 9/2023 times three months for review and further recommendations.		

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F 740	Continued From page 75 The SA (State Agency) notified the facility's Administrator of the IJ on 8/24/23 at 5:15 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 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 for CFR 483.40 Behavioral health services (F740) was lowered from a "J" to a "D" 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: On 8/23/23 a review of the facility's policy/procedure for "Behavior Management and Psycho-pharmacological Medications Monitoring Protocol", last revised "3/18" revealed, "Purpose: Residents with behaviors that are displayed routinely, that effect the resident's psychosocial well-being or that of other residents, or behaviors that can have potential for harm to self or others will be assessed with the development of a behavior program." Policy/procedure review of the facility's policy/procedure for "Suicide Precautions", last revised "2/19" revealed " ...Procedure 8. Undertake emergency transfer of resident to appropriate treatment setting."	F 740			

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F 740	Continued From page 76 Record review of Resident #1's Face Sheet revealed that he was admitted on 8/8/23 to the facility with diagnoses including Malignant Neoplasm of Larynx, unspecified, and Depression, unspecified. Record review of Resident #1's "Physician Orders" for "August 2023" revealed an order for "psych. (psychiatric) consult for evaluation/treatment" with no time provided. A "Physician Telephone Order" dated "8/9/23" read to "d/c (discontinue) psych consult d/t (due to) admit to hospice" with no time provided. Record review also 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 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	F 740			

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F 740	Continued From page 77 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. An interview with the Administrator on 8/24/23 at 4:10 PM, regarding the discontinued psych. evaluation order written on 8/9/23 revealed "He went on hospice. That is why the order was discontinued. Hospice won't pay for a psychiatric (psych.) evaluation. He 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 discontinuing the psych.evaluation because hospice would provide for his needs. He said he understood. No, I didn't contact his Responsible Party (RP)." Record review of the MD's (Medical Doctor) order to discontinue the psych evaluation written on 8/9/23 revealed the administrator is also a Registered Nurse and wrote the order to	F 740			

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F 740	Continued From page 78 discontinue the psych. evaluation. An interview with Resident #1's Medical Doctor (MD) on 8/24/23 at 8:30 AM, revealed that "the psych evaluation was discontinued because hospice won't pay for psych." 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 was 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 an EKG and there was no heart activity. Hospice arrived and called the coroner and family. 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. 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	F 740			

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F 740	Continued From page 79 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. 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	F 740			

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F 740	Continued From page 80 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 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 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	F 740			

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F 740	Continued From page 81 #1, and social worker #2 were in attendance. *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 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 *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	F 740			

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F 740	Continued From page 82 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 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 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. *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	F 740			

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F 740	Continued From page 83 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 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. *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. *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.	F 740			

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F 740	Continued From page 84 *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 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.	F 740			

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F 740	Continued From page 85 *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 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 #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.	F 740			

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F 740	Continued From page 86 *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. *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.	F 740			

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F 740	Continued From page 87 *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 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 (PASARR) policy was created for the facility to coincide with federal and state guidelines. The	F 740			

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F 740	Continued From page 88 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. 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	F 740			

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F 740	Continued From page 89 (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 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	F 740			

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F 740	Continued From page 90 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 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	F 740			

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F 740	Continued From page 91 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, 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	F 740			

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F 740	Continued From page 92 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 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.	F 740			

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F 740	Continued From page 93 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 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	F 740			

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F 740	Continued From page 94 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 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	F 740			

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F 740	Continued From page 95 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.	F 740			
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and	F 835		10/6/23	

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F 835	Continued From page 96 efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on 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) residents, 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 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	F 835	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 resident 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, 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 the audits will be maintained in the ED office. The ED will forward the results of the audit to the Quality Assurance (QA) monthly starting 9/2023, times three months for review and further recommendations.		

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F 835	Continued From page 97 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 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: 42 CFR 483.70 Administration F835-Scope and Severity at a "J" 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. 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 and SQC was removed on 9/8/23, prior to exit. Therefore, the scope and severity of at 42 CFR 483.70 Administration F835 was lowered to a Scope and Severity of "D" while the facility develops a plan of correction to monitor the effectiveness of systemic changes to	F 835			

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F 835	Continued From page 98 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." Policy/procedure review of the facility's policy/procedure for "Suicide Precautions", last revised "2/19" revealed " ...Procedure 8. Undertake emergency transfer of resident to appropriate treatment setting." Record review of Resident #1's Face Sheet revealed he was admitted on 8/8/23 to the facility with diagnoses which included Malignant Neoplasm of Larynx, unspecified and Depression, unspecified. Record review of the initial notification to the State Department of Health Licensure and	F 835			

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F 835	Continued From page 99 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 ambulance and hospice right after he was found. I did not update the SA office when he died. The sheriff came after the resident was removed from the facility. We notified EMS, Coroner, hospice, and the sheriff. His body is going to the state crime lab. The coroner took the cord with the body. " She revealed she was told to report the incident as a "suicide attempt" by the facility's Regional Nurse Consultant. 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. Interview with the Director of Nurses (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." 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	F 835			

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F 835	Continued From page 100 discontinued. Hospice won't pay for a psych eval. He (Resident #1) knew he had a psychiatric 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 (discontinuing) 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. 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	F 835			

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F 835	Continued From page 101 diagnosis of malignant neoplasm of larynx." Record review of the MD's (Medical Doctor) order to discontinue the psych evaluation written on 8/9/23 revealed the administrator, who is also a Registered Nurse, wrote the order to discontinue the psych evaluation. 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. 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	F 835			

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F 835	Continued From page 102 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". 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:	F 835			

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F 835	Continued From page 103 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. 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	F 835			

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F 835	Continued From page 104 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 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 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.	F 835			

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F 835	Continued From page 105 *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 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 *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	F 835			

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F 835	Continued From page 106 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 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 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. *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	F 835			

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F 835	Continued From page 107 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 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. *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. *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.	F 835			

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F 835	Continued From page 108 *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 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.	F 835			

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F 835	Continued From page 109 *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 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 #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	F 835			

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F 835	Continued From page 110 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. *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	F 835			

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F 835	Continued From page 111 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 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 (PASARR) policy was created for the facility to coincide with federal and state guidelines. The policy was created by the Executive	F 835			

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F 835	Continued From page 112 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. 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	F 835			

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F 835	Continued From page 113 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 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	F 835			

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F 835	Continued From page 114 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 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	F 835			

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F 835	Continued From page 115 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, 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	F 835			

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F 835	Continued From page 116 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 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	F 835			

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F 835	Continued From page 117 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 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.	F 835			

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F 835	Continued From page 118 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 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.	F 835			

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F 835	Continued From page 119 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.	F 835			
F 841 SS=J	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director.	F 841		10/6/23	

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F 841	Continued From page 120 §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, policy/procedure review and interviews, the Medical Director failed to coordinate, implement and evaluate the facility's care of one (1) of seven (7) residents, Resident #1, as evidence by Resident #1 committed suicide by hanging himself with the remote control cord of his bed on an exposed pipe in the ceiling of his room 10 days after the Medical Director discontinued the Physician Order for a Psychiatric (psych) Evaluation (eval) for suicidal ideations. During the admission process on 8/9/23, 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". On 8/9/23, a Medical Doctor's (MD) order was written for a psychiatric evaluation. On 8/9/23, Resident #1 wanted to be admitted to hospice services. Another 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. An interview with Certified Nursing Assistant (CNA) #1 revealed that she saw Resident #1 on 8/19/23 "around 7:36 AM". 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.	F 841	1. Resident #1 committed suicide on 8/19/2023. The Medical Director failed to coordinate, implement, and evaluate the facility's care of Resident #1. 2. All residents have the potential to be affected. 3. An in-service education on the Medical Director policy was provided to the Medical Director on 9/07/2023 by the Executive Director (ED). 4. DON will monitor interdisciplinary notes and physician orders five times a week for eight weeks to ensure a psychiatric evaluation is ordered and completed, and physician orders are timed and dated with signatures. This audit was started on 8/21/2023. Results of the audit will be forwarded to the ED, weekly times eight weeks starting 8/28/2023 to audit for accuracy and completeness and 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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F 841	Continued From page 121 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 Medical Director failed to oversee the medical care and other designated care and services available for Resident #1 after he expressed suicidal ideations on 8/8/23 and committed suicide on 8/19/23 by hanging himself with the remote control of his bed on an exposed pipe in the ceiling of his room. This placed other residents at risk of 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) 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 IJ existed at: 42 CFR 483.70(h)(2)(ii) Responsibilities of Medical Director - F841 - Scope/Severity "J" 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. The facility submitted an acceptable Removal Plan on 9/8/23, in which they alleged all corrective	F 841			

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F 841	Continued From page 122 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 42 CFR 483.70(h)(2)(ii) Responsibilities of Medical Director (F841) was lowered to a Scope and Severity of "D" 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 policy/procedure for "MEDICAL DIRECTOR" last revised "1/16" revealed the "PURPOSE: To ensure the presence of a Medical Director to coordinate medical care and to be responsible for implementation of resident care policies, in compliance with applicable regulations." Record review of Resident #1's face sheet revealed he was admitted on 8/8/23 to the facility with diagnoses which included Malignant Neoplasm of Larynx, unspecified and Depression, unspecified. Record review of a handwritten physician order "Physician Telephone Order" dated "8/9/23" read "psychiatric consult for evaluation/treatment" with no time that order was given and review of "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. Both of these orders were signed by the Resident's physician who is also the Medical Director but did not have a date of the signature.	F 841			

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F 841	Continued From page 123 Record review of the printed "Physician's Telephone Order" dated "8/9/23" with a time of "4:00 PM" revealed to "Admit to hospice (proper name) related to diagnosis of malignant neoplasm of larynx." There were no printed orders for either the psychiatric evaluation on 8/9/23 or the discontinuation of the psychiatric evaluation on 8/9/23. Record review of the MD's (Medical Doctor) order to discontinue the psych evaluation written on 8/9/23 revealed the administrator, who is also a Registered Nurse, wrote the order to discontinue the psych evaluation. Interview with the Administrator, 8/24/23 at 4:10 PM regarding the discontinued psychiatric (psych) evaluation order on 8/9/23 revealed "He (Resident #1) 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 (discontinuing) the psych evaluation because hospice would provide for his needs. He said he understood." Interview with Resident #1's physician, who is also the Facility Medical Director on 8/24/23 at 8:30 AM revealed that the psychiatric evaluation was discontinued "because hospice won't pay for psych.". The Medical Director went on to say that "I didn't know the psych eval had been dc'd (discontinued) until this past Tuesday." The Tuesday referenced by the Medical Director was 8/22/23 which was three (3) days following the death of the resident.	F 841			

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F 841	Continued From page 124 A follow-up interview with the Facility Medical Director on 8/24/23 at 1:05 PM confirmed he was unaware of the psychiatric evaluation being discontinued until 8/22/23. The Medical Director stated, "I sign hundreds of things when I visit on Tuesdays, and it must have slipped through without me noticing." 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. 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	F 841			

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F 841	Continued From page 125 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. 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 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	F 841			

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F 841	Continued From page 126 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 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 (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 facility implemented the policy for PASARR,	F 841			

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F 841	Continued From page 127 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. *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	F 841			

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F 841	Continued From page 128 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 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 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. *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 PASARRs to ensure status change of assessment has been completed to include new diagnosis and to reflect	F 841			

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F 841	Continued From page 129 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 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. *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	F 841			

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F 841	Continued From page 130 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 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.			F 841			

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F 841	Continued From page 131 *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. *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	F 841			

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F 841	Continued From page 132 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. *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.	F 841			

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F 841	Continued From page 133 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 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 (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	F 841			

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F 841	Continued From page 134 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. 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	F 841			

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F 841	Continued From page 135 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 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	F 841			

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F 841	Continued From page 136 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 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 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	F 841			

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F 841	Continued From page 137 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. 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.	F 841			

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F 841	Continued From page 138 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 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.	F 841			

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F 841	Continued From page 139 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 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	F 841			

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F 841	Continued From page 140 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 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.	F 841			

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F 841	Continued From page 141 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.	F 841			
F 849 SS=J	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an	F 849		10/6/23	

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F 849	Continued From page 142 LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services	F 849			

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F 849	Continued From page 143 provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.	F 849			

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F 849	Continued From page 144 §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient.	F 849			

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F 849	Continued From page 145 (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, policy/procedure review and interviews, the facility failed to ensure an effective communication process, including how the communication would be documented between the Long-Term Care (LTC) facility and the hospice provider, to ensure that the needs of the resident were addressed and met 24 hours a day for one (1) of seven (7) residents sampled. Resident #1. During the admission process on 8/8/23, 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". On 8/9/23, a Medical	F 849	1. Resident #1 committed suicide on 8/19/2023. The facility failed to ensure an effective communication process, including how the communication would be documented between the facility and the hospice provider, to ensure that the needs of the residents are addressed and met 24 hours a day. 2. All residents have the potential to be affected. 3. A phone meeting was held with the Executive Director (ED) and the area Vice		

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F 849	Continued From page 146 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 on 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 at 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 communication with the hospice provider for Resident #1 lead to Resident #1's death and placed other residents in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) which began on 8/9/23 when the facility failed to assure and notify hospice of the physician's order for the psychiatric evaluation and discontinuation of the order. The State Agency (SA) investigated the death of Resident #1 on 8/22/23 through 8/28/23. After review by the SA, the SA extended the survey	F 849	President of Sales for hospice on 8/23/2023 concerning communication and collaboration between hospice and facility to provide better service for the residents receiving hospice care in the nursing facility. The new system change included a hospice communication book to be placed at each nurses station for any change in condition to hospice residents. An in-service education was provided to all the licensed nursing staff to notify hospice of all changes in condition, which includes 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 the hospice notification form (Form #1) in the hospice communication book. This in-service was completed by the DON on 8/23/2023. 4. The Director of Nursing (DON) will audit hospice communication book five times a week for eight weeks to ensure hospice and facility staff is communicating all changes in condition, which include decline or improvement, medication changes, new orders of any type, and psychiatric needs and/or evaluations. This audit was started on 8/21/2023. Results of the audit will be forwarded to the 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		

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F 849	Continued From page 147 from 9/7/23 through 9/11/23 and the situation was determined to be an Immediate Jeopardy (IJ) 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 State Agency identified Immediate Jeopardy at: CFR 483.70(o)(2)(ii)(D)(E)(1)(2) Hospice Services (849)-Scope and Severity of "J". The State Agency (SA) notified the facility's Administrator of the IJ on 8/24/23 at 5:15 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 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 for CFR 483.70(o)(2)(ii)(D)(E)(1)(2) Hospice Services (849) was lowered to a "D" 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: Interview on 8/24/23 at 4:00 PM, revealed the administrator stated that the facility does not have a specific policy/procedure for hospice services but does have one for palliative care for residents. Policy/Procedure review of the facility's "Palliative	F 849	three months starting 9/2023 for review and further recommendations.		

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F 849	Continued From page 148 Care" policy/procedure last reviewed on "1/15" revealed the "Definition: Palliative care is defined as measures and treatments provided to offer comfort to the resident, neither hastening nor prolonging the natural process of dying." Record review by the State Agency (SA) of Resident #1's Face Sheet revealed he was admitted on 8/8/23 to the facility with diagnoses which included Malignant Neoplasm of Larynx, unspecified and Depression, unspecified. Record review of Resident #1's "Physician Orders" for "August 2023" revealed Do Not Resuscitate (DNR). Record review also revealed a handwritten "Physician Telephone Order" dated "8/9/23" that read, "psychiatric (psych) consult for evaluation/treatment" with no time that order was given. Record review further revealed a "Physician Telephone Order" dated "8/9/23" that 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 to "Admit to hospice (proper name) related to diagnosis of malignant neoplasm of larynx." 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." The SA interview on 8/24/23 at 12:45 PM, with the Executive Director of the hospice company, revealed that if a resident of a nursing home and a patient of their hospice needed a psychiatric (psych) evaluation that they can have a psych evaluation. She said they were not aware of the	F 849			

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F 849	Continued From page 149 psych evaluation being ordered or discontinued. She said anyone they admit, their social worker goes for the first visit within 24 hours of admit. "If it was necessary for him to have a psych evaluation, we would cover the cost. No one ever expressed anything at all regarding a psych evaluation." She looked at the nursing home orders for Resident #1 and did not have the handwritten or a printed order for the psych evaluation or the discontinued order for the psych evaluation. She stated Resident #1 never expressed to hospice staff any suicidal ideations. She said the hospice chaplain went and visited him and the hospice social worker went several times. "We knew he had verbalized suicidal ideations because the nursing home staff did tell the hospice staff what he said. We were never called to a care plan meeting. I have no handwritten orders at all on Resident #1. If we have a cardiac patient that wants to see their cardiologist, we would actually cover it." An interview with the Administrator on 8/24/23 at 4:10 PM revealed the facility did not communicate with hospice that Resident #1's psych evaluation had been dc'd (discontinued). The administrator stated she did not the facility did not communicate with hospice when the facility was decreasing monitoring of the resident from one-on-one observation to every hour observation. The administrator stated she had a telephone meeting with the Vice President of sales for the hospice company 8/23/23 before 10:30 AM. The administrator stated "we discussed better communication between hospice staff, the Nurse Practitioner, Nurse and nursing home staff and me." The Administrator stated she wanted to know what is going on with the facility's hospice patients. "I asked if hospice	F 849			

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F 849	Continued From page 150 had a policy on providing psych services if needed and was told they didn't have one. I told the Vice President of sales I felt the hospice wasn't communicating with me when there are changes with a hospice resident. SA interview with Vice President of Sales for hospice company by phone on 8/24/23 at 4:25 PM, confirmed he did talk with the Administrator about how the facility nurses can better communicate with hospice staff. The SA interview with the Account Executive for hospice company, on 8/24/23 at 4:30 PM revealed that the hospice company does not have a policy/procedure for psych services. "Yes, we talked about better communication when a resident is declining. We spoke about having our staff talk with the nursing home's staff." 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	F 849			

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F 849	Continued From page 151 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 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 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	F 849			

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F 849	Continued From page 152 #1, and social worker #2 were in attendance. *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 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 *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	F 849			

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F 849	Continued From page 153 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 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 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. *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	F 849			

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F 849	Continued From page 154 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 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. *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. *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.	F 849			

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F 849	Continued From page 155 *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 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.	F 849			

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F 849	Continued From page 156 *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 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 #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.	F 849			

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F 849	Continued From page 157 *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. *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.	F 849			

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F 849	Continued From page 158 *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 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 (PASARR) policy was created for the facility to coincide with federal and state guidelines. The	F 849			

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F 849	Continued From page 159 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. 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	F 849			

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F 849	Continued From page 160 (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 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	F 849			

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F 849	Continued From page 161 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 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	F 849			

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F 849	Continued From page 162 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, 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	F 849			

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F 849	Continued From page 163 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 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.	F 849			

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F 849	Continued From page 164 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 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	F 849			

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F 849	Continued From page 165 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 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	F 849			

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F 849	Continued From page 166 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.	F 849			