STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185227	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Pointe Healthcare	100 Marshall Court Paducah, KY 42001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on interview, record review and review of facility policy, the facility failed to provide and ensure Resident (R) 84 received necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. R84's level 1 Pre-Admission Screening and Resident Review (PASRR) indicated a level 2 PASRR was needed. The level 2 PASRR indicated R84 MUST receive psychiatric (psych) services on a monthly basis. However, the facility failed to ensure R84 received the required monthly psych services. Therefore, on [DATE] at 2:10 AM, R84 was found lying on her bed with oxygen tubing wrapped ,d+[DATE] times around her neck, and was pronounced deceased . Review of the death certificate dated [DATE], revealed R84's cause of death was noted as Ligature Asphyxiation, rubber oxygen tubing used to intentionally obstruct airway, and the death was ruled a suicide. The findings include: Review of the facility policy titled, Behavioral Assessment, Intervention, and Monitoring, dated ,d+[DATE], revealed residents were to receive and the facility was to provide behavioral health services as needed to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Continued review revealed provision of behavioral health services were to be provided in accordance with the resident's comprehensive assessment and plan of care. Review revealed behavioral health services were to be provided by qualified staff who had the competencies and skills necessary to provide appropriate services to the residents. Continued review of the policy Behavioral Assessment, Intervention, and Monitoring dated ,d+[DATE], revealed under the assessment section all residents were to receive a Level 1 PASRR screening prior to admission. Per review, if the level 1 PASRR indicated an individual might meet the criteria for a mental disorder, intellectual disability, or related condition, he or she was to be referred to the State PASRR representative for the level 2 PASRR screening process. Review revealed the level 2 PASRR evaluation was to be used when conducting the resident's assessment and development of the care plan. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional review of the Behavioral Assessment, Intervention, and Monitoring, dated ,d+[DATE], revealed under the management section, the (facility's) Interdisciplinary Team (IDT) was to evaluate residents' behavioral symptoms to determine the degree of severity, distress, and potential safety risk to the resident and develop a plan of care accordingly. Per policy review, under the monitoring section, if a resident was being treated for altered behavior or mood, the IDT team was to seek and document any improvements or worsening in the individual's behavior, mood, and function. Further policy review revealed the IDT team was to monitor the resident's progress .until stable, with interventions adjusted based on the impact on behavior and other systems symptoms. Review of R84's closed record, Resident Face Sheet, revealed the facility admitted the resident on [DATE] with diagnoses to include; schizoaffective disorder, bipolar type, generalized anxiety disorder and major depressive disorder, recurrent, mild. Review of the facility's Admission Minimum Data Set (MDS) Assessment for R84 dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. Continued MDS review of section D for mood, revealed a score of 21, which indicated R84 had been assessed as being severely depressed. Review of the Quarterly MDS assessment dated [DATE], of section D for mood, revealed a score of 10, which indicated R84 was assessed as being moderately depressed. Review of R84's Comprehensive Care plan dated [DATE], revealed the facility developed a focus problem for Depression/Mood State related to dysfunctional grieving, depression related to life changes, medical conditions, and psychiatric conditions. Review revealed the goal for R84 was management of her depression symptoms at an acceptable level to her through the next review date with a revision date of [DATE]. Review further revealed the interventions included encouraging R84 to verbalize feelings and offer emotional support. Continued review of R84's Comprehensive Care Plan revealed the facility also developed a Psychotic Disorder, altered thought process, related to bipolar effective disorder and schizoaffective disorder dated [DATE]. Review revealed the goal was to manage R84's symptoms of altered thought process through the next review date, revised on [DATE]. Per review , the interventions included: attempting to identify stressors contributing to R84's behaviors and removing them if possible; administering her medication as ordered; and providing a mental health consult when ordered. Further review revealed the interventions additionally included: observing for signs and symptoms of change in R84's condition and notifying the Physician as needed, and providing emotional support and reassurance. Review of the hospital record information dated [DATE], prior to R84's admission to the facility, revealed, the patient had a historical note of illicit drug use and advanced depression. Continued review revealed following medical stabilization, the intent was for R84 to transition to a facility; however, underlining suicidal gestures and actual indigestion of a foreign body (wedding rings). Per review, R84 was to be transitioned to the mental health unit for ongoing medical management and interventions. Further review revealed diagnoses for R84 included a history of Post Traumatic Stress Disorder (PTSD), psychosis, anxiety disorder, major depressive disorder, recurrent and bipolar disorder. Review of the Nursing Facility PASRR level 1 dated [DATE], under section 6 revealed the nursing facility staff were to refer the applicant to the Community Mental Health Center for completion of a Level 2 PASRR. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the PASRR, Level 2, Comprehensive Evaluation for Serious Mental Illness and Intellectual Disability/Related Conditions, dated [DATE], revealed the evaluation had been completed online. Per review, the PASRR representative had attempted to contact the facility for additional information on [DATE] at 10:25 AM, and 3:45 PM, on [DATE] at 8:15 AM, and on [DATE] at 10:00 AM, with no success, and no way to leave a voicemail. Continued review revealed under Section 8, determination revealed R84 met criteria for serious mental illness; however, did not require specialized services and the resident's total care needs could be met in the nursing facility. Review of a document titled, Notification of Recommended Services, for R84, and for the nursing facility, revealed the PASRR professional recommended completing the evaluation, and the resident had mental illness. Continued review revealed the recommended services to best meet R84's individual needs MUST be part of the care plan to ensure continuity of care and stabilization of depressive symptoms. Further review revealed R84 was to receive individual behavior or mental health services therapy on a monthly basis. Review of the physician order dated [DATE], revealed an order for R84's consults included consults as needed for neuro-psych, psychiatric and treatment as needed for the resident's health and comfort. Review of records from an outside psychiatric (psych) provider dated ,d+[DATE] through [DATE], revealed R84 failed to keep the following appointments on: [DATE], [DATE], [DATE] and [DATE] and on [DATE]. Continued review revealed R84 was discharged from the outside provider's services for failure to adhere to her treatment plan and no call no show for appointments. Further review of revealed the last psych treatment scheduled for R84 was on [DATE]. Review of the consent form for the facility's psych services provider revealed that on [DATE], the Social Services Director (SSD) documented R84, had refused to be seen by the facility's psych service group. However, further review of the form revealed no documented evidence the document had been signed by R84. Review of the Progress Note dated [DATE] at 10:47 AM, revealed, R84 had been sitting on the side of her bed sobbing. Continued review of the Note revealed the nurse asked R84 if she needed someone to talk to, and the nurse also told the resident the facility had a Social Worker or the nurse would listen to the resident. Further review revealed R84 stated as sobbing heavily, I will be alright I need no one at this time to tell my business to. Additional review revealed no documented evidence the nurse attempted to further address R84's behaviors, nor contacted the medical provider or psych services provider for additional interventions. Review of the Behavior Note dated [DATE] at 12:23 AM, revealed R84 had been crying and was visibly upset while talking on the phone with her husband. Per review, the Registered Nurse (RN) and aides provided emotional support for the resident, with PRN (as necessary) medications (meds) for anxiety given and documented. Further review revealed R84's behavior/emotional status observed by the nurse had been reported to the supervising nurse. Additional review revealed however, no documented evidence the supervising nurse addressed R84's emotional stated, nor notified the medical or psych provider of the resident's behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Behavior Note dated [DATE] at 5:46 AM, revealed R84 had been up most of the night, silently crying. Per review, when the nurse asked R84 what was the matter, the resident just said, I am just thinking about life. Continued review revealed R84's scheduled Alprazolam (generic for Xanax, an anti-anxiety medication) given. Further review revealed the nurse would report R84 to social services and the clinical director for her behavioral concern. Additionally, review revealed R84 calmed down and slept soundly from 3:00 AM to 6:00 AM. Review of the Health Note dated [DATE] at 9:27 AM, documented by a Licensed Practical Nurse (LPN), revealed R84 had increased tearfulness this shift. Continued review revealed LPN sat with R84 to tried to comfort her and let her know we were here if she needed someone to talk to. Further review revealed the information regarding R84 was placed in the Advanced Practice Registered Nurse (APRN) book so the APRN could assess the resident when doing rounds tomorrow. Review of a Progress Note, documented by the APRN on [DATE], revealed she assessed R84 who had increased anxiety. Continued review revealed per nursing staff R84 had been more tearful and anxious at times recently. Further review revealed the patient reported she had just recently found out that she would be moving out of the nursing facility and was anxious about the upcoming changes and about living by herself. Review of the Behavior Note dated [DATE] at 4:15 PM, revealed, R84 came to the nurse and stated, I think I'm having a manic episode. Per review, R84 told the nurse, I'm going crazy. Continued review revealed the nurse noted having previously given R84 a PRN (as needed) Benadryl related to itching. Further review revealed the nurse contacted the Nurse Practitioner (NP) with no new orders received at that time. In addition, review revealed the nurse informed R84 she was due for her scheduled 6:00 PM Xanax soon, and the resident verbalized understanding and went back to her room. Review of the Progress Note dated [DATE] at 5:45 PM, revealed R84 came to the nurse's station requesting more nerve medication, stating her nerves were really bothering her. Review revealed the NP was notified and the nurse was given a one-time only order for Vistaril (antihistamine also used to treat anxiety) 50 milligrams (mg) by mouth. Continued review revealed R84 expressed she was not happy with that medication, and stated, This isn't going to do anything, I need something to knock me out. Further review revealed R84 ended up taking the (Vistaril) medication, and the nurse told the resident to wait for medicine the to kick in and see how she felt when it did. Review of the Progress Note dated [DATE] at 7:57 PM, revealed a one-time physician's order for an extra dose of Xanax 1 mg related to the resident's anxiety. Further review revealed R84 stated, I'm crawling out of my skin. Review of the Progress Note dated [DATE] at 8:45 PM, revealed R84 was standing at the nurses' station calm and stating, I've got to have something. Per review, the nurse informed R84 she could not have her pain meds until 9:30 PM, with the resident stating, I'm on edge. Continued review revealed the nurse informed R84 she just had Xanax and the only other thing we can do was to send her to hospital. Review further revealed R84 stated, I don't want to go to the hospital, and then returned to her room at that time. Review of the Progress Note dated [DATE] at 5:01 AM, revealed at approximately 2:10 AM, R84 was found lying on her bed with oxygen tubing wrapped four to five times around her neck. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Kentucky Certificate of Death for R84 dated [DATE], revealed it listed the cause of the resident's death as Ligature Asphyxiation, rubber oxygen tubing used to intentionally obstruct airway. Further review revealed R84's death was ruled a suicide. In interview On [DATE] at 8:55 AM, Certified Nursing Assistant (CNA) 5 stated she had worked the night R84 passed away. Per CNA 5's interview, she and CNA 6 had been sitting at the nurse's station that night and R84 was walking down the hall and said, Hi girls, as she headed to the kitchen to get some tea. She stated she saw R84 go back to her room and there were no indicators the resident was in any distress or was in a bad mood. The CNA stated she had seen R84 have mood changes before after phone calls with her spouse. She stated R84 sometimes also seemed different and distant. CNA 5 further stated R84 told her (CNA 5) that her spouse had promised to come get her out of the facility and take her home. In interview on [DATE] at 9:08 AM, CNA 6 stated she had not seen changes in R84 the night of the event. In interview on [DATE] at 9:52 AM, Registered Nurse (RN) 2 stated she had been working at the facility since September of 2022, as the night shift nurse. She stated R84 had been cognitively intact and able to ambulate independently. RN 2 said she witnessed R84 occasionally having crying spells but on the night of the event, there had been no indications she was depressed. She stated that night R84 discussed her upcoming appointment to be cleared for cataract surgery and said she was pleased her son was coming to take her to that appointment. The RN stated R84 had been up around 12:30 AM to go get tea from the kitchen and had greeted staff sitting at the nurse's station on her way to the kitchen. She stated R84 returned to her room after getting the tea. RN 2 stated at approximately 2:10 AM, when she entered R84's room to obtain her vital signs she found the resident lying on the bed with her oxygen tubing looped around her neck five or six times. She additionally stated she assessed R84 and found no pulse, so she yelled for help and initiated cardiopulmonary resuscitation (CPR). In an interview with the facility's former Social Services Director (SSD) 1 on [DATE] at 8:50 PM, she stated she did not have a degree in social work; however, had been in the position of SSD from April of 2022 to April of 2023. Former SSD 1 stated she received no training for her role as SSD. She stated the facility had limited resources and the Social Services Assistant (SSA) was a former Certified Nursing Assistant (CNA). Per former SSD 1's interview, she had not been working at the facility when R84 was admitted and had no knowledge of the resident's history. The former SSD stated she thought she should have been informed of R84's psych history. She stated she was not aware R84 was supposed to have been receiving mental health services monthly and was not aware of R84 had seen an outside provider. Former SSD 1 stated that she had been responsible for completion of the Patient Health Questionnaire (PHQ) 9 indicators for the Depression Scale. She said if a resident scored high on the PHQ 9 she referred the resident to psych services, and the NP and Director of Nursing (DON) and that was all she knew who to report to. The former SSD stated she could not recall the date she completed the PHQ 9 for R84; however, the resident had scored high, so she referred her to the facility's psych provider, which she refused. The former SSD further stated she could not recall if she had documented the discussion but she did document it on the resident's consent form. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an telephonic (phone) interview with the facility's former SSD 2 on [DATE] at 9:52 AM, she stated she had a bachelors degree in human services and had left employment at the facility in [DATE]. She stated she did not do anything with the PASRR's and the Business Office Manager (BOM) completed a resident's PASRR on admission and notified her of the results. Former SSD 2 stated she was not aware of the results of R84's level 2 PASRR or of any recommendations made. She stated she had no knowledge of R84 seeing an outside psych provider for mental health services. Former SSD 2 also stated she was not made aware of most of the clinical things that occurred in the facility. During an interview with the former DON on [DATE] at 12:11 PM, she stated on admission to the facility R84 had declined psych services from the facility's psych provider. The DON stated R84 reported she would continue with the outside provider she was familiar with. She stated she was unsure if that had been documented in the resident's medical record though. The former DON stated R84 had been her own person, and had made her own appointments and arranged for her own transportation. She stated the facility should have been monitoring R84's behaviors or for changes on the medication administration record (MAR); however, that had not occurred. The former DON stated R84 had been a private person who kept to herself, and she did not know if they would have seen/observed anything different with the resident. During an interview with the Medical Director on [DATE] at 12:11 PM, he stated R84 had been a new patient to him when she was admitted to the facility. The Medical Director stated he had not been aware of R84's mental health history until he reviewed her chart following her admission. He stated he did not recall being informed of R84 missing her scheduled mental health appointments or of her not receiving mental health services until after her death. The Medical Director stated it did happen sometimes that he was not made aware of changes in residents. The Medical Director further stated he was not aware of R84 interactions with her spouse that affected her mood and did not see that as a problem. He additionally stated he did not think R84's medications would have contributed to her having suicidal ideations. During an interview with the Administrator on [DATE] at 2:01 PM, she stated that she had been the facility's Administrator for about two and a half years. She stated her knowledge of R84 included the resident having been a nurse at one time and that she had experienced a hard home life with her spouse. The Administrator stated she had not been aware R84 had a history of mental health issues until her death on [DATE]. She stated R84 had been her own person, made her own decisions and had a BIMS score of 15, indicating she was cognitively intact. The Administrator said she did not recall any concerns with psych issues for R84 and had never met the resident's spouse. She stated she was unsure of how communication should have occurred between the outside psych provider and the facility in regards to the mental health appointments that R84 had attended with them. The Administrator further stated she did not recall receiving any documentation from the preferred provider about appointments or of them discharging R84 from their services. In continued interview on [DATE] at 2:01 PM, the Administrator stated the SSD might have set up appointments for psych telehealth for R84; however, nursing should have been made aware of that information. She stated when residents made threats of self harm or indicated signs and symptoms of self harm, that would be a significant change for a resident. The Administrator additionally stated the facility would initiate 1:1 supervision for residents with that behavior, and proceed with transfer to a behavioral health unit or to the emergency room (ER) for evaluation.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on interview, record review and review of the facility's Medical Director's responsibilities, it was determined the Medical Director failed to resident care policies for behaviors were implemented and failed to coordinate the medical care within the facility for 1 of 22 sampled residents, (R)84. The facility admitted R84 to the facility on [DATE] and the level 1 Pre-Admission Screening and Resident Review (PASRR), indicated a level 2 was indicated. The level 2 PASRR indicated R84 MUST receive psychiatric (psych) services on a monthly basis. However, the facility's Medical Director was not aware of that information and therefore, failed to ensure the facility provided R84 with the recommended psych services. On [DATE] at 2:10 AM, R84 was found in her bed with oxygen tubing wrapped ,d+[DATE] times around her neck and was pronounced deceased at 2:43 AM. Review of R84's Certificate of Death dated [DATE], revealed the cause of death as Ligature Asphyxiation, rubber oxygen tubing used to intentionally obstruct airway, and the death was ruled a suicide. The findings include: Review of the facility policy titled, Medical Director dated ,d+[DATE], revealed the Medical Director was a licensed Physician in the State and was to be responsible for ensuring adequate and appropriate Physician services. Per review, the Medical Director's functions included: acting as a consultant to the Director of Nursing (DON) in matters relating to resident care services. Further review revealed the Medical Director was also to help assure residents received adequate services appropriate to meet their needs, and helping assure residents' care plans accurately reflected the medical regimen. Review of the facility's, Medical Director Service Agreement, signed by the Medical Director on [DATE], revealed the Medical Director agreed to coordinate medical care, participate in the development and updating of patient care policies, and was responsible for seeing the policies were executed. Continued review revealed the Medical Director was also responsible for the overall coordination of the medical care provided in the facility to ensure the adequacy and appropriateness of the medical services provided to patients. Further review revealed the Medical Director additionally shared responsibility for assuring the facility was providing appropriate care as required and was responsible for evaluating and taking appropriate steps to correct any possibility of inadequate medical care. Review of the closed record for R84 revealed the facility admitted the resident on [DATE], with diagnoses that included: major depressive disorder, recurrent, mild; schizoaffective disorder, bipolar type; and generalized anxiety disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment for R84 dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. Record review revealed the Medical Director had been R84's primary care Physician (PCP). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R84's Comprehensive Care plan dated [DATE], revealed the facility developed a care plan for Depression/Mood State related to depression, dysfunctional grieving, depression related to life changes, medical condition and psychiatric conditions. Per review, the facility also developed a care plan for Psychotic Disorder, altered thought process, related to bipolar effective disorder and schizoaffective disorder dated [DATE]. Continued review revealed the interventions for those care plans included: encouraging R84 to verbalize feelings and offer emotional support; and attempt to identify stressors contributing to R84's behaviors and remove them if possible. Further review revealed to administer R84's medication as ordered; provide a mental health consult when ordered; observe for signs and symptoms of change in her condition and notify the Physician as needed. Review of the records from an outside behavioral health services provider revealed R84 failed to keep her appointments on [DATE], [DATE], [DATE] and [DATE]. Continued review revealed the outside behavioral health services provider discharged R84 on [DATE], to adhere to her treatment plan by keeping her appointments. Review of the consent form dated [DATE], from the facility psychiatric (psych) services provider revealed the Social Services Director (SSD) documented R84 refused to be seen by the facility psych service group. However, further review revealed no documented evidence the outside behavioral health services provider was contacted for R84's treatment or of the Medical Director being notified of the resident's refusal of the facility's psych service provider. Review of the handwritten document titled, Nursing Facility Initial Visit, revealed the Medical Director saw R84 on [DATE]. Continued review revealed the Medical Director noted R84 had a past medical history of schizoaffective disorder, and anxiety. Further review revealed the Medical Director documented R84 had no apparent distress and under Assessment noted the resident's depression and schizoaffective disorders were stable. Review of the handwritten document titled, Progress Note, dated [DATE], revealed the Medical Director completed a nursing home follow-up visit with R84. Per review, the Medical Director noted R84's fatigue, depression, and anxiety were stable. Review further revealed the Medical Director documented R84's medications had been reviewed and the facility was to continue the same. Review of the handwritten document titled, Progress Note, dated [DATE], revealed the Medical Director completed a nursing home follow-up visit with R84. Further review revealed the Medical Director documented R84 continued to have fatigue, her depression was stable, and her medications were reviewed. Review of the Nursing Progress Note dated [DATE], documented by Registered Nurse (RN) 2 revealed she had witnessed R84 to occasionally have crying spells which she was going to report to social services. However, further review of R84's medical record revealed no documented evidence of RN following up with social services. Additional record review revealed R84 had been seen by the APRN on [DATE], related to having increased anxiety. Review of the handwritten document titled, Progress Note, dated [DATE], revealed the Medical Director completed a nursing home follow-up visit with R84. Review further revealed the Medical Director noted R84 was stable with her anxiety, and her medications were reviewed. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the handwritten document titled, Progress Note, dated [DATE], revealed the Medical Director completed a nursing home follow-up visit with R84 and her anxiety was stable. Review of the Nursing Progress Note dated [DATE] at 5:01 AM, documented by Registered Nurse (RN) 2 revealed the RN entered R84's room to obtain vital signs around 2:00 AM. Per review, upon entering the room RN 2 observed the resident lying on the bed with her oxygen tubing wrapped around her neck five to six times. Continued review revealed the RN called for assistance from Certified Nursing Assistants (CNAs) and two other nurses in the facility. Further review revealed Cardiopulmonary Resuscitation (CPR) was initiated by the charge nurse, RN 3. Additionally, review revealed Licensed Practical Nurse (LPN) 3 notified Emergency Medical Services (EMS) and CPR was continued until their arrival. EMS arrived and took over the CPR, and connected R84 to the defibrillator; however, the resident was asystole (no pulse). Review of the Death Certificate for R84, received from the County Coroner's office, dated [DATE], revealed the resident's presumed time of death was at 2:43 AM. Continued review revealed R84's manner of death was suicide with a history of depression. Additionally, review revealed R84's cause of death was noted to be Ligature Asphyxiation, using rubber oxygen tubing, to intentionally obstruct the airway. In an interview with the Coroner on [DATE] at 4:24 PM, she stated she responded to the facility's report of a suicide on [DATE]. She stated upon her arrival, R84 was deceased and she observed the resident to have four deep grooves in the neck from the oxygen tubing. The Coroner stated R84 also had discoloration around the neck, petechial hemorrhages to both eyes, a red face, and her chest area was blanched. She stated R84 had bleeding from the nose and both ears which was not uncommon. The Coroner stated there was no evidence to indicate R84 had made any adjustments to the tubing or attempted to self release the tubing. She further stated it would have taken only one to two minutes of hard pressure to the neck before the resident expired. Review of the facility's investigation revealed it included witness statements from staff that were working at the time of the incident. Per review, of the facility's interviews, located in the investigation, with RN 2, LPN 3, CNA 5 and CNA 6 revealed all staff reported they observed no changes in R84 on the night of the event. Continued review of the investigation revealed RN 2 said R84 had a scheduled appointment on [DATE] with a pulmonologist and seemed excited to be going out with her son for the appointment. Additionally, review revealed following the investigation it was determined R84 had self inflicted an injury which resulted in her death on [DATE]; however, there was no indication that staff could have predicted her actions. Review of the Ad Hoc Meeting documentation dated [DATE] at 1:56 PM, revealed the Medical Director was present via telephone call. Continued review revealed a discussion was held during the meeting regarding the recent event of a self-inflicted death (R84's) and the ongoing investigation related to the incident. In an interview with CNA 5 on [DATE] at 8:55 AM, she stated she had observed mood changes in R84 following phone calls with her spouse and/or children. The CNA stated sometimes R84 seemed different and distant and had told her (CNA 5) that her spouse had promised to come get her out of the facility and take her home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185227	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Pointe Healthcare	100 Marshall Court Paducah, KY 42001

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA 6 on [DATE] at 9:08 AM, she stated she did not wish to discuss the event regarding R84's death. She stated it was devastating, the worst thing she had experienced as a CNA. CNA 6 did state however, she had not seen changes in R84 that day. In an interview with RN 2 on [DATE] at 9:52 AM, she stated she started working at the facility in September of 2022, as the night shift nurse on the 100 hall where R84 resided. She stated R84 had been cognitively intact and ambulated about ad lib. The RN said she had witnessed R84 to occasionally have crying spells. She stated on the night of the event, there had been no indications that R84 was depressed and the resident had discussed with her (RN 2) the upcoming appointment on [DATE], her son was taking her to. Per RN 2's interview, R84 returned to her room after getting tea from the kitchen. She stated at approximately 2:15 AM, when she (RN 2) entered the room to obtain the resident's vital signs, she saw R84 lying on the bed with her oxygen tubing looped around her neck four or five times. In an interview with the former Social Services Director (SSD) on [DATE] at 8:50 PM, she stated had been the facility's SSD from April, 2022 to April, 2023; however, she did not have a degree in social work. The former SSD stated she had been responsible for completion of the Patient Health Questionnaire (PHQ) 9 indicators for Depression Scale. Per the former SSD's interview, if a resident scored high on the PHQ 9 she referred them to psych services and to the Nurse Practitioner (NP) and DON. She said R84 had scored high on the PHQ 9 that had been completed, but she was unable to recall the date it was performed. The SSD stated she informed the DON of R84's high PHQ 9 score. The former SSD stated she referred R84 to the facility's psych services; however, the resident did not want to see that psych services. She said she did not attempt to refer R84 to an alternative psych provider for psych services. The former SSD stated she did not recall R84 having any kind of telehealth visits, including psych, scheduled through the facility and she never attempted to offer the resident further psych services. In interview with the former DON on [DATE] at 9:30 AM, she stated she received a call from LPN 3 stating R84 had wrapped her oxygen tubing around her neck and was deceased . She stated she called the Administrator and headed to the facility where the Coroner and law enforcement were upon her arrival. In additional interview on [DATE] at 12:11 PM, with the former DON, she stated on admission to the facility R84 had declined receiving psych services from the facility. Per the former DON, R84 told staff she would continue with a different provider as she was familiar with them. She stated R84 was her own person, made her own appointments and had her own transportation. The former DON stated she was not aware until R84 died that she had not been receiving services from her preferred psych provider. She further stated R84 had a toxic relationship with her spouse who she went out of the facility with often. The former DON also stated R84 and her spouse would sometimes argue on the phone and after that the resident sometimes seemed sad. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Medical Director on [DATE] at 12:11 PM, he stated R84 had been a new patient to him when she was admitted to the facility. The Medical Director stated he had not been aware of R84's mental health history until he reviewed her chart after admission. He stated he had been R84's PCP; however, did not recall being informed of R84 missing her scheduled mental health appointments and but stated, sometimes things got missed. Per the Medical Director's interview, he had not been aware of R84 interactions with her spouse that affected her mood. He stated he did not think her medications would contribute to suicidal ideations. He stated the death of R84 was gut wrenching and devastating. The Medical Director stated the facility held a Quality Assurance Performance Improvement (QAPI) meeting following the event involving R84 which he attended. In interview on [DATE] at 2:01 PM, the Administrator stated her knowledge of R84 was that the resident had been a nurse at one time and had experienced a hard home life with her spouse. She stated she was not aware of R84's mental health history until her death on [DATE]. The Administrator stated she did not recall any concerns with psych issues related to R84. She stated she not sure of how communication should have happened between the resident, the preferred psych provider and the facility in regards to the mental health appointments Resident 84 had and did not go to. The Administrator stated she would have had expected the mental health provider however, to communicate with the facility when appointments were scheduled for R84 or when the resident failed to show for those appointments. She stated she also would have expected the mental health provider to communicate with the facility when they discharged R84 from their services. The Administrator stated she did not recall receiving any documentation from the resident's preferred (psych) provider however. Per the Administrator's interview, the SSD might have set up appointments for telehealth psych visits, but the nursing department should have been made aware of such appointments. She stated when residents exhibited threats of self harm or indicated any signs/symptoms of self harm that was a significant change. The Administrator said if that occurred the facility would initiate one to one supervision of the resident and proceed with transfer of the resident to a behavioral health unit or to the emergency room (ER) for evaluation. She stated she did not feel R84 had experienced a significant change prior to her suicide. The Administrator stated when the social worker completed the PHQ 9 indicator for depression scale and it was high she expected the social worker to notify the DON and/or the Physician or NP of the results, so it could be discussed with the clinical team.