STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365305	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willoughby Post Acute	37603 Euclid Ave Willoughby, OH 44094

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. Based on medical record review, interview and review of facility policy, the facility failed to ensure behavioral health services were appropriately provided for one resident (#122) of three reviewed for behavioral health services. The facility census was 121.Findings include:Review of the closed medical record for Resident #122 revealed an admission date of 10/14/25 and discharge date of 04/04/26. Diagnoses included but were not limited to Raynaud's syndrome, liver disease, history of transient ischemic attack (TIA), osteoarthritis, obstructive uropathy, major depressive disorder, generalized anxiety disorder, peripheral vascular disease (PVD), obesity, alcohol abuse, and nicotine dependence. Review of the facility supplemental admission agreement dated 10/15/25 for Resident #122 revealed the resident had signed the form granting permission to receive psych services while at the facility.Review of the physician order dated 10/15/25 for Resident #122 revealed an order for staff to record behavior monitoring each shift . The scale indicated to record zero (0) if no behaviors, record 1 if the resident was afraid, two (2) if the resident was agitated, three (3) if the resident was angry, four (4) if the resident was anxious, five (5) if the resident had a mood change, six (6) if the resident was noisy, seven (7) if the resident was restless, eight (8) if the resident was withdrawn or depressed, nine (9) if the resident was crying, and ten (10) if the resident was combative. Continued review of Resident #122's physician orders revealed medication orders dated 10/15/25 for Fluoxetine Hydrochloride 40 milligrams (mg) once daily for depression, Buspirone Hydrocholoride 15 mg twice daily for anxiety, Mirtazapine 15 mg orally at bedtime for depression, and Seroquel 100 mg once daily for agitation. Review of the 01/07/26 Patient Health Questionaire-9 (PHQ-9), a multipurpose instrument for screening diagnosing, monitoring and measuring the severity of depression, for Resident #122 indicated a level of 15 which indicated moderately severe depression and proposed treatment actions included pharmacotherapy with psychotherapy. Review of the 01/18/26 PHQ-9 for Resident #122 indicated a level of 2 which indicated minimal depression.Review of the progress note dated 01/18/26 timed at 2:43 P.M. written by Social Worker (SW) #324 revealed a PHQ-9 score of 2 which indicated minimal depression.Review of the care plan dated 01/21/26 for Resident #122 revealed resident required anti-anxiety medication related to anxiety disorder. Interventions included but were not limited to administering anti-anxiety medication as ordered by the physician, pharmacy review as indicated and psychiatrist consult as indicated. An additional care plan focus revealed the resident required antipsychotic medication related to agitation. Interventions listed included but were not limited to administering antipsychotic medication as order, psychiatrist consult as indicated and social services visits as indicated. A third care plan focus indicated the resident required antidepressant medication related to a diagnosis of major depressive disorder. Interventions included to obtain a pharmacy review as indicated, a psychiatrist consult as indicated, and social service visits as indicated.Review of 01/27/26 quarterly Minimum Data Set (MDS) 3.0 for Resident #122 revealed a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. Review of activities of daily living (ADLs) revealed Resident #122 required moderate assistance for oral hygiene, personal hygiene, and wheeling 50 feet, maximum assistance for dressing and wheeling 150 feet, and was dependent on staff for toileting, bathing and Hoyer transfers. Resident #122 was (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted to have little interest in doing things 12-14 days of the 14-day lookback period, was noted to have a poor appetite 12-14 days and had a total mood severity score of 15 which indicated moderately severe depression. Resident #122 was noted to receive an antipsychotic, antidepressant, and opioid. No behaviors were noted. Review of the physician order dated 03/16/26 for Resident #122 revealed an order for Hydroxyzine 25 mg to be given orally every six hours as needed for anxiety or itching for a duration of 14 days.Review of the progress note dated 03/17/26 timed at 9:30 A.M. written by Nurse Practitioner (NP) #322 revealed Resident #122 was noted to have had a history of anxiety and reported increased anxiety over the last several days due to worrying about finances. The NP note referenced Hydroxyzine was resumed due to increased anxiety.Review of the phone text messages dated 03/23/26 provided by Resident #122's family sent to SW #324 revealed a request for some kind of therapy. Resident #122's son wrote in the message .Is there any chance of getting him (Resident #122) some kind of therapy. He's very depressed and starting to talk about making some very bad decisions. Not like killing himself but he's so bothered by the lack of availability for physical therapy daily and is ready to give up altogether, just when he is making progress. They had at one point prescribed something for him. I don't know what your resources are there, but it would be helpful if someone could talk him through sticking the course out. If he keeps going with the therapy and there's any chance of increasing it (every doctor has written that he needs intensive therapy. I don't know if two days a week meets that). He might just get himself out of there walking. But if he refuses it, he might as well just sign up to stay in that bed. The phone text message indicated it was read on 03/23/26.Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated March 2026 for Resident #122 revealed the as needed Hydroxyzine was given eight days (03/18/26, 03/19/26, 03/20/26, 03/23/26, 03/26/26, 03/27/26, 03/28/26, and 03/29/26) of the 14 days prescribed. No behaviors were indicated on the MAR.Review of the nursing progress notes on 03/18/26, 03/19/26, 03/20/26, 03/23/26, 03/26/26, 03/27/26, 03/28/26, and 03/29/26 revealed Hydroxyzine was administered but there were no corresponding notes to distinguish whether it was given for itching or anxiety.Review of a progress note dated 03/31/26 timed at 8:15 A.M. written by NP #322 revealed Resident #122 stated he had difficulty sleeping and Melatonin was increased from 5 mg to 10 mg at bedtime for insomnia.Review of the nursing progress noted dated 04/04/26 timed at 4:31 P.M. written by Licensed Practical Nurse (LPN) #317 revealed Resident #122's son called the facility and reported concern for a change in resident condition. Resident #122 was noted with change in mental status and behavior, observed with flat affect on assessment. The note indicated Resident #122 was speaking clearly with respiration even and unlabored and no respiratory distress noted. Vital signs were obtained and within resident's baseline. Resident was alert and responsive, denied pain or discomfort, and no emesis was noted at time of the assessment. Due to the change, 911 was activated for further evaluation. Resident #122's physician was notified and the resident was transferred from the facility via emergency medical services (EMS) for further evaluation. Interview on 04/22/26 at 9:21 A.M. with Licensed Practical Nurse (LPN) #314 revealed she was working the day of the incident with Resident #122. LPN #314 stated Resident #122's son called stating his father called stating goodbye. LPN #314 went down to Resident #122's room to assist LPN #317 who had already called 911. Resident #122 was observed to be alert and had a bright yellow substance all down the front of him and on his blanket. Resident #122 admitted to putting antifreeze (a chemical additive commonly used to lower the freezing point of a water-based liquid which is not intended for ingestion) in a coffee cup and was drinking it. LPN #314 asked what he was doing and he responded he could not get a gun. Resident #122 stated he ordered the antifreeze on Amazon the day before. The bottle of antifreeze was on his bedside table in the open amazon box. EMS arrived and Resident #122 went to the hospital.Telephone interview on 04/22/26 at 11:18 A.M. with Resident #122's son revealed he had contacted Social Worker #324 on 03/23/26 via phone text to express concerns that Resident #122 appeared dark and his family was concerned about his mental state and was asking if psychological services could see and evaluate Resident #122. Resident (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#122's son stated the resident had previously made statements of wanting to harm himself but had not attempted it and stated his depression appeared to intensify a few weeks leading up to the suicide attempt with antifreeze. Resident #122 stated the resident was frustrated and wanted to leave the facility.Telephone interview on 04/22/26 at 12:41 P.M. with LPN #317 revealed she passed meds to Resident #122 between approximately 8:00 and 8:10 A.M. and did not notice anything different and did not notice the box of antifreeze in the resident's room at that time. She stated she checked on him around 9:30 A.M. and again did not notice anything out of the ordinary. Around 11:20 A.M., Resident #122's son called and stated his father had just called him and told him goodbye. She told the son okay and ran to Resident #122's room. When she entered Resident #122's room, she saw the resident with a bottle of antifreeze sitting on his bedside table. Resident #122's gown was saturated with a yellow substance. Resident #122 appeared to be alert and was talking to her and his vitals were stable. Another nurse came in and was taking his vitals while she called 911. LPN #317 was speaking with the family while they were in the room until EMS arrived to transport Resident #122 to a local hospital.Interview on 04/23/26 at 8:58 A.M. with Certified Nursing Assistant (CNA) #326 revealed it was her first day off of training working independently. CNA #326 she checked on Resident #122 upon her arrival and went to get him some water. CNA #326 changed Resident #122 while in the room and he was talking with her. Resident #122's bedside table had a closed box on it when she went back to bring his breakfast. When CNA #326 went back in to pick up his breakfast tray, Resident #122 asked for another cup of coffee which she brought back to him. CNA #326 then went to get a Hoyer (mechanical lift) pad from laundry downstairs to give Resident #122 a bath. When she got off the elevator, she was made aware Resident #122 drank antifreeze and went to his room. LPNs #309, #314 and #317 were in the resident's room to assist. While in the room, staff asked Resident #122 why he drank the antifreeze and he stated he did not have the courage to buy a gun and had researched the fastest ways to kill himself. The staff stayed in the room until EMS arrived.Interview on 04/22/26 at 12:58 P.M. with the Director of Nursing (DON) revealed she received a call at home about the incident with Resident #122 and was told he was speaking clearly and vitals appeared to be normal.Interview on 04/22/26 at 1:47 P.M. with Nurse Practitioner (NP) #322 revealed Resident #122 reported down days but had never reported suicidal ideations and stated he was frustrated he was unable to walk. NP #322 stated she was not aware of any family reported concerns related to his care or mental status.Interview on 04/23/26 at 9:14 A.M. with Social Worker (SW) #324 revealed she did not have a lot of one-on-one interaction with Resident #122 and was aware family was trying to initiate additional physical therapy. SW #322 confirmed she received a text from Marketing #319 stating Resident #122's sister had contacted her about transferring to another facility but did not recall anything about concerns about depression. SW #324 also confirmed she received a text from Resident #122's son on 03/23/26 about increased depression but did not make a referral for psychological services and was unable to provide evidence of Resident #122 was seen or evaluated by psychological services since admitting to the facility.Interview on 04/23/26 at 9:44 A.M. with the DON revealed she was not aware of any family or staff reported concerns of depression for Resident #122. DON confirmed if a resident had a PHQ-9 score of 15, they may have behaviors. The DON confirmed Resident #122 did not receive psychological services while at the facility and confirmed Resident #122 had a signed permission to receive psychological services. The DON confirmed the Hydroxyzine was given and was unable to provide evidence of behaviors or whether it given for anxiety or itchiness for the eight times it was given during the month of March 2026. Telephone interview on 04/23/26 at 3:15 P.M. with Resident #122 revealed he signed the paperwork upon admission but was never offered to have behavioral health services visit him while at the facility.Review of the written witness statement dated 04/04/26 written by NP#325 revealed on Saturday 04/04/26 at roughly 11:30 A.M., LPN #317 received a phone call from Resident #122's son stating his father had just called him and told him goodbye but didn't inform him of what the plan was. LPN #317 notified LPN #309 who informed NP #325 of the emergency at hand. Resident #122 was (continued on next page)

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