STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555668	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Skilled Nursing & Wellness Centre, LLC	11510 Imperial Highway Norwalk, CA 90650

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on interview and record review, the facility failed to ensure the licensed nurses notified the physician when a resident with diagnosis of depression (mental health disorder characterized by persistently low mood or loss of interest in activities, causing significant impairment in daily life) experienced a change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive behavioral, or functional status) manifested by sobbing (crying spells) and verbalization that someone wants to kill him by putting poison in his water pitcher for one of three sampled residents (Resident 1). This failure resulted in Resident 1 committing suicide (the act or an instance of ending one's own life voluntarily and intentionally). On [DATE] at 4:40 a.m. Resident 1 was found hanging in the bathroom with a phone charging cord around his neck. The resident was lowered to the floor, cardiopulmonary resuscitation ([CPR]-an emergency procedure that can save a person life if their breathing or heart stops) was initiated and 911 (emergency services) was called. The Emergency Medical Services ([EMS]- medical professionals providing emergency medical care) arrived at the facility and Resident 1 was pronounced dead on [DATE] at approximately 5:25 a.m. Findings During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and readmitted [DATE]. On [DATE] Resident 1 was discharged home and readmitted back to the facility on [DATE] with diagnoses including depression, cerebral infarction (damage to the brain from interruption of its blood supply) with right sided hemiplegia (paralysis of one side of the body and right hemiparesis(weakness of one side of the body) , and failure to thrive (a syndrome that describes a decline in an older adult's health that can include weight loss, poor nutrition, and inactivity). During a review of Resident 1's History & Physical (H&P) dated [DATE], the H& P indicated Resident 1 had the capacity to understand and make decisions. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Actual harm Residents Affected - Few	During a review of Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated [DATE], the MDS indicated Resident 1 had moderate cognitive (ability to think, understand, learn, and remember) impairment for daily decision making and required supervision or touching assistance with bed mobility, transfer from chair/bed-to-chair transfer (ability to transfer to and from a bed to chair or wheelchair), walking 10 feet (ability to walk at least 10 feet in a room, corridor or similar space once standing) and personal hygiene. During a review of Resident 1's Care Plan titled Resident 1 uses antidepressant medication Lexapro (medication used to treat depression and anxiety) related to depression initiated on [DATE], the Care Plan indicated a goal for Resident 1 was to decrease resident's episodes of signs and symptoms of depression. The Care Plan's interventions included to administering antidepressant medications as ordered by the physician, monitoring, documenting, reporting as needed change in behavior/mood/cognition (mental process involved in knowing, learning, and understanding things), hallucinations (false perception of reality), delusions (having false or unrealistic beliefs), social isolation, suicidal thoughts, and withdrawal (removes themselves from interactions with others). During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had an active diagnosis of depression and was taking anti-depressant (prescription medications that can help treat depression and other mental health conditions) medication. During an interview on [DATE], at 6:25 a.m., CNA 1 stated on [DATE] at 12:00 a.m., Resident 1 was restless standing up next to his bed crying. CNA 1 stated she informed Licensed Vocational Nurse (LVN 1) in charge that Resident 1 was restless and crying. CNA 1 stated Resident 1 continues to cry when he was assisted back to bed. CNA 1 stated it was important to report to the charge nurse any changes in a resident's behavior so the charge nurse can check on the resident and assess the behavior. CNA 1 stated she returned to check on Resident 1 at 1:00 a.m. and observed Resident 1 was awake in bed. CNA 1 stated at 4 a.m. she saw Resident 1 standing up next to his bed talking with CNA 3 and LVN 1. CNA 1 stated when Resident 1 saw her he pointed at her and stated, that was her, she was trying to kill me, you poisoned the water while pointing to his water pitcher. During an interview on [DATE], at 6:45 a.m., LVN 1 stated CNA 3 informed her that Resident 1 appeared worried and concerned and was telling CNA 3 someone was trying to poison him. LVN 1 stated she went to assess him, and Resident 1 was alert and oriented and did not appear to be confused. LVN 1 stated Resident 1 calmed down after she explained to him that CNAs were delivering water pitchers with fresh water and offered to get him another, but Resident 1 declined. LVN 1 stated she felt there was a misunderstanding between her and Resident 1 and not a change in the resident's condition that was the reason she did not call Resident 1's doctor about the resident's worried/anxious behavior and his statement that someone was trying to poison him. During a concurrent interview and record review on [DATE], at 7:25 a.m., LVN 1 stated she did not informed Resident 1's physician when Resident 1 had change in his behavior. LVN 1 stated Resident 1 was exhibiting delusions when he and repeatedly was saying that someone was trying to poison him. LVN 1 stated Resident 1 suicide could have been prevented if she would have stayed with Resident 1, called his doctor, and had done 1:1 monitoring (a type of care where a patient is constantly observed by a healthcare professional to ensure patient safety) but because he calmed down, she did not think she needed to. (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 0580 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on [DATE], at 11:45 a.m., with the Psychiatric Nurse Practitioner ([PNP] a registered nurse with advanced training who provides mental health care to residents) stated Resident 1's doctor should have been notified immediately of Resident 1's new behavior when he was observed crying and stating someone was trying to poison him. The PNP stated nursing staff should have been closely monitoring Resident 1 for behavioral symptoms. The PNP stated Resident 1's behavior could have been a delusion when he verbalized somebody was putting poison in his water, a symptom of mental illness, or a symptom of another medical illness. During an interview on [DATE], at 12:00 p.m., Registered Nurse Supervisor (RNS 3) stated if he had observed Resident 1 crying and stating someone was poisoning his water, he would have done a COC and let the doctor know. RNS 3 stated this behavior could have been due to infection or the resident's depression. RNS 3 stated a COC was an important monitoring and communication tool to let other staff members aware of what was going on with a resident. RNS 3 stated if he had been Resident 1's nurse, he would have provided the resident with 1:1 monitoring for the resident's safety, called the resident's doctor, and done a COC because the resident's behavior was not normal for him. During a concurrent interview and record review on [DATE], at 12:30 p.m., with the Director of Nursing (DON) stated LVN 1 should have done a COC, notified Resident 1's doctor, and probably transferred Resident 1 to a higher level of care (an acute general hospital) when the resident was exhibiting behavior manifested by crying spells, shaking his hands, scared, anxious, and verbalizing someone was trying to kill him. Reviewed Resident 1's medical record, the DON stated there was no COC completed for Resident 1, but one should have been done because Resident 1 was not at his baseline and his behavior indicated there was a medical problem occurring. After reviewing Resident 1's care plan for Lexapro, the DON stated one of the care plan interventions was to monitor for changes in Resident 1's behavior and mood and report to the doctor, but it was not done. During a review of the facility's RN Supervisor Job Description, undated, the job description indicated, Duties: Ensure that notification is given to the resident's attending physician, as well as the resident's representative, when the resident has a significant change in condition. During a review of the facility's P&P titled, Change in Condition Notification, revised [DATE], the P&P indicated, The facility will promptly inform the resident's Attending Physician and notify the resident's legal representative when the resident endures a significant change in their condition caused by a significant change in the resident's physical, mental, or psychosocial status. Change of Condition related to Attending Physician notification is defined as when the Attending Physician must be notified when any sudden and marked adverse change in the resident's condition which is manifested by signs and symptoms different than usual denote a new problem, complication, or permanent change in status and require a medical assessment, coordination, and consultation with the Attending Physician and a change in the treatment plan. The Licensed Nurse will notify the resident's Attending Physician and an appropriate family member when there is a significant change in the resident's physical, mental, or psychosocial status. Cross Reference F740 and F656

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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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review, the facility failed to ensure the licensed nurses (Licensed Vocational Nurse [LVN 1] Registered Nurse Supervisor [RNS 2]) implemented the resident's care plan interventions related to the use of Lexapro (prescription medicine that treats depression [a mental health condition that involves a persistent feeling of sadness and loss of interest in activities, along with other symptoms that affect daily life] and anxiety (feeling of worry, nervousness or unease) to prevent the resident from committing suicide (the act or an instance of ending one's own life voluntarily and intentionally) for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Licensed Vocational Nurse (LVN 1) implemented interventions of Resident 1's care plan titled, Resident 1 uses antidepressant medication Lexapro including assessment, monitoring, and documentation related to Resident 1's change in behavior and mood. On ,d+[DATE]/ 2024 at 12:15 a.m. Resident 1 was observed having crying spells, shaking his hands, appeared scared, anxious, and verbalized that someone was trying to kill him by poisoning his water pitcher. 2. Ensure the licensed nurses (Licensed Vocational Nurse [LVN 1] Registered Nurse Supervisor [RNS 2]) followed the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning which indicated to address resident specific health and safety concerns to prevent decline or injury and identify needs for supervision, behavioral interventions. These failures resulted in Resident 1 committing suicide on [DATE]. Resident 1, who had diagnosis of depression and a history of suicidal ideation (thinking about or formulating plans for suicide) on [DATE] at 4:40 a.m. was found hanging in the bathroom with a phone charging cord around his neck. The resident was lowered to the floor, cardiopulmonary resuscitation ([CPR]-an emergency procedure that can save a person life if their breathing or heart stops) was initiated and 911 (emergency services) was called. The Emergency Medical Services ([EMS]- medical professionals providing emergency medical care) arrived at the facility and Resident 1 was pronounced dead on [DATE] at approximately 5:25 a.m. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and readmitted [DATE]. On [DATE] Resident 1 was discharged home and readmitted back to the facility on [DATE] with diagnoses including depression, cerebral infarction (damage to the brain from interruption of its blood supply) with right sided hemiplegia (paralysis of one side of the body) and right hemiparesis (weakness of one side of the body), and failure to thrive (a syndrome that describes a decline in an older adult's health that can include weight loss, poor nutrition, and inactivity). During a review of Resident 1's History & Physical (H&P) dated [DATE], the H&P indicated Resident 1 had the capacity to understand and make decisions. (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 0656 Level of Harm - Actual harm Residents Affected - Few	During a review of Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated [DATE] , the MDS indicated Resident 1 had moderate cognitive (ability to think, understand, learn, and remember) impairment for daily decision making and required supervision or touching assistance with bed mobility, transfer from chair/bed-to-chair transfer (ability to transfer to and from a bed to chair or wheelchair), walking 10 feet (ability to walk at least 10 feet in a room, corridor or similar space once standing) and personal hygiene. During a review of Resident 1's Care Plan titled Resident 1 uses antidepressant medication Lexapro related to diagnosis of depression, initiated on [DATE], the Care Plan indicated a goal for Resident 1 to decrease the resident's episodes of signs and symptoms of depression. The Care Plan's interventions included to administer antidepressant medications as ordered by the physician, monitor, document, and report a change the resident's behavior/mood/cognition, presence of hallucinations (false perception of reality), and delusions (having false or unrealistic beliefs), social isolation, suicidal thoughts (thinking about or formulating plans for suicide), and withdrawal (removes themselves from interactions with others). During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had an active diagnosis of depression and was taking anti-depressant (prescription medications that can help treat depression and other mental health conditions) medication. During a review of Resident 1's Nurses Progress Notes dated [DATE] and timed at 12:51 a.m., the Nurses Progress Notes indicated that on [DATE] at around 12:15 a.m., Certified Nursing Assistant (CNA 1) called Licensed Vocational Nurse (LVN 1) in charge to Resident 1's room. The Nurses Progress Notes indicated LVN 1 entered Resident 1's room and found Resident 1 sitting on the side of his bed. Resident 1 appeared worried and stated someone was trying to kill him by poisoning his water pitcher or cup, pointing at his water pitcher. The Nurses Progress Notes indicated Resident 1's blood pressure ([BP] a force of blood pushing against artery walls when the heart pumps blood throughout the body) was ,d+[DATE] millimeters of mercury (mm/Hg unit of measurement, BP reference range is ,d+[DATE] mm/Hg) Resident 1's had a headache rated four out of 10 on a pain scale rating (a tool to measure pain intensity by asking patient to rate their pain on a scale of 0 to10, where a zero represents no pain and 10 represents the worse pain possible). The Nurses Progress Notes indicated at 12:18 a.m. Resident 1 received Tylenol (medicine used to relieve pain) and at 12:38 a.m. Resident 1 received Clonidine (medicine used to lower blood pressure) for high BP. The Nurses Progress Notes indicated on [DATE], at around 4:40 a.m. CNA 3 entered Resident 1's bathroom and found Resident 1 kneeling on the floor facing the wall with a red cord around his neck and tied around the handrail of the bathroom. The Nurses Progress Notes indicated Resident 1 was unresponsive, not breathing, and staff was unable to obtain his BP reading. The Nurses Progress Notes indicated the facility staff (unknown) called 911 (emergency services) and CPR was initiated The Emergency Medical Services ([EMS]- medical professionals providing emergency medical care) arrived at the facility and pronounced Resident 1 dead on [DATE] at approximately 5:25 a.m. During a phone interview on [DATE], at 11:45 a.m., the Psychiatric Nurse Practitioner ([PNP] a registered nurse with advanced training who provides mental health care to residents), stated the licensed nurses should have monitored Resident 1's behavioral symptoms. The PNP stated Resident 1's crying spells and statement of someone wanted to kill him by placing poison in his water pitcher, could have been manifestation of Resident 1 was experiencing a delusion. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's initial Psychiatric Evaluation (a comprehensive examination of a person's mental, emotional, and behavioral health), dated [DATE], the initial Psychiatric Evaluation indicated Resident 1 was oriented to person, place, and time. The initial Psychiatric Evaluation indicated, under the treatment plan, to observe the resident for deterioration in function, resident was educated to report worsening of symptoms and to report, if noted, changes in mood and behavior. Gradual dose reduction ([GDR] a step in tapering a dose of a medication) for Lexapro (medication to treat depression) was contraindicated at this time as it may exacerbate (to make something worse) resident symptoms (not specified). During an interview on [DATE] at 2:50 p.m., with Resident 1's roommate (Resident 2), Resident 2 stated on the night of [DATE], he could not sleep well as Resident 1 was crying a lot. Resident 2 stated a staff member (unknown) came in the room to calm Resident 1 down on [DATE] at 3:00 a.m., and after the staff member left, Resident 1 began crying again. Resident 2 stated on the same night, around 4 a.m., he heard Resident 1 struggling to walk to the bathroom, as he (Resident 1) was holding onto the walls while walking to the restroom. Resident 2 stated after that he went back to sleep and did not hear anything until someone told him the next day what happened to Resident 1 (committed suicide). During an interview on [DATE], at 6:25 a.m., CNA 1 stated on [DATE] at 12:00 a.m., Resident 1 was restless standing up next to his bed crying. CNA 1 stated she informed LVN 1 that Resident 1 was restless and crying. CNA 1 stated Resident 1 continues to cry when he was assisted back to bed on [DATE] (unknown time). During an interview on [DATE], at 7 a.m., CNA 3 stated when she was passing out water pitchers at approximately 12:00 a.m. on [DATE], Resident 1 verbalized to CNA 3 that another CNA (unknown) was trying to poison him. CNA 3 stated Resident 1 appeared nervous, scared, his hands were shaking, and verbalized repeatedly that a lady was trying to poison him. CNA 3 stated she reported Resident' 1s behavior to LVN 1. During an interview on [DATE], at 7:23 a.m. LVN 1 stated she gave Resident 1 Tylenol (medication to treat pain) for his headache on [DATE] at 12:18 a.m. and Clonidine (medication to treat high BP) at 12:30 a.m. LVN 1 stated it was difficult to obtain Resident 1's BP because he was moving a lot and was pointing at his water pitcher. LVN 1 stated Resident 1 had depression and a high BP. LVN 1 stated when Resident 1 stated someone was trying to poison him on it could have been related to his depression. LVN 1 stated on [DATE] she observed Resident 1 being anxious, worried, with a lot of concerns (not specified). LVN 1 stated she should have done a COC when Resident 1 had changes in his behavior so nurses could better monitor him. LVN 1 stated after CNA 3's report of Resident 1 change in behavior on [DATE] at approximately 12:00 a.m. they (facility staff) visually checked on him more frequently but did not document it was done. LVN 1 stated Resident 1 was exhibiting delusions when he repeatedly verbalized that someone was trying to poison him on [DATE]. LVN 1 stated Resident 1 suicide could have been prevented if she would have called his doctor and placed the resident on 1:1 monitoring (a type of care where a patient is assigned a staff member to provide constant observation and assistance to ensure a patient safety) on [DATE] but because he calmed down, she did not think she needed to do so. (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 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE], at 12:24 p.m., Registered Nurse Supervisor (RNS 2) stated when CNA 1 informed her on [DATE] that Resident 1 verbalized someone was trying to poison him, she thought it was because Resident 1 was confused. RNS 2 stated she failed to do a COC as she thought Resident 1's delusion was due to his confusion. RNS 2 stated she was not aware of Resident 1 having behavior of crying spells, shaking hands, feeling scared and anxious. RNS 2 stated LVN 1 did not inform her about Resident 1's change in behavior and if she has known, she would have placed Resident 1 on 1:1 monitoring/observation to keep him safe, call Resident 1's doctor and family member, complete a COC, and transfer Resident 1 to a higher level of care (a general acute care hospital). During an interview on [DATE], at 10:42 a.m. LVN 5 stated it was important to follow and implement plan of care interventions. LVN 5 stated care plan enables nursing staff to monitor, assess, and inform the doctor when Resident 1 was exhibiting behavioral changes including crying spells and delusions. During a concurrent interview and record review on [DATE] at 1:06 p.m. with RNS 3, Resident 1's Care Plan for the administration of Lexapro dated [DATE] was reviewed. RNS 3 stated licensed nurses were responsible to initiate, modify and implement the comprehensive care plan of a resident (in general). RNS 3 stated Resident 1's Care Plan for Lexapro required monitoring for any adverse side effects (undesired effect of a drug) of the medication, documenting them, and reporting any changes in Resident 1's behavior, mood, cognition, including delusion and suicidal ideation to Resident 1's doctor. RNS 3 stated the care plan serves as guidelines to address and implement interventions for a particular Resident 1's health condition. RNS 3 stated licensed nurses (LVN 1 and RNS 2) failed to follow a care plan and implement Resident 1's plan of care when he exhibited changes in behavior including crying spells and verbalization of somebody was putting poison in his water and was trying to kill him on [DATE]. During a concurrent interview and record review on [DATE], at 2:35 p.m. the Director of Nursing (DON) stated the care plan provides a detailed outline of the interventions the staff were to perform for a specific identified physical or psychological problem. The DON stated the care plan served as a checklist for necessary staff actions regarding the resident's issue or problem. The DON reviewed Resident 1's care plan dated [DATE] related to the use of Lexapro , and stated that LVN 1 failed to follow and implement Resident 1's care plan interventions including monitoring and/or recognizing changes in the resident's behavior and reporting to the doctor any change in Resident 1's condition when the resident was observed having crying spells, shaking hands, was feeling scared, anxious, and verbalizing someone was trying to kill him. During a review of facility's policy and procedure (P&P) titled Comprehensive Person-Centered Care Planning revised ,d+[DATE], the P&P indicated the facility will provide person-centered, comprehensive, care that reflects the best practice standards for meeting health, safety, psychosocial, behavioral needs of the resident to maintain or obtain the highest physical, mental, and psychosocial being. The P&P indicated the Care Plan should address resident specific health and safety concerns to prevent decline or injury and will identify needs for supervision, behavioral interventions, and assistance with activities of daily living. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During a review of facility's P&P titled Change of Condition Notification revised ,d+[DATE], the P&P indicated the facility will notify the attending physician when there is any sudden and marked adverse change in the resident's condition manifested by signs and symptoms different than usual denoting a new problem, complication requiring a medical assessment, coordination and consultation with the Attending Physician or a change in the treatment plan. During a review of facility's P&P titled Behavior /Psychoactive Drug Management revised ,d+[DATE], the P&P indicated if a resident manifests a change in his/her mood for behavior symptoms, the licensed nurse will assess the resident's mood and behavior utilizing the change of condition process. Cross Reference F740 and F580

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety 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** 49145 Based on interview and record review, the facility failed to ensure the resident, who had diagnosis of depression (mental health disorder characterized by persistently low mood or loss of interest in activities, causing significant impairment in daily life) and a history of suicidal ideation (thinking about or formulating plans for suicide [the act or an instance of ending one's own life voluntarily and intentionally) did not commit suicide for one of three sampled residents out of 38 residents with a diagnosis of depression (Resident 1). The facility failed to: 1. Ensure Licensed Vocational Nurse (LVN 1) initiated continuous Resident 1's assessment and closed monitoring of Resident 1's change in behavior, mood, cognition (ability to think, understand, learn, and remember), presence of hallucinations (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real), and delusions (believing things that are not true), and suicidal ideation, when Certified Nursing Assistant (CNA 1) reported to LVN 1 that Resident 1 was observed sobbing (crying spells) and accusing CNA 1 of putting poison in his water pitcher on [DATE] @ 12:15 a.m. 2. Ensure a change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status) assessment was completed when Resident 1 was having crying spells, shaking hands, anxious (uneasy or worried), and verbalizing being scared and that someone was trying to kill him. 3. Ensure staff followed Resident 1's care plan titled Resident uses antidepressant (Lexapro- medication for depression) related to depression initiated on [DATE], indicated interventions to monitor, document, and report as necessary changes in Resident 1's behavior, mood, cognition, hallucinations, delusions, and suicidal thoughts, withdrawal (removes themselves from interactions with others), and notify the physician of COC. 4. Ensure Resident 1 primary care physician was notified when Resident 1 experienced a COC, when Resident 1 was observed sobbing (crying) and accusing CNA 1 of putting poison in his water pitcher on [DATE] at 12:15 a.m. 5. Ensure Social Services Director (SSD) reviewed and assessed Resident 1's history of wanting to die on [DATE] as documented in Resident 1's medical record from Resident 1's previous admissions to the facility. 6. Ensure SSD assessed Resident 1 upon admission and gather information to complete Resident 1's Patient Health Questionnaire ([PHQ 9- a validated interview that screens for symptoms of depression) on the 7th day after admission 7. Ensure nursing staff followed the facility's policy and procedure (P&P) titled, Resident Safety, which indicated the residents will be evaluated whenever there is a change in condition, to identify circumstances that pose a risk for the safety and wellbeing of the resident. (continued on next page)

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Norwalk Skilled Nursing & Wellness Centre, LLC	11510 Imperial Highway Norwalk, CA 90650

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	As a result of these failures, Resident 1 was found hanging in the bathroom with a phone charging cord around his neck, on [DATE] at 4:40 a.m. The resident was lowered to the floor, cardiopulmonary resuscitation ([CPR]-an emergency procedure that can save a person life if their breathing or heart stops) was initiated and 911 (emergency services) was called. The Emergency Medical Services ([EMS]- medical professionals providing emergency medical care) arrived at the facility and pronounced Resident 1 dead on [DATE] at approximately 5:25 a.m. On [DATE] at 6:16 p.m., the Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to assess, monitor and inform Resident 1's primary physician when Resident 1 exhibited changes in behavior. On [DATE] at 6:55 p.m., the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP implementation through observation, interview, and record review, the IJ was removed on [DATE] at 7:07 p.m., in the presence of the ADM and the DON. The IJRP included the following immediate actions: 1.On [DATE]-[DATE], the DON provided a 1:1 (individualized instruction) education to LVN 1, CNA 1, Registered Nurse Supervisor (RNS), LVNs and CNAs that worked on [DATE] on 11 p.m. to 7 p.m. shift regarding COC process, with emphasis on the following: a. Assessment and close monitoring of residents with change in behavior, mood, cognition, hallucinations, delusions, and suicidal thoughts, disruptive vocalizations (verbal noises [screaming, yelling, nonsense talking, cursing] which are generally considered unusual, inappropriate or are upsetting to others, and difficulty sleeping. b. Ensuring a COC assessment was completed for residents having a change in behavior; paranoid behavior (distrust and suspicion of others), verbalization of hurting self, hallucinations, delusions, that is disruptive vocalizations, yelling, difficulty sleeping. c. Monitoring, documenting, and reporting as necessary any change in resident's behavior, mood, cognition, hallucinations, delusions, and suicidal thoughts, and notifying the physician of the COC. d. Non-Pharmacological Interventions (healthcare interventions that do not primarily rely on medication) to care for residents with depression; include removing stressors, offering food and beverages, increasing therapeutic activities of choice/routine, psychosocial (mind and emotions) support, encouraging family involvement, other non-pharmacological interventions to include but not limited to physical comfort (food, activities of daily living (ADL) assistance), environmental (offer soothing activities such as, TV, reading book, music, getting fresh air, offer a walk). Continuously monitoring the resident's mood and adjusting interventions as necessary to ensure the environment is maintained safe. e. Informing physician and responsible party when resident had COC in behavior, mood, delusions, hallucinations, and suicidal thoughts, and recognition of residents who were depressed and have a history of suicidal ideation. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. Behavior management. g. Suicide prevention. 2. On [DATE], the Administrator provided a 1:1 in - service education to SSD regarding completion of Assessments, including PHQ-9 following the Resident Assessment Instrument (RAI-standardized assessment tool) Manual guidelines. 3. On [DATE], the DON/designee conducted an audit of current residents with diagnosis of serious mental illness such as schizophrenia (a serious mental disorder in which people interpret reality abnormally), major depression, bipolar disorders (a mental health condition that causes extreme mood swings that include emotional highs [mania] and lows[depression] that make it difficult to carry out day-to-day tasks and activities), mood disorders, psychotic disorders (severe mental illnesses that cause people to lose touch with reality and have an abnormal thinking) and other psychiatric (mental) diagnoses to determine residents who have had a change in behavior, mood, cognition, hallucinations, delusions, within the last 30 days, and current or history of suicidal ideations or suicide attempt, to ensure that: a. Residents are assessed and closely monitored for changes in mood (that is disruptive vocalizations, yelling, difficulty sleeping, mood, cognition, hallucinations, delusions, and suicidal thoughts). b. A COC is completed as indicated for changes in behavior such as disruptive vocalizations, yelling, difficulty sleeping, mood, cognition, hallucinations, delusions, and suicidal thoughts, i.e. disruptive vocalizations, yelling, difficulty sleeping. c. Care plan initiated, and interventions are implemented to be followed. d. Primary Care Physician is notified of COC, and e. SSD Assessments are completed within 7 days of the resident's admission,quarterly/annually, and based on significant change of condition. PHQ-9 Assessment is completed per assessment reference date schedule following admission, quarterly, and for significant change of condition assessments. 4. On [DATE], SSD conducted an audit of current residents with diagnosis of serious mental illness such as schizophrenia, major depression, bipolar disorders, mood disorders, psychotic disorders, and other psychiatric diagnoses. Out of 99 residents there were 38 residents identified to have a diagnosis of depression. One resident was identified to have exhibited a change in mood and was assessed by licensed nurse, COC was competed, and the attending physician was notified. A PHQ-9 Assessment of other 37 identified residents with diagnosis of depression were completed by the SSD on [DATE] through [DATE]. 5. On [DATE], the DON/Designees conducted interviews of current interviewable residents to identify any potential changes in behavior or mood. 6.On [DATE], the DON/Designee provided an in-service education to the staff on Behavior Management/Suicide Management. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Informed Consent (the process in which a healthcare provider educated a patient about the risks, benefits, and alternatives of a given procedure, treatment, or intervention), dated [DATE], the Informed Consent indicated Resident 1 was prescribed Lexapro (medication used to treat depression) for depression and persistent verbalization of sadness. During a review of Resident 1's Care Plan titled Resident 1 uses antidepressant medication Lexapro related to depression initiated on [DATE], the Care Plan indicated a goal for Resident 1 was to decrease resident's episodes of signs and symptoms of depression. The Care Plan's interventions included to administer antidepressant medications as ordered by the physician, monitoring, documenting, reporting as needed change in behavior/mood/cognition (mental process involved in knowing, learning, and understanding things), hallucinations (false perception of reality), delusions, social isolation (no relationships with other), suicidal thoughts, and withdrawal. During a review of Resident 1's initial Psychiatric Evaluation (a comprehensive examination of a person's mental, emotional, and behavioral health), dated [DATE], the initial Psychiatric Evaluation indicated Resident 1 was oriented to person, place, and time. The initial Psychiatric Evaluation, under the treatment plan, indicated to observe the resident for deterioration in function, resident was educated to report worsening of symptoms and to report if noted with changes in mood and behavior. Gradual dose reduction ([GDR] a step in tapering a dose of a medication) for Lexapro was contraindicated at this time as it may exacerbate (to make something worse) resident symptoms (not specified). During a review of Resident 1's Nurses Progress Notes, dated [DATE], the Nurses Progress Notes indicated Resident 1 was on monitoring due to hallucination episode. The Nurses Progress Notes indicated Resident 1 could not sleep because he was experiencing strange things in the room during the night such as pages of a book in his closet flipping by themselves. During a review of Resident 1's PHQ-,d+[DATE] questionnaire, dated [DATE], the PHQ ,d+[DATE] indicated a score of 10 (a score of ,d+[DATE] is moderate depression). During a review of Resident 1's Nurses Progress Notes, dated [DATE], the Nurses Progress Notes indicated a Social Worker met with Resident 1 for verbalization of wanting to die and Lexapro was increased to 20 milligrams ([mg]-unit of measurement). During a review of Resident 1's Nurses Progress Notes, dated [DATE], the Nurses Progress Notes indicated Resident 1 was being monitored for episodes of verbalization of wanting to die. During a review of Resident 1's Nurses Progress Notes, dated [DATE], the Nurses Progress Notes indicated Resident 1 was being monitored for panic attacks (a sudden episode of intense fear or discomfort that can cause physical and mental symptoms) and tachycardia (a heart rate that is faster than 100 beats per minute). (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Nurses Progress Notes dated [DATE] timed at 12:51 a.m., the Nurses Progress Notes indicated on [DATE] at around 12:15 a.m., CNA 1 called Resident 1's assigned charge nurse (LVN 1) to resident's room. The Nurses Progress Notes indicated LVN 1 entered Resident 1's room and found Resident 1 sitting on the side of his bed appeared worried and stated someone was trying to poison him pointing to his water pitcher/cup. The Nurses Progress Notes indicated Resident 1's blood pressure ([BP] force of blood pushing against artery [blood vessel] walls when the heart pumps blood throughout the body) was ,d+[DATE] millimeters of mercury (mm/Hg unit of measurement [reference range for normal blood pressure is less than ,d+[DATE]], the resident had a headache rated four out of 10 on a pain scale (tool to measure pain intensity by asking patient to rate their pain on a scale of 0 to 10, where zero is no pain and 10 is the worse pain possible). The Nurses Progress Notes indicated at 12:18 a.m., Resident 1 received Tylenol (medicine used to relieve pain) and at 12:38 a.m. Resident 1 received Clonidine (medicine used to lower blood pressure) for high BP. The Nurses Progress Notes indicated on [DATE], at around 4:40 a.m., CNA 3 entered the Resident 1's bathroom and found Resident 1 kneeling on the floor facing the wall with a red cord around his neck, and the cord was tied around the handrail. The Nurses Progress Notes indicated Resident 1 was unresponsive, not breathing and the staff was unable to obtain a blood pressure reading. The Nurses Progress Notes indicated Resident 1's pulse rate was 186 beats per minute (reference range for adult pulse is 60 to 90 beats per minute). The Nurses Progress Notes indicated a facility staff (unknown) called 911 (emergency services) and initiated CPR. At 5:01 a.m., paramedics (Emergency Medical Services) arrived and continued CPR. Resident 1 was pronounced dead at around 5:25 a.m. During an interview on [DATE] at 2:50 p.m., with Resident 1's roommate (Resident 2), Resident 2 stated on the night of [DATE], he could not sleep well as Resident 1 was not sleeping and crying a lot. Resident 2 stated a staff member (unknown) came into the room to calm Resident 1 down on [DATE] at 3:00 a.m., and after staff member left Resident 1 began crying again. Resident 2 stated around 4 am. he heard Resident 1 struggling to walk to the bathroom, as he was holding onto the walls while walking. Resident 2 stated after that he went back to sleep and did not hear anything until someone told him the next day what happened to Resident 1 (committed suicide). During an interview on [DATE], at 6:25 a.m., CNA 1 stated on [DATE] at 12:00 a.m., Resident 1 was restless standing next to his (Resident 1) bed crying. CNA 1 stated she informed LVN 1 that Resident 1 was restless and crying. CNA 1 stated Resident 1 continues to cry when he was assisted back to bed. CNA 1 stated it was important to report to the charge nurse any changes in a resident's behavior so the charge nurse can check on the resident and assess the behavior. CNA 1 stated she returned to check on Resident 1 at 1:00 a. m. and observed Resident 1 was awake lying in bed. CNA 1 stated at 4 a.m., she saw Resident 1 standing up next to his bed talking with CNA 3 and LVN 1. CNA 1 stated when Resident 1 saw her he pointed at her and stated, that was her, she was trying to kill me, you poisoned the water, while pointing to his water pitcher. During an interview on [DATE], at 6:45 a.m., LVN 1 stated CNA 3 informed her that Resident 1 appeared worried and concerned and was telling CNA 3 someone was trying to poison him. LVN 1 stated she went to assess him, and Resident 1 was alert and oriented and did not appear to be confused. LVN 1 stated Resident 1 calmed down after she explained to him that the CNAs were delivering the new water pitchers and offered to get him a new CNA but Resident 1 declined. LVN 1 stated she felt there was a misunderstanding between her (LVN 1) and Resident 1 and not a change of condition, and that was the reason she did not call Resident 1's doctor to inform of the resident's behavior. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 7 a.m., with CNA 3 stated when she was passing out water pitchers at approximately 12:00 a.m. on [DATE], Resident 1 verbalized to CNA 3 that another CNA (unknown) was trying to poison him. CNA 3 stated Resident 1 appeared nervous, scared, his hands were shaking, and verbalized repeatedly that a lady was trying to poison him. CNA 3 stated she stayed with Resident 1 to listen to his concerns and then reported his behavior to LVN 1. During a concurrent interview and record review on [DATE], at 7:25 a.m., with LVN 1, Resident 1's medication administration record (MAR) was reviewed. LVN 3 stated she gave Resident 1 Tylenol for his headache at 12:18 a.m., and Clonidine at 12:30 a.m. LVN 1 stated it was difficult to obtain Resident 1's blood pressure because he was moving a lot and was pointing at his water pitcher. LVN 1 stated Resident 1 had depression and high blood pressure, and when Resident 1 was stating someone was trying to poison him it could have been related to his depression. LVN 1 stated Resident 1 was taking Lexapro for his depression for targeted behaviors of persistent verbalization of sadness. LVN 1 stated when she saw Resident 1, he appeared anxious, worried, and had a lot of concerns (not specified). LVN 1 stated she should have done a COC when Resident 1 had changes in his behavior so they could have better monitored him. LVN 1 stated she failed to inform Resident 1's physician when Resident 1 had changes in his behavior. LVN 1 stated they (facility staff) did not do any monitoring but visually checked on him more frequently but did not document it was done. LVN 1 stated Resident 1 was exhibiting delusions when he continued to think that someone was trying to poison him. LVN 1 stated Resident 1 suicide could have been prevented if she would have stayed with Resident 1, called his doctor, and placed the resident on 1:1 (a type of care where a patient is constantly observed by a healthcare professional to ensure patient safety) observation/monitoring but because he calmed down, she did not think she needed to do so. During a phone interview on [DATE], at 10:05 a.m., LVN 3 stated on [DATE] approximately 4:40 a.m., she was called by CNA 3 to Resident 1's room and found Resident 1 in the bathroom of his room, on his knees, facing the wall on the right side of the toilet, with a cord around his neck. LVN 3 stated she used scissors to cut the cord around Resident 1's neck. LVN 3 stated Resident 1 was still warm to touch and thought he had a faint carotid (neck) pulse. LVN 3 stated Resident 1 was not breathing so she initiated CPR with CNA 5. During an interview on [DATE], at 11:05 a.m., the Social Services Director (SSD) stated Resident 1 was admitted on [DATE] and she only saw him once on [DATE]. The SSD stated she did not complete Resident 1's required screenings (Brief Interview for Mental Status [BIMS], PHQ9, depression screening, social determinants of health, social service assessments, because she had seven days to complete from the time of Resident 1's admission on [DATE]. During a phone interview on [DATE], at 11:45 a.m., the Psychiatric Nurse Practitioner ([PNP] a registered nurse with advanced training who provides mental health care to residents), stated Resident 1's doctor should have been notified immediately of Resident 1's new behavior when he was observed crying and stating someone was trying to poison him. The PNP stated possible interventions to prevent the resident's suicide would have been closed monitoring of the resident for behavioral symptoms. The PNP stated Resident 1's behavior could have been a delusion when he verbalized somebody was putting poison in his water, a symptom of mental illness, or a symptom of another medical illness. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 12:24 p.m., Registered Nurse Supervisor (RNS 2) stated when CNA 1 informed her that Resident 1 verbalized someone was trying to poison him, she thought it was because Resident 1 was confused. RNS 2 stated she failed to do a COC as she thought Resident 1's delusion was because he was confused. RNS 2 stated she was not aware of Resident 1's behavior of crying spells, having hands tremor (shaking), feeling scared, and being anxious. RNS 2 stated she was not told by LVN 1 about Resident 1's change in behavior and if she would have known, she would have placed Resident 1 on 1:1 monitoring to keep him safe, call Resident 1's primary physician, complete a COC, and transfer Resident 1 to a higher level of care. During an interview on [DATE], at 10:10 a.m., the Minimum Data Set Coordinator (MDSC) stated the SSD was responsible for completing Section D (Mood) of the MDS and should be continuously assessing residents (through observation, interview, and record review) during the Assessment Reference Date ([ARD] marks the end of a seven-day period during which a resident is observed and assessed) from admission. The MDSC stated the SSD should have started Resident 1's assessments upon admission and to have an ongoing resident's assessments during the seven days following admission and not just one visit with the resident. The MDSC stated psychosocial assessments (an evaluation of a resident's mental health, and social well-being) was a part of the residents needs so it was important to conduct the assessments continuously from the time of admission. During an interview on [DATE], at 11:05 a.m., SSD stated knowing a resident's (in general) past medical history was important so you can develop a person-centered care plan. The SSD stated she does not review previous notes for those that were previously admitted to the facility because she prefers to do her own assessment of the resident. The SSD stated she was made aware by staff that Resident 1 was admitted to the facility in the past but did not review his previous records. The SSD stated she did not complete the PHQ9 or BIMS for Resident 1 because she was busy and did not have time to complete her assessment after seeing him on [DATE]. The SSD stated her progress notes and Resident 1's assessment that she completed on [DATE] was based on one-time interaction with the resident (on [DATE]). The SSD stated she started to write a note for Resident 1 assessment on [DATE] but did not submit it until [DATE] because she wanted to include her conversation with Resident 1's son. The SSD stated, she should have reviewed Resident 1's progress notes from previous admission to the facility. The SSD stated moving forward she will incorporate review of records in her assessment. The SSD stated, if she would have reviewed Resident 1's previous SSD notes from previous admission, she would have completed her assessments right away when he was admitted , would initiate plans for monitoring and assessing, and would push for the psychologist (mental health professional who help resident cope with mental health conditions) to see him. During an interview on [DATE], at 12:00 p.m., RNS 3 stated if he had observed Resident 1 crying and stating someone was poisoning his water, he would have done a COC and let the resident's primary care physician know. RNS 3 stated this behavior could have been due to infection or depression. RNS 3 stated a COC was an important monitoring and communication tool to let other staff members aware of what was going on with a resident. RNS 3 stated if he had been Resident 1's nurse, he would have provided 1:1 monitoring for the resident's safety, called the resident's doctor, and completed a COC because the resident's behavior was not his usual/normal behavior for him. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's Charge Nurse Job Description, undated, the Charge Nurse Job Description indicated, Qualifications: Ability to provide patient care in accordance with applicable standards, policies, and procedures; Possess critical thinking skills to analyze, synthesize, and evaluate clinical data and observations in developing a nursing plan of care; Comprehensive knowledge of applicable nursing principles, practices, and standards of care. Duties: Makes daily rounds to interview physical and emotional status and to implement any requires nursing interventions. During a review of the facility's RN Supervisor Job Description, undated, the RN Supervisor Job Description indicated, Duties: Assure that residents have a clean, safe, orderly, and comfortable environment; Ensure that notification is given to the resident's attending physician, as well as the resident's representative, when the resident has a significant change in condition. [NAME][TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555668	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Skilled Nursing & Wellness Centre, LLC	11510 Imperial Highway Norwalk, CA 90650

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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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based an observation, interview, and record review the facility failed to ensure facility staff including, Social Service Director, (SSD), Registered Nurses (RNs), Licensed Vocational Nurses (LVNs) and certified nursing assistants (CNAs) had competencies needed to care for residents with mental disorders and psychosocial disorders) for 38 sampled residents (Resident 1). The facility failed to: 1. Intervene when Resident 1 was observed sobbing (crying spells) and was accusing CNA 1 of putting poison in his water pitcher on 9/14/2024 at 12:15 a.m. This deficient practice resulted in a lack of care plan interventions to address Resident 1's symptoms of depression and Resident 1 did not receive the necessary care, services, and interventions to address Resident 1's emotional, behavioral, and psychosocial (support given to help meet the mental, emotional, social, and spiritual needs of patients) needs. Resident 1 had delusional thoughts and was crying and upset. Four hours later, Resident 1 committed suicide by hanging himself in the bathroom with a phone charging cord wrapped around his neck and was pronounced dead on 9/14/2024, at 5:25 a.m. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and readmitted [DATE]. On 4/2/2024 Resident 1 was discharged home and readmitted back to the facility on [DATE] with diagnoses including depression, cerebral infarction (damage to the brain from interruption of its blood supply) with right sided hemiplegia (paralysis of one side of the body and right hemiparesis(weakness of one side of the body) , and failure to thrive (a syndrome that describes a decline in an older adult's health that can include weight loss, poor nutrition, and inactivity). During a review of Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 3/15/2024, the MDS indicated Resident 1 had moderate cognitive (ability to think, understand, learn, and remember) impairment and required supervision or touching assistance with bed mobility, transfer from chair/bed-to-chair transfer (ability to transfer to and from a bed to chair or wheelchair), walking 10 feet (ability to walk at least 10 feet in a room, corridor or similar space once standing) and personal hygiene. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had an active diagnosis of depression and was taking anti-depressants (prescription medications that can help treat depression and other mental health conditions). During a review of Resident 1's informed consent (the process in which a healthcare provider educated a patient about the risks, benefits, and alternatives of a given procedure, treatment, or intervention), dated 9/10/2024, informed consent indicated Resident 1 was prescribed Lexapro (anti-depressant medication) for depression and persistent verbalization of sadness. (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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 1's Care Plan titled Resident 1 uses antidepressant medication Lexapro (medicine used to treat depression) related to depression initiated on 9/12/2024, the Care Plan indicated a goal to decrease resident's episodes of signs and symptoms of depression. The Care Plan's interventions included to administering antidepressant medications as ordered by the physician, monitoring, documenting, reporting as needed change in behavior/mood/cognition (mental process involved in knowing, learning, and understanding things), hallucinations (false perception of reality), delusions (having false or unrealistic beliefs), social isolation, suicidal thoughts, and withdrawal. During a review of Resident 1's initial Psychiatric evaluation (a comprehensive examination of a person's mental, emotional, and behavioral health), dated 9/13/2024, the initial Psychiatric evaluation indicated Resident 1 was oriented to person, place, and time. The initial Psychiatric evaluation indicated under the treatment plan indicated to observe for deterioration in function, resident was educated to report worsening of symptoms and to report if noted with changes in mood and behavior. Gradual dose reduction ([GDR] a step in tapering a dose of a medication), was contraindicated at this time as it may exacerbate (to make something worse) resident symptoms (not specified). During an interview on 9/17/2024, at 6:25 a.m., with CNA 1, CNA 1 stated on 9/14/2024 at 12:00 a.m., Resident 1 was restless standing up next to his bed crying. CNA 1 stated she informed LVN 1 that Resident 1 was restless and crying. CNA 1 stated Resident 1 continues to cry when he was assisted back to bed. CNA 1 stated it was important to report to the charge nurse any changes in a resident's behavior so the charge nurse can check on the resident and assess the behavior. CNA 1 stated she returned to check on Resident 1 at 1:00 a.m. and observed Resident 1 was awake laying in bed. CNA 1 stated at 4 a.m. she saw Resident 1 standing up next to his bed talking with CNA 3 and LVN 1. CNA 1 stated when Resident 1 saw her, (CNA 1) he pointed at her and stated, that is her, she is trying to kill me, you poisoned the water while pointing to his water pitcher. During an interview on 9/17/2024, at 6:45 a.m., with LVN 1, LVN 1 stated CNA 3 informed her that Resident 1 appeared worried and concerned and was telling CNA 3 someone was trying to poison him. LVN 1 stated she went to assess him, and Resident 1 was alert and oriented and did not appear to be confused. LVN 1 stated Resident 1 calmed down after she explained to him that the CNAs were delivering the new water pitchers and offered to get him a new CNA but Resident 1 declined. LVN 1 stated she medicated Resident 1 with Clonidine (medication to treat high blood pressure {the force of your blood pushing against the walls of your arteries}) for his elevated blood pressure of 179/81 and Tylenol (medication to treat pain) for his headache. LVN 1 stated she felt there was a misunderstanding between her and Resident 1 and not a change of condition that was the reason she did not call Resident 1's doctor for his behavior. During an interview on 9/17/2024, at 7 a.m., with CNA 3, CNA 3 stated when she was passing out water pitchers at approximately 12:00 a.m. on 9/14/2024, Resident 1 verbalized to CNA 3 that another CNA (unknown) was trying to poison him. CNA 3 stated Resident 1 appeared nervous, scared, his hands were shaking, and verbalized repeatedly that a lady was trying to poison him. CNA 3 stated she stayed with Resident 1 to listen to his concerns and then reported his behavior to LVN 1. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 9/17/2024, at 7:25 a.m., with LVN 1, reviewed Resident 1's medication administration record (MAR). LVN 3 stated she gave Resident 1 Tylenol (medication to treat pain) for his headache at 12:18 a.m. and Clonidine (medication to treat high blood pressure at 12:30 a.m. LVN 1 stated it was difficult to obtain Resident 1's blood pressure because he was moving a lot and was pointing at his water pitcher. LVN 1 stated Resident 1 had depression and high blood pressure and when Resident 1 was stating someone was trying to poison him it could have been related to his depression. LVN 1 stated Resident 1 was taking Lexapro for his depression for targeted behaviors of persistent verbalization of sadness. LVN 1 stated when she saw Resident 1, Resident 1 was anxious, worried, and had a lot of concerns (not specified). LVN 1 stated she should have done a COC when Resident 1 had changes with his behavior so they could better monitor him. LVN 1 stated she failed to informed Resident 1's physician when Resident 1 had changes with his behavior. LVN 1 stated they did not do any monitoring but visually checked on him more frequently but did not document it was done. LVN 1 stated Resident 1 was exhibiting delusions when he continued to think that someone was trying to poison him. LVN 1 stated Resident 1 suicide could have been prevented if she would have stayed with Resident 1, called his doctor, and had done 1:1 monitoring (provide one to one nursing or observation care to an individual resident for a period of time) but because he calmed down, she did not think she needed to. During an interview on 9/18/2024, at 11:05 a.m., with SSD, SSD stated knowing a resident's (in general) past medical history was important so you can develop a person-centered care plan. SSD stated she does not review previous notes for those that were previously admitted to the facility because she prefers to do her own assessment of the resident. SSD stated she was made aware by the staff that Resident 1 was admitted to the facility in the past but did not review his previous records. SSD stated she did not complete the PHQ9 or BIMS for Resident 1 because she was busy and did not have time to complete her assessment after seeing him on 9/11/2024. SSD stated her progress note and assessment that she did complete on 9/14/2024 for Resident was based on a one-time interaction (on 9/11/2024). SSD stated she started a note for Resident 1 on 9/11/2024 but did not submit it until 9/14/2024 because she wanted to include her conversation with Resident 1's son. The SSD stated, she should have reviewed Resident 1's progress notes from previous admission to the facility. The SSD stated moving forward she will incorporate review of records to her assessment. The SSD stated, if she would have reviewed Resident 1's previous SSD notes from previous admission, she would have completed her assessments right away when he was admitted , initiated plans for monitoring and assessing, and pushed more for the psychologist to see him. During an interview on 9/17/2024, at 12:24 p.m., with Registered Nurse Supervisor (RNS) 2, RNS 2 stated when CNA 1 informed her that Resident 1 verbalized someone was trying to poison him, she thought it was because Resident 1 was confused. RNS 2 stated she failed to do a COC as she thought Resident 1's delusion was because he was confused. RNS 2 stated she was not aware of Resident 1's behavior of crying spells, shaking his hands, scared, and anxious. RNS 2 stated she was not told by LVN 1 about Resident 1's change in behavior and if she would have known, she would have placed Resident 1 with 1:1 monitoring to keep him safe, call Resident 1's doctor, complete a COC, and transfer Resident 1 to a higher level of care. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 9/18/2024, at 12:30 p.m., with the Director of Nursing (DON), the DON stated it was important to review the resident (in general) past medical history and past admissions records from the facility prior to seeing the resident upon their admission. The DON stated LVN 1 should have done a COC, notified his doctor, and maybe transferred Resident 1 to a higher level of care when he was exhibiting behavior manifested by crying spells, shaking his hands, scared, anxious, and verbalized someone was trying to kill him. The DON stated there was no COC completed for Resident 1, but one should have been done because Resident 1 was not at his baseline and his behavior indicated there was a medical problem occurring. The DON stated the COC was a tool to inform the nurses for what to assess, monitor and plan of care for Resident 1. The DON stated LVN 1 should have assessed and monitor Resident 1 after he exhibited change of behavior because one look at the resident does not provide enough information. The DON stated LVN 1 should have reviewed Resident 1 care plan for Lexapro dated 9/12/2024, which indicated interventions to monitor for changes in behavior, mood, and other adverse reactions to the medication. The DON stated LVN 1should have competencies to implement care plan interventions. During a review of the facility's facility assessment tool, updated 7/31/2024, indicated The purpose of the facility assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain the highest practicable physical, mental, and psychosocial well-being. Services we offer and care we are able to provide is based on the needs of the resident include mental health and behavior: manage the medical conditions and medication, related issues, causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues, such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post-traumatic stress disorder (PTSD- a mental and behavioral disorder that can develop after experiencing a traumatic event), other psychiatric (mental) diagnosis, intellectual and developmental disabilities. During a review of the facility's Charge Nurse Job Description, undated, the job description indicated, Qualifications: Ability to provide patient care in accordance with applicable standards, policies, and procedures; Possess critical thinking skills to analyze, synthesize, and evaluate clinical data and observations in developing a nursing plan of care; Comprehensive knowledge of applicable nursing principles, practices, and standards of care. Duties: Makes daily rounds to interview physical and emotional status and to implement any requires nursing interventions. During a review of the facility's RN Supervisor Job Description, undated, the job description indicated, Duties: Assure that residents have a clean, safe, orderly, and comfortable environment; Ensure that notification is given to the resident's attending physician, as well as the resident's representative, when the resident has a significant change in condition. Supervision: Make resident rounds to ensure appropriate care is being rendered, identifying, and making corrections as necessary; Meet with nursing personnel to assist in identifying and correcting problem areas and/or the improvement of resident care. During a review of the facility's Social Services Coordinator Job description, undated, the job description indicated, Principal Responsibilities: Ensure the residents' psychosocial and concrete needs are identified and met; Assess the psychosocial, mental and emotional needs of residents; Timely and accurate completion of the MDS. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Resident Safety, revised 4/15/2021, the P&P indicated, Residents will be evaluated on admission, quarterly, and whenever there is a change in condition to identify circumstances that pose a risk for the safety and wellbeing of the resident. Any facility staff member who identifies an unsafe situation, practice, or environmental risk factors should immediately notify their supervisor or charge nurse. During a review of the facility's P&P titled, Staff Competency Validation, revised 2024, the P&P indicated, The purpose is to protect the health, safety, and well-being of the residents in care facilities. During a review of the facility's P&P titled, Social Services Assessment, revised 12/1/2013, the P&P indicated, To assist Social Services Staff in obtaining information about the resident in an effort to develop a plan to address psychosocial, concrete and discharge planning needs. The Social Services Assessment will address the resident's physical and psychosocial needs that should be considered in developing the resident's plan of care. The SSD will complete the assigned sections of the Resident Assessment Instrument (RAI) Assessment. For new admissions, the medical record review should include a review of the transfer records and history and physical. Cross Reference F740

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview, and record review the facility's Quality Assurance Performance Improvement (QAPI, a data driven proactive approach to improvement used to ensure services are meeting quality standards) failed to identify resident care issues, develop, implement appropriate plans of action, and evaluate measures necessary to provide behavioral health care and services for the treatment of the resident's emotional and mental condition by ensuring: 1.Resident 1 who had a diagnosis of depression and history of suicidal thoughts from previous admission on 3/10/2024 was assessed, monitored closely and primary care physician notified after observed having crying spells, anxiety (feeling of uneasy and worried), fear and verbalized Certified Nursing Assistant (CNA)1 put poison in his water pitcher on 9/14/2024 at 12:15 a.m. This failure resulted in Resident 1 not receiving the necessary care and services to address Resident 1's mental and emotional health needs and led to Resident 1's death by committing suicide (the act or an instance of ending one's own life voluntarily and intentionally) on 9/14/2024. Findings: During an interview on 9/18/2024, at 11:05 a.m. with Social Services Director (SSD), SSD stated Resident 1 was admitted on [DATE] and she only saw him once on 9/11/2024. SSD stated she did not review Resident 1's previous admission documents from the facility and based her assessment on the current admitted . SSD stated she did not document the Patient Health Questionnaire (PHQ-9, is a depression screening tool) for Resident 1 because she had 7 days to complete the assessment. SSD stated she should have completed her assessment and do frequent checks on Resident 1 behavior, and emotional condition because it could help meet his psychosocial needs. During a review of Resident 1's Nurses Progress Notes, dated 2/8/2024, the Nurses Progress Notes indicated Resident 1 was on monitoring due to hallucination episode, could not sleep because he was experiencing strange things in the room during the night such as pages of a book in his closet flipping by themselves. During a review of Resident 1's PHQ-2-9 questionnaire, dated 2/25/2024, the PHQ 2-9 indicated a score of 10 (a score of 10-14 is moderate depression). During a review of Resident 1's Nurses Progress Notes, dated 2/29/2024, the Nurses Progress Notes indicated a Social Worker met with Resident 1 for verbalization of wanting to die and Lexapro was increased to 20 milligrams ([mg]-unit of measurement). (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/18/2024, at 10:10 a.m., the Minimum Data Set Coordinator (MDSC) stated the SSD was responsible for completing Section D (Mood) of the MDS and should be continuously assessing residents (through observation, interview, and record review) during the Assessment Reference Date ([ARD] marks the end of a seven-day period during which a resident is observed and assessed) from admission. The MDSC stated the SSD should have started Resident 1's assessments upon admission and to have an ongoing resident's assessments during the seven days following admission and not just one visit with the resident. The MDSC stated psychosocial assessments (an evaluation of a resident's mental health, and social well-being) was a part of the residents needs so it was important to conduct the assessments continuously from the time of admission. During a concurrent interview and record review on 9/17/2024, at 7:25 a.m., with LVN 1, Resident 1's medication administration record (MAR) was reviewed. LVN 3 stated she gave Resident 1 Tylenol for his headache at 12:18 a.m. and Clonidine at 12:30 a.m. LVN 1 stated it was difficult to obtain Resident 1's blood pressure because he was moving a lot and was pointing at his water pitcher. LVN 1 stated Resident 1 had depression and high blood pressure, and when Resident 1 was stating someone was trying to poison him it could have been related to his depression. LVN 1 stated Resident 1 was taking Lexapro for his depression for targeted behaviors of persistent verbalization of sadness. LVN 1 stated when she saw Resident 1, he appeared anxious, worried, and had a lot of concerns (not specified). LVN 1 stated she should have done a COC when Resident 1 had changes in his behavior so they could have better monitored him. LVN 1 stated she failed to informed Resident 1's physician when Resident 1 had changes in his behavior. LVN 1 stated they (facility staff) did not do any monitoring but visually checked on him more frequently but did not document it was done. LVN 1 stated Resident 1 was exhibiting delusions when he continued to think that someone was trying to poison him. LVN 1 stated Resident 1 suicide could have been prevented if she would have stayed with Resident 1, called his doctor, and placed the resident on 1:1 (a type of care where a patient is constantly observed by a healthcare professional to ensure patient safety) observation/monitoring but because he calmed down, she did not think she needed to do so. During an interview on 9/17/2024, at 12:24 p.m., Registered Nurse Supervisor (RNS 2) stated when CNA 1 informed her that Resident 1 verbalized someone was trying to poison him, she thought it was because Resident 1 was confused. RNS 2 stated she failed to do a COC as she thought Resident 1's delusion was because he was confused. RNS 2 stated she was not aware of Resident 1's behavior of crying spells, having hands tremor (shaking), feeling scared, and being anxious. RNS 2 stated she was not told by LVN 1 about Resident 1's change in behavior and if she would have known, she would have placed Resident 1 on 1:1 monitoring to keep him safe, call Resident 1's primary physician, complete a COC, and transfer Resident 1 to a higher level of care. During a phone interview on 9/17/2024, at 11:45 a.m., the Psychiatric Nurse Practitioner ([PNP] a registered nurse with advanced training who provides mental health care to residents), stated Resident 1's doctor should have been notified immediately of Resident 1's new behavior when he was observed crying and stating someone was trying to poison him. The PNP stated possible interventions to prevent the resident's suicide would have been closed monitoring of the resident for behavioral symptoms. The PNP stated Resident 1's behavior could have been a delusion when he verbalized somebody was putting poison in his water, a symptom of mental illness, or a symptom of another medical illness. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 1's initial Psychiatric Evaluation (a comprehensive examination of a person's mental, emotional, and behavioral health), dated 9/13/2024, the initial Psychiatric Evaluation indicated Resident 1 was oriented to person, place, and time. The initial Psychiatric Evaluation, under the treatment plan, indicated to observe the resident for deterioration in function, resident was educated to report worsening of symptoms and to report if noted with changes in mood and behavior. Gradual dose reduction ([GDR] a step in tapering a dose of a medication), was contraindicated at this time as it may exacerbate (to make something worse) resident symptoms (not specified). During an interview on 9/20/2024, at 2:30 pm with the Director of Nursing (DON), the DON stated facility were working on fall, pressure injury (damage to the skin or soft tissue caused by prolonged or severe pressure) , and Interdisciplinary Team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) were part of their QAPI program. During a review of QAPI Committee Minutes dated from 6/26/2024 up to 8/28/2024 indicated fall, pressure injury and IDT were being addressed but nothing about the behavioral, psychosocial needs and assessment of residents who have diagnosis of depression and exhibiting change in mood and behavior. During a review of facility's policy and procedure (P&P) titled Quality Assurance and Performance Improvement Program, the P&P indicated the five elements of the facility QAPI are utilized to implement and sustain the QAPI program by the following: 1.Design and scope of the plan will address the full range of services offered by the facility and includes all departments. 2.Guidance and leadership of the facility will seek input from staff, residents, and families. 3.Feedback, data systems and monitoring will be accomplished using performance indicators for a wide range of care processes and findings. The P&P indicated the facility will implement and maintain an ongoing, facility wide Quality Assurance and Performance Improvement Program designed to monitor and evaluate residents' care and methods to improve quality of care.