STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676281	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westover Hills Rehabilitation and Healthcare	9922 State Hwy. 151 San Antonio, TX 78251

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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 - Minimal harm or potential for 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** 26481 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 5 residents (Resident #1) reviewed for care plans. The facility failed to develop a person-centered care plan with interventions that addressed Resident #1's diagnosis of depression and anti-depressant medication Zoloft. This failure could place residents at risk for not having their needs and preferences met. The findings included: Record review of Resident #1's Admission Record (face sheet), dated 11/2/2024, revealed he was admitted to the facility on [DATE], readmitted on [DATE] and discharged on [DATE]. Resident #1 was a [AGE] year-old male with diagnoses which included hemiplegia and hemiparesis following a cerebral infarction (partial weakness and paralysis of one side of the body due to a stroke), dysphagia (difficulty swallowing), dysarthria (speech sound disorder caused by brain damage), and depression (feelings of severe despondency and dejection). Record review of Resident #1's MDS Admission Assessment, dated 07/25/2024, reflected Resident #1 had diagnoses which included stroke and depression. Resident #1's MDS Assessment also reflected a BIMS of 6, indication of severe cognitive impairment. Record review of Resident #1's electronic Physician Orders revealed an order for Trazodone (medication for depression and insomnia) 50 mg 1 tab once a day at bedtime for insomnia with a start date of 07/30/2024, and an order for Zoloft (medication for major depressive disorder) 50 mg 1 tab once a day for depression with a start date of 07/26/2024. Record review of Resident #1's July 2024 MAR revealed he received Zoloft 50 mg 1 tab daily from 07/26/2024 to 07/31/2024, and trazodone 50 mg tab daily from 07/30/2024 to 07/31/2024. Record review of Resident #1's August 2024 MAR revealed he received Zoloft 50 mg 1 tab daily from 08/01/2024 to 08/31/2024, and trazodone 50 mg tab daily from 08/01/2024 to 08/31/2024. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's September 2024 MAR revealed he received Zoloft 50 mg 1 tab daily from 09/01/2024 to 09/30/2024, and trazodone 50 mg tab daily from 09/01/2024 to 09/30/2024. Record review of Resident #1's October 2024 MAR revealed he received Zoloft 50 mg 1 tab daily from 10/01/2024 to 10/31/2024, and trazodone 50 mg tab daily from 10/01/2024 to 10/31/2024. Record review of Resident #1's Care Plans revealed a care plan for Antidepressant medication use r/t [related to] insomnia for medication Trazodone initiated 07/31/2024 and there was no care plan for depression or for the anti-depressant Zoloft. Interview on 11/3/2024 at 4:58 p.m., MDS Nurse A stated she had missed creating a care plan for Resident #1's depression and anti-depressant Zoloft when the medication was ordered. MDS Nurse A said she would look at the order listing reports in the morning to determine if a resident needed to have a new care plan developed. Interview on 11/04/2024 from 3:31 p.m. to 4:10 p.m., the DON stated Resident #1 did not have a care plan for his anti-depressant medication Zoloft or for his diagnosis of depression. The DON said care plans for residents were started with 48-hours of their admission to the facility, and the harm of not having a care plan could result in the lack of continuity of care. Interview on 11/04/2024 from 7:00 PM to 7:40 PM, the Administrator stated a care plan should be initiated when there is a change in a resident's condition or a change in their medications. The Administrator stated morning meetings were held daily to discuss changes in the residents' care and standard of care meetings were held to ensure their care plans would be updated. The Administrator stated the harm of not having a resident's care plan updated could result in the resident missing appointments, treatments, or a variety of other things. Record review of the facility's Comprehensive Person-Centered Care Planning policy, revised 08/2017, revealed It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26481 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 5 residents (Resident #1) reviewed for quality of care, in that: The facility failed to coordinate care with hospice and implement interventions to address Resident #1's mental health needs. Resident #1 was readmitted to the facility with the diagnosis of depression, hospice had communicated to the facility staff that was overheard by ADON C, that the resident had tried to harm himself when he was at home. On 11/01/2024, Resident #1 hung himself with a gait belt attached to the bar in the closet that resulted in his death. An IJ was identified on 11/04/2024. The IJ template was provided to the facility on [DATE] at 8:32 PM. While the IJ was removed on 11/07/2024, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because the facility needed to monitor the implementation of the plan of removal. The failure placed all residents at risk for serious injury, harm, and/or death. The findings included: Record review of Resident #1's Admission Record (face sheet), dated 11/02/2024, revealed he was admitted to the facility on [DATE], readmitted on [DATE] and discharged on [DATE]. The Admission Record did not indicate when he was discharged prior to his readmission 07/19/2024. Resident #1 was [AGE] year-old male with diagnoses which included hemiplegia and hemiparesis following a cerebral infarction (partial weakness and paralysis of one side of the body due to a stroke), dysphagia (difficulty swallowing), dysarthria (speech sound disorder caused by brain damage), and depression (feelings of severe despondency and dejection). Record review of Resident #1's Discharge Summary and Post-Discharge Plan of Care, dated 07/01/2024, revealed the resident received skilled nursing services and hospice services while he was in the facility from 12/31/2023 to 07/01/2024 and was discharged to home on 07/01/2024 with hospice services from Hospice A. Record review of Resident #1's MDS Admission Assessment, dated 07/25/2024, reflected Resident #1 had diagnoses which included stroke and depression, received hospice services, and had a BIMS of 6 out of 15, an indication of severe cognitive impairment. Resident #1's MDS revealed he used a wheelchair for mobility which he could propel 150 feet without assistance; was dependent on staff for toileting and lower body dressing; required substantial/maximal assistance with upper body dressing, putting on/taking off footwear, personal hygiene, sit-to stand, and toilet transfer. Record review of Resident #1's Care Plans revealed a care plan for Antidepressant medication use r/t [related to] insomnia for medication Trazodone initiated 07/31/2024 and there was no care plan for depression or for the anti-depressant Zoloft. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's electronic Physician Orders revealed an order to Admit to Hospice A services with a start date of 07/19/2024. Record review of Resident #1's electronic Physician Orders revealed an order for Activity - Chairbound, can stand for transfers with a start date of 07/19/2024. Record review of Resident #1's electronic Physician Orders revealed an order for DNR/Do Not Attempt Resuscitation [when the heart has stopped beating] with a start date of 07/19/2024. Record review of Resident #1's electronic Physician Orders revealed an order for Use erase [white] board with resident to communicate with a start date of 07/19/2024. Record review of Resident #1's electronic Physician Orders revealed an order for Zoloft (medication for major depressive disorder) 50 mg 1 tab once a day for depression with a start date of 07/26/2024. Record review of Resident #1's electronic Physician Orders revealed an order for Trazodone (medication for depression and insomnia) 50 mg 1 tab once a day at bedtime for insomnia with a start date of 07/30/2024. Record review of Resident #1's electronic Physician Orders revealed an order to monitor anti-depressant targeted behavior with the following codes: 0=no behavior, 1=social isolation, 2=tearfulness, 3=refusal to eat, and 4=other, with a start date of 07/31/2024. Record review of Resident #1's electronic Physician Orders revealed an order for isolation contact/droplet precautions with a start date of 10/29/24. Record review of Resident #1's electronic Physician Orders from 07/19/2024 to 11/01/2024 revealed there were no orders for mental health services. Record review of Resident #1's July 2024 MAR revealed he received Zoloft 50 mg 1 tab daily from 07/26/2024 to 07/31/2024, and trazodone 50 mg tab daily from 07/30/2024 to 07/31/2024, and the anti-depressant targeted behavior monitoring was coded as 0. Record review of Resident #1's August 2024 MAR revealed he received Zoloft 50 mg 1 tab daily from 08/01/2024 to 08/31/2024, and trazodone 50 mg tab daily from 08/01/2024 to 08/31/2024, and the anti-depressant targeted behavior monitoring was coded as 0 every day. Record review of Resident #1's September 2024 MAR revealed he received Zoloft 50 mg 1 tab daily from 09/01/2024 to 09/30/2024, and trazodone 50 mg tab daily from 09/01/2024 to 09/30/2024, and the anti-depressant targeted behavior monitoring was coded as 0 every day. Record review of Resident #1's October 2024 MAR revealed he received Zoloft 50 mg 1 tab daily from 10/01/2024 to 10/31/2024, and trazodone 50 mg tab daily from 10/01/2024 to 10/31/2024, and the anti-depressant targeted behavior monitoring was coded as 0 every day. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Resident Mood Interview PHQ-9 (Patient Health Questionnaire is a nine-item tool that assesses the severity of depressive symptoms) dated 07/23/2024 revealed a score of 0 which could be interpreted as no depression, and was completed by Social Services Staff A. Record review of Resident #1's Social Services Assessment, completed by Social Services Staff A dated 07/23/2024, revealed Resident #1 was pleasant and engaging; alert and oriented to person, place, time, and situation; non-speaking, understood and communicated via white board and hand gestures to make his needs known; was diagnosed with depression with no prescribed medication, no behaviors, no trauma assessed to interfere with his care. Record review of Resident #1's Resident Mood Interview PHQ-9, dated 10/25/2024, completed by Social Services Staff A revealed the resident was feeling tired or having little energy for 7-11 days, and a score of 2 which could be interpreted as minimal depression. Resident #1 responded No to all the other questions which included Feeling bad about yourself, or that you are a failure or have let yourself or your family down and Thoughts that you would be better off dead, or of hurting yourself in some way. Record review of Resident #1's Social Services Assessment, completed by Social Services Staff A dated 10/25/2024, revealed Resident #1 was pleasant and engaging; alert and oriented to person, place, time, and situation; non-speaking, understood and communicated via white board and hand gestures to make his needs known; resident participated in PHQ-9 interview and scored 2, minimal depression, has diagnosed of depression with prescribed Zoloft medication, no behaviors, no trauma assessed to interfere with his care. Record review of Resident #1's Hospice A Binder revealed a Comprehensive Assessment, dated 09/12/2024, with a note from Hospice Social Worker dated 08/08/2024, This [Social Worker] sat in the care plan meeting for Resident #1 at his nursing home. The meeting was attended by Hospice RN A, nursing staff from the facility and facility Social Services Staff A .A review of the [resident's] current medications was discussed along with the erratic behavior that was displayed at home when he returned there recently. It was noted that [resident] is not displaying this degree of violent behavior that was displayed at home when he was . at home. [Resident] has been taking Trazodone at night to assist with his sleeping. [Resident] will be screened for possible psychiatric care at the facility .There were no immediate concerns expressed by the nursing staff. No other actions. Record review of Resident #1's facility Nurses' Note, dated 08/09/2024 by ADON B, revealed Per hospice physician .may refer to psych [psychiatric services] with VA and there was no indication the resident needed to be monitored for behaviors of self-harm or to ensure his environment was free of accident hazards. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Hospice A Binder revealed a Comprehensive Assessment, dated 09/26/2024, p.3 Resident #1 .admitted to Hospice with a DX [diagnoses] of left sided CVA [Cerebral Vascular Accident - stroke], .He resides at Nursing Facility. He is alert and oriented x 3. He was always very angry and unreasonably demanding. Spent 3 weeks at home but family unable to care for him. Meds were started shortly after he arrived to (sic) facility because of heightened emotions and him threatening to harm himself before he left home. He is nonverbal but communicates by writing on eraser [white] board. Since then meds have been effective in calming his behavior .he did ask to be off the Zoloft because 'can't focus'. His family wants him on the meds because they agreed improvement in behavior. Had a care plan meeting at facility and they were going to request VA to have a psychiatric evaluation. It was denied and ADON [did not specify which ADON] asked if the facility can pay for it, Still pending. Record review of Resident #1's Hospice A Binder revealed a Comprehensive Assessment, dated 09/26/2024, p.4, a note from Hospice Social Worker, dated 09/13/2024, This [social worker] met with the patient [Resident #1] just outside of his room. Patient [Resident #1] recognized this [social worker] from previous visits and was alert and oriented x3. He nodded that things were going okay but he wrote on this [social worker's] note pad that he's tired of his depression meds. He also noted that .his new room is working out okay for him. When asked if Family Member A is still visiting him on a regular basis he wrote on the notepad that Family Member A visits him every Tuesday and Thursday. Patient [Resident #1] still stands up next to his wheelchair to stretch .This [social worker] spoke to the patient's [Resident #1] Family Member A . and she said that patient's [Resident #1] mood had been better since he is now on Zoloft .she had no immediate concerns for him at this time . Record review of Resident #1's Hospice A Binder revealed a Comprehensive Assessment, dated 09/26/2024, p.8, a note from Hospice RN A, dated 09/13/2024, Resident #1 sitting in wheelchair. Spoke to MDS Nurse A about update for having psychiatric evaluation .she said she will bring it up in the morning meeting . Record review of the facility's EHR for Resident #1, revealed a Psychotropic IDT note dated 09/18/24 by ADON B, had Resident is not currently on psych services. Record review of Resident #1's Nurses' Note, dated 11/01/2024 by ADON B, revealed at 1520 [3:20 PM] Resident #1 was sitting in doorway in room and waved me over. When I went to see what he needed, he wheeled back in the room and pointed to his tv remote on the floor. I picked it up and gave it to him and he shook his head and smiled and gave me a fist bump. I asked if he needed anything else and he shook his head no, Resident #1 was in good spirits at this time. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Nurses' Note, dated 11/01/2024 at 17:36 [5:36 PM] by LVN H revealed Resident #1 was witnessed in wheelchair in the doorway of his room approximately 10 min [minutes] prior to incident, resident had no c/o [complaints of] pain or discomfort, and no s/s [signs/symptoms] of facial grimacing noted, Resident #1 was in stable condition while sitting in entry way of his room, Resident #1 was his usual self .Hospice CNA A entered the room and communicated resident was noted to be in closet in an upright position with the gait belt noted around his neck. Hospice CNA A alerted CNA PP and CNA GG who alerted this nurse at approximately 1612 [4:12 PM]. This nurse entered room and noticed Resident #1 appeared to be of blue discoloration and hanging from the closet rod with a gait belt noted around his neck. LVN J, ADON B, MA A had followed behind this nurse and assisted Resident #1 to the floor, RN B called 911 at 1613 [4:13 PM], police arrived at 16:18 [4:18 PM], 911 EMS arrived, and medic called time of death at 1623 [4:23 PM] and pronounced by Medical Examiner .this nurse called hospice at 1627 [4:27 PM]. Hospice A notified this nurse that, they would contact resident's Family Member A. Family Member B and Family Member A arrived to (sic) facility approximately 20 minutes later .body was released to medical examiner. Record review of Resident #1's Nurses' Note, dated 11/01/2024 at 16:13 [4:13 PM] by RN B revealed This nurse made call to .911 and they are in route and will arrive shortly. Record review of Resident #1's undated Inventory List revealed no belt or gait belt was on the Inventory List that was signed by Family Member A. Record review of an undated typed Time line (sic) of events on 11/1/24 for Resident #1 provided by the facility revealed Nurse Practitioner A saw Resident #1 at 1500 (3 PM) sitting in doorway to his room. ADON B had seen Resident #1 at 1520 (3:20 PM) sitting in the doorway to his room. LVN H saw Resident #1 in his wheelchair in the doorway to his room approximately 10 minutes prior to the incident. At approximately 1612 (4:12 PM) Hospice CNA A alerted CNA PP and CNA GG who alerted LVN H. EMS was called by RN B at 1613 (4:13 PM). The Administrator was notified at 1615 (4:15 PM). Local police arrived at 1618 (4:18 PM). EMS arrived and medic called time of death at 1623 (4:23 PM) and was pronounced. Hospice A was notified at 1627 (4:27 PM). The Medical Examiner picked up Resident #1 at 1800 (6 PM). The Ombudsman was notified at 2000 (8 PM). The Medical Director was notified at 2002 (8:02 PM). Record review of the statement from CNA BB, dated 11/02/2024, revealed she had last seen Resident #1 on 11/01/2024 sitting in his doorway around 2 PM, she told him she was leaving for the day, and he did not show any signs of depression, pain, or sadness; and the resident had not ever displayed suicidal ideations with his communication board. Record review of the statement from MA B, dated 11/02/2024, revealed she had last seen Resident #1 on 11/01/2024 in his wheelchair around 1345 (1:45 PM), Resident #1 indicated he wanted CNA BB to change him, she did not see any difference in his mood, and he did not show any signs of depression, pain, or sadness; and the resident had not ever displayed suicidal ideations with his communication board. Record review of the statement from CNA PP, dated 11/02/2024, revealed she had last seen Resident #1 on 11/01/2024 at approximately 1400 (2 PM) sitting in his doorway and she assisted with his face mask, his mood was okay, and he did not show any signs of depression, pain, or sadness; and the resident had not ever displayed suicidal ideations with his communication board. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Statement from NP A, dated 11/01/2024, revealed Around 1500 (3 PM) I walked into [the facility] and walked into the ADON's office on the 200 hall. At that time, I saw Resident #1, out of bed and in his wheelchair in the entryway of his room Record review of the statement from LVN F, dated 11/02/2024, revealed she had last seen Resident #1 on 11/01/2024 sitting in his wheelchair in the doorway to his room wearing a mask around 1530 (3:30 PM), he was fine, and he did not show any signs of depression, pain, or sadness; and the resident had not ever displayed suicidal ideations with his communication board. Record review of the statement from ADON C, dated 11/02/2024, revealed she had last seen Resident #1 on 11/01/2024 sitting in his doorway about 20 minutes before the incident, he appeared to be in good spirits and gave her a thumbs up sign, and he did not show any signs of depression, pain, or sadness; and the resident had not ever displayed suicidal ideations with his communication board. Record review of the statement from LVN H, dated 11/02/2024, revealed she had last seen Resident #1 on 11/01/2024 sitting in his doorway in his wheelchair about 10 minutes prior to the event, she did not have an impression of his mood, he had just wanted his routine bolus feeding, and he did not show any signs of depression, pain, or sadness; and the resident had not ever displayed suicidal ideations with his communication board. Record review of Hospice CNA A's undated typed statement revealed she arrived at the facility on 11/01/2024 at approximately 3:50 PM. She gathered towels to give Resident #1 a bed bath, spoke to facility CNA PP who informed her the resident was positive for COVID. Hospice CNA A stopped outside the door to his room to don PPE, then entered the room a little past 4 PM. The first thing I saw was the resident's empty wheelchair facing his closet. When I looked down at the floor, I saw Resident #1's feet. I then went to the door [of his room] and from the door[way] I yelled to the CNA's 'Resident #1 is on the floor!' and they replied 'What?' and again I said, 'Resident #1 is on the floor!' and rushed back towards Resident #1. I said out loud, 'Resident #1's first name, what are you doing on the floor' and that's when I fully arrived to (sic) the closet and saw that Resident #1 had the gait belt around his neck and the gait belt was around the closet bar. I turned around to notify the CNA's, but they had already arrived to the room and I said 'Resident #1 is hanging in the closet'. That's when CNA GG and CNA PP alerted the other facility staff. I exited the room and went to the restroom to call Hospice Staff at 4:14 PM but there was no answer. I then called Hospice RN A at 4:15 PM but there was no answer .So I called Hospice A office at 4:17 PM and I spoke with secretary, and she transferred me to Hospice DCS. That's when I told Hospice DCS about what I had just witnessed with Resident #1 and she said I could go home .After speaking with [Hospice DCS], I attempted to return to the room, but the cops had arrived and stated .that I could not enter. I then went to speak with LVN H at the facility who said she was already speaking with the office staff at Hospice A. So, I left and got in my car at 4:35 PM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/02/2024 from 3:12 PM to 3:25 PM, MDS Nurse A stated Resident #1 would give her a high-five and fist bumps with his hands to her every day. She described his mood as stable, fine and there was nothing to indicate an issue with the resident. MDS Nurse A said Resident #1 was placed on isolation precautions on 10/29/24 or 10/30/24 because he was positive for COVID. MDS Nurse A stated on 11/01/2024 she assisted Resident #1 by placing his shoes on him and the footrests on his wheelchair, he was in good spirits at that time with no indication he was feeling down before she left the facility at 2:55 PM. He gave her a fist pump and thumbs up sign before she left his room. She returned to the facility around 3:45 PM and about 20 minutes later she heard help, ran to where she heard help. MDS Nurse A said when she entered Resident #1's room, other staff were trying to lift him up and get the gait belt off his neck, she assisted with trying to lift him up and get the gait belt off him, he didn't have a pulse and his body was still warm to touch. MDS Nurse A stated she could not think of who the other staff were assisting with lifting Resident #1 up. In a telephone interview on 11/05/2024 at 2:59 PM, LVN H stated on 11/01/2024 she was Resident #1's nurse for the 2 PM to 10 PM shift, and she saw Resident #1 sitting in his wheelchair in the doorway as she sat at the nurses' station around 4 PM. LVN H stated later, at approximately 4:15 PM, she saw Resident #1's hospice CNA and the facility CNAs waved her into his room. LVN H said when she walked into Resident #1's room, he was hanging in the closet with a gait belt around his neck, was bluish in color, and his wheelchair near him and his right leg was under part of the wheelchair. LVN H stated she lifted him up, his neck was bent, the gait belt was around his neck so tight that she could not get a finger underneath the gait belt and was trying to loosen it with one hand while holding the resident with her other arm. Other staff entered the room and assisted her with getting Resident #1 down. LVN H stated she called 911 and hospice who said they would contact Resident #1's family. LVN H said Resident #1 didn't appear to be depressed, and he seemed to be level headed. In a telephone interview on 11/06/2024 at 12:07 p.m., CNA PP stated on 11/01/2024 she saw Resident #1 around 2 PM sitting in the doorway to his room, CNA PP got a mask for him and with the assistance of MDS Nurse A, put his shoes on him, the foot pedals on his wheelchair and he was fine. In a further interview in person on 11/06/2024 at 2:04 PM, CNA PP stated on 11/01/2024 Hospice CNA A went into Resident #1's room to bathe him and came out screaming. CNA PP went into his room and found him in the closet and the CNA went and asked for help. CNA PP said Resident #1 had never expressed he wanted to hurt himself and he did not show any signs of depression to her. Interview on 11/02/2024 from 4:44 PM to 4:59 PM, CNA GG stated she had not seen Resident #1 on 11/01/2024 before the incident, the last time she saw him was on 10/30/2024 and was good that day. CNA GG said on 11/01/2024 Hospice CNA A had entered Resident #1's room, found him on the floor, came out of the room, and yelled for staff to assist her. CNA GG said she and another CNA went into Resident #1's room, she saw him on the floor in the closet with a gait belt around his neck and thought it was attached to the closet bar. She ran out of his room and yelled for a nurse to assist them. CNA GG said Resident #1's wheelchair was by the closet and Resident #1 was leaning toward his left side when she entered the room. (continued on next page)

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	676281	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westover Hills Rehabilitation and Healthcare	9922 State Hwy. 151 San Antonio, TX 78251

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/02/2024 from 5:10 PM to 5:24 PM, LVN J stated she had only cared for Resident #1 a few times when she worked the night shift, he would come out in the hallway to do his sit-to-stand exercises [holding onto the handrail], used his white board to communicate, and would laugh with the CNAs. LVN J stated she was working on another hall on 11/01/2024 on the 2 PM to 10 PM shift and only saw Resident #1 after the incident. LVN J stated she entered Resident #1's room following behind LVN H, along with ADON B and MA A. LVN J stated when she entered Resident #1's room he was hanging by a cloth gait belt in the closet, LVN H was trying to undo the gait belt and lift Resident #1 up but couldn't. MA A had entered the room and assisted the nurses with lifting Resident #1 up, undoing the gait belt and they got him down. LVN H said ADON B had checked for a pulse on Resident #1. Interview on 11/06/2024 at 1:08 PM, MA A stated on 11/01/2024 he was by the medication cart when he heard ADON B call for help. When MA A entered the room, Resident #1 was in the closet dangling by a gait belt face forward [towards the closet] on his knees with his knees touching the floor. MA A stated he and LVN J grabbed Resident #1 and picked him up, ADON B got between them to help lift Resident #1 up. They were all trying to undo the gait belt that was cinched tightly around his neck and cinched tightly to the closet bar. MA A stated he was able to get the gait belt off the closet bar, then they laid Resident #1 down and then they were able to get the gait belt off his neck. Someone yelled to call 911, and shortly after the fire department came followed by the police. MA A stated Resident #1 had never expressed to the MA that he was feeling down or depressed. Interview on 11/02/2024 from 5:25 PM to 5:30 PM, ADON B said she last saw Resident #1 on 11/01/2024 around 3:20 or 3:30 PM when she had gone into her office that was near his room. Resident #1 had gestured for her to come over and pointed to his TV remote that was on the floor. ADON B said she went into his room, picked up the remove for him and he gave her the thumb up sign. ADON B said later she heard staff calling for help, she ran down the hall. When she entered Resident #1's room, she saw him on the floor, she bent down and grabbed his legs, several staff were trying to pick him up, he was hanging with a gait belt around his neck and attached to the bar in the closet. ADON B said she felt Resident #1, his body was warm, asked if he was a DNR and another nurse had called 911 before she entered the room. Interview on 11/02/2024 from 5:40 PM to 5:55 PM, ADON C said on 11/01/2024 she saw Resident #1 twenty minutes before the incident, he was sitting in his doorway with the door open. ADON C said she educated him that the isolation was not going to last long, to keep his mask on when he was in the doorway, and he was in a good mood. ADON C stated she was in the office [near his room], she heard commotion of staff calling for the floor nurse and she came out of the office area, walked into his room, thought the other nurses were trying to get him off the floor and that was when she saw the gait belt around Resident #1's neck and he was hanging from the closet bar. They were all trying to get him off the gait belt, they finally got him loose. ADON C stated when Resident #1 fell between her legs, he didn't have any signs of life at that time, ADON B did sternal rubs to see if there was any sign of life, Resident #1 was not responsive, other staff had called 911 and when the police and EMS arrived, ADON C said she stepped out of the room. Interview on 11/03/2024 from 11:15 AM to 11:19 AM, NP A said Resident #1 was not on her case load. On 11/01/2024 she saw Resident #1 around 1500 (3 PM) when she went into the nursing office near his room. NP A stated Resident #1 was sitting in his wheelchair in the doorway to his room and was waving at people as they walked by him, and he did not appear to be in distress from what she could see from a far. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/03/2024 at 11:34 AM, Hospice CNA A was called with no answer, and she had no voice mail box to leave a message. A text message was sent to the CNA with no response back. Interview on 11/03/2024 from 11:46 AM to 12:00 PM, CNA S said she would not use a gait belt on Resident #1 when she transferred him from his bed to his wheelchair because once he was in a sitting position with his feet on the floor, he could stand up, turn and pivot and sit down in his wheelchair with stand-by-supervision, and was steady most of the time when he was transferred. CNA S stated she saw Resident #1 sitting in his doorway communicating with another CNA on 11/01/2024 around 2 PM before her shift ended and he appeared to be fine at that time. Interview on 11/03/2024 from 12:19 PM to 12:43 PM, Social Services Staff A stated the PHQ-9 assessments were completed by her and the LMSW, it was a way to see if a resident had signs of depression or hopelessness, and scores under 10 were less of a concern than a score above 10, and stated it's always a concern if it's [PHQ-9 score] not a zero. Social Services Staff A said when a resident's PHQ-9 score increases, if the resident was not on any anti-psychotic medication, she would talk to the NP to get a referral for psychiatric services. Social Services Staff A said Resident #1 would use his white board to communicate his answers to the PHQ-9 questions, and his PHQ-9 score increased to a 2 on his 10/25/2024 PHQ-9 assessment because he answered he was feeling tired, having little energy and had answered zero [which was a no] to questions of feeling helpless, depressed, feeling bad about himself, thoughts hurting yourself. Social Services Staff A stated that sometimes feeling tired could be from feeling sick or not feeling their normal energy. Social Services Staff A stated when Resident #1's PHQ-9 score increased to a 2, she didn't think his medications were changed and thought that he might not have been feeling well or was just feeling tired. Interview on 11/03/24 at 4:03 PM, Social Services Staff A said on 10/25/2024, when she asked Resident #1 the PHQ-9 questions and he responded that he was tired, she did not ask him why he was tired, did not ask if he wanted any counseling services or psych services, and did not inform anyone the score had increased. Social Services Staff A said if Resident #1 had responded yes to the self-harm questions, she would have probed further and asked if he wanted any psychiatric services and would notify other staff at that point. Interview on 11/03/2024 at 4:11 PM, the LMSW stated the PHQ-9 assessment score had ranges: 0-4 indicated there was no depression, mild was 5-9, and 10 or above indicated start of moderate depression which was a red flag that something was going on and they would reach out to a health provider at that point. Interview on 11/03/2024 at 5:23 PM, Administrator stated when he went into Resident #1's room after the incident, he saw the gait belt on the floor, it was a light-colored cloth gait belt, and he thought it had writing on it but was not positive. Later when he went back into the room after the police, EMS and medical examiner had left, the belt was no longer in the room. The Administrator said he thought the police or medical examiner had taken it. The Administrator stated the facility switched to a black plastic gait belt sometime during the pandemic and thought it was in 2022 or 2023; and he didn't know where it came from or how long the cloth gait belt had been in Resident #1's room. In a telephone interview on 11/04/2024 at 9:05 AM, Employee A from the Medical Examiner's office stated Resident #1's death was suicide hanging. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 11/04/2024 from 9:21 AM to 9:31 AM, Hospice DCS stated on 11/01/2024 the receptionist received a phone call from Hospice CNA A who was very frantic. Hospice DCS spoke with Hospice CNA A around 4:19 PM who reported the CNA had found one of the residents [Resident #1] who had hung themselves. Hospice CNA A informed her she had gathered the things she needed to give Resident #1 a bath before she entered his room since he was COVID positive. When Hospice CNA A entered Resident #1's room, she found him hanging from a gait belt in his closet, she panicked, ran out of the room yelling for help and she didn't go back into the room because the facility staff went into his room to see what happened. Hospice DCS said she asked for a statement from Hospice CNA A but the CNA indicated she was too upset to speak about it but she did send the Hospice DCS a written statement in an email. In a telephone interview on 11/04/2024 at 10:18 AM, Hospice MD A stated he couldn't remember how long he had been Resident #1's physician, he had recommended a psychiatric consult, but it never was done that he remembered. He did not remember Resident #1 had any thoughts of suicide of history or suicide. Hospice MD A stated he thought the hospice nurse had informed him of the increase in Resident #1's PHQ-9 score that was done on 10/25/2024. In a telephone interview on 11/04/2024 from 11:22 AM to 12:08 PM, Hospice RN A said she had been Resident #1's hospice nurse since he was first admitted to the facility in December 2023 until July 2024 when he went home for 19 days, then he was under the care of another hospice nurse, and she resumed care of him when he returned to the facility on [DATE]. Hospice RN A said when she had Resident #1 from December 2023 to July 2024, he was very demanding, very impatient, it was my way or no way with Resident #1. Hospice RN A stated the VA worked on getting home care for Resident #1 because he wanted to go home so that Family Member A would not be overwhelmed trying to care for him at home. Hospice RN A said it didn't work out for Resident #1 to be at home because Family Member A could not care for him, and the private care giver had quit. Hospice RN A said when Resident #1 was readmitted to the facility in [NAME][TRUNCATED]