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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415085	A. BUILDING _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT ST RITA HEALTH CENTRE	15 SUMNER BROWN ROAD CUMBERLAND, RI 02864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification and Complaints Investigation Survey, ACTS Reference Number 79348, 79201, 79500 was conducted at Mount St. Rita Nursing Home from 05/02/2021 through 05/06/2021 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure and emergency preparedness surveys were also conducted at this facility. During the survey a finding which constituted Immediate Jeopardy was identified under 42 CFR 483.40 F 742 for the failure to ensure that a resident who displays or is diagnosed with a mental disorder of psychosocial adjustment difficulty, or who has a history of trauma, receives appropriate treatment and services to attain the highest practicable mental and psychosocial well-being relative to suicidal ideation's. This failure had the likelihood to result in serious harm, impairment or death. The Administrator was informed of the Immediate Jeopardy and was provided with the Immediate Jeopardy template on 05/04/2021. On 05/04/2021, the Facility submitted an immediate plan to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including re-education of nursing staff and review of other residents with a history of mental illness. On 05/06/2021, an on-site survey was conducted. It was determined that the facility had conducted staff education per their immediate plan. As a result of this survey it was determined the Immediate Jeopardy for F742 was removed as of 05/06/2021. The facility remained out of compliance for F570, F580, F655, F689, and F740.	F 000 5/27/21 MR	RECEIVED MAY 26 2021 FACILITIES REGULATION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William J. Kenny | TITLE: Administrator | (X6) DATE: 5-26-21

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

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F 570 SS=B	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to purchase a surety bond, or otherwise provide assurance for the security of all personal funds of residents deposited within the facility. Findings are as follows: Record review revealed the facility had a surety bond for $30,000.00 effective 11/20/2020. Further record review of the "Mount St. Rita Health Centre Trust" bank statements revealed the following: - Account balance on 4/30/2021 was $63,291.03 - Account balance on 3/31/2021 was $34,574.11 - Account balance on 2/28/2021 was $33,795.58 During a surveyor interview with the Business Office Manager on 5/5/2021 at approximately 12:00 PM, she acknowledged that the surety bond did not cover the total balance of resident funds that were held by the facility from February 2021 through the end of April 2021.	F 570	The filing of this Plan of Correction (POC) does not constitute that the deficiencies alleged did in fact exist, rather this POC is filed as evidence of the facility's continuing commitment to high quality resident care in full compliance with state and federal regulations. In-services have been underway and are ongoing. We are alleging compliance effective June 5, 2021. **As a Plan of Correction (POC) for Tag F F570:** a) There were no residents identified in this tag. b) Although there were no residents identified specifically in this tag, we recognize the potential impact on our resident population. c) The Business Officer Manager resolved the issue effective May 5, 2021, by increasing the amount of the bond to cover the increase account balances (which were increased due to the recent stimulus checks received); this was an unpredictable occurrence that led to the inflated account balances. Moving forward, we will certainly stay alert to any unanticipated increase in account balances and respond appropriately and timely. d) The Business Office (B.O.) Manager is responsible to ensure the surety bond covers the total balance. The B.O. Manager will communicate to the Administrator (NHA) timely in the event there is a discrepancy. The QAPI Committee will also be informed of any further issues related to the surety bond and account balances.	6-5-21
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident;	F 580		

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F 580	Continued From page 2 consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility	F 580	**As a POC for Tag F 580:** a) Residents ID #272 is stable at this time and the MD and Representative are current with the resident's condition and cognitive state. We disagree that this was a change in condition as the resident had verbalized this on a prior occasion; just a few hours earlier, at which time the MD and Representative were notified, and action was taken. b) We have since reviewed all residents who may have had a change in condition so as to ensure timely notification to the MD and Representative. We are responding accordingly. c) We have reviewed our system of identifying and communicating changes in residents' condition; we are making some changes to our reporting and rounding practices as well as Risk meetings so as to better capture even subtle changes in resident condition. The nurses are also being re-educated to conditions or circumstances that would be defined as a change in condition so that they are more aware and comfortable identifying these changes and responding accordingly. The Director of Nursing (DNS)/designee will provide feedback to nurses regarding their assessment of changes in condition and communication to MD and Representative.	6-5-21

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F 580	Continued From page 3 that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to consult with the resident's physician and notify the resident representative of a significant change in the resident's mental status (that is, a deterioration in mental status in either life-threatening conditions or clinical complications), for 1 of 1 resident with suicidal ideation, (thinking about, considering, or planning suicide), Resident ID #272. Findings are as follows: Resident ID #272 was admitted to the facility in April of 2021 with diagnoses including, but not limited to, displaced fracture of base of neck and right femur, vascular dementia with behavioral disturbance, and cognitive communication deficit. Record review of a progress note dated 4/30/2021, revealed the resident expressed that s/he was going to kill him/herself. Record review failed to reveal evidence that the physician was consulted, or that the resident's representative was notified of the resident's significant change in mental status. During a surveyor interview on 5/3/2021 at 3:09 PM with Staff B, Licensed Practical Nurse (LPN), she revealed that she did not notify the physician	F 580	d) The Director of Nurses (DNS)/designee is responsible to implement this plan. The routine rounding and Risk meetings will allow recognition of changes in condition; audits will be conducted to confirm that timely notification has been made to the MD and Representative. The results of the audits will be shared with the QAPI committee. Changes will be made to our plan as needed to ensure compliance. These audits will be done for no less than 3 months after which time, the QAPI Committee will determine the need to continue the plan based on our results and compliance. MR 5/27/21	

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F 580	Continued From page 4 of the resident's change in condition. During a surveyor interview on 5/4/2021 at 10:46 AM, with the physician, she revealed that neither she, nor her nurse practitioner, were aware of the resident's above statement.	F 580		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655 NR 5/27/21	**As a POC for Tag F 655:** a) Resident ID #272 is currently stable, and the care plan has been revised to include the concern regarding suicidal ideation. b) We have since reviewed the care plans of other residents who may have a change in condition that requires a care plan update and have made the appropriate updates. This is ongoing. c) We have provided education to the nurses related to changes in condition that require a revision to the care plan timely. We have since reviewed our internal systems associated with identification of changes in condition and updating care plans timely. We are making some changes with those work processes, which will allow for a timelier notification of changes and update to the care plan. The DNS/designee will monitor these revised internal work processes to ensure effectiveness of our new plan. d) The Director of Nurses (DNS)/designee is responsible to implement this plan.	6-5-21

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F 655	Continued From page 5 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to revise the baseline care plan for 1 of 1 sample residents with suicidal ideation, Resident ID #272. Findings are as follows: Record review for Resident ID #272 revealed that s/he was admitted in April of 2021 with diagnoses including, but not limited to, displaced fracture of base of neck and right femur, vascular dementia with behavioral disturbance, and cognitive communication deficit. Clinical record review revealed a 4/19/2021 progress note indicating that the resident was transferred to the 2 South unit at approximately 3:45 PM. Upon arrival the resident stated that s/he was going to jump out of the window. The physician was called and requested that s/he be transported to the hospital for a change in mental status. S/he was transported at 6:00 PM, kept overnight for observation and returned to the facility the following day.	F 655 MR 5/27/21	The routine rounding and Risk meetings will allow for optimal recognition of changes in condition; audits will be conducted to confirm that timely revisions to care plans are being made. The results of the audits will be shared with the QAPI Committee. Changes will be made to our plan as needed to ensure compliance. These audits will be done for no less than 3 months after which time, the QAPI Committee will determine the need to continue the plan based on our results and compliance.	

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F 655	Continued From page 6 A review of the hospital discharge instructions reveals that the resident "came in today because [s/he] has been reportedly attempting to harm [him/herself] by threatening to jump out of the window." Further clinical record review revealed a progress note written on 4/30/2021 at 2:44 PM, indicating the resident was found trying to open the window in his/her room at 7:45 AM. When asked what s/he was doing, the resident replied that s/he tried to open the window and jump out. A 4/30/2021 progress note written at 10:33 PM indicated the resident became agitated at approximately 10:00 PM and stated s/he was going to kill him/herself. A 5/3/2021 progress note written at 10:16 PM revealed that the resident was very agitated. A subsequent progress note written at 11:08 PM clarified that the resident had refused dinner, became combative, and said s/he wanted to die. Surveyor review of the resident's admission baseline care plan failed to reveal evidence of a revision to the care plan to include interventions for suicidal ideation. The suicidal ideation interventions were not added to the resident's care plan until 5/3/2021. During a surveyor interview on 5/4/2021 at 1:55 PM with the Director of Nursing Services, she could not provide evidence that a care plan for suicidal ideations was initiated for this resident until 5/3/2021.	F 655	MR 5/27/21	

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F 689	Continued From page 7	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, staff and family interview, it has been determined that the facility failed to ensure that each resident receives adequate supervision to prevent accidents for 1 of 1 resident reviewed with suicidal ideations, Resident ID #272. Findings are as follows: Review of the facility policy titled, "Suicide Precautions," states in part, "When a Resident expresses verbally or through behavioral symptoms, the thought that he/she no longer wishes to live and that he/ she will terminally harm themselves, the facility must initiate suicide precautions... 1. The facility will maintain a one-on-one relationship with the resident. The resident will not be left alone when actively suicidal... 7. The staff will report no less than hourly any observed behavior changes to the charge nurse of the unit. Intervals of greater frequency, such as every 15 minutes, may be required and will be determined by the charge nurse.	F 689 MR 5/27/21	**As a POC for Tag F689:** a) Resident ID#272 is currently stable. We disagree that adequate supervision was not provided to prevent accidents; as evidenced by, there was no accident that occurred based on our response to the verbalizations of this resident. b) Upon review of residents' condition and current status, we have not identified any issues associated with a potential for accident hazards or accidents. We will continue to monitor this on an ongoing basis. c) Our nursing management team will have an increased sense of awareness related to potential resident-related issues associated with accidents and hazards; especially as it relates to verbalizations of ideas and/or intentions to harm oneself. During our routine rounding and shift to shift report, we will have a heightened focus on potential risks associated with accidents and hazards and respond accordingly if necessary. The nursing management team will also have discussion on such risks at our Risk meetings. The nursing team are being re-educated regarding the importance of effective communication of any resident changes in condition.	6-5-21

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F 689	Continued From page 8 8. The charge nurse will chart behaviors in the nursing notes and reassess as needed. 9. The suicide precautions will remain in effect until the physician or psychological consult releases the precautions..." Record review for Resident ID #272 revealed that s/he was admitted in April of 2021 with diagnoses including, but not limited to, displaced fracture of base of neck and right femur, vascular dementia with behavioral disturbance, and cognitive communication deficit. Review of the admission Minimum Data Set (MDS), dated 4/19/2021, reveals that the resident has severe cognitive impairment. During a surveyor interview with the resident's family member/Healthcare Power of Attorney (HPOA) on 5/3/2021 at 1:55 PM, she revealed that it was reported to her that the resident expressed wanting to jump out of the window, which she found concerning. Record review revealed that on 4/19/2021, the resident stated that s/he was going to jump out of the window. The resident was sent out to the Emergency Department for threatening to harm himself/herself and returned to the facility on 4/20/2021. Further record review revealed that on 4/30/2021 at approximately 7:45 AM, the resident was observed trying to open the window and stated s/he wanted to jump out. The resident was evaluated by Nurse Practitioner, Staff A. On 4/30/2021 at approximately 10 PM, the resident	F 689 MR 5/17/21	d) The Director of Nurses (DNS)/designee is responsible to implement this plan. The routine rounding and Risk meetings will allow for optimal recognition of changes in condition; audits will be conducted to confirm proper response to risks associated with accidents and hazards to residents. The results of the audits will be shared with the QAPI committee. Changes will be made to our plan as needed to ensure compliance. These audits will be done for no less than 3 months after which time, the QAPI Committee will determine the need to continue the plan based on our results and compliance.	

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F 689	Continued From page 9 stated that s/he "was going to kill... [himself/herself] ..." During a surveyor interview with Nurse, Staff B, on 5/3/2021 at 3:09 PM, she acknowledged that she was working on the night of 4/30/2021 when the resident stated s/he "was going to kill... [himself/herself]." Additionally, she revealed that the resident was not put on one-to-one supervision and she was unaware of the facility's "Suicide Precautions" policy. During a surveyor interview with the Director of Nursing Services and the Administrator on 5/4/2021 at 1:55 PM, they could not provide evidence that the resident received adequate supervision in accordance with the facility "Suicide Precautions" policy when the resident presented with suicidal ideations on 4/30/2021.	F 689		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on surveyor record review and staff interview, it has been determined that the facility failed to ensure each resident receives the	F 740 MR 5/27/21	**As a POC for Tag 740:** a) Resident ID#23 has since had a psychiatric consult on May 13, 2021 with orders for medication changes to be made. The resident was not assessed to have an urgent need for these services; it was on the care plan as a consideration when needed. b) We have since reviewed all residents who may be in need of psych services so that we may ensure appropriate follow through for any residents in need of these services. *It should be noted that it is a well-known fact in the state of RI that psychiatric services are exceedingly difficult to ascertain for our long-term care residents. It is an industry wide issue; we are doing our best to the degree we have control over the response time of these outside consultants.*	6-5-21

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F 740	Continued From page 10 necessary behavioral health care and services to attain the highest practicable mental and psychosocial well-being relative to 1 of 10 residents reviewed for behavioral health services, Resident ID #23. Findings are as follows: Record review revealed that Resident ID #23 was admitted to the facility in December of 2020 with diagnoses including but not limited to: nondisplaced fracture of the left lower leg, osteoarthritis, hearing loss, and muscle weakness. Review of the resident's care plan, last updated on 3/09/2021, revealed being at risk for depressed mood. Interventions added on 1/18/2021 include to arrange for a psychiatric consult with follow up as indicated and to monitor, document, and report any signs or symptoms of depression. Review of a social services quarterly progress note dated 3/01/2021 revealed that the resident's Brief Interview for Mental Status indicated s/he was cognitively intact and the Patient Health Questionnaire scale indicated resident is moderately to severely depressed. This progress note also indicated that the resident reported feeling fatigued, down and depressed. Review of a social services progress note dated 5/05/2021 revealed that the resident reported feeling down and that the care plan will be maintained through the next review date. Record review revealed that a psychiatric consult was never obtained for the resident since his/her	F 740	c) Our Director of Social Services will follow up with all residents who are in need of psychiatric consultation so as to ensure these residents are stable and not experiencing a negative outcome due to any unforeseen delay in receiving these services. We have spoken with our contracted psych service to emphasize the importance of timely response to our requests for psych consultation for our residents; our Medical Director is also aware of the challenge and is working with us to find a solution. Any residents with an urgent need will be reported to the Attending Physician for further treatment orders. d) The Director of Social Services/designee will be responsible to monitor this issue and communicate to the DNS any delays in psych services for those residents in need. This information will also be shared with the QAPI Committee for any necessary follow up or action plans. We will monitor this for no less than the next 3 months after which time, the Committee will review the situation and determine the need to continue our tracking based on the response of psych services.	

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	415085	A. BUILDING _____ B. WING _____	05/06/2021

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F 740	Continued From page 11 admission date. During a surveyor interview with the Director of Nursing Services on 5/06/2021 at 12:55 PM, she was unable to provide evidence that a psychiatric consult was ever ordered or obtained for the resident.	F 740		
F 742 SS=J	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review, staff and family interview, it has been determined that the facility failed to ensure that a resident who displays or is diagnosed with a mental disorder of psychosocial adjustment difficulty, or who has a history of trauma, receives appropriate treatment and services to attain the highest practicable mental and psychosocial well-being relative to 1 of 1 resident reviewed for suicidal ideations, Resident ID #272. Findings are as follows: Review of the facility policy titled, "Suicide Precautions," states in part, "When a Resident	F 742 MR 5/27/21	**As a POC for Tag F742:** ***Please refer to the DPOC previously written and sent to the facility.*** In accordance with Federal regulations at 42 CFR §488.424, a DPOC is imposed on the facility. The DPOC is as follows: Starting immediately upon receipt of this enforcement letter, The Infection Preventionist and Director of Nursing, in conjunction with the Medical Director, and senior leadership/Governing Body concurrence, shall complete the following: - The facility must retain , at its own expense, a third-party consultant, acceptable to RIDOH, to assist the facility with recent Behavioral Health Services	6.5.21

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F 742	Continued From page 12 expresses verbally or through behavioral symptoms, the thought that he/she no longer wishes to live and that he/ she will terminally harm themselves, the facility must initiate suicide precautions... 1. The facility will maintain a one-on-one relationship with the resident. The resident will not be left alone when actively suicidal. 2. The facility will notify the physician and obtain an order for a psychological consult. The physician's orders will be implemented. IF the resident is in immediate danger to self or others, the facility will proceed with an emergency transfer (911). 3. The facility will notify the resident's family or legal representative of behavior changes and request them to come in to offer support... 7. The staff will report no less than hourly any observed behavior changes to the charge nurse of the unit. Intervals of greater frequency, such as every 15 minutes, may be required and will be determined by the charge nurse. 8. The charge nurse will chart behaviors in the nursing notes and reassess as needed. 9. The suicide precautions will remain in effect until the physician or psychological consult releases the precautions..." Record review for Resident ID #272 revealed that s/he was admitted in April of 2021 with diagnoses including, but not limited to, displaced fracture of base of neck and right femur, vascular dementia with behavioral disturbance, and cognitive	F 742	and Quality of Care issues identified on survey . This consultant must be present at the facility at a minimum of 8 hours per week. Such consultant shall be retained for a minimum of 4 months, consulting at least weekly for the first four months and then monthly thereafter. - Conduct a root cause analysis ("RCA") by the ICP, QAPI Committee, and Governing Body. Detailed documentation of the RCA will be completed. Please note an acceptable and effective RCA will include the following elements: Identify the root cause resulting in the facility's failure. This includes asking the Who, What, Where, When, and Why questions which can be done by conducting internal investigations; Develop solutions and systemic changes that need to be taken to address the root cause; and Implement the solution. The RCA should focus on behavioral health services in the facility. The RCA should be completed by 05/19/2021. - A QAPI should focus on behavioral health services in the facility. This shall be completed by 5/19/2021.	

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F 742	Continued From page 13 communication deficit. Review of the admission Minimum Data Set (MDS), dated 4/19/2021, reveals that the resident has severe cognitive impairment. Review of the Trauma Informed Care Assessment, dated 4/21/2021, reveals that the resident has had exposure to a warzone and has witnessed the following: a natural disaster, captivity, life-threatening illness or injury, and sudden/violent death. Review of the resident's care plan reveals the following: - Initiated 4/19/2021: Agitation at times related to skilled nursing facility admission and desire to return home. Monitor/record/report to doctor mood patterns of signs/symptoms of depression and anxiety as needed. "Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.)" - Initiated 4/19/2021: Resident was in the Navy and lost many peers while oversees and mentions negative experiences in unrelated conversation. Place referral for consult with psych practitioner, provide 1:1 support as indicated. - Initiated 4/19/2021: the resident continues to grieve the loss of friends. S/he is the "only one left." Provide 1:1 support as indicated, refer/order consult for psychiatry. - Initiated 4/26/2021: Use of antidepressant medication (Trazodone) related to agitation and restlessness. Monitor/document/report adverse reactions as needed such as suicidal thoughts.	F 742	MR 5/27/21	

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F 742	Continued From page 14 During a surveyor interview with the resident's family member/Healthcare Power of Attorney (HPOA) on 5/3/2021 at 1:55 PM, she revealed that she was worried about the resident's depression. Furthermore, she indicated that the resident does not seem to be happy at the nursing home and that s/he has become more agitated/aggressive since his/her admission. Additionally, she revealed that it was reported to her that the resident expressed wanting to jump out of the window, which she found concerning. Review of a progress note, dated 4/19/2021 at 5:00 PM, revealed that upon entering the resident's room s/he stated, "I am going to jump out the window and kill everyone..." Of note, the resident resides on the second floor of the nursing home. Further record review revealed that the resident was sent out to the hospital on 4/19/2021, after threatening to jump out the window. Review of the hospital discharge instructions, dated 4/19/2021, states in part, the resident "came in today because ... [s/he] has been reportedly attempting to harm... [himself/herself] by threatening to jump out of the window..." Further record review revealed that the resident returned to the nursing home on 4/20/2021. Review of the resident's care plan failed to reveal that interventions were put into place for the suicidal ideations until 5/3/2021. Review of a progress note, dated 4/30/2021 at 2:44 PM, states in part, the resident "was found	F 742	MR 5/27/21	

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F 742	Continued From page 15 standing in front of the window in... [his/her] room this morning at 7:45 am trying to open the window..." Additionally, it indicates that when staff inquired, the resident told staff that s/he tried to open it and jump out. Review of a progress note by Nurse Practitioner (NP), Staff A, dated 4/30/2021 at 3:24 PM, revealed that she was notified by the nurse that the resident was in his/her room by the window attempting to open it and stated that s/he wanted to jump out. The NP ordered a psychiatry evaluation at this time. Further review of a progress note by Nurse, Staff B, dated 4/30/2021 at 10:33 PM, states in part "around 10pm... [s/he] became agitated saying... [s/he] was going to kill... [himself/herself] ..." During a surveyor interview with Nurse, Staff B, on 5/3/2021 at 3:09 PM, she acknowledged that she wrote the progress note above, indicating that the resident stated that s/he was going to kill himself/herself. Additionally, she revealed that the resident was not put on one-to-one supervision and she was unaware of the facility's "Suicide Precautions" policy. Furthermore, she acknowledged that the physician was not notified of the resident's suicidal ideations. Record review failed to reveal evidence that the resident's physician or family were notified of the suicidal ideation statement made by the resident on 4/30/2021 at approximately 10:00 PM. During multiple surveyor observations on both 5/2/2021 and 5/3/2021, the resident was sitting in his/her room with no staff present.	F 742	MR 5/27/21	

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F 742	Continued From page 16 During further surveyor observations on 5/3/2021 at 3:00 PM and 5/4/2021 at 8:47 AM, there were multiple cords noted in the resident's room. Additionally, on 5/4/2021 at 8:34 AM, the resident was noted to have regular silverware with breakfast. During a surveyor interview with Nursing Assistant, Staff C, on 5/3/2021 at 3:01 PM, she indicated that the resident has mentioned wanting to kill himself/herself previously; however, she acknowledged that the resident is not provided one-on-one supervision and that they do not document when they check on the resident. Review of a progress note by the social worker, dated 5/2/2021 at 10:41 AM, revealed the social worker was aware of the resident's statement and attempt to open the bedroom window. Additionally, it indicates that the resident was placed on the list for a psychiatry consult and that she would contact psychiatry services to obtain an emergent consult. Further record review failed to reveal evidence that the facility attempted to obtain a psychiatry consult on 4/30/2021 or 5/1/2021, after the resident presented with suicidal ideations on 4/30/2021. Additionally, there is no evidence that the resident was seen by psychiatry services at the facility since admission. Review of the progress note by the social worker, dated 5/3/2021 at 7:33 PM, revealed that she spoke with psychiatry services who "Requested implementation of 15 minute safety checks until psych [psychiatry] consult on 5/5. Recommended... [resident] is sent out for eval [evaluation] if bx's [behaviors] worsen and	F 742	MR 5/27/21	

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F 742	Continued From page 17 presents an immediate threat to self and others..." There is no evidence that the facility implemented scheduled checks for this resident from 4/30/2021 at 10:00 PM, upon resident's statement that s/he was going to kill himself/herself until 5/3/2021 at 4:30 PM, when recommended by psychiatry services. Review of a progress note, dated 5/3/2021 at 11:08 PM, revealed that the resident refused dinner saying that s/he wanted to die. Additionally, it reveals that the resident got "very combative" and told one staff member that s/he was going to shoot her. Further record review revealed that the resident was medicated with Trazodone and remained in the facility. Review of a physician progress note dated 5/4/2021 at 11:18 AM, states in part, "Patient has had delirium, agitation, also SI [Suicidal Ideation] statement...Trazodone started for restlessness and anxiety. Likely needs baseline antidepressant. Psych services has not seen... [him/her]..." Further review revealed that the resident was started on Zoloft (an antidepressant medication). The facility failed to implement their "Suicide Precautions" policy which includes notification of the physician and one-on-one supervision until cleared by a physician or psychological consult. Record review revealed that the resident was not seen by the physician until 5/4/2021 and a psychological consult did not occur until 5/5/2021, putting the resident at immediate risk related to his/her suicidal ideations.	F 742	MR 5/27/21	

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F 742	Continued From page 18 During a surveyor interview with the Director of Nursing Services and the Administrator on 5/4/2021 at 1:55 PM, they could not provide evidence that the resident received appropriate treatment and services to attain the highest practicable mental and psychosocial well-being when the resident presented with suicidal ideations on 4/30/2021.	F 742		

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