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
	465082	A. BUILDING ____ B. WING ____	C 1/31/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW CARE CENTER	1053 WEST 1020 SOUTH PROVO, UT 84601

MAR 06 2003
3-5-03

(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) COMPLETE DATE
F 224 SS=J	483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.) This REQUIREMENT is not met as evidenced by: Based on interviews and medical record review, it was determined that the facility neglected to assess, monitor, report and intervene with a significant change in a residents' mental status. Subsequently, the resident died of a polydrug overdose that was "certified as suicide" by the medical examiner. Resident 1 was admitted to the facility on 1/8/02. Resident 1 had a verifiable serious mental illness of Major Depression, recurrent, moderate. On 11/8/02, nurses notes documented that resident 1 was crying and yelling in the hallway. At that time, resident 1 yelied "I'm going to hoard my pain pills and take them all at once!" On 11/23/02, resident 1 expired in the hospital. Interviews with facility staff during this investigation from 1/27/03 through 1/31/03 revealed that prior to and after resident 1 made this suicidal threat, she was experiencing a major life change and extreme mental distress. There was no evidence that the facility assessed her mental status after she declared her intention on 11/8/02. There was no evidence that facility staff who had knowledge of the suicidal threat, notified the attending physician, the facility's social service worker (SSW), the licensed clinical social worker (LCSW) consultant or other administrative staff.	F 224 OK 3-10-03	This letter is to serve as our letter of credible allegation of compliance for our immediate jeopardy tags. We have addressed the issues that you shared with us during your exit conference. The decision point of asking if the same circumstances presented today would the facility respond in the same way is the gage we are using to judge ourselves and we feel as of noon today the answer to that question is no. We feel like no resident was in immediate jeopardy as of Saturday February 1, 2003 but our mandatory in servicing was not completed until noon on Monday February 3, 2003. The particular aspects of our actions taken to date are as follows: 1. The facility contracted with a consultant MSW to do in servicing to the entire staff on signs and symptoms of emotional trauma and suicide precautions. 2. The consultant MSW reviewed our current policy and procedure to ensure proper coverage. 3. The consultant MSW reviewed the charts of residents with a diagnosis of depression. 4. The consultant MSW has committed to increased time in the facility to ensure ongoing compliance, and is following those residents needing a level two-passar screen. 5. The consultant MSW is co signing the facility social worker's notes to help identify training needs.	

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

See attached for a signed copy of the POC

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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FORM APPROVED
2567-L

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F 224 SS=J	483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.) This REQUIREMENT is not met as evidenced by: Based on interviews and medical record review, it was determined that the facility neglected to assess, monitor, report and intervene with a significant change in a residents' mental status. Subsequently, the resident died of a polydrug overdose that was "certified as suicide" by the medical examiner. Resident 1 was admitted to the facility on 1/8/02. Resident 1 had a verifiable serious mental illness of Major Depression, recurrent, moderate. On 11/8/02, nurses notes documented that resident 1 was crying and yelling in the hallway. At that time, resident 1 yelled "I'm going to hoard my pain pills and take them all at once!" On 11/23/02, resident 1 expired at the hospital. Interviews with facility staff during this investigation from 1/27/03 through 1/31/03 revealed that prior to and after resident 1 made this suicidal threat, she was experiencing a major life change and extreme mental distress. There was no evidence that the facility assessed her mental status after she declared her intention on 11/8/02. There was no evidence that facility staff who had knowledge of the suicidal threat, notified the attending physician, the facility's social service worker (SSW), the licensed clinical social worker (LCSW) consultant or other administrative staff.	F 224	This letter is to serve as our letter of credible allegation of compliance for our immediate jeopardy tags. We have addressed the issues that you shared with us during your exit conference. The decision point of asking if the same circumstances presented today would the facility respond in the same way is the gage we are using to judge ourselves and we feel as of noon today the answer to that question is no. We feel like no resident was in immediate jeopardy as of Saturday February 1, 2003 but our mandatory in servicing was not completed until noon on Monday February 3, 2003. The particular aspects of our actions taken to date are as follows: 1. The facility contracted with a consultant MSW to do in servicing to the entire staff on signs and symptoms of emotional trauma and suicide precautions. 2. The consultant MSW reviewed our current policy and procedure to ensure proper coverage. 3. The consultant MSW reviewed the charts of residents with a diagnosis of depression. 4. The consultant MSW has committed to increased time in the facility to ensure ongoing compliance, and is following those residents needing a level two-passar screen. 5. The consultant MSW is co signing the facility social worker's notes to help identify training needs.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marian Lindeller (signature) TITLE: Administrator (X6) DATE: 2/28/03

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F 224	Continued From page 1 There was no evidence that the one staff member who identified resident 1 with severe depression the night prior to the suicide had notified anyone or intervened. There was no documentation to evidence that facility staff were monitoring the mental status of resident 1. There was no documentation to evidence that facility staff attempted to intervene when resident 1 was identified with extreme mental distress and voiced a specific suicidal threat. In addition, once the facility became aware that resident 1 committed suicide, they failed to investigate the events surrounding her death. The facility's failure to assess, monitor, report and intervene with resident 1 led to a determination of Immediate Jeopardy for neglect. The facility was found to have removed the immediate jeopardy on 2/3/03. Also, during the survey, no other residents were found to have psychological problems of an immediate nature which were not being addressed by the facility. Findings include: 1. Resident 1 was a 59 year old female who was admitted to the facility on 1/8/02 with the diagnoses of pneumonia, chondrodystrophy, fibromyalgia, osteoarthrosis, arthropathy and diabetes. Resident 1 also had a verifiable serious mental illness of Major Depression, recurrent, moderate. The medical record of resident 1 was reviewed during all days of survey, 1/27/03 through 1/31/03. The admission psychosocial assessment, dated 1/20/02, documented that prior to her admission to the nursing home, resident 1 had been living with her 94 year old mother "for many years." It also	F 224	6. The facility has taped and held in-services from the county mental health services. The in-services were to help with access and to identify needs for referrals. 7. The county mental health services reviewed the policy and procedure to ensure that their proper numbers were in place. 8. The county has in serviced the entire staff. 9. The facility has reviewed three months of charting to ensure that no other notations of suicide ideation. None was found. 10. The facility reviewed the plans of care for residents with a diagnosis of depression; to ensure proper care plan approaches were included. 11. The results of the chart audit and in-services have been reviewed by the facility practices committee for development of further action plans. 12. The facility staff has been given competency testing over protocols for suicide prevention. 13. The facility has posted important numbers and standard protocols for emotional distress recognition and intervention.	

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F 224	Continued From page 2 documented that the siblings of resident 1 were "concerned with the effort her mother has had to expend, which has been detrimental to her own health, to care for [resident 1]. According to her family, [resident 1] has not moved from the couch for over a year. They reported that her mother slept at the end of the couch so [resident 1] could awaken her to meet her needs or reposition herself by pushing against her body." It should be noted that resident 1 and her mother were admitted to this same nursing home on the same day (1/8/02) and shared the same room until 11/7/02. The preadmission screening resident review for serious mental illness (PASRR), level 2, was completed on 1/23/02 and documented that resident 1 was "very dependent on 94 year old mother...appears preoccupied with parent to exclusion of others". Another part of this report documented "She describes sad feelings, withdrawl behaviors, lack of sleep, poor interaction with others, increased anger...Tends to only want to interact with her mother. Relationship appears to be symbiotic." A social service note, dated 11/5/02, documented "Update - several staff members expressed concerns re: [resident 1's] increasing demands on her mother/rm mate - felt [resident 2] was becoming increasingly tired and upset by [resident 1's] continual 'instructions'. Social services will contact guardian (son of resident 2), to pass on concerns and room options for her mother." A social service note, dated 11/6/02, documented an "update" regarding the son of resident 2 and his wife which noted that "both stated they had become increasingly frustrated with [resident 1's] verbalizations - They stated they had recently told	F 224	14. The administrator and social services have been given in-services by the MSW on recognition of emotional distress. 15. The standard in-service calendar has been adapted to include quarterly training on emotional distress and suicide precautions. 16. The facility medical director has consulted with us to ensure proper medical interventions for residents with emotional distress or suicide ideation. We feel the above actions have adverted any negative affect on our residents. The resident complaint under your investigation is continuing to ensure that this resident can continue to help us understand how systems would help to avoid this circumstance. A consultant physician with expertise in mental health has been contacted to review this chart, due to the questionable death certificate.	

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F 224	Continued From page 3 [resident 1] if she continued to 'upset mom' or give her commands they would move [resident 2] to either another room or another facility...Other DEPT. (department) heads who had experienced the frequent demanding/upsetting interaction between [resident 1] and [resident 2] also felt it would be in [resident 2's] best interest." On 11/7/02, resident 2, the 95 year old mother of resdient 1, was moved to a different room in the facility. A social service note, dated 11/7/02, documented "Social services explained to [resident 1] that it was her own behavior with the tx (treatment) of her mom that resulted in the move rather that everyone being 'hateful' as she had accused - [Resident 1] requested a visit with her mother that instantly had both [resident 1] and [resident 2] sobbing and [resident 1] making suggestions to [resident 2] about death and killing people..." A note in the medical record of resident, written by nurse A, dated 11/8/02, documented "...Pt. (patient) requesting to eat lunch in DR (dining room). SSW instructed nsg (nursing) to discourage pt d/t (due to) directives to separate [resident 1] and [resident 2] When nurse approached [resident 1], pt began crying, yelling in hallway. Assisted back to room, lips et (and) mouth cyanotic. Refused 02 (oxygen). 'I'm going to hoard my pain pills and take them all at once! One way or another I'm going to get my mama back.' Witnessed taking all meds." A nurse's note, dated 11/23/02 at 7:00 AM, documented "Pt was found at 0645 (6:45 AM) unconscious. Not breathing et no pulse...EMS (emergency medical services) left the care center with	F 224 OK 3/10/03 LB	F 224 Resident number 1 was no longer in the facility at the time of this complaint investigation. Residents with a change in psychosocial well-being have the potential to be affected. A complete chart audit was done for the previous three months to determine if any other residents were in need of acute intervention, none was found. The policy and procedure for assessing, monitoring, and reporting changes in mental well-being was reviewed and re-in serviced to the entire staff. Competency testing on the policy was done on a random basis to ensure education was effective. The contracted LCSW held in-services on the emotional distress and interventions and the local mental health organization in serviced employees on how to access and recognize the need for interventions. The last month of 24-hour reports were reviewed to ensure that residents were being identified with emotional distress and interventions taken. The DON, ADM, and Social Worker were re in serviced on the emotional needs and identification of distress in the nursing home client.	

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F 224	Continued From page 4 the pt at 0720 (7:20 AM)." A letter from the medical examiner's office, dated 12/20/02, addressed to resident 2 (the mother of resident 1) stated "Investigation by our office and law enforcement personnel has determined the [resident 1] died as a result of a polydrug overdose. The manner has been certified as suicide." During review of the nurse's notes from 11/8/02 to the day resident 1 died on 11/23/02, there was no documentation to evidence that facility staff notified the attending physician, the facility's social service worker (SSW), the licensed clinical social worker (LCSW) consultant or other administrative staff of the suicidal threat. There was no evidence that facility staff assessed her mental status after resident 1 declared her intention on 11/8/02 to hoard all her pain pills and take them all at once. There was no documentation to evidence that facility staff sought any type of mental health consultation for resident 1 to address the suicidal threat. Based on review of the facility's November 2002 nursing schedule, there were ten nurses who worked with resident 1 from 11/8/02 through 11/23/02. During interviews with all ten nurses (beginning on 1/27/03 and ending 2/3/03), it was discovered that 7 of the nurses denied any knowledge of the suicidal threat voiced by resident 1. During the interviews, it was determined that none of the three remaining nurses, who stated they were aware of the suicidal threat, notified the attending physician, the facility's social service worker, the LCSW consultant or other administrative staff Nurses A, G, and C were aware of the specific suicidal threat made by resident 1 and did not report	F 224	The orientation and in service calendars have been adapted to have specific times to address this issue. The results of the audits will be reported to the Quality of Life committee for review and to determine action plans as needed. This will be on an ongoing issue to be addressed monthly. The ADM is responsible for ongoing compliance.	

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F 224	Continued From page 5	F 224		

it to the attending physician, the facility's social service worker, the LCSW consultant or other administrative staff.

In continuing the interviews with the other seven nurses, it was clear that they were not aware of what procedures to follow had they become aware of the suicidal threat. Each of the seven nurses were asked what they would have done if they had been told of the suicidal threat. Their responses are as follows:

Nurse B would have talked to her about it.
Nurse D would have checked her every half hour throughout the night and first thing in the morning would have reported the suicidal threat to the attending physician and the social worker.
Nurse E would have called the doctor.
Nurse F would have talked to resident 1 about it and then called the physician.
Nurse H would have checked resident 1's mouth to make sure she was swallowing her pills and then would have looked in her room and drawers for pills.
Nurse K would have made sure resident 1 had taken her pills and then made the director of nurses aware.
Nurse J would have talked with resident 1, held her pills and notified the social worker and director of nurses (DON).

Although nurses E and H were not aware of the specific suicidal threat, they both documented evidence of resident 1's extreme mental distress and then failed to document that any follow-up had been done.

The DON was interviewed on 1/27/03 at approximately 4:30 PM. She denied being aware that resident 1 had threatened to hoard her pain pills and take them all at once.

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F 224	Continued From page 6	F 224		

The social service worker (SSW) and administrator were interviewed on 1/27/03. Both the SSW and administrator stated that resident 1 could be manipulative, demanding and dramatic. They stated that resident 1 would make many demands of her elderly mother and that her other siblings were concerned about their mother's health. The SSW stated that after resident 1 and 2 were placed in different rooms, by request of the guardian (who was also the son of resident 2), resident 1 became very upset and contacted a lawyer. During interview with the SSW on 1/31/03, she stated that resident's 1 and 2 were being kept apart, again by request of resident 2's guardian. The SSW also stated that resident 1 called her mother (resident 2) on the telephone and would say "Mother, I'm somewhere here in the facility. You have to find me. You have to find me." Both the Administrator and SSW denied being aware of any specific suicidal threat from resident 1.

Resident 1's attending physician was interviewed by telephone on 1/30/03 at 9:45 AM. During this interview, the physician was "shocked" to hear that the medical examiner had certified resident 1's death to be a suicide. He stated that he did not remember any calls saying she (resident 1) was suicidal and denied being aware of the specific suicidal threat. He stated that if he had been aware, he would have taken it seriously and involved a psychiatrist and a social worker. "I would have acted more aggressively."

The facility's medical director was interviewed by phone on 1/30/03 at approximately 9:55 AM. He stated that he had not been made aware of the suicide and was not aware that resident 1 had made a specific suicidal threat.

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On 1/27/02 at 3:15 PM nurse H was interviewed. Nurse H took care of resident 1 on numerous occassions and the night before she died. Nurse H was not aware that on 11/8/02 resident 1 had threatened to hoard her pills and take them all at one time. Nurse H stated that sometime before the involuntary separation, the nurse recalled a telephone conversation involving resident 1 and 2 and a family member. Nurse H stated that resident 2 told the family member, as instructed by resident 1, that resident 2 would kill herself if they were seperated. Nurse H stated that after resident 1 was involuntarily separated from her mother, at first resident 1 was angry and ornery. Resident 1 complained, why did they have to move her? Then resident 1 would cry and scream. Nurse H stated that then resident 1 got actively involved in trying to get her mother's power of attorney. Nurse H stated that on the evening of 11/22/02 resident 1 was very down and wouldn't eat her dinner. Nurse H explained that resident 1 decided to go to the Ballroom Dance Activity held that evening in hopes of seeing and talking with her mother. Resident 1 came back from the activity,even more depressed, "the worst I'd ever seen," because according to resident 1 her brother would not let resident 1 sit near her mother. Nurse H stated that if she had known about resident 1's comment reguarding hoarding her pills she would have looked in her mouth after administering her medications and would have checked in resident 1's drawers/room for pills.

On 1/29/02 at 2:50 PM nurse E was interviewed. Nurse E was not aware that resident 1 had committed suicide. Upon learning that resident 1 died the afternoon of 11/23/02 nurse E stated that she "was surprised - but not surprised. I knew she was depressed, having a hard time about that whole thing-

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being separated- she had never been away from her mother before. I had heard the she had taken her O2 (oxygen) off. I didn't think she was ill enough for that to have made a difference. In report it had been shared that she was sad. My personal thought, that it was all about her mother- being separated. She had been saying how she was so sad, she wanted her mama, she didn't want to live - well not live... I don't know if suicide came to my mind because she was bed ridden and couldn't hang herself and as far as meds (medications)- we control her meds, so that wasn't an issue." Nurse E stated that since resident 1's forced separation from her mother, resident 1 seemed to isolate herself more and seemed more depressed. Nurse E was not aware that resident 1 had talked of hoarding her pills and taking them all at one time. Nurse B stated that if she had known that resident 1 had had suicidal ideations, she would have"done something.. but then I didn't think she had the means. I would have called the doctor and told him this what they said and this is how they were going to do it."

There was no documentation in the medical record to evidence that facility staff were addressing, monitoring, reporting or interveing with the extreme mental distress being exhibited by resident 1. The extreme mental distress was evidenced by:

- the comment of 11/8/02 when she was crying and yelling and threatening to hoard all her pain pills and take them all at once,
- the observation by nurse A when resident 1 was cyanotic and refusing to put on her oxygen
- contacting several lawyers.
- calling her mother on the phone and saying "You have to find me. You have to find me.",
- the observation made by the SSW of resident 1 sobbing and making suggestions about death and

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F 224	Continued From page 9 killing people. - the observations made by nurse H where resident 1 would not eat her dinner, and would cry and scream - the observation made by nurse H the night before resident 1 died saying "she [resident 1] was the worst I'd ever seen." - the comment heard by nurse H in which resident 1 was heard to tell her mother to tell the guardian (the son) that the mother would kill herself if separated from resident 1, - the statement by nurse E in which she stated that after being separated from her mother, resident 1 became more depressed and was observed to isolate more	F 224		
F 225 SS=G	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and	F 225	OK 3/10/03 LB	

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certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on interviews and medical record review, it was determined that the facility did not have evidence that an allegation of neglect had been investigated. Resident 1 died on 11/23/02. On the morning of 11/23/02, nurse C suggested to the paramedics who responded to the 911 call that the situation with resident 1 could be a "possible overdose". The medical examiner's office sent a letter to the facility, dated 12/20/02, which stated that resident 1 died of a polydrug overdose that was "certified as suicide". The facility had no documentation to evidence that events surrounding the death of resident 1 had been investigated. The resident's attending physician and the facility's licensed clinical social worker (LCSW) were not aware that the resident had committed suicide.

Findings include:

Resident 1 was admitted to the facility on 1/8/02. Resident 1 had a verifiable serious mental illness of Major Depression, recurrent, moderate. On 11/8/02, nurses notes documented that resident 1 was crying

F 225

Resident number 1 was no longer in the facility at the time of this complaint investigation.

Residents with a change in psychosocial well-being have the potential to be affected.

The facility contracted with a consultant MSW to do in servicing to the entire staff on signs and symptoms of emotional trauma and suicide precautions. The facility has taped and held in-services from the county mental health services. The in-services were to help with access and to identify needs for referrals. The county mental health services reviewed the policy and procedure to ensure that their proper numbers were in place.
The county has in serviced the entire staff.

The facility has posted important numbers and standard protocols for emotional distress recognition and intervention. The administrator and social services have been given in-services by the MSW on recognition of emotional distress. The standard in-service calendar has been adapted to include quarterly training on emotional distress and suicide precautions.

The Administrator is responsible for ongoing compliance.

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F 225	Continued From page 11 and yelling in the hallway. At that time, resident 1 yelled "I'm going to hoard my pain pills and take them all at once!" On 11/23/02, resident 1 expired in the hospital. Interviews with facility staff during this investigation from 1/27/03 through 1/31/03 revealed that prior to and after resident 1 made this suicidal threat, she was experiencing a major life change and extreme mental distress. There was no evidence that the facility addressed the extreme mental distress being exhibited by resident 1. Please also refer to tag F - 224. On 11/23/02 at 6:45 AM, when nurse C found resident 1, she was "...unconscious. Not breathing et (and) no pulse..." Facility staff called 911. One of the paramedics who responded was told by nurse C that resident 1 "had verbally threatened suicide previously" and that an "overdose of medication might have occurred." On 11/23/02, resident 1 died. Later that same day, the state's medical examiner performed an autopsy. The official "report of examination" was obtained from the medical examiner's office by state survey on 1/30/03. The opinion of the medical examiner was that resident 1 "died as the consequence of an intentional acute amitriptyline and tramadol overdose." The medical examiner's office sent a letter to the facility, dated 12/20/02, which stated that resident 1 died of a polydrug overdose that was "certified as suicide". Based on review of the facility's November 2002 nursing schedule, there were ten nurses who worked with resident 1 from 11/8/02 (the day of the specific suicidal threat) through 11/23/02 (the day resident 1	F 225		

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died). During interviews with all ten nurses (beginning on 1/27/03 and ending 2/3/03), it was discovered that 7 of the nurses denied any knowledge of the suicidal threat voiced by resident 1. During the interviews, it was determined that none of the three remaining nurses, who stated they were aware of the suicidal threat, notified the attending physician, the facility's social service worker (SSW), the LCSW consultant or other administrative staff. In continuing the interviews with the other seven nurses, it was clear that they were not aware of what procedures to follow had they become aware of the suicidal threat.

During interviews with the Administrator, the director of nurses (DON), and the SSW on 1/27/03, they stated that they were aware that resident 1's death was a suicide. All three denied being made aware of the comment resident 1 made on 11/8/02, when she threatened to hoard her pain pills and take them all at once.

During interview with the LCSW consultant on 1/29/03 at 3:45 PM, he stated that he had not been told that resident 1 had committed suicide.

Resident 1's attending physician was interviewed by telephone on 1/30/03 at 9:45 AM. During this interview, the physician was "shocked" to hear that the medical examiner had certified resident 1's death to be a suicide.

Facility staff could not provide any evidence that the events surrounding the suicide death of resident 1 had been investigated by them and that measures had been put into place to provide staff with clear directions on what to do the next time someone exhibited mental/emotional distress.

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F 225	Continued From page 13 On 1/31/03, the administrator was asked to provide the facility's quality assurance (QA) minutes for the most recent quarter to determine whether the QA committee had investigated the events surrounding the suicide death of resident 1. The administrator stated that those details would not be in the QA minutes because those events had not been investigated.	F 225		
F 250 SS=J	483.15(g) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview it was determined that the facility failed to provide medically related social services for the extreme mental distress and major depression experienced by resident 1 as a result of a significant life change. It was found that there was a lack of communication concerning the mental health/social service needs of resident 1 between nursing staff, social services personnel and/or administrative staff. This failure contributed to the finding by the Medical Examiner that resident 1 died as the result of a self-inflicted, poly-drug overdose. Findings included: 1. Resident 1 was admitted to the facility on 1/8/02 with diagnoses that included pneumonia, chondrodystrophy, fibromyalgia, osteoarthrosis,	F 250		

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F 250	Continued From page 14 arthropathy, diabetes and major depression. In addition resident 1's mother, resident 2, was admitted to the facility on 1/8/02. Residents 1 and 2 were placed in the same room with no other roommate. 2. The social services worker (SSW) was interviewed on 1/27/03. The SSW stated that resident 1 and resident 2 shared the same room in the facility from 1/8/02 until 11/6/02. Upon admission to the facility resident 1 requested to share the same bed with resident 2. This request was denied. Resident 1 had always lived with resident 2. Resident 1 had never been married or had any children. During an interview with the SSW on 1/27/03, it was stated that a Wasatch Mental Health worker had told the SSW that the relationship between the residents was "symbiotic". Symbiotic is defined as a relationship which is mutually reinforcing between two persons who are dependent on each other. The SSW stated that resident 2 was moved to another room in the facility on 11/6/02 per a family member request. This family member had obtained full guardianship and power of attorney over resident 2 because the family member felt that the demands of resident 1 on resident 2 were unhealthy for resident 2. Though the facility had attempted to prepare resident 1 for the separation from resident 2, the room change resulted in extreme mental distress for resident 1. The SSW stated that after the room change, every time resident 1 was allowed to talk to or visit with resident 2, it would result in both residents "just sobbing." The SSW also stated that resident 1 had called resident 2 on the telephone and would say "Mother, I'm somewhere here in the facility. You have to find me. You have to find me."	F 250 OK 3/10/03	F 250 Resident number 1 was no longer in the facility at the time of this complaint investigation. Residents with a change in psychosocial well-being have the potential to be affected. The facility contracted with a consultant MSW to do in servicing to the entire staff on signs and symptoms of emotional trauma and suicide precautions. The consultant MSW reviewed our current policy and procedure to ensure proper coverage. The consultant MSW reviewed the charts of residents with a diagnosis of depression. The consultant MSW has committed to increased time in the facility to ensure ongoing compliance, and is following those residents needing a level two-passar screen. The consultant MSW is co signing the facility social worker's notes to help identify training needs. The quality of life committee is reviewing the chart audits and will develop action plans as needed as well as doing a Quality of Life audit monthly indefinitely. The Administrator is responsible for ongoing compliance.	

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F 250	Continued From page 15 3. A review of resident 1's nursing notes was done on 1/27/03. The 11/08/02 nursing notes documented that resident 1 was observed to be crying and yelling in the hallway. At that time, it was documented that resident 1 yelled, "I'm going to hoard my pain pills and take them all at once! One way or another I'm going to get my Mama back." 4. The nursing notes for 11/23/02 documented "Patient was found at 0645 unconscious. Not breathing et (and) no pulse." According to the nursing notes, the resident was taken to the hospital via ambulance. 5. An autopsy was performed by the medical examiner. On 1/27/03, a review of the letter report from the medical examiner's office (dated 12/20/02) was done. The letter was addressed to resident 2 and it documented that resident 1 "died on 11/23/02"... as a result of a polydrug overdose. The manner has been certified as suicide." 6. A review of resident 1's medical record was completed on 1/30/03. The following was documented: a. A review of resident 1's PASRR-I/II (Preadmission Screening Resident Review for Serious Mental Illness)-level one dated 1/21/02 and level two dated 1/25/02, was done on 1/28/03. The PASRR-II documents a diagnosis of " Major Depression, recurrent, moderate." The comments section of the PASRR-II documents that "resident 1 is "very dependent on 94 year old mother...appears preoccupied with parent to exclusion of others." The treatment recommendations documented resident 1 needs "support and encouragement" and that the	F 250		

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"primary physician follow-up psychiatric consult as needed." The "Mental Status Examanation/Summary documents that resident 1..."very dependent on mother for all care until her mother suffered a stroke...Tends to only want to interact with her mother. Relationship appears to be symbiotic." The Psychosocial evaluation/summary documents that resident 1 resided in a "private home with mother" prior to living in the facility. Resident 1 "never married." Resident 1 is "dependent on mother for care and support."

7. A review of the social service notes was completed on 1/30/03. There was no documentatior that the SSW was made aware of resident 1's talk of suicide on 11/8/02. There was no documentation that the licensed clinical social worker (LCSW) was made aware of resident 1's talk of suicide

On 11/7/02, one day after resident 1 and resident 2 were separated, it was documented that resident 1 felt that "everyone was being hateful" to her. Resident 1 had requested a visit with resident 2 that resulted in both residents "sobbing" and resident 1 was making suggestions to resident 2 "about death and killing people."

On 11/14/02 it was documented that resident 1 was in contact with an attorney "because she wanted to see/be with her mother." On 11/18/02 it was documented that resident 1 felt that her rights were being violated. On 11/21/02 it was documented that family "remains adamant" that resident 1's " behavior would still be upsetting to" resident 2. It indicates that the family felt that until resident 1 "could pleasantly visit they would like resident 2 to maintain some distance from resident 1."

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8. A review of all physician progress notes and telephone orders from 11/8/02 to 11/23/02 was done on 1/30/03. There was no documentation that the physician was made aware of resident 1's talk of suicide on 11/8/02.

9. A review of the nursing schedule was done on 1/30/03. It documented that between 11/08/02 (when resident 1 made her suicidal threat) and 11/23/02 (when resident 1 expired), ten nurses had cared for resident 1. Based on interviews conducted with all 10 of these nurses, only three of the ten nurses were aware that resident 1 had made the suicidal threat on 11/8/02.

a. On 1/27/03 at 4:58 PM, nurse A was interviewed. Nurse A was the nurse that documented resident 1's suicidal threat on 11/8/02. When asked if she had notified the physician about this specific suicidal threat, she answered "probably not." When asked if she notified the SSW she replied, "I can't recall."

Nurse A stated that she reported the suicidal threat to the nurse on the following shift. When asked why she had documented this specific behavioral episode, the nurse replied that resident 1 was "cyanotic" and " wasn't interested in her O2 (oxygen) and would not put it on." Nurse A also stated that resident 1 was yelling very loudly and while resident 1 had been very dramatic in the past, this time she voiced a specific suicidal threat.

b. On 2/3/03 at 10:40 AM, nurse G was interviewed via telephone. Nurse G stated that she was aware that resident 1 had died but was not aware how resident 1 had died. Nurse G worked the night shift on 11/8/02 to the morning of 11/9/02. Nurse G

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was asked if she remembered being told about resident 1's suicidal threat.

Nurse G stated that she remembers knowing about the threat because nurse G remembered checking resident 1's mouth for failing to swallow the pills. However, nurse G couldn't remember the exact date or time she became aware of resident 1's threat.

Nurse G also remembered talking with resident 1 about her threat to hoard all her pills and take them all at once. Nurse G when asked if she had notified the physician, the SSW, or the Director of Nursing, she replied "No." When asked if she reported resident 1's suicidal threat to the nurse on the next shift, she replied that she remembers verbally passing on her concerns.

c. On 1/28/03 at 11:00 AM and 1/30/03 at 8:05 AM nurse C was interviewed. Nurse C worked the next shift after nurse G had worked. (Nurse G had stated that she had verbally told Nurse C, the next nurse on shift, about resident 1's threat.) However when Nurse C was asked how she learned of the threat, she stated that she might have received this information either in report or from a CNA a few weeks before the suicide. When nurse C was asked if she reported resident 1's talk of suicide to the DON, attending physician, SSW or any other facility staff, she stated that she couldn't recall because it was "so long ago."

Nurse C further stated that the nurses had instructed each other not to leave any pills with resident 1. Nurse C said that she always helped resident 1 take her pills and never left the room until all her pills were swallowed.

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F 250	Continued From page 19 Nurse C was the nurse who found resident 1 in her room, unresponsive, on the morning of 11/23/02. According to nurse C, she requested that 911 be called, checked resident 1's blood sugar and initiated CPR. Nurse C stated that when the paramedics arrive, they asked the nurse what she thought might be wrong with resident 1. Nurse C indicated that she replied that it maybe a possible overdose and requested that the paramedics administer Narcan to resident 1. (Narcon is used medically as an antidote for an overdose of narcotics.) d. On 1/30/03 at 10:45 AM, nurse B was interviewed. Nurse B stated that they were not aware how resident 1 had died, nor that resident 1 had talked of hoarding her pills and taking them all at one time. Nurse B stated that if she had known that resident 1 was thinking of suicide, she would have talked to her about it. e. On 1/30/03 at 10:10 AM, nurse D was interviewed. Nurse D stated that she was not aware how resident 1 had died. Nurse D stated that she was aware that resident 1 was depressed but not aware that resident 1 had threatened to hoard her pills and take them all at one time. Nurse D stated that if she had known that resident 1 was having suicidal ideations, nurse D would have checked resident 1 every half hour through out the night. Then, first thing in the morning nurse D would have reported the suicidal threat to the attending physician and the SSW. f. On 1/29/03 at 2:50 PM, nurse E was interviewed. Nurse E stated that she was unaware how resident 1 had died. When nurse E was informed on the afternoon of 11/23/02 that resident 1 had died,	F 250		

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nurse E stated that she "was surprised - but not surprised."

Nurse E said that resident 1 had been depressed and having difficulties being separated from resident 2. Nurse E stated that she knew that resident 1 had never been away from resident 2. Nurse E stated that "I (nurse E) had heard the she had taken her O2 (oxygen) off. I didn't think she was ill enough for that to have made a difference. In report, it had been shared that she was sad. My personal thought - that it was all about her mother- being separated."

Nurse E related that resident 1 "was so sad, she wanted her momma, she didn't want to live - well not live... I don't know if suicide came to my mind because she was bed ridden and couldn't hang herself and as far as meds (medications) - we (the facility) control her meds, so that wasn't an issue." Nurse E stated that since resident 1's involuntary separation from her mother, resident 1 seemed to isolate herself more and seemed more depressed.

Nurse E stated that she was not aware resident 1 had threatened to hoard her pills and take them all at one time. Nurse E further stated that if she had been aware that resident 1 verbalized suicidal ideations, she would have "done something...but then I didn't think she had the means. I would have called the doctor and told him this what they said and this is how they were going to do it."

g. On 1/30/03 at 4:45 PM nurse F, was interviewed via telephone. Nurse F stated that she was not aware that resident 1 had threatened to hoard her pills and take them all at one time. Nurse F stated that if she had known that resident 1 was thinking of suicide, she would have talked to resident 1 about it

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F 250	Continued From page 21 and then would have notified the attending physician. h. On 1/27/03 at 3:15 PM nurse H was interviewed. Nurse H took care of resident 1 on numerous occassions and the night before she died. Nurse H was not aware that on 11/8/02 resident 1 had threatened to hoard her pills and take them all at one time. Nurse H stated that sometime before the involuntary separation of resident 1 and resident 2, nurse H recalled a telephone conversation that she overheard involving resident 1 and 2 and a family member. Nurse H stated that resident 2 told the family member, as instructed by resident 1, that resident 2 would kill herself if they were seperated. Nurse H stated that after resident 1 was involuntarily separated from her mother, resident 1 became "angry and ornery". Resident 1 complained to nurse H that she didn't understand why resident 2 was forced to move to another room. After discussions about the move, nurse H stated that resident 1 would cry and scream. Nurse H stated that on the evening of 11/22/02, the night before resident 1 expired, nurse H observed that resident 1 was very depressed and wouldn't eat her dinner. Nurse H explained that resident 1 had gone to a facility activity attempting to contact resident 2. Nurse H stated that resident 1 came back from the activity depressed and was "the worst I'd ever seen." Resident 1, in response to nurse H asking about why she returned to her room, explained that a family member would not let resident 1 sit near resident 2. Nurse H stated that had she known about resident 1's threat to hoard her pills she would have looked in her	F 250		

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	465082	A. BUILDING ____ B. WING ____	C 1/31/2003

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F 250	Continued From page 22	F 250		

mouth after administering her medications and would have checked in resident 1's room and drawers for pills.

i) During the morning of 1/30/03, nurse K was interviewed via telephone. Nurse K stated that she was not aware of any specific suicidal threats reguarding resident 1. Nurse K stated that she was not aware that on 11/8/02, resident 1 had threatened to hoard her pills and take them all at one time. Nurse K indicated that she she could not remember hearing from other nursing staff about resident 1's suicidal threat.

Nurse K stated that if she had known that resident 1 was thinking of suicide, she would have made sure that resident 1 took her medications and would have informed the DON.

j) On 1/30/03 at 11:30 AM, nurse J was interviewed. Nurse J stated that she was not aware of any specific suicidal threats regarding resident 1. Nurse J stated she was not aware that on 11/8/02, resident 1 had threatened to hoard her pills and take them all at one time.

Nurse J stated that if she had known that resident 1 was thinking of suicide, she would have talked with resident 1, not given her any pills and reported the suicidal threat to the SSW and the DON.

7. On 1/29/03 at 3:45 PM, a telephone interview was conducted with the facility's licensed clinical social worker (LCSW) consultant. In response to questions about his knowledge of the facts surrounding resident 1's death, he indicated that he knew that resident 1 had died, but that he didn't know until contacted by the surveyor, that suicide was connected with resident

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F 250	Continued From page 23	F 250		

1's death. He stated that he had not been made aware of resident 1's threat to hoard all her pills and take them at 1 time.

The LCSW stated that the last time he had contact with resident 1 was on 11/18/03. He stated that the contact was when resident 1 called him into her room and indicated that she wanted Power of Attorney over resident 2. The LCSW response was to offer to assist her in finding legal counsel, to which resident 1 refused his assistance and angrily asked him to leave. The LCSW indicated that resident 1's demeanor during this interchange was "agitated" but did not show any depression.

The LCSW was questioned concerning what response he would have given had he been aware of resident 1' suicidal threats. He indicated that he would have had the DON assess resident 1 and determine if the resident was in immediate danger or not. Then he indicated that the LCSW, SSW and the DON would work together to determine the appropriate type of mental health intervention needed.

8. On 1/27/03 at 4:00 PM, an interview was conducted with the facility's administrator. In response to questions about her knowledge of the facts surrounding resident 1's death, she indicated that she had no knowledge that the death was a suicide. She learned the cause of death when a family member showed her a letter from the Medical Examiner indicating that resident 1's death was caused by a poly-drug overdose that was self-inflicted. The date on the Medical Examiner's letter was 12/20/02.

The administrator was asked what investigation she had conducted and/or steps she had taken to ensure

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F 250	Continued From page 24 that other resident weren't at risk when she had found out about resident 1's suicide. She indicated that she had not invesigated the death nor taken any steps to ensure the safety of other residents.	F 250		
F 490 SS=G	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from the annual recertification survey ending 11/5/02. Based on the findings of this complaint survey which was performed from 1/27/03 through 1/31/03, it was determined that the facility was not being administered in a manner that enabled it to use its resources effectively and efficiently. Immediate Jeopardy and Substandard Quality of Care were identified for the facility neglecting to assess, monitor, report and intervene with a resident who was exhibiting extreme mental distress and who told staff of her exact suicide plan. (F224) The resident died of a polydrug overdose on 11/23/02. The facility failed to investigate the events surrounding the suicide death of this resident. (F 225) The facility failed to provide sufficient and appropriate social services to meet the mental and psychosocial well-being of the resident. (F 250) The facility failed to consult with the quality assurance committee regarding the events surrounding the suicide death of the resident and failed to establish a corrective action	F 490		

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F 490	Continued From page 25 plan. Resident identifier: 1. Findings include: Resident 1 was admitted to the facility on 1/8/02. Resident 1 had a verifiable serious mental illness of Major Depression, recurrent, moderate. On 11/8/02, nurses notes documented that resident 1 was crying and yelling in the hallway. At that time, resident 1 yelled "I'm going to hoard my pain pills and take them all at once!" On 11/23/02, resident 1 expired in the hospital after being transported from the facility. Interviews with facility staff during this investigation, from 1/27/03 through 1/31/03, revealed that prior to and after resident 1 made this suicidal threat, she was experiencing a major life change and extreme mental distress. There was no evidence that the facility assessed her mental status after she declared her intention on 11/8/02. There was no evidence that facility staff who had knowledge of the suicidal threat notified the attending physician, the facility's social service worker (SSW), the licensed clinical social worker (LCSW) consultant or other administrative staff. There was no evidence that the one staff member who identified resident 1 with severe depression the night prior to the suicide had notified anyone or intervened. There was no documentation to evidence that facility staff were monitoring the mental status of resident 1. There was no documentation to evidence that facility staff attempted to intervene when resident 1 was identified with extreme mental distress and voiced a specific suicidal threat. In addition, once the facility became aware that resident 1 committed suicide, they failed to investigate the events surrounding her death. The facility's failure to assess, monitor, report and	F 490	OK 3-10-03 F 490 (see 224, 225, 250) Resident number 1 was no longer in the facility at the time of this complaint investigation. Residents with a change in psychosocial well-being have the potential to be affected. The administrator and social services have been given in-services by the MSW on recognition of emotional distress. The standard in-service calendar has been adapted to include quarterly training on emotional distress and suicide precautions. The facility medical director has consulted with us to ensure proper medical interventions for residents with emotional distress or suicide ideation. The facility QA team will review the Quality of Life committee review at least monthly and develop action plans as indicated. The General Partner on a monthly basis is reviewing the QA for three months to ensure ongoing compliance with the QA process. The Administrator is responsible for ongoing compliance.	

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F 490	Continued From page 26 intervene with resident 1 led to a determination of Immediate Jeopardy for neglect. Facility administration neglected to ensure that staff assessed, monitored, reported and intervened with a resident who was exhibiting extreme mental distress and who told staff of her exact suicide plan (F224) Facility administration failed to investigate the events surrounding the suicide death of resident 1. (F 225) Facility administration failed to ensure sufficient and appropriate social services to meet the needs of resident 1 who was exhibiting extreme mental distress. Resident 1 committed suicide on 11/23/02. (F 250) Facility administration failed to ensure that failed to consult with the quality assurance committee regarding the events surrounding the suicide death of the resident and failed to establish a corrective action plan. (F521)	F 490		
F 521 SS=G	483.75(o)(2)&(3) ADMINISTRATION The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such	F 521		

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committee with the requirements of this section.

This **REQUIREMENT** is not met as evidenced by:

Based on interview, it was determined that the quality assurance (QA) committee did not identify issues with respect to which quality assessment and assurance activities are necessary. The QA committee did not develop or implement plans of action to correct identified quality deficiencies. Specifically, Immediate Jeopardy and Substandard Quality of Care were identified for the facility neglecting to assess, monitor, report and intervene with a resident who was exhibiting extreme mental distress and who told staff of her exact suicide plan. (F224) The resident died of a polydrug overdose on 11/23/02. The facility failed to investigate the events surrounding the suicide death of this resident. (F 225) The facility failed to provide sufficient and appropriate social services to meet the mental and psychosocial well-being of the resident. (F 250) The facility failed to consult with the quality assurance committee regarding the events surrounding the suicide death of the resident and failed to establish a corrective action plan. Resident identifier: 1.

Findings include:

Resident 1 was admitted to the facility on 1/8/02. Resident 1 had a verifiable serious mental illness of Major Depression, recurrent moderate. On 11/8/02, nurses notes documented that resident 1 was crying and yelling in the hallway. At that time, resident 1 yelled "I'm going to hoard my pain pills and take them all at once!" On 11/23/02, resident 1 expired in the hospital. Interviews with facility staff during this investigation from 1/27/03 through 1/31/03 revealed that prior to and after resident 1 made this suicidal threat, she was experiencing a major life change and extreme mental distress

F 521

Resident number 1 was no longer in the facility at the time of this complaint investigation.

Residents with a change in psychosocial well-being have the potential to be affected.

The administrator and social services have been given in-services by the MSW on recognition of emotional distress. The standard in-service calendar has been adapted to include quarterly training on emotional distress and suicide precautions. The facility medical director has consulted with us to ensure proper medical interventions for residents with emotional distress or suicide ideation.

The facility QA team will review the Quality of Life committee review at least monthly and develop action plans as indicated. The General Partner on a monthly basis is reviewing the QA for three months to ensure ongoing compliance with the QA process.

The Administrator is responsible for ongoing compliance

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There was no evidence that the facility assessed her mental status after she declared her intention on 11/8/02. There was no evidence that facility staff who had knowledge of the suicidal threat, notified the attending physician, the facility's social service worker (SSW), the licensed clinical social worker (LCSW) consultant or other administrative staff. There was no evidence that the one staff member who identified resident 1 with severe depression the night prior to the suicide had notified anyone or intervened. There was no documentation to evidence that facility staff were monitoring the mental status of resident 1. There was no documentation to evidence that facility staff attempted to intervene when resident 1 was identified with extreme mental distress and voiced a specific suicidal threat. In addition, once the facility became aware that resident 1 committed suicide, they failed to investigate the events surrounding her death.

The facility also failed to consult with the quality assurance committee regarding the events surrounding the suicide death of the resident and failed to establish a corrective action plan.

During interview with the facility's administrator on 1/31/03 at 2:30 PM, she was asked for the facility's quality assurance minutes for the most recent quarter to determine whether the facility had investigated the suicidal death of resident 1 and then established a plan of action to ensure that similar circumstances would be avoided. The administrator stated that those details would not be in the QA minutes because those events had not been investigated.