STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056431	A. Building B. Wing	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41511 Based on interview and record review, the facility staff failed to follow its own policy and procedure for Change in a Resident's Condition or Status for one of four sampled residents (Resident 1) by failing to: 1. Notify Resident 1's physician of Resident 1's suicidal ideation (thoughts and plans to harm himself) on 10/8/2021. 2. Notify Resident 1's Registered Nurse Practitioner 1 (RNP 1) of Resident 1's self-harming behaviors (punching himself) and suicidal ideation on 10/9/2021. 3. Notify facility staff (in general) caring for Resident 1 about his suicidal ideation on 10/08/2021. These deficient practices had the potential for Resident 1's suicide attempt to be successful and allow the 56 residents in the facility receiving antipsychotic medications with diagnoses of schizophrenia (mental disorder characterized by hallucinations, hearing voices, and disorganized thoughts and behaviors), depression, and bipolar disorder (mental disorder characterized by drastic periods of happiness and drastic declines in mental condition leading to deep depression) to harm themselves. Findings: A review of Resident 1's face sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included schizophrenia and bipolar disorder. A review of Resident 1's undated History and Physical (H&P), indicated the resident was able to make his needs known, but could not make medical decisions. A review of Resident 1's care plan for schizophrenia dated 10/5/2021, indicated the resident was at risk for confusion and disordered thoughts. The care plan indicated interventions required for Resident 1 included keeping the environment free of hazards, and to notify the physician if the resident's behavior interfered with functioning. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's care plan for impaired status behavior dated 10/7/2021, indicated the resident had multiple behavioral issues including: verbally abusive, physically abusive, resisting care and medications, sexually inappropriate, and episodes of eating his own feces. The care plan indicated these behaviors required interventions which included monitoring medications and behavior manifestations, as well has providing a safe environment. A review of Resident 1's untimed physician order list dated 10/8/2021, indicated an order was given to send the resident to another facility for 51/50 (code for a California law which allows a person to be detained for 72 hours for mental help when they are a danger to themselves or others) danger to others. A review of Resident 1's departmental notes dated 10/8/2021 at 5:36 PM, indicated at 4:45 PM that day (10/08/2021) Resident 1 was ripping the curtains off the ceiling, throwing his dresser and the drawers, and began punching himself in the head. The notes indicated Resident 1 told certified nursing assistant 1 (CNA1) he (Resident 1) wanted to kill himself. The notes indicated Resident 1 asked licensed vocational nurse 2 (LVN2) to be taken to a mental hospital as he was punching himself in the head. The notes indicated new orders were received to transfer Resident 1 out on a 51/50 hold. The notes did not indicate Resident 1 was transferred as ordered. A review of Resident 1's untimed situation background assessment and recommendation (SBAR) form dated 10/8/2021, indicated the resident was displaying aggressive behavior towards staff and had suicidal ideation (considering or planning suicide). The SBAR form indicated the resident was a danger to himself and others. The SBAR form indicated Resident 1 would not allow staff in his room and would throw things at them when they attempted to enter the resident's room. The SBAR form also indicated Resident 1 told the nursing staff he wanted to kill himself and wanted to be transferred to a mental hospital as he punched himself in the head. The SBAR form indicated the Resident was to be sent out on a 51/50. The SBAR form did not indicate Resident 1 was sent out to another facility. A review of Resident 1's psychiatry initial evaluation dated 10/09/2021 (no time), indicated the resident was aggressive towards the psychiatrist and verbally abusive. The evaluation indicated the psychiatrist wanted Resident 1 to go to any psychiatric facility that had a bed available. A review of Resident 1's physician order list dated 10/09/2021 (no time), indicated a follow up for the psychiatric bed placement was ordered. A review of Resident 1's departmental notes dated 10/09/2021 at 2:59 PM, indicated the resident was still at the facility and was noted to yell and hit his tattoo on his arm. A review of Resident 1's departmental notes dated 10/09/2021 at 5:05 PM, indicated Registered Nurse Practioner 1 (RNP 1) went to the facility to see the resident. The notes did not indicate why Resident 1 had not been transferred for psychiatric assessment or if RNP1 was notified about Resident 1's suicidal ideation. A review of Resident 1's physician phone orders dated 10/12/2021 at 3:30 PM, indicated Resident 1 was to be monitored for any suicidal ideations, behaviors, and verbalizations. The orders indicated if Resident 1 displayed or verbalized suicidal ideations the facility was to notify the physician. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's departmental notes dated 10/12/2021 at 11:17 PM, indicated Registered Nurse Supervisor 1 (RNS1) entered Resident 1's room to provide him with a blanket and noticed he looked pale. The notes indicated RNS1 returned to Resident 1's room with Vocational Nurse 1 (LVN1) and found Resident 1 with an electrical wire from the wall wrapped around his neck. The notes indicated Resident 1 destroyed the air conditioning panel with a nail clipper and pulled out the electrical wire. A review of Resident 1's departmental notes dated 10/13/2021 at 12 AM, indicated around 10 PM on 10/12/2021, RNS1 informed LVN1 the resident looked pale and sound like he was praying. The notes indicated LVN1 went to check on Resident 1 and found the door to the resident's room was closed. The notes indicated LVN1 opened the door and found Resident 1 pulling the thermostat from the wall and wrapped it around his neck. The notes indicated LVN1 attempted to talk to Resident 1 and the resident became very upset and threatening. The notes indicated RN1 called 911 and Resident 1 was transferred to the local emergency room for 51/50 eval. During an interview and record review on 10/14/2021 at 11 AM, LVN2 stated if a resident verbalized, they wanted to kill themselves that was suicidal ideation. LVN2 stated the resident should then be monitored with a staff nearby and any dangerous items such as utensils, metal, and the call light with cord should be removed from the room. LVN2 reviewed the departmental notes dated 10/08/2021 at 5:36 PM and stated the physician was notified of Resident 1's suicidal ideation and an order was received to transfer the resident out on a 51/50. LVN2 stated the resident was not transferred out because there were no available beds at the receiving facility. During a concurrent interview and record review on 10/14/2021 at 12:46 PM, the director of nursing (DON) reviewed Resident 1's departmental notes dated 10/08/2021 at 5:36 PM and stated the resident should have been transferred out of the facility. The DON stated 1:1 monitoring for the resident's safety should have been implemented and was not. The DON stated Resident 1 needed to be monitored, especially after expressing the desire to kill himself and for the safety of others. During an interview on 10/14/2021 at 2:23 PM, registered nurse practitioner 1 (RNP1) stated he was never informed the resident had verbalized wanting to commit suicide on 10/08/2021. RNP1 stated on 10/09/2021 RNP1 went to the facility to see Resident 1 and was not informed about any suicidal ideation only aggressive behavior. RNP1 stated he never received a follow up call from the facility on Resident 1's mental status. RNP1 stated on 10/12/2021 it was mentioned the RNP1 by facility staff that Resident 1 had suicidal ideation. RNP1 stated the facility was a new environment for Resident 1 and it was very important for the staff to communicate the resident's mental status. RNP1 stated if the facility had informed him of Resident 1's desire to commit suicide on 10/08/2021 he would have ordered a 1:1 sitter and sent the resident out for psychiatric evaluation. RNP1 stated the incident on 10/12/2021 when Resident 1 tried to kill himself could have been prevented. During an interview on 10/14/2021 at 4:23 PM, registered nurse supervisor 1 (RNS1) stated she was not informed on 10/08/2021 that Resident 1 stated he wanted to kill himself. RNS1 stated she was informed the resident was mad, threatening the staff, and had an order to be transferred out. RNS1 stated she called the receiving facility, but no bed was available. RNS1 stated if she had been notified Resident 1 had suicidal ideation on 10/08/2021, RNS1 would have prevented the incident that happened on 10/12/2021 when the resident tried to commit suicide. RNS1 confirmed no safety interventions to prevent suicide were implemented for Resident 1 on and after 10/08/2021. RNS1 stated Resident 1 should have been placed on close monitoring, transferred out of the facility, and care plans created. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/14/2021 at 4:39 PM, LVN1 stated on 10/12/2021 at 11:00 AM LVN1 saw Resident 1 punching himself in the head. LVN1 stated Resident 1 was not placed on 1:1 monitoring at that time. LVN1 stated around 9:30 PM (10/12/2021) Resident 1 was sitting next to the door of his room, screaming and yelling. LVN1 stated he did not place Resident 1 on 1:1 monitoring but did check on the resident frequently. LVN1 stated he was asked by RNS1 to go check on Resident 1 and LVN1 noticed the door to Resident 1's room was closed. LVN1 stated when he opened Resident 1's door the resident was holding the wire from the thermostat attempting to wrap it around his neck. LVN1 stated he immediately stopped the resident and took the wire away from the resident. LVN1 stated RNS1 called 911. LVN1 stated he did not know Resident 1 had verbalized wanting to kill himself during the resident's stay at the facility. LVN1 stated Resident 1's suicide attempt should have been prevented if his verbalization of wanting to kill himself had been communicated. LVN1 stated Resident 1 should have been assigned a sitter to monitor him and all the cords removed from the resident's room. During a follow up interview on 10/14/2021 at 4:55 PM, the DON stated Resident 1's suicide attempt could have been prevented if the proper notification, care plan revision, and monitoring had been done. The DON stated 911 should have been called on 10/08/2021 when Resident 1 verbalized wanting to kill himself. A review of the facility's policy titled Change in a Resident's Condition or Status dated November 2015, indicated the physician must be notified of any change in condition by the nurse supervisor or charge nurse. The policy identified reasons to notify the physician which included: refusal of treatment or medications, a significant change in the resident's mental condition, and a need to transfer a resident to a hospital or treatment center. The policy indicated the notification of changes needed to be documented in the resident's medical record. A review of the facility's policy titled Suicide Threats dated December 2017, indicated resident suicide threats needed to be taken seriously. The policy indicated all staff caring for the resident were to be informed of suicide threats and to report changes in the resident's behavior immediately. The policy indicated if the resident was in the facility during the suicide threat the staff were required to monitor the resident's moods and behavior, and update care plans until a physician determined the risk of suicide was no longer present.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41511 Based on observation, interview, and record review the facility failed to assess, develop, and implement, and revise an individualized (resident-specific) care plan for one of four sampled residents (Resident 1) with suicidal ideations (thoughts or plans to commit suicide) as indicated in the facility's policy. On 10/8/2021 at 4:45 pm the facility staff (Licensed Vocational Nurse 1 [LVN 1]) did not revise Resident 1's care plan after the resident verbalized wanting to commit suicide, punched himself in the head, and requested to go to a mental health hospital. On 10/12/2021 Resident 1 used a thermostat wire and put it around his neck to try to kill himself. This deficient practice had the potential for Resident 1's suicide attempt to be successful and allow the 56 residents in the facility receiving antipsychotic medications with diagnoses of schizophrenia (mental disorder characterized by hallucinations, hearing voices, and disorganized thoughts and behaviors), depression, and bipolar disorder (mental disorder characterized by drastic periods of happiness and drastic declines in mental condition leading to deep depression) to harm themselves. Findings: A review of Resident 1's face sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included schizophrenia and bipolar disorder. A review of Resident 1's History and Physical (H&P) (no date), indicated the resident was able to make his needs known, but could not make medical decisions. A review of Resident 1's care plan for schizophrenia dated 10/05/2021, indicated the resident was at risk for confusion and disordered thoughts. The care plan indicated interventions required for Resident 1 included keeping the environment free of hazards, and to notify the physician if the resident's behavior interfered with functioning. A review of Resident 1's care plan for impaired status behavior dated 10/07/2021 (no time), indicated the resident had multiple behavioral issues including: verbally abusive, physically abusive, resisting care and medications, sexually inappropriate, and episodes of eating his own feces. The care plan indicated these behaviors required interventions which included monitoring medications and behavior manifestations, as well has providing a safe environment. A review of Resident 1's departmental notes dated 10/08/2021 at 5:36 PM, indicated at 4:45 PM that day (10/08/2021) Resident 1 was ripping the curtains off the ceiling, throwing his dresser and the drawers, and began punching himself in the head. The notes indicated Resident 1 told certified nursing assistant 1 (CNA1) he (Resident 1) wanted to kill himself. The notes indicated Resident 1 asked licensed vocational nurse 2 (LVN2) to be taken to a mental hospital as he was punching himself in the head. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's situation background assessment and recommendation (SBAR) form dated 10/08/2021 (no time), indicated the resident was displaying aggressive behavior towards staff and had suicidal ideation (considering or planning suicide). The SBAR form indicated the resident was a danger to himself and others. The SBAR form indicated Resident 1 would not allow staff in his room and would throw things at them when they attempted to enter the resident's room. The SBAR form also indicated Resident 1 told the nursing staff he wanted to kill himself and wanted to be transferred to a mental hospital as he punched himself in the head. A review of Resident 1's care plans for 10/08/2021, indicated LVN2 did not create a care plan for suicidal ideation. A review of Resident 1's departmental notes dated 10/09/2021 at 2:59 PM, indicated the resident was still at the facility and was noted to yell and hit his tattoo on his arm. A review of Resident 1's care plans for 10/09/2021, indicated a care plan was not created for self-harm. A review of Resident 1's departmental notes dated 10/12/2021 at 3:20 PM, indicated around 11:00 AM that day (10/12/2021) Resident 1 was very agitated and hitting/punching himself. The notes indicated the physician was notified and orders received to transfer Resident 1 to a general acute care hospital (GACH) for evaluation. A review of Resident 1's care plans for 10/12/2021, indicated a care plan was not created for self-harm. A review of Resident 1's departmental notes dated 10/12/2021 at 11:17 PM, indicated Registered Nurse Supervisor 1 (RNS1) entered Resident 1's room to provide him with a blanket and noticed he looked pale. The notes indicated RNS1 returned to Resident 1's room with Vocational Nurse 1 (LVN1) and found Resident 1 with an electrical wire from the wall wrapped around his neck. The notes indicated Resident 1 destroyed the air conditioning panel with a nail clipper and pulled out the electrical wire. A review of Resident 1's departmental notes dated 10/13/2021 at 12:00 AM, indicated around 10:00 PM on 10/12/2021, RNS1 informed LVN1 the resident looked pale and sound like he was praying. The notes indicated LVN1 went to check on Resident 1 and found the door to the resident's room was closed. The notes indicated LVN1 opened the door and found Resident 1 pulling the thermostat from the wall and wrapped it around his neck. The notes indicated LVN1 attempted to talk to Resident 1 and the resident became very upset and threatening. The notes indicated RN1 called 911 and Resident 1 was transferred to the local emergency room for 51/50 eval. During an interview and record review on 10/14/2021 at 11:00 AM, licensed vocational nurse 2 (LVN2) stated if a resident verbalizes, they want to kill themselves that is suicidal ideation. LVN2 stated the resident should then be monitored with a staff nearby and any dangerous items such as utensils, metal, and the call light with cord should be removed from the room. LVN2 stated she notified RNS1 of Resident 1's suicidal ideation on 10/08/2021 and RNS1 was called to the resident's room. LVN2 stated there was no one to one (1:1) sitter assigned to monitor the resident. LVN2 also stated Resident 1's call light was not removed from the resident's room and should have been because the cord was a weapon that the resident could use to kill himself with. LVN2 confirmed no care plan was created for suicidal ideation or self-harm on 10/08/2021. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/14/2021 at 12:46 PM, the director of nursing (DON) reviewed Resident 1's departmental notes dated 10/08/2021 at 5:36 PM and stated 1:1 monitoring for the resident's safety should have been implemented and was not. The DON confirmed no care plan was created. The DON stated a care plan should have been created so everyone could know how to care for Resident 1, and what approached to take. Resident 1 needed to be monitored, especially after expressing the desire to kill himself and for the safety of others. During an interview on 10/14/2021 at 4:23 PM, registered nurse supervisor 1 (RNS1) stated she was not informed on 10/08/2021 that Resident 1 stated he wanted to kill himself. RNS1 stated she was informed the resident was mad, threatening the staff, and had an order to be transferred out. RNS1 confirmed no safety interventions to prevent suicide were implemented for Resident 1 on and after 10/08/2021. RNS1 stated Resident 1 should have been placed on close monitoring, transferred out of the facility, and care plans created. During a follow up interview on 10/14/2021 at 4:55 PM, the DON stated Resident 1's suicide attempt could have been prevented if the proper notification, care plan revision, and monitoring had been done. The DON stated 911 should have been called on 10/08/2021 when Resident 1 verbalized wanting to kill himself. A review of the facility's policy titled Care Plans - Comprehensive dated September 2010, indicated individualized care plans included measurable objectives and timelines needed to meet the resident's physical, mental, and psychological needs. The policy indicated assessments of care plans were on going and revisions made as resident conditions changed. A review of the facility's policy titled Suicide Threats dated December 2017, indicated resident suicide threats needed to be taken seriously. The policy indicated all staff caring for the resident were to be informed of suicide threats and to report changes in the resident's behavior immediately. The policy indicated if the resident was in the facility during the suicide threat the staff were required to monitor the resident's moods and behavior, and update care plans until a physician determined the risk of suicide was no longer present.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41511 Based on interview, and record review, the facility failed to have a system in place to provide behavioral health care and services for one of two sampled residents (Resident 1) who had suicidal (saying or doing something that reveals a self-destructive desire) threats and attempts in the facility by failing to: 1. Identify and address Resident 1's suicidal threats on 10/8/2021. 2.Develop and implement a person-centered care plan that included and support the behavioral healthcare needs of Resident 1's suicidal ideations/threats. 3. Supervise, identify, and remove environmental hazards, such as items that could potentially be used by Resident 1 to harm himself in his room. 4. Ensuring Resident 1 was transferred out on 5150 hold (code for a California law which allows a person to be detained for 72 hours for mental help when they are a danger to themselves or others) on 10/8/2021 as ordered by the physician. 5. Ensuring staff caring for the resident were informed and alerted of Resident 1's verbalization of wanting to kill himself on 10/8/2021 to ensure the resident was monitored and supervised closely to prevent the resident from attempting suicide. As a result, on 10/12/2021 at 10PM, Resident 1 wrapped a thermostat wire around his neck by using a nail clipper to cut through the facility's air conditioning (AC) panel mounted in the resident's room wall in an attempt to kill himself. This placed Resident 1 at risk for death. The facility staff called 911 (emergency services) and Resident 1 was transferred to a General Acute Care Hospital (GACH) on 10/12/2021 at 10:30 PM. This deficient practice had the potential for the other 56 identified residents in the facility receiving antipsychotic medications (medication used to treat psychosis [a serious mental disorder characterized by defective or lost contact with reality] and other mental and emotional conditions) and with diagnoses of schizophrenia (mental disorder characterized by abnormal social behavior and failure to understand what is real), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (extreme mood swings that include mania [emotional highs] and depression which may lead to impaired functioning) to be at risk for injury, harm and death. The Department called an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirement of participation has caused or is likely to cause serious injury, impairment or death to a resident) situation on 10/14/2021 at 5:15 PM, in the presence of the Administrator (ADM), Director of Nursing (DON) and [NAME] President of Operations. The ADM and DON were informed of the facility's failure to have systems in place to ensure Resident 1 was provided supervision and safe environment to prevent Resident 1's attempt to kill himself, transfer to GACH on a 5150 hold as ordered by physician on 10/8/21 and notify all staff regarding Resident 1's verbalization of wanting to kill himself on 10/8/21. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/17/2021 at 3:41PM, IJ was removed after verification of the Plan of Action (POA, a detailed plan to address findings) through observations, interviews, and record review, in the presence of ADM, DON, and [NAME] President of Operations. The POA was as follows: a. On 10/14/2021, Quality Assurance Nurse/Designee screened interviewable Residents for Suicidal ideations. A Situation Background Assessment and Recommendation (SBAR) was initiated, physician and family were notified of change of condition for the Residents who verbalized thoughts of suicidal ideation (thoughts of killing oneself). b. On 10/14/2021, an inservice on Suicide Warnings, Immediate Communication to Nursing Supervisor and Administration, Documentation on 24 hour log and Incident Report, Notification of Physician and Family and One to One Monitoring was initially conducted by DON and Director of Staff Development (DSD) to all facility staff. c. On 10/14/2021, an inservice on 5150 or Acute Incident Management, Admission Assessment and Care Planning Process was initially conducted by DON and DSD to all Licensed Nursing Staff. c. On 10/15/2021, Licensed Vocational Nurse 2 (LVN 2) received a written one to one disciplinary action from the DON regarding responding to change of condition (COC) and suicidal ideation. d. On 10/15/2021 DON further assessed the 56 identified residents in the facility on antipsychotic medications and with diagnoses of schizophrenia, depression, and bipolar disorder, using the Suicide Risk Screening Tool. e. Medical Record Director (MRD)/Designee will conduct daily audits of 24 hour/COC log, incident reports, SBARs, Physician orders and updated care plan to ensure all aberrant behavioral events are captured and addressed immediately. A report will be provided daily to DON or Designee for follow up and intervention. f. MRD/Designee will complete weekly audit log on all behavior monitoring logs to ensure behaviors are monitored and appropriately addressed for follow up and intervention. g. Environmental rounds for rooms with Residents identified with Suicidal Ideation risk will be conducted by Maintenance Director/ Designee. h. MRD will report monthly to the Quality Assurance Performance Improvement Committee for the next three months and quarterly thereafter and will be overseen by the DON. Findings: A review of Resident 1's Face Sheet (admission record) indicated the facility admitted Resident 1 on 10/5/2021 with diagnoses of pneumonia (lung inflammation caused by bacterial or viral infection), schizophrenia and bipolar disorder. A review of Resident 1's undated History and Physical (H&P), indicated the resident was able to make needs known, but unable to make medical decisions. (continued on next page)

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	056431	A. Building B. Wing	10/29/2021

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Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1's Care Plan titled, Schizophrenia, dated 10/5/2021, indicated Resident 1 was at risk for confusion and disordered thoughts (disorganized way of thinking that leads to abnormal ways of expressing language when speaking and writing). The care plan interventions included keeping the environment free of hazards and to notify the physician if the resident's behavior interfered with functioning. A review of Resident 1's Care Plan titled, Impaired Behavior Status, dated 10/7/2021, indicated Resident 1 had multiple behavioral issues that included being verbally and physically abusive, resisting care and medications, being sexually inappropriate, and having episodes of eating his own feces. The care plan interventions included monitoring the resident's medications and behavior manifestations and providing a safe environment. A review of Resident 1's Physician's Order, dated 10/8/2021, indicated to send Resident 1 out on 5150 due to being a danger to others. A review of Resident 1's Departmental Notes, dated 10/8/2021 at 5:36 PM, indicated at 4:45 PM on 10/8/2021, Resident 1 was observed ripping the curtains off the ceiling, throwing his dresser and the drawers, and began punching himself in the head. The notes indicated Resident 1 told Certified Nursing Assistant 1 (CNA1) he wanted to kill himself and asked Licensed Vocational Nurse 2 (LVN2) for him to be taken to a mental hospital as Resident 1 was punching himself in the head. The notes indicated a physician's order was received to transfer Resident 1 to GACH on a 5150 hold. The notes did not indicate Resident 1 was transferred as ordered. A review of Resident 1's (SBAR) form, dated 10/8/2021, indicated the Resident 1 was displaying aggressive behavior towards staff and had suicidal ideation (considering or planning suicide). The SBAR form also indicated Resident 1 was a danger to himself and others, would not allow staff in his room and would throw things at the staff when they attempted to enter Resident 1's room. The SBAR form also indicated Resident 1 told the nursing staff he wanted to kill himself and wanted to be transferred to a mental hospital as he punched himself in the head. The SBAR form indicated Resident 1 was to be sent out on a 5150. The SBAR form did not indicate Resident 1 was sent out to another facility. A review of Resident 1's Psychiatry Initial Evaluation, dated 10/9/2021, indicated Resident 1 was aggressive and was verbally abusive towards the psychiatrist. The evaluation indicated the psychiatrist wanted Resident 1 to go to any psychiatric facility that had a bed available. A review of Resident 1's Physician's Order, dated 10/9/2021, indicated a follow up for the psychiatric bed placement. A review of Resident 1's Departmental Notes, dated 10/9/2021 at 2:59 PM, indicated Resident 1 was still at the facility and was noted to yell and hit his tattoo on his arm. A review of Resident 1's Departmental Notes, dated 10/9/2021 at 5:05 PM, indicated Nurse Practitioner 1 (NP 1) was at the facility to see Resident 1. The notes did not indicate why Resident 1 had not been transferred for psychiatric assessment or if NP1 was notified about Resident 1's suicidal ideation. A review of Resident 1's Departmental Notes, dated 10/10/2021 at 7:50 PM, indicated Resident 1 was throwing urine and feces at staff. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1's Interdisciplinary Team (IDT, involving two or more disciplines) notes, dated 10/12/2021, indicated Resident 1 had been eating his own stool, refusing medications, displayed multiple behaviors such as violent and sexual behaviors toward staff and had suicidal ideations. The notes indicated other referrals were necessary but did not indicate which specific referrals were needed. A review of Resident 1's Departmental Notes, dated 10/12/2021 at 3:20 PM, indicated around 11:00 AM on 10/12/2021, Resident 1 was very agitated and was hitting/punching himself. The notes indicated the physician was notified and an order was received to transfer Resident 1 to GACH for evaluation. A review of Resident 1's Physician's Order, dated 10/12/2021 at 3:30 PM, indicated Resident 1 was to be monitored for any suicidal ideations, behaviors, and verbalizations. The Physician's Order orders indicated if Resident 1 displayed or verbalized suicidal ideations, the facility was to notify the physician. A review of Resident 1's Departmental Notes, departmental notes dated 10/12/2021 at 5:28 PM, indicated GACH was notified of Resident 1's transfer on 5150. The notes indicated the GACH would call the facility back with bed availability. A review of Resident 1's Departmental Notes, dated 10/12/2021 at 11:17 PM, indicated Registered Nurse Supervisor 1 (RNS1) entered Resident 1's room to provide him with a blanket and noticed Resident 1 looked pale. The notes indicated RNS1 returned to Resident 1's room with LVN1 and found Resident 1 with an electrical wire from the wall wrapped around his neck. The notes indicated Resident 1 destroyed the air conditioning panel with a nail clipper and pulled out the electrical wire. A review of Resident 1's Departmental Notes, dated 10/13/2021 at 12AM, indicated around 10PM on 10/12/2021, RNS1 informed LVN1 Resident 1 looked pale and sound like he was praying. The notes indicated LVN1 went to check on Resident 1 and found the door to Resident 1's room closed. The notes indicated LVN1 opened the door and found Resident 1 pulling the thermostat from the wall and wrapped it around his neck. The notes indicated LVN1 attempted to talk to Resident 1 and the resident became very upset and threatening. The notes indicated RN1 called 911 and Resident 1 was transferred to the local emergency room for 5150 evaluation. During an interview and record review on 10/14/2021 at 11AM, LVN2 stated suicidal ideation meant resident verbalizing wanting to kill him/herself. LVN2 stated the resident should then be monitored with a staff nearby and any dangerous items such as utensils, metal, and the call light with cord should be removed from the room. LVN2 reviewed the Departmental Notes, dated 10/8/2021 at 5:36 PM and stated the physician was notified of Resident 1's suicidal ideation and an order was received to transfer Resident 1 out on a 5150. LVN2 stated Resident 1 was not transferred out because there were no available beds at the receiving facility. LVN2 stated she notified RNS1 of Resident 1's suicidal ideation on 10/8/2021 and RNS1 was called to check on Resident 1 in his room. LVN2 also stated Resident 1's call light should have been removed from the resident's room because the resident could have used the call light cord to harm himself. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent record review of Resident 1's Departmental Notes, dated 10/08/2021 at 5:36 PM and interview on 10/14/2021 at 12:46 PM, DON stated Resident 1 should have been transferred out of the facility on 10/8/2021 via 5150 as ordered by NP 1. The DON stated the facility should have implemented 1:1 monitoring for the resident's safety. The DON stated Resident 1 needed to be closely monitored, especially after expressing the desire to kill himself and for the safety of others. During an interview on 10/14/2021 at 2:23 PM, NP 1 stated he was never informed Resident 1 had verbalized wanting to commit suicide on 10/8/2021. NP1 stated he went to the facility on [DATE] and visited Resident 1 and was informed by RNS1 of Resident 1's aggressive behavior but was not informed of the resident's suicidal ideation. NP1 stated he was notified of Resident 1's suicidal ideation on 10/12/21 (4 days after the resident verbalized wanting to kill himself). NP1 stated the facility was a new environment for Resident 1 and it was very important for the staff to communicate Resident 1's mental status to the NP. NP1 stated he never received a follow up call from the facility on the resident's mental status. NP1 stated if the facility had informed him of Resident 1's desire to commit suicide on 10/8/2021, NP1 would have ordered a 1:1 sitter (continuous staff observation to safeguard patients judged likely to harm themselves or others) and would have transferred the resident out for psychiatric evaluation. NP1 stated the incident on 10/12/2021 when Resident 1 tried to kill himself could have been prevented. During an interview on 10/14/2021 at 4:23 PM, RNS1 stated she was not informed on 10/8/2021 that Resident 1 stated he wanted to kill himself. RNS1 stated she was informed Resident 1 was mad, threatening the staff, and had an order to be transferred out. RNS1 stated she called the receiving facility, but no bed was available. RNS1 stated if she had been notified Resident 1 had suicidal ideation on 10/8/2021, RNS1 would have prevented the incident that happened on 10/12/2021 when the resident tried to commit suicide. RNS1 stated there were no safety interventions implemented for Resident 1 to prevent suicide on and after 10/8/2021. RNS1 stated Resident 1 should have been placed on close monitoring, transferred out of the facility, and care plans created to prevent further harming himself. During an interview on 10/14/2021 at 4:39 PM, LVN1 stated on 10/12/2021 at 11:00 AM, LVN1 saw Resident 1 punching himself in the head. LVN1 stated around 9:30 PM on 10/12/2021, Resident 1 was sitting next to the door of his room, screaming and yelling. LVN1 stated Resident 1 was not placed on 1:1 monitoring, but LVN 1 checked on Resident 1 frequently. LVN1 stated RNS1 asked [NAME] to check on Resident 1. LVN1 noticed the door to Resident 1's room was closed. LVN1 stated when he opened Resident 1's door, Resident 1 was holding the wire from the thermostat attempting to wrap it around his neck. LVN1 stated he immediately stopped Resident 1 and took the wire away from him. LVN1 stated RNS1 called 911 while he stayed with Resident 1 in his room. LVN1 stated could not do a full assessment due to Resident 1 being aggressive. LVN1 stated 911 personnel came and took Resident 1 to a local hospital. LVN1 stated he did not know Resident 1 had verbalized wanting to kill himself on 10/8/21. LVN1 stated he had informed the physician about Resident 1's behavior of punching/hitting himself in the head. LVN1 stated Resident 1's suicide attempt could have been prevented if his verbalization of wanting to kill himself had been communicated among the facility staff. LVN1 stated Resident 1 should have been assigned a sitter to monitor him and all the cords should have been removed from Resident 1's room. During a follow up interview on 10/14/2021 at 4:55 PM, DON stated Resident 1's suicide attempt could have been prevented if there was a physician/NP and DON notification, care plan was developed, and monitoring have been done. The DON stated 911 (call for emergency assistance) should have been called on 10/8/2021 when Resident 1 verbalized wanting to kill himself. (continued on next page)

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