STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555375	A. Building B. Wing	03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Post Acute	3232 E. Artesia Blvd. Long Beach, CA 90805

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 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** 19152 Based on interview and record review the facility's nursing staff failed to developed a care plan to address the resident's suicide attempt with interventions to remove all cords or other objects from Resident A's room that could be potentially used to harm himself and to monitor the resident frequently for signs and symptoms of depression and harmful behavior to ensure the resident's safety for one of one sampled resident (Resident A). Resident A who had diagnoses of major depressive disorder ([MDD] a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy and suicidal thoughts) attempted to commit suicide by wrapping a telephone cord around his neck on 3/1/2022. This deficient practice had a high potential for Resident A to use available cords in his room as a tool to attempt suicide as he previously attempted (3/1/2022) to commit suicide by wrapping a telephone cord around his neck on. Findings: A review of Resident A's Admission Records indicated he was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including recurrent MDD, shizoaffective disorder bipolar type (a combination of symptoms of schizophrenia [a mental disorder often characterized by abnormal social behavior and failure to recognize what is real], a mood disorder [a term that broadly describes all types of depression]) and anxiety (extreme worry or fear). During a review Resident A's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 3/12/2022, MDS indicated Resident A's cognitive skills for daily decision-making were moderately impaired. The MDS Mood section indicated Resident A felt bad about himself or felt as though he was a failure or that he let himself or his family down 2-6 days of the week. Per the MDS Resident A required extensive one-person physical assist for bed mobility, and locomotion on/off the unit and required extensive two plus person physical assist to transfer. According to the MDS Resident A had a functional limitation in range of motion ([ROM] the distance and direction a joint can move to its full potential) to one of his upper extremities. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Situation Background Assessment Recommendation (SBAR- a form of communication between members of a health care team) Communication Form, dated 3/1/2022, indicated Resident A attempted to loosely wrap a telephone cord around his neck. During a review, a Care Plan dated 3/8/2021, indicated Resident A had a potential for a behavior problem related to (r/t) schizoaffective bipolar and psychosis manifested by physical aggression and a history of suicidal ideation by attempting to loosely wrap a telephone cord around his neck. Per psych: Resident A was no longer a danger to himself/others and no longer had suicidal ideation at this time. During a continued review of Resident A's clinical records (care plans) there was no written documentation available to indicate a care plan was developed specifically to address Resident A's suicide attempt and interventions related to monitor and keep Resident A safe. During an interview on 3/27/2022 at 4:49 p.m., Registered Nurse Supervisor 1 (RN 1) after reviewing Resident A's care plan stated Resident A was cleared (no suicidal ideation) by the hospital's psychiatrist before being readmitted to the facility and was seen by the facility's psychiatrist who had also cleared Resident A. RN 1 stated Resident A was monitored by a CNA 1 who was assigned to him but there was no documentation to show CNA 1 was monitoring Resident A. During a telephone interview on 4/13/2022, at 11:35 a.m., the Director of Nursing (DON) stated a care plan was not developed specifically for Resident A's suicide attempt because Resident A was no longer considered a suicide risk. The DON stated a care plan was developed related to Resident A's diagnoses of schizoaffective bipolar and psychosis where his suicide attempt was addressed, and interventions included removing his telephone and replacing his call light with a bell. A review, a facility's policy and procedure titled Suicide Prevention dated 11/2012 indicated the interdisciplinary team will continually monitor residents for indicators of acute depression associated with suicidality and provide immediate intervention. Any resident with a history of suicidal ideation, behavioral attempts or any signs and/or symptoms of acute depression will be monitored for the recurrence of such signs and symptoms. Once it has been determined that the resident can be maintained safe in the facility, his/her care plan will be updated to reflect changes in approach in response to the suicidal ideation.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19152 Based on interview and record review the facility failed to ensure the licensed nurses obtained a treatment regimen, or documentation indicating the resident physician was aware of the resident's blood sugar level out of range due to diagnosis of diabetes and confirmed there was no treatment warranted for one of one sampled resident (Resident A). This deficient practice resulted in Resident A's blood sugar ([b/s] the concentration of glucose (sugar) in the blood) level being above the reference range of 70-100 milligrams/deciliter (mg/dl) on several occasions without a recognized treatment or plan. This deficient practice had the potential to lead to hyperglycemia (an excessive amount of glucose in the bloodstream, often associated with diabetes) side effect including damage to body organs, damage to eyes, heart attack, nerve damage and other ill affects of hyperglycemia. Findings: A review of Resident A's Admission Records indicated he was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including diabetes. A review of Resident A's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 3/12/2022, indicated Resident A's cognitive skills for daily decision-making were moderately impaired. A review of Physician's Orders dated 2/26/2022 indicated to obtain a b/s via a finger stick ([fs] a method by which blood is obtained by pricking the finger) two times a day and to call the physician if Resident A's b/s is less than 60 milligrams per deciliter (mg/dl) or greater than 400 mg/dl. During a review of Resident A's Vital Sign record for blood sugars, dated 2/26/2022 - 3/27/2022, the record indicated the following out of range b/s results: 2/26/2022 - 165 mg/dl. 2/27/2022 - 221 mg/dl. 2/28/2022 - 187 mg/dl, 110 mg/dl. 3/1/2022 - 121 mg/dl, 118 mg/dl. 3/7/2022 - 122 mg/dl. 3/8/2022 - 155 mg/dl, 62 mg/dl. 3/9/2022 - 121 mg/dl, 167 mg/dl. 3/10/2022 - 137 mg/dl, 140 mg/dl. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/11/2022 - 187 mg/dl, 222 mg/dl. 3/12/2022 - 108 mg/dl, 190 mg/dl. 3/13/2022 - 178 mg/dl, 163 mg/dl. 3/14/2022 - 115 mg/dl. 3/15/2022 - 150 mg/dl. 3/16/2022 - 135 mg/dl. 3/17/2022 - 155 mg/dl, 162 mg/dl. 3/18/2022 - 106 mg/dl, 137 mg/dl. 3/19/2022 - 267 mg/dl, 142 mg/dl. 3/20/2022 - 138 mg/dl. 3/21/2022 - 121 mg/dl. 3/22/2022 - 147 mg/dl. 3/24/2022 - 114 mg/dl. 3/25/2022 - 117mg/dl. 3/26/2022 - 250 mg/dl, 122 mg/dl. 3/27/2022 - 170 mg/dl, 137 mg/dl. During an interview on 3/27/2022 at 3:58 p.m., Licensed Vocational Nurse 2, (LVN 2) stated Resident A's b/s is taken on his shift (3-11 p.m.) at 4:30 p.m., but there was no treatment order for Resident A if the resident's b/s was above the normal range. LVN 2 stated Resident A's b/s is usually not high on the 3-11 p.m., shift. LVN 2 stated if Resident A's b/s was high he would call the resident's physician. LVN 2 stated he did not know why there was no treatment order for Resident A's diabetes. During an interview on 3/30/2022 at 4:13 p.m., Registered Nurse Supervisor 1 (RN 1) stated there was an order to call the physician if Resident A's b/s was less than 60 mg/dl or greater than 400 mg/dl. RN 1 stated the physician was aware of Resident A's diabetes diagnosis and was monitoring Resident A's b/s. RN 1 stated when Resident A was admitted from the general acute care hospital (GACH) he had no treatment ordered for his diabetes other than obtaining a b/s reading two times daily. RN 1 stated the admission orders were verified with the physician at that time of Resident A's admission to the facility but there was no documentation specific to Resident A's diabetes to indicate the physician was aware of Resident A's diagnoses and was in agreement with no treatment ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review, a facility policy and procedure (P/P), titled Physician's Orders, Accepting, Transcribing and Implementing dated 11/2012, indicated all physician orders are to be complete and clearly defined to ensure accurate implementation. Licensed nursing shall verify each order for completeness, clarity, and appropriateness of doses.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19152 Based on observation, interview, and record review, the facility's failed to ensure one of one sampled resident (Resident A), who had a history of a suicide attempt by wrapping a telephone cord around his neck, was provided an environment free of cords to prevent Resident A from utilizing cords as a tool to attempt suicide. The facility failed to: 1. Ensure Resident A, who had a recent suicide attempt by wrapping a telephone cord around his neck, was not left alone in a room with multiple cords accessible to the resident with the door closed. 2. Have interventions in place to address Resident A's safety monitoring and removal of objects Resident A used previously to attempt suicide, including telephone cords, call light cords, and other objects Resident A could use to harm himself. 3. Ensure the Interdisciplinary Team (IDT) assessed and monitored Resident A upon re-admission to the facility on [DATE] for the symptoms of recurrence of suicidal ideations, behavioral attempts, or any signs and/or symptoms of acute depression due to the history of Resident A's previous suicidal attempt (3/1/2022) by completing from PHQ9 (nine question form used to screen depression and monitor changes in signs/symptoms of depression) per the facility's policy and procedure titled Suicide Prevention. 4. Ensure Certified Nursing Assistant 1 (CNA 1), who was assigned to monitor Resident A, was informed of the resident's previous suicide attempt to ensure CNA 1 had knowledge for what behavior to monitor Resident A. 5. Develop a care plan for Resident A's past suicidal attempt with interventions to prevent any potential future attempts. This deficient practice had a high potential for Resident A to use available cords in his room as a tool to attempt suicide as he previously attempted (3/1/2022) to commit suicide by wrapping a telephone cord around his neck on. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/1/2022 Resident A attempted suicide by wrapping a telephone cord around his neck. On the same day, Resident A was transferred to a general acute care hospital (GACH) for evaluation and treatment, and on 3/7/2022 the resident was transferred back to the facility. On 3/20/2022, while at the facility, Resident A tested positive for COVID-19 (a highly contagious viral infection) and was relocated to a room with four beds, located on the facility's red zone (a designated area where COVID -19 positive residents were cohorted) where Resident A was the sole resident in the room. On 3/27/2022 at 4:47 p.m., Resident A was observed behind closed doors alone in a room with three unoccupied beds. On each unoccupied bed was a call light cord measuring approximately three feet in length on top of the bare mattress. On the bed directly across from Resident A, in addition to a call light cord was a telephone with an attached cord measuring approximately three feet in length at the foot of the bed. Two of three beds had cords attached to the light fixtures located behind the beds. The call light cords, telephone cords, and light fixtures cords were in full view of Resident A and accessible to him. Resident A was observed to be agitated and according to him was experiencing high levels of anxiety. On 3/27/2022 at 8:54 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) was called via a telephone conference in the presence of the facility's Administrator (ADM) and Director of Nursing (DON) due to the facility's failure to ensure Resident A, who had a history of a previous suicide attempt by wrapping a telephone cord around his neck, was not left alone in a room with multiple cords accessible to him. On 3/30/2022 at 2 p.m., the facility submitted an acceptable IJ Removal Plan (IJRP). After onsite verification of IJPR implementation through observation, interview, and record review, the ADM was notified that IJ situation was removed. The facility's IJRP included the following actions: 1. On 3/27/2022 at 8:50 p.m., the call light cords were removed from Resident A's room. 2. On 3/27/2022, at 9:10 p.m., two registered nurse supervisors (RN) assessed Resident A for the risk of suicide. 3. On 3/27/2022 a certified nursing assistant (CNA) continued to be dedicated to the red zone on all shifts. The CNA was assigned to provide care and monitor Resident A every 30 minutes while he is on isolation precautions. 4. On 3/27/2022 the Director of Staff Development (DSD) conducted an in-service to staff regarding suicide prevention and environmental hazard monitoring. This in-service will be conducted monthly for 3 months and quarterly thereafter. 5. On 3/27/2022 the DON and designee conducted an in-service regarding the facility's protocol on development of a comprehensive care plan. This in-service will be conducted for 3 monthly and quarterly thereafter. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. On 3/27/2022 the DON updated the care plans for Resident A's history of attempted suicide indicating new nursing interventions such as every two-hour monitoring by the licensed nurses and every 30 minutes monitoring by the CNA assigned to Resident A every shift until the isolation has been completed in the red zone. Findings: During a review, Resident A's Admission Records indicated Resident A was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including COVID-19, recurrent major depressive disorder ([MDD] a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep feeling of guilt or inadequacy and suicidal thoughts), schizoaffective disorder of bipolar type (a combination of symptom of schizophrenia [a mental disorder often characterized by abnormal social behavior and failure to recognize what is real], a mood disorder [a health that broadly describes all types of depression]), anxiety (extreme worry or fear) and insomnia (difficulty sleeping and/or remaining asleep) During a review, Resident A's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 3/12/2022, indicated Resident A's cognitive skills for daily decision-making were moderately impaired. The MDS Mood section indicated Resident A felt bad about himself or felt as though he was a failure or that he let himself or his family down 2 to 6 days during a seven-day week. The MDS indicated Resident A required extensive one-person physical assist for bed mobility, with locomotion on and off the unit, and required extensive two plus person physical assist with transfer (how a resident moves between surfaces including to or from: bed, chair, wheelchair, standing position). According to the MDS Resident A had a functional limitation in range of motion ([ROM] the distance and direction a joint can move to its full potential) to one of his upper extremities. During a review, of Situation Background Assessment Recommendation (SBAR) communication form (a form of communication between members of a health care team), dated 3/1/2022, the SBAR indicated Resident A attempted to loosely wrap a telephone cord around his neck and staff immediately intercepted. Resident A was placed on one-on-one monitoring for suicidal watch/precautions and the resident's physician, psychiatrist and the social worker were notified of the incident. During a review of Physician's Order dated 3/1/2022 and timed at 7:03 p.m., the Physician's Order indicated there was an order to transfer Resident A to a GACH emergency room (ER) for behavioral management and medication review. During a review of Physician's Order dated 3/7/2022 the Physician's Order indicated Resident A was readmitted to the facility. During a review, a COVID test dated 3/20/2022, indicated Resident A tested positive for COVID-19. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Interdisciplinary Team (IDT) Progress Note, dated 3/21/2022 and timed at 4:12 p.m., the IDT Progress Notes indicated Resident A was placed in the red zone. The IDT notes indicated there was no documentation to demonstrate the IDT assessed and monitored Resident A upon re-admission to the facility on [DATE] for the symptoms of recurrence of suicidal ideations, behavioral attempts, or any signs and/or symptoms of acute depression due to the history of Resident A's previous suicidal attempt (3/1/2022) by completing form PHQ9 (nine question form used to screen depression and monitor changes in signs/symptoms of depression) per the facility's policy and procedure titled Suicide Prevention. A review of Resident A's all care plans indicated there was no written documentation a care plan for the resident's past suicidal attempt with interventions to prevent any potential future attempts was developed. There was not documented evidence the interventions to remove all cords and other objects from Resident A's room that could be potentially used to harm himself and to frequently monitor the resident for signs and symptoms of depression and behavior of harmful activity were care planned to ensure the Resident A's safety. A review of Resident A's clinical record indicated there was no written documentation to indicate Resident A was being monitored to determine if he displayed any harmful behaviors. During an observation and concurrent interview on 3/27/2022 at 4:57 p.m., Resident A was noted to be in a four-beds room alone with the door closed. Resident A was observed in bed awake and stated he was very anxious and had asked the nurses for medication earlier and the nurses were taking a long time to give it to him. Resident A stated it was difficult for him to sleep and the medication was helping to rest his mind. During a telephone interview on 3/27/2022 at 4:21p.m., the DON stated Resident A was admitted to the facility at the end of February but was discharged about a week after admission because of a suicide attempt on 3/1/2022. The DON stated Resident A was readmitted on [DATE] and was placed in the yellow zone (an area where residents are placed for a designated time while they are monitored for COVID symptoms) where he was monitored for symptoms of COVID -19 and when the resident tested negative, he was moved to the green zone (an area where COVID-19 free residents are cared for). The DON stated Resident A was tested during their routine COVID-19 testing on 3/20/2022 and the results on 3/21/2022 indicated Resident A was positive for COVID-19 Resident A was moved to the red zone on the same day where he was the only resident. The DON stated CNA 1 was designated to the red zone and Resident A's care. The DON stated CNA 1 sat outside of Resident A's room and checked on the resident's care needs frequently. The DON stated Resident A was provided a bell to alert staff when he needed assistance. The DON stated the telephone and call lights were removed from Resident A's room and the only cord left in his room was the resident's bed control cord which was not that long. The DON stated there was a care plan developed but they did not document when Resident A was monitored. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/27/2022, at 4:49 p.m., and a subsequent interview on 4/6/2022 at 4:05 p.m., Registered Nurse Supervisor 1 (RN 1) stated she was doing rounds on 3/1/2022 when she heard Resident A call out for a nurse. RN 1 stated she went to Resident A's room and found him with a telephone cord wrapped one time loosely around his neck. RN 1 stated she removed the telephone cord from Resident A's neck, placed the resident on one-to-one observation (continuous observation of one resident by one nurse) and called the resident's physician (MD) who ordered Resident A's transfer to a GACH. RN 1 stated Resident A was cleared (had no suicidal ideations) by the psychiatrist (a physician specializing in the diagnosis and treatment of mental illness) at the GACH prior to the resident's readmission to the facility. RN 1 reviewed Resident A's care plan and confirmed the care plan did not include interventions to monitor Resident A and remove the cords from his room. During an interview on 3/27/2022, at 5:05 p.m., and a subsequent interview on 3/30/2022 at 12:35 p.m., CNA 1 stated she usually works part-time, and this was her first time caring for Resident A. CNA 1 stated on 3/27/2022 she came to work a little late and the nurses from the previous shift were already gone so no one gave her report. CNA 1 stated she asked the CNAs, who were sitting at the nursing station, if they knew anything about Resident A. CNA 1 stated the nurses told her Resident A gets anxious, was a fall risk, and could not move his left side but they never reported he was a suicide risk. CNA 1 stated Resident A received a phone call but there was only one phone in his room connected to Bed A which was directly across from Resident A. CNA 1 stated she tried to connect the telephone to a phone port near Resident A so he could talk but the call disconnected. CNA 1 stated Resident A began to get stressed out when she told him about the person on the phone would call him back tomorrow. CNA 1 stated Resident A kept asking over and over when they were going to call back. During an interview on 3/28/2022 at 2:30 p.m., the DON and ADM stated the Resident A could not transfer himself or walk without assistance so neither of them believed the cords on the other beds were a threat. The DON stated the cords were removed from Resident A's surrounding area and his call light was replaced with a bell that he was able to ring when he needed assistance. During an observation and concurrent interview on 3/30/2022, at 11:48 a.m., the Occupational Therapist ([OT] licensed health care professionals who help people develop, recover, improve, and maintain skills need to do daily activities) stated initially when Resident A began occupational therapy the resident was dependent and could not perform many of the task, however today Resident A has made great improvements in his ability to follow direction and to complete movements. During an observation Resident A was assisted by the OT to sit on the right side of his bed and was able to scoot to the edge of the bed when the OT instructed Resident A to do so. Resident A was observed following the OT's instructions and was able to perform exercises with his right arm and right leg which had little to no functional limitation. Resident A was able to perform some of the same exercises with his left arm and leg although his left arm required more active assistance from the OT and Resident A who at times would move his left arm with his right arm. Resident A was observed kicking and moving his left leg around with little to no difficulty. The OT was observed assisting Resident A to lie down on the bed and instructed the resident to grab the handrail with his right arm to pull himself over without difficulty. The OT was observed again assisting Resident A to sit up on the right side of his bed, scoot to the edge of the bed and placing a gait belt (a device place around a resident's waist used to aid the resident in the safe movement from a sitting to standing position) around Resident A's waist. Resident A was then assisted by the OT to a standing position where he was able to stand on his own for a short time. The OT then verbally instructed Resident A and physically assisted him to sit in his wheelchair. Resident A was then provided his lunch tray and after the CNA set up the resident's tray Resident A was observed eating his meal unassisted using his right hand. (continued on next page)

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	555375	A. Building B. Wing	03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Post Acute	3232 E. Artesia Blvd. Long Beach, CA 90805

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review, a facility policy and procedure (P/P), titled Suicide Prevention and dated 11/2022, indicated the IDT will continually monitor residents for indicators of acute depression associated with suicidality and provide immediate intervention. Any resident with a history of suicidal ideation, behavioral attempts, or any signs and/or symptoms of acute depression will be monitored for the recurrence of such signs and symptoms. Residents will be assessed upon admission, quarterly, or when significant changes occur using the PHQ9. A room search will be conducted following facility room search policies, to remove potentially dangerous objects. Items such as sharps, glass, call light electrical cords, belts, shoelaces, ties, combs, portable mirrors, shaving cream, and food and beverage items may need to be removed or temporarily confiscated for the resident's safety. Other personal items may be temporarily confiscated as clinically appropriate for the resident's protections.