STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675336	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KIRKLAND COURT HEALTH AND REHABILITATION CENTER	1601 KIRKLAND DR AMARILLO, TX 79106

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 -** Actual harm **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** Based on interviews and record review, it was determined the facility failed to ensure residents remained free from accidents, hazards, and each resident received adequate supervision and assistance when being monitored for 1 of 6 residents (Resident #2) reviewed for accident/hazards and supervision. LVN A, who was alone on the secured unit, failed to notice Resident #1 moving in his wheelchair down the hallway to Resident #2's room. LVN A heard a noise and thought someone fell . LVN A went to Resident #2's room and found Resident #1 hitting Resident #2 with the leg extension off of his wheelchair. Resident #2 was sent to the hospital and was found to have facial fractures and several lacerations requiring sutures. This deficient practice has the potential to affect all residents in the building who required supervision by allowing resident to resident interactions, falls, lacerations, fractures, and even death. The evidence is as follows: Resident #1 Record review of Resident #1's Face Sheet documented a [AGE] year old male who was admitted to the facility on [DATE], with the following Diagnoses: [REDACTED]. -Care Plan: impulsive behavior - cursing at staff/threatening to hit staff with cane, yelling at female residents, [MEDICAL CONDITION] drug use. -An admission MDS resident assessment, dated 2/2/2020, documented the resident can usually make himself understood and usually understands others, scored 11 of 15 on a mini-mental exam, disorganized thinking, no behavioral symptoms at this time, limited assistance by one staff for bed mobility, transfers and personal hygiene, required extensive assistance by one staff for dressing and toileting, totally dependent on one staff for bathing, uses a cane and a wheelchair at times, occasionally incontinent of bladder, had falls prior to admission, 63 inches tall, 115 pounds. -Nurses Notes documented the following: 2/14/2020 at 9:30 a.m. - resident hallucinating, stating car was broke down and had his five kids and needed help with car. Resident became very angry, cursing at staff and yelling and cussing in the dining room. Staff attempted to talk with resident and resident will not listen. Staff called spouse to attempt to calm resident and resident got more aggressive and verbally aggressive. Resident was left alone without anyone bothering him. continue to monitor. Spouse stated that's why she didn't want him home, cause he was abusive to her. 2/14/2020 at 2:30 p.m. - staff escorting resident to go out to smoke, resident became aggressive, attempting to hit staff with cane. Cane was removed from resident, resident very verbally and physically aggressive. 2/14/2020 at 7:15 p.m. - Resident had another resident's wheelchair, wheeling himself up and down hallway and in dining room. Staff attempted to redirect resident so wheelchair could be returned to other resident. Resident stood up, slinging wheelchair around and yelling at staff. This nurse and another nurse explained to resident the wheelchair needed to be returned to other resident. Resident visibly upset, nurse was able to redirect. 2/15/2020 at 10:00 a.m. - Resident verbally aggressive with staff, pacing the dining area, unable to redirect, resident making fist with both hands pacing the dining area, stating he does not want to be here, nurse attempted to give resident a PRN medication, Resident stated, leave me alone and I am not going to take nothing. Nurse unable to give medication. Nurse Practitioner called, give [MEDICATION NAME] 10 mg IM times one and [MEDICATION NAME] 5 mg by mouth twice a day. [DATE] at 2:45 p.m. - CNA came in from smoking resident and informed nurse that resident was upset that he wanted to call his wife. Nurse dialed wife and informed resident's wife was on the phone. Resident spoke with wife on phone and was yelling for her to come get him and hung up. Resident became very angry yelling at female residents to get away from him. Nurse went to get cane because resident was swinging it, resident wouldn't give this nurse cane. CNA removed other residents from this resident and nurse called for help. Resident was combative, male resident offered this resident a cigarette and took resident to smoke. DON called nurse practitioner to inform, gave order for Zyprexia 10 mg IM now. [DATE]20 at 8:00 p.m. - this nurse went into resident's room, attempted to administer medications, resident grabbed spoon from nurse and tossed on floor. NOTE: Record review revealed no issues of aggression toward Resident #2 or other residents. Resident #2 Record review of Resident #2's Face Sheet documented a [AGE] year old male who was admitted to the facility on [DATE], with the following Diagnoses: [REDACTED]. -Care Plan: documented Resident #2 was placed on the secure unit due to wandering behavior, impulsive behaviors - grabbed another resident's shirt and would not let go causing the resident to fall to the ground. -An annual MDS resident assessment, dated 2/20/2020, documented the resident scored 7 of 15 on a mini-mental exam, required extensive assistance by two staff for transfers and toileting, required extensive assistance by one staff for bed mobility, dressing and personal hygiene, totally dependent on one staff for bathing, used a wheelchair, incontinent of bladder, 65 inches tall and 237 pounds. Nurses Note documenting the incident on [DATE] at 4:20 a.m. on the secured unit between Resident #1 (the aggressor) and Resident #2: Heard noise and walked down hall. Noise was coming from room at end of the hall. This resident (Resident #1) was standing over Resident #2 in room [ROOM NUMBER]A and hitting him with leg off of a wheelchair. This nurse got Resident #1 out of the room and into hall. Other nursing staff arrived. Resident #1 said, He's sleeping with my wife. I'm going to kill him. I'm going to kill him. Resident #1 was saying this while swinging mop bucket handle and wheelchair leg. Staff nurse stayed with Resident #1 until police arrived. Resident #1's wife notified, facility management here and know about altercation. Police department took Resident #1's medications and resident out of facility. Review of Hospital Records for Resident #2 documented the following: -CT of the Head or Brain - [DATE] at 7:05 a.m. Multiple facial contusions Acute displaced fractures of the anterior and posterior walls of the right sinus cavity Acute mildly displaced [MEDICAL CONDITION] zygomatic arch (an arch formed by the zygomatic bone with the temporal bone) Acute displaced [MEDICAL CONDITION] of the left frontal sinus Acute displaced [MEDICAL CONDITION] wall of the left orbit (eye) Acute displaced [MEDICAL CONDITION] borders of the left orbit (eye) Acute displaced fractures of the superior/lateral midline aspect of the mandible (jaw) Physical Exam in emergency room - [DATE] Skin: multiple lacerations about the face and scalp including: lateral to left eye - 4.7 cm Inferior to left eye - 2.4 cm Upper lip laceration - 2.2 cm - full thickness Midline lower lip/chin midline - 6.5 cm - full thickness left side of eye - 1.4.cm left side of head - 3.4 cm right side of head - 3.4 Right die of eye - 2.4 Right anterior scalp - 2.4 cm Right forehead - 1.1 cm During an interview on [DATE] at 8:30 a.m., the Administrator stated Resident #2 was in bed asleep when Resident #1 hit him with the wheelchair leg. The Administrator stated Resident #1 would be up and down all throughout the night time. During an interview on [DATE] at 10:25 a.m., CNA D stated when Resident #1 first came to the facility he was nice and then later on he would be sitting in a chair and just freak out for no reason CNA D stated Resident #1 would try and hit staff with his cane and would yell and cuss at staff. CNA D stated Resident #1 would wave his cane like he was going to hit them but the nurse took his cane away. CNA D stated Resident #1's behaviors were gradually getting worse. During an interview on [DATE] at 4:20 p.m., LVN A stated the two CNAs were off of the secured unit changing a resident on the rehab hallway. LVN A stated she was sitting behind the desk charting on the secured unit when it sounded like someone fell . LVN A stated she found Resident #1 in Resident #2's room hitting him with the leg of his wheelchair. Julia stated she pushed Resident #1 out of the room but Resident #2 kept trying to get back in the room. LVN A stated she braced herself against the door and Resident #1 finally quit trying to get in.

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

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KIRKLAND COURT HEALTH AND REHABILITATION CENTER	1601 KIRKLAND DR AMARILLO, TX 79106

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) LVN A stated she was scared to death. LVN A stated Resident #2 was bleeding profusely and there was blood everywhere and it was the scariest thing she had ever seen. LVN A did not say what kind of assessment was completed on Resident #2 or what was done ot stop the bleeding. LVN A stated a lot of times Resident #1 would get mad at staff but never another resident. During an interview on [DATE] at 4:55 p.m., Resident #2's son stated his father had just gotten out of ICU yesterday. Resident #2's son stated when the family would visit during the day, there was always staff who redirected residents who were going into each other's rooms so where were they that night. Resident #2 wanted to know where the supervision was when the nurse was not redirecting the resident who beat up his father. Resident #2's son stated, Where were the other staff at? One person on the secured unit was not enough. Resident #2's son stated the Administrator at the facility assured the family their father would receive the supervision around the clock to ensure he was safe and kept from harm. During an interview on [DATE] at 2:58 p.m., CNA E stated there was a resident on the rehab hallway that needed to be changed so they (CNA E and CNA F) left the secured unit to change the resident. CNA E stated when they got back to the secure unit, Resident #1 was standing in the hallway. CNA E stated he asked Resident #1 what was going on and Resident #1 said he got in a fight with Resident #2. CNA E stated Resident #1 had a leg of a wheelchair in his hand and it had blood all over it. CNA E stated he tried to get into Resident #2's room but he would not open the door and he could not find the LVN working on the secured unit. CNA E stated he went to the other side of the building and got the other charge nurse to help and when they came back to the secured unit, Resident #2's door was open. CNA E stated there was blood everywhere in Resident #2's room and all over Resident #2's head. CNA E stated that night Resident #1 was up and down all night.
F 0741 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined the facility failed to ensure that staff who provided direct services to residents had the appropriate competencies and skills sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being for 2 of 6 residents (Residents #1 and #2) whose care was reviewed in that: The facility failed to adequately staff the secured unit resulting in a resident to resident altercation which resulted in major injuries for Resident #2. LVN A, who was alone on the secured unit with 22 residents, failed to notice Resident #1 moving in his wheelchair down the hallway to Resident #2's room. LVN A, who was sitting at the nurses station charting, heard a noise and thought someone fell . LVN A went to Resident #2's room and found Resident #1 hitting Resident #2 with the leg extension off of his wheelchair. Resident #2 was sent to the hospital and was found to have facial fractures and several lacerations requiring sutures. CNA E and CNA F were off of the secured unit changing a resident on the rehab hallway. This failure could place all residents at risk for maintaining their safety and attaining the highest practicable physical, mental and psychosocial well-being. The evidence is as follows: Resident #1 Record review of Resident #1's Face Sheet documented a [AGE] year old male who was admitted to the facility on [DATE], with the following Diagnoses: [REDACTED]. -Care Plan: impulsive behavior - cursing at staff/threatening to hit staff with cane, yelling at female residents, [MEDICAL CONDITION] drug use. -An admission MDS resident assessment, dated 2/2/2020, documented the resident can usually make himself understood and usually understands others, scored 11 of 15 on a mini-mental exam, disorganized thinking, no behavioral symptoms at this time, limited assistance by one staff for bed mobility, transfers and personal hygiene, required extensive assistance by one staff for dressing and toileting, totally dependent on one staff for bathing, uses a cane and a wheelchair at times, occasionally incontinent of bladder, had falls prior to admission, 63 inches tall, 115 pounds. -Nurses Notes documented the following: 2/14/2020 at 9:30 a.m. - resident hallucinating, stating car was broke down and had his five kids and needed help with car. Resident became very angry, cursing at staff and yelling and cussing in the dining room. Staff attempted to talk with resident and resident will not listen. Staff called spouse to attempt to calm resident and resident got more aggressive and verbally aggressive. Resident was left alone without anyone bothering him. continue to monitor. Spouse stated that's why she didn't want him home, cause he was abusive to her. 2/14/2020 at 2:30 p.m. - staff escorting resident to go out to smoke, resident became aggressive, attempting to hit staff with cane. Cane was removed from resident, resident very verbally and physically aggressive. 2/14/2020 at 7:15 p.m. - Resident had another resident's wheelchair, wheeling himself up and down hallway and in dining room. Staff attempted to redirect resident so wheelchair could be returned to other resident. Resident stood up, slinging wheelchair around and yelling at staff. This nurse and another nurse explained to resident the wheelchair needed to be returned to other resident. Resident visibly upset, nurse was able to redirect. 2/15/2020 at 10:00 a.m. - Resident verbally aggressive with staff, pacing the dining area, unable to redirect, resident making fist with both hands pacing the dining area, stating he does not want to be here, nurse attempted to give resident a PRN medication, Resident stated, leave me alone and I am not going to take nothing. Nurse unable to give medication. Nurse Practitioner called, give [MEDICATION NAME] 10 mg IM times one and [MEDICATION NAME] 5 mg by mouth twice a day. [DATE] at 2:45 p.m. - CNA came in from smoking resident and informed nurse that resident was upset that he wanted to call his wife. Nurse dialed wife and informed resident's wife was on the phone. Resident spoke with wife on phone and was yelling for her to come get him and hung up. Resident became very angry yelling at female residents to get away from him. Nurse went to get cane because resident was swinging it, resident wouldn't give this nurse cane. CNA removed other residents from this resident and nurse called for help. Resident was combative, male resident offered this resident a cigarette and took resident to smoke. DON called nurse practitioner to inform, gave order for Zyprexia 10 mg IM now. [DATE]20 at 8:00 p.m. - this nurse went into resident's room, attempted to administer medications, resident grabbed spoon from nurse and tossed on floor. NOTE: Record review revealed no issues of aggression toward Resident #2 or other residents. Resident #2 Record review of Resident #2's Face Sheet documented a [AGE] year old male who was admitted to the facility on [DATE], with the following Diagnoses: [REDACTED]. -Care Plan: documented Resident #2 was placed on the secure unit due to wandering behavior, impulsive behaviors - grabbed another resident's shirt and would not let go causing the resident to fall to the ground. -An annual MDS resident assessment, dated 2/20/2020, documented the resident scored 7 of 15 on a mini-mental exam, required extensive assistance by two staff for transfers and toileting, required extensive assistance by one staff for bed mobility, dressing and personal hygiene, totally dependent on one staff for bathing, used a wheelchair, incontinent of bladder, 65 inches tall and 237 pounds. Nurses Note documenting the incident on [DATE] at 4:20 a.m. on the secured unit between Resident #1 (the aggressor) and Resident #2: Heard noise and walked down hall. Noise was coming from room at end of the hall. This resident (Resident #1) was standing over Resident #2 in room [ROOM NUMBER]A and hitting him with leg off of a wheelchair. This nurse got Resident #1 out of the room and into hall. Other nursing staff arrived. Resident #1 said, He's sleeping with my wife. I'm going to kill him. I'm going to kill him. Resident #1 was saying this while swinging mop bucket handle and wheelchair leg. Staff nurse stayed with Resident #1 until police arrived. Resident #1's wife notified, facility management here and know about altercation. Police department took Resident #1's medications and resident out of facility. 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The Administrator stated Resident #1 would be up and down all throughout the night time. During an interview on [DATE] at 10:25 a.m., CNA D stated when Resident #1 first came to the facility he was nice and then later on he would be sitting in a chair and just freak out for no reason CNA D stated Resident #1 would try and hit staff with his cane and would yell and cuss at staff. CNA D stated Resident #1 would wave his cane like he was going to hit them but the nurse took his cane away. CNA D stated Resident #1's behaviors were gradually getting worse. During an interview on [DATE] at 4:20 p.m., LVN A stated the two CNAs were off of the secured unit changing a resident on the rehab hallway. LVN A stated she was sitting behind the desk charting on the secured unit when it sounded like someone fell . LVN A stated she found Resident #1 in Resident #2's room hitting him with the leg of his wheelchair. Julia stated she pushed Resident #1 out

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F 0741 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) of the room but Resident #2 kept trying to get back in the room. LVN A stated she braced herself against the door and Resident #1 finally quit trying to get in. LVN A stated she was scared to death. LVN A stated Resident #2 was bleeding profusely and there was blood everywhere and it was the scariest thing she had ever seen. LVN A did not say what kind of assessment was completed on Resident #2 or what was done to stop the bleeding. LVN A stated a lot of times Resident #1 would get mad at staff but never another resident. During an interview on [DATE] at 4:55 p.m., Resident #2's son stated his father had just gotten out of ICU yesterday. Resident #2's son stated when the family would visit during the day, there was always staff who redirected residents who were going into each other's rooms so where were they that night. Resident #2 wanted to know where the supervision was when the nurse was not redirecting the resident who beat up his father. Resident #2's son stated, Where were the other staff at? One person on the secured unit was not enough. Resident #2's son stated the Administrator at the facility assured the family their father would receive the supervision around the clock to ensure he was safe and kept from harm. During an interview on [DATE] at 2:58 p.m., CNA E stated there was a resident on the rehab hallway that needed to be changed so they (CNA E and CNA F) left the secured unit to change the resident. CNA E stated when they got back to the secure unit, Resident #1 was standing in the hallway. CNA E stated he asked Resident #1 what was going on and Resident #1 said he got in a fight with Resident #2. CNA E stated Resident #1 had a leg of a wheelchair in his hand and it had blood all over it. CNA E stated he tried to get into Resident #2's room but he would not open the door and could not find the LVN working on the secured unit. CNA E stated he went to the other side of the building and got the other charge nurse to help and when they came back to the secured unit, Resident #2's door was open. CNA E stated there was blood everywhere in Resident #2's room and all over Resident #2's head. CNA E stated that night Resident #1 was up and down all night.