STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675407	A. BUILDING _____ B. WING _____	04/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RALLS NURSING HOME	1111 AVENUE P RALLS, TX 79357

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment, were reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures; in that: a)The facility failed to immediately report allegations of abuse or neglect to the State Survey Agency. Resident #2 subjected Resident #1 to physical aggression on 3/21/20 and 3/31/20. These incidents resulted in Resident #1 sustaining facial bruising which included swollen and blackened eyes. The facility failed to report either of the incidents to the State survey agency. These problems could result in additional incidents of abuse and neglect not being reported which could lead to an increase in resident injuries. The findings include: Background: Record review of the admission record for Resident #1 revealed that the resident was admitted to the facility on [DATE] and was [AGE] years old. Further record review revealed that the resident had [DIAGNOSES REDACTED]. walking, not elsewhere classified, pain in right knee, cognitive communication deficit, dysphagia, oropharyngeal phase, other chronic allergic [MEDICAL CONDITION], [DIAGNOSES REDACTED] with [MEDICAL CONDITION] or convulsions, unspecified lack of coordination, [MEDICAL CONDITIONS] of native coronary artery without [MEDICAL CONDITION] pectoris, urinary tract infection, site not specified, and pneumonia, unspecified organism. On 4/15/20 beginning at 10:01 AM a resident tour of the facility was conducted with LVN #1. She stated that Resident #1 was confused and walks. When asked about any incidents regarding the resident she stated Resident #2 is gone to Psychiatric Hospital #1. He didn't like her, and he hit her. It was about a month ago. It happened at night when I was not here. She had bruising on her face. It (bruising) was pretty good on one side more than the other . On 4/15/20 at 10:45 AM Resident #1 was observed. It was noted that she had fading yellow bruising to her left eye area and to the side of her face on the left side. She was confused, verbal, and walking. She wandered the corridors continually and had little regard for personal space of staff and residents. Record review of the admission record for Resident #2 revealed that the resident was admitted to the facility on [DATE] and was [AGE] years old. Further record review revealed that the resident had [DIAGNOSES REDACTED]. On 4/15/20 beginning at 10:01 AM a resident tour of the facility was conducted with LVN #1. She stated that Resident#1 had lived in room [ROOM NUMBER] and that they had sent him to Psychiatric Hospital #1 due to aggression. She stated that the resident had a [MEDICAL CONDITION]. She added, If you got in his way he got mad. He would not redirect. He did a lot of spitting. He went to (Psychiatric Hospital #1) last Saturday (4/11/20). Incident Information: Record review of the incident reports from February 2020 thru April 2020 revealed the following physical aggression incidents that included Residents #1 and #2: -3/21/20 at 9:45 PM Resident #2 had a physical aggression incident with Resident #1 which caused bruising to Resident #1's left ear and face. Nursing Description: (Resident #1) walking in hallway coming out of room, holding onto left side of head. Purpleish/blue bruising starting on left temporal area into frontal hairline. Resident description: resident states numerous times, 'he hit me, he hit me'. The resident's pain level was a six. The corresponding incident related to Resident #2 documented, Nursing Description: was informed that resident was standing up in other residents' room, using A bed to balance self. No noted injuries (Resident #2). Resident Description: Yeah, I would do it again. Resident #2 was administered [MEDICATION NAME] and [MEDICATION NAME] IM after the incident. -3/31/20 at 1:02 PM Resident #2 punched Resident #1 in the face and caused bruising. Nursing description: (Resident #1) was sitting in dining room when another resident (Resident #2) grabbed her by her blouse and started punching her in the face. Resident description: resident unable to give description. The resident sustained [REDACTED]. The pain level was documented at three. Record review of the corresponding incident report revealed Nursing Description: (Resident #2) was sitting in dining room and he started punching another female resident (Resident #1) in the face. Resident was holding the other resident by her blouse and punching her in the face. Resident Description: resident unable to give description. This was witnessed by a staff member. Record review of the Health and Human Services Commission Tulip Complaints/Incident System revealed that there was no self-report related to the 3/21/20 and 3/31/20 physical aggression incidents between Residents #1 and #2. Staff/Resident Interviews: On 4/15/20 at 1:18 PM an interview was conducted with CNA #2 regarding the physical aggression incidents initiated by Resident #2 against Resident #1. She stated, She had black eyes that were dark purple. It was three or four days before she perked up. She had no color to her face. She was leaning more to the side when she walked. I think that was from the incident on 3/21/20. She looked like a raccoon. Her eye was closed more than usual but not completely. The second incident (3/31/20) was not as bad as the first one. On 4/15/20 at 1:22 PM the DON was interviewed and asked if he was present during the physical aggression incident with Residents #1 and #2 on 3/31/20 and what Resident #1 looked like after the incident on the 31st. He stated, Her left eye was bruised. What I heard, she ducked her head when he hit her. It was in the dining room. When asked about the 3/21/20 incident, he stated, We did a facial x-ray. It looked bad. It was on the 21st. The DON was asked what prompted him to obtain a facial x-ray on Resident #1. He stated, I was prompted by being told he attacked her and hit her in the face. Record review of the clinical record for Resident #1 revealed two x-ray reports dated 3/24/20 for her face and skull. The reports were negative for fractures. On 4/15/20 at 2:07 PM CNA #1 was asked about the physical aggression incident with Resident #1 and Resident #2. He stated, I came in the next day after (3/21/20). The bruising turned worse from green to purple (on Resident #1). It was a shiner, a blackeye. He (Resident #2) was a very aggressive resident . His fuse was small. He went to Psychiatric Hospital #1. He doesn't fit here. On 4/15/20 at 4:20 PM a confidential interview was conducted with Resident A regarding Resident #2's March physical aggression incidents initiated against Resident #1. When asked if she knew anything about the incidents between Resident #2 and Resident #1 she said, She (Resident #1) wasn't doing nothing. He (Resident #2) even hit workers. She was pretty banged up. She had bruises on her arms and face. She looked like she got out of a fight with Mike Tyson. It's about two or three weeks ago before he (Resident #2) left. She had black eyes. I don't know what was wrong with Resident #2. It happened in the hallway or dining room. I think it was late afternoon . I can handle myself, but she (Resident #1) can't . On 4/15/20 at 5:40 PM an interview was conducted with LVN #2. She was asked about the March 2020 physical aggression incidents with Resident #1 and #2. She stated, . Afterwards she (Resident #1) had bruises . She had bruises on her face . She had black eyes. ~ Administrator Interview: On 4/15/20 at 7:00 PM an interview with the Administrator regarding incidents where Resident #2 was physically aggressive to Resident #1. The Administrator was asked why she failed to report to the State the incidents between Resident #1 and #2 that occurred on 3/2/201 and 3/31/20. Regarding the incident on 3/21/20 she stated, It's possible I was not informed. I saw the aftermath (injury/bruising). I did see the after effects of it. I saw her a day or two after. Regarding the incident on 3/31/20 she stated, I didn't know about this one. I don't know about this at all . His (Resident #2) BIMs score was a 4. He and Resident #1 have the same BIMs score. We started to try to get him out of here on 4/2/20 . I believe we tried psych meds too. The Administrator was then asked what system the facility used to communicate incidents to her. She stated, Usually

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

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

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) they (staff) tell me. They had to have told me. That is kind of disturbing. It's my fault . Policy: Record review of the current facility policy labeled Abuse, Neglect, Exploitation General Policy, Abuse, Neglect, Exploitation Prevention revealed the following documentation, Standard: This facility has developed and implemented this policy and procedure to prohibit mistreatment, neglect, and abuse of all elders . PURPOSE: To ensure that all elders of this facility will be free of physical, emotional, and sexual abuse, neglectful treatment The accompanying procedures are employed to assure total staff adherence to this policy . PROCEDURE .Identification . 7. The DON or registered nurse on duty will assist the elder who may be a victim of possible abuse, neglect . a. Per training criteria, the following indications will be investigated: (not all inclusive) i. Physical signs of abuse . 5. Cuts, welts, discoloration of eye . g. The facility Chief Executive or designee is responsible for reporting cases of possible abuse, neglect .to external agencies in accordance with law and regulation. Investigation. 1. All facility employees, family members and volunteers or educated that all alleged or suspected violations involving mistreatment, neglect or abuse . are reported immediately to the Administrator. 2. The Chief Executive Officer and/or Administrator ensures that all alleged or suspected violations involving mistreatment, neglect, or abuse . are investigated and reported immediately to the Texas Department On Aging And Disability Services complaint hotline. 3. In the event an incident that meets or has the potential to meet one of the definitions stated in the policy on abuse or a neglect of an elder is reported to the Administrator or designee, and investigation of the incident will be commenced immediately. The Administrator will contact the Texas Department On Aging And Disability Services abuse hotline Within two hours (working hours) of the incident and will proceed with the investigation . 15. Within five days of the incident, the Administrator will review the information from the investigation and prepare a written report that will include the following . Reporting . 12. The results of all investigations will be reported to the Texas Department On Aging And Disability Services by the Administrator in accordance with law and regulations .