STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676391	A. BUILDING _____ B. WING _____	**04/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR CALALLEN	**4162 WILDCAT DR CORPUS CHRISTI, TX 78410**

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

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's right to be free from abuse for one of three residents (R #1) reviewed for abuse. 1. The facility failed to develop and implement effective interventions to address R #2's physically aggressive behaviors after R #2 physically assaulted R #1 on 03/15/20 and then again on 03/27/20. R #1 was punched on the shoulder and/or face on two separate occasions by R #2, sustaining pain to her left shoulder, which required an x-ray. R #1 sustained pain to her shoulder and facial bruising to the left side of her face. R #1 stated and displayed signs of being fearful of R #2. 2. The facility failed to develop and implement effective interventions to address R #1's behaviors, such as provocation, physical aggression, and resistance to care. 3. The facility failed to identify R #2's two separate acts of physical aggression towards R #1 as acts of abuse, instead, the facility identified the acts as behaviors. 4. The Administrator, who was the Abuse Coordinator did not identify R #2 punching R #1 on 03/15/20 and then again on 03/27/20 as abuse therefore, the incidents were not reported as acts of abuse. The Abuse Coordinator did not thoroughly investigate the first incident and missed the identification of R #1's fear of and anger for R #2, all of which contributed to a second incident of physical abuse 5. The facility failed to protect R #1, allowing R #2 ongoing access to R #1. R #1 expressed changes in behavior of increased agitation, aggression, and provocation whenever R #2 was in sight. 6. The facility failed to assess R #1's psychosocial effects after she was the recipient of two separate incidents of physical abuse and allowed the perpetrator, R #2, to remain in the near vicinity of R #1. An Immediate Jeopardy (IJ) situation was identified 04/07/20. While the IJ was removed on 04/09/20 at 4:42 p.m., the facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These deficient practices of the facility's failure to intervene after abusive incidents could result in further abuse and injury. The findings included: Record review of R #1's Face Sheet dated 04/06/20 documented a [AGE] year-old female admitted [DATE] with the [DIAGNOSES REDACTED]. Record review of R #1's Comprehensive Care Plan dated 01/20/20 documented: -(R #1) is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) cognitive deficits . -(R #1) is an elopement risk/wanderer r/t history of attempts to leave facility unattended, Impaired safety awareness, resident wanders aimlessly -(R #1) resides in the secure unit due to wandering, she is new to facility and has been packing and unpacking belongings . -(R #1) has impaired cognitive function/dementia or impaired thought processes r/t dementia -(R #1) uses antidepressant medication r/t poor adjustment to admission [MEDICATION NAME] and [MEDICATION NAME] PATCH . The resident uses anti-anxiety medications ([MEDICATION NAME]) r/t anxiety disorder . The resident uses antipsychotic medications [MEDICATION NAME] . Monitor/record occurrence of/for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others etc. and document per facility protocol. Record review of R #1's Quarterly Minimum (MDS) data set [DATE] documented she: -had adequate hearing and clear speech -understood others and made self-understood -had a brief interview of mental status score of 4-severely impaired -required supervision for bed mobility, transfers, dressing, and limited assistance for personal care -had physical behavioral symptoms towards others and other behavioral symptoms not towards others that occurred 1-3 days. Record review of R #1's Nursing Progress Notes and Change in Condition Communication Form dated 03/15/20 documented 10:16 PM- SN (Skilled Nurse) notified by CNA (Certified Nurse Aide) that resident received physical aggression and was physical towards another resident (R #2). Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated (she) and another resident were arguing when he hit her on her shoulder and she then bit his hand. SN asked resident if she had any pain and resident denied. SN assessed both of resident's shoulders and no redness or discoloration was observed. Vitals were . SN notified DON (Director of Nurses), RP (Responsible Party), and MD (Medical Doctor). No new orders received from MD. RP aware and no concerns at this time. SN placed resident on 72-hour (hr) critical behavior monitoring every hour. Resident remains in her room. Safety has been maintained, will continue to monitor. Record review of R #1's Incident/Accident Report dated 03/15/20 documented 10:30 PM- SN notified by CNA that resident received physical aggression and was physical towards another resident. Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated she and another resident (R #2) were arguing when he hit her on her shoulder, she then bit his hand. SN asked resident if she had any pain and resident denied. SN assessed both of resident's shoulders and no redness or discoloration was observed . SN notified DON, RP, and MD. No new orders received from MD. RP aware and no concerns at this time. SN placed resident on 72-hour critical behavior monitoring every hour. Resident remains in her room. Safety has been maintained. Will continue to monitor. Residents separated. Resident assessed, all appropriate parties notified. Upon investigation this resident was observed in her room sitting on her bed. Resident noted to be upset saying a man hit her on her shoulder and she bit him back. Noted bilateral shoulders with redness, bruising at present. Shoulders will be monitored. Resident denies being fearful of other resident at present. CNA will help separate and continue to monitor for further behaviors. Resident offered pain medicine. RP and MD notified of incident. Behavior monitoring for residents hourly X 72 hours. In an interview with CNA A on 04/06/20 at 4:05 PM, she stated the day following the incident (03/16/20), R #1 told her she was afraid of R #2, she (R #1) said she did not want him around. CNA A said R #1 put a chair and wheelchair to block the doorway to her room to keep him (R #2) from coming in the room. CNA A said she (R #1) stayed distant, she stayed in her room for a couple of days behind the privacy curtain. CNA A stated, She did not want to be next to him (R #2) at all. Then a couple of days later she would constantly follow (R #2) with her eyes and purposely walk in front of (R #2), staring him down. Record review of R #1's Acute Care Plan dated 03/15/20 documented Behavior - Problem: Physical aggression/combativeness related to unknown .Approach: Reorient and redirect to self; Notify MD/RP of any changes in behavior; one-hour behavior monitoring for 72 hours. The care plan did not include any interventions in attempt to prevent incidents of physical aggression from re-occurring or what actions to implement should the aggression occur again. Record review of R #1's Nursing Progress Notes dated 03/18/20 documented 1:24 PM - 72-hour behavior (monitoring). Resident, this 6-2pm shift not having aggressive behaviors. SN placed call to daughter regarding approx. 1in. x 1in. discoloration to left shoulder . Resident at this time is able to perform full range of motion in all extremities with no non-verbal signs of pain nor is pain verbalized. Resident able to make needs known. Behavioral monitoring continued. Record review of R #1's left shoulder x-ray result, for a [DIAGNOSES REDACTED].#1 did not have a fracture. Record review of R #1's Nursing Progress Notes dated 03/23/20 documented 3:51 PM - Par meeting held IDT (interdisciplinary team)-Res had combative behaviors throughout the day with staff care at intervals. New onset of resisting care. Res was not easily redirected . Record review of R #1's Social Services Progress Note dated 03/24/20 documented 2:50 PM - Resident with recent changes in behavior

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) including increased agitation. Current precautions in place in this facility are restricting visitors and resulting in some disruption to (R #1's) daily routine. Will continue to monitor and offer support as needed. This note documented changes in behavior with increased agitation but did not address R #1's psychosocial needs, her fear or her feelings towards her aggressor (R #2). Record review revealed there was no Social Services note regarding the 03/15/2020 altercation with another resident. In an interview with the Social Worker (SW) on 04/07/20 at 10:05 AM, she said the IDT did not further explore or investigate R #1's increased agitation and resisting of care. The SW said R #1's behaviors could have been a result of R #2 being within her line of sight, possibly being fearful and angry at R #2 for punching her. Record review of R #1's Nursing Progress Notes dated 03/26/20 documented 1:37 PM - resident continues with agitation and verbal aggression towards other residents in the unit. Resident believes another male resident is after her, unable to redirect due to impaired cognition. Resident continues with delusions, resident closely monitored, SN notified MD of current behavior. Pending response at this time. RP notified, will continue to monitor. Record review of R #1's Nursing Progress Notes dated 03/26/20 documented 2:04 PM - new orders from (physician) received to decrease PRN [MEDICATION NAME] to 0.5mg prn every 6 hours and to increase Trazadone to 50 mg tid. SN notified RP. Will continue to monitor. Record review of R #1's Nursing Progress Notes and Change in Condition Communication Form dated 03/27/20 documented 9:42 PM - SN notified by CNA that resident had received physical aggression from another resident. Upon assessment resident was observed sitting in chair in her bedroom. SN assessed resident and observed a hematoma to the top of her left eyebrow. Resident noted with bruising/discoloration from fall that previously happened. Resident verbalized pain to area and PRN Tylenol was administered. SN asked resident what happened, and she stated she was hit in the face. CNA stated that she witnessed another resident (R #2) hit (R #1) twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. Upon assessment, no other injuries were apparent. Vitals at the time of incident were . SN notified (physician) and no new orders. DON was notified. RP notified, no concerns or issues at this time. SN initiated 72-hour critical behavior monitoring hourly, and neuro checks x72 hours. Resident remained in room, safety maintained, will continue to monitor. Record review of R #1's Incident/Accident Report dated 03/27/20 documented 9:30 PM - .SN asked resident what happened, and she stated she was hit in the face. Upon investigation this resident was observed by CNA being hit on the left eye by another resident. Residents were both separated immediately. This resident (R #1) resides on the dementia unit and is able to state what occurred, oriented X1. Ice pack applied, and neuro checks were monitored. Prior to this incident resident had sustained a fall and noted with bruising discoloration to left side of eye (fall occurred on 03/20/20) RP and MD notified of incident. PRN adjustment for physical aggression, on 03/26/20 with new order for [MEDICATION NAME] 0.5 mg PRN (as needed) every 6 hours. Will continue to monitor. Resident denies being fearful of other resident at this time. After resident's family gave consent, resident was trialed outside the unit as an intervention. She did well for 4 hours then resident was observed ambulating down the hallway asking for way out of the facility. Resident required redirection but asked a second time how to get out of the building. Was then assisted back to the unit for safety. Due to recent restrictions related to COVID-19 resident is not a candidate to be out of the unit or for transfer to another facility and family cannot care for her at home at this time. Record review of R #1's Accident Investigation Report - Witness Interview documented by CNA B dated 03/27/20 documented A physical altercation between (R #1) and (R #2). I was assisting a resident in her room when I heard yelling. I ran out and saw (R #2) punching (R #1) twice, once near her temple and again her eye. I stepped between them and (R #2) grabbed my hand. He would not respond to his name and was intently staring at (R #1). I yelled his name loudly and he asked me who I was. I told him my name and that he was hurting me. He immediately let go of my hand and said he was sorry. Record review of R #1's Nursing Progress Notes dated 03/28/20 documented 10:24 AM - 24 hour follow up physical aggression received, resident stable, no s/s of distress, resident continues with contusion to left upper brow and temple. Resident medicated with PRN pain medication for complaints of general pain. Resident alert, watching tv in common room, will continue to monitor . The 03/27/20 incident was the second incident of abuse, there was no documentation of any other interventions to protect R #1 from R #2, other than will continue to monitor. Record review of R #1's Nursing Progress Notes dated 03/30/20 documented 10:41 AM - 72-hour behavior monitoring. Patient is alert with discoloration to the left eye. Patient voiced that she has pain to the site. Ice pack and PRN medication administered. No signs of aggressive behaviors or fearful behavior noted. Record review of R #1's Physician order [REDACTED]. Observation of R #1 on 04/06/20 at 10:19 AM revealed she had purple discoloration beneath her left eye, on her left temple, down to her left cheek. R #1 was sitting in a chair in the common area of the secured unit watching television. At 10:21 AM, CNA D asked R #1 if she would like to go to the bathroom, R #1 said yes, and she ambulated to her room using a rolling walker. R #1 walked out of the bathroom and ambulated to her bed and sat on the edge of her bed. The privacy curtain was pulled around R #1's bed. R #1 frequently looked around the privacy curtain towards the hallway. When asked what R #1 was looking for, R #1 said Ese viejo (that man). Record review of R #1's Nursing Progress Notes dated 04/03/20 documented 11:44 AM - notified RP of resident (R #1) aggressive behavior towards male resident (R #2). Resident was observed attempting to hit resident (R #2) with walker. Male resident was not engaged in any behavior prior to resident's aggression. SN separated residents, will continue to monitor. There was no evidence the facility took any further action other than resident separation. Interview with R #1 on 04/06/20 at 10:26 AM revealed she was alert to self, able to correctly state her name, stating she was not in her home but was unable to state her current location and time. R #1 was sitting on the edge of her bed with the privacy curtain pulled all the way around her bed. R #1 stated she was hit by a male resident, whom the only description she gave was a white man with no teeth. R #1 stated the male resident entered her room when it was still somewhat dark outside since she could see outside her window. R #1 said she was lying down on her right side, in bed, when the male resident entered her room and began pulling down her bed sheets. R #1 stated she yelled at him to leave her room and he kept telling her Shhh and called her Mammacita. R #1 said she held on to her sheets tightly as he tried to pull them off. R #1 said as she began to sit up, the male resident hit her in the face twice using his closed right fist. R #1 said she fell back on the bed when she got hit. R #1 said she pushed him with her walker and kicked him in his groin. R #1 said after that, she stood up and began to walk forward when he cornered her to the wall and hit her again on her left shoulder, using his closed fist. R #1 said she bit R #2's hand just before someone came into the room and escorted R #2 out. R #1 said her left eye, left temple, and right temple hurt. Further inspection of R #1's face revealed she had a slight raised area to her right temporal region. R #1 also complained of pain to her left shoulder. R #1 said she felt drunk from lack of sleep because she did not sleep well at night. When asked why she did not sleep well, R #1 said she was afraid the man was going to come back and hurt her again. R #1 said she hated that man for hitting her and was afraid of him. R #1 said the man continued to live in the facility because she was told the man had a right to live there. R #1 could not recall who or when she was told that. R #1 said she wanted her curtain pulled all the way around her bed so He don't see me when he is walking back and forth. Record review of R #1's Comprehensive Care Plan revised 04/06/20 documented The resident is/has potential to be physically aggressive related to dementia and depression. Due to resident's past history from family, resident has some issues with men. Can become aggressive with staff and at times other residents Interventions: Analyze times of day, places, circumstances, triggers, de-escalating behavior and document; Anticipate resident needs; Provide physical and verbal cues to alleviate anxiety. This revision of R #1's care plan was completed by the facility after the surveyor had started the investigation, while the survey was in progress. In an interview with the DON on 04/07/20 at 10:40 AM, she said R #1 did not have any other revisions to her care plan that specifically addressed effective interventions to prevent further behaviors, prior to the revision on 4/6/20. Observation of R #1 on 04/07/20 at 10:20 AM revealed she sat on the couch in the secured unit's common area, behind R #2. Both R #1 and R #2 kept to themselves and watched television. At 10:24 AM, R #2 stood up and ambulated down the hallway towards his room. R #1 continuously stared at R #2 until R #2 was no longer in sight. R #2: Record review of R #2's Face Sheet dated 04/06/20 documented an [AGE] year-old male admitted [DATE] with the [DIAGNOSES REDACTED]. Record review of R #2's Admission Minimum (MDS) data set [DATE] documented he: - had minimal difficulty hearing and clear speech -had a brief interview of mental status score of 4- severely impaired -had inattentive fluctuating behavior -required limited assistance for bed mobility; extensive assistance with one-person physical assist for transfers, dressing, toilet use, and personal hygiene. Record review of R #2's Comprehensive Care Plan dated 03/03/20 documented: -The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t cognitive deficits - The resident has an ADL self-care performance deficit r/t dementia . - The resident has a behavior problem (R #2) will urinate where ever he can. Corners trash cans closets and other residents' rooms. (R #2) is to be monitored when up and ambulating . - The resident is an elopement risk/wanderer r/t disoriented to place, impaired safety awareness, resident wanders aimlessly, significantly intrudes on the privacy or activities . - The resident has impaired cognitive function/dementia or impaired thought processes r/t

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) altered cognitive status . Record review of R #2's Nursing Progress Notes and Change of Condition Communication Form dated 03/15/20 documented 10:53 PM - SN notified by CNA resident was physical towards another resident (R #1) and then received physical aggression. Upon entering the secured unit resident was observed standing in the living/common area. SN approached resident and asked resident to see his right hand. upon further assessment resident was observed with discoloration/bruising. SN asked resident what happened and resident unable to verbalize. SN asked resident if he was in any pain and resident stated no. SN then assisted resident back to his room, assisted with toileting needs, and assisted resident to bed . resident remains in bed at this time. Safety maintained. DON notified, RP notified, no concerns at this time. On call for (physician) was notified new order for UA (urine) C&S (culture & sensitivity) and (lab). Oncoming 10-6 nurse aware of new orders. Orders have been transcribed, lab slip placed in binder. SN placed resident on 72- hour critical behavior monitoring, will continue to monitor. There was no documentation of any interventions put in place to prevent incident re-occurrence or protection. Record review of R #2's Acute Care Plan dated 03/15/20 documented Behavior - Problem: Physical aggression/combativeness related to unknown .Approach: Reorient and redirect to self; Notify MD/RP of any changes in behavior; 72-hour behavior monitoring. The care plan did not include any interventions in attempt to prevent incidents of physical aggression from re-occurring or what actions to implement should the aggression occur again. Record review of R #2's Nursing Progress Notes dated 03/16/20 documented 5:24 PM - resident 24-hour follow up behavior. Resident observed walking throughout hallway no s/s of pain. No s/s of anxiety or distress. Safety has been maintained. Resident remains on 72-hour critical behavior monitoring, will continue to monitor. Record review of R #2's Nursing Progress Notes and Change in Condition Communication Form dated 03/27/20 documented 8:50 PM - SN notified by CNA at approx. 4:30 PM that resident was physically aggressive towards another resident (R #1). Upon entering 500 hall, resident was observed sitting at desk at the end of the hall eating his dinner. Resident observed with no s/s of anxiety/distress or pain/discomfort. SN assessed resident and no injuries were present .CNA stated that she saw resident walking down hall towards dining area while assisting another resident in her room and when she entered dining area resident was physically hitting another resident (R #1), CNA stated that she witnessed him hit (R #1) twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. SN initiated 72-hr. critical behavior monitoring hourly. Nurse Practitioner (NP) was notified and new order for [MEDICATION NAME] 0.5 mg every 12hrs. PRN x2weeks was received. SN transcribed order and faxed it over to pharmacy. new order also received to have (psychological) services evaluate and treat . DON notified of incident and all new orders. RP was also notified, no concerns at this time. Safety has been maintained. Will continue to monitor. Record review of R #2's clinical record including physician's orders [REDACTED]. Record review of R #2's Accident Investigation Report - Witness Interview documented by CNA B dated 03/27/20 documented A physical altercation between (R #1) and (R #2). I was assisting a resident in her room when I heard (R #1) yelling. I ran out and saw (R #2) punching (R #1) twice near her temple and eye. I stepped between them and (R #2) grabbed my hand as I stopped (R #2) from hitting (R #1). R #2 was staring at (R #1) intently. I had to yell to get his attention. He let go of my hand and I walked him away from (R #1) who was calling (R #2) names. Record review of R #2's Nursing Progress Notes dated 03/28/20 documented 10:14 AM - 24-hour follow up physical aggression initiated. Resident continues with agitation at beginning of shift, SN administered prn medication for anxiety. Resident redirected, resident with SN at nurses' station reading magazines and drinking coffee. Resident calm, no anxiety observed . Observation of R #2 on 04/06/20 beginning at 10:21 AM, revealed he independently ambulated back and forth in the hallway, the same hallway R #1's room was located. In an interview with R #2 on 04/06/20 at 11:45 AM, he correctly stated his name. R #2 was not able to correctly state the day/time or place. R #2 said he was well taken care of and did not have issues or feared anyone in the facility. R #2 denied getting into any verbal or physical confrontations with anyone in the facility. In an interview with CNA A on 04/06/20 at 4:05 PM, she stated On 03/15/20 after dinner, (R #1) said she was going to her room to get ready to go to bed. CNA A said (R #2) had already been agitated that afternoon. CNA A explained she was documenting on the tracker when she heard thumps. CNA A said the tracker was located approximately a couple of feet adjacent to R #1's room. CNA A stated she went to find where the thump came from and heard some voices coming from R #1's room. CNA A said she walked into R #1's room and saw R #2 had R #1 pinned between the wall and the closet and he was hitting her with his right hand, closed fist on her right shoulder. CNA A said R #1 was trying to block R #2's hits. CNA A stated she immediately intervened and blocked some of the punches. CNA A explained CNA B was in the shower room and Licensed Vocational Nurse (LVN) C was working the other hall when the incident happened. CNA A said R #2 made a comment a couple of hours earlier before the incident happened, saying That son of a b**** needs to be hit, referring to R #1. CNA A said the next day on 03/16/20, R #1 had bruising on her left shoulder and stated R #2 punched R #1 on her left shoulder and that he choked her. CNA A said she never saw R #2 choking R #1 but the following day she had bruise marks on her neck. I felt bad for her. (There was no documentation of bruising to R #1's neck in R #1's clinical record). CNA A said she did not inform a nurse of R #1's neck bruising because she thought the nurse already saw it when she assessed R #1. CNA A stated they were told to ensure both residents avoided contact with each other, which was difficult because it was a small area. CNA A also said they were told to monitor their (R #1 and R #2's) behaviors. CNA A said R #1 had a bruise to her left eye from a fall she had prior to the assault from R #2 however, R #1's left eye bruising worsened and grew in size. CNA A said on 03/27/20, prior to 9:00 AM, she was in the bathroom and when she arrived at the scene, she saw R #1 upset, sitting on the couch. CNA A said CNA B told her she witnessed R #2 punch R #1 on the face a couple of times. When asked if she was aware if R #2 had hit or hurt any other resident, CNA A said on 03/15/20, prior to R #2 hitting R #1 in her bedroom, she witnessed R #2 hit R #3 on her back while CNA A was escorting R #3 to the common area. CNA A said she redirected R #2 which was successful. CNA A said R #3 denied any discomfort. CNA A said she told LVN C of the incident but did not report the incident to the Abuse Coordinator. Record review of R #3's nursing progress notes and incident/accident reports dated 03/2020 revealed no documented incident of R #2 hitting R #3. In an interview with CNA B on 04/06/20 at 5:07 PM, she said on 03/15/20, she worked in the secured unit but did not witness the incident involving R #1 and R #2 because she was in the shower room. CNA B said CNA A told her that R #2 went to R #1's room and punched her on the shoulders. CNA B said R #1 stated that she bit R #2's hand. CNA B said before R #1 and R #2 got into the altercation, they kept staring at each other throughout the day and she recalled R #2 made a comment saying, That son of a b**** needed to be hit. CNA B said R #2 was staring at R #1 when he made the comment. CNA B said on 03/27/20, she was in a room helping another resident while CNA A went on break. CNA B said she was the only staff in the secured unit when she saw R #2 push a television tray and was pushing it down the hallway. CNA B said she suddenly heard R #1 yelling at R #2 and found both residents in the back area and witnessed R #2 hit R #1 twice on the left side of her face with his closed hand. CNA B said R #1 was also trying to hit R #2 but was unsuccessful because CNA B's arm was in the way and the television tray was between the two residents keeping R #1 from being within R #2's reach. CNA B said she grabbed R #2's hands and R #2 held on to her wrists. CNA B said she could not re-direct R #2 until she yelled his name loudly. CNA B said she told R #2 he was hurting her and he replied he was sorry for hurting her hand. CNA B stated R #2 seemed to think everyone in the unit was a man and sometimes referred to the unit as the barracks. CNA B said R #2 frequently confused R #1 as a man. CNA B said sometimes R #1 would instigate things such as stand in front of R #2 or she would say a comment towards him. CNA B said R #1 seemed to have anger towards R #2 because she remembers him hitting her. When asked what interventions she had been trained to implement when R #1 or R #2 display their behaviors, CNA B said We just re-direct. Interview with SW on 04/07/20 at 10:05 AM revealed she was informed of R #1 and R #2's physical altercations during the morning meetings. The SW said she spoke to the nurse and reviewed the nursing notes about the incidents. The SW said she had a basic conversation with both residents after the second incident. When asked to explain what a basic conversation meant, the SW said she asked each one if they were okay, if everything was okay and they both seemed fine. I just asked how they were feeling and if anything was wrong, the conversation did not go very far with either one of them. When asked if she spoke to R #1 and R #2 about the incidents and their feelings regarding the incident and each other, the SW said There was no conversation about the actual altercations. I asked if they were doing okay this morning and feeling alright, I did not ask them if they were comfortable or if they were fearful because I did not want to put that into their head. We felt (R #2) was a trigger for (R #1) which agitated (R #1) and showed aggression. I've seen her since the incident and she did not seem fearful or reserved. No, I did not specifically ask her how she felt about R #2 or if she feared anyone. At 10:20 AM, the SW and the surveyor visited R #1 in her room. The SW stated she did not understand Spanish and R #1 was primarily Spanish speaking. The SW asked CNA E to translate for her. When asked how she received her facial bruising, R #1 said A man (pointing to the hallway) that is over there hit me with his hand. His hand was closed (Resident demonstrated a closed fist). I feel very angry that he did that because no man should hit a woman. I feel angry and with disconfianza (distrust) and (am) scared. R #1 said the staff removed the male resident away from her

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	676391	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR CALALLEN	4162 WILDCAT DR CORPUS CHRISTI, TX 78410

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) and got mad at him for hitting her but he's still here. Observation of R #2 on 04/07/20 at 10:25 AM while the surveyor exited R #1's room revealed R #2 wandered throughout the secured unit hallway walking back and forth, past R#1's room each time. In an interview with the SW on 04/07/20 at 10:26 AM, she said she was not aware of R #1's feelings of anger, distrust and fear. In an interview with LVN C on 04/07/20 at 12:18 PM, she said she did not recall being told of R #2 hitting any another resident other than R #1. In an interview with the DON on 04/07/20 at 10:40 AM, when asked if R #1 and R #2's altercations were reported to the State agency, the DON said It was not reported to the state because they are both confused, it didn't fall under the guidelines to report. If they were not confused, then we would have definitely reported it. The DON stated the incidents were not reported to the local police either. When asked if being punched in the face or anywhere on the body, causing bruising, by another person met the definition of physical abuse, the DON did not reply to the surveyor's question. The DON
F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their written policies and procedures that prohibited and prevented the abuse of residents for one Resident (R#1) of three residents reviewed for abuse, in that: 1. The facility failed to develop and implement effective interventions to address R #2's physically aggressive behaviors after R #2 physically assaulted R #1 on 03/15/20 and then again on 03/27/20. R #1 was punched on the shoulder and/or face on two separate occasions by R #2, sustaining pain to her left shoulder, which required an x-ray. R #1 sustained pain to her shoulder and facial bruising to the left side of her face. R #1 stated and displayed signs of being fearful of R #2. 2. The facility failed to develop and implement effective interventions to address R #1's behaviors, such as provocation, physical aggression, and resistance to care. 3. The facility failed to identify R #2's two separate acts of physical aggression towards R #1 as acts of abuse, instead, the facility identified the acts as behaviors. 4. The Administrator, who was the Abuse Coordinator did not identify R #2 punching R #1 on 03/15/20 and then again on 03/27/20 as abuse therefore, the incidents were not reported as acts of abuse. The Abuse Coordinator did not thoroughly investigate the first incident and missed the identification of R #1's fear of and anger for R #2, and a second incident of physical abuse towards R #1 occurred. 5. The facility failed to protect R #1, allowing R #2 ongoing access to R #1. R #1 expressed changes in behavior of increased agitation, aggression, and provocation whenever R #2 was in sight. 6. The facility failed to assess R #1's psychosocial effects after she was the recipient of two separate incidents of physical abuse and allowed the perpetrator, R #2, to remain in the near vicinity of R #1. An Immediate Jeopardy (IJ) situation was identified 04/07/20. While the IJ was removed on 04/09/20 at 4:42 p.m., the facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These deficient practices of the facility's failure to implement their policy and procedures to intervene after abusive incidents could result in further abuse and injury. The findings included: Record review of the facility's Abuse Prevention Program: Policy Statement dated September 2018 documented: Our residents have the right to be free from abuse, neglect, misappropriation of residents' property, corporal punishment and involuntary seclusion. 1. Our facility is committed to protecting our residents from abuse by anyone including but not necessarily limited to: employees, other residents, consultants, volunteers, agents or power of attorney, and or staff from other agencies providing services to our residents, family members, legal guardians, surrogates, resident responsible parties, friends, visitors, or any other individual. The Administrator is overall responsible for all the overall coordination and implementation of our facility's abuse prevention program policies and procedures. Our facility will protect residents from harm during investigations of alleged abuse. 1. During investigations of alleged abuse, residents will be protected from harm by the following measures: .c. If alleged abuse involves another resident, the accused resident's representative and attending physician will be informed of the alleged abuse incident and that there may be restrictions on the accused ability to visit other resident's rooms unattended. If necessary, the accused resident's family members may be required to help meet this requirement. 2. Appropriate authorities will be notified of the investigation. Please refer to the policy Reporting Abuse to State Agencies and Other Entities. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Mental abuse is defined as, but is not limited to humiliation, harassment, threats of punishment, or withholding of treatment or services. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness . 9. The Administrator or Director of Nursing Services must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and or Director of Nursing Services must be called at home or must be paged and informed of such incident. 10. When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred . 11. Upon receiving reports of physical abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record. The person performing the examination must document the findings in the medical record and obtain a written, signed, and dated statement from the person reporting the incident. 12. A completed copy of documentation forms and written statements from witnesses, if any, must be provided to the Administrator. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the Administrator. 13. Upon receiving information concerning a report of abuse, the Director of Nursing Services will request that a representative of the Social Services Department monitor the resident's reactions to and statements regarding the incident and his/her involvement in the investigation. Reporting Abuse to State Agencies and Other Entities: All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law. 1. Should a suspected violation or substantiated incident of neglect, injuries of an unknown source, or abuse (including resident to resident abuse), misappropriation of resident property be reported the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally or written) of such incident: a. The State Licensing/Certification Agency responsible for surveying/licensing the facility b. The local/state ombudsman c. The resident representative of record d. Law enforcement officials when a crime is suspected to have occurred e. The resident's attending physician f. The facility medical director g. Other agencies as needed . 3. Should a suspected crime resulting in serious bodily injury, the employee shall report the suspicion immediately, but no later than 2 hours after forming the suspicion. 4. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five working days of the occurrence of the incident . Abuse Investigations: All reports of alleged resident abuse, neglect, misappropriation of resident property and injuries of unknown source shall be promptly and thoroughly investigated by facility management . 2. The individual conducting the investigation will, as a minimum: a. Review the resident's medical record to determine events leading up to the alleged incident; b. Interview the person(s) reporting the incident; c. Interview any witnesses to the incident; d. Interview the resident (as medically appropriate); e. Interview the resident's attending physician as needed to determine the resident's current level of cognition function and medical condition; f. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; g. Interview the resident's roommate, family members, and visitors; h. Interview other residents with whom the individual provides care or services and/or interacts; and i. Review all events leading up to the alleged incident . Record review of R #1's Face Sheet dated 04/06/20 documented a [AGE] year-old female admitted [DATE] with the [DIAGNOSES REDACTED]. Record review of R #1's Comprehensive Care Plan dated 01/20/20 documented: -(R #1) is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) cognitive deficits . -(R #1) is an elopement risk/wanderer r/t history of attempts to leave facility unattended, Impaired safety awareness, resident wanders aimlessly -(R #1) resides in the secure unit due to wandering, she is new to facility and has been packing and unpacking belongings . -(R #1) has impaired cognitive function/dementia or impaired thought processes r/t dementia -(R #1) uses antidepressant medication r/t poor adjustment to admission [MEDICATION NAME] and [MEDICATION NAME] PATCH . The resident uses anti-anxiety medications ([MEDICATION NAME]) r/t anxiety disorder . The resident uses antipsychotic medications [MEDICATION NAME] . Monitor/record occurrence of/for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others etc. and document per facility protocol. Record review of R #1's Quarterly Minimum (MDS) data set [DATE] documented she: -had adequate hearing and clear speech -understood others and made self-understood -had a brief interview of mental status score of 4-severely impaired -required supervision for bed mobility, transfers, dressing, and limited assistance for personal care -had physical behavioral symptoms towards others and other behavioral symptoms not towards others that occurred 1-3 days. Record review of R #1's Nursing Progress

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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 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) Notes and Change in Condition Communication Form dated 03/15/20 documented 10:16 PM- SN (Skilled Nurse) notified by CNA (Certified Nurse Aide) that resident received physical aggression and was physical towards another resident (R #2). Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated (she) and another resident (R #2) were arguing when he hit her on her shoulder and she then bit his hand. SN asked resident if she had any pain and resident denied. SN assessed both of resident's shoulders and no redness or discoloration was observed. Vitals were . SN notified DON (Director of Nurses), RP (Responsible Party), and MD (Medical Doctor). No new orders received from MD. RP aware and no concerns at this time. SN placed resident on 72-hour (hr) critical behavior monitoring every hour. Resident remains in her room. Safety has been maintained, will continue to monitor. Record review of R #1's Incident/Accident Report dated 03/15/20 documented 10:30 PM- SN notified by CNA that resident received physical aggression and was physical towards another resident. Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated she and another resident (R #2) were arguing when he hit her on her shoulder, she then bit his hand. SN asked resident if she had any pain and resident denied. SN assessed both of resident's shoulders and no redness or discoloration was observed . SN notified DON, RP, and MD. No new orders received from MD. RP aware and no concerns at this time. SN placed resident on 72-hour critical behavior monitoring every hour. Resident remains in her room. Safety has been maintained. Will continue to monitor. Residents separated. Resident assessed, all appropriate parties notified. Upon investigation this resident was observed in her room sitting on her bed. Resident noted to be upset saying a man hit her on her shoulder and she bit him back. Noted bilateral shoulders with redness, bruising at present. Shoulders will be monitored. Resident denies being fearful of other resident at present. CNA will help separate and continue to monitor for further behaviors. Resident offered pain medicine. RP and MD notified of incident. Behavior monitoring for residents hourly X 72 hours. In an interview with CNA A on 04/06/20 at 4:05 PM, she stated the day following the incident (03/16/20), R #1 told her she was afraid of R #2, she (R #1) said she did not want him around. CNA A said R #1 put a chair and wheelchair to block the doorway to her room to keep him from coming in the room. CNA A said she (R #1) stayed distant, she stayed in her room for a couple of days behind the privacy curtain. CNA A stated, She did not want to be next to him (R #2) at all. Then a couple of days later she would constantly follow (R #2) with her eyes and purposely walk in front of (R #2), staring him down. Record review of R #1's Acute Care Plan dated 03/15/20 documented Behavior - Problem: Physical aggression/combativeness related to unknown .Approach: Reorient and redirect to self; Notify MD/RP of any changes in behavior; one-hour behavior monitoring for 72 hours. The care plan did not include any interventions in attempt to prevent incidents of physical aggression from re-occurring or what actions to implement should the aggression occur again. Record review of R #1's Nursing Progress Notes dated 03/18/20 documented 1:24 PM - 72-hour behavior (monitoring). Resident, this 6-2pm shift not having aggressive behaviors. SN placed call to daughter regarding approx. 1in. x 1in. discoloration to left shoulder . Resident at this time is able to perform full range of motion in all extremities with no non-verbal signs of pain nor is pain verbalized. Resident able to make needs known. Behavioral monitoring continued. Record review of R #1's left shoulder x-ray result, for a [DIAGNOSES REDACTED].#1 did not have a fracture. Record review of R #1's Nursing Progress Notes dated 03/20/20 documented 5:00 PM - SN observed resident being verbally aggressive towards male resident (R #2) in secure unit. Upon assessing resident, resident stated she knows male resident from years before and she doesn't like him. SN provided redirection and monitoring. SN notified MD for hyper fixating on male resident. New orders received for Trazadone 25mg tid (three times a day). SN notified RP, will continue to monitor. Record review of R #1's Nursing Progress Notes dated 03/23/20 documented 3:51 PM - Par meeting held IDT (interdisciplinary team)-Res had combative behaviors throughout the day with staff care at intervals. New onset of resisting care. Res was not easily redirected . Record review of R #1's Social Services Progress Note dated 03/24/20 documented 2:50 PM - Resident with recent changes in behavior including increased agitation. Current precautions in place in this facility are restricting visitors and resulting in some disruption to (R #1's) daily routine. Will continue to monitor and offer support as needed. This note documented changes in behavior with increased agitation but did not address R #1's psychosocial needs, her fear or her feelings towards her aggressor (R #2). Record review revealed there was no Social Services note regarding the 03/15/2020 altercation with another resident. In an interview with the Social Worker (SW) on 04/07/20 at 10:05 AM she said the IDT did not further explore or investigate R #1's increased agitation and resisting of care. The SW said R #1's behaviors could have been a result of R #2 being within her line of sight, possibly being fearful and angry at R #2 for punching her. Record review of R #1's Nursing Progress Notes dated 03/26/20 documented 1:37 PM - resident continues with agitation and verbal aggression towards other residents in the unit. Resident believes another male resident is after her, unable to redirect due to impaired cognition. Resident continues with delusions, resident closely monitored, SN notified md of current behavior. Pending response at this time, RP notified, will continue to monitor. Record review of R #1's Nursing Progress Notes dated 03/26/20 documented 2:04 PM - new orders from (physician) received to decrease PRN [MEDICATION NAME] to 0.5mg prn every 6 hours and to increase Trazadone to 50 mg tid. SN notified RP. Will continue to monitor. Record review of R #1's Nursing Progress Notes and Change in Condition Communication Form dated 03/27/20 documented 9:42 PM - SN notified by CNA that resident had received physical aggression from another resident. Upon assessment resident was observed sitting in chair in her bedroom. SN assessed resident and observed a hematoma to the top of her left eyebrow. Resident noted with bruising/discoloration from fall that previously happened. Resident verbalized pain to area and PRN Tylenol was administered. SN asked resident what happened, and she stated she was hit in the face. CNA stated that she witnessed another resident (R #2) hit (R #1) twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. Upon assessment, no other injuries were apparent. Vitals at the time of incident were . SN notified (physician) and no new orders. DON was notified. RP notified, no concerns or issues at this time. SN initiated 72-hour critical behavior monitoring hourly, and neuro checks x72 hours. Resident remained in room, safety maintained, will continue to monitor. Record review of R #1's Incident/Accident Report dated 03/27/20 documented 9:30 PM - .SN asked resident what happened, and she stated she was hit in the face. Upon investigation this resident was observed by CNA being hit on the left eye by another resident. Residents were both separated immediately. This resident (R #1) resides on the dementia unit and is able to state what occurred, oriented X1. Ice pack applied, and neuro checks were monitored. Prior to this incident resident had sustained a fall and noted with bruising discoloration to left side of eye (fall occurred on 03/20/20) RP and MD notified of incident. PRN adjustment for physical aggression, on 03/26/20 with new order for [MEDICATION NAME] 0.5 mg PRN (as needed) every 6 hours. Will continue to monitor. Resident denies being fearful of other resident at this time. After resident's family gave consent, resident was trialed outside the unit as an intervention. She did well for 4 hours then resident was observed ambulating down the hallway asking for way out of the facility. Resident required redirection but asked a second time how to get out of the building. Was then assisted back to the unit for safety. Due to recent restrictions related to COVID-19 resident is not a candidate to be out of the unit or for transfer to another facility and family cannot care for her at home at this time. Record review of R #1's Accident Investigation Report - Witness Interview documented by CNA B dated 03/27/20 documented A physical altercation between (R #1) and (R #2). I was assisting a resident in her room when I heard yelling. I ran out and saw (R #2) punching (R #1) twice, once near her temple and again her eye. I stepped between them and (R #2) grabbed my hand. He would not respond to his name and was intently staring at (R #1). I yelled his name loudly and he asked me who I was. I told him my name and that he was hurting me. He immediately let go of my hand and said he was sorry. Record review of R #1's Nursing Progress Notes dated 03/28/20 documented 10:24 AM - 24 hour follow up physical aggression received, resident stable, no s/s of distress, resident continues with contusion to left upper brow and temple. Resident medicated with prn pain medication for complaints of general pain. Resident alert, watching tv in common room, will continue to monitor . The 03/27/20 incident was the second incident of abuse, there was no documentation of any other interventions to protect R #1 from R #2, other than will continue to monitor. Record review of R #1's Nursing Progress Notes dated 03/30/20 documented 10:41 AM - 72-hour behavior monitoring. Patient is alert with discoloration to the left eye. Patient voiced that she has pain to the site. Ice pack and PRN medication administered. No signs of aggressive behaviors or fearful behavior noted. Record review of R #1's Physician order [REDACTED]. Observation of R #1 on 04/06/20 at 10:19 AM revealed she had purple discoloration beneath her left eye, on her left temple, down to her left cheek. R #1 was sitting in a chair in the common area of the secured unit watching television. At 10:21 AM, CNA D asked R #1 if she would like to go to the bathroom, R #1 said yes, and she ambulated to her room using a rolling walker. R #1 walked out of the bathroom and ambulated to her bed and sat on the edge of her bed. The privacy curtain was pulled around R #1's bed. R #1 frequently looked around the privacy curtain towards the hallway. When asked what R #1 was looking for, R #1 said Ese viejo

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) (that man). Record review of R #1's Nursing Progress Notes dated 04/03/20 documented 11:44 AM - notified RP for resident (R #1) aggressive behavior towards male resident (R #2). Resident was observed attempting to hit resident (R #2) with walker. Male resident was not engaged in any behavior prior to resident's aggression. SN separated residents, will continue to monitor. There was no evidence the facility took any further action other than resident separation. Interview with R #1 on 04/06/20 at 10:26 AM revealed she was alert to self, able to correctly state her name, stating she was not in her home but was unable to state her current location and time. R #1 was sitting on the edge of her bed with the privacy curtain pulled all the way around her bed. R #1 stated she was hit by a male resident, whom the only description she gave was a white man with no teeth. R #1 stated the male resident entered her room when it was still somewhat dark outside since she could see outside her window. R #1 said she was lying down on her right side, in bed, when the male resident entered her room and began pulling down her bed sheets. R #1 stated she yelled at him to leave her room and he kept telling her Shhh and called her Mammacita. R #1 said she held on to her sheets tightly as he tried to pull them off. R #1 said as she began to sit up, the male resident hit her in the face twice using his closed right fist. R #1 said she fell back on the bed when she got hit. R #1 said she pushed him with her walker and kicked him in his groin. R #1 said after that, she stood up and began to walk forward when he cornered her to the wall and hit her again on her left shoulder, using his closed fist. R #1 said she bit R #2's hand just before someone came into the room and escorted R #2 out. R #1 said her left eye, left temple, and right temple hurt. Further inspection of R #1's face revealed she had a slight raised area to her right temporal region. R #1 also complained of pain to her left shoulder. R #1 said she felt drunk from lack of sleep because she did not sleep well at night. When asked why she did not sleep well, R #1 said she was afraid the man was going to come back and hurt her again. R #1 said she hated that man for hitting her and was afraid of him. R #1 said the man continued to live in the facility because she was told the man had a right to live there. R #1 could not recall who or when she was told that. R #1 said she wanted her curtain pulled all the way around her bed so He don't see me when he is walking back and forth. Record review of R #1's Comprehensive Care Plan revised 04/06/20 documented The resident is/has potential to be physically aggressive related to dementia and depression. Due to resident's past history from family, resident has some issues with men. Can become aggressive with staff and at times other residents Interventions: Analyze times of day, places, circumstances, triggers, de-escalating behavior and document; Anticipate resident needs; Provide physical and verbal cues to alleviate anxiety. This care plan revision was done after the surveyor began the investigation, when the survey was in progress. In an interview with the DON on 04/07/20 at 10:40 AM, she said R #1 did not have any other revisions to her care plan that specifically addressed effective interventions to prevent further behaviors. Observation of R #1 on 04/07/20 at 10:20 AM revealed she sat on the couch in the secured unit's common area, behind R #2. Both R #1 and R #2 kept to themselves and watched television. At 10:24 AM, R #2 stood up and ambulated down the hallway towards his room. R #1 continuously stared at R #2 until R #2 was no longer in sight. R #2: Record review of R #2's Face Sheet dated 04/06/20 documented an [AGE] year-old male admitted [DATE] with the [DIAGNOSES REDACTED]. Record review of R #2's Admission Minimum (MDS) data set [DATE] documented he: - had minimal difficulty hearing and clear speech -had a brief interview of mental status score of 4- severely impaired -had inattentive fluctuating behavior -required limited assistance for bed mobility; extensive assistance with one-person physical assist for transfers, dressing, toilet use, and personal hygiene. Record review of R #2's Comprehensive Care Plan dated 03/03/20 documented: -The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t cognitive deficits - The resident has an ADL self-care performance deficit r/t dementia . - The resident has a behavior problem (R #2) will urinate where ever he can. Corners trash cans closets and other residents' rooms. (R #2) is to be monitored when up and ambulating . - The resident is an elopement risk/wanderer r/t disoriented to place, impaired safety awareness, resident wanders aimlessly, significantly intrudes on the privacy or activities . - The resident has impaired cognitive function/dementia or impaired thought processes r/t altered cognitive status . Record review of R #2's Nursing Progress Notes and Change of Condition Communication Form dated 03/15/20 documented 10:53 PM - SN notified by CNA resident was physical towards another resident (R #1) and then received physical aggression. Upon entering the secured unit resident was observed standing in the living/common area. SN approached resident and asked resident to see his right hand. upon further assessment resident was observed with discoloration/bruising. SN asked resident what happened and resident unable to verbalize. SN asked resident if he was in any pain and resident stated no. SN then assisted resident back to his room, assisted with toileting needs, and assisted resident to bed . resident remains in bed at this time. Safety maintained. DON notified, RP notified, no concerns at this time. On call for (physician) was notified new order for UA (urine) C&S (culture & sensitivity) and (lab). Oncoming 10-6 nurse aware of new orders. Orders have been transcribed, lab slip placed in binder. SN placed resident on 72- hour critical behavior monitoring, will continue to monitor. There was no documentation of any interventions put in place to prevent incident re-occurrence or protection. Record review of R #2's Acute Care Plan dated 03/15/20 documented Behavior - Problem: Physical aggression/combativeness related to unknown .Approach: Reorient and redirect to self; Notify MD/RP of any changes in behavior; 72-hour behavior monitoring. The care plan did not include any interventions in attempt to prevent incidents of physical aggression from re-occurring or what actions to implement should the aggression occur again. Record review of R #2's Nursing Progress Notes dated 03/16/20 documented 5:24 PM - resident 24-hour follow up behavior. Resident observed walking throughout hallway no s/s of pain. No s/s of anxiety or distress. Safety has been maintained. Resident remains on 72-hour critical behavior monitoring, will continue to monitor. Record review of R #2's Nursing Progress Notes and Change in Condition Communication Form dated 03/27/20 documented 8:50 PM - SN notified by CNA at approx. 4:30 PM that resident was physically aggressive towards another resident (R #1). Upon entering 500 hall, resident was observed sitting at desk at the end of the hall eating his dinner. Resident observed with no s/s of anxiety/distress or pain/discomfort. SN assessed resident and no injuries were present .CNA stated that she saw resident walking down hall towards dining area while assisting another resident in her room and when she entered dining area resident was physically hitting another resident (R #1), CNA stated that she witnessed him hit (R #1) twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. SN initiated 72-hr. critical behavior monitoring hourly. Nurse Practitioner (NP) was notified and new order for [MEDICATION NAME] 0.5 mg every 12hrs. PRN x2weeks was received. SN transcribed order and faxed it over to pharmacy. New order also received to have (psychological) services evaluate and treat . DON notified of incident and all new orders. RP was also notified, no concerns at this time. Safety has been maintained. Will continue to monitor. Record review of R #2's clinical record including physician's orders [REDACTED]. Record review of R #2's Accident Investigation Report - Witness Interview documented by CNA B dated 03/27/20 documented A physical altercation between (R #1) and (R #2). I was assisting a resident in her room when I heard (R #1) yelling. I ran out and saw (R #2) punching (R #1) twice near her temple and eye. I stepped between them and (R #2) grabbed my hand as I stopped (R #2) from hitting (R #1). R #2 was staring at (R #1) intently. I had to yell to get his attention. He let go of my hand and I walked him away from (R #1) who was calling (R #2) names. Record review of R #2's Nursing Progress Notes dated 03/28/20 documented 10:14 AM - 24-hour follow up physical aggression initiated. Resident continues with agitation at beginning of shift, SN administered prn medication for anxiety. Resident redirected, resident with SN at nurses' station reading magazines and drinking coffee. Resident calm, no anxiety observed . Observation of R #2 on 04/06/20 beginning at 10:21 AM, revealed he independently ambulated back and forth in the hallway, the same hallway R #1's room was located. In an interview with R #2 on 04/06/20 at 11:45 AM, he correctly stated his name. R #2 was not able to correctly state the day/time or place. R #2 said he was well taken care of and did not have issues or feared anyone in the facility. R #2 denied getting into any verbal or physical confrontations with anyone in the facility. In an interview with CNA A on 04/06/20 at 4:05 PM, she stated On 03/15/20 after dinner, (R #1) said she was going to her room to get ready to go to bed. CNA A said (R #2) had already been agitated that afternoon. CNA A explained she was documenting on the tracker when she heard thumps. CNA A said the tracker was located approximately a couple of feet adjacent to R #1's room. CNA A stated she went to find where the thump came from and heard some voices coming from R #1's room. CNA A said she walked into R #1's room and saw R #2 had R #1 pinned between the wall and the closet and he was hitting her with his right hand, closed fist on her right shoulder. CNA A said R #1 was trying to block R #2's hits. CNA A stated she immediately intervened and blocked some of the punches. CNA A explained CNA B was in the shower room and Licensed Vocational Nurse (LVN) C was working the other hall when the incident happened. CNA A said R #2 made a comment a couple of hours earlier before the incident happened, saying That son of a b**** needs to be hit, referring to R #1. CNA A said the next day on 03/16/20, R #1 had bruising on her left shoulder and stated R #2 punched R #1 on her left shoulder and that he choked her. CNA A said she never saw R #2 choking R #1 but the following day she had bruise marks on her neck. I felt bad for her. (There was
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Timely report suspected abuse, neglect, or theft and report the results of the**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676391	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR CALALLEN	4162 WILDCAT DR CORPUS CHRISTI, TX 78410

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** - Some	(continued... from page 6) **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, were reported immediately, but not later than 2 hours to the State Survey Agency and other officials, for one Resident (R#1) of three residents reviewed for abuse, in that: The facility did not report to the Health and Human Services Commission (HHSC)/State Survey Agency and other officials two separate incidents of possible abuse of R #1. Specifically, R #2 was witnessed by staff to punch R #1 on her torso and face, causing facial and shoulder bruising and pain, on two separate occasions. These deficient practices could affect residents residing in the secured unit and place them at risk of further abuse and delays in having their incidents investigated timely by the facility and state agency to ensure policies and procedures were implemented for the prevention and protection of abuse. The findings included: Record review of R #1's Face Sheet dated 04/06/20 documented a [AGE] year-old female admitted [DATE] with the [DIAGNOSES REDACTED]. Record review of R #1's Comprehensive Care Plan dated 01/20/20 documented: - (R #1) is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) cognitive deficits . - (R #1) is an elopement risk/wanderer r/t history of attempts to leave facility unattended, Impaired safety awareness, resident wanders aimlessly - (R #1) resides in the secure unit due to wandering, she is new to facility and has been packing and unpacking belongings . - (R #1) has impaired cognitive function/dementia or impaired thought processes r/t dementia - (R #1) uses antidepressant medication r/t poor adjustment to admission [MEDICATION NAME] and [MEDICATION NAME] PATCH . The resident uses anti-anxiety medications ([MEDICATION NAME]) r/t anxiety disorder . The resident uses antipsychotic medications [MEDICATION NAME] . Monitor/record occurrence of/for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others etc. and document per facility protocol. Record review of R #1's Quarterly Minimum (MDS) data set [DATE] documented she: -had adequate hearing and clear speech -understood others and made self-understood -had a brief interview of mental status score of 4-severely impaired -required supervision for bed mobility, transfers, dressing, and limited assistance for personal care -had physical behavioral symptoms towards others and other behavioral symptoms not towards others that occurred 1-3 days. Record review of R #1's Nursing Progress Notes and Change in Condition Communication Form dated 03/15/20 documented 10:16 PM- SN (Skilled Nurse) notified by CNA (Certified Nurse Aide) that resident received physical aggression and was physical towards another resident (R #2). Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated (she) and another resident (R #2) were arguing when he hit her on her shoulder and she then bit his hand. SN asked resident if she had any pain and resident denied. SN assessed both of resident's shoulders and no redness or discoloration was observed. Vitals were . SN notified DON (Director of Nurses), RP (Responsible Party), and MD (Medical Doctor). No new orders received from MD. RP aware and no concerns at this time. SN placed resident on 72-hour (hr) critical behavior monitoring every hour. Resident remains in her room. Safety has been maintained, will continue to monitor. Record review of R #1's Incident/Accident Report dated 03/15/20 documented 10:30 PM- SN notified by CNA that resident received physical aggression and was physical towards another resident. Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated she and another resident (R #2) were arguing when he hit her on her shoulder, she then bit his hand. SN asked resident if she had any pain and resident denied. SN assessed both of resident's shoulders and no redness or discoloration was observed . SN notified DON, RP, and MD. No new orders received from MD. RP aware and no concerns at this time. SN placed resident on 72-hour critical behavior monitoring every hour. Resident remains in her room. Safety has been maintained. Will continue to monitor. Residents separated. Resident assessed, all appropriate parties notified. Upon investigation this resident was observed in her room sitting on her bed. Resident noted to be upset saying a man hit her on her shoulder and she bit him back. Noted bilateral shoulders with redness, bruising at present. Shoulders will be monitored. Resident denies being fearful of other resident at present. CNA will help separate and continue to monitor for further behaviors. Resident offered pain medicine. RP and MD notified of incident. Behavior monitoring for residents hourly X 72 hours. In an interview with CNA A on 04/06/20 at 4:05 PM, she stated the day following the incident (03/16/20), R #1 told her she was afraid of R #2, she (R #1) said she did not want him around. CNA A said R #1 put a chair and wheelchair to block the doorway to her room to keep him from coming in the room. CNA A said she (R #1) stayed distant, she stayed in her room for a couple of days behind the privacy curtain. She did not want to be next to him (R #2) at all. Then a couple of days later she would constantly follow (R #2) with her eyes and purposely walk in front of (R #2), staring him down. Record review of R #1's Acute Care Plan dated 03/15/20 documented Behavior - Problem: Physical aggression/combativeness related to unknown .Approach: Reorient and redirect to self; Notify MD/RP of any changes in behavior; one-hour behavior monitoring for 72 hours. The care plan did not include any interventions in attempt to prevent incidents of physical aggression from re-occurring or what actions to implement should the aggression occur again. Record review of R #1's Nursing Progress Notes dated 03/18/20 documented 1:24 PM - 72-hour behavior (monitoring). Resident, this 6-2pm shift not having aggressive behaviors. SN placed call to daughter regarding approx. 1in. x 1in. discoloration to left shoulder . Resident at this time is able to perform full range of motion in all extremities with no non-verbal signs of pain nor is pain verbalized. Resident able to make needs known. Behavioral monitoring continued. Record review of R #1's left shoulder x-ray result dated 03/18/20 revealed R #1 did not have a fracture. Record review of R #1's Nursing Progress Notes dated 03/23/20 documented 3:51 PM - Par meeting held IDT (interdisciplinary team)-Res had combative behaviors throughout the day with staff care at intervals. New onset of resisting care. Res was not easily redirected . Record review of R #1's Social Services Progress Note dated 03/24/20 documented 2:50 PM - Resident with recent changes in behavior including increased agitation. Current precautions in place in this facility are restricting visitors and resulting in some disruption to (R #1's) daily routine. Will continue to monitor and offer support as needed. This note documented changes in behavior with increased agitation but did not address R #1's psychosocial needs, her fear or her feelings towards her aggressor (R #2). Record review revealed there was no Social Services note regarding the 03/15/2020 altercation with another resident. Interview with Social Worker (SW) on 04/07/20 at 10:05 AM revealed she confirmed the IDT did not further explore or investigate R #1's increased agitation and resisting of care. The SW said R #1's behaviors could have been a result of R #2 being within her line of sight, possibly being fearful and angry at R #2 for punching her. Record review of R #1's Nursing Progress Notes dated 03/26/20 documented 1:37 PM - resident continues with agitation and verbal aggression towards other residents in the unit. Resident believes another male resident is after her, unable to redirect due to impaired cognition. Resident continues with delusions, resident closely monitored, SN notified md of current behavior. Pending response at this time, RP notified, will continue to monitor. Record review of R #1's Nursing Progress Notes dated 03/26/20 documented 2:04 PM - new orders from (physician) received to decrease PRN [MEDICATION NAME] to 0.5mg prn every 6 hours and to increase Trazadone to 50 mg tid. SN notified RP. Will continue to monitor. Record review of R #1's Nursing Progress Notes and Change in Condition Communication Form dated 03/27/20 documented 9:42 PM - SN notified by CNA that resident had received physical aggression from another resident. Upon assessment resident was observed sitting in chair in her bedroom. SN assessed resident and observed a hematoma to the top of her left eyebrow. Resident noted with bruising/discoloration from fall that previously happened. Resident verbalized pain to area and PRN Tylenol was administered. SN asked resident what happened, and she stated she was hit in the face. CNA stated that she witnessed another resident (R #2) hit (R #1) twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. Upon assessment, no other injuries were apparent. Vitals at the time of incident were . SN notified (physician) and no new orders. DON was notified. RP notified, no concerns or issues at this time. SN initiated 72-hour critical behavior monitoring hourly, and neuro checks x72 hours. Resident remained in room, safety maintained, will continue to monitor. Record review of R #1's Incident/Accident Report dated 03/27/20 documented 9:30 PM - .SN asked resident what happened, and she stated she was hit in the face. Upon investigation this resident was observed by CNA being hit on the left eye by another resident. Residents were both separated immediately. This resident (R #1) resides on the dementia unit and is able to state what occurred, oriented X1. Ice pack applied, and neuro checks were monitored. Prior to this incident resident had sustained a fall and noted with bruising discoloration to left side of eye (fall occurred on 03/20/20) RP and MD notified of incident. PRN adjustment for physical aggression, on 03/26/20 with new order for [MEDICATION NAME] 0.5 mg prn (as needed) every 6 hours. Will continue to monitor. Resident denies being fearful of other resident at this time. After resident's family gave consent, resident was trialed outside the unit as an

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) intervention. She did well for 4 hours then resident was observed ambulating down the hallway asking for way out of the facility. Resident required redirection but asked a second time how to get out of the building. Was then assisted back to the unit for safety. Due to recent restrictions related to COVID-19 resident is not a candidate to be out of the unit or for transfer to another facility and family cannot care for her at home at this time. Record review of R #1's Accident Investigation Report - Witness Interview documented by CNA B dated 03/27/20 documented A physical altercation between (R #1) and (R #2). I was assisting a resident in her room when I heard yelling. I ran out and saw (R #2) punching (R #1) twice, once near her temple and again her eye. I stepped between them and (R #2) grabbed my hand. He would not respond to his name and was intently staring at (R #1). I yelled his name loudly and he asked me who I was. I told him my name and that he was hurting me. He immediately let go of my hand and said he was sorry. Record review of R #1's Nursing Progress Notes dated 03/28/20 documented 10:24 AM - 24-hour follow up physical aggression received, resident stable, no s/s of distress, resident continues with contusion to left upper brow and temple. Resident medicated with PRN pain medication for complaints of general pain. Resident alert, watching tv in common room, will continue to monitor . The 03/27/20 incident was the second incident of abuse, there was no documentation of any other interventions to protect R #1 from R #2, other than will continue to monitor. Record review of R #1's Nursing Progress Notes dated 03/30/20 documented 10:41 AM - 72-hour behavior monitoring. Patient is alert with discoloration to the left eye. Patient voiced that she has pain to the site. Ice pack and PRN medication administered. No signs of aggressive behaviors or fearful behavior noted. Record review of R #1's Physician order [REDACTED]. Observation of R #1 on 04/06/20 at 10:19 AM revealed she had purple discoloration beneath her left eye, on her left temple, down to her left cheek. R #1 was sitting in a chair in the common area of the secured unit watching television. At 10:21 AM, CNA D asked R #1 if she would like to go to the bathroom, R #1 said yes, and she ambulated to her room using a rolling walker. R #1 walked out of the bathroom and ambulated to her bed and sat on the edge of her bed. The privacy curtain was pulled around R #1's bed. R #1 frequently looked around the privacy curtain towards the hallway. When asked whatt R #1 was looking for, R #1 said Ese viejo (that man). Record review of R #1's Nursing Progress Notes dated 04/03/20 documented 11:44 AM - notified RP for resident (R #1) aggressive behavior towards male resident (R #2). Resident was observed attempting to hit resident (R #2) with walker. Male resident was not engaged in any behavior prior to resident's aggression. SN separated residents, will continue to monitor. There was no evidence the facility took any further action other than resident separation and continuation of monitoring. Interview with R #1 on 04/06/20 at 10:26 AM revealed she was alert to self, able to correctly state her name, stating she was not in her home but was unable to state her current location and time. R #1 was sitting on the edge of her bed with the privacy curtain pulled all the way around her bed. R #1 stated she was hit by a male resident, whom the only description she gave was a white man with no teeth. R #1 stated the male resident entered her room when it was still somewhat dark outside since she could see outside her window. R #1 said she was lying down on her right side, in bed, when the male resident entered her room and began pulling down her bed sheets. R #1 stated she yelled at him to leave her room and he kept telling her Shhh and called her Mammacita. R #1 said she held on to her sheets tightly as he tried to pull them off. R #1 said as she began to sit up, the male resident hit her in the face twice using his closed right fist. R #1 said she fell back on the bed when she got hit. R #1 said she pushed him with her walker and kicked him in his groin. R #1 said after that, she stood up and began to walk forward when he cornered her to the wall and hit her again on her left shoulder, using his closed fist. R #1 said she bit R #2's hand just before someone came into the room and escorted R #2 out. R #1 said her left eye, left temple, and right temple hurt. Further inspection of R #1's face revealed she had a slight raised area to her right temporal region. R #1 also complained of pain to her left shoulder. R #1 said she felt drunk from lack of sleep because she did not sleep well at night. When asked why she did not sleep well, R #1 said she was afraid the man was going to come back and hurt her again. R #1 said she hated that man for hitting her and was afraid of him. R #1 said the man continued to live in the facility because she was told the man had a right to live there. R #1 could not recall who or when she was told that. R #1 said she wanted her curtain pulled all the way around her bed so He don't see me when he is walking back and forth. Record review of R #1's Comprehensive Care Plan revised 04/06/20 documented The resident is/has potential to be physically aggressive related to dementia and depression. Due to resident's past history from family, resident has some issues with men. Can become aggressive with staff and at times other residents Interventions: Analyze times of day, places, circumstances, triggers, de-escalating behavior and document; Anticipate resident needs; Provide physical and verbal cues to alleviate anxiety. In an interview with the DON on 04/07/20 at 10:40 AM, she confirmed R #1 did not have any other revisions to her care plan that specifically addressed effective interventions to prevent further behaviors. Observation of R #1 on 04/07/20 at 10:20 AM revealed she sat on the couch in the secured unit's common area, behind R #2. Both R #1 and R #2 kept to themselves and watched television. At 10:24 AM, R #2 stood up and ambulated down the hallway towards his room. R #1 continuously stared at R #2 until R #2 was no longer in sight. R #2: Record review of R #2's Face Sheet dated 04/06/20 documented an [AGE] year-old male admitted [DATE] with the [DIAGNOSES REDACTED]. Record review of R #2's Admission Minimum (MDS) data set [DATE] documented he: - had minimal difficulty hearing and clear speech -had a brief interview of mental status score of 4- severely impaired -had inattentive fluctuating behavior -required limited assistance for bed mobility; extensive assistance with one-person physical assist for transfers, dressing, toilet use, and personal hygiene. Record review of R #2's Comprehensive Care Plan dated 03/03/20 documented: -The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t cognitive deficits - The resident has an ADL self-care performance deficit r/t dementia . - The resident has a behavior problem (R #2) will urinate where ever he can. Corners trash cans closets and other residents' rooms. (R #2) is to be monitored when up and ambulating . - The resident is an elopement risk/wanderer r/t disoriented to place, impaired safety awareness, resident wanders aimlessly, significantly intrudes on the privacy or activities . - The resident has impaired cognitive function/dementia or impaired thought processes r/t altered cognitive status . Record review of R #2's Nursing Progress Notes and Change of Condition Communication Form dated 03/15/20 documented 10:53 PM - SN notified by CNA resident was physical towards another resident (R #1) and then received physical aggression. Upon entering the secured unit resident was observed standing in the living/common area. SN approached resident and asked resident to see his right hand. upon further assessment resident was observed with discoloration/bruising. SN asked resident what happened and resident unable to verbalize. SN asked resident if he was in any pain and resident stated no. SN then assisted resident back to his room, assisted with toileting needs, and assisted resident to bed . resident remains in bed at this time. Safety maintained. DON notified, RP notified, no concerns at this time. On call for (physician) was notified new order for UA (urine) C&S (culture & sensitivity) and (lab). Oncoming 10-6 nurse aware of new orders. Orders have been transcribed, lab slip placed in binder. SN placed resident on 72- hour critical behavior monitoring, will continue to monitor. There was no documentation of any interventions put in place to prevent incident re-occurrence or protection. Record review of R #2's Acute Care Plan dated 03/15/20 documented Behavior - Problem: Physical aggression/combativeness related to unknown .Approach: Reorient and redirect to self; Notify MD/RP of any changes in behavior; 72-hour behavior monitoring. The care plan did not include any interventions in attempt to prevent incidents of physical aggression from re-occurring or what actions to implement should the aggression occur again. Record review of R #2's Nursing Progress Notes dated 03/16/20 documented 5:24 PM - resident 24-hour follow up behavior. Resident observed walking throughout hallway no s/s of pain. No s/s of anxiety or distress. Safety has been maintained. Resident remains on 72-hour critical behavior monitoring, will continue to monitor. Record review of R #2's Nursing Progress Notes and Change in Condition Communication Form dated 03/27/20 documented 8:50 PM - SN notified by CNA at approx. 4:30 PM that resident was physically aggressive towards another resident (R #1). Upon entering 500 hall, resident was observed sitting at desk at the end of the hall eating his dinner. Resident observed with no s/s of anxiety/distress or pain/discomfort. SN assessed resident and no injuries were present .CNA stated that she saw resident walking down hall towards dining area while assisting another resident in her room and when she entered dining area resident was physically hitting another resident (R #1), CNA stated that she witnessed him hit (R #1) twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. SN initiated 72-hr. critical behavior monitoring hourly. Nurse Practitioner (NP) was notified and new order for [MEDICATION NAME] 0.5 mg every 12hrs. PRN x2weeks was received. SN transcribed order and faxed it over to pharmacy. new order also received to have (psychological) services evaluate and treat . DON notified of incident and all new orders. RP was also notified, no concerns at this time. Safety has been maintained. Will continue to monitor. Record review of R #2's clinical record including physician's orders [REDACTED]. Record review of R #2's Accident Investigation Report - Witness Interview documented by CNA B dated 03/27/20 documented A physical altercation between (R #1) and (R #2). I was assisting a resident in her room when I heard (R #1) yelling. I ran out and saw (R #2) punching (R #1) twice near her temple and eye. I stepped between them and (R #2) grabbed my hand as I

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) stopped (R #2) from hitting (R #1). R #2 was staring at (R #1) intently. I had to yell to get his attention. He let go of my hand and I walked him away from (R #1) who was calling (R #2) names. Record review of R #2's Nursing Progress Notes dated 03/28/20 documented 10:14 AM - 24-hour follow up physical aggression initiated. Resident continues with agitation at beginning of shift, SN administered prn medication for anxiety. Resident redirected, resident with SN at nurses' station reading magazines and drinking coffee. Resident calm, no anxiety observed . Observation of R #2 on 04/06/20 beginning at 10:21 AM, revealed he independently ambulated back and forth in the hallway, the same hallway R #1's room was located. In an interview with R #2 on 04/06/20 at 11:45 AM, he correctly stated his name. R #2 was not able to correctly state the day/time or place. R #2 said he was well taken care of and did not have issues or feared anyone in the facility. R #2 denied getting into any verbal or physical confrontations with anyone in the facility. In an interview with CNA A on 04/06/20 at 4:05 PM, she stated On 03/15/20 after dinner, (R #1) said she was going to her room to get ready to go to bed. CNA A said (R #2) had already been agitated that afternoon. CNA A explained she was documenting on the tracker when she heard thumps. CNA A said the tracker was located approximately a couple of feet adjacent to R #1's room. CNA A stated she went to find where the thump came from and heard some voices coming from R #1's room. CNA A said she walked into R #1's room and saw R #2 had R #1 pinned between the wall and the closet and he was hitting her with his right hand, closed fist on her right shoulder. CNA A said R #1 was trying to block R #2's hits. CNA A stated she immediately intervened and blocked some of the punches. CNA A explained CNA B was in the shower room and Licensed Vocational Nurse (LVN) C was working the other hall when the incident happened. CNA A said R #2 made a comment a couple of hours earlier before the incident happened, saying That son of a b**** needs to be hit, referring to R #1. CNA A said the next day on 03/16/20, R #1 had bruising on her left shoulder and stated R #2 punched R #1 on her left shoulder and that he choked her. CNA A said she never saw R #2 choking R #1 but the following day she had bruise marks on her neck. I felt bad for her. (There was no documentation of bruising to R #1's neck in R #1's clinical record). CNA A said she did not inform a nurse of R #1's neck bruising because she thought the nurse already saw it when she assessed R #1. CNA A stated they were told to ensure both residents avoided contact with each other, which was difficult because it was a small area. CNA A also said they were told to monitor their (R #1 and R #2's) behaviors. CNA A said R #1 had a bruise to her left eye from a fall she had prior to the assault from R #2 however, R #1's left eye bruising worsened and grew in size. CNA A said on 03/27/20, prior to 9:00 AM, she was in the bathroom and when she arrived at the scene, she saw R #1 upset, sitting on the couch. CNA A said CNA B told her she witnessed R #2 punch R #1 on the face a couple of times. When asked if she was aware if R #2 had hit or hurt any other resident, CNA A said on 03/15/20, prior to R #2 hitting R #1 in her bedroom, she witnessed R #2 hit R #3 on her back while CNA A was escorting R #3 to the common area. CNA A said she redirected R #2 which was successful. CNA A said R #3 denied any discomfort. CNA A said she told LVN C of the incident but did not report the incident to the Abuse Coordinator. Record review of R #3's nursing progress notes and incident/accident reports dated 03/2020 revealed no documented incident of R #2 hitting R #3. In an interview with CNA B on 04/06/20 at 5:07 PM, she said on 03/15/20, she worked in the secured unit but did not witness the incident involving R #1 and R #2 because she was in the shower room. CNA B said CNA A told her that R #2 went to R #1's room and punched her on the shoulders. CNA B said R #1 stated that she bit R #2's hand. CNA B said before R #1 and R #2 got into the altercation, they kept staring at each other throughout the day and she recalled R #2 made a comment saying, That son of a b**** needed to be hit. CNA B said R #2 was staring at R #1 when he made the comment. CNA B said on 03/27/20, she was in a room helping another resident while CNA A went on break. CNA B said she was the only staff in the secured unit when she saw R #2 push a television tray and was pushing it down the hallway. CNA B said she suddenly heard R #1 yelling at R #2 and found both residents in the back area and witnessed R #2 hit R #1 twice on the left side of her face with his closed hand. CNA B said R #1 was also trying to hit R #2 but was unsuccessful because CNA B's arm was in the way and the television tray was between the two residents keeping R #1 from being within R #2's reach. CNA B said she grabbed R #2's hands and R #2 held on to her wrists. CNA B said she could not re-direct R #2 until she yelled his name loudly. CNA B said she told R #2 he was hurting her and he replied he was sorry for hurting her hand. CNA B stated R #2 seemed to think everyone in the unit was a man and sometimes referred to the unit as the barracks. CNA B said R #2 frequently confused R #1 as a man. CNA B said sometimes R #1 would instigate things such as stand in front of R #2 or she would say a comment towards him. CNA B said R #1 seemed to have anger towards R #2 because she remembers him hitting her. When asked what interventions she had been trained to implement when R #1 or R #2 display their behaviors, CNA B said We just re-direct. Interview with SW on 04/07/20 at 10:05 AM revealed she was informed of R #1 and R #2's physical altercations during the morning meetings. The SW said she spoke to the nurse and reviewed the nursing notes about the incidents. The SW said she had a basic conversation with both residents after the second incident. When asked to explain what a basic conversation meant, the SW said she asked each one if they were okay, if everything was okay and they both seemed fine. I just asked how they were feeling and if anything was wrong, the conversation did not go very far with either one of them. When asked if she spoke to R #1 and R #2 about the incidents and their feelings regarding the incident and each other, the SW said There was no conversation about the actual altercations. I asked if they were doing okay this morning and feeling alright, I did not ask them if they were comfortable or if they were fearful because I did not want to put that into their head. We felt (R #2) was a trigger for (R #1) which agitated (R #1) and showed aggression. I've seen her since the incident and she did not seem fearful or reserved. No, I did not specifically ask her how she felt about R #2 or if she feared anyone. At 10:20 AM, the SW and the surveyor visited R #1 in her room. The SW stated she did not understand Spanish and R #1 was primarily Spanish speaking. The SW asked CNA E to translate for her. When asked how she received her facial bruising, R #1 said A man (pointing to the hallway) that is over there hit me with his hand. His hand was closed (Resident demonstrated a closed fist). I feel very angry that he did that because no man should hit a woman. I feel angry and with disconfianza (distrust) and (am) scared. R #1 said the staff removed the male resident away from her and got mad at him for hitting her but he's still here. Observation of R #2 on 04/07/20 at 10:25 AM while the surveyor exited R #1's room revealed R #2 wandered throughout the secured unit hallway walking back and forth, past R#1's room each time. In an interview with the SW on 04/07/20 at 10:26 AM, she said she was not aware of R #1's feelings of anger, distrust and fear. In an interview with LVN C on 04/07/20 at 12:18 PM, she said she did not recall being told of R #2 hitting any another resident other than R #1. In an interview with the DON on 04/07/20 at 10:40 AM, when asked if R #1 and R #2's altercations were reported to the State agency, the DON said It was not reported to the state because they are both confused, it didn't fall under the guidelines to report. If they were not confused, then we would have definitely reported it. The DON stated the incidents were not reported to the local police either. When asked if being punched in the face or anywhere on the body, causing bruising, by another person met the definition of physical abuse, the DON did not reply to the surveyor's question. The DON explained R #2 did not have a history of physical aggression, however, R #1's family said that she had been hit in the past by her spouse. That may be part of her aggression towards a man. The DON said she was informed by staff that R #2 believed R #1 was a man because of her short hair So maybe that's why he would think it was okay to hit her. The DON said she interviewed staff regarding the incident. At this time the surveyor requested documentation of the investigations and interviews conducted. The DON said R #1 already had bruising to her left eye brow from the fall she sustained on 03/20/20, and the hit she received on 03/27/20 by R #2, unfortunately, in the same area made the bruising worse. The bruising traveled down from her eye to her cheek. When asked if she had any other statements or any other documents of investigation of the incidents, other than an incident/accident report and nursing notes, the DON said No. and could not provide any other documentation. In an interview with the Administrator on 04/07/20 at 11:27 AM, she stated she was the facility's abuse coordinator. The Administrator said the charge nurse notified the DON, then the DON notified the Administrator of R #1 and R #2's incidents. The Administrator confirmed she was notified the day of the incidents by the DON. The Administrator explained her team reviewed all incidents that happened the day before during the morning meetings. When asked what her investigation of the incidents inc
F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated for one Resident (R#1), of three residents reviewed for abuse, in that: The facility did not thoroughly investigate the first incident of physical abuse contributing to a second incident and the missed identification of R #1's fear and anger of R #2. R#1 was witnessed by staff to be punched in the face and torso by R #2, on two separate occasions. An Immediate Jeopardy (IJ) situation was identified 04/07/20. While the IJ was removed on 04/09/20 at 4:42 p.m., the facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems These deficient practices could affect residents residing

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	676391	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR CALALLEN	4162 WILDCAT DR CORPUS CHRISTI, TX 78410

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F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) in the secured unit and place them at risk of further abuse and delays in having their incidents investigated timely by the facility and for preventative interventions being put into place. The findings included: Record review of R #1's Face Sheet dated 04/06/20 documented a [AGE] year-old female admitted [DATE] with the [DIAGNOSES REDACTED]. Record review of R #1's Comprehensive Care Plan dated 01/20/20 documented: -(R #1) is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) cognitive deficits . -(R #1) is an elopement risk/wanderer r/t history of attempts to leave facility unattended, Impaired safety awareness, resident wanders aimlessly -(R #1) resides in the secure unit due to wandering, she is new to facility and has been packing and unpacking belongings . -(R #1) has impaired cognitive function/dementia or impaired thought processes r/t dementia -(R #1) uses antidepressant medication r/t poor adjustment to admission [MEDICATION NAME] and [MEDICATION NAME] PATCH . The resident uses anti-anxiety medications ([MEDICATION NAME]) r/t anxiety disorder . The resident uses antipsychotic medications [MEDICATION NAME] . Monitor/record occurrence of/for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others etc. and document per facility protocol. Record review of R #1's Quarterly Minimum (MDS) data set [DATE] documented she: -had adequate hearing and clear speech -understood others and made self-understood -had a brief interview of mental status score of 4-severely impaired -required supervision for bed mobility, transfers, dressing, and limited assistance for personal care -had physical behavioral symptoms towards others and other behavioral symptoms not towards others that occurred 1-3 days. Record review of R #1's Nursing Progress Notes and Change in Condition Communication Form dated 03/15/20 documented 10:16 PM- SN (Skilled Nurse) notified by CNA (Certified Nurse Aide) that resident received physical aggression and was physical towards another resident (R #2). Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated (she) and another resident were arguing when he hit her on her shoulder and she then bit him his hand. SN asked resident if she had any pain and resident denied. Sn assessed both of resident's shoulders and no redness or discoloration was observed. Vitals were . SN notified DON (Director of Nurses), RP (Responsible Party), and MD (Medical Doctor). No new orders received from MD. RP aware and no concerns at this time. SN placed resident on 72-hour (hr) critical behavior monitoring every hour. Resident remains in her room. Safety has been maintained, will continue to monitor. Record review of R #1's Incident/Accident Report dated 03/15/20 documented 10:30 PM- SN notified by CNA that resident received physical aggression and was physical towards another resident. Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated she and another resident (R #2) were arguing when he hit her on her shoulder, she then bit his hand. SN asked resident if she had any pain and resident denied. SN assessed both of resident's shoulders and no redness or discoloration was observed . SN notified DON, RP, and MD. No new orders received from MD. RP aware and no concerns at this time. SN placed resident on 72-hour critical behavior monitoring every hour. Resident remains in her room. Safety has been maintained. Will continue to monitor. Residents separated. Resident assessed, all appropriate parties notified. Upon investigation this resident was observed in her room sitting on her bed. Resident noted to be upset saying a man hit her on her shoulder and she bit him back. Noted bilateral shoulders with redness, bruising at present. Shoulders will be monitored. Resident denies being fearful of other resident at present. CNA will help separate and continue to monitor for further behaviors. Resident offered pain medicine. RP and MD notified of incident. Behavior monitoring for residents hourly X 72 hours. In an interview with CNA A on 04/06/20 at 4:05 PM, she stated the day following the incident (03/16/20), R #1 told her she was afraid of R #2, she (R #1) said she did not want him around. CNA A said R #1 put a chair and wheelchair to block the doorway to her room to keep him from coming in the room. CNA A said she (R #1) stayed distant, she stayed in her room for a couple of days behind the privacy curtain. She did not want to be next to him (R #2) at all. Then a couple of days later she would constantly follow (R #2) with her eyes and purposely walk in front of (R #2), staring him down. Record review of R #1's Acute Care Plan dated 03/15/20 documented Behavior - Problem: Physical aggression/combativeness related to unknown .Approach: Reorient and redirect to self; Notify MD/RP of any changes in behavior; one-hour behavior monitoring for 72 hours. The care plan did not include any interventions in attempt to prevent incidents of physical aggression from re-occurring or what actions to implement should the aggression occur again. Record review of R #1's Nursing Progress Notes dated 03/18/20 documented 1:24 PM - 72-hour behavior (monitoring). Resident, this 6-2pm shift not having aggressive behaviors. SN placed call to daughter regarding approx. 1in. x 1in. discoloration to left shoulder . Resident at this time is able to perform full range of motion in all extremities with no non-verbal signs of pain nor is pain verbalized. Resident able to make needs known. Behavioral monitoring continued. Record review of R #1's left shoulder x-ray result dated 03/18/20 revealed R #1 did not have a fracture. Record review of R #1's Nursing Progress Notes dated 03/23/20 documented 3:51 PM - Par meeting held IDT (interdisciplinary team)-Res had combative behaviors throughout the day with staff care at intervals. New onset of resisting care. Res was not easily redirected . Record review of R #1's Social Services Progress Note dated 03/24/20 documented 2:50 PM - Resident with recent changes in behavior including increased agitation. Current precautions in place in this facility are restricting visitors and resulting in some disruption to (R #1's) daily routine. Will continue to monitor and offer support as needed. This note documented changes in behavior with increased agitation but did not address R #1's psychosocial needs, her fear or her feelings towards her aggressor (R #2). Record review revealed there was no Social Services note regarding the 03/15/2020 altercation with another resident. Interview with Social Worker (SW) on 04/07/20 at 10:05 AM revealed she confirmed the IDT did not further explore or investigate R #1's increased agitation and resisting of care. The SW said R #1's behaviors could have been a result of R #2 being within her line of sight, possibly being fearful and angry at R #2 for punching her. Record review of R #1's Nursing Progress Notes dated 03/26/20 documented 1:37 PM - resident continues with agitation and verbal aggression towards other residents in the unit. Resident believes another male resident is after her, unable to redirect due to impaired cognition. Resident continues with delusions, resident closely monitored, SN notified MD of current behavior. Pending response at this time, RP notified, will continue to monitor. Record review of R #1's Nursing Progress Notes dated 03/26/20 documented 2:04 PM - new orders from (physician) received to decrease PRN [MEDICATION NAME] to 0.5mg prn every 6 hours and to increase Trazadone to 50 mg tid. SN notified RP. Will continue to monitor. Record review of R #1's Nursing Progress Notes and Change in Condition Communication Form dated 03/27/20 documented 9:42 PM - SN notified by CNA that resident had received physical aggression from another resident. Upon assessment resident was observed sitting in chair in her bedroom. SN assessed resident and observed a hematoma to the top of her left eyebrow. Resident noted with bruising/discoloration from fall that previously happened. Resident verbalized pain to area and PRN Tylenol was administered. SN asked resident what happened, and she stated she was hit in the face. CNA stated that she witnessed another resident (R #2) hit (R #1) twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. Upon assessment, no other injuries were apparent. Vitals at the time of incident were . SN notified (physician) and no new orders. DON was notified. RP notified, no concerns or issues at this time. SN initiated 72-hour critical behavior monitoring hourly, and neuro checks x72 hours. Resident remained in room, safety maintained, will continue to monitor. Record review of R #1's Incident/Accident Report dated 03/27/20 documented 9:30 PM - .SN asked resident what happened, and she stated she was hit in the face. Upon investigation this resident was observed by CNA being hit on the left eye by another resident. Resident were both separated immediately. This resident resides on the dementia unit and is able to state what occurred, oriented X1. Ice pack applied, and neuro checks were monitored. Prior to this incident resident had sustained a fall and noted with bruising discoloration to left side of eye (fall occurred on 03/20/20) RP and MD notified of incident. PRN adjustment for physical aggression, on 03/26/20 with new order for [MEDICATION NAME] 0.5 mg PRN (as needed) every 6 hours. Will continue to monitor. Resident denies being fearful of other resident at this time. After resident's family gave consent, resident was trialed outside the unit as an intervention. She did well for 4 hours then resident was observed ambulating down the hallway asking for way out of the facility. Resident required redirection but asked a second time how to get out of the building. Was then assisted back to the unit for safety. Due to recent restrictions related to COVID-19 resident is not a candidate to be out of the unit or for transfer to another facility and family cannot care for her at home at this time. Record review of R #1's Accident Investigation Report - Witness Interview documented by CNA B dated 03/27/20 documented A physical altercation between (R #1) and (R #2). I was assisting a resident in her room when I heard yelling. I ran out and saw (R #2) punching (R #1) twice, once near her temple and again her eye. I stepped between them and (R #2) grabbed my hand. He would not respond to his name and was intently staring at (R #1). I yelled his name loudly and he asked me who I was. I told him my name and that he was hurting me. He immediately let go of my hand and said he was sorry. Record review of R #1's Nursing Progress Notes dated 03/28/20 documented 10:24 AM - 24-hour follow up physical aggression received, resident stable, no s/s of

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F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) distress, resident continues with contusion to left upper brow and temple. Resident medicated with PRN pain medication for complaints of general pain. Resident alert, watching tv in common room, will continue to monitor . The 03/27/20 incident was the second incident of abuse, there was no documentation of any other interventions to protect R #1 from R #2, other than will continue to monitor. Record review of R #1's Nursing Progress Notes dated 03/30/20 documented 10:41 AM - 72-hour behavior monitoring. Patient is alert with discoloration to the left eye. Patient voiced that she has pain to the site. Ice pack and PRN medication administered. No signs of aggressive behaviors or fearful behavior noted. Record review of R #1's Physician order [REDACTED]. Observation of R #1 on 04/06/20 at 10:19 AM revealed she had purple discoloration beneath her left eye, on her left temple, down to her left cheek. R #1 was sitting in a chair in the common area of the secured unit watching television. At 10:21 AM, CNA D asked R #1 if she would like to go to the bathroom, R #1 said yes, and she ambulated to her room using a rolling walker. R #1 walked out of the bathroom and ambulated to her bed and sat on the edge of her bed. The privacy curtain was pulled around R #1's bed. R #1 frequently looked around the privacy curtain towards the hallway. When asked waht R #1 was loking for, R #1 said Ese viejo (that man). Record review of R #1's Nursing Progress Notes dated 04/03/20 documented 11:44 AM - notified RP for resident (R #1) aggressive behavior towards male resident (R #2). Resident was observed attempting to hit resident (R #2) with walker. Male resident was not engaged in any behavior prior to resident's aggression. SN separated residents, will continue to monitor. There was no evidence the facility took any further action other than resident separation. Interview with R #1 on 04/06/20 at 10:26 AM revealed she was alert to self, able to correctly state her name, stating she was not in her home but was unable to state her current location and time. R #1 was sitting on the edge of her bed with the privacy curtain pulled all the way around her bed. R #1 stated she was hit by a male resident, whom the only description she gave was a white man with no teeth. R #1 stated the male resident entered her room when it was still somewhat dark outside since she could see outside her window. R #1 said she was lying down on her right side, in bed, when the male resident entered her room and began pulling down her bed sheets. R #1 stated she yelled at him to leave her room and he kept telling her Shhh and called her Mammacita. R #1 said she held on to her sheets tightly as he tried to pull them off. R #1 said as she began to sit up, the male resident hit her in the face twice using his closed right fist. R #1 said she fell back on the bed when she got hit. R #1 said she pushed him with her walker and kicked him in his groin. R #1 said after that, she stood up and began to walk forward when he cornered her to the wall and hit her again on her left shoulder, using his closed fist. R #1 said she bit R #2's hand just before someone came into the room and escorted R #2 out. R #1 said her left eye, left temple, and right temple hurt. Further inspection of R #1's face revealed she had a slight raised area to her right temporal region. R #1 also complained of pain to her left shoulder. R #1 said she felt drunk from lack of sleep because she did not sleep well at night. When asked why she did not sleep well, R #1 said she was afraid the man was going to come back and hurt her again. R #1 said she hated that man for hitting her and was afraid of him. R #1 said the man continued to live in the facility because she was told the man had a right to live there. R #1 could not recall who or when she was told that. R #1 said she wanted her curtain pulled all the way around her bed so He don't see me when he is walking back and forth. Record review of R #1's Comprehensive Care Plan revised 04/06/20 documented The resident is/has potential to be physically aggressive related to dementia and depression. Due to resident's past history from family, resident has some issues with men. Can become aggressive with staff and at times other residents Interventions: Analyze times of day, places, circumstances, triggers, de-escalating behavior and document; Anticipate resident needs; Provide physical and verbal cues to alleviate anxiety. R #1's care plan was revised after surveyor started the investigation, when the survey was in progress. In an interview with the DON on 04/07/20 at 10:40 AM, she said R #1 did not have any other revisions to her care plan that specifically addressed effective interventions to prevent further behaviors, prior to the 4/6/20 revision. Observation of R #1 on 04/07/20 at 10:20 AM revealed she sat on the couch in the secured unit's common area, behind R #2. Both R #1 and R #2 kept to themselves and watched television. At 10:24 AM, R #2 stood up and ambulated down the hallway towards his room. R #1 continuously stared at R #2 until R #2 was no longer in sight. R #2: Record review of R #2's Face Sheet dated 04/06/20 documented an [AGE] year-old male admitted [DATE] with the [DIAGNOSES REDACTED]. Record review of R #2's Admission Minimum (MDS) data set [DATE] documented he: - had minimal difficulty hearing and clear speech -had a brief interview of mental status score of 4- severely impaired -had inattentive fluctuating behavior -required limited assistance for bed mobility; extensive assistance with one-person physical assist for transfers, dressing, toilet use, and personal hygiene. Record review of R #2's Comprehensive Care Plan dated 03/03/20 documented: -The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t cognitive deficits - The resident has an ADL self-care performance deficit r/t dementia . - The resident has a behavior problem (R #2) will urinate where ever he can. Corners trash cans closets and other residents' rooms. (R #2) is to be monitored when up and ambulating . - The resident is an elopement risk/wanderer r/t disoriented to place, impaired safety awareness, resident wanders aimlessly, significantly intrudes on the privacy or activities . - The resident has impaired cognitive function/dementia or impaired thought processes r/t altered cognitive status . Record review of R #2's Nursing Progress Notes and Change of Condition Communication Form dated 03/15/20 documented 10:53 PM - SN notified by CNA resident was physical towards another resident (R #1) and then received physical aggression. Upon entering the secured unit resident was observed standing in the living/common area. SN approached resident and asked resident to see his right hand. upon further assessment resident was observed with discoloration/bruising. SN asked resident what happened and resident unable to verbalize. SN asked resident if he was in any pain and resident stated no. SN then assisted resident back to his room, assisted with toileting needs, and assisted resident to bed . resident remains in bed at this time. Safety maintained. DON notified, RP notified, no concerns at this time. On call for (physician) was notified new order for UA (urine) C&S (culture & sensitivity) and (lab). Oncoming 10-6 nurse aware of new orders. Orders have been transcribed, lab slip placed in binder. SN placed resident on 72- hour critical behavior monitoring, will continue to monitor. There was no documentation of any interventions put in place to prevent incident re-occurrence or protection. Record review of R #2's Acute Care Plan dated 03/15/20 documented Behavior - Problem: Physical aggression/combativeness related to unknown .Approach: Reorient and redirect to self; Notify MD/RP of any changes in behavior; 72-hour behavior monitoring. The care plan did not include any interventions in attempt to prevent incidents of physical aggression from re-occurring or what actions to implement should the aggression occur again. Record review of R #2's Nursing Progress Notes dated 03/16/20 documented 5:24 PM - resident 24-hour follow up behavior. Resident observed walking throughout hallway no s/s of pain. No s/s of anxiety or distress. Safety has been maintained. Resident remains on 72-hour critical behavior monitoring, will continue to monitor. Record review of R #2's Nursing Progress Notes and Change in Condition Communication Form dated 03/27/20 documented 8:50 PM - SN notified by CNA at approx. 4:30 PM that resident was physically aggressive towards another resident (R #1). Upon entering 500 hall, resident was observed sitting at desk at the end of the hall eating his dinner. Resident observed with no s/s of anxiety/distress or pain/discomfort. SN assessed resident and no injuries were present .CNA stated that she saw resident walking down hall towards dining area while assisting another resident in her room and when she entered dining area resident was physically hitting another resident (R #1), CNA stated that she witnessed him hit (R #1) twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. SN initiated 72-hr. critical behavior monitoring hourly. Nurse Practitioner (NP) was notified and new order for [MEDICATION NAME] 0.5 mg every 12hrs. PRN x2weeks was received. SN transcribed order and faxed it over to pharmacy. new order also received to have (psychological) services evaluate and treat . DON notified of incident and all new orders. RP was also notified, no concerns at this time. Safety has been maintained. Will continue to monitor. Record review of R #2's clinical record including physician's orders [REDACTED]. Record review of R #2's Accident Investigation Report - Witness Interview documented by CNA B dated 03/27/20 documented A physical altercation between (R #1) and (R #2). I was assisting a resident in her room when I heard (R #1) yelling. I ran out and saw (R #2) punching (R #1) twice near her temple and eye. I stepped between them and (R #2) grabbed my hand as I stopped (R #2) from hitting (R #1). R #2 was staring at (R #1) intently. I had to yell to get his attention. He let go of my hand and I walked him away from (R #1) who was calling (R #2) names. Record review of R #2's Nursing Progress Notes dated 03/28/20 documented 10:14 AM - 24-hour follow up physical aggression initiated. Resident continues with agitation at beginning of shift, SN administered prn medication for anxiety. Resident redirected, resident with SN at nurses' station reading magazines and drinking coffee. Resident calm, no anxiety observed . Observation of R #2 on 04/06/20 beginning at 10:21 AM, revealed he independently ambulated back and forth in the hallway, the same hallway R #1's room was located. In an interview with R #2 on 04/06/20 at 11:45 AM, he correctly stated his name. R #2 was not able to correctly state the day/time or place. R #2 said he was well taken care of and did not have issues or feared anyone in the facility. R #2 denied getting into any verbal or physical confrontations with anyone in the facility. In an interview with CNA A on 04/06/20 at 4:05 PM, she stated On 03/15/20 after dinner, (R #1)

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F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) said she was going to her room to get ready to go to bed. CNA A said (R #2) had already been agitated that afternoon. CNA A explained she was documenting on the tracker when she heard thumps. CNA A said the tracker was located approximately a couple of feet adjacent to R #1's room. CNA A stated she went to find where the thump came from and heard some voices coming from R #1's room. CNA A said she walked into R #1's room and saw R #2 had R #1 pinned between the wall and the closet and he was hitting her with his right hand, closed fist on her right shoulder. CNA A said R #1 was trying to block R #2's hits. CNA A stated she immediately intervened and blocked some of the punches. CNA A explained CNA B was in the shower room and Licensed Vocational Nurse (LVN) C was working the other hall when the incident happened. CNA A said R #2 made a comment a couple of hours earlier before the incident happened, saying That son of a b**** needs to be hit, referring to R #1. CNA A said the next day on 03/16/20, R #1 had bruising on her left shoulder and stated R #2 punched R #1 on her left shoulder and that he choked her. CNA A said she never saw R #2 choking R #1 but the following day she had bruise marks on her neck. I felt bad for her. (There was no documentation of bruising to R #1's neck in R #1's clinical record). CNA A said she did not inform a nurse of R #1's neck bruising because she thought the nurse already saw it when she assessed R #1. CNA A stated they were told to ensure both residents avoided contact with each other, which was difficult because it was a small area. CNA A also said they were told to monitor their (R #1 and R #2's) behaviors. CNA A said R #1 had a bruise to her left eye from a fall she had prior to the assault from R #2 however, R #1's left eye bruising worsened and grew in size. CNA A said on 03/27/20, prior to 9:00 AM, she was in the bathroom and when she arrived at the scene, she saw R #1 upset, sitting on the couch. CNA A said CNA B told her she witnessed R #2 punch R #1 on the face a couple of times. When asked if she was aware if R #2 had hit or hurt any other resident, CNA A said on 03/15/20, prior to R #2 hitting R #1 in her bedroom, she witnessed R #2 hit R #3 on her back while CNA A was escorting R #3 to the common area. CNA A said she redirected R #2 which was successful. CNA A said R #3 denied any discomfort. CNA A said she told LVN C of the incident but did not report the incident to the Abuse Coordinator. Record review of R #3's nursing progress notes and incident/accident reports dated 03/2020 revealed no documented incident of R #2 hitting R #3. In an interview with CNA B on 04/06/20 at 5:07 PM, she said on 03/15/20, she worked in the secured unit but did not witness the incident involving R #1 and R #2 because she was in the shower room. CNA B said CNA A told her that R #2 went to R #1's room and punched her on the shoulders. CNA B said R #1 stated that she bit R #2's hand. CNA B said before R #1 and R #2 got into the altercation, they kept staring at each other throughout the day and she recalled R #2 made a comment saying, That son of a b**** needed to be hit. CNA B said R #2 was staring at R #1 when he made the comment. CNA B said on 03/27/20, she was in a room helping another resident while CNA A went on break. CNA B said she was the only staff in the secured unit when she saw R #2 push a television tray and was pushing it down the hallway. CNA B said she suddenly heard R #1 yelling at R #2 and found both residents in the back area and witnessed R #2 hit R #1 twice on the left side of her face with his closed hand. CNA B said R #1 was also trying to hit R #2 but was unsuccessful because CNA B's arm was in the way and the television tray was between the two residents keeping R #1 from being within R #2's reach. CNA B said she grabbed R #2's hands and R #2 held on to her wrists. CNA B said she could not re-direct R #2 until she yelled his name loudly. CNA B said she told R #2 he was hurting her and he replied he was sorry for hurting her hand. CNA B stated R #2 seemed to think everyone in the unit was a man and sometimes referred to the unit as the barracks. CNA B said R #2 frequently confused R #1 as a man. CNA B said sometimes R #1 would instigate things such as stand in front of R #2 or she would say a comment towards him. CNA B said R #1 seemed to have anger towards R #2 because she remembers him hitting her. When asked what interventions she had been trained to implement when R #1 or R #2 display their behaviors, CNA B said We just re-direct. Interview with SW on 04/07/20 at 10:05 AM revealed she was informed of R #1 and R #2's physical altercations during the morning meetings. The SW said she spoke to the nurse and reviewed the nursing notes about the incidents. The SW said she had a basic conversation with both residents after the second incident. When asked to explain what a basic conversation meant, the SW said she asked each one if they were okay, if everything was okay and they both seemed fine. I just asked how they were feeling and if anything was wrong, the conversation did not go very far with either one of them. When asked if she spoke to R #1 and R #2 about the incidents and their feelings regarding the incident and each other, the SW said There was no conversation about the actual altercations. I asked if they were doing okay this morning and feeling alright, I did not ask them if they were comfortable or if they were fearful because I did not want to put that into their head. We felt (R #2) was a trigger for (R #1) which agitated (R #1) and showed aggression. I've seen her since the incident and she did not seem fearful or reserved. No, I did not specifically ask her how she felt about R #2 or if she feared anyone. At 10:20 AM, the SW and the surveyor visited R #1 in her room. The SW stated she did not understand Spanish and R #1 was primarily Spanish speaking. The SW asked CNA E to translate for her. When asked how she received her facial bruising, R #1 said A man (pointing to the hallway) that is over there hit me with his hand. His hand was closed (Resident demonstrated a closed fist). I feel very angry that he did that because no man should hit a woman. I feel angry and with disconfianza (distrust) and (am) scared. R #1 said the staff removed the male resident away from her and got mad at him for hitting her but he's still here. Observation of R #2 on 04/07/20 at 10:25 AM while the surveyor exited R #1's room revealed R #2 wandered throughout the secured unit hallway walking back and forth, past R#1's room each time. In an interview with the SW on 04/07/20 at 10:26 AM, she said she was not aware of R #1's feelings of anger, distrust and fear. In an interview with LVN C on 04/07/20 at 12:18 PM, she said she did not recall being told of R #2 hitting any another resident other than R #1. In an interview with the DON on 04/07/20 at 10:40 AM, when asked if R #1 and R #2's altercations were reported to the State agency, the DON said It was not reported to the state because they are both confused, it didn't fall under the guidelines to report. If they were not confused, then we would have definitely reported it. The DON stated the incidents were not reported to the local police either. When asked if being punched in the face or anywhere on the body, causing bruising, by another person met the definition of physical abuse, the DON did not reply to the surveyor's question. The DON explained R #2 did not have a history of physical aggression, however, R #1's family said that she had been hit in the past by her spouse. That may be part of her aggression towards a man. The DON said she was informed by staff that R #2 believed R #1 was a man because of her short hair So maybe that's why he would think it was okay to hit her. The DON said she interviewed staff regarding the incident. At this time the surveyor requested documentation of the investigations and interviews conducted. The DON said R #1 already had bruising to her left eye brow from the fall she sustained on 03/20/20, and the hit she received on 03/27/20 by R #2, unfortunately, in the same area made the bruising worse. The bruising traveled down from her eye to her cheek. When asked if she had any other statements or any other documents of investigation of the incidents, other than an incident/accident report and nursing notes, the DON said No. and could not provide any other documentation. In an interview with the Administrator on 04/07/20 at 11:27 AM, she stated she was the facility's abuse coordinator. The Administrator said the charge nurse notified the DON, then the DON notified the Administrator of R #1 and R #2's incidents. The Administrator confirmed she was notified the day of th
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for two of three residents (R #1) whose care plans were reviewed, in that: 1. R #1's care plan was not reviewed or revised to include she exhibited agitation and provoking/instigating behaviors. 2. R #2's care plan was not revised following two witnessed occurrences of resident-to resident physical abuse, placing the abused resident (R #1) and other residents at risk for serious injury. 3. The facility failed to revise the care plans for R #1 and R #2 to include distancing them from each other to avoid physical aggressive behaviors towards one another. These deficient practices could affect residents that display or are a victim of physical and aggressive behaviors and place them at risk of lack of behavior monitoring, a delay in individualized interventions to prevent injury, and abuse. The findings included: Record review of R #1's Face Sheet dated 04/06/20 documented a [AGE] year-old female admitted [DATE] with the [DIAGNOSES REDACTED]. Record review of R #1's Quarterly Minimum (MDS) data set [DATE] documented she: -had adequate hearing and clear speech -understood others and made self-understood -had a brief interview of mental status score of 4-severely impaired -required supervision for bed mobility, transfers, dressing, and limited assistance for personal care -had physical behavioral symptoms towards others and other behavioral symptoms not towards others that occurred 1-3 days Record review of R #1's Comprehensive Care Plan dated 01/20/20 documented: - (R #1) is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) cognitive deficits .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676391	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR CALALLEN	4162 WILDCAT DR CORPUS CHRISTI, TX 78410

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) - (R #1) is an elopement risk/wanderer r/t history of attempts to leave facility unattended, Impaired safety awareness, resident wanders aimlessly - (R #1) resides in the secure unit due to wandering, she is new to facility and has been packing and unpacking belongings . - (R #1) has impaired cognitive function/dementia or impaired thought processes r/t dementia - (R #1) uses antidepressant medication r/t poor adjustment to admission [MEDICATION NAME] and [MEDICATION NAME] PATCH . The resident uses anti-anxiety medications ([MEDICATION NAME]) r/t anxiety disorder . The resident uses antipsychotic medications [MEDICATION NAME] . Monitor/record occurrence of/for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others etc. and document per facility protocol. -Revised on 04/06/20 - The resident is/has potential to be physically aggressive related to dementia and depression. Due to resident's past history from family, resident has some issues with men. Can become aggressive with staff and at times other residents Interventions: Analyze times of day, places, circumstances, triggers, de-escalating behavior and document; Anticipate resident needs; Provide physical and verbal cues to alleviate anxiety. R #1's care plan did not include R #1's instigating behaviors staff reported R #1 displayed. Record review of R #1's Nursing Progress Notes and Change in Condition Communication Form dated 03/15/20 documented 10:16 PM- SN (Skilled Nurse) notified by CNA (Certified Nurse Aide) that resident received physical aggression and was physical towards another resident (R #2). Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated (she) and another resident were arguing when he hit her on her shoulder and she then bit his hand. SN asked resident if she had any pain and resident denied. SN assessed both of resident's shoulders and no redness or discoloration was observed. Vitals were . SN notified DON (Director of Nurses), RP (Responsible Party), and MD (Medical Doctor). No new orders received from MD. RP aware and no concerns at this time. SN placed resident on 72 hour (hr) critical behavior monitoring every hour. Resident remains in her room. Safety has been maintained, will continue to monitor. Record review of R #1's Incident/Accident Report dated 03/15/20 documented 10:30 (PM)- SN notified by CNA that resident received physical aggression and was physical towards another resident. Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated she and another resident (R #2) were arguing when he hit her on her shoulder, she then bit his hand. SN asked resident if she had any pain and resident denied. SN assessed both of resident's shoulders and no redness or discoloration was observed . SN notified DON, RP, and MD. No new orders received from MD. RP aware and no concerns at this time. SN placed resident on 72-hour critical behavior monitoring every hour. Resident remains in her room. Safety has been maintained. Will continue to monitor. Residents separated. Resident assessed, all appropriate parties notified. Upon investigation this resident was observed in her room sitting on her bed. Resident noted to be upset saying a man hit her on her shoulder and she bit him back. Noted bilateral shoulders with redness, bruising at present. Shoulders will be monitored. Resident denies being fearful of other resident at present. CNA will help separate and continue to monitor for further behaviors. Resident offered pain medicine. RP and MD notified of incident. Behavior monitoring for residents hourly X 72 hours. Record review of R #1's Acute Care Plan dated 03/15/20 documented Behavior - Problem: Physical aggression/combativeness related to unknown .Approach: Reorient and redirect to self; Notify MD/RP of any changes in behavior; one-hour behavior monitoring for 72 hours. The care plan did not include interventions to prevent incidents of physical aggression from re-occurring or how to deal with the problem should it occur again. Record review of R #1's Nursing Progress Notes dated 03/18/20 documented 1:24 PM - 72-hour behavior resident this 6-2pm shift not having aggressive behaviors. SN placed call to daughter regarding approx. 1in. x 1in. discoloration to left shoulder. Daughter voices she does not think she needs an X-Ray done. Resident at this time is able to perform full range of motion in all extremities with no non-verbal signs of pain nor is pain verbalized. Resident able to make needs known. Behavioral monitoring continued. Record review of R #1's Nursing Progress Notes dated 03/20/20 documented 5:00 PM - SN observed resident being verbally aggressive towards male resident (R #2) in secure unit. upon assessing resident, resident stated she knows male resident from years before and she doesn't like him. SN provided redirection and monitoring. SN notified MD for hyper fixating on male resident. new orders received for Trazadone 25mg TID (three times a day). SN notified RP, will continue to monitor. Record review of R #1's Nursing Progress Notes dated 03/23/20 documented 3:51 PM - Par meeting held IDT (interdisciplinary team)-Res had combative behaviors throughout the day with staff care at intervals. New onset of resisting care. Res was not easily redirected. Md notified and RP, new order received for Trazadone (sedative/antidepressant) 25mg TID (three times daily) on 3/21 res sustained falls x 2- res was transferred to ER d/t head injury and returned with no n/o (new orders). Res has had a decline in function-not able to perform ADLs (activities of daily living) as per baseline. Will continue to monitor. Record review of R #1's Social Services Progress Note dated 03/24/20 documented 2:50 PM - Resident with recent changes in behavior including increased agitation. Current precautions in place in this facility are restricting visitors and resulting in some disruption to (R #1's) daily routine. Will continue to monitor and offer support as needed. This note documented changes in behavior with increased agitation but did not address R #1's psychosocial needs, her fear or her feelings towards her aggressor (R #2). Record review revealed there was no Social Services note regarding the 03/15/2020 altercation with another resident. Record review of R #1's Nursing Progress Notes dated 03/26/20 documented 1:37 PM - resident continues with agitation and verbal aggression towards other residents in the unit. resident believes another male resident is after her, unable to redirect due to impaired cognition. Resident continues with delusions, resident closely monitored, SN notified md of current behavior. Pending response at this time, RP notified, will continue to monitor. Record review of R #1's Nursing Progress Notes dated 03/26/20 documented 2:04 PM - new orders from (physician) received to decrease PRN [MEDICATION NAME] to 0.5mg prn every 6 hours and to increase trazadone to 50 mg TID. SN notified RP. Will continue to monitor. Record review of R #1's Nursing Progress Notes and Change in Condition Communication Form dated 03/27/20 documented 9:42 PM - SN notified by CNA that resident had received physical aggression from another resident. upon assessment resident was observed sitting in chair in her bedroom. SN assessed resident and observed a hematoma to the top of her left eyebrow. Resident noted with bruising/discoloration from fall that previously happened. Resident verbalized pain to area and PRN Tylenol was administered. SN asked resident what happened, and she stated she was hit in the face. CNA stated that she witnessed another resident hit her twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. Upon assessment, no other injuries were apparent . SN notified (physician) and no new orders. DON was notified. RP notified. No concerns or issues at this time. SN initiated 72-hour critical behavior monitoring hourly, and neuro checks x72 hours. Resident remained in room, safety maintained, will continue to monitor. Record review of R #1's Incident/Accident Report dated 03/27/20 documented 4:30 PM - SN notified by CNA that resident had received physical aggression from another resident (R #2). Upon assessment resident was observed sitting in chair in her bedroom. SN assessed resident and observed a hematoma to the top of her left eyebrow. Resident noted with bruising/discoloration from fall that previously happened. Resident verbalized pain to area and PRN Tylenol was administered. SN asked resident what happened, and she stated she was hit in the face. CNA stated that she witnessed another resident (R #2) hit her twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. Upon assessment no other injuries were apparent .SN notified MD and no new orders. DON was notified. RP notified, no concerns or issues at this time. SN initiated 72-hour critical behavior monitoring hourly, and neuro checks x72 hours. Resident remained in room, safety maintained. Will continue to monitor. SN asked resident what happened, and she stated she was hit in the face. Upon investigation this resident was observed by CNA being hit on the left eye by another resident. Residents were both separated immediately. This resident resides on the dementia unit and is able to state what occurred, oriented X1. Ice pack applied, and neuro checks were monitored. Prior to this incident resident had sustained a fall and noted with bruising discoloration to left side of eye (fall occurred on 03/20/20) RP and MD notified of incident. PRN adjustment for physical aggression, on 03/26/20 with new order for [MEDICATION NAME] 0.5 mg prn (as needed) every 6 hours. Will continue to monitor. Resident denies being fearful of other resident at this time. After resident's family gave consent, resident was trialed outside the unit as an intervention. She did well for 4 hours then resident was observed ambulating down the hallway asking for way out of the facility. Resident required redirection but asked a second time how to get out of the building. Was then assisted back to the unit for safety. Due to recent restrictions related to COVID-19 resident is not a candidate to be out of the unit or for transfer to another facility and family cannot care for her at home at this time. Record review of R #1's Accident Investigation Report - Witness Interview documented by CNA B dated 03/27/20 documented A physical altercation between (R #1) and (R #2). I was assisting a resident in her room when I heard yelling I ran out and saw (R #2) punching (R #1) twice once near her temple and again her eye. I stepped between them and (R #2) grabbed my hand. He would not respond to his name and was intently staring at (R #1). I yelled his name loudly and he asked me who I was. I

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	676391	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR CALALLEN	4162 WILDCAT DR CORPUS CHRISTI, TX 78410

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 13) told him my name and that he was hurting me. He immediately let go of my hand and said he was sorry. Record review of R #1's Nursing Progress Notes dated 04/03/20 documented 11:44 AM - notified RP for resident (R #1) aggressive behavior towards male resident (R #2). Resident was observed attempting to hit resident with walker. Male resident was not engaged in any behavior prior to resident's aggression. SN separated residents, will continue to monitor. Observation of R #1 on 04/06/20 at 10:19 AM revealed she was appropriately dressed and groomed, without mal-odors. R #1 had purple discoloration beneath her left eye, on her left temple, down to her left cheek. R #1 was sitting in a chair in the common area of the secured unit watching television. At 10:21 AM, CNA D asked R #1 if she would like to go to the bathroom, R #1 said yes and she ambulated to her room using a rolling walker. R #1 walked out of the bathroom and ambulated to her bed and sat on the edge of her bed. The privacy curtain was pulled around R #1's bed. Interview with R #1 on 04/06/20 at 10:26 AM revealed she was alert to self, able to correctly state her name, stating she was not in her home but was unable to state her current location and time. R #1 was sitting on the edge of her bed with the privacy curtain pulled all the way around her bed. R #1 stated she was hit by a male resident whom the only description she gave was a white man with no teeth. R #1 stated the male resident entered her room, when it was still somewhat dark outside since she could she outside from her window. R #1 said she was laying down on her right side, in bed, when the male resident entered her room and began pulling down her bed sheets. R #1 stated she yelled at him to leave her room and he kept telling her Shhh and called her Mammacita. R #1 said she held on to her sheets tightly as he tried to pull them off. R #1 said as she began to sit up the male resident hit her in the face twice using his closed right fist. R #1 said she fell back on the bed when she got hit. R #1 said she pushed him with her walker and kicked him in his groin. R #1 said after that, she stood up and began to walk forward when he cornered her to the wall and hit her again on her left shoulder, using his closed fist. R #1 said she bit R #2's hand just before someone came into the room and escorted R #2 out. R #1 said her left eye, left temple, and right temple hurt her. Further inspection of R #1's face revealed she had a slight raised area to her right temporal region. R #1 also complained of pain to her left shoulder. R #1 said she felt drunk from lack of sleep because she did not sleep well at night. When asked why she did not sleep well, R #1 said she was afraid the man was going to come back and hurt her again. R #1 said she hated that man for hitting her and was afraid of him. R #1 said the man continued to live in the facility because she was told the man had a right to live there. R #1 could not recall who or when she was told that. R #1 said she wanted her curtain pulled all the way around her bed so He don't see me when he is walking back and forth. Observation of R #1 on 04/07/20 at 10:20 AM revealed she sat on the couch in the secured unit's common area, behind R #2. Both R #1 and R #2 kept to themselves and watched television. At 10:24 PM, R #2 stood up and ambulated down the hallway towards his room. R #1 continuously stared at R #2 until R #2 was no longer in sight. R #1 frequently looked towards the hallway. R #2: Record review of R #2's Face Sheet dated 04/06/20 documented an [AGE] year-old male admitted [DATE] with the [DIAGNOSES REDACTED]. Record review of R #2's Admission Minimum (MDS) data set [DATE] documented he: -minimal difficulty hearing and clear speech -had a brief interview of mental status score of 4- severely impaired -had inattentive fluctuating behavior -required limited assistance for bed mobility; extensive assistance with one-person physical assist for transfers, dressing, toilet use, and personal hygiene. Record review of R #2's Comprehensive Care Plan dated 03/03/20 documented: -The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t cognitive deficits - The resident has an ADL self-care performance deficit r/t dementia . - The resident has a behavior problem (R #2) will urinate where ever he can. Corners trash cans closets and other residents' rooms. (R #2) is to be monitored when up and ambulating . - The resident is an elopement risk/wanderer r/t disoriented to place, impaired safety awareness, resident wanders aimlessly, significantly intrudes on the privacy or activities . - The resident has impaired cognitive function/dementia or impaired thought processes r/t altered cognitive status . R #2's care plan did not address physically aggressive behaviors or previous altercations he was involved in. Record review of R #2's Nursing Progress Notes and Change of Condition Communication Form dated 03/15/20 documented 10:53 PM - SN notified by CNA that resident was physical towards another resident and then received physical aggression. upon entering the secured unit resident was observed standing in the living/common area. SN approached resident and asked resident to see his right hand. Upon further assessment resident was observed with discoloration/bruising. SN asked resident what happened and resident unable to verbalize. SN asked resident if he was in any pain and resident stated no. SN then assisted resident back to his room, assisted with toileting needs, and assisted resident to bed . resident remains in bed at this time. safety maintained. DON notified, RP notified no concerns at this time. on call for (physician) was notified new order for UA (urine) C&S (culture & sensitivity) and (lab). Oncoming 10-6 nurse aware of new orders. Orders have been transcribed, lab slip placed in binder. SN placed resident on 72-hour critical behavior monitoring, will continue to monitor. Record review of R #2's Acute Care Plan dated 03/15/20 documented Behavior - Problem: Physical aggression/combativeness related to unknown .Approach: Reorient and redirect to self; Notify MD/RP of any changes in behavior; 72-hour behavior monitoring. The care plan did not include any interventions in attempt to meet or prevent the objective of physical aggression from re-occurring or how to deal with the problem should it occur again. Record review of R #2's Nursing Progress Notes and Change in Condition Communication Form dated 03/27/20 documented 8:50 PM - SN notified by CNA at approx. 4:30 PM that resident was physically aggressive towards another resident. Upon entering 500 hall residents was observed sitting at desk at the end of the hall eating his dinner. Resident observed with no s/s of anxiety/distress or pain/discomfort. SN assessed resident an no injuries were present . CNA stated that she saw resident walking down hall towards dining area while assisting another resident in her room and when she entered dining area resident was physically hitting another resident (R #1), CNA stated that she witnessed him hit her twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. SN initiated 72hr. critical behavior monitoring hourly. Nurse Practitioner (NP) was notified and new order for [MEDICATION NAME] 0.5 mg every 12hrs. PRN x2weeks was received. SN transcribed order and faxed it over to pharmacy. new order also received to have (psych) services evaluate and treat . DON notified of incident and all new orders. RP was also notified. no concerns at this time. Safety has been maintained. Will continue to monitor. Record review of R #2's Accident Investigation Report - Witness Interview documented by CNA B dated 03/27/20 documented A physical altercation between (R #1) and (R #2). I was assisting a resident in her room when I heard (R #1) yelling I ran out and saw (R #2) punching (R #1) twice near her temple and eye. I stepped between them and (R #2) grabbed my hand as I stopped (R #2) from hitting (R #1). R #2 was staring at (R #1) intensely. I had to yell to get his attention. He let go of my hand and I walked him away from (R #1) who was calling (R #2) names. Observation of R #2 on 04/06/20 beginning at 10:21 AM, revealed he independently ambulated back and forth in the hallway, the same hallway R #2's room was located. In an interview with R #2 on 04/06/20 at 11:45 AM, he correctly stated his name. R #2 was not able to correctly state the day/time or place. R #2 said he was well taken care of and did not have issues or feared anyone in the facility. R #2 denied getting into any verbal or physical confrontations with anyone in the facility. In an interview with CNA A on 04/06/20 at 4:05 PM, she stated on 03/15/20, after dinner, (R #1) said she was going to her room to get ready to go to bed. CNA A said (R #2) had already been agitated that afternoon. CNA A explained she was documenting on the tracker when she heard thumps. CNA A said the tracker was located approximately a couple of feet adjacent to R #1's room. CNA A stated she went to find where the thump came from and heard some voices coming from R #1's room. CNA A said she walked into R #1's room and saw R #2 had R #1 pinned between the wall and the closet and he was hitting her with his right hand, closed fist on her right shoulder. CNA A said R #1 was trying to block R #2's hits. CNA A stated she immediately intervened and blocked some of the punches. CNA A explained CNA B was in the shower room and Licensed Vocational Nurse (LVN) C was working the other hall when the incident happened. CNA A said R #2 made a comment a couple of hours earlier before the incident happened saying That son of a b**** needs to be hit referring to R #1. CNA A said the next day R #1 had bruising on her left shoulder and stated R #2 punched her on her left shoulder and that he choked her. We were told to ensure both residents avoided contact with each other, which is difficult because it is a small area, and to monitor their behaviors. CNA A said on 03/27/20, prior to 9:00 AM, she was in the bathroom and when she arrived at the scene, she saw R #1 upset, sitting on the couch. CNA A said CNA B told her she witnessed R #2 punch R #1 on the face a couple of times. CNA A said R #1 seemed to provoke R #2 by trying to hit him or trip him with her walker and walk in front of him to get his attention. In an interview with CNA B on 04/06/20 at 5:07 PM, she said on 03/15/20, she worked in the secured unit but did not witness the incident involving R #1 and R #2 because she was in the shower room. CNA B said CNA A told her that R #2 went to R #1's room and punched her on the shoulders. CNA B said R #1 stated that she bit R #2's hand. CNA B said before R #1 and R #2 got into the altercation, they kept starring at each other throughout the day and recalled R #2 made a comment saying, That son of a b**** needed to be hit. CNA B said R #2 was staring at R #1 when he made the comment. CNA B said on 03/27/20, she was in a room helping another resident while CNA A went on break. CNA B said she was the only staff in the secured unit when she saw R #2 push a television tray and was

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	676391	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR CALALLEN	4162 WILDCAT DR CORPUS CHRISTI, TX 78410

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 14) pushing it down the hallway. CNA B said she suddenly heard R #1 yelling at R #2 and found both residents in the back area and witnessed R #2 hit R #1 twice on the left side of her face with his closed hand. CNA B said R #1 was also trying to hit R #2 but was unsuccessful because CNA B's arm was in the way and the television tray was between the two residents keeping R #1 from being within R #2's reach. CNA B said sometimes R #1 would instigate things such as stand in front of R #2 or she would say a comment towards him. CNA B said R #1 seemed to have anger towards R #2 because she remembers him hitting her. In an interview with the Director of Nurses (DON) on 04/07/20 at 10:40 AM, she explained R #2 did not have a history of physical aggression, however, R #1's family said that she had been hit in the past by her spouse. That may be part of her aggression towards a man. The DON said she was informed by staff that R #2 believed R #1 was a man because of her short hair So maybe that's why he would think it was okay to hit her. The DON stated R #1 had provoking/instigating behaviors towards R #2. When asked if those behaviors she explained R #1 had should be included in her care plan, the DON said yes. When asked if R #2's physically aggressive behaviors should be included in his care plan, the DON said yes. After referring to R #2's acute care plan dated 03/15/20, the DON said the interventions were reactive to the problem rather than an action to meet an objective. When asked why R #1 and R #2's care plan had not been updated and revised to include their behaviors, the DON did not respond. The DON explained the purpose of a comprehensive care plan was to identify the resident's needs and to develop appropriate interventions to assist in the care of those needs. In an interview with the Administrator on 04/07/20 at 11:27 AM, she agreed that R #1 and R #2's current care plans did not include their behaviors and/or interventions to meet their behavioral needs.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one of one Resident (R #1) reviewed for quality of care/treatment and monitoring of injuries. The facility did not ensure R #1's facial bruising she received after a fall and then again after being punched in the face, were consistently monitored and documented with a detailed description of the injury. This deficient practice could result in residents' change in condition not being addressed in a timely manner to prevent resident decline. The findings included: Record review of R #1's Face Sheet dated 04/06/20 documented a [AGE] year-old female admitted [DATE] with the [DIAGNOSES REDACTED]. Record review of R #1's Quarterly Minimum (MDS) data set [DATE] documented she: -had adequate hearing and clear speech -understood others and made self-understood -had a brief interview of mental status score of 4-severely impaired -required supervision for bed mobility, transfers, dressing, and limited assistance for personal care -had physical behavioral symptoms towards others and other behavioral symptoms not towards others that occurred 1-3 days Record review of R #1's Comprehensive Care Plan dated 01/20/20 documented: - (R #1) is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) cognitive deficits . - (R #1) is an elopement risk/wanderer r/t history of attempts to leave facility unattended, Impaired safety awareness, resident wanders aimlessly - (R #1) resides in the secure unit due to wandering, she is new to facility and has been packing and unpacking belongings . - (R #1) has impaired cognitive function/dementia or impaired thought processes r/t dementia -Revised on 04/06/20 - The resident is/has potential to be physically aggressive related to dementia and depression. Due to resident's past history from family, resident has some issues with men. Can become aggressive with staff and at times other residents Interventions: Analyze times of day, places, circumstances, triggers, de-escalating behavior and document; Anticipate resident needs; Provide physical and verbal cues to alleviate anxiety. Record review of R #1's Nursing Progress Notes and Change in Condition Communication Form dated 03/15/20 documented 10:16 PM- SN (Skilled Nurse) notified by CNA (Certified Nurse Aide) that resident received physical aggression and was physical towards another resident. Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated she and another resident were arguing when he hit her on her shoulder and she then bit his hand. SN asked resident if she had any pain and resident denied. SN assessed both of resident's shoulders and no redness or discoloration was observed . Record review of R #1's Incident/Accident Report dated 03/15/20 documented 10:30 AM- SN notified by CNA that resident received physical aggression and was physical towards another resident. Upon entering the secured unit SN was informed that resident was in her room. Upon entering resident's room, she was observed sitting on her bed. SN asked resident what happened, and she stated she and another resident were arguing when he hit her on her shoulder and she then bit him back on his hand. SN asked resident if she had any pain and resident denied. Sn assessed both of resident's shoulders and no redness or discoloration was observed . SN asked resident what happened, and she stated she and another resident were arguing when he hit her on her shoulder and she then bit him back on his hand. Upon investigation this resident was observed in her room sitting on her bed. Resident noted to be upset saying a man hit her on her shoulder and she bit him back. Noted bilateral shoulders with redness, bruising at present. The note did not provide a detailed description of R #1's facial bruising. Record review of R #1's Nursing Progress Notes dated 03/18/20 documented 1:24 PM - 72-hour behavior resident this 6-2pm shift not having aggressive behaviors'. SN placed call to daughter regarding approx. 1in (inch). x 1in. discoloration to left shoulder . The note did not detail the actual appearance of her discoloration. Record review of R #1's Nursing Progress Notes dated 03/22/20 documented 10:15 AM - 48 hour follow up fall x 2 from 3/20/20 at 6pm and 9:50pm. Resident stable, using wheelchair for mobility due to general weakness, rp aware. Resident with no s/s (signs/symptoms) of pain or distress. Resident able to verbalize needs, resident continues with discoloration to left upper brow. No other injuries observed upon skin assessment . The note did not detail the size or actual color of her discoloration. Record review of R #1's Nursing Progress Notes and Change in Condition Communication Form dated 03/27/20 documented 9:42 PM - SN notified by CNA that resident had received physical aggression from another resident. Upon assessment resident was observed sitting in chair in her bedroom. SN assessed resident and observed a hematoma to the top of her left eyebrow. Resident noted with bruising/discoloration from fall that previously happened. Resident verbalized pain to area and PRN (as needed) Tylenol was administered. SN asked resident what happened, and she stated she was hit in the face. CNA stated that she witnessed another resident hit her twice on her temple and side of the eye and she immediately separated the two and called for assistance of other CNA and notified SN. Upon assessment no other injuries were apparent . SN notified (physician) and no new orders. DON was notified. RP notified, no concerns or issues at this time. SN initiated 72-hour critical behavior monitoring hourly, and neuro checks x72 hours. resident remained in room, safety maintained, will continue to monitor. The note did not detail the size or actual color of her discoloration or the size of the hematoma on her left eyebrow. Record review of R #1's Incident/Accident Report dated 03/27/20 documented 4:30 PM - SN notified by CNA that resident had received physical aggression from another resident. Upon assessment resident was observed sitting in chair in her bedroom. SN assessed resident and observed a hematoma to the top of her left eyebrow. resident noted with bruising/discoloration from fall that previously happened. resident verbalized pain to area and PRN Tylenol was administered. SN asked resident what happened, and she stated she was hit in the face. CNA stated that she witnessed another resident hit her twice on her temple and side of the eye and she immediately separated the two and called for assistance of another CNA and notified SN. Upon assessment no other injuries were apparent . SN notified MD and no new orders. DON was notified. RP notified no concerns or issues at this time. SN initiated 72-hour critical behavior monitoring hourly, and neuro checks x72 hours. resident remained in room, safety maintained. will continue to monitor. SN asked resident what happened, and she stated she was hit in the face. Upon investigation this resident was observed by CNA being hit on the left eye by another resident. Resident were both separated immediately. This resident resides on the Dementia Unit and is able to state what occurred, oriented X1. Ice pack applied, and neuro checks were monitored. Prior to this incident resident had sustained a fall and noted with bruising discoloration to left side of eye (fall occurred on 03/20/20). The note did not detail the size or actual appearance of her bruising/discoloration of her left eye/eyebrow. Record review of R #1's Nursing Progress Notes dated 03/28/20 documented 10:24 AM - 24 hour follow up physical aggression received, resident stable, no s/s of distress, resident continues with contusion to left upper brow and temple. Resident medicated with PRN pain medication for complaints of general pain. Resident alert, watching tv in common room, will continue to monitor . The note did not detail a measurement or appearance of the contusion. Record review of R #1's Nursing Progress Notes dated 03/30/20 documented 10:41 AM - 72-hour behavior monitoring. Patient is alert with discoloration to the left eye. Patient voiced that she has pain to the site. Ice pack and PRN medication administered. No signs of aggressive

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 15) behaviors or fearful behavior noted. The note did not detail a measurement or appearance of the discoloration. Record review of R #1's Physician order [REDACTED]. Observation of R #1 on 04/06/20 at 10:19 AM revealed she had purple discoloration beneath her left eye, on her left temple, down to her left cheek. R #1 was sitting in a chair in the common area of the secured unit watching television. At 10:21 AM, CNA D asked R #1 if she would like to go to the bathroom, R #1 said yes, and she ambulated to her room using a rolling walker. R #1 walked out of the bathroom and ambulated to her bed and sat on the edge of her bed. The privacy curtain was pulled around R #1's bed. In an interview with the Director of Nurses (DON) on 04/07/20 at 10:40 AM, she stated (R #1) already had bruising to her left eye brow from the fall she sustained on 03/20/20, and the hit she received on 03/27/20 by (R #2), unfortunately, in the same area, made the bruising worse. The bruising traveled down from her eye to her cheek. The DON said that the lack of detailed documentation of R #1's injury to the left side of her face made it difficult to distinguish the extent of the bruising R #1 sustained from her fall on 03/20/20 and the punch in the face she received from R #2 on 03/27/20. When asked if R #1's nurse's notes should document consistent and a detailed description of her injury, the DON said Yes, the nurses should be documenting a detailed description of the injury to include location, size, and appearance at least daily for 7-14 days and documented in the nursing notes. The DON said the facility did not have a policy or procedure regarding documenting injuries and expected nursing staff to document detailed descriptions of injuries as learned in nursing school. Review of Lippincott Nursing Procedures Eighth Edition page 34-35 documented, Assessment Techniques: Inpection: -Use your eyes to observe the patient. Pay close attention to the details of the patient's appearance, behavior, and movement, such as facial expressions, mood, physique, and conditioning . -To inspect a specific body area, first make sure the area is sufficiently exposed. Survey the entire area, noting key landmarks and checking its overall condiction. Focus on specifics - color, shape, texture, size, and movement. Note findings, as well as unusual and predictable findings.