STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676411	A. BUILDING _____ B. WING _____	**06/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLARENDON NURSING HOME	**TEN MEDICAL CENTER DR CLARENDON, TX 79226**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review; the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. for 3 of 6 residents (Resident #2, Resident #3 and Resident #6) reviewed for Care Plans. The facility failed to update Resident #2's Care Plan after Resident #2 assaulted Resident #3, and Resident #3 sustained bleeding, contusions, abrasions, lacerations and a fractured nose, orbital bone and skull. The facility failed to update Resident #2's Care Plan after Resident #2 assaulted Resident #6, and Resident #6 sustained contusions, abrasions and a fractured finger. The facility failed to update Resident #3's Care Plan after Resident #2 assaulted him resulting in Resident #3 sustaining bleeding, contusions, abrasions, lacerations and a fractured nose, orbital bone and skull. The facility failed to update Resident #6's Care Plan after Resident #2 assaulted him resulting in Resident #6 sustaining contusions, abrasions and a fractured finger. This deficient practice placed residents at risk for falls, sprains, bruising, fractures, pain, internal or external bleeding, assaults, abuse and transmission of communicable bloodborne diseases. Findings include: Resident #2 Review of Resident #2's current face sheet, revealed he was a [AGE] year-old male, admitted to the facility on [DATE]. Resident #2 had [DIAGNOSES REDACTED]. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 7 on 4/18/20, indicating severe cognitive impairment. The MDS, last updated on 4/18/20, reveals he has depression; no listed behaviors; requires only setup assistance for all activities of daily living (ADLs); is ambulatory; is always continent of bladder and bowel; and is at risk for pressure sores. Record Review of Resident #2's Care Plan, last updated 4/27/20, revealed he has a DNR, has cognitive impairment, has behaviors of sexually inappropriate behavior toward female staff, requires total assist for ADLs, has pain issues, is at risk for injuries related to smoking, and [MEDICAL CONDITION] medication, and is at risk for weight loss. The facility failed to update the Care Plan with the 5/5/20 assault on Resident #3 and the 5/15/20 assault on Resident #6. Record Review of Resident #2's Nurses' Notes revealed: 5/5/2020 8:45: Late Entry: Resident was in his room , Resident (#3) a was in the rest room at this time, Resident then became angry and became violent towards Resident (#3), Resident physically assaulted resident (#3) causing bodily injury to resident (#3), Resident then dragged resident (#3) into his room and put him on his bed and closed the curtain to his side and walked out of his room and returned to the dining area, Resident was calm and started eating his breakfast and watching tv, Resident was questioned by staff and the sheriff's department and admitting to the physical assaulting resident (#3). Dr. was notified at this time and ordered to watch resident closely and chart every 1 hr., Dr. ordered injection. (Sic)- ADON 5/15/2020 12:53 AM: at 11:30 PM after being alerted by CNA's when I came upon scene found this resident standing up in aggressive mode holding guitar et threatening staff cursing yelling out while his roommate (Resident #6) was lying on the floor after being hit by this resident after talking to resident he put down guitar and yelled you better get him out before I kill him staff was allowed to get roommate up et out of room with no further attacks resident asked to stay in room via said nurse resident remains in room monitored via staff et cameras will continue to monitor. (Sic)-LVN J During an observation on 5/13/20 at 11:59 AM, Resident #2 had an angry affect when Surveyor approached. During a simultaneous interview, Resident #2 stated, I ain't talking to you. It's time for lunch. Go on now. During an interview on 5/13/20 at 12:22 PM, CI #2 was unsure whether Resident #2 had any history of violence. CI #2 confirmed Resident #2 has a history of [MEDICAL CONDITION]. During an observation on 5/14/20 at 11:09 AM, Resident #2 had an angry affect when Surveyor approached. During a simultaneous interview Resident #2 stated, I told you, I ain't talking to you. Now get out. Resident #3 Review of Resident #3's current face sheet, revealed he was a [AGE] year-old male, admitted to the facility on [DATE], with transfer to hospital with admission on 5/5/20 and readmit to facility on 5/7/20. Resident #3 had [DIAGNOSES REDACTED]. Resident #3 had a Brief Interview for Mental Status (BIMS) score of 12 on 3/31/20, indicating moderate cognitive impairment. The MDS, last updated on 3/31/20, reveals he has speech and vision impairment; depression; no listed behaviors; setup assistance for all activities of daily living (ADLs); and occasionally incontinent of bladder and bowel; and is at risk for pressure sores. Record Review of Resident #3's Care Plan, last updated 1/5/20, revealed he is a full code, has vision, communication and cognitive impairment, has incontinence issues, has behaviors of physical aggression, requires assistance for ADLs, has pain issues, is at risk for injuries related to [MEDICAL CONDITION]'s and [MEDICAL CONDITION], diabetes and [MEDICAL CONDITION] therapy, and is at risk for weight loss. The facility failed to update the Care Plan with the 5/5/20 assault that resulted in Resident #3 sustaining bleeding, contusions, abrasions, lacerations and a fractured nose, orbital bone and skull. Record Review of Resident #3's Nurses' Notes revealed: 5/5/2020 8:44 AM: (CNA F) was answering a call light in room [ROOM NUMBER]B, (CNA F) came upon resident laying in residents 125 b bed with blood all over him, (CNA F) yelled for assistance, Staff ran into the room where resident was laying in bed, Resident was alert and never lost consciousness, This nurse applied pressure to residents right eye where resident has a large hematoma formed with 5+ [MEDICAL CONDITION], Resident has a 2 inch laceration above his eye brow, 2 cm laceration below his right eye , after applying pressure bleeding sustained, Resident did start having some convulsions lasted about 15 seconds x 3 times, Resident nose swollen about 3+ [MEDICAL CONDITION] bleeding was stopped, this nurse applied simple mask, Resident received a laceration right upper lip 2 cm wide and 2 inch long , Resident has 3 inch hematoma left side of back of his head, scattered multiply small hematomas about head, Small laceration left side tip of his nose about 1 inch, Resident right great toe nail ripped off, Resident left pupil was reactive and right eye unable to see. Resident oxygen saturation on room air sat was sitting at 88 % before applying oxygen, Resident heart rate was 66 per min, Resident was complaining of pain stated it was his head. Ems arrived in residents room taken over, Resident ambulated to gurney with assistance, Resident was up talking when been transported out the facility. (Sic)-ADON 5/5/2020 12:22 PM: Called (Hospital) report was received ., Resident has multiple fractures on right orbit. Resident has small brain bleed. Resident's sinus' cavities completely caved in. Resident maxilla bone both sides fractured. -ADON 5/6/2020 8:23 AM: NP from (Hospital) called for update with Resident receiving a CT scan at this time if clear will be sent back to nursing home. Will need to follow up with neuro surgeon and will be placed on an antibiotic for 10 days. Everything will be set up before discharge-ADON 5/7/2020 12:05 PM: Resident arrived back at facility at 11:50 AM, upon arrival residents vitals were taken and assessment was completed as follows BP 99/67, oxygen saturation 95%, P 77 RR 18, Temp 98.5, resident denies any pain. Resident was placed in 117 for isolation due to being admitted to (Hospital), assessment was done in that room, resident entire right eye is swollen shut and completely bruised leading to whole cheek being bruised as well due to fracture, right jaw is swollen due to fracture, laceration to entire right eye brow, there is slight bruising under left eye, no notable swelling to left eye, small scratch to right temple, slight bruise to entire nose with dried blood still in both nostrils, top lip noticeably swollen and bruised with

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) only slight bruising to bottom lip, small laceration and bruising to top/crown of head, resident resting in bed with call light in reach, resident was educated that we would bring him all of his meals and medication to his room due to him being in isolation for 14 days, will continue to monitor and follow up as needed. (Sic)-LVN K During an observation on 5/13/20 at 12:06 PM, Resident #3 had old bruising and healing lacerations to his face. During a simultaneous interview, Resident #3 was unable to recall incident, and he appeared to be a poor historian and unable to track conversation. During an interview on 5/13/20 at 10:25 AM, CI #3 confirmed Resident #3 was taken to their ER, evaluated, diagnosed with [REDACTED]. Resident #3 was discharged back to facility the following day. CI #3 confirmed Resident #3 was transferred to their hospital for evaluation after being assaulted by another resident. During an interview on 5/13/20 at 10:35 AM, CI #4 confirmed Resident #3 was transported to the hospital after another resident beat him down pretty bad. The staff said, 'another resident beat him up because he was taking too long in the restroom.' The first thing I saw when I walked in was there was a lot of blood. His face was really bloody, and his eye was swollen. It looked like he had been worked over pretty bad. CI #4 confirmed facility staff was unable to provide how many times Resident was struck before staff intervened. Resident #6 Review of Resident #6's current face sheet, revealed he was a forty-two-year-old male, admitted to the facility on [DATE]. Resident #6 had [DIAGNOSES REDACTED]. Resident #6 had a Brief Interview for Mental Status (BIMS) score of 10 on 3/19/20, indicating moderate cognitive impairment. The MDS, last updated on 3/19/20, reveals he has hearing and vision impairment; depression; behaviors of verbal aggression; requires setup assistance for all activities of daily living (ADLs); has unilateral upper and lower extremity impairment; is ambulatory; is occasionally incontinent of bladder and always continent of bowel; has occasional pain that requires medication; no falls; and is at risk for pressure sores. Record Review of Resident #6's Care Plan, last updated 1/5/20, revealed he has vision, hearing and cognitive impairment, has incontinence issues, has behaviors of verbal aggression, requires setup assistance for ADLs, has pain issues, is at risk for injuries related to [MEDICAL CONDITIONS], diabetes and [MEDICAL CONDITION] therapy, and is at risk for weight loss. The facility failed to update Resident #6's Care Plan after Resident #2 assaulted him on 5/15/20, resulting in Resident #6 sustaining contusions, abrasions and a fractured finger. Record Review of Resident #6's Nurses Notes revealed: 5/15/2020 2:22 AM: resident found in floor of room via staff after being slung down by roommate after roommate trying to go to bathroom resident stated roommate called him a punk then he called resident one then resident charged him slung him down then with continued abuse struck him in the head three times stated resident kept saying he was going to kill him resident assisted from floor via staff et assisted to nurses station assessed et treated for [REDACTED]. (Sic)-LVN J 5/15/2020 8:30 AM: Resident at nurses station to get PM medications. Resident states his left hand was hurting and swollen. Upon assessment, residents left index and middle finger are swollen and painful to touch. Contacted Dr. Now Order to obtain a portable 3 View X-ray to left hand portable due to being in a locked unit. Contacted admin and left message with Power Of Attorney. Awaiting return call. Will continue to monitor. (Sic)-LVN L 5/16/2020 3:11 AM: Late Entry: Received X-ray report. Report as follows. Impacted fracture noted at base of proximal phalanx in index finger. Attempted to call Dr. with No answer. Message was left and text sent. Contacted ADON with results. ADON reported to Administrator and DON. Message left with Power of Attorney. Awaiting orders if any. Will continue to monitor. (Sic)-LVN L During an observation on 5/18/20 at 8:35 AM, Resident #6's right index and middle fingers were bruised. The bruise extended down to hand and distal wrist. During a simultaneous interview, when asked about the injury, Resident #6 stated, That[***] knocked me down and broke my damn finger. It is my best finger. It is my trigger finger. When asked to clarify which Resident knocked him down and broke his finger, Resident #6 stated, My roommate was in the bathroom, and I needed to go. I knocked on the door to see how much longer. He said, 'Go away, Punk.' I yelled back, 'I ain't nobody's punk, Punk.' He came [MEDICATION NAME] out of the bathroom and hit me and knocked me down. After I fell he kept hitting me. During an interview on 5/15/20 at 10:31 AM, when asked who is responsible for updating Care Plans, ADON stated, (MDS), I believe. When asked whether aggressive behaviors, wounds, injuries should be on a Resident's Care Plan, ADON stated, It should, yes. During an interview on 5/15/20 at 1:22 PM, when asked who is responsible for updating Care Plans, DON stated, A licensed nurse. When asked whether aggressive behaviors, wounds, injuries should be on a Resident's Care Plan, DON stated, It should, yes. When informed these items were not updated after the assaults, DON stated, I see what you are saying. DON confirmed no assault updates were in the Care Plans. Record review of facility provided policy for Care Plan, Comprehensive, Person Centered, dated 12/2016, stated: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretations and Implementation 8. The comprehensive, person-centered care plan will include: A. Measurable objectives and timetables; . H. Incorporate identified problem areas.