STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676347	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMARILLO CENTER FOR SKILLED CARE	**6641 W AMARILLO BLVD AMARILLO, TX 79106**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assure the MDS accurately reflected the resident's status for 1 of 6 residents (Resident #5) reviewed for MDS assessments. - The facility failed to document aggressive behavior toward staff and delusional beliefs held by Resident #5. This failure could affect all residents currently in the facility receiving care by not accurately assessing the resident's status. Findings included: Record review of Resident #5's clinical record revealed a [AGE] year-old female admitted to the facility initially on 12-1-2018 and readmitted on [DATE]. Resident #5 was discharged from the facility on 3-9-2020. Resident #5's [DIAGNOSES REDACTED]. Record review of Resident #5's MDS Section C, dated 1-3-2020, revealed a BIMS score of 13 of 15 showing no cognitive deficit. Review of MDS section E0100, revealed the Resident #5 was not coded as the resident having delusional behaviors. Review of MDS section E0200, revealed the Resident #5 was not coded as having verbal behavioral symptoms directed toward others Record review of Resident #5's progress notes, dated 12-28-2019, revealed the Resident #5 stated what did yall tell that man that's next door the nurse asked resident what man, and there is no men that live next door to her, resident then states that man that's sitting over there with (roommate) why did yall tell him I killed them I'm not crazy even though you think I am. Record review of Resident #5's progress notes, dated 12-28-2019, revealed the Resident #5 revealed res. very restless this shift, has not slept. lashing out at staff members who are attempting to assist. attempts to redirects unsuccessful. During an interview with the DON on 6-17-2020 at 1:45 PM, she was asked if it was her expectation that the MDS be filled out and completed accurately. She responded that it was her expectation that the MDS be accurate. DON was asked for a policy on MDS coding. She replied that the facility follows the RAI Manual. No other policies were presented. Record review of CMS Guidelines - Resident Assessment Instrument dated October 2019, page E-5 revealed: Steps for Assessment 1. Review the medical record for the 7-day look-back period. 2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident. 3. Observe the resident in a variety of situations during the 7-day look-back period. Coding Instructions o Code 1, behavior of this type occurred 1-3 days: if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days. o Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated. o Code as present, even if staff have become used to the behavior or view it as typical or tolerable. o Behaviors in these categories should be coded as present or not present, whether or not they might represent a rejection of care.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement a comprehensive 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 and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #5)of 6 Residents reviewed for comprehensive care plans. - The facility failed to care plan Resident #5 for suicidal ideation and attempted suicide This failure could affect all residents currently in the facility receiving care per comprehensive person-centered care plans resulting in resident's not being able to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: Resident #5 Record review of Resident #5's clinical record revealed a [AGE] year-old female admitted to the facility initially on 12-1-2018 and readmitted on [DATE]. Resident #5 was discharged from the facility on 3-9-2020. Resident #5's [DIAGNOSES REDACTED]. Record review of Resident #5's MDS, dated [DATE], revealed a BIMS score of 13 of 15 showing no cognitive deficit. Further review of Resident #5's clinical record revealed a care plan that was last reviewed 1-13-2020 and has no mention of suicidal ideation or suicide attempt within the care plan. Record review of Resident #5's progress notes, dated 12-27-2019, revealed the Resident #5 stated I'm going to kill myself to an aide. Record review of Resident #5's progress notes, dated 1-19-2020, revealed that resident was slurring words and slow to respond. This nurse and 3 other nurses went in to evaluate resident. Resident laying in chair with feet up. Resident responded to voice. Pupils equal and reactive. BP 114/64 HR 92 O2 97% on room air. Resident suspected to have taken some other medication other than what is prescribed by this facility due to recent behaviors and slow to respond lethargic behavior. Resident was asked by 400 hall nurse did you take something besides your scheduled meds the nurse is giving you? Resident responded to the question with a nod of the head no This nurse with 3 other nurses present found an orange pouch in bedside drawers with large amount of pink pills that appear to be [MEDICATION NAME]. Resident at this time is not able to verbalize any acknowledgement of taking pills. Pouch was taken out of room and witnessed by 3 nurses and put in 200 hall medcart. Record review of Resident #5's progress notes, dated1-19-2020, revealed Resident #5 stated to RN #1 what happened last night . I tried to kill myself with pills. During an interview with the DON on 6-17-2020 at 1:45 PM, she was asked if it was her expectation that a resident who threatened suicide once and attempted suicide once within a 3-month period, should be care planed for suicidal ideation and attempted suicide. The DON responded that it was her expectation that a resident who has threatened suicide and admitted a suicide attempt, should be care planed. Record Review of facility provided policy titled Comprehensive Care Planning not dated, reflects in part: The facility will develop and implement a comprehensive person -centered care plan for each resident, consistent with the resident rights 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. The comprehensive care plan will describe the following - - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being - The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and service that will be implemented. No other policies were provided.
F 0740 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance 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 0740 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the comprehensive assessment and plan of care for 1 of 6 residents (Resident #5). - The facility failed to care plan Resident #5 for suicidal ideation and attempted suicide This failure could affect all residents currently in the facility receiving care per comprehensive person-centered care plans resulting in resident's not being able to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: Resident #5 Record review of Resident #5's clinical record revealed a [AGE] year-old female admitted to the facility initially on 12-1-2018 and readmitted on [DATE]. Resident #5 was discharged from the facility on 3-9-2020. Resident #5's [DIAGNOSES REDACTED]. Record review of Resident #5's MDS, dated [DATE], revealed a BIMS score of 13 of 15 showing no cognitive deficit. Further review of Resident #5's clinical record revealed a care plan that was last reviewed 1-13-2020 and has no mention of suicidal ideation or suicide attempt within the care plan. Record review of Resident #5's progress notes, dated 12-27-2019, revealed the Resident #5 stated I'm going to kill myself to an aide. Record review of Resident #5's progress notes, dated 1-19-2020, revealed that resident was slurring words and slow to respond. This nurse and 3 other nurses went in to evaluate resident. Resident laying in chair with feet up. Resident responded to voice. Pupils equal and reactive. BP 114/64 HR 92 O2 97% on room air. Resident suspected to have taken some other medication other than what is prescribed by this facility due to recent behaviors and slow to respond lethargic behavior. Resident was asked by 400 hall nurse did you take something besides your scheduled meds the nurse is giving you? Resident responded to the question with a nod of the head no This nurse with 3 other nurses present found an orange pouch in bedside drawers with large amount of pink pills that appear to be [MEDICATION NAME]. Resident at this time is not able to verbalize any acknowledgement of taking pills. Pouch was taken out of room and witnessed by 3 nurses and put in 200 hall medcart. Record review of Resident #5's progress notes, dated1-19-2020, revealed Resident #5 stated to RN #1 what happened last night . I tried to kill myself with pills. During an interview with the DON on 6-17-2020 at 1:45 PM, she was asked if it was her expectation that a resident who threatened suicide once and attempted suicide once within a 3-month period, should be care planed for suicidal ideation and attempted suicide. The DON responded that it was her expectation that a resident who has threatened suicide and admitted a suicide attempt, should be care planed. Record Review of facility provided policy titled Comprehensive Care Planning not dated, reflects in part: The facility will develop and implement a comprehensive person -centered care plan for each resident, consistent with the resident rights 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. The comprehensive care plan will describe the following - - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being - The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and service that will be implemented. No other policies were provided.