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 _____	09/15/2020

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**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 interview and record review, the facility failed to ensure a resident's right to be free from abuse for two of 12 residents (R #2 and #3) reviewed for abuse. The facility failed to develop and implement effective interventions to address R #1's physically aggressive behaviors. R #1 physically assaulted R #2 on [DATE], causing serious bodily injury, and physically assaulted R #3 on [DATE] causing serious bodily injury. This was determined to be past non-compliance that existed from [DATE] and was corrected on [DATE] due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey. The failure of the facility to intervene after an abusive incident resulted in further abuse and injury. The findings include: A. Resident #1 Review of R #1's undated face sheet reflected a [AGE] year-old male resident who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R #1's Quarterly MDS dated [DATE] reflected: had adequate hearing and clear speech understood others and made self-understood had a BIMs status score of 7 - severely impaired required supervision for bed mobility, transfers, dressing, and limited assistance for personal care had no physical behavioral symptoms towards others. Record Review of Resident #1's Nurses' Notes reflected: [DATE] 8:45: Late Entry: Resident was in his room , Resident (#2) a was in the rest room at this time, Resident then became angry and became violent towards Resident (#2), Resident physically assaulted resident (#2) causing bodily injury to resident (#2), Resident then dragged resident (#2) 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 (#2). Dr. was notified at this time and ordered to watch resident closely and chart every 1 hr., Dr. ordered injection. Record review of Resident #1's Physician Orders, dated [DATE] reflected Chart 1-hour behavior and where about of resident. Monitor closely keep 2 staff at all times around this resident. Every hour incident reporting. Pharmacy: [MEDICATION NAME] Tablet 1 mg ([MEDICATION NAME]) give 1 mg by mouth every 6 hours as needed for increased anxiety related to [MEDICAL CONDITION]. Start date ,[DATE]//20. [MEDICATION NAME] Solution 5MG/ML ([MEDICATION NAME]) Inject 5 mg IM one time only related to Anxiety Disorder. Record Review of Resident #1's Care Plan, [DATE] reflected the resident had behaviors of sexually inappropriate behavior toward female staff. The facility failed to update the Care Plan with the [DATE] assault on Resident #2. Resident #2 Review of R #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Updated [DIAGNOSES REDACTED]. Review of R #2's Quarterly MDS dated [DATE] reflected: had adequate hearing and unclear speech usually understood others and made self-understood had a BIMs score of 7 - severely impaired required supervision for bed mobility, transfers, dressing, and limited assistance for personal care had no physical behavioral symptoms towards others. Review of R #2's Comprehensive Care Plan dated [DATE] reflected no documented physical or verbal aggression towards staff or residents. Record Review of Resident #2's Nurses' Notes reflected: [DATE] 8:44: CNA (A) was answering a call light in resident (#1) room. CNA (A) came upon resident (#2) laying in resident (#1)'s bed with blood all over him. CNA (A) yelled for assistance, staff ran into the room where resident (#2) was lying in bed. Resident was alert and never lost consciousness. The nurse applied pressure to resident (#2)'s right eye where resident has a large hematoma formed with 5+ [MEDICAL CONDITION]. Resident (2) has a two-inch laceration above his eye brow, two cm. laceration below his right eye, after applying pressure bleeding sustained. Resident (#2) did start having some convulsions lasted about 15 seconds x 3 times. Resident (#2) nose swollen about 3= [MEDICAL CONDITION] bleeding was stopped, this nurse applied simple mask O2, 5 liters. Resident (#2) received a laceration right upper lip 2 cm wide and 2 inches long. Resident (#2) has 3-inch hematoma to the left side of the back of his head, scattered multiple small hematomas about the head. Small laceration left side tip of his nose about 1 inch. Resident (#2) right toe nail ripped off. Resident (#2)'s left pupil was reactive and right eye unable to see. Resident O2 on room air saturation was sitting at 88% before applying oxygen. Resident (#2)'s hear rate was 66 beats per minute. Resident (#2) was complaining of pain stated it was his head. EMS arrived in resident's room and took over. Resident (#2) ambulated to gurney with assistance. Resident (#2) was up talking when transported out of facility. [DATE] 12:22: Resident (#2) has multiple fractures on right orbital side of his eye, Resident (#2) has small brain bleed, Resident (#2) sinus cavities completely caved in, Resident (#2) maxilla bone both sides fractured . [DATE] 12:05: Resident (#2) arrived back at facility at 1150, upon arrival resident's vitals were taken and assessment was completed as follows BP ,[DATE], O2 95%, . Resident denies any pain. Resident was placed on isolation due to being admitted to hospital. Assessment was done in that room, resident (#2)'s entire right eye is swollen shut and completely bruised leading to whole cheek being bruised as well due to fx, right jaw is swollen du to fx, laceration to entire right eye brow, there is a 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 only slight bruising to bottom lip. Small laceration and bruising to top/crown of head . Review of Resident #2's Hospital records, dated [DATE] reflected: Discharge Diagnosis - Blow out fracture of orbit, closed lamina papyracea fracture, Dementia, Fracture of maxillary sinus, nasal bone fracture, and traumatic intraparenchymal hemorrhage. In an interview on [DATE] at 9:00 AM the SW stated Resident #1 attacked Resident #2 in the bathroom. She stated it was a blood bath. She stated the facility tried to discharge the resident to a mental health hospital, and the state hospital. Neither facility would accept Resident #1 due to his aggressive behaviors. She further stated Resident #1 was placed on one to one supervision for a few days, however the facility could have placed Resident #1 on one to one observations until he was discharged from the facility to prevent further behaviors. She stated the facility previously had Hall Monitors who walked the halls to observe staff. She was not sure what happened to them, however, they have since been rehired. SW stated Resident #2 was moved to another private room, but Resident #1 stayed in his room with his roommate Resident #3. She believed Resident #3 refused to moved rooms. In an interview on [DATE] at 9:14 PM CNA B stated Resident #1was very aggressive towards staff and residents. She felt Resident #1 was a violent aggressive person. He would smile at you one minute and the next minute he would become aggressive. She stated she was not there for the first incident between Resident #1 and Resident #2 but was informed of how awful the incident was. She stated at the time of the incident there were no Hall Monitors. She felt Hall Monitors could have called for help and prevented the incident from escalating to the extent it did. In an interview on [DATE] at 9:21 AM LVN G stated Resident #1 attacked Resident #2 during breakfast time. Resident #2 received his meal tray in his room and everything appeared to be fine. A CNA went down the hall to check on a call light coming from Resident #1 and Resident #3's room. The CNA saw Resident #2 was in Resident #1's bed completely bloody. The CNA alerted staff who ran down to assess the situation. Resident #1 beat Resident #2 badly in the shared bathroom then dragged him to his own bed (resident #1) and continued to beat him. LVN G stated it looked like a slaughter. There was a bloody mess all over the bathroom and bedroom. Resident #1

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.

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 _____	09/15/2020

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) shut the bed curtain leaving Resident #2 hidden from the hall way. Resident #1 cleaned off the blood from his hands and changed clothes in an attempt to cover up the incident. Resident #2's toe nails were ripped off from being dragged from the bathroom to the bed. It was evident Resident #1 beat Resident #2 in the head. One side of Resident #2's head was swollen immediately, there were lumps on the side of his head, areas of his head were mush. LVN G further stated staff called the Sherriff's and wanted Resident #1 arrested but the Sherriff's department felt he was already in a locked facility and did not arrest him. LVN G stated after the first incident staff initially conducted 15-minute checks on Resident #1 to ensure he did not attack another resident. She stated Resident #1 behavior would change quickly, staff would never know how quick he would react and become aggressive. LVN G stated she was not sure why Resident #1 remained in a room with a roommate after such a terrible incident. She stated at the time of the incident the facility did not have Hall Monitors. She stated the facility previously had Hall Monitors but was unaware of why they no longer worked in the facility. In an interview on [DATE] at 9:31 AM CNA A stated Resident #2 was a very private person who always ate in his room. She passed him his meal tray when Resident #2 said he was going to the bathroom. CNA A did not think much of it at the time. She stated a couple minutes later she call light in the adjoining room (Resident #1 and #3's room) was on. She walked in to the room and noticed Resident #1's bed curtain was drawn closed. She first noticed blood on the floor. She pulled back the curtain and witnessed Resident #2 was curled in a ball. Resident #2 was beaten so bad his face was almost no recognizable. Resident #2 was covered in blood. CNA A stated she believed Resident #2 was dead. She stated his eye was poking out of his head. CNA A felt no resident deserved to be abused like that. She stated Resident #1 had changed his clothes and washed the blood off his hands. Resident #1 walked down to the dining room where he was watching television and laughing. CNA A asked Resident #1 if he had physically abused Resident #2. He responded yes because Resident #2 was sitting on the toilet peeing and he felt that made Resident #2 a homosexual. He admitted to physically assaulting Resident #2, placing him in his (Resident #1) bed. CNA A stated Resident #3 pushed the call light because he woke up and heard something. She felt had he not pressed the call light, Resident #1 would have died . She stated prior to the incident the facility had Hall Monitors. She was not sure why Hall Monitors were not employed at the time of the incident. In an interview on [DATE] at 10:00 AM CNA C stated Resident #1 physically assaulted Resident #2 in the bathroom because he was sitting on the toilet. Another CNA found Resident #2 in Resident #1's bed. She stated there was blood everywhere. Resident #1 beat Resident #2 in the bathroom, dragged him to his bed (Resident #1), and closed the bead curtain so ad to ensure staff would not see Resident #2. She descried Resident #2's as being very bad. Resident #2's eye was swollen, and he was almost not recognizable. CNA C stated it was clear Resident #2 had fallen back and hit his head against the shower control. Resident #1 was severely injured. CNA C stated staff observed Resident #1 more closely after the incident, keeping eyes on him while out of his bedroom at all times. Resident #2 was moved to another hall and isolated from Resident #1. She was unaware as to why Resident #1 was not separated from other residents. In an interview on [DATE] at 12:19 PM LVN H (scheduling coordinator) stated the facility was fully staff and now have hall monitors in place who make rounds daily to observe residents who wander and to redirect residents who have some behavioral concerns. LVN stated Resident #1 physically assaulted Resident #2 because he was sitting on the toilet. Resident #1 called Resident #2 a homosexual because he was sitting and proceeded to beat him in the bathroom. Resident #1 dragged resident #2 to Resident #1's bed and continued to beat him. When Resident #2 was found he was soaked in blood, he had a large hematoma to the left side of his face and his eye was bulging. Resident #2 also had several small lacerations to the back of his head and top of scalp. He had bruising all over his face, and his toes on both feet were peeled back from being dragged. Resident #2's hands, lips, and nose were busted open. It was evident Resident #1's nose was broken. LVN H stated there was blood all over the room, on the door knobs, air conditioner, dresser, floor, bathroom, shower, and shower handles. She said it was clear Resident #2 had fallen back and hit his head on the shower nob. LVN H added one of Resident #2's toe nails was found behind the toilet. Resident #2 started seizing and started to code. Staff pulled the crash cart but fortunately Resident #2 came out of the [MEDICAL CONDITION]. LVN H stated she walked down to the dining room with a CNA to ask Resident #1 if he had beat up Resident #2. Resident #1 replied yes and asked if resident #2 was dead and went back to eating his breakfast. The Physician was immediately notified and immediately prescribed medications to level him out. LVN H added Resident #1 had aggressive behaviors but never to this level. He had never been violent. The facility immediately tried to discharge Resident #1 due to the severity of the physical assault. She stated the first mental health hospital would not accept him. LVN H stated initially the facility put in place one to one monitoring. In an interview on [DATE] at 12:46 PM the ADON stated when she observed Resident #2 after the abuse from Resident #1 it looked like a massacre. Resident #1 admitted to doing it. She stated the facility attempted to discharge Resident #1, however, other facilities would not accept the resident do the severity of the abuse. She stated the facility rehired hall monitors and provided radios for better and quicker communication. Resident #2 was moved to another room and isolated from Resident #1. In an interview on [DATE] at 2:41 PM the DON stated she recalled the incident between Resident #1 and Resident #2. She was aware of the severity of the incident. She stated Resident #2's body was found in bad condition and was sent to the hospital. The DON stated the police were called and several referrals were made in attempt to discharge Resident #1 to another facility. She stated it took a couple weeks for the facility to hire hall monitors and she was able to purchase radios for staff to communicate more effectively. She stated Resident #2 was move to another room with a private bathroom. The DON stated Resident #1 had not previously had violent behaviors. B. Resident #1 Record Review of Resident #1's Nurses' Notes reflected: [DATE] 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 threatening staff cursing yelling out while his roommate (Resident #3) 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 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. Record review of Resident #1's Physician Orders, dated [DATE] reflected Pharmacy: [MEDICATION NAME] Tablet 1 mg ([MEDICATION NAME]) give 1 mg by mouth two times a day related to [MEDICAL CONDITION]. Start date [DATE]. [MEDICATION NAME] Tablet Delayed Release ([MEDICATION NAME] Sodium) Give 250 mg by mouth at bedtime related to Major [MEDICAL CONDITION] Single Episode. Start Date [DATE]. [MEDICATION NAME] Tablet Delayed Release ([MEDICATION NAME] Sodium) Give 500 mg by mouth two times a day related to Major [MEDICAL CONDITION] Single Episode. Start Date [DATE]. [MEDICATION NAME] Capsule 20 Mg (ziprasidone HCl) Give 20 mg by mouth at bed time related to [MEDICAL CONDITION]. Start date [DATE]. [MEDICATION NAME] Capsule 20 Mg (ziprasidone HCl) Give 40 mg by mouth two times a day related to [MEDICAL CONDITION]. Start date [DATE]. [MEDICATION NAME] Tablet 50 mg (QUEtapine [MEDICATION NAME]) Give 50 mg by mouth tow times a day related to [MEDICAL CONDITION]. Start date [DATE]. Review of R #1's Comprehensive Care Plan dated [DATE] reflected: Focus: I have potential to be physically aggressive related to Dementia, History of harm to others, Poor impulse control, [MEDICAL CONDITION]. Date initiated: [DATE] Interventions/Task: Followed by Senior Psych Care. Notify me of any escalation in behaviors, ineffectiveness, or side effects of psychiatric medications. Give me as many choices as possible about care and activities. Monitor me for physically aggressive behavior q shift. Document observed behavior and attempted interventions in behavior log. Monitor/document/report PRN any s/sx of me posing danger to myself and others. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Resident #3 Review of R #3's undated face sheet reflected a [AGE] year-old male resident who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R #3's Comprehensive Care Plan dated [DATE] reflected no documented physical or verbal aggression towards staff or residents. Review of R #3's Quarterly MDS dated [DATE] reflected: had adequate hearing and clear speech understood others and made self-understood had a brief interview of mental status score of 10 - moderately impaired required supervision for bed mobility, transfers, dressing, and extensive assistance for personal care had no physical behavioral symptoms towards others. Review of Resident #3's Nurses' Notes reflected: [DATE] 02:22: Resident (#3) found in floor of room via staff after being slung down by roommate (resident #1) after roommate trying to go to bathroom, resident (#3) 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 (#1) kept saying he was going to kill him, resident (#3) assisted from floor via staff et assisted to nurses station assessed et treated for [REDACTED].#3) stated that he felt ok that his third digit on his left hand hurt some resident able to move all digits no bruising or swelling noted to area at this time will continue to monitor asleep now without incident. [DATE] 03:11 Late Entry: Received X-ray report. Report as follows. Impacted FX noted at bas of proximal phalanx in index finger . [DATE] 18:31: Resident (#3) continues to refuse to move to a different room made available due to altercation with his roommate, he choose to stay in room, instructed resident on precautions and risk of staying in room, he voiced understanding. Review of Resident #3's X-ray record, dated [DATE] reflected Impacted fracture

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 _____	**09/15/2020**

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) noted at base of proximal phalanx in index finger. In an interview on [DATE] at 9:00 AM the SW stated just a few days after the initial incident between Resident #1 and Resident #2, Resident #1 got into it with his roommate (Resident #3), he just went crazy on him. He broke his (Resident #3) finger. She stated after the second incident the resident was separated from others and she gathered a referral packet and was able to transfer Resident #1 to the state hospital. She stated it was an ongoing process to get the resident out of the facility. She was not sure why Resident #1 remained in his room with a roommate after the first incident. In an interview on [DATE] at 9:14 PM CNA B stated Resident #1was very aggressive towards staff and residents. She felt Resident #1 was a violent aggressive person. He would smile at you one minute and the next minute he would become aggressive. She stated staff heard commotion coming from down the hall way and when they went to observe the situation they saw Resident #3 on the floor while Resident #1 was above him swinging at him with a guitar. Staff tried to separate the residents, however, Resident #1tried to strike the staff with the guitar. Resident #3 yelled at Resident #1 to stop him from attacking staff. Resident #1 again started trying to attack Resident #3. A nurse was finally able to separate Resident #1 form Resident #3 who sustained a couple abrasions. CNA B stated after the first incident staff checked on the resident regularly but was not sure why he was not isolated from other residents. In an interview on [DATE] at 9:21 AM LVN G stated she was not sure why Resident #1 remained in a room with a roommate after such a terrible incident. In an interview on [DATE] at 9:31 AM CNA A stated a few days after the Incident with Resident #2, Resident #1 attacked his roommate resident #3 and broke his finger. She was unaware as to why Resident #1 was not isolated after such an aggressive incident. She stated Resident #1 and #3 continued to be roommates after the first incident. In an interview on [DATE] at 10:00 AM CNA C stated She was unaware as to why Resident #1 was not separated from other residents after the first incident with Resident #2. Subsequently Resident #1 attacked his roommate Resident #3 a few days later with a guitar causing some abrasions and a fx finger. She stated after the second incident with his roommate. CNA C stated there were resident rooms with private bathrooms that could have been utilized. In an interview on [DATE] at 12:19 PM LVN H (scheduling coordinator) stated they offered Resident #1's roommate, Resident #3 to change rooms but he refused to change rooms. The facility hired hall monitors again to observe the halls for behaviors. Staff were all equipped with walk talkies to communicate more effectively. Subsequently Resident #1 attacked resident #3 in their room with a guitar breaking Resident #3's finger. After the second physical assault by Resident #1 he was discharged to the state hospital. LVN H added the hall monitors were not allowed to touch the resident, they did call for assistance, however, by the time staff arrived, Resident #1 had already attacked Resident #3, knocked him on the floor and hit him with the guitar. LVN H stated the facility previously had Hall Monitors, however, overtime staff had left and the facility did not rehire them until after the incidents. In an interview on [DATE] at 12:46 PM the ADON stated after the incident with Resident #2, Resident #1 remained in his room with his roommate, Resident #3. The ADON stated Resident #3 did not want to change rooms. A few days later Resident #1 attacked Resident #3. Resident #1 pushed Resident #3 to the floor breaking his finger. She stated after the second incident the facility was able to discharge Resident #1 to the state hospital. She stated she was not sure why the facility had not attempted to move Resident #1 to a private room. In an interview on [DATE] at 2:41 PM the DON stated after the first incident Resident #3 was asked if he wanted to move from his room with Resident #1, but he chose not to. The DON stated shortly after Resident #1 had an altercation with Resident #3. The DON added Resident #3 and Resident #1 had always gotten along and never thought there would be an issue. Resident #1 was discharged to the state hospital after the second incident. They have a system in place where they try to send out residents to a facility if they are not able to care for them in the currently building. Review of the facility's undated Abuse, Neglect, Exploitation General Policy, reflected: ABUSE, NEGLECT, EXPLOITATION, PREVENTION STANDARD: This facility has developed and implemented this policy and procedure to prohibit mistreatment, neglect and abuse of all elders and misappropriate of elder property. Abuse means any act or failure to act perfumed intentionally or recklessly that caused or is likely to cause harm to an elder . PURPOSE: To ensure that all elders of this facility will be free of physical, emotional, and sexual abuse, neglectful treatment and misappropriation of funds and resource. The accompanying procedures are employed to assure total staff adherence to this policy. PROCEDURE: . Protection 4 All elders receive protective oversight twenty-four (24) hours a day. The staff is charged with the responsibility to protect elders from abusive staff members, family members and from other elders who might be acting in an aggressive manner. It was determined these failures placed Resident #2 and #3 in an Immediate Jeopardy situation from [DATE] to [DATE] When Resident #1 was discharged from the facility. The facility took the following actions to correct the non-compliance on [DATE]: Observations on [DATE] between 9:00 AM and 4:00 PM, and on [DATE] between 10:00 AM and 5:00 PM revealed Hall Monitors walking the facility hallways observing all residents. The Hall Monitors were equipped with radios and made rounds frequently throughout the facility and on the facility grounds. Direct care staff were observed with and utilizing radios for quicker communication. Staff called for assistance and communicated with each other regularly with the radios. The facility reported both incidents to the appropriate state authority on [DATE] and [DATE]. Record review reflected the facility conducted an internal investigation. Record review reflected the facility was cited for failure to update care plans regarding Resident #1's physical abuse on [DATE]. Review of the facility's In-service training reporter reflected: Abuse and Neglect on [DATE], [DATE], [DATE], [DATE], and [DATE] Assault on staff or residents [DATE] Radio [DATE], and [DATE] Behavior Training [DATE] Interview with staff throughout the investigation revealed staff were trained on abuse and neglect, could identify forms of abuse, were aware of how to intervene with residents who had aggressive behaviors, and were able to identify when and to whom to report abuse and neglect. Two CNAs one LVN on the evening shift, three CNAs and two LVNs on the morning shift, and three CNAs and two LVNs on the afternoon shift were interviewed. Review of Hall Monitor's hire Dates reflected the first hall monitor was hired on [DATE]. In an interview on [DATE] at 10:50 AM Hall Monitor D and E stated they are trained to make rounds daily and watch the halls for any concerns. They focus on the wonderers who can go into different rooms because some Residents typically get upset if they go in to their rooms. They are trained to redirect those wonderers. They also make rounds every hour of the perimeter. They stated there is typically one hall monitor per hall. The facility is composed of two main resident halls. Review of Resident #1's Transfer/Discharge Reported, reflected Resident #1 was discharged to a Psychiatric hospital on [DATE] In an interview on [DATE] at 4:50 PM the NFA and ADON were notified of PNC IJ was Identified.