STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676157	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
USSERY ROAN TEXAS STATE VETERANS HOME	1020 TASCOSA RD AMARILLO, TX 79124

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that the residents environment remained as free from accident hazards as was possible; and that each resident received adequate supervision to prevent accident hazards for 3 residents (Resident #1, #2, and #3) of 3 residents observed for accident hazards. The facility failed to ensure adequate steps were taken to ensure Resident #1, #2, and #3 were monitored to prevent altercations. This failure could place residents at risk for diminished quality of life due to the lack of treatment and prevention to maintain resident safety. Finding include: Resident #1 Record review of Resident #1's clinical record revealed a [AGE] year-old male resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's last MDS revealed a quarterly completed on 2-20-2020 with a BIMS of 15 indicating he is cognitively intact, and he has a functionality of set-up help to one-person assistance. Record review or Resident #1's progress notes revealed the following: 12-17-2019-Resident noted standing in hallway in front of other resident, holding other resident by the right side of his collar. Resident stated, You better no say that to me ever again. 12-20-2019-Noted resident in dining room ambulating to chair with use of rolling walker. No injuries noted. Resident stated, I was walking to get my coffee and he pushed his w/c in the way and wouldn't let me pass. I told him to move and he wouldn't, so I went to move his w/c and he hit me in the chest. That's when I hit him back and then the kitchen guy came out and tole us to stop. 12-21-2019-Resident yelling out at staff, verbally abusive with staff . 2-17-2020-Called to room by CNA. Upon entering room resident and his roommate were in a verbal altercation . 2-18-2020-Staff from housekeeping came and got this nurse stating that there are two residents on the ground outside fighting. This SN observed Resident #1 and Resident #2 on the ground right ouds the great room .Both resident state that the other was trying to fight . 2-19-2020-Resident noted per staff member/on one on one cussing at roommate . Review of the progress notes from 12-17-2019 to 3-9-2020 revealed no documentation of the physical incident between Resident #1 and Resident #3 Record review of facility provided Behavioral Agreement revealed to maintain my safety and the safety of others. I agree to reach out to an URTSVH team member if something occurs that aggravates me and not act myself. Signed by Resident #1 on 2-19- Record review of Resident #1's current care plan revealed the following: Problem: I have potential to demonstrate physical and or verbal behaviors when I am provoked r/t Poor impulse control Date Initiated: 12/30/2019 Revision on: 12/30/2019 Goal: Wll not harm self or others through the review date. Date Initiated: 12/30/2019 Created on: 12/30/2019 Target Date: 05/20/2020 Intervention:1 on 1 at this time until evaluated by psychiatric services. Date Initiated: 03/09/2020 Revision on: 03/11/2020 o Behavior Agreement discussed and signed Date Initiated: 02/19/2020 Created on: 03/03/2020 o Keep resident away from other residents that have been known to provoke him. Date Initiated: 12/31/2019 o When I become 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. Date Initiated: 12/31/2019 Problem:-Poblematic manner in which resident acts characterized by ineffective coping; verbal/ physical Aggression related to: Anger associated [MEDICAL CONDITION] Date Initiated: 09/25/2019 Revision on: 09/25/2019 Goal: I will have no further incidents of aggression or angry outbursts through the review period. Date Initiated: 09/25/2019 Revision on: 09/25/2019 Target Date: 05/20/2020 Intervention: Be cognizant of not invading resident's personal space. Date Initiated: 09/25/2019 Revision on: 09/25/2019 o Discuss resident's options for appropriate channeling of anger with resident - through VA Mental Health Date Initiated: 09/25/2019 Revision on: 12/20/2019 o Do not make unrealistic demands on resident. Date Initiated: 09/25/2019 Revision on: 09/25/2019 o Document summary of each episode. Note cause & successful interventions, include frequency and duration . Date Initiated: 09/25/2019 Revision on: 12/20/2019 o I was moved to another room/hall away from resident that yelled out frequently in the next room. Date Initiated: 09/25/2019 During an interview on 3-11-2020 at 10:21 AM when questioned how he was doing Resident #1 stated, I'm alive. When questioned about the facility and current incidents Resident #1 stated, I'm very disappointed in the facility here. They have criticized me and evaluated me against the individuals involved. They do not correct the issues that need to be corrected. Resident #1 then turned back to his computer and did not address any more questions. Resident #2 Record review of Resident #2's clinical record revealed a [AGE] year-old male resident admitted to the facility on [DATE] with diagnosed to include metabolic [MEDICAL CONDITIONS] dementia, hypertension, [MEDICAL CONDITION], muscle weakness, [MEDICAL CONDITION], drug induced subacute dyskinesia, dysphagia, anxiety paranoid [MEDICAL CONDITION], and [MEDICAL CONDITION]. Record review of resident #2's last MDS revealed a quarterly completed on 1-28-2020 with a BIMS of 15 indicating he is cognitively intact, and he has a functionality of set-up to one-person assistance with activities. Record review of facility provided investigation report for the confrontation between Resident #1 and Resident #2 documented the following: Description of injury: Resident #2 with scratches noted to face on upper eye lid and below both eyes. Bruising noted to both eyes, left wrist, right hand 4th digit, and nose. During an interview on 3-11-2020 at 08:59 when questioned about the incident with Resident #1, Resident #2 stated, I was coming off the patio and another resident was in the doorway blocking it. For some reason Resident #1 started yelling at me. We got into an argument and we went at each other. Resident #1 leaned over and bear hugged me. That's when we went to the floor. Resident #1 was then trying to gouge at my eye and I was hitting him in the mid-section. The nurses separated us and when we were separating he whispered in my ear and threatened my life. When asked how he was doing currently Resident #2 stated, I'm still worried about it. Nobody has threatened my life before. I have only been in two fights in my life, once when I was a kid and the second time with Resident #1. I don't believe I should have to live here in fear. Resident #3 Record review of Resident #3's clinical record revealed an [AGE] year-old male resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. walking, difficulty communicating, [MEDICAL CONDITION], and [MEDICAL CONDITION]. Record review of Resident #3's last MDS revealed an annual completed on 2-16-2020 with a BIMS that could not be evaluated due to no response or rarely ever understood and a functionality of requiring two-person assistance with all activities. Record review of facility provided statement from the DON for the witness FM A documented that Resident #1 was witnessed grabbing the back of Resident #3's neck and stating, go to your table. Resident #1 then let go of Resident #3. During 3 observations on 3-11-2020 of Resident #3, he was noted in his hallway, in the main lobby, and in the dining room. During all 3 observation Resident #3 was asleep in his chair. Resident #3 did not wake to verbal ques. Resident #3 did wake once to gentle shaking but went back to sleep before questioning. Resident #3 was dressed well and appeared in good condition During an interview on 3-11-2020 at 08:13 AM when this surveyor reported that Resident #1 had had several incidents of confrontation the admin stated, This is new to me. When asked what the facility was doing to ensure the residents were safe and resident rights were being maintained the administrator stated, I know that Resident #1 told me he would think about going back to counseling and then he threw me out of his room. Resident #1 also threatened to sue the facility if we attempted to discharge him. During an interview on 3-11-2020 at 08:43 AM when questioned concerning Resident

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) #1 and his incidents with other residents and what the facility was doing to protect residents right the DON stated, We have asked the psych Dr to see him, Resident #1 is going to the VA Vet Center for group therapy and I, the Adm, and VLBR have talked to him. We have separated him from the residents in the dining room he is having trouble with, and he has signed a behavioral health agreement. During an interview on 3-11-2020 at 2:37 PM when asked what her expectation were for Resident #1 the DON stated, We will continue his counseling. We are encouraging him letting someone from the VA come out and talk with him. We want psych therapy to keep trying to get him to try pharmacological interventions and if it happens again Resident #1 will need to seek an alternative environment. During an interview on 3-11-2020 at 3:02 PM when questioned concerning Resident #1 and his behaviors VLBR stated, Resident #1 is going back to the mental health clinic at the VA monthly. We are getting to the 3 strikes and you're out point with him. When asked if Resident #1 had been notified of this VLBR stated, It had been discussed but not documented. We do have a new behavioral agreement with him. When asked for a copy it was not presented by the exit of this investigation. During an interview on 3-11-2020 at 3:30 PM the ADM stated, I can tell you right now, if Resident #1 has done this three times, he needs to be gone. Record review of facility provided policy titled Rights of Nursing Facility Residents dated April 28, 2019 revealed the following: By law, every Texas nursing facility resident has the right . To be treated with dignity and respect -To live in safe, decent, and clean conditions. Record review of facility provided polity titled G. Resident-To-Resident Abuse dated revised July 2018, revealed the following: 2. Should a resident be observed/accused of abusing another resident, the following actions will be implemented: f. Develop/Update the care plan that includes interventions to prevent the recurrence of such incident. g. Inform team members involved in the care of the resident of the care plan interventions and to promptly report behavioral changed to the charge nurse. h. Document in the resident clinical record all interventions and their effectiveness k. Transfer the resident if deemed by the clinical nursing management team as being a danger to him/herself or to others for psychiatric evaluation.
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 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 for 3 (Resident #1, #2, and #3) of 3 residents reviewed for behavioral health services. The facility failed to ensure adequate steps were taken to ensure Resident #1, #2, and #3 were monitored to prevent altercations. This failure could place residents at risk for diminished quality of life due to the lack of treatment and prevention to maintain resident safety. 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F 0740 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) residents were safe and resident rights were being maintained the administrator stated, I know that Resident #1 told me he would think about going back to counseling and then he threw me out of his room. Resident #1 also threatened to sue the facility if we attempted to discharge him. During an interview on 3-11-2020 at 08:43 AM when questioned concerning Resident #1 and his incidents with other residents and what the facility was doing to protect residents right the DON stated, We have asked the psych Dr to see him, Resident #1 is going to the VA Vet Center for group therapy and I, the Adm, and VLBR have talked to him. We have separated him from the residents in the dining room he is having trouble with, and he has signed a behavioral health agreement. During an interview on 3-11-2020 at 2:37 PM when asked what her expectation were for Resident #1 the DON stated, We will continue his counseling. We are encouraging him letting someone from the VA come out and talk with him. We want psych therapy to keep trying to get him to try pharmacological interventions and if it happens again Resident #1 will need to seek an alternative environment. During an interview on 3-11-2020 at 3:02 PM when questioned concerning Resident #1 and his behaviors VLBR stated, Resident #1 is going back to the mental health clinic at the VA monthly. We are getting to the 3 strikes and you're out point with him. When asked if Resident #1 had been notified of this VLBR stated, It had been discussed but not documented. We do have a new behavioral agreement with him. When asked for a copy it was not presented by the exit of this investigation. During an interview on 3-11-2020 at 3:30 PM the ADM stated, I can tell you right now, if Resident #1 has done this three times, he needs to be gone. Record review of facility provided policy titled Rights of Nursing Facility Residents dated April 28, 2019 revealed the following: By law, every Texas nursing facility resident has the right . To be treated with dignity and respect -To live in safe, decent, and clean conditions. Record review of facility provided polity titled G. Resident-To-Resident Abuse dated revised July 2018, revealed the following: 2. Should a resident be observed/accused of abusing another resident, the following actions will be implemented: f. Develop/Update the care plan that includes interventions to prevent the recurrence of such incident. g. Inform team members involved in the care of the resident of the care plan interventions and to promptly report behavioral changed to the charge nurse. h. Document in the resident clinical record all interventions and their effectiveness k. Transfer the resident if deemed by the clinical nursing management team as being a danger to him/herself or to others for psychiatric evaluation.