STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675407	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849 Based on interview and record review, the facility failed to immediately notify the resident's representative(s) when there was a significant change in the resident's physical status for (Residents #1, #3, #4, #5, #11) of 5 residents reviewed for incident reporting notifications, in that: The facility failed to notify the residents, representatives, and families when their family member was involved in a physically aggressive peer on peer altercation in that: a) 5 of 5 residents (Residents #1, #3, #4, #5, #11) had no documentation of the residents, resident representative and resident families being consistently informed of their resident being involved in a resident to resident physical altercation. This failure placed residents at risk of not receiving appropriate care and interventions. The Findings included: Record review of Resident #1's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: encephalopathy (disturbance in brain function), hemiplegia and hemiparesis following cerebral infarction (partial paralysis following stroke), muscle weakness, malnutrition, difficulty walking, Alzheimer's, psychotic disorder with delusions (severe mental illness including distorted beliefs), and anxiety disorder. Record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 99, indicating the resident could not complete the assessment. Record review of Resident #3's face sheet dated 09/30/22 revealed a [AGE] year-old female admitted on [DATE] with diagnoses including the following: Alzheimer's disease, paranoid schizophrenia (serious mental health disease causing misinterpretation of reality), malnutrition, seizures (uncontrolled electrical disturbance in the brain), muscle weakness, difficulty in walking, conversion disorder with seizures or convulsions (condition where a mental health issue disrupts how the brain works), generalized anxiety disorder, schizoaffective disorder bipolar type (mental health disorder with symptoms of distorted reality and mood fluctuation), major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that cause happiness), and lack of coordination. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's MDS dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. Record review of Resident #4's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: hemiplegia and hemiparesis following cerebral infarction (partial paralysis following stroke), intermittent explosive disorder (repeated sudden outbursts of anger), muscle weakness, lack of coordination, muscle wasting and atrophy (breakdown of muscles), schizoaffective disorder (mental health disorder with symptoms of distorted reality), major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that cause happiness), anxiety disorder, and epilepsy (disorder that causes abnormal brain function like seizures). Record review of Resident #4's MDS dated [DATE] revealed a BIMS score of 13, indicating intact cognitive function. Record review of Resident #5's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: history of traumatic brain injury (injury that changes how the brain works), muscle wasting and atrophy (breakdown of muscles), other recurrent depressive disorders (mental health illness causing prolonged sadness), and difficulty in walking. Record review of Resident #5's MDS dated [DATE] revealed a BIMS score of 15, indicating intact cognitive function. Record review of Resident #11's face sheet dated 09/30/22 revealed an [AGE] year-old female admitted on [DATE] with diagnoses including the following: unspecified dementia, psychotic disorder with hallucinations (severe mental illness including seeing things that are not there), insomnia, impulse disorder (lack of ability to control self), major depressive disorder (mental illness caused by lack of chemicals that cause happiness in the brain), and anxiety disorder. Record review of Resident #11's MDS dated [DATE] revealed a BIMS score of 00, indicating severe cognitive impairment. Record review of Resident #1, #3, #4, #5, and #11's clinical records revealed no notifications of positive COVID-19 results were made on 9/12/22 or 9/13/22 to residents or family members. In a record review of incident reports 799 and 800 dated 9/12/22 at 9:48 p.m. revealed Resident #1 attacked Resident #4. Resident 1 wandered into Resident 4's room. Resident 1 grabbed his t-shirt sleeve and tried to hit Resident 4, but Resident 4 took down Resident 1 by sweeping his legs out from under him with his good arm (Resident 4 has hemiplegia). Resident 4 had a torn shirt. Resident 1 had a skin tear to left distal forearm, a scratch on top of his left forearm, a busted blood vessel to his right eye, blood coming from left nostril and multiple small scratches to right side of his face. The incident reports reflected the RPs of the residents were not contacted regarding the incident. In a record review of incident reports 808, 809, and 810, dated 9/17/22 at 4:00 p.m. revealed, Resident 1 was in the hall with an aide at his side and he struck out and hit Resident 2. He was then escorted to his room and was in an altercation with his roommate. Resident 1 then walked up to Resident 3 in the hallway and grabbed her face and started shaking her head back and forth. No injuries were documented for any residents in these incidents. The incident reports reflected the RP's of the residents were not contacted regarding the incident. (continued on next page)

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Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a record review of incident 814 dated 9/18/22 at 11:00 a.m. revealed, Resident 1 attacked Resident 11. Resident 1 grabbed Resident 11 by her arm and was pulling her. She yelled for help. Resident 11 was noted to have 3 small bruises on her right inner arm. Her family member was notified but there was no documentation of Resident 1's family being notified. In a record review of incident 813 and 816 dated 9/18/22 at 12:50 p.m. Resident 1 told Resident 3 shut the fuck up bitch. Resident #3 was yelling for help and Resident 1 got in her face and continued yelling. Resident 3 threw water in his face and Resident 1 turned around and pushed Resident 3 causing her to fall on the scale in the dining room. Resident #1 tried to attack her again; staff intervened, and he attacked the staff, chasing them down the hall. Resident 3 stated she was scared; her family member was notified. No documentation of Resident 1's family being notified was found. In a record review of incidents 832, 834, and 835 dated 9/24/22 at 3:00 pm revealed, Resident 1 was wandering in the hall and attacked Resident 2 (who was sitting in his wheelchair). He then attacked Resident 4 by hitting him in the back. No injuries were noted, and there was not documentation that family members were notified. During an interview on 9/21/22 at 2:13 p.m. LVN C stated families are notified when their resident is involved in a peer-on-peer aggressive incident. Stated she personally did the notifications to family members via phone. Stated she documents the notifications in the progress notes in Point Click Care(resident electronic file program) on the computer. Stated that she has to complete notifications before she ends her shift and leaves the facility. During an interview on 9/21/22 at 4:25 p.m. the DON stated incidents of resident aggression towards other residents should be in progress notes but maybe on injury reports. The DON reviewed Resident #4's progress notes and injury reports and stated there is no documentation that the family was notified of the physical incident with Resident #1. DON stated the charge nurse should have documented the notification if it was made, and notifications have to be made to keep family members informed. DON stated the progress notes should reflect the notifications to family members of residents involved in incidents involving residents. DON stated that the charge nurse during the incidents of resident on resident aggression should document immediately after notifying the resident representative. Stated that resident representatives should be notified as soon as the resident is assessed and safe and should be done before the charge nurse ends their shift that same day. During an interview on 9/21/22 at 4:30 p.m., the Nurse Consultant stated the charge nurse should have notified all resident representatives and family members when their resident was involved in an aggressive physical incident with another resident, and it should be documented in the progress notes. Review of the facility provided policy, titled: Change in a Resident's condition or status, dated 2001, Revised May 2017, reflected, -Our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and /or status. -A nurse will notify the resident representatives when the resident is involved in any accident or incident that results in an injury including injuries of an unknown source. (continued on next page)

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Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated facility policy, titled: Resident to Resident Altercations, reflected, To be done Immediately, 1. Separate residents and make sure all the residents are safe. 2. Assess for injuries, 3. Report incident to primary care doctor and get treatment orders. 4. Report altercation to Administrator, 5. Report altercation to the DON/ADON. 6. Call [NAME], FNP at Senior Psych Services, 7. Call and inform the families of the residents involved in the incident. 8. Fill out incident report in PCC 9. Fill out progress reports on all residents involved.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 43849 Based on interview and record review, the facility failed to provide a safe environment free from abuse for 10 of 10 residents (Resident #1, #2, #3, 4, #5, #6, #7, #8, #9, #10) reviewed for abuse. The facility failed to implement and provide immediate interventions to assure the safety of residents to protect from resident-to-resident abuse from Resident #1, a resident who had a history of being physically aggressive from continuing to physically attack and target other residents in the facility. The facility failed to implement and provide immediate interventions to assure the safety of residents to protect from resident-to-resident abuse from Resident #2, a resident who had a history of being physically aggressive from continuing to physically attack and target other residents in the facility. These failures placed residents at risk of abuse, mental anguish, injury, fear, and hopelessness. This failure resulted in an identification of an Immediate Jeopardy (IJ) situation on 09/30/22. While the IJ was removed on 10/03/22, the facility remained out of compliance at a severity level of actual harm, and a scope identified as pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective syst The findings include: Record review of Resident #1's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: encephalopathy (disturbance in brain function), hemiplegia and hemiparesis following cerebral infarction (partial paralysis following stroke), muscle weakness, malnutrition, difficulty walking, Alzheimer's, psychotic disorder with delusions (severe mental illness including distorted beliefs), and anxiety disorder. Record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 99, indicating the resident could not complete the assessment. Record Review of Resident #1's progress note dated 9/18/22 at 1:00 PM, entered by DON revealed; 1:1 for resident #1; administrator confirmed 1:1 at 3:33 pm Record review of Resident #2's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: unspecified dementia with behavioral disturbance (breakdown of thought process causing disruptive behavior), intermittent explosive disorder (repeated sudden outbursts of anger), epileptic seizures related to external causes (sudden uncontrolled electrical disturbance in the brain), unspecified lack of coordination, history of falling, schizoaffective disorder bipolar type (mental health disorder with symptoms of distorted reality and mood fluctuation), anxiety disorder, encephalopathy (disturbance in brain function), muscle weakness, abnormalities of gait and mobility, unspecified convulsions, and history of traumatic brain injury (injury that changes how the brain works). (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2' MDS dated [DATE] revealed a BIMS score of 05, indicating severe cognitive impairment. Record review of Resident #3's face sheet dated 09/30/22 revealed a [AGE] year-old female admitted on [DATE] with diagnoses including the following: Alzheimer's disease, paranoid schizophrenia (serious mental health disease causing misinterpretation of reality), malnutrition, seizures (uncontrolled electrical disturbance in the brain), muscle weakness, difficulty in walking, conversion disorder with seizures or convulsions (condition where a mental health issue disrupts how the brain works), generalized anxiety disorder, schizoaffective disorder bipolar type (mental health disorder with symptoms of distorted reality and mood fluctuation), major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that cause happiness), and lack of coordination. Record review of Resident #3s MDS dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. Record review of Resident #4's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: hemiplegia and hemiparesis following cerebral infarction (partial paralysis following stroke), intermittent explosive disorder (repeated sudden outbursts of anger), muscle weakness, lack of coordination, muscle wasting and atrophy (breakdown of muscles), schizoaffective disorder (mental health disorder with symptoms of distorted reality), major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that cause happiness), anxiety disorder, and epilepsy (disorder that causes abnormal brain function like seizures). Record review of Resident #4's MDS dated [DATE] revealed a BIMS score of 13, indicating intact cognitive function. Record review of Resident #5's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: history of traumatic brain injury (injury that changes how the brain works), muscle wasting and atrophy (breakdown of muscles), other recurrent depressive disorders (mental health illness causing prolonged sadness), and difficulty in walking. Record review of Resident #5's MDS dated [DATE] revealed a BIMS score of 15, indicating intact cognitive function. Record Review of Resident #6's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: Unspecified dementia with behavioral disturbance (breakdown of thought process causing disruptive behavior), adjustment disorder with mixed anxiety and depressed mood (mental health issues caused by a sudden change), other seizures, restlessness and agitation, and metabolic encephalopathy (problems in the brain from chemicals in the blood), and insomnia. Record Review of Resident #6's MDS dated [DATE] revealed a BIMS score of 00, indicating severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #7's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: altered mental status (change in brain function), unspecified lack of coordination, cognitive communication deficit (impaired thought processes), difficulty in walking, rheumatoid arthritis (autoimmune inflammation of the joints), paranoid schizophrenia (serious mental health disease causing misinterpretation of reality), Alzheimer's disease, Bipolar disorder (mental health disease causing severe mood swings), major depressive disorder (mental illness caused by lack of chemicals in the brain that cause happiness), and anxiety disorder. Record review of Resident #7's MDS dated [DATE] revealed a BIMS score of 10, indicating moderate cognitive impairment. Record review of Resident #8's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: Alzheimer's disease, paranoid schizophrenia (serious mental health disease causing misinterpretation of reality), intermittent explosive disorder (repeated sudden outbursts of anger), history of transient ischemic attack (stroke), neuroleptic induced parkinsonism (irregular movements caused by use of antipsychotics), muscle weakness, difficulty in walking, and unsteadiness on feet. Record review of Resident #8's MDS dated [DATE] revealed a BIMS score of 00, indicating severe cognitive impairment. Record review of Resident #10's's face sheet dated 09/30/22 revealed a [AGE] year-old female admitted on [DATE] with diagnoses including the following: cerebral infarction (stroke), malnutrition, anorexia (not eating), lack of coordination, muscle weakness, unsteadiness on feet, schizoaffective disorder (mental health disorder with symptoms of distorted reality), major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that cause happiness), anxiety disorder, seizures (uncontrolled electrical disturbance in the brain), and abnormalities of gait and mobility. Record review of Resident #10's MDS dated [DATE] revealed a BIMS score of 7, indicating severe cognitive impairment. Record review of Resident #11's face sheet dated 09/30/22 revealed an [AGE] year-old female admitted on [DATE] with diagnoses including the following: unspecified dementia, psychotic disorder with hallucinations (severe mental illness including seeing things that are not there), insomnia, impulse disorder (lack of ability to control self), major depressive disorder (mental illness caused by lack of chemicals that cause happiness in the brain), and anxiety disorder. Record review of Resident #11's MDS dated [DATE] revealed a BIMS score of 00, indicating severe cognitive impairment. Resident #1 Record review of facility incident reports reflected Resident #1 initiated 10 residents to resident altercations between 09/12/22 and 09/24/22: (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9/12/22 - at 9:48 pm Resident 1 attacked Resident 4. Resident 1 wandered into Resident 4's room, Resident 1 grabbed hit t-shirt sleeve and tried to hit Resident 4, but Resident 4 took down Resident 1 by sweeping his legs out from under him with his good arm (Resident 4 has hemiplegia). Resident 4 had torn shirt. Resident 1 had a skin tear to left distal forearm, scratch on top of left forearm, busted blood vessel to right eye, blood coming from left nostril and multiple small scratches to right side of face. Neither Resident 1's nor Resident 4's family were notified per incident report and progress notes. 9/16/22 - at 9:08 pm, Resident 1 swung at Resident 2 and hit him on his shoulder in the hallway, then Resident 1 wandered into Resident 10's room. Resident 10 was heard yelling for help and stated, he just came in here and hit me!. Family members of Residents 1, 2 and 10 were not notified according to documentation in the incident reports and progress notes for each resident. 9/17/22 - at 4:00 pm, Resident 1 was in the hall with an aide at his side and he struck out and hit Resident 2, he was then escorted to his room and was in an altercation with his roommate, Resident 1 then walked up to Resident 3 in the hallway and grabbed her face and started shaking her head back and forth. No injuries were documented for any residents in these incidents. No family members were notified based on progress notes and incident reports. 9/18/22 - at 11:00 am, Resident 1 attacked Resident 11; Resident 1 grabbed Resident 11 by her arm and was pulling her, she yelled for help. Resident 11 was noted to have 3 small bruises on her right inner arm. Her husband was notified, no documentation of Resident 1's family being notified. 9/18/22 - at 12:50 pm Resident 1 told Resident 3 shut the fuck up bitch, Resident #3 began yelling for help, Resident 1 got in her face and continued yelling, Resident 3 threw water in his face, and Resident 1 turned around and pushed Resident 3 causing her to fall on the scale in the dining room, and he tried to attack her again, staff intervened and he attacked staff, chasing them down the hall. Resident 3 stated she was scared; her husband was notified. No documentation of Resident 1's family being notified was found. 9/18/22- at 7:20 pm Resident 10 was yelling for help; Resident 1 was in Resident 10's room with Resident 10 in a headlock with her arm extended back while Resident 1 said I am going to kill this bitch. Resident 10 stated, He just came into my room and hit me, he hurt my shoulder. Her family was notified, but there was no documentation of Resident 1's family being notified of the incident in either the report or the progress notes. 9/19/22 - at 10:44 pm, Resident 1 was in Resident 8's room swinging on Resident 8. Resident 8 was kicking and swinging to protect himself from Resident 1. No injuries were documented in the incident report, but no incident report was found for Resident 8 and no progress note was found in Resident 8's chart. No documentation of either family being notified of the incident. 9/20/22 - at 4:50 am, Resident 1 was found in Resident 8's room swinging at him. Resident 8 was swinging and trying to defend himself. Resident 8 was noted to have a skin tear to his left hand; no injuries were noted on Resident 1. No incident report for Resident 8 or progress note for Resident 8 was found related to this incident, no documentation of notification of family was found for either resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9/20/22 - at 8:00 am, Resident 1 and Resident 2 had an altercation, and after they were separated, Resident 1 attacked Resident 5, hitting him in head. No injuries were noted, family of Resident 2 and Resident 5 were notified; no documentation of Resident 1's family being notified. Resident 2 required Ativan after this incident. 9/24/22 - at 3:00 pm, Resident 1 was wandering in the hall and attacked Resident 2 (who was sitting in his wheelchair); then attacked Resident 4 by hitting him in the back. No injuries were noted, and no family members were notified per review of incident reports and progress notes. Resident #2 Record review of incident reports reflected Resident #2 has initiated 6 residents to resident altercations between 9/17/22 and 9/25/22: 9/17/22 - at 10:53 am, Resident 2 tipped over Resident 8's wheelchair causing a skin tear to his left hand. No injuries were noted on Resident 2. 9/17/22 - at 6:00 pm, Resident 2, having just been hit by Resident 1, hit Resident 6 as he walked past, which knocked Resident 6 to the ground. No injuries were noted, and no family members were notified according to progress notes and incident reports. 9/20/22 - at 5:07 pm, Resident 1 walked in the dining room and Resident 2 said, back up bitch and both residents hit each other. Resident 1 had scratches on his face, a skin tear to his right arm, and his left wrist was scratched. Resident 1's family was notified, but no documentation of Resident 2's family being notified was found in progress notes or incident reports. 9/23/22- at 1:35 p.m., Resident 2 attacked Resident 1 causing scratches to Resident 1's face, a deep skin tear to his right forearm from nails, and a shallow bit on Resident 1's right top ear, causing bleeding. Staff intervened. Resident 2 was moved to different area, and Resident 1 was given a sedative. 9/24/22 - at 4:30 pm, Resident 2 attacked Resident 7 hitting him, then biting him on the right upper back and refusing to release his mouth from Resident 7's back. Resident 2 has a diagnosis of Hepatitis C, which is transmissible via bodily fluids. No documentation of either family being notified of this incident and no incident report with Resident 7's information. 9/25/22 - at 8:41 pm, Resident 2 pulled Resident 6 to the ground and hit him. Resident 11 walked into the area and Resident 2 slapped her 4 times in the face. No injuries were noted for any of the 3 residents involved. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/21/22 at 10:05 a.m. with the facility Administrator (ADM) and Director of Nurses(DON); ADM stated that Resident #1 has had several physical aggression incidents in the last 9 days since admission on 9/12/22 with several residents and several staff. ADM stated that Resident #1 came from another facility, but the transfer paper did not document this type of behaviors. ADM stated that when he is awake, they have him on a 1:1 level of supervision and when he is asleep, he is on every 15-minute checks. DON stated that Resident #1 has been moved to a room, next to her and the ADON office so he can be monitored closely. DON stated that Resident #1 is NPO Nothing by mouth and when he sees people with food he will go and grab it from them. DON stated that Resident #1 hit resident #5 on 9/20/22. Stated that Resident #1 has attacked the following residents: Resident #10, Resident #3 by knocking her down and she wears a helmet to protect her head from seizures; Resident #2, Resident #4, Resident #5 who punched Resident #1 in the face but left no marks; and Resident #11 by scratching her arm. DON stated that Resident #1 has been physically aggressive with several staff including, DON, ADM, Housekeeping, Aide, Assistant Director of Nursing (ADON). DON stated that he put the housekeeping staff into a choke hold. DON stated that Investigator (INV) should not enter Resident #1's room alone or approach him without a staff member with the INV. DON stated that INV should be aware of surroundings if Resident #1 is out of his room. During an interview and observation on 9/21/22 at 10:35 a.m. with Resident #4, stated he punched another male resident [Resident #1] in the face when the resident came up and grabbed him in his room. Stated he gave him a black eye and he will fight back if needed. During an interview and observation on 9/21/22 at 10:38 a.m. with Resident #11, stated that the man (Resident #1) grabbed her wrists and scratched her and pointed to bruising on her right wrist. DON stated the bruises were a result from Resident #1 grabbing Resident #11. During an interview on 9/21/22 at 10:44 a.m. with the Director of Nurses (DON), stated that this is a dangerous situation because Resident #1 becomes aggressive with no warning. DON stated I cannot ensure safety of the residents or staff due to the aggressive behavior of Resident #1. Observation on 9/21/22 at 11:55 a.m. of Resident #1 laying in bed awake and had no 1:1 supervision. DON notified and 1:1 was assigned. During an observation and interview on 9/21/22 at 1:15 p.m. with Nurses Assistant A(NA), sitting in chair in Resident #1's room. Resident #1 was observed sleeping in his bed. NA stated she has only worked here for 3 days and started at 6 a.m. today. Stated that she is Resident #1's 1:1 level of supervision right now and that she is aware of his physical aggression behaviors but is not afraid to work with him. During an interview on 9/21/22 at 1:50 p.m. with CNA A, stated she did not observe the incident with Resident #1 and Resident #3. CNA A stated she was here for the incident with Resident #1 and Resident #11, and it was unprovoked, and Resident #1 started hitting and punching. Stated that she and LVN C intervened by trying to redirect Resident #1 and removing the residents he was targeting. Stated that Resident #1 chases staff, and they try to redirect with snacks. CNA A stated that Resident #1 is okay as long as he is in his bed but once he gets out of bed, they have issues. Stated that they check him every 2 hours if he is awake or not. Stated that if he is asleep, he is left alone in his room and checked on. CNA A stated if he is awake, he is 1:1 level of supervision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675407	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/21/22 at 2:13 p.m. with LVN C, stated that Resident #1 is being aggressive and attacking other residents or staff, they intervene by taking the other resident out of the situation. Stated that it's hard to redirect Resident #1 because it seems like he is focused on the behavior, so if he is moved away from a resident and sees someone in front of him, he will attack them. During an observation on 9/21/22 at 2:15 p.m., Nurses assistant(NA) observed sitting in chair in Resident #1's room. NA had face resting on hand and asleep while Resident #1 was awake in bed. Nurse assistant did not acknowledge INV was in room and continued to sleep. DON notified. Interview and observation of Resident #1 in room [ROOM NUMBER] on 9/21/22 at 2:49 p.m.; DON with INV and Nurse Assistant (NA) in room. Resident #1 was awake lying in bed. Nurse assistant observed eating skittles from her pocket, mask lowered and using personal cell phone. Resident #1 stated he was doing okay. When asked where he lives, Resident #1 pointed to the door and stated, I live in the door. INV asked if he remembers getting into a physical altercation with another resident and resident stated no. Resident #1 observed with bruising to face and eye area, numerous scratches, and abrasions to face and arms. Interview on 9/21/22 at 3:12 p.m. with Nurse Assistant (NA), stated she was not sleeping but stated she did not see INV stand in front of her. Nurse assistant stated she knows Resident #1 is food aggressive and that it could have become a dangerous situation with her eating in front of him. During an observation and interview on 9/21/22 at 3:20 p.m. with Resident #3, observed sitting in dining room with activity director, in her wheelchair, wearing helmet. Resident #3 stated he hit me and grabbed me, he pushed me to the ground. Look at my arm. Resident #3 pointed to right arm where a red abrasion and bruising were observed near her elbow. Resident #3 stated she is not scared anymore because they are going to send him away. During an interview on 9/21/22 at 3:38 p.m. with Housekeeping Supervisor, stated she has observed Resident #1 having behaviors and he has hit her, grabbed her from the neck and started slapping her. Stated that he has also gotten her arm, showed right forearm with red scrape/abrasion. Stated he will attack out of nowhere and some residents are scared. Stated when he gets physically aggressive staff immediately intervene by trying to separate him from the other person, but he can turn on that staff member. During an interview on 9/21/22 at 4:57 p.m. with Resident #5, stated he was doing okay and likes it here. Stated that he tried to hit me, he hit me on my shoulder. And pointed to room [ROOM NUMBER] where Resident #1 was. Stated he hit Resident #1 back and would do it again if he had to. (continued on next page)

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Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 9/28/22 at 12:22 p.m. with the Administrator; stated last incident with Resident #1 was on 9/23/22 with Resident #2. Stated the incident started verbal with Resident #2 yelling at Resident #1. Stated that Resident #1 started swinging at Resident #2 and Resident #2 ended up biting Resident #1 on the ear near the nurses' station. Stated that all residents were cleared from the area . Stated Resident #1 and #2 were separated by staff to different areas. Stated Resident #1 became physically violent towards staff who were attempting to intervene, and the nurse administered Zyprexa and he calmed down and was assessed for injury to ear. Stated Resident #1 was bleeding from ear and no sutures were needed. Stated that Resident #2 has Hepatitis C and Resident #1 was treated with medications, tetanus shot, and a Hep panel was run. Stated Resident #2 has scratches and redness to eye. ADM stated she cannot verify if Resident #1 was on a 1:1 at that time. Stated that he is/was supposed to be but could not confirm. Stated that Resident #1 has had no other incidents since INV left on 9/21/22 besides above incident with Resident #2 on 9/23/22. ADM stated that now that Resident #1 has calmed down, they are having issues with Resident #2 having physical aggression on 9/23/22 with Resident #1, and with two separate incidents on 9/25/22 with 2 different residents. ADM stated she reported to the State Survey Agency. During an interview on 9/29/22 at 1:18 p.m. with Administrator (ADM) and RN Nursing consultant; ADM stated that Resident #2 is being transferred to another facility. ADM stated that Resident #1 is being admitted to Hospice. ADM stated that Resident #1 was a trigger for Resident #2 and if Resident #2 saw Resident #1 he would start attacking. ADM stated that there was an incident between Resident #2 and Resident #7 where Resident #2 bit Resident #7's back but did not break skin. ADM stated that there was also an incident involving Resident #2 and Resident #6, where Resident #2 pushed Resident #6 and then Resident #2 went after Resident #11 and slapped her several times in the face. RN Consultant stated that Resident #1 is not on a level of supervision but is eyes on because he is no longer getting out of bed. Stated that Resident #1 was on Q15 minute checks when he had the incident where Resident #2 bit him on the back. RN Consultant stated that Resident #1 was put on Hospice referral on 9/21/22 and was on 1:1. RN Consultant stated Resident #2 was placed on eyes on as he wanders. Interview on 9/29/22 at 1:45 p.m. with ADON/LVN; stated she has close monitoring sheets for Resident #1 from 9/18/22 to 9/21/22 and then 9/26/22 but does not have the dates in-between. Stated there should have been monitoring sheets from 9/22/22 to 9/25/22. Stated she was having 3 CNAs on shift and would designate verbally which CNA was assigned to 1:1 on Resident #1 but has no actual sign on sheets for him. Stated that the CNA could leave the room if Resident #1 was sleeping, and they should have checked Q 15 min but there are no close monitoring sheets for those days to confirm. Stated on 9/23/22 Resident #1 was on 1:1 and there were 2 CNA's who were supposed to alternate but there is no sign on sheets to prove it. Stated that she cannot say who was watching him when the incident happened. Stated the Activity director witnessed incident. Stated Resident #1 was put on 1:1 to prevent these incidents of aggression from occurring and to prevent injuries. Stated he is still assigned 1:1. Stated Resident #1 should be 1:1 at all times, but they have not been with him at all times. Stated when he is asleep staff come out of the room. Stated when he is awake, they are supposed to be in there. Stated there is no system in place right now to make sure that there is 1:1 coverage on Resident #1 when he awakes from sleeping. Stated there is no method of documentation or checking to verify what he is doing. And No Q 15 checks. Stated on 9/23/22 she did not have someone designated to be Resident #1 1:1 because she did not have enough staff. Stated that Resident #2 is all over the place, we always knew where he was and kept him separated from Resident #1. Stated Resident #1 is a trigger for him, so if he sees him, Resident #2 flips out and it's a trigger. Stated when Resident #1 is not around, Resident #2 is fine. Stated Resident #2 was not put on a 1:1 or Close monitoring. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/29/22 3:28 p.m. with CNA B, stated on 9/23/22 she was working 6 a to 6 p. Stated she was not assigned to Resident #1's level of supervision and does not believe anyone else was either. Stated 9/23/22 they would check on him, but they didn't start doing the close monitoring form for 15 Q checks. Stated that she has had no training on what to do when Resident #1 attacks a resident or when he is attacking staff. Stated she doesn't know how she is to protect him or others. Stated Resident #1 will attack everyone in the building. Stated today is the first time she has seen a 1:1 Level of supervision (LOS) on Resident #1, and only because the Investigator (INV) is in the building. Stated that there are only 2 aides during the day shift, and they cannot do 1:1 and perform their duties. During an interview on 9/29/22 at 4:45 p.m. with the activity director; Stated on 9/23/22 Resident #2 was sitting in his wheelchair and Resident #1 came out of his room alone and put his hand out to Resident #2, like he wanted to shake his hand. Stated she immediately tried to get between them, but it happened so quickly. Stated Resident #2 pulled Resident #1 to the floor. Stated she started yelling for help and Resident #2 was biting Resident #1. , Stated a male nurse came and separated them. Stated there was an in-service after 9/12/22 when the first incident occurred with Resident #1. We have not received any in-service regarding Resident #1 and #2 having physical incidents or how Resident #2 is set off by Resident #1. Stated that before today, there were not enough staff to assist, and she was afraid of what could happen. Stated that they had a hard time trying to keep Resident #1 from attacking other residents. Stated that Resident #2 will attack residents if he feels that a resident is in his way or in his space. Stated that once Resident #2 is in an aggressive state he stays in that state. IJ called at 9/30/22 at 1:13 p.m. with Administrator and RN Consultant. Investigator provided 3 strikes letter, IJ Template, Plan of Removal form. No questions asked at this time. During an interview on 9/30/22 at 2:08 p.m. with the Director of Nurses, stated that the Administrator and Business Manager are admitting residents without having me review their needs to see if we can meet their medical needs. Stated she was never asked to review the admission packet for Resident #1. Stated she did not know he was being admitted until he was already approved. Stated no eyes were laid on him before he got here. Stated we are not equipped to take some of these residents if they are physically aggressive or a wanderer. Stated she did not find out about incident's until 9/26/22 of anything that occurred over the weekend. Stated no one is notifying her of anything. Stated she has presented in-services on patient aggression, remaining calm and has sign in sheets for some of them. Stated Resident #1 was on close monitoring, but no one had been filling out the sheet and we can't prove that. Stated no one from the facility laid eyes on him before he got here. Stated We are not equipped to take some of these residents if they are physically aggressive or a wanderer. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/30/22 at 3:30 p.m. with the Administrator, Stated Resident #1 came from New Mexico at a hospital, and they sent the referral. He had been at another nursing facility previously before coming here. Stated that she reviewed the admit records along with the Business Manager, Corporate Manager, DON and ADON. Stated she did not see anything, and they didn't talk about there being any concerns. Stated she didn't see anything on the referral about behaviors and she would be happy to get what was sent in the referral so we can go over it. ADM returned and stated that the hospital was ready to discharge him, and the NH refused to take him back. When asked why they refused to take Resident #1 back, ADM stated because of his behaviors. Like Resident #2 he was here for months no problems then I don't know I don't know what set him off. When asked the referral documentation does have behaviors and aggression documents she stated, it does mention he was becoming aggressive with residents and staff. She stated first physical altercation was on 9/12/22 the day he admitted to the facility. ADM stated she told staff to not let Resident #2 and Resident #1 and near each other. When asked was staff keeping them separated, she stated I did not witness if they did or not. When asked if you told staff to monitor and keep Resident #1 and Resident #2 separated how did they continue to have altercations? ADM stated, I am not sure that is a good question. ADM stated it could have been a pretty serious outcome. INV asked how staff were notified of 1:1 or Q15 minute check, ADM stated Resident #1 was never on 1:1 and when he was out in the hall, we had staff with him. During an interview on 10/1/22 at 6:23 a.m. with LVN A, stated that the facility did not have staff or resources to care for Resident #1 because he has too many behaviors. Stated that she complained to the ADON about it and the ADON stated she was doing the best she could. Stated that it was not fair to the rest of the residents. Stated when Resident #1 was admitted it was all downhill from there. Stated Resident #2 is loud and cusses, he is an old biker. Stated she never had any incidents with Resident #2 but when Resident #1 came, it became bad. Stated Resident #2 was our protector and if he saw Resident #1 hit one of the staff or one of the lady residents, Resident #2 would become very upset. Stated the only intervention provided by the administration was to just keep an eye on him meaning Resident #1. Stated at night it is very hard to do because they do not have the staff. Stated there was no way to monitor Resident #1 every 15 minutes during the 6 p to 10 p timeframe. Stated they would try but they could not do it. 10/1/22 7:24 p.m. Plan of Removal received via email from ADM; Investigator forwarded it to region 1 for review. During an interview on 10/1/22 at 8:13 a.m. with Resident #4; stated Resident #1 tried to pull me out of my wheelchair and the chair ended up on top of him. Stated that he kicked at Resident #1 and made him fall. Stated that he feels reasonably safe here. Stated that Resident #1 has the right to live here too but [TRUNCATED]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 43849 Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent resident to resident altercations for 2 of 2 residents reviewed for supervision. (Resident #1 and #2) The facility did not develop and implement consistent or effective supervision to prevent Resident #1, a resident who had a history of being physically aggressive from continuing to physically attack and target other residents in the facility. The facility did not develop and implement consistent or effective supervision to prevent Resident #2, a resident who had a history of being physically aggressive from continuing to physically attack and target other residents in the facility. This failure could placed all residents at risk of being harmed, injured or possible death. This failure resulted in an identification of an Immediate Jeopardy (IJ) situation on 09/30/22. While the IJ was removed on 10/03/22, the facility remained out of compliance at a severity level of actual harm, and a scope identified as pattern due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. The findings include: Record review of Resident #1's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: encephalopathy (disturbance in brain function), hemiplegia and hemiparesis following cerebral infarction (partial paralysis following stroke), muscle weakness, malnutrition, difficulty walking, Alzheimer's, psychotic disorder with delusions (severe mental illness including distorted beliefs), and anxiety disorder. Record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 99, indicating the resident could not complete the assessment. Record Review of Resident #1's progress note dated 9/18/22 at 1:00 PM, entered by DON revealed; 1:1 for resident #1; administrator confirmed 1:1 at 3:33 pm Record review of Resident #2's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: unspecified dementia with behavioral disturbance (breakdown of thought process causing disruptive behavior), intermittent explosive disorder (repeated sudden outbursts of anger), epileptic seizures related to external causes (sudden uncontrolled electrical disturbance in the brain), unspecified lack of coordination, history of falling, schizoaffective disorder bipolar type (mental health disorder with symptoms of distorted reality and mood fluctuation), anxiety disorder, encephalopathy (disturbance in brain function), muscle weakness, abnormalities of gait and mobility, unspecified convulsions, and history of traumatic brain injury (injury that changes how the brain works). (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2' MDS dated [DATE] revealed a BIMS score of 05, indicating severe cognitive impairment. The facility has failed to provide adequate supervision and maintain an environment free from accident hazards when the risk of resident-to-resident altercations had been identified. Resident #1 Record review of facility incident reports reflected Resident #1 initiated 10 residentresidents to resident altercations between 09/12/22 and 09/24/22: 9/12/22 - at 9:48 pm Resident 1 attacked Resident 4. Resident 1 wandered into Resident 4's room, Resident 1 grabbed hit t-shirt sleeve and tried to hit Resident 4, but Resident 4 took down Resident 1 by sweeping his legs out from under him with his good arm (Resident 4 has hemiplegia). Resident 4 had torn shirt. Resident 1 had a skin tear to left distal forearm, scratch on top of left forearm, busted blood vessel to right eye, blood coming from left nostril and multiple small scratches to right side of face. Neither Resident 1's nor Resident 4's family were notified per incident report and progress notes. 9/16/22 - at 9:08 pm, Resident 1 swung at Resident 2 and hit him on his shoulder in the hallway, then Resident 1 wandered into Resident 10's room. Resident 10 was heard yelling for help and stated, he just came in here and hit me!. Family members of Residents 1, 2 and 10 were not notified according to documentation in the incident reports and progress notes for each resident. 9/17/22 - at 4:00 pm, Resident 1 was in the hall with an aide at his side and he struck out and hit Resident 2, he was then escorted to his room and was in an altercation with his roommate, Resident 1 then walked up to Resident 3 in the hallway and grabbed her face and started shaking her head back and forth. No injuries were documented for any residents in these incidents. No family members were notified based on progress notes and incident reports. 9/18/22 - at 11:00 am, Resident 1 attacked Resident 11; Resident 1 grabbed Resident 11 by her arm and was pulling her, she yelled for help. Resident 11 was noted to have 3 small bruises on her right inner arm. Her husband was notified, no documentation of Resident 1's family being notified. 9/18/22 - at 12:50 pm Resident 1 told Resident 3 shut the fuck up bitch, Resident #3 began yelling for help, Resident 1 got in her face and continued yelling, Resident 3 threw water in his face, and Resident 1 turned around and pushed Resident 3 causing her to fall on the scale in the dining room, and he tried to attack her again, staff intervened and he attacked staff, chasing them down the hall. Resident 3 stated she was scared; her husband was notified. No documentation of Resident 1's family being notified was found. 9/18/22- at 7:20 pm Resident 10 was yelling for help; Resident 1 was in Resident 10's room with Resident 10 in a headlock with her arm extended back while Resident 1 said I am going to kill this bitch. Resident 10 stated, He just came into my room and hit me, he hurt my shoulder. Her family was notified, but there was no documentation of Resident 1's family being notified of the incident in either the report or the progress notes. (continued on next page)

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Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9/19/22 - at 10:44 pm, Resident 1 was in Resident 8's room swinging on Resident 8. Resident 8 was kicking and swinging to protect himself from Resident 1. No injuries were documented in the incident report, but no incident report was found for Resident 8 and no progress note was found in Resident 8's chart. No documentation of either family being notified of the incident. 9/20/22 - at 4:50 am, Resident 1 was found in Resident 8's room swinging at him. Resident 8 was swinging and trying to defend himself. Resident 8 was noted to have a skin tear to his left hand; no injuries were noted on Resident 1. No incident report for Resident 8 or progress note for Resident 8 was found related to this incident, no documentation of notification of family was found for either resident. 9/20/22 - at 8:00 am, Resident 1 and Resident 2 had an altercation, and after they were separated, Resident 1 attacked Resident 5, hitting him in head. No injuries were noted, family of Resident 2 and Resident 5 were notified; no documentation of Resident 1's family being notified. Resident 2 required Ativan after this incident. 9/24/22 - at 3:00 pm, Resident 1 was wandering in the hall and attacked Resident 2 (who was sitting in his wheelchair); then attacked Resident 4 by hitting him in the back. No injuries were noted, and no family members were notified per review of incident reports and progress notes. Resident #2 Record review of incident reports reflected Resident #2 has initiated 6 residents to resident altercations between 9/17/22 and 9/25/22: 9/17/22 - at 10:53 am, Resident 2 tipped over Resident 8's wheelchair causing a skin tear to his left hand. No injuries were noted on Resident 2. 9/17/22 - at 6:00 pm, Resident 2, having just been hit by Resident 1, hit Resident 6 as he walked past, which knocked Resident 6 to the ground. No injuries were noted, and no family members were notified according to progress notes and incident reports. 9/20/22 - at 5:07 pm, Resident 1 walked in the dining room and Resident 2 said, back up bitch and both residents hit each other. Resident 1 had scratches on his face, a skin tear to his right arm, and his left wrist was scratched. Resident 1's family was notified, but no documentation of Resident 2's family being notified was found in progress notes or incident reports. 9/23/22 - at 1:35 p.m., Resident 2 attacked Resident 1 causing scratches to Resident 1's face, a deep skin tear to his right forearm from nails, and a shallow bit on Resident 1's right top ear, causing bleeding. Staff intervened. Resident 2 was moved to different area, and Resident 1 was given a sedative. 9/24/22 - at 4:30 pm, Resident 2 attacked Resident 7 hitting him, then biting him on the right upper back and refusing to release his mouth from Resident 7's back. Resident 2 has a diagnosis of Hepatitis C, which is transmissible via bodily fluids. No documentation of either family being notified of this incident and no incident report with Resident 7's information. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9/25/22 - at 8:41 pm, Resident 2 pulled Resident 6 to the ground and hit him. Resident 11 walked into the area and Resident 2 slapped her 4 times in the face. No injuries were noted for any of the 3 residents involved. During an interview on 9/21/22 at 10:05 a.m. with the facility Administrator (ADM) and Director of Nurses(DON); ADM stated that Resident #1 has had several physical aggression incidents in the last 9 days since admission on 9/12/22 with several residents and several staff. ADM Stated that Resident #1 came from another facility, but the transfer paper did not document this type of behaviors. ADM stated that when he is awake, they have him on a 1:1 level of supervision and when he is asleep, he is on every 15-minute checks. DON stated that Resident #1 has been moved to a room , next to her and the ADON office so he can be monitored closely. DON stated that Resident #1 is NPO Nothing by mouth and when he sees people with food he will go and grab it from them. DON state d that Resident #1 hit resident #5 on 9/20/22. Stated that Resident #1 has attacked the following residents: Resident #10, Resident #3 by knocking her down and she wears a helmet to protect her head from seizures; Resident #2, Resident #4, Resident #5 who punched Resident #1 in the face but left no marks; and Resident #11 by scratching her arm. DON stated that Resident #1 has been physically aggressive with several staff including, DON, ADM, Housekeeping, Aide, Assistant Director of Nursing (ADON). DON stated that he put the housekeeping staff into a choke hold. DON stated that Investigator (INV) should not enter Resident #1's room alone or approach him without a staff member with the INV. DON stated that INV should be aware of surroundings if Resident #1 is out of his room. Facility became aware of Resident #1's physically aggressive behavior on 9/12/22 and from 9/12/22 to 9/24/22 Resident #1 has initiated 9 separate physically aggressive incidents with other residents including resident #2. -Resident #1 has initiated 10 residents to resident altercations. 9/12/22 In a record review of incident reports 799 and 800 dated 9/12/22 at 9:48 pm Resident 1 attacked Resident 4. Resident 1 wandered into Resident 4's room, Resident 1 grabbed hit t-shirt sleeve and tried to hit Resident 4, but Resident 4 took down Resident 1 by sweeping his legs out from under him with his good arm (Resident 4 has hemiplegia). Resident 4 had torn shirt. Resident 1 had a skin tear to left distal forearm, scratch on top of left forearm, busted blood vessel to right eye, blood coming from left nostril and multiple small scratches to right side of face. Neither Resident 1's nor Resident 4's family were notified per incident report and progress notes. 9/16/22 In a record review of incident reports 802, 803, and 804 dated 9/16/22 at 9:08 pm, Resident 1 swung at Resident 2 and hit him on his shoulder in the hallway, then Resident 1 wandered into Resident 10's room. Resident 10 was heard yelling for help and stated, he just came in here and hit me!. Family members of Residents 1, 2 and 10 were not notified according to documentation in the incident reports and progress notes for each resident. 9/17/22 In a record review of incident reports 808, 809, and 810, dated 9/17/22 at 4:00 pm, Resident 1 was in the hall with an aide at his side and he struck out and hit Resident 2, he was then escorted to his room and was in an altercation with his roommate, Resident 1 then walked up to Resident 3 in the hallway and grabbed her face and started shaking her head back and forth. No injuries were documented for any residents in these incidents. No family members were notified based on progress notes and incident reports. (continued on next page)

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	675407	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9/18/22 In a record review of incident 814 dated 9/18/22 at 11:00 am, Resident 1 attacked Resident 11; Resident 1 grabbed Resident 11 by her arm and was pulling her, she yelled for help. Resident 11 was noted to have 3 small bruises on her right inner arm. Her husband was notified, no documentation of Resident 1's family being notified. 9/18/22 In a record review of incident 813 and 816 dated 9/18/22 at 12:50 pm Resident 1 told Resident 3 shut the fuck up bitch, she was yelling for help, Resident 1 got in her face and continued yelling, Resident 3 threw water in his face, and Resident 1 turned around and pushed Resident 3 causing her to fall on the scale in the dining room, and he tried to attack her again, staff intervened and he attacked staff, chasing them down the hall. Resident 3 stated she was scared; her husband was notified. No documentation of Resident 1's family being notified was found. 09/18/22 In a record review of incident 815 dated 9/18/22 7:20 pm Resident 10 was yelling for help; Resident 1 was in Resident 10's room with Resident 10 in a headlock with her arm extended back while Resident 1 said I am going to kill this bitch. Resident 10 stated, He just came into my room and hit me, he hurt my shoulder. Her family was notified, but there was no documentation of Resident 1's family being notified of the incident in either the report or the progress notes. 9/19/22 In a record review of incident 818 dated 9/19/22 at 10:44 pm, Resident 1 was in Resident 8's room swinging on Resident 8. Resident 8 was kicking and swinging to protect himself from Resident 1. No injuries were documented in the incident report, but no incident report was found for Resident 8 and no progress note was found in Resident 8's chart. No documentation of either family being notified of the incident. 9/20/22 In a record review of incident 819 dated 9/20/22 at 4:50 am, Resident 1 was again found in Resident 8's room swinging at him. Resident 8 was swinging and trying to defend himself. Resident 8 was noted to have a skin tear to his left hand; no injuries were noted on Resident 1. No incident report for Resident 8 or progress note for Resident 8 was found related to this incident, no documentation of notification of family was found for either resident. 9/20/22 In a record review of incidents 820, 821, and 822 dated 9/20/22 at 8:00 am, Resident 1 and Resident 2 had an altercation, and after they were separated, Resident 1 attacked Resident 5, hitting him in head. No injuries were noted, family of Resident 2 and Resident 5 were notified; no documentation of Resident 1's family being notified. Resident 2 required Ativan after this incident. 9/24/22 In a record review of incidents 832, 834, and 835 dated 9/24/22 at 3:00 pm, Resident 1 was wandering in the hall and attacked Resident 2 (who was sitting in his wheelchair); then attacked Resident 4 by hitting him in the back. No injuries were noted, and no family members were notified per review of incident reports and progress notes. Resident #2 -Resident #2 has initiated 6 residents to resident altercations. 9/17/22 In a record review of incident reports 805 and 807 dated 9/17/22 at 10:53 am, Resident 2 tipped over Resident 8's wheelchair causing a skin tear to his left hand. No injuries were noted on Resident 2. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9/17/22 In a record review of incident reports 811 and 812 dated 9/17/22 at 6:00 pm, Resident 2, having just been hit by Resident 1, hit Resident 6 as he walked past, which knocked Resident 6 to the ground. No injuries were noted, and no family members were notified according to progress notes and incident reports. 9/20/22 In a record review of incident reports 823 and 824 dated 9/20/22 at 5:07 pm, Resident 1 walked in the dining room and Resident 2 said, back up bitch and both residents hit each other. Resident 1 had scratches on his face, a skin tear to his right arm, and his left wrist was scratched. Resident 1's family was notified, but no documentation of Resident 2's family being notified was found in progress notes or incident reports. 9/23/22 In a record review of incident reports 826 and 827, Resident 2 attacked Resident 1 causing scratches to Resident 1's face, a deep skin tear to his right forearm from nails, and a shallow bit on Resident 1's right top ear, causing bleeding. Staff intervened. Resident 2 was moved to different area, and Resident 1 was given a sedative. 9/24/22 In a record review of incident report 833 dated 9/24/22 at 4:30 pm, Resident 2 attacked Resident 7 hitting him, then biting him on the right upper back and refusing to release his mouth from Resident 7's back. Resident 2 has a diagnosis of Hepatitis C, which is transmissible via bodily fluids. No documentation of either family being notified of this incident and no incident report with Resident 7's information. 9/25/22 In a record review of incident reports 828, 829, and 830 dated 9/25/22 starting at 8:41 pm, Resident 2 pulled Resident 6 to the ground and hit him. Resident 11 walked into the area and Resident 2 slapped her 4 times in the face. No injuries were noted for any of the 3 residents involved. Record review of Resident #1's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: encephalopathy (disturbance in brain function), hemiplegia and hemiparesis following cerebral infarction (partial paralysis following stroke), muscle weakness, malnutrition, difficulty walking, Alzheimer's, psychotic disorder with delusions (severe mental illness including distorted beliefs), and anxiety disorder. Record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 99, indicating the resident could not complete the assessment. Record Review of Resident #1's progress note dated 9/18/22 at 1:00 PM, entered by DON revealed; 1:1 for resident #1; administrator confirmed 1:1 at 3:33 pm Record review of Resident #2's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: unspecified dementia with behavioral disturbance (breakdown of thought process causing disruptive behavior), intermittent explosive disorder (repeated sudden outbursts of anger), epileptic seizures related to external causes (sudden uncontrolled electrical disturbance in the brain), unspecified lack of coordination, history of falling, schizoaffective disorder bipolar type (mental health disorder with symptoms of distorted reality and mood fluctuation), anxiety disorder, encephalopathy (disturbance in brain function), muscle weakness, abnormalities of gait and mobility, unspecified convulsions, and history of traumatic brain injury (injury that changes how the brain works). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2' MDS dated [DATE] revealed a BIMS score of 05, indicating severe cognitive impairment. Record review of Resident #3's face sheet dated 09/30/22 revealed a [AGE] year-old female admitted on [DATE] with diagnoses including the following: Alzheimer's disease, paranoid schizophrenia (serious mental health disease causing misinterpretation of reality), malnutrition, seizures (uncontrolled electrical disturbance in the brain), muscle weakness, difficulty in walking, conversion disorder with seizures or convulsions (condition where a mental health issue disrupts how the brain works), generalized anxiety disorder, schizoaffective disorder bipolar type (mental health disorder with symptoms of distorted reality and mood fluctuation), major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that cause happiness), and lack of coordination. Record review of Resident #3s MDS dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. Record review of Resident #4's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: hemiplegia and hemiparesis following cerebral infarction (partial paralysis following stroke), intermittent explosive disorder (repeated sudden outbursts of anger), muscle weakness, lack of coordination, muscle wasting and atrophy (breakdown of muscles), schizoaffective disorder (mental health disorder with symptoms of distorted reality), major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that cause happiness), anxiety disorder, and epilepsy (disorder that causes abnormal brain function like seizures). Record review of Resident #4's MDS dated [DATE] revealed a BIMS score of 13, indicating intact cognitive function. Record review of Resident #5's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: history of traumatic brain injury (injury that changes how the brain works), muscle wasting and atrophy (breakdown of muscles), other recurrent depressive disorders (mental health illness causing prolonged sadness), and difficulty in walking. Record review of Resident #5's MDS dated [DATE] revealed a BIMS score of 15, indicating intact cognitive function. Record Review of Resident #6's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: Unspecified dementia with behavioral disturbance (breakdown of thought process causing disruptive behavior), adjustment disorder with mixed anxiety and depressed mood (mental health issues caused by a sudden change), other seizures, restlessness and agitation, and metabolic encephalopathy (problems in the brain from chemicals in the blood), and insomnia. Record Review of Resident #6's MDS dated [DATE] revealed a BIMS score of 00, indicating severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #7's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: altered mental status (change in brain function), unspecified lack of coordination, cognitive communication deficit (impaired thought processes), difficulty in walking, rheumatoid arthritis (autoimmune inflammation of the joints), paranoid schizophrenia (serious mental health disease causing misinterpretation of reality), Alzheimer's disease, Bipolar disorder (mental health disease causing severe mood swings), major depressive disorder (mental illness caused by lack of chemicals in the brain that cause happiness), and anxiety disorder. Record review of Resident #7's MDS dated [DATE] revealed a BIMS score of 10, indicating moderate cognitive impairment. Record review of Resident #8's face sheet dated 09/30/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: Alzheimer's disease, paranoid schizophrenia (serious mental health disease causing misinterpretation of reality), intermittent explosive disorder (repeated sudden outbursts of anger), history of transient ischemic attack (stroke), neuroleptic induced parkinsonism (irregular movements caused by use of antipsychotics), muscle weakness, difficulty in walking, and unsteadiness on feet. Record review of Resident #8's MDS dated [DATE] revealed a BIMS score of 00, indicating severe cognitive impairment. Record review of Resident #10's's face sheet dated 09/30/22 revealed a [AGE] year-old female admitted on [DATE] with diagnoses including the following: cerebral infarction (stroke), malnutrition, anorexia (not eating), lack of coordination, muscle weakness, unsteadiness on feet, schizoaffective disorder (mental health disorder with symptoms of distorted reality), major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that cause happiness), anxiety disorder, seizures (uncontrolled electrical disturbance in the brain), and abnormalities of gait and mobility. Record review of Resident #10's MDS dated [DATE] revealed a BIMS score of 7, indicating severe cognitive impairment. Record review of Resident #11's face sheet dated 09/30/22 revealed an [AGE] year-old female admitted on [DATE] with diagnoses including the following: unspecified dementia, psychotic disorder with hallucinations (severe mental illness including seeing things that are not there), insomnia, impulse disorder (lack of ability to control self), major depressive disorder (mental illness caused by lack of chemicals that cause happiness in the brain), and anxiety disorder. Record review of Resident #11's MDS dated [DATE] revealed a BIMS score of 00, indicating severe cognitive impairment. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/21/22 at 10:05 a.m. with the facility Administrator (ADM) and Director of Nurses(DON); ADM stated that Resident #1 has had several physical aggression incidents in the last 9 days since admission on 9/12/22 with several residents and several staff. Stated that it is a dangerous situation, and the facility is trying to find another facility for him but due to Resident #1 having a peg tube for feeding they are not having any success in transferring him. Stated that Resident #1 came from another facility, but the transfer paper did not document this type of behaviors. Stated that when he is awake, they have him on a 1:1 level of supervision and when he is asleep, he is on every 15-minute checks. Stated resident has BIMS of 0 and history of dementia. During the same interview, DON stated that Resident #1 has been moved to a room [ROOM NUMBER], next to her and the ADON office so he can be monitored closely. Stated that when he is awake, they have him on a 1:1 level of supervision and when he is asleep, he is on every 15-minute checks. DON confirmed resident #1 has a BIMS of 0 and history of dementia. DON stated that Resident #1 is NPO Nothing by mouth and when he sees people with food he will go and grab it from them. Stated that his Resident #1's wife signed the senior psych referral. Stated that Resident #1 hit resident #5 on 9/20/22. Stated that Resident #1 has attacked the following residents: Resident #10, Resident #3 by knocking her down and she wears a helmet to protect her head from seizures; Resident #2, Resident #4, Resident #5 who punched Resident #1 in the face but left no marks; and Resident #11 by scratching her arm. Stated that Resident #1 has been physically aggressive with several staff including, DON, ADM, Housekeeping, Aide, Assistant Director of Nursing (ADON). Stated that he put the housekeeping staff into a choke hold. Stated that their priority is to find placement by end of business today but so far, no luck and have contacted several facilities in the area. DON stated that Investigator (INV) should not enter Resident #1's room alone or approach him without a staff member with the INV. DON stated that INV should be aware of surroundings if Resident #1 is out of his room. During an interview and observation on 9/21/22 at 10:35 a.m. with Resident #4, stated he punched another male resident [Resident #1] in the face when the resident came up and grabbed him in his room. Stated he gave him a black eye and he will fight back if needed. During an interview and observation on 9/21/22 at 10:38 a.m. with Resident #11, stated that the man grabbed her wrists and scratched her and pointed to bruising on her right wrist. DON stated the bruises were a result from Resident #1 grabbing Resident #11. During an interview on 9/21/22 at 10:44 a.m. with the Director of Nurses (DON), stated that this is a dangerous situation because Resident #1 becomes aggressive with no warning. Stated I cannot ensure safety of the residents or staff due to the aggressive behavior of Resident #1. Stated that they are using the maintenance director in assisting with Resident #1 and having the maintenance director use bear hug physical restraints on Resident #1. Stated a bear hug restraint is coming from behind the resident and holding him from behind with his arms held in front of the resident to prevent him from hitting others. Stated that they are also using Zyprexa every 12 hours as needed (PRN) to calm Resident #1 down but the medication wears out about 8 hours after given. Stated that the facility is continuing to find another facility to take Resident #1 but is not having any luck. Observation on 9/21/22 at 11:55 a.m. of Resident #1 laying in bed awake and had no 1:1 supervision. DON notified and 1:1 was assigned. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 9/21/22 at 1:15 p.m. with Nurses Assistant A(NA), sitting in chair in Resident #1's room. Resident #1 was observed sleeping in his bed. NA A stated she has only worked here for 3 days and started at 6 a.m. today. Stated that she is Resident #1's 1:1 level of supervision right now and that she is aware of his physical aggression behaviors but is not afraid to work with him. During an interview on 9/21/22 at 1:50 p.m. with CNA A, stated she did not observe the incident with Resident #1 and Resident #3. Stated she was here for the incident with Resident #1 and Resident #11, and it was unprovoked, and Resident #1 started hitting and punching. CNA Sstated that she and LVN C intervened by trying to redirect Resident #1 and removing the residents he was targeting. CNA A Sstated that Resident #1 chases staff, and they try to redirect with snacks. Stated that Resident #1 is okay as long as he is in his bed but once he gets out of bed, they have issues. Stated that they check him every 2 hours if he is awake or not. Stated that if he is asleep, he is left alone in his room and checked on. CNA stated if he is awake, he is 1:1 level of supervision. During an interview on 9/21/22 at 2:13 p.m. with LVN C, stated that Resident #1 is being aggressive and attacking other residents or staff, they intervene by taking the other resident out of the situation. Stated that it's hard to redirect Resident #1 because it seems like he is focused on the behavior, so if he is moved away from a resident and sees someone in front of him, he will attack them. Stated she feels bad for Resident #1 because he is not aware of what he is doing. Stated there was an in-service on how to redirect him the other day. Stated that Resident #3 is scared of Resident #1 and stated the incident between them started when Resident #1 was reaching for something from the table where Resident #3 was. Stated Resident #3 started screaming and Resident #1 said, shut up bitch and pushed her. Stated she assessed Resident #3 and she had no injuries and was wearing her helmet at the time. LVN C stated Resident #1 swung at her as she was trying to call him away from Resident #3. Stated Resident #1 started chasing her and another CNA down the hall and she told the CNA to lock herself in a room until he forgot. Stated if Resident #1 is angered, it can take a few minutes before he calms down. Stated Resident #1 put Resident #10 in a headlock, and we had to get x-rays on her right arm, but she had no injuries. Stated families are being notified when these incidents happened. Stated she has personally done the notifications to family members via phone. Stated she is documenting the notifications in the progress notes in Point Click Care on the computer. During an observation on 9/21/22 at 2:15 p.m., Nurses assistant (NA) observed sitting in chair in Resident #1's room. NA had face resting on hand and asleep while Resident #1 was awake in bed. Nurse assistant did not acknowledge INV was in room and continued to sleep. DON notified. Interview and obse [TRUNCATED]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43849 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 medication/treatment cart (Medication/Treatment carts #1) reviewed for storage: The facility failed to ensure medication cart/treatment cart #1 was locked when unattended. This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm or drug diversions. Findings included: During an observation and interview with LVN A on 10/01/22 at 5:30 a.m. revealed upon following LVN A to the nurse's station, a medication/treatment cart behind the nurses' station was unlocked with no staff near the unlocked cart. The HHSC Investigator was able to open all drawers and observed prescribed medication ointments and creams in pharmacy labeled boxes and over counter medications. LVN A stated the medication/treatment cart was assigned to her and had prescription ointments and creams in pharmacy labeled boxes and over counter medications in the cart. LVN A stated it should have been locked but she forgot since she had been working in it. During an observation on 10/1/22 from 7:48 a.m. to 7:51 a.m. revealed a medication/treatment cart #1 near the nurses' station was observed unlocked with the push key lock not pushed in, with no staff in the area. The HHSC Investigator observed an unknown female kitchen staff exit the kitchen and asked the staff member to get the facility Administrator. During an interview and observation on 10/1/22 at 7:52 a.m. with the facility Administrator the HHSC Investigator showed the Administrator that the cart was unlocked and could be opened. The Administrator stated it was a treatment cart and did not have medications in it. The HHSC Investigator opened the top 2 drawers and showed the Administrator that there were prescribed medications in the cart. The Administrator stated the medications were prescribed medications, and the treatment cart should be locked at all times just like a medication cart. During an interview on 10/1/22 at 8:16 a.m. with LVN B stated she was assigned the medication/treatment cart #1 that is located near the nurses' station. LVN B stated the treatment cart has prescribed medications in it, including creams and ointments. LVN B stated the treatment cart was supposed to be locked because it has medications in it. LVN B stated she was assisting another resident who was yelling about getting his medications and she got flustered and forgot to lock the cart. LVN B stated the medication has to be locked due to safety and medication diversion. LVN B stated a resident could have gotten ahold of a medication in the treatment cart and ate the medication or put it on themselves. LVN B stated if the resident had a reaction or allergy to the medication, they would not know the resident consumed or used a medication from the treatment cart and the resident could get sick or have side effects. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Security of Medication Cart last revised April 2007 reflected the following: . Policy statement The medication cart shall be secured during medication passes Policy interpretation and Implementation 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 2. The medication cart should be parked in the doorway of the resident's room during the medication pass 3. When medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849 Based on observations, interviews and record reviews, the facility failed to maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for residents, staff, and visitors to the facility. The facility failed to ensure Resident #9 washed her hands after picking at her skin causing bleeding. The failure placed residents at risk for the development and spread of infection. Findings included: Record review of #9's face sheet dated 10/03/22 revealed a [AGE] year-old female admitted on to the facility 09/29/22 with diagnoses including the following: Autistic disorder (developmental abnormality in brain function), anxiety disorder, excoriation (skin-picking) disorder, intermittent explosive disorder (repeated sudden outbursts of anger), and intellectual disabilities. Record review of Resident #9's medical record revealed due to being admitted on [DATE] there was not a completed MDS or Care Plan. During an observation and interview on 10/2/22 at 3:54 p.m. with Resident #9 in the hallway outside of the DON's office revealed white forearm coverings on both forearms to have red and brown stains on them. Resident #9 reached out to touch Investigator's hand and arm and the Investigator observed brown and red staining on both hands and under the fingernails of both of Resident #9's hands. The Investigator notified the DON the resident has what appears to be blood on her fingers and under her nails. The DON handed the resident antibacterial wipes and told the resident to wipe her hands. The DON stated that Resident #9 picks at her skin and wears protective coverings on her arms to prevent her from picking her skin. DON stated that the facility needs to look into getting other protective coverings so the ones Resident #9 can be washed. During an observation on 10/3/22 at 9:10 a.m. revealed Resident #9 was sitting in her wheelchair in the dining room. Observed brown/red stains on Resident #9's white cloth arm sleeves and a clear bandage over a wound on her left arm pulled halfway off revealing a sore. Observed Resident #9's hands and fingernails soiled with red/brown stains as she reached out to grab the Investigator's hands. During an observation on 10/3/22 at 9:30 a.m. of Resident #9 in the hallway near the nurse's station revealed Resident #9 stated it was her birthday and reached out to touch the Investigator. The Investigator observed brown and red residue on the resident's fingertips and on her white sleeve coverings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675407	A. Building B. Wing	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ralls Nursing Home	1111 Avenue P Ralls, TX 79357

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/22 9:48 a.m. the ACT, stated Resident #9 has blood on her hands all the time and tries to reach out and hug. The ACT stated that Resident #9 picks at her skin and sores with her fingers leaving blood on her hands and the forearm cloth coverings. The ACT stated it is an infection control issue with Resident #9 having blood on her hands and touching others. The ACT stated she has not observed staff telling Resident #9 to wash her hands. Stated she has washed Resident #9's hands when she observes blood. The ACT stated that after she washes Resident #9's hands with wipes, she disposes of the wipes and then washes her hands with soap and water. Stated she has been trained on infection control and proper hand washing to prevent the spread of infection. During an interview on 10/3/22 at 3:56 p.m. the DON stated the facility has tried to find another placement for Resident #9. Stated Resident #9 has autism and constantly picks at her skin. The DON stated it is an infection control issue when Resident #9 has blood under her nails or on her hands and is touching others. Review of the facility's policy titled, Standard Precautions dated 2001, revised December 2007, reflected, Standard precautions will be used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intake skin and mucous membranes may contain transmissible infectious agents. -Standard precautions include the following practices: 1. Hand hygiene.: a. Refers to handwashing with soap OR alcohol-based hand rubs that do not require access to water. b. Hands shall be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such, and before eating and after using the restroom.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Report COVID19 data to residents and families. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43849 Based on interview and record review, the facility failed to inform residents, their representatives, and resident families by 5 p.m. the next calendar day following the occurrence of a confirmed facility staff infection of COVID-19 infections for the entire facility (Residents #1, #3, #4, #5, #11) of 5 residents reviewed for COVID-19 reporting notifications, in that: The facility failed to notify 5 of 5 residents, representatives, and/or families of each positive COVID-19 case in the facility by 5 p.m. the next business day after a positive COVID-19 test (Residents #1, #3,# 4, #5, #11). These failures could result in residents, families and responsible parties not being kept updated of the COVID-19 case status in the facility. The findings include: Record Review of the Provider Investigation Report, dated 09/20/2022 revealed the Contract Employee, contracted by the facility tested positive for COVID-19 on 9//12/22 upon arriving for her shift. Incident date listed as 9/13/22, all staff and residents were tested immediately. Record Review of an untitled document, dated 9/13/22, revealed the Contract staff tested positive on 9/13/22 via nasal swab and the test administrator was the DON. During an interview on 9/21/22 at 10:44 a.m., the DON stated the Social Worker was required to make notifications of COVID-19 positive staff or residents by 5 p.m. the next business day to residents, resident representatives, and family members. During an interview on 9/21/22 at 4:25 p.m., the DON stated the Social Worker made notifications of COVID-19 to family members and residents and documented it in the progress notes. The DON reviewed Resident #4's progress notes and stated there was no documentation that the family was notified of the positive COVID-19 staff member. The DON stated the progress notes should reflect the notifications to family members of COVID-19 positive staff and/or residents and any incidents involving residents. During an interview on 9/21/22 at 4:26 p.m., the SW stated she was not aware there had been a positive COVID-19 staff member, and no one notified her. The SW stated that she is normally notified by a text message that is sent out to everyone. The SW stated she never received notification. The SW stated if she would have been notified of the positive staff member, she would have notified all resident representatives and/or family members and documented it in the residents' progress notes. She stated it had to be done by the next day because we are required to make the notifications. During an interview on 9/21/22 at 4:30 p.m., the Registered Nurse Consultant stated all residents, resident representatives, and family members must be notified by 5 p.m. the next calendar day of any COVID-19 positive residents or staff members to keep them informed of current COVID-19 outbreaks in the facility. The Registered Nurse Consultant stated they followed the Nursing Facility COVID-19 response plan. (continued on next page)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/21/22 at 5 p.m., the Administrator(ADM) stated the Social Worker was supposed to notify the resident representatives and/or family members of positive COVID-19 resident or staff cases by 5 p. m. the next calendar day. The Administrator stated the social worker was notified via a mass text. The ADM stated she cannot find record of the Social Worker being notified of the text or that the text was sent out. Stated that notifications are to keep resident representatives/family members informed of current COVID-19 cases in the facility. Stated she cannot find a company policy regarding notifying of COVID-19. Stated the facility follows the current Nursing Facility COVID-19 response plan that directs the facility to inform by 5 p.m. the next calendar day and that response plan is included in their COVID-19 Response/Infection Control binder. Record Review of Resident #1's face sheet dated 9/21//22, revealed a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Hemiplegia and Hemiparesis following cerebral infarction affecting left dominant side, Unspecified Dementia-unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, Hyperlipidemia, Anxiety Disorder, Hypertension. Record Review of Resident #1's MDS dated [DATE] revealed no information or BIMS score completed. Record Review of Resident #3's face sheet dated 9/21/22, revealed a [AGE] year-old female resident admitted to the facility on [DATE] with the following diagnoses: Alzheimer's disease, Paranoid Schizophrenia, Seizures, generalized anxiety disorder, schizoaffective disorder, bi-polar type. Record Review of Resident #3's MDS dated [DATE] revealed a BIMS score of 11. Record Review of Resident #4's face sheet dated 9/21/22, revealed a [AGE] year-old male admitted to the facility on [DATE] with the following diagnosis: Hemiplegia and Hemiparesis following cerebral infarction affecting left dominant side, Type 2 diabetes, Intermittent explosive disorder. Record Review of Resident #4's MDS dated [DATE] revealed a BIMS score of 13. Record review of Resident #5's face sheet dated 09/21/22 revealed a [AGE] year-old male admitted on [DATE] with diagnoses including the following: history of traumatic brain injury (injury that changes how the brain works), muscle wasting and atrophy (breakdown of muscles), other recurrent depressive disorders (mental health illness causing prolonged sadness), and difficulty in walking. Record review of Resident #5's MDS dated [DATE] revealed a BIMS score of 15, indicating intact cognitive function. Record Review of Resident #11's face sheet dated 9/21/22, revealed an [AGE] year-old female resident admitted to the facility on [DATE] with the following diagnoses: Unspecified Dementia, Psychotic Disorder with Hallucinations, Impulse Disorder, Major Depressive Disorder, Essential(primary) Hypertension. Record Review of Resident #11's MDS dated [DATE] revealed a BIMS score of 00. Record review of Resident #1, #3, #4, #5, and #11's clinical records revealed no notifications of positive COVID-19 results were made on 9/12/22 or 9/13/22 to residents or family members. (continued on next page)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #1, #3, #4, #5, and #11's resident progress notes on 9/12/22 and 9/13/22, revealed that there was no documentation that the residents or their representatives were notified of COVID-19 positive staff members by 5 p.m. the next business day. Review of the facility's copy of COVID-19 Response for Nursing Facilities, Version 4.3 6/27/22 revealed that on pages 49-50 under section: Reporting COVID-19 instructs facilities CMS also requires NFs to keep all residents and their representatives up to date on the conditions inside the NF, such as when new cases of COVID-19 occur. Inform residents, their representatives, and families by 5 p.m. the next calendar day following the occurrence of a single confirmed infection of COVID-19. Provide updates weekly, or sooner, when there are new COVID-19 cases, or three or more residents or staff with new-onset of respiratory symptoms.