DEPARTMENT OF HEALTH CENTERS FOR MEDICARE (PRINTED:11/13/2018 FORM APPROVED OMB NO. 0938-0391
TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 455517	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/23/2017
AME OF PROVIDER OF SU	PPLIER	STREET ADDRES	S, CITY, STATE, ZIP
ARDENDALE REHABILII	TATION AND NURSING CENTR	ER 1521 E RUSK JACKSONVILLE	, TX 75766
or information on the nursing	home's plan to correct this deficient	cy, please contact the nursing home or the state survey	y agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIENCY MUST BE PF MATION)	RECEDED BY FULL REGULATORY
F 0224		d mistreatment, neglect and abuse of residents and	l theft
Level of harm - Immediate jeopardy	Based on observation, interview, a	S HAVE BEEN EDITED TO PROTECT CONFIDE and record review, the facility failed to implement their glect, and exploitation of residents and misappropriation	ir written policies and procedures
Residents Affected - Some	residents reviewed for neglect. (R 1. The facility did not implement i Resident #7 was hit repeatedly in by Resident #1 at least three time 2. The facility did not implement i #4 stabbed Resident #5's hand wi 4. The facility did not provide ade to walk to the convenience store, The facility did not provide supervision to ensure Res- perform safety assessments prior t implement interventions to protect implement the care plan to accomp prevent Resident #6 from leaving implement revised safety measure An Immediate Jeopardy situation remained out of compliance at a s minimal harm, due to the facility' These failures could place 20 resid Findings included: The Policy to Prohibit the Mistrea dated 12/2016, indicated each res the facility is doing all that is with	esident #s 1, 2, 3, 4, 5, 6, 7, and 8) nterventions to protect Resident #s 3 and 7, from bein the face by Resident #1 and sustained lacerations to to ts; being hit on the back of the head, shoved, and hit in nterventions to supervise and protect Resident #2 wh sive behaviors, and was displaying [MEDICAL CONI interventions to protect Resident #s 5 and 8 from being th an ink pen. Resident #4 was wrestling/grappling wi quate supervision for Resident #6, who had an unstead sometimes in the dark. ident #6's safety when he walked to a nearby convenied o allowing Resident #6 to leave unaccompanied; and supervise Resident #6 twhen he went to the store pany Resident #6 to the store;	ng hit and attacked by Resident #1. he face. Resident #3 was attacked the side of the head. en she injected herself with insulin, DITION]. g attacked by Resident #4. Resident th Resident #8. dy gait and hallucinations, was known ence store; ; huring Resident #6's walks to the store. I on 10/20/17; however, the facility with potential for more than ystems. re injury. propriation of Resident Property, y's purpose was to .assure that
	The most current care plan, dated 09/21/17, hit roommate; 09/30/17, hit another resident whil 10/01/17, pushed another resident 10/08/17, struck another resident. The interventions listed for the res aggression, and monitor every shi An Incident Report dated 09/21/17 repeatedly in the head. These resi	TE], indicated Resident #1 was severely cognitively 10/09/17, indicated Resident #1 had the following agg le walking past them; that was attempting to sit on couch; ident's aggressive behavior indicated providing one-o	ressive behaviors: n-one supervision as needed for it another resident (Resident #7) end of the secure unit hallway.
	hand, Resident #7 had lacerations During an interview on 10/11/17 a said at approximately 9:00 p.m., I the hall. He said he saw Resident were standing at the entrance to tl the door, and Resident #1 was hit up and saw what was happening, residents for injuries. He said Res		re unit on the evening of 09/21/17. He e looked up and saw movement down ere roommates at the time, and they the handrail in the hallway outside his LVN said as soon as he looked ated them, and began to assess both
	the resident to the secure unit. The most current MDS, dated [DA The most current care plan, dated behaviors.	TE], indicated Resident #7 had moderately impaired 09/08/17, indicated Resident #7 had impaired cognitiv dent #1 indicated on 09/25/17 at 10:00 a.m., resident y	ve function, wandered, and had verbal
	supervision per administration. The resident was kicking at the couch Resident #1 went into her persona kept approaching her, then reside one-to-one supervision, and behar A Nursing Progress Note for Resi Resident #1 was just walking by a started on one-to-one supervision An Incident Report dated 09/30/17 An Incident Report dated 09/30/17 resident (Resident #3) in the head	his entry was timed at 11:45 a.m., and further noted th where another resident was reclining, when the CNA al space and stated do you want me to hit you. The CN nt was distracted by another staff. The Nurse Practitio viors on this day. dent #1 indicated on 09/30/17 at 6:00 p.m., resident hi another resident and then hit the other resident in the b. 7, indicated Resident #1 hit Resident #3 in the head. T 7, indicated Resident #1 was placed on one-to-one sup	at a CNA informed this nurse that attempted to intervene and redirect, JA began stepping back and resident ner was notified of discontinued it another resident in the hallway. pack of the head. Resident #1 was 'here were no injuries noted. pervision due to hitting another
	09/30/17, going forward to 10/09/ An Incident Report dated 10/01/17 resident (Resident #3) came into t		a sleeping on the couch, when another ent #1 told Resident #3 to get up,

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.

Event ID: YL1011 Facility ID: 455517

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:11/13/2018 FORM APPROVED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTIO A. BUILDING B. WING	N	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 10/23/2017		
NAME OF PROVIDER OF SU	455517 PPLIER	ST	TREET ADDRESS, CITY, STA	ATE, ZIP		
GARDENDALE REHABILIT	TATION AND NURSING CENTI		21 E RUSK ACKSONVILLE, TX 75766			
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					
F 0224 Level of harm - Immediate jeopardy Residents Affected - Some	CNA B was providing one-to-one and CNA B was sitting on the arr loveseat as if to sit down, going b the floor. CNA A said Resident # During an interview on 10/10/17 supervision on the 6:00 a.m. to 2:	tt 10:08 a.m., CNA A said she was w supervision for Resident #1. She sa n of the other end of the loveseat. Re etween Resident #1 and CNA B. CN 1 seemed to be targeting Resident #3 tt 11:01 a.m., CNA B said she was as 00 p.m. shift on 10/01/17. She said s	id Resident #1 was standing at sident #3 came into the room a IA A said Resident #1 pushed I 3. signed to provide Resident #1 he did the best she could do, bu	one end of the loveseat nd stepped to the Resident #3, and he fell to with one-to-one at she was also		
	stay right with Resident #1. She s	e unit and sometimes other residents aid at one point on this shift they hea sident was stabbing another resident	ard a resident calling out, and si	he had to go down		
	The Nursing Progress Notes for R one-to-one supervision.	esident #1, dated 10/01/17 through 1	0/08/17, indicated resident con	tinued to recieve		
	it back from resident and resident made to family, nurse practitioner A Nursing Progress Note for Resid	dent #1 indicated on 10/05/17 at 4:35 stated you ain't f**king bad. Reside r, administrator, and ADON. dent #1 indicated on 10/05/17 at 10:1	nt was redirected by nurse and	notifications were		
	behaviors, and stayed with him. S facility at approximately 3:00 a.m informed CNA N and LVN F that	tt 11:01 a.m., CNA B said she transp the said the hospital would not keep a. the following morning. CNA B sai t the administrator said Resident #1 v	the resident, and she brought th d she brought the resident back	e resident back to the to the secure unit, and		
	facility. During an interview on 10/09/17 at 12:18 p.m., CNA N said she worked the 10:00 p.m. to 6:00 a.m. shift on the secure unit when CNA B brought Resident #1 back from the hospital at 3:00 a.m. on 10/05/17. She said CNA B informed her and LVN F that the administrator said Resident #1 was to be placed on one-to-one supervision, and then CNA B left. CNA N said she was the regular staff present on the secure unit at the time, and had other duties to take care of. She said she was unable to					
	During an interview on 10/17/17 a secure unit when CNA B brought was supposed to be one-to-one su for the remainder of that night be	or Resident #1 for the rest of that shi tt 6:09 a.m., LVN F said she was the Resident #1 back to the facility at 3: pervision, but she said they were un cause there was no one available to d	charge nurse for the 10:00 p.m :00 a.m., on 10/06/17. She said able to provide one-to-one supe lo it.	she knew the resident ervision for the resident		
	increased anxiety, staff in observa		· · · · ·			
	A Progress Note for Resident #1 indicated on 10/08/17 at 1:20 p.m., Resident #1 struck another resident on the left side of the face, when the two came in close contact with each other in the doorway of the dayroom. The noted indicated the staff intervened.					
	An Incident Report dated 10/08/17 at 1:30 p.m., indicated Resident #1 struck Resident #3 on the left side of his face. Resident #3 said that he got hit and stated that it hurt a little. The left side of the resident's face was slightly red. The resident was assessed and sent to the emergency room.					
	During an interview on 10/10/17 a the glass door of the secure unit a holding his face. She said Residee into the secure unit and there wer two CNAs came out of the showe During an interview on 10/09/17 a	tt 1:55 p.m., LVN C said she worked nd saw Resident #3's head fly to the tt #1 was right beside Resident #3, a e no staff present, anywhere. LVN C r room. She said Resident #1 was nc tt 10:44 a.m., the administrator said 1 g one-to-one supervision. She said 1	side. LVN C said Resident #3 nd she saw no staff anywhere. said she started attending to th to being supervised by anyone, Resident #1 hit another residen	bent over and was She immediately went le residents, and then when the incident occurred. t yesterday (10/08/17),		
	observation. Physician orders [REDACTED].# admit	3, admitted [DATE], was [AGE] yea	-			
	2. Physician orders [REDACTED included: [MEDICATION NAM injections per sliding scale based every day. There were no orders f	ATE], indicated Resident #3 had seve [.#2, admitted [DATE], was [AGE] 2 milligrams injected every 24 ho on blood sugar readings; and, insulir or self-administration of medication	years old with [DIAGNOSES F urs as needed for agitation; Hu a detemir solution 100 units per s.	EDACTED]. Medication orders malog solution insulin milligram 40 units		
	symptoms directed towards other towards others that occurred 1 to	ATE], indicated Resident #2 was moo s that occurred 1 to 3 days in seven d 3 days in seven days. sident #2 was dated 08/24/17. The ca	lays, and had verbal behavioral	symptoms directed		
	addressed potential to demonstrat when resident becomes agitated, . There were no indications on the	e physical behaviors in reference to l resident will be placed on one-to-on- e care plan that the resident self-adm	history of mental illness. Interv e supervision for resident safet	entions indicated y and safety of others		
	3:18 p.m., resident had been awak talking about leaving all day and 7:02 p.m., resident was yelling and busted the picture frame and was	esident #2, documented by LVN C, e all shift, went to church this morni knew the codes to the door. Resident d had thrown a glass pickle jar into ti yelling she wants her injection. Resi 'king talk to her or she will beat the	ng and was now back at facility t still on every 15 minute check he hallway and busted, ran into dent was yelling at nurse, sayir	y, resident had been s. another room and g she hates her,		
	ADON, and resident remained on 7:16 p.m., resident received 1 mill harm herself or others) were bein nurse and she could not find a km	every 15 minute checks. iliter of [MEDICATION NAME] in g removed out of her room. Resident ife so she busted a pickle jar so she c	jection, resident things (anythin said she went in her room to g	ng that she could use to et a knife to stab the		
	hang herself with the call light bu	the floor saying she was about to del tton, saying that it is the voices in he she needed to kill herself. Resident	er head going off. The resident	was saying she		
	7:30 p.m., resident said she gave h This nurse was not aware of how notified.	erself insulin, and gave the insulin p much insulin the resident gave herse	elf, but there was a CNA who w	vitnessed it. 911 was		
	During an interview on 10/10/17 a resident knew the codes to the faa sometimes when she would go to grounds just walking around, so t and a picture frame and was three her on one-on-one supervision, b situation. LVN C said CNA P wa her belongings, placed a needle in to wrap a call cord around her net anything with her because it is no	tt 1:55 p.m., LVN C said on 10/01/1' ility exit doors. She said Resident #' check on her, she could not find her he resident knew how to get out of th tening to cut her. She said she report the every 15 minute checks with Re ccause Resident #1 was already on or s trying to watch out for Resident #2 it, dialed it to about 50, and injectec k. LVN C said she called the police t against the law to have a mental ill	2 was placed on every 15 minu . She said she would find Resic he building. LVN C said Residk ted Resident #2's behaviors to t sident #2 because they did not ne-on-one supervision. LVN C when the resident took a prelo d herself. CNA P also reported and ambulance, but the police ness. She said the police were I	te checks, and lent #2 on the outside mt #2 broke a pickle jar he ADON and DON. She have enough staff to put said it was a frightening aded insulin pen out of the resident tried said they would not do eaving the		
	tacility, when Resident #2 got a n	netal rod and was trying to attack her	with it. LVN C said the police	heard the noise and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				PRINTED:11/13/2018 FORM APPROVED OMB NO. 0938-0391
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	455517			
NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP				
GARDENDALE REHABILITATION AND NURSING CENTER 1521 E RUSK JACKSONVILLE, TX 75766				
For information on the nursing l	nome's plan to correct this deficien	cy, please contact the nursing hor	ne 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)			FULL REGULATORY	

F 0224	(continued from page 2)
Level of harm - Immediate jeopardy	came back, and they got Resident #2 to settle down. LVN C said the facility staff took the resident to the hospital, and the administrator said someone had to go and stay with the resident at the hospital. LVN C said Resident #2 got the pickle jar and the insulin pen from her personal belongings in her room.
Residents Affected - Some	During an interview on 10/11/17 at 9:51 a.m., LVN L said when Resident #2 crashed the pickle jar on the floor, she became a threat to self and others and should have been placed on one-on-one supervision. She also said that anytime a resident exhibited [MEDICAL CONDITION] they should be placed on one-to-one supervision. LVN L said the DON was terminated during the
	previous week. A Nursing Progress Note for Resident #2, dated 10/01/17 at 11:26 p.m., indicated the resident was still at the hospital. This was the last entry in the progress notes, with no indication that the resident returned to the facility.
	3. Physician orders [REDACTED].#4, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. There were orders to admit the resident to the secured unit.
	The Care Plan dated 07/24/17 for Resident #4, indicated the resident had potential for physically intrusive behavior towards staff and other residents, may pinch/scratch/hit at staff and/or residents attempting to get what she wants or sees, she is difficult to re-direct at times. Interventions for behaviors included: monitor every shift and PRN, separate resident if she becomes intrusive, separate resident when behavior escalates to prevent injury. The care plan indicated the following dates of incidents of physical aggression: 04/08/17, patient to patient grabbing;
	05/25/17, grabbing glasses off another resident; 06/02/17, grabbing at another resident, attempting to punch at resident; 06/20/17, hitting and scratching another resident over a cup of coffee;
	06/30/17, grabbing another resident's arm and attempting to pull them off toilet; 06/30/17, resident intrusive towards others; 08/02/17, pushed another resident down in hall;
	08/16/17, grabbed another resident; and, 09/18/17, grabbed object from another resident. The most current MDS, dated [DATE], indicated Resident #4 had severely impaired cognitive skills, physical behaviors
	directed towards others 1 to 3 days per seven days, and physical behaviors not directed towards others 4 to 6 days per seven days. An incident report dated 10/01/17 at 10:30 p.m., indicated staff heard loud talking coming from down the hall, and saw
	Resident #s 4 and 5 standing very close to each other in front of room in hallway. LVN Q went to assess incident and found Resident #4 had an ink pen and was writing on Resident #5's hand. There was no apparent injury noted. A Nursing Progress Note (per LVN Q) for Resident #4 dated on 10/01/17 at 10:32 p.m., indicated staff heard loud talking coming from down the hall, looked up and saw this resident and another resident standing very close to each other in front of room in hallway. LVN Q went to assess incident to find that Resident #4 was writing on the other resident's left hand.
	Residents were separated and redirected. During an interview on 10/10/17 at 11:01 a.m., CNA B she worked the 6:00 a.m. to 2:00 p.m. shift, on the secured unit on 10/01/17. She said she heard yelling down the hall and she ran to the residents. She said it was Resident #s 4 and 5. CNA B said Resident #4 had an ink pen in her hand, and she was stabbing Resident #5's hand with it. She said the resident had red marks on the top of her hand from the pressure of the pen, but the skin was not broken. CNA B said she intervened and
	notified the nurse. During an interview on 10/10/17 at 1:01 p.m., CNA A said she worked on the secured unit on 10/01/17. She said she and CNA B heard residents yelling down the hall and they found Resident #4 had an ink pen and was stabbing Resident #5's hand with it. She said Resident #5 had harsh, red pressure point areas on her hand where the other resident had been stabbing her with the pen, but there was no broken skin. She said Resident #4 is intrusive with the other residents, tries to take
	things from other residents, and frequently was an ink pen. Physician orders [REDACTED].#5, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. There were orders to admit
	the resident to the secure unit. The most current MDS, dated [DATE], indicated Resident #5 had severely impaired cognitive skills for daily decision making. The most current care plan, dated 07/14/17, indicated Resident #5 had [MEDICAL CONDITION] or acute confusional episodes, wandered, and had physical aggression at times.
	An Incident Report dated 10/03/17 at 9:15 a.m., indicated Resident #4 was tusseling with Resident #8 inside Resident #8's room. Staff intervened and no injuries were noted. The Incident Report indicated no notifications were listed. During an interview on 10/10/17 at 9:40 a.m., LVN O said she witnessed Resident #s 4 and 8, 'tusseling'. She said the residents were standing facing each other, each was holding the others forearms, and they were grappling with each other.
	She said she intervened and separated the residents. During an interview on 10/10/17 at 9:40 a.m., LVN O said she witnessed Resident #s 4 and 8, 'tusseling.' She said the residents were standing facing each other, each was holding the others forearms, and they were grappling with each other. She said she intervened and separated the residents, and there were no injuries. 4. Physician orders [REDACTED].#6, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. The orders
	indicated the physician had reviewed and approved the resident's plan of care. The resident had orders for routine medications that included: [MEDICATION NAME] 250 milligrams (for paranoid [MEDICAL CONDITION]); klonopin 0.5 milligrams (for paranoid [MEDICAL CONDITION]); [MEDICATION NAME] 80 milligrams (for [MEDICAL CONDITION]); [MEDICATION NAME]-
	hydrocholrothiazide 20-12.5 milligrams (for hypertension); [MEDICATION NAME] 25 milligrams (for hypertension); and, [MEDICATION NAME] 5020
	milligrams (for diabetes). A care plan for Resident #6, dated 05/13/17, indicated the resident was non-compliant with having staff accompany him to walk to local convenience store and often went without letting staff know and was at risk for injury. The goal indicated Resident #6 would not leave the facility unattended through the next review date. The interventions included re-instruct resident of facility's requirement that he must be accompanied to go off premises in language he could understand. The care plan also addressed Resident #6 had a communication problem and had auditory hallucinations. (this care plan item was
	initiated on 06/04/13) The most current MDS dated [DATE], indicated Resident #6 was cognitively intact and had behavioral symptoms not directed toward others for 1 to 3 days per seven days. The assessment indicated Resident #6 rejected evaluation or care that is necessary to achieve the resident's goals for health and well-being 1 to 3 days per seven days. The Fall Risk Evaluation for Resident #6, dated 07/19/17, indicated the resident was a moderate fall risk and had experienced 1 to 2 falls in the past six months. Resident #6 strays off the straight path of walking, and uses short
	discontinuous steps and/or shuffling steps. The evaluation indicated Resident #6 took medications that included anti-hypertensive, benzodiazepine, and narcotics more than three times a week. Resident #6 had agitated behavior that occurred less than daily in the last seven days. The Wandering Risk Assessment for Resident #6 dated 07/19/17, indicated the following:
	forgetful/short attention span; exhibits/expresses fear and/or anxiety; disturbed by environmental noise levels; experiencing feelings of anger/fear of abandonment;
	medications include antipsychotics, antidepressants, anti-anxiety/hypnotics, and narcotics; and, moderate risk for wandering. The most current care plan for Resident #6, dated 08/10/17, indicated the resident was non-compliant with having staff accompany him to walk to local convenience store and often goes without letting staff know and was at risk for injury. The
	goal indicated the resident would not leave the facility inattended through the next review date. The interventions included re-instruct resident of facility's requirement that he must be accompanied to go off premises in language he can understand. Additional areas addressed on the care plan were: resident had exhibited episodes of non-compliance with maladaptive behaviors; resident had impaired cognitive function/dementia or impaired thought processes reference to impaired decision making;
	resident had [MEDICAL CONDITION] or acute confusional episodes;
FORM CMS-2567(02-99) Previous Versions Obsolete	Event ID: YL1011 Facility ID: 455517 If continuation sheet Page 3 of 8

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NAME OF PROVIDER OF SU	455517 PPLIER	STREET ADDI	RESS, CITY, STATE, ZIP
	CATION AND NURSING CENT		, , ,
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state su	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	EFICIENCIES (EACH DEFICIENCY MUST BI AATION)	E PRECEDED BY FULL REGULATORY
F 0224	(continued from page 3)	,	02(04/12)
Level of harm - Immediate	resident had a behavior problem re-	blem and had auditory hallucinations (initiated on ference to episodes of yelling at delusions; blood supers:	06/04/13);
jeopardy Residents Affected - Some	resident had potential for unstable resident had the potential for falls reference to confusion;	reference to [MEDICAL CONDITION] with left-	sided weakness, continues at risk for falls
Residents Affected - Some	resident had potential for safety ha resident used [MEDICAL COND]		
	An RN had reviewed this resident During an observation on 10/16/17 approximately one fifth of a mile had two sharp curves. There was There were no speed limit signs C visible from the facility, nor was During an interview on 10/16/17 a Resident #6. She said about a wee himself. CNA I said she did not r before 6:00 a.m., and she saw the reported this to the charge nurse. She said Resident #6 sometimes to During an interview on 10/16/17 a went to the store by himself. She said Resident #6 had been remind did not report this to anyone else, almost running over the resident a behaviors of yelling at someone i During an interview on 10/16/17 a Resident #6. She said Resident #6 convenience store out on the high the convenience store by himself, know if he was allowed to go to t driving down the driveway of the #6 was walking in the driveway of the tornymed the charge nurse of whe During an interview on 10/16/17 a Resident #6. She said Resident #4 though she has counseled him n During an interview on 10/16/17 a Resident #6. She said Resident #4 but when he headed for the front going from the store, when she w said Resident #6 had an unsteady were not there. LVN K said Resid numerous times to tell them wher During an interview on 10/16/17 a s a superior authority above everyo and lighter he purchased at the sta authority status and say that he w and has conversations with a pers wander guard system and no list of	s plan of care. <i>i</i> at 11:40 a.m., the facility was completely surrou down a driveway from a main four lane highway, a convenience store at the corner of the facility's d n the driveway, and the driveway had multiple po he facility visible from the convenience store. t 12:43 p.m., CNA I said she worked the 6:00 a.m. k ago at approximately 11:00 a.m. she saw the re- sport this to anyone. She said about a month ago s resident going to the store by himself. She said sh CNA I said the nurse told her she would talk to th alked and yelled in his room, but there was no one t 1:11 p.m., LVN G said about a month ago the said when he got back she talked to him about not de numerous times to tell staff before he left the E but had reported past occurrences to the DON. L' 11 the time, because he walked in the middle of th h his room, but there was no one there. t 1:52 p.m., CNA D said she worked the 6:00 a.m. is ambulated independently, but had an unsteady gr way at the end of the facility driveway opened at. She said she had never received any training conno the store by himself or not. CNA D said approximately facility coming to work at approximately 5:30 a.r. y himself. She said the resident was at the edge of right at the resident before she saw him. She said of her vehicle, and she almost hit him. CNA D said re the resident twas. t 2:23 p.m., CNA J said she worked the 10:00 p.n. thift, Resident #6 went back and forth for coffee, a d forth to the store by himself. She said sometimes to not there. She said the resident leaves and goes I umerous times to tell them when he is leaving. t 2:23 p.m., LVN K said she worked the 2:00 p.m. thift, Resident #6 went back and forth for coffee, a d forth to the store by himself. She said sometimes to uthere. She said the resident Baes and goes I umerous times to tell them when he is leaving. t 2:37 p.m., LVN K said she worked the 2:00 p.m. there she said the resident leaves and goes I umerous times to tell them when he is leaving. t 2:37 p.m.	The driveway was wooded on each side and hriveway and the four lane highway. tholes. The convenience store was not 1. to 2:00 p.m. shift, and provided care for sident go to the store and back by she was coming to work, and it was just the came on to the facility, and the resident about it when he got back. e else in the room. aff made her aware that Resident #6 had t signing out prior to leaving. LVN G building, but he would not. She said she VN G said the night staff talked about the driveway. She said Resident #6 had t. to 2:00 p.m. shift and provided care for ait and staggered at times. CNA D said the 5:00 a.m. She said Resident #6 goes to cerning Resident #6's care and did not ately seven to eight days ago, she was m. She said it was still dark and Resident f the facility's driveway. CNA D said the Resident #6's care and did not ately seven to eight days ago, she was m. She said it was still dark and Resident f the facility's driveway. CNA D said the f the facility's driveway. CNA D said the f the facility and n. to 6:00 a.m. shift, and provided care for and out to the patio. CNA J said as far s you can hear him yelling in his room to the store without telling anyone, a. to 10:00 p.m. shift, and provided care for at went for smoke breaks, and coffee, es she had seen the resident coming or d these situations scared her. LVN K lls and talked to people in his room that nyone, although she has counseled him 5 go to the store during the day by himself oor. She said she did not feel it was the resident had delusions that he was the gresident #6 to retrive the cigarettes scribed himself as having superior to get him. She said Resident #6 yells nours. LVN L said the facility had no msupervised.
F 0323	supervision to prevent avoidabl		•
Level of harm - Immediate jeopardy	Based on observation, interview, a and interventions to prevent accid	S HAVE BEEN EDITED TO PROTECT CONFI nd record review, the facility failed to ensure resi ents for 8 of 8 residents reviewed for supervision.	dents received adequate supervision
Residents Affected - Some	Resident #7 was hit repeatedly in by Resident #1 at least three time 2. The facility did not implement i was displaying physically aggress 3. The facility did not implement i #4 stabbed Resident #5's hand wi 4. The facility did not provide ade to walk to the convenience store, The facility did not: provide supervision to ensure Res perform safety assessments prior t implement interventions to protect implement the care plan to accomprevent Resident #6 from leaving implement revised safety measure Resident #6's walks to the store. An Immediate Jeopardy situation remained out of compliance at a s minimal harm, due to the facility? These failures could place 20 resit Findings included: 1. Physician orders [REDACTED to admit the resident to the secure un The most current MDS, dated [D4]	dent #6's safety when he walked to a nearby conv o allowing Resident #6 to leave unaccompanied; and supervise Resident #6 when he went to the sr oany Resident #6 to the store; alone in the dark; s when staff became aware of near-missed accider was identified on 10/11/17. While the IJ was remo cope of pattern and a severity level of no actual he s need to evaluate the effectiveness of the correcti lents with behavioral healthcare needs at risk for s 1,#1, admitted [DATE], was [AGE] years old with hit. TE], indicated Resident #1 was severely cognitiv 10/09/17, indicated Resident #1 had the following	to the face. Resident #3 was attacked it in the side of the head. when she injected herself with insulin, ons. being attacked by Resident #4. Resident g with Resident #8. steady gait and hallucinations, was known renience store; tore; tore; mts during oved on 10/20/17; however, the facility arm with potential for more than ve systems. severe injury. a [DIAGNOSES REDACTED]. There were orders rely impaired, and had no physical behaviors.
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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:11/13/2018 FORM APPROVED OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 455517	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/23/2017			
AME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP ARDENDALE REHABILITATION AND NURSING CENTER JACKSONVILLE, TX 75766						
For information on the nursing (X4) ID PREFIX TAG	SUMMARY STATEMENT OF D	cy, please contact the nursing home or the state survey agency. EFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED				
F 0323	OR LSC IDENTIFYING INFORM (continued from page 4)					
Level of harm - Immediate jeopardy	10/08/17, struck another resident. The interventions listed for the res	that was attempting to sit on couch; ident's aggressive behavior indicated providing one-on-one supe	rvision as needed for			
	 10/08/17, struck another resident. The interventions listed for the ress aggression, and monitor every shi An Incident Report dated 09/21/17 repeatedly in the head. These resis Staff provided immediate interven hand, Resident #7 had lacerations During an interview on 10/11/17 a side at approximately 9:00 p.m., It the hall. He said he saw Resident were standing at the entrance to It the door, and Resident #1 was hit up and saw what was happening, residents for injuries. He said Res Physician orders [REDACTED].# admit the resident to the secure unit. The most current MDS, dated [DAThe most current dated 09/30/17]. An Incident Report dated 09/30/17] an incident Report dated 10/10/17] as upervision on the 6:00 a.m. to 2: working regular duty on the secure stay right with Resident #1]. She sthe hall to interview on 10/10/17] as upervision on the 6:00 a.m. to 2: working regular duty on the secure stay right wi	ident's aggressive behavior indicated providing one-on-one supe ft. 7 at 9:55 p.m., indicated staff witnessed Resident #1 hit another r dents were at the entrance of their shared room, at the end of the titon, made notifications, and assessed for injuries. Resident #1 I to the face. t 2:27 p.m., LVN M said he was working on the secure unit on t ie was at the nursing station for the secure unit, and he looked up at hitting Resident #7. He said these two residents were roomm- neir room. LVN M said Resident #7 was holding onto the handra- ting Resident #7 in his face, repeatedly with his fist. This LVN s he immediately ran straight to the residents and separated them, ident #1 was placed on one-to-one supervision. 7, admitted [DATE], was [AGE] years old with [DIAGNOSES I with [DIATE], was [AGE] years old with [DIAGNOSES I with a subsect on 09/25/17 at 10:00 a.m., resident was remove is entry was timed at 11:45 a.m., and further noted that a CNA i where another resident was reclining, when the CNA attempted al space and stated do you want me to hit you. The CNA began su- twas distracted by another staff. The Nurse Practitioner was no viors on this day. Lent #1 indicated on 09/30/17 at 6:00 p.m., resident hit another r unother resident and then hit the other resident in the back of the 7, indicated Resident #1 hit Resident #3 in the head. There were t 7, indicated Resident #1 was placed on one-to-one supervision d 1, indicated Resident #1 was placed on one-to-one supervision d 1, indicated Resident #1. She said Resident #1 was standing o the day room and was going to sit at the couch. Resident #1 tother 10:08 a.m., CNA A said she was warking on the secure unit on 10 was tho 10/01/17. She said Resident #1 was attanding of the other end of the loveseat. Resident #3 came into the roor etween Resident #1 and CNA B. Suid Resident #1 was standing of the other end of the loveseat. Resident #3 came into the roor etween Resident #1 and CNA B. Suid Resident #1 was tanding out an sometimes other resident sneeded her attention.	esident (Resident #7) secure unit hallway. had lacerations to his he evening of 09/21/17. He band saw movement down ates at the time, and they il in the hallway outside aid as soon as he looked and began to assess both REDACTED]. There were orders to kills for daily decision making. , wandered, and had verbal ed from one-to-one nformed this nurse that to intervene and redirect, tepping back and resident tified of discontinued esident in the hallway. head. Resident #1 was no injuries noted. te to hitting another vision continually starting on in the couch, when another Resident #3 to get up, the morning of 10/01/17 and at one end of the loveseat in and stepped to the d Resident #3, and he fell to #1 with one-to-one but she was also B said she could not always d she had to go down en, leaving Resident #1 continued to recieve and from CNA, then CNA took and notifications were orted to the hospital for pital on [DATE] for the resident back to the tack to the secure unit. B informed her and LVN F that ff. CNA N said she was the e was unable to to m. to 6:00 a.m. on the uid she knew the resident upervision for the resident unding in place, displaying dident on the left side of noted indicated the staff ff side of his face. s slightly red. 7. She said she walked up to 45 bent over and was e. She immediately went othe residents, and then e, when the incident occurred.			
	observation. Physician orders [REDACTED].# admit the resident to the secure unit. The most current MDS, dated [DA 2. Physician orders [REDACTED included: Ativan 2 milligrams inj sliding scale based on blood suga There were no orders for self-adm	ng one-to-one supervision. She said they had increased the reside 3, admitted [DATE], was [AGE] years old with [DIAGNOSES H TE], indicated Resident #3 had severely impaired cognitive skil [#2, admitted [DATE], was [AGE] years old with [DIAGNOSE] ected every 24 hours as needed for agitation; Humalog solution i r readings; and, insulin detemir solution 100 units per milligram inistration of medications. TE], indicated Resident #2 was moderately cognitively impaired	REDACTED]. There were orders to ls, and no behavior issues. S REDACTED]. Medication orders nsulin injections per 40 units every day.			
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STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY DEFICIENCIES / CLIA A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF IDENNTIFICATION B. WING 10/23/2017 10/23/2017 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP	EPARTMENT OF HEALTH ENTERS FOR MEDICARE &				PRINTED:11/13/2018 FORM APPROVED
NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GARDENDALE REHABILITATION AND NURSING CENTER 1521 E RUSK For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. 1521 E RUSK (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR' OR LSC IDENTIFYING INFORMATION) F 0323 (continued from page 5) jsopardy (continued from page 5) Residents Affected - Some (continued comes agitated, resident #2 was dated 08/24/17. The care plan was updated on 09/30/17 and 10/02/17, and addressed potential to demonstrate physical behaviors in reference to history of mental illness. Interventions indicated or when resident becomes agitated, resident will be placed on one-to-one supervision for resident safety and safety of others suicidal ideations. The wors progress Notes for Resident #2, documented by LVN C, on 10/01/17, indicated the following:	EFICIENCIES ND PLAN OF	Ì CLIA IDENNTIFICATION NUMBER	A. BUILDING		COMPLETED
JACKSONVILLE, TX 75766 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 REGULATOR' OR LSC IDENTIFYING INFORMATION) F 0323 (continued from page 5) symptoms directed towards others that occurred 1 to 3 days in seven days, and had verbal behavioral symptoms directed towards others that occurred 1 to 3 days in seven days. The most current care plan for Resident #2 was dated 08/24/17. The care plan was updated on 09/30/17 and 10/02/17, and addressed potential to demonstrate physical behaviors in reference to history of mental illness. Interventions indicated when resident becomes agitated, resident will be placed on one-to-one supervision for resident safety and safety of others There were no indications on the care plan that the resident self-administered medications, nor any indication of suicidal ideations. The Nursing Progress Notes for Resident #2, documented by LVN C, on 10/01/17, indicated the following:	ME OF PROVIDER OF SUP		STREE	T ADDRESS, CITY, STA	ATE, ZIP
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR' OR LSC IDENTIFYING INFORMATION) F 0323 (continued from page 5) symptoms directed towards others that occurred 1 to 3 days in seven days, and had verbal behavioral symptoms directed towards others that occurred 1 to 3 days in seven days. The most current care plan for Resident #2 was dated 08/24/17. The care plan was updated on 09/30/17 and 10/02/17, and addressed potential to demonstrate physical behaviors in reference to history of mental illness. Interventions indicated .when resident becomes agitated, resident will be placed on one-to-one supervision for resident safety and safety of others . There were no indications on the care plan that the resident self-administered medications, nor any indication of suicidal ideations. The Nursing Progress Notes for Resident #2, documented by LVN C, on 10/01/17, indicated the following:	ARDENDALE REHABILIT	ATION AND NURSING CENTE			
OR LSC IDENTIFYING INFORMATION) F 0323 (continued from page 5) symptoms directed towards others that occurred 1 to 3 days in seven days, and had verbal behavioral symptoms directed towards others that occurred 1 to 3 days in seven days. The most current care plan for Resident #2 was dated 08/24/17. The care plan was updated on 09/30/17 and 10/02/17, and addressed potential to demonstrate physical behaviors in reference to history of mental illness. Interventions indicated .when resident becomes agitated, resident will be placed on one-to-one supervision for resident safety and safety of others . There were no indications on the care plan that the resident self-administered medications, nor any indication of suicidal ideations. The Nursing Progress Notes for Resident #2, documented by LVN C, on 10/01/17, indicated the following:					Y FULL REGULATORY
Level of harm - Immediate jeopardysymptoms directed towards others that occurred 1 to 3 days in seven days, and had verbal behavioral symptoms directed towards others that occurred 1 to 3 days in seven days. The most current care plan for Resident #2 was dated 08/24/17. The care plan was updated on 09/30/17 and 10/02/17, and addressed potential to demonstrate physical behaviors in reference to history of mental illness. Interventions indicated . when resident becomes agitated, resident will be placed on one-to-one supervision for resident safety and safety of others suicidal ideations. The were no indications on the care plan that the resident self-administered medications, nor any indication of suicidal ideations. The Nursing Progress Notes for Resident #2, documented by LVN C, on 10/01/17, indicated the following:	· ·	OR LSC IDENTIFYING INFORM			
 cilling about levening all day and have with codes to be done. Resident will on every 15 minure checks. 7.92 p.m. resident way sylling all on ditrovas at gains pickie jurino the hallway and baseling, fan into another room and baseling the picture frame and way sylling all on an event of the minure checks. 7.16 p.m., resident reserved 11 militation of Avran injection, resident things (anyting that she could not so how the minure checks. 7.16 p.m., resident way sylling in the advance of the picture of Avran injection, resident things (anyting that she could not so how the minure checks. 7.16 p.m., resident way sylling in the advance of the advance of the picture of the advance of the picture of the picture of the advance of the board of the picture of the advance of the picture of the pi	F 0323 Level of harm - Immediate jeopardy	OR LSC IDENTIFYING INFORM (continued from page 5) symptoms directed towards other: towards others that occurred 1 to The most current care plan for Res addressed potential to demonstrat when resident becomes agitated, . There were no indications on the suicidal ideations. The Nursing Progress Notes for R. 3:18 p.m., resident had been awak talking about leaving all day and 1 7:02 p.m., resident remained on 7:16 p.m., resident remained on 7:16 p.m., resident received 1 mill or others) were being removed ou could not find a knife so she busts receiving her requested injection. 7:27 p.m., resident was legave h not aware of how much insulin th During an interview on 10/10/17 a resident knew the codes to the fac sometimes when she would go to grounds just walking around, so the situation. LVN C said CNA P was her belongings, placed a needle in to wrap a call cord around her need anything with her because it is no facility, when Resident #2 got an came back, and they got Resident the administrator said someone ha jar and the insulin pen from her p During an interview on 10/11/17 a threat to self and others and shoul exhibited suicidal ideations they s previous week. A Nursing Progress Note for Resid This was the last entry in the prog 3. Physician orders [REDACTED to admit the resident to the secured a threat to self and others and shoul exhibited suicidal ideations they s previous week. A Nursing Progress Note for Resid This was the last entry in the prog 3. Physician orders [REDACTED to admit the resident to the secured a the care Plan dated 07/24/17 for i staff and other resident, may pind difficult to re-direct at times. Inter she becomes intrusive, separate re do(30/17, grabbing another resident 08/02/17, grabbing another resident 08/02/17, grabbing another resident 09/18/17, patient to patient grabbi 05/25/17, grabbing another resident 06/30/17, resident so the so to things from other secure unit. The most current MDS, dated [DA directed towards others 1 to 3 day seven days. An Incident report dated 10/01/17	MATION) s that occurred 1 to 3 days in seven days, 3 days in seven days. sident #2 was dated 08/24/17. The care pl te physical behaviors in reference to histor resident will be placed on one-to-one sup e care plan that the resident self-administe esident #2, documented by LVN C, on 10 te all shift, went to church this morning an knew the codes to the door. Resident still d had thrown a glass pickle jar into the ha yelling she wants her injection. Resident 'king talk to her or she will beat the nurse tevery 15 minute checks. liliter of Ativan injection, resident things (to fher room. Resident said she went in f ed a pickle jar so she could use the glass j. the floor saying she was about to deliver a toom. Resident said she went in f ed a pickle jar so she could use the glass j. the floor saying she was about to deliver a toom, asying that it is the voices in her hea t she needed to kill herself. Resident now herself insulin, and gave the insulin pen to the resident gave herself, but three was a Ci at 1:55 p.m., LVN C said on 10/01/17, Re- ility exit doors. She said Resident #2 was check on her, she could not find her. She her esvigent y15 minute checks with Resider ecause Resident #1 was already on one-on- s trying to watch out for Resident #2 whe resck. LVN C said she called the police and a t against the law to have a mental illness. thet al to go and stay with the resident at the for- sck. LVN C said she called the police and a t against the law to have a mental illness. the avery 15 minute checks with Resident exoans belongings in her room. at 9:51 a.m., LVN L said when Resident # tha have been placed on one-on-one supervision dent #2, dated 10/01/17 at 11:26 p.m., ind press notes, with no indication that the ress].#4, admitted [DATE], was [AGE] years unit. Resident #4, indicated the resident had po ch/scratch/hit at staff and/or residents atter rventions for behaviors included: monitor esident when behavior escalates to preven ression: ng; other resident.	and had verbal behavioral an was updated on 09/30/ y of mental illness. Interv revision for resident safet red medications, nor any /01/17, indicated the folk dwas now back at facility on every 15 minute check (lawy and busted, ran into was yelling at nurse, sayin s' ass. This nurse notified (anything that she could u her room to get a knife to : a rat to cut the nurse because (anything that she could u her room to get a knife to : a to cut the nurse because (anything that she could u her room to get a knife to : pare to cut the nurse because (anything that she could u her room to get a knife to : placed on every 15 minu sid she would find Resic ilding. LVN C said Resid (angthe would find Resic ilding. LVN C said Resid (lay be haviors to 1 the 2 because they did not hone supervision. LVN C for solf. CNA P also reported ambulance, but the police ystaff took the resident to cospital. LVN C said the poloc ystaff took the resident to cospital. LVN C said the poloc ystaff took the resident to cospital. LVN C said the poloc ystaff took the resident to cospital. LVN C said the poloc ystaff took the resident to cospital. LVN C said the poloc ystaff took the resident to cospital. LVN C said the DON v iccated the resident was sti ident returned to the facili old with [DIAGNOSES F tential for physically intru- mpting to get what she wa every shift and PRN, sep t injury. The care plan ind with she said the towards other alking coming from dowr llway. LVN Q went to as to 30 apparent injury not out 10:32 p.m., indicated sta it, be said it was Residen the secured unit on 10/01/ k pen and was stabbing R ere the other resident had i with the other resident had e with the other resident fac ium or acute confusional of tusseling with Resident #% icated no notifications we esident #4 and 8, 'tusseli arms, and they were grap	I symptoms directed 17 and 10/02/17, and zentions indicated y and safety of others indication of owing: y, resident had been (s. o another room and ng she hates her, the DON and se to harm herself stab the nurse and she e she was not g. Resident tried to was saying she n and the DON, ADON, ntus. This nurse was was notified. t leaving all day, and the te checks, and ten #2 on the outside ent #2 broke a pickle jar the ADON and DON. She have enough staff to put said it was a frightening vaded insulin pen out of the resident tried said they would not do leaving the e heard the noise and o the hospital, and dent #2 go the pickle in the floor, she became a nytime a resident was terminated during the ill at the hospital. ity. REDACTED]. There were orders asive behavior towards ants or sees, she is arate resident if licated the following physical behaviors rs 4 to 6 days per in the hall, and saw sess incident and found ted. iff heard loud talking to each other in front resident #5's hand with been stabing her the stabing her tries to take DACTED]. There were orders to for daily decision making. episodes, wandered, and S inside Resident #8's re listed. ing'. She said the pluing with each other.

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			F	RINTED:11/13/2018 ORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 455517	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X CC	(3) DATE SURVEY DMPLETED (23/2017
NAME OF PROVIDER OF SU	PPLIER		ADDRESS, CITY, STATI	E, ZIP
GARDENDALE REHABILI	FATION AND NURSING CENTI		RUSK ONVILLE, TX 75766	
For information on the nursing (X4) ID PREFIX TAG		cy, please contact the nursing home or the DEFICIENCIES (EACH DEFICIENCY M		THE RECHLATORY
	OR LSC IDENTIFYING INFORM			
F 0323		ated the residents, and there were no injur		
jeopardy	indicated the		-	-
Level of harm - Immediate jeopardy Residents Affected - Some	She said she intervened and separ 4. Physician orders (REDACTED indicated the physician had reviewed and appro- included: Depakote 250 milligram 1 atuda 80 milligrams (for psychos tartrate 25 milligrams (for hyperte A care plan for Resident #6, dated walk to local convenience store a Resident #6 would not leave the f resident of facility's requirement 1 plan also addressed Resident #6 f initiated on 06/04/13) The most current MDS dated [DA toward others for 1 to 3 days per necessary to achieve the resident The Fall Risk Evaluation for Resi experienced 1 to 2 falls in the pas discontinuous steps and/or shuffli anti-hypertensive, benzodiazepino occurred less than daily in the las The Wandering Risk Assessment forgetful/short attention span; exhibits/expresses fear and/or anx disturbed by environmental noise experiencing feelings of anger/fea medications include antipsychotic moderate risk for wandering. The most current care plan for Re- accompany him to walk to local C goal indicated the resident would included re-instruct resident of fa understand. Additional areas addr understand. Additional areas addr resident had ebhavior problem re- resident had behavior problem re- resident had potential for falls falls reference to confusion; resident had potential for falls falls reference to confusion; resident had potential for falls falls reference to confusion; resident had neviewed thir sesident During an observation on 10/16/17 approximately one fifth of a mile had two sharp curves. There was There were no speed limit signs c visible from the facility, nor was During an interview on 10/16/17 a went to the store by himself. She said Resident #6 sometimes t During an interview on 10/16/17 a went to the store by himself. She said Resident #6 had been remind did not report this to anyone else, almost running over the resident #6 convenience store ov tin the ight he convenience store ov tin the ight he formed the charge nurse of whe During an interview on 10/16/17 a Resident #6. She said Resident ## convenience store wi	J.#6, admitted [DATE], was [AGE] years of wed the resident's plan of care. The reside ns (for paranoid schizophrenia); klonopin (is); Lisinopril-hydrocholrothiazide 20-12. ension); and, metformin hydrochloride 502 05/13/17, indicated the resident was non- nd often went without letting staff know at acility unattended through the next review hat he must be accompanied to go off pre- tad a communication problem and had aud TE], indicated Resident #6 was cognitivel seven days. The assessment indicated Resis goals for health and well-being 1 to 3 day lent #6, dated 07/19/17, indicated the resic t six months. Resident #6. strays off the st ng steps. The evaluation indicated Resider, e, and narcotics more than three times a we t seven days. for Resident #6 dated 07/19/17, indicated the resic south the dated 08/10/17, indicated the resi- onvenience store and often goes without he not leave the facility unattended through t rotility's requirement that he must be accom ressed on the care plan were: non-compliance with maladaptive behavin notion/demetia or impaired thought proce- fusional episodes; blem and had auditory hallucinations (initii ference to episodes of yelling at delusions blood sugars; reference to cerebral vascular accident wit a convenience store at the corner of the faa a the driveway, and the driveway had mul the facility visible from the convenience st at 12:43 p.m., CNA I said she worked the (Sk ago at approximately 11:00 a.m. she saa eport this to anyone. She said about a mon resident going to the store by himself. She CNA I said the nurse told her she would the alked and yelled in his room, but there was at the end of the facility driveway op She said she had never received any train he store by himself or not. CNA D said ap facility coming to work at approximately way at the	and had orders for routine me b.5 milligrams (for paranoid 5 milligrams (for paranoid 5 milligrams (for paranoid 5 milligrams (for paranoid 5 milligrams (for paranoid to milligrams (for paranoid to milligrams (for paranoid to milligrams (for paranoid to have a trisk for injury. The date. The interventions incl mises in language he could u itory hallucinations. (this ca- y intact and had behavioral s- dent #6 rejected evaluation or s per seven days. tent was a moderate fall risk aight path of walking, and u t #6 took medications that i tek. Resident #6 had agitated he following: and narcotics; and, ident was non-compliant wi tting staff know and was at he next review date. The intu- sesses reference to impaired of ated on 06/04/13); ; h left-sided weakness, conti ore. :00 a.m. to 2:00 p.m. shift, a v the resident go to the store th ago she was coming to w s ad she came on to the fac lk to the resident about it will s no one else in the room. oth estaff made her aware to yout not signing out prior to off the building, but he woul 100 a.m. to 2:00 p.m. shift, a ueady gait and staggered at t ateady gait and staggered at t ateady gait and staggered at t ateady agit and stagder at t ateady and stagder at t and cance on to to eight d 5:30 a.m. She said it was sti the of the facility's drivew he said she came on to the patio. :00 p.m. to 6:00 a.m. shift, a :00 p.m. to 6:00 p.m. shift, :00 p.m. to 6:00 p.m. shift, :00 p.m. to 10:00 p.m. shift, :00 p.m	dications that schizophrenia); on); metoprolol accompany him to e goal indicated luded re-instruct inderstand. The care re plan item was symptoms not directed or care that is and had uses short ncluded d behavior that th having staff risk for injury. The erventions language he can decision making; nues at risk for facility was vooded on each side and r lane highway. ence store was not and provided care for and back by ork, and it was just ility, and hen he got back. that Resident #6 had leaving. LVN G d not. She said she staff talked about I Resident #6 had leaving. LVN G d not. She said she staff talked about I Resident #6 had leaving uter to fact and provided care for imes. CNA D said the esident #6 goes to s care and did not lays ago, she was II dark and Resident 'ay. CNA D said the esigered in front of e facility and and provided care for cNA J said as far elling in his room elling anyone, and provided care for caks, and coffee,
	said Resident #6 had an unsteady were not there. LVN K said Resin numerous times to tell them wher During an interview on 10/16/17 a up to three times a week. She sai safe for Resident #6 to go to the s a superior authority above everyo and lighter he purchased at the sti authority status and say that he w and has conversations with a pers wander guard system and no list of During an interview on 10/16/17 a she went to the staff and asked if	tt 3:42 p.m., LVN L said she had seen Res I the resident knew the code to exit out the tore by himself, especially in the dark. Shh ne else. LVN L said for example when qu ore, he would ask if you knew who he was as leaving and his Rolls Royce would be a on in his room that was not there, sometin of residents who were unsafe to leave the f tt 5:40 p.m., LVN L said she saw Resident they knew the resident had left, and they d	tt #6 yells and talked to peop Illing anyone, although she l Ident #6 go to the store durin front door. She said she did said the resident had delusi estioning Resident #6 to retr and described himself as h described himself as h acility unsupervised. #6 go to the store a couple of id not.	ple in his room that has counseled him ng the day by himself not feel it was ions that he was rieve the cigarettes aving superior Resident #6 yells e facility had no of weeks ago. She said
		at 5:51 a.m., CNA E said she worked the 1		provided care for

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED:11/13/2018 FORM APPROVED OMB NO. 0938-0391
TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/23/2017
AME OF PROVIDER OF SU	455517	STREE	ADDRESS, CITY, STATE, ZIP
	TATION AND NURSING CENT		RUSK ONVILLE, TX 75766
		cy, please contact the nursing home or the	state survey agency.
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY M MATION)	UST BE PRECEDED BY FULL REGULATORY
F 0323 Level of harm - Immediate	(continued from page 7) Resident #6. She said the residen going. CNA E said sometimes th	t sometimes went to the store by himself, a ey did not know t (TRUNCATED)	nd sometimes did not tell anyone that he was
jeopardy Residents Affected - Some			
Solid Solid			