STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455517	A. BUILDING _____ B. WING _____	**10/23/2017**

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 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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 8 of 8 residents reviewed for neglect. (Resident #s 1, 2, 3, 4, 5, 6, 7, and 8) 1. The facility did not implement interventions to protect Resident #s 3 and 7, from being hit and attacked by Resident #1. Resident #7 was hit repeatedly in the face by Resident #1 and sustained lacerations to the face. Resident #3 was attacked by Resident #1 at least three times; being hit on the back of the head, shoved, and hit in the side of the head. 2. The facility did not implement interventions to supervise and protect Resident #2 when she injected herself with insulin, was displaying physically aggressive behaviors, and was displaying [MEDICAL CONDITION]. 3. The facility did not implement interventions to protect Resident #s 5 and 8 from being attacked by Resident #4. Resident #4 stabbed Resident #5's hand with an ink pen. Resident #4 was wrestling/grappling with Resident #8. 4. The facility did not provide adequate supervision for Resident #6, who had an unsteady gait and hallucinations, was known to walk to the convenience store, sometimes in the dark. The facility did not: provide supervision to ensure Resident #6's safety when he walked to a nearby convenience store; perform safety assessments prior to allowing Resident #6 to leave unaccompanied; implement interventions to protect and supervise Resident #6 when he went to the store; implement the care plan to accompany Resident #6 to the store; prevent Resident #6 from leaving alone in the dark; implement revised safety measures when staff became aware of near-missed accidents during Resident #6's walks to the store. An Immediate Jeopardy situation was identified on 10/11/17. While the IJ was removed on 10/20/17; however, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place 20 residents with behavioral healthcare needs at risk for severe injury. Findings included: The Policy to Prohibit the Mistreatment, Neglect, and Abuse of Residents and the Misappropriation of Resident Property, dated 12/2016, indicated each resident has the right to be free from neglect . The facility's purpose was to .assure that the facility is doing all that is within their control to prevent occurrences . 1. Physician orders [REDACTED].#1, 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 #1 was severely cognitively impaired, and had no physical behaviors. The most current care plan, dated 10/09/17, indicated Resident #1 had the following aggressive behaviors: 09/21/17, hit roommate; 09/30/17, hit another resident while walking past them; 10/01/17, pushed another resident that was attempting to sit on couch; 10/08/17, struck another resident. The interventions listed for the resident's aggressive behavior indicated providing one-on-one supervision as needed for aggression, and monitor every shift. An Incident Report dated 09/21/17 at 9:55 p.m., indicated staff witnessed Resident #1 hit another resident (Resident #7) repeatedly in the head. These residents were at the entrance of their shared room, at the end of the secure unit hallway. Staff provided immediate intervention, made notifications, and assessed for injuries. Resident #1 had lacerations to his hand, Resident #7 had lacerations to the face. During an interview on 10/11/17 at 2:27 p.m., LVN M said he was working on the secure unit on the evening of 09/21/17. He said at approximately 9:00 p.m., he was at the nursing station for the secure unit, and he looked up and saw movement down the hall. He said he saw Resident #1 hitting Resident #7. He said these two residents were roommates at the time, and they were standing at the entrance to their room. LVN M said Resident #7 was holding onto the handrail in the hallway outside the door, and Resident #1 was hitting Resident #7 in his face, repeatedly with his fist. This LVN said as soon as he looked up and saw what was happening, he immediately ran straight to the residents and separated them, and began to assess both residents for injuries. He said Resident #1 was placed on one-to-one supervision. Physician orders [REDACTED].#7, 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 #7 had moderately impaired cognitive skills for daily decision making. The most current care plan, dated 09/08/17, indicated Resident #7 had impaired cognitive function, wandered, and had verbal behaviors. A Nursing Progress Note for Resident #1 indicated on 09/25/17 at 10:00 a.m., resident was removed from one-to-one supervision per administration. This entry was timed at 11:45 a.m., and further noted that a CNA informed this nurse that resident was kicking at the couch where another resident was reclining, when the CNA attempted to intervene and redirect, Resident #1 went into her personal space and stated do you want me to hit you. The CNA began stepping back and resident kept approaching her, then resident was distracted by another staff. The Nurse Practitioner was notified of discontinued one-to-one supervision, and behaviors on this day. A Nursing Progress Note for Resident #1 indicated on 09/30/17 at 6:00 p.m., resident hit another resident in the hallway. Resident #1 was just walking by another resident and then hit the other resident in the back of the head. Resident #1 was started on one-to-one supervision. An Incident Report dated 09/30/17, indicated Resident #1 hit Resident #3 in the head. There were no injuries noted. An Incident Report dated 09/30/17, indicated Resident #1 was placed on one-to-one supervision due to hitting another resident (Resident #3) in the head. A One-on-One Documentation Sheet for Resident #1, indicated he was placed on one-to-one supervision continually starting on 09/30/17, going forward to 10/09/17. An Incident Report dated 10/01/17 at 6:40 a.m., indicated Resident #1 was waking from sleeping on the couch, when another resident (Resident #3) came into the day room and was going to sit at the couch. Resident #1 told Resident #3 to get up, while at the same time slightly pushing Resident #3 to keep him from sitting on the couch.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455517	A. BUILDING _____ B. WING _____	10/23/2017

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 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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) During an interview on 10/10/17 at 10:08 a.m., CNA A said she was working on the secure unit on the morning of 10/01/17 and CNA B was providing one-to-one supervision for Resident #1. She said Resident #1 was standing at one end of the loveseat and CNA B was sitting on the arm of the other end of the loveseat. Resident #3 came into the room and stepped to the loveseat as if to sit down, going between Resident #1 and CNA B. CNA A said Resident #1 pushed Resident #3, and he fell to the floor. CNA A said Resident #1 seemed to be targeting Resident #3. During an interview on 10/10/17 at 11:01 a.m., CNA B said she was assigned to provide Resident #1 with one-to-one supervision on the 6:00 a.m. to 2:00 p.m. shift on 10/01/17. She said she did the best she could do, but she was also working regular duty on the secure unit and sometimes other residents needed her attention. CNA B said she could not always stay right with Resident #1. She said at one point on this shift they heard a resident calling out, and she had to go down the hall to intervene where one resident was stabbing another resident in her hand with a writing pen, leaving Resident #1 without one-to-one supervision. The Nursing Progress Notes for Resident #1, dated 10/01/17 through 10/08/17, indicated resident continued to recieve one-to-one supervision. A Nursing Progress Note for Resident #1 indicated on 10/05/17 at 4:35 p.m., resident took clipboard from CNA, then CNA took it back from resident and resident stated you ain't f**king bad. Resident was redirected by nurse and notifications were made to family, nurse practitioner, administrator, and ADON. A Nursing Progress Note for Resident #1 indicated on 10/05/17 at 10:12 p.m., resident was transported to the hospital for behaviors via facility van. During an interview on 10/10/17 at 11:01 a.m., CNA B said she transported Resident #1 to the hospital on [DATE] for behaviors, and stayed with him. She said the hospital would not keep the resident, and she brought the resident back to the facility at approximately 3:00 a.m. the following morning. CNA B said she brought the resident back to the secure unit, and informed CNA N and LVN F that the administrator said Resident #1 was to be placed on one-to-one supervision, and left the 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 provide one-on-one supervision for Resident #1 for the rest of that shift. During an interview on 10/17/17 at 6:09 a.m., LVN F said she was the charge nurse for the 10:00 p.m. to 6:00 a.m. on the secure unit when CNA B brought Resident #1 back to the facility at 3:00 a.m., on 10/06/17. She said she knew the resident was supposed to be one-to-one supervision, but she said they were unable to provide one-to-one supervision for the resident for the remainder of that night because there was no one available to do it. A Nursing Progress Note for Resident #1 indicated on 010/08/17 at 8:30 a.m., increased pacing, standing in place, displaying increased anxiety, staff in observance of resident. 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 at 1:55 p.m., LVN C said she worked on the east wing on 10/08/17. She said she walked up to the glass door of the secure unit and saw Resident #3's head fly to the side. LVN C said Resident #3 bent over and was holding his face. She said Resident #1 was right beside Resident #3, and she saw no staff anywhere. She immediately went into the secure unit and there were no staff present, anywhere. LVN C said she started attending to the residents, and then two CNAs came out of the shower room. She said Resident #1 was not being supervised by anyone, when the incident occurred. During an interview on 10/09/17 at 10:44 a.m., the administrator said Resident #1 hit another resident yesterday (10/08/17), although Resident #1 was receiving one-to-one supervision. She said they had increased the resident to two-to-one observation. Physician orders [REDACTED].#3, 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 #3 had severely impaired cognitive skills, and no behavior issues. 2. Physician orders [REDACTED].#2, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. Medication orders included: [MEDICATION NAME] 2 milligrams injected every 24 hours as needed for agitation; Humalog solution insulin injections per sliding scale based on blood sugar readings; and, insulin detemir solution 100 units per milligram 40 units every day. There were no orders for self-administration of medications. The most current MDS, dated [DATE], indicated Resident #2 was moderately cognitively impaired, had physical behavioral 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 [MEDICAL CONDITION]. The Nursing Progress Notes for Resident #2, documented by LVN C, on 10/01/17, indicated the following: 3:18 p.m., resident had been awake all shift, went to church this morning and was now back at facility, resident had been talking about leaving all day and knew the codes to the door. Resident still on every 15 minute checks. 7:02 p.m., resident was yelling and had thrown a glass pickle jar into the hallway and busted, ran into another room and busted the picture frame and was yelling she wants her injection. Resident was yelling at nurse, saying she hates her, calling her a [***] , and not to f**king talk to her or she will beat the nurses' ass. This nurse notified the DON and ADON, and resident remained on every 15 minute checks. 7:16 p.m., resident received 1 milliliter of [MEDICATION NAME] injection, resident things (anything that she could use to harm herself or others) were being removed out of her room. Resident said she went in her room to get a knife to stab the nurse and she could not find a knife so she busted a pickle jar so she could use the glass jar to cut the nurse because she was not receiving her requested injection. 7:27 p.m., resident was laying on the floor saying she was about to deliver a baby, yelling it is coming. Resident tried to hang herself with the call light button, saying that it is the voices in her head going off. The resident was saying she was sorry to everyone but she felt she needed to kill herself. Resident now on one-to-one supervision and the DON, ADON, and Administrator were notified. 7:30 p.m., resident said she gave herself insulin, and gave the insulin pen to nurse. The insulin was [MEDICATION NAME]. This nurse was not aware of how much insulin the resident gave herself, but there was a CNA who witnessed it. 911 was notified. During an interview on 10/10/17 at 1:55 p.m., LVN C said on 10/01/17, Resident #2 had talked about leaving all day, and the resident knew the codes to the facility exit doors. She said Resident #2 was placed on every 15 minute checks, and sometimes when she would go to check on her, she could not find her. She said she would find Resident #2 on the outside grounds just walking around, so the resident knew how to get out of the building. LVN C said Resident #2 broke a pickle jar and a picture frame and was threatening to cut her. She said she reported Resident #2's behaviors to the ADON and DON. She said the DON told her to continue the every 15 minute checks with Resident #2 because they did not have enough staff to put her on one-on-one supervision, because Resident #1 was already on one-on-one supervision. LVN C said it was a frightening situation. LVN C said CNA P was trying to watch out for Resident #2 when the resident took a preloaded insulin pen out of her belongings, placed a needle in it, dialed it to about 50, and injected herself. CNA P also reported the resident tried to wrap a call cord around her neck. LVN C said she called the police and ambulance, but the police said they would not do anything with her because it is not against the law to have a mental illness. She said the police were leaving the facility, when Resident #2 got a metal rod and was trying to attack her with it. LVN C said the police heard the noise and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455517	A. BUILDING _____ B. WING _____	**10/23/2017**

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 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 0224

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 2)
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.
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 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 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;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455517	A. BUILDING _____ B. WING _____	10/23/2017

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 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 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 3) resident had a communication problem and had auditory hallucinations (initiated on 06/04/13); resident had a behavior problem reference to episodes of yelling at delusions; resident had potential for unstable blood sugars; resident had the potential for falls reference to [MEDICAL CONDITION] with left-sided weakness, continues at risk for falls reference to confusion; resident had potential for safety hazard/injury reference to smoking; resident used [MEDICAL CONDITION] medications; and, An RN had reviewed this resident's plan of care. During an observation on 10/16/17 at 11:40 a.m., the facility was completely surrounded by woods. The facility was approximately one fifth of a mile down a driveway from a main four lane highway. The driveway was wooded on each side and had two sharp curves. There was a convenience store at the corner of the facility's driveway and the four lane highway. There were no speed limit signs on the driveway, and the driveway had multiple pot holes. The convenience store was not visible from the facility, nor was the facility visible from the convenience store. During an interview on 10/16/17 at 12:43 p.m., CNA I said she worked the 6:00 a.m. to 2:00 p.m. shift, and provided care for Resident #6. She said about a week ago at approximately 11:00 a.m. she saw the resident go to the store and back by himself. CNA I said she did not report this to anyone. She said about a month ago she was coming to work, and it was just before 6:00 a.m., and she saw the resident going to the store by himself. She said she came on to the facility, and reported this to the charge nurse. CNA I said the nurse told her she would talk to the resident about it when he got back. She said Resident #6 sometimes talked and yelled in his room, but there was no one else in the room. During an interview on 10/16/17 at 1:11 p.m., LVN G said about a month ago the staff made her aware that Resident #6 had went to the store by himself. She said when he got back she talked to him about not signing out prior to leaving. LVN G said Resident #6 had been reminded numerous times to tell staff before he left the building, but he would not. She said she did not report this to anyone else, but had reported past occurrences to the DON. LVN G said the night staff talked about almost running over the resident all the time, because he walked in the middle of the driveway. She said Resident #6 had behaviors of yelling at someone in his room, but there was no one there. During an interview on 10/16/17 at 1:52 p.m., CNA D said she worked the 6:00 a.m. to 2:00 p.m. shift and provided care for Resident #6. She said Resident #6 ambulated independently, but had an unsteady gait and staggered at times. CNA D said the convenience store out on the highway at the end of the facility driveway opened at 5:00 a.m. She said Resident #6 goes to the convenience store by himself. She said she had never received any training concerning Resident #6's care and did not know if he was allowed to go to the store by himself or not. CNA D said approximately seven to eight days ago, she was driving down the driveway of the facility coming to work at approximately 5:30 a.m. She said it was still dark and Resident #6 was walking in the driveway by himself. She said the resident was at the edge of the facility's driveway. CNA D said the driveway was curvy, and she was right at the resident before she saw him. She said Resident #6 then staggered in front of her vehicle, coming into the path of her vehicle, and she almost hit him. CNA D said she came on to the facility and informed the charge nurse of where the resident was. During an interview on 10/16/17 at 2:23 p.m., CNA J said she worked the 10:00 p.m. to 6:00 a.m. shift, and provided care for Resident #6. She said during her shift, Resident #6 went back and forth for coffee, and out to the patio. CNA J said as far as she knew, he could go back and forth to the store by himself. She said sometimes you can hear him yelling in his room and he is talking to a person that is not there. She said the resident leaves and goes to the store without telling anyone, although she has counseled him numerous times to tell them when he is leaving. During an interview on 10/16/17 at 2:37 p.m., LVN K said she worked the 2:00 p.m. to 10:00 p.m. shift, and provided care for Resident #6. She said Resident #6 went to the store by himself. She said the resident went for smoke breaks, and coffee, but when he headed for the front door he was going to the store. LVN K said at times she had seen the resident coming or going from the store, when she was driving to arrive or leaving the facility. She said these situations scared her. LVN K said Resident #6 had an unsteady gait, at times. She said sometimes Resident #6 yells and talked to people in his room that were not there. LVN K said Resident #6 left and went to the store without telling anyone, although she has counseled him numerous times to tell them when he is leaving. During an interview on 10/16/17 at 3:42 p.m., LVN L said she had seen Resident #6 go to the store during the day by himself up to three times a week. She said the resident knew the code to exit out the front door. She said she did not feel it was safe for Resident #6 to go to the store by himself, especially in the dark. She said the resident had delusions that he was a superior authority above everyone else. LVN L said for example when questioning Resident #6 to retrieve the cigarettes and lighter he purchased at the store, he would ask if you knew who he was, and described himself as having superior authority status and say that he was leaving and his Rolls Royce would be arriving to get him. She said Resident #6 yells and has conversations with a person in his room that was not there, sometimes for hours. LVN L said the facility had no wander guard system and no list of residents who were unsafe to leave the facility unsupervised. During an interview on 10/16/17 at 5:40 p.m., LVN L said she saw Resident #6 go to the store a couple of weeks ago. She s (TRUNCATED)
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and interventions to prevent accidents for 8 of 8 residents reviewed for supervision. (Resident #s 1, 2, 3, 4, 5, 6, 7, and 8) 1. The facility did not implement interventions to protect Resident #s 3 and 7, from being hit and attacked by Resident #1. Resident #7 was hit repeatedly in the face by Resident #1 and sustained lacerations to the face. Resident #3 was attacked by Resident #1 at least three times; being hit on the back of the head, shoved, and hit in the side of the head. 2. The facility did not implement interventions to supervise and protect Resident #2 when she injected herself with insulin, was displaying physically aggressive behaviors, and was displaying suicidal ideations. 3. The facility did not implement interventions to protect Resident #s 5 and 8 from being attacked by Resident #4. Resident #4 stabbed Resident #5's hand with an ink pen. Resident #4 was wrestling/grappling with Resident #8. 4. The facility did not provide adequate supervision for Resident #6, who had an unsteady gait and hallucinations, was known to walk to the convenience store, sometimes in the dark. The facility did not: provide supervision to ensure Resident #6's safety when he walked to a nearby convenience store; perform safety assessments prior to allowing Resident #6 to leave unaccompanied; implement interventions to protect and supervise Resident #6 when he went to the store; implement the care plan to accompany Resident #6 to the store; prevent Resident #6 from leaving alone in the dark; implement revised safety measures when staff became aware of near-missed accidents during Resident #6's walks to the store. An Immediate Jeopardy situation was identified on 10/11/17. While the IJ was removed on 10/20/17; however, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place 20 residents with behavioral healthcare needs at risk for severe injury. Findings included: 1. Physician orders [REDACTED].#1, 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 #1 was severely cognitively impaired, and had no physical behaviors. The most current care plan, dated 10/09/17, indicated Resident #1 had the following aggressive behaviors: 09/21/17, hit roommate; 09/30/17, hit another resident while walking past them;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455517	A. BUILDING _____ B. WING _____	10/23/2017

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 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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) 10/01/17, pushed another resident that was attempting to sit on couch; 10/08/17, struck another resident. The interventions listed for the resident's aggressive behavior indicated providing one-on-one supervision as needed for aggression, and monitor every shift. An Incident Report dated 09/21/17 at 9:55 p.m., indicated staff witnessed Resident #1 hit another resident (Resident #7) repeatedly in the head. These residents were at the entrance of their shared room, at the end of the secure unit hallway. Staff provided immediate intervention, made notifications, and assessed for injuries. Resident #1 had lacerations to his hand, Resident #7 had lacerations to the face. During an interview on 10/11/17 at 2:27 p.m., LVN M said he was working on the secure unit on the evening of 09/21/17. He said at approximately 9:00 p.m., he was at the nursing station for the secure unit, and he looked up and saw movement down the hall. He said he saw Resident #1 hitting Resident #7. He said these two residents were roommates at the time, and they were standing at the entrance to their room. LVN M said Resident #7 was holding onto the handrail in the hallway outside the door, and Resident #1 was hitting Resident #7 in his face, repeatedly with his fist. This LVN said as soon as he looked up and saw what was happening, he immediately ran straight to the residents and separated them, and began to assess both residents for injuries. He said Resident #1 was placed on one-to-one supervision. Physician orders [REDACTED].#7, 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 #7 had moderately impaired cognitive skills for daily decision making. The most current care plan, dated 09/08/17, indicated Resident #7 had impaired cognitive function, wandered, and had verbal behaviors. A Nursing Progress Note for Resident #1 indicated on 09/25/17 at 10:00 a.m., resident was removed from one-to-one supervision per administration. This entry was timed at 11:45 a.m., and further noted that a CNA informed this nurse that resident was kicking at the couch where another resident was reclining, when the CNA attempted to intervene and redirect, Resident #1 went into her personal space and stated do you want me to hit you. The CNA began stepping back and resident kept approaching her, then resident was distracted by another staff. The Nurse Practitioner was notified of discontinued one-to-one supervision, and behaviors on this day. A Nursing Progress Note for Resident #1 indicated on 09/30/17 at 6:00 p.m., resident hit another resident in the hallway. Resident #1 was just walking by another resident and then hit the other resident in the back of the head. Resident #1 was started on one-to-one supervision. An Incident Report dated 09/30/17, indicated Resident #1 hit Resident #3 in the head. There were no injuries noted. An Incident Report dated 09/30/17, indicated Resident #1 was placed on one-to-one supervision due to hitting another resident (Resident #3) in the head. A One-on-One Documentation Sheet for Resident #1, indicated he was placed on one-to-one supervision continually starting on 09/30/17, going forward to 10/09/17. An Incident Report dated 10/01/17 at 6:40 a.m., indicated Resident #1 was waking from sleeping on the couch, when another resident (Resident #3) came into the day room and was going to sit at the couch. Resident #1 told Resident #3 to get up, while at the same time slightly pushing Resident #3 to keep him from sitting on the couch. During an interview on 10/10/17 at 10:08 a.m., CNA A said she was working on the secure unit on the morning of 10/01/17 and CNA B was providing one-to-one supervision for Resident #1. She said Resident #1 was standing at one end of the loveseat and CNA B was sitting on the arm of the other end of the loveseat. Resident #3 came into the room and stepped to the loveseat as if to sit down, going between Resident #1 and CNA B. CNA A said Resident #1 pushed Resident #3, and he fell to the floor. CNA A said Resident #1 seemed to be targeting Resident #3. During an interview on 10/10/17 at 11:01 a.m., CNA B said she was assigned to provide Resident #1 with one-to-one supervision on the 6:00 a.m. to 2:00 p.m. shift on 10/01/17. She said she did the best she could do, but she was also working regular duty on the secure unit and sometimes other residents needed her attention. CNA B said she could not always stay right with Resident #1. She said at one point on this shift they heard a resident calling out, and she had to go down the hall to intervene where one resident was stabbing another resident in her hand with a writing pen, leaving Resident #1 without one-to-one supervision. The Nursing Progress Notes for Resident #1, dated 10/01/17 through 10/08/17, indicated resident continued to recieve one-to-one supervision. A Nursing Progress Note for Resident #1 indicated on 10/05/17 at 4:35 p.m., resident took clipboard from CNA, then CNA took it back from resident and resident stated you ain't f**king bad. Resident was redirected by nurse and notifications were made to family, nurse practitioner, administrator, and ADON. A Nursing Progress Note for Resident #1 indicated on 10/05/17 at 10:12 p.m., resident was transported to the hospital for behaviors via facility van. During an interview on 10/10/17 at 11:01 a.m., CNA B said she transported Resident #1 to the hospital on [DATE] for behaviors, and stayed with him. She said the hospital would not keep the resident, and she brought the resident back to the facility at approximately 3:00 a.m. the following morning. CNA B said she brought the resident back to the secure unit, and informed CNA N and LVN F that the administrator said Resident #1 was to be placed on one-to-one supervision, and left the 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 provide one-on-one supervision for Resident #1 for the rest of that shift. During an interview on 10/17/17 at 6:09 a.m., LVN F said she was the charge nurse for the 10:00 p.m. to 6:00 a.m. on the secure unit when CNA B brought Resident #1 back to the facility at 3:00 a.m., on 10/06/17. She said she knew the resident was supposed to be one-to-one supervision, but she said they were unable to provide one-to-one supervision for the resident for the remainder of that night because there was no one available to do it. A Nursing Progress Note for Resident #1 indicated on 010/08/17 at 8:30 a.m., increased pacing, standing in place, displaying increased anxiety, staff in observance of resident. 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 at 1:55 p.m., LVN C said she worked on the east wing on 10/08/17. She said she walked up to the glass door of the secure unit and saw Resident #3's head fly to the side. LVN C said Resident #3 bent over and was holding his face. She said Resident #1 was right beside Resident #3, and she saw no staff anywhere. She immediately went into the secure unit and there were no staff present, anywhere. LVN C said she started attending to the residents, and then two CNAs came out of the shower room. She said Resident #1 was not being supervised by anyone, when the incident occurred. During an interview on 10/09/17 at 10:44 a.m., the administrator said Resident #1 hit another resident yesterday (10/08/17), although Resident #1 was receiving one-to-one supervision. She said they had increased the resident to two-to-one observation. Physician orders [REDACTED].#3, 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 #3 had severely impaired cognitive skills, and no behavior issues. 2. Physician orders [REDACTED].#2, admitted [DATE], was [AGE] years old with [DIAGNOSES REDACTED]. Medication orders included: Ativan 2 milligrams injected every 24 hours as needed for agitation; Humalog solution insulin injections per sliding scale based on blood sugar readings; and, insulin detemir solution 100 units per milligram 40 units every day. There were no orders for self-administration of medications. The most current MDS, dated [DATE], indicated Resident #2 was moderately cognitively impaired, had physical behavioral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455517	A. BUILDING _____ B. WING _____	10/23/2017

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 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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(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: 3:18 p.m., resident had been awake all shift, went to church this morning and was now back at facility, resident had been talking about leaving all day and knew the codes to the door. Resident still on every 15 minute checks. 7:02 p.m., resident was yelling and had thrown a glass pickle jar into the hallway and busted, ran into another room and busted the picture frame and was yelling she wants her injection. Resident was yelling at nurse, saying she hates her, calling her a [***] , and not to f**king talk to her or she will beat the nurses' ass. This nurse notified the DON and ADON, and resident remained on every 15 minute checks. 7:16 p.m., resident received 1 milliliter of Ativan injection, resident things (anything that she could use to harm herself or others) were being removed out of her room. Resident said she went in her room to get a knife to stab the nurse and she could not find a knife so she busted a pickle jar so she could use the glass jar to cut the nurse because she was not receiving her requested injection. 7:27 p.m., resident was laying on the floor saying she was about to deliver a baby, yelling it is coming. Resident tried to hang herself with the call light button, saying that it is the voices in her head going off. The resident was saying she was sorry to everyone but she felt she needed to kill herself. Resident now on one-to-one supervision and the DON, ADON, and Administrator were notified. 7:30 p.m., resident said she gave herself insulin, and gave the insulin pen to nurse. The insulin was lantus. This nurse was not aware of how much insulin the resident gave herself, but there was a CNA who witnessed it. 911 was notified. During an interview on 10/10/17 at 1:55 p.m., LVN C said on 10/01/17, Resident #2 had talked about leaving all day, and the resident knew the codes to the facility exit doors. She said Resident #2 was placed on every 15 minute checks, and sometimes when she would go to check on her, she could not find her. She said she would find Resident #2 on the outside grounds just walking around, so the resident knew how to get out of the building. LVN C said Resident #2 broke a pickle jar and a picture frame and was threatening to cut her. She said she reported Resident #2's behaviors to the ADON and DON. She said the DON told her to continue the every 15 minute checks with Resident #2 because they did not have enough staff to put her on one-on-one supervision, because Resident #1 was already on one-on-one supervision. LVN C said it was a frightening situation. LVN C said CNA P was trying to watch out for Resident #2 when the resident took a preloaded insulin pen out of her belongings, placed a needle in it, dialed it to about 50, and injected herself. CNA P also reported the resident tried to wrap a call cord around her neck. LVN C said she called the police and ambulance, but the police said they would not do anything with her because it is not against the law to have a mental illness. She said the police were leaving the facility, when Resident #2 got a metal rod and was trying to attack her with it. LVN C said the police heard the noise and 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. 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 suicidal ideations 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 delirium 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455517	A. BUILDING _____ B. WING _____	10/23/2017

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 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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) 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: Depakote 250 milligrams (for paranoid schizophrenia); klonopin 0.5 milligrams (for paranoid schizophrenia); latuda 80 milligrams (for psychosis); Lisinopril-hydrocholrothiazide 20-12.5 milligrams (for hypertension); metoprolol tartrate 25 milligrams (for hypertension); and, metformin hydrochloride 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 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 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 delirium or acute confusional episodes; resident had a communication problem and had auditory hallucinations (initiated on 06/04/13); resident had a behavior problem reference to episodes of yelling at delusions; resident had potential for unstable blood sugars; resident had the potential for falls reference to cerebral vascular accident with left-sided weakness, continues at risk for falls reference to confusion; resident had potential for safety hazard/injury reference to smoking; resident used psychotropic medications; and, An RN had reviewed this resident's plan of care. During an observation on 10/16/17 at 11:40 a.m., the facility was completely surrounded by woods. The facility was approximately one fifth of a mile down a driveway from a main four lane highway. The driveway was wooded on each side and had two sharp curves. There was a convenience store at the corner of the facility's driveway and the four lane highway. There were no speed limit signs on the driveway, and the driveway had multiple pot holes. The convenience store was not visible from the facility, nor was the facility visible from the convenience store. During an interview on 10/16/17 at 12:43 p.m., CNA I said she worked the 6:00 a.m. to 2:00 p.m. shift, and provided care for Resident #6. She said about a week ago at approximately 11:00 a.m. she saw the resident go to the store and back by himself. CNA I said she did not report this to anyone. She said about a month ago she was coming to work, and it was just before 6:00 a.m., and she saw the resident going to the store by himself. She said she came on to the facility, and reported this to the charge nurse. CNA I said the nurse told her she would talk to the resident about it when he got back. She said Resident #6 sometimes talked and yelled in his room, but there was no one else in the room. During an interview on 10/16/17 at 1:11 p.m., LVN G said about a month ago the staff made her aware that Resident #6 had went to the store by himself. She said when he got back she talked to him about not signing out prior to leaving. LVN G said Resident #6 had been reminded numerous times to tell staff before he left the building, but he would not. She said she did not report this to anyone else, but had reported past occurrences to the DON. LVN G said the night staff talked about almost running over the resident all the time, because he walked in the middle of the driveway. She said Resident #6 had behaviors of yelling at someone in his room, but there was no one there. During an interview on 10/16/17 at 1:52 p.m., CNA D said she worked the 6:00 a.m. to 2:00 p.m. shift and provided care for Resident #6. She said Resident #6 ambulated independently, but had an unsteady gait and staggered at times. CNA D said the convenience store out on the highway at the end of the facility driveway opened at 5:00 a.m. She said Resident #6 goes to the convenience store by himself. She said she had never received any training concerning Resident #6's care and did not know if he was allowed to go to the store by himself or not. CNA D said approximately seven to eight days ago, she was driving down the driveway of the facility coming to work at approximately 5:30 a.m. She said it was still dark and Resident #6 was walking in the driveway by himself. She said the resident was at the edge of the facility's driveway. CNA D said the driveway was curvy, and she was right at the resident before she saw him. She said Resident #6 then staggered in front of her vehicle, coming into the path of her vehicle, and she almost hit him. CNA D said she came on to the facility and informed the charge nurse of where the resident was. During an interview on 10/16/17 at 2:23 p.m., CNA J said she worked the 10:00 p.m. to 6:00 a.m. shift, and provided care for Resident #6. She said during her shift, Resident #6 went back and forth for coffee, and out to the patio. CNA J said as far as she knew, he could go back and forth to the store by himself. She said sometimes you can hear him yelling in his room and he is talking to a person that is not there. She said the resident leaves and goes to the store without telling anyone, although she has counseled him numerous times to tell them when he is leaving. During an interview on 10/16/17 at 2:37 p.m., LVN K said she worked the 2:00 p.m. to 10:00 p.m. shift, and provided care for Resident #6. She said Resident #6 went to the store by himself. She said the resident went for smoke breaks, and coffee, but when he headed for the front door he was going to the store. LVN K said at times she had seen the resident coming or going from the store, when she was driving to arrive or leaving the facility. She said these situations scared her. LVN K said Resident #6 had an unsteady gait, at times. She said sometimes Resident #6 yells and talked to people in his room that were not there. LVN K said Resident #6 left and went to the store without telling anyone, although she has counseled him numerous times to tell them when he is leaving. During an interview on 10/16/17 at 3:42 p.m., LVN L said she had seen Resident #6 go to the store during the day by himself up to three times a week. She said the resident knew the code to exit out the front door. She said she did not feel it was safe for Resident #6 to go to the store by himself, especially in the dark. She said the resident had delusions that he was a superior authority above everyone else. LVN L said for example when questioning Resident #6 to retrieve the cigarettes and lighter he purchased at the store, he would ask if you knew who he was, and described himself as having superior authority status and say that he was leaving and his Rolls Royce would be arriving to get him. She said Resident #6 yells and has conversations with a person in his room that was not there, sometimes for hours. LVN L said the facility had no wander guard system and no list of residents who were unsafe to leave the facility unsupervised. During an interview on 10/16/17 at 5:40 p.m., LVN L said she saw Resident #6 go to the store a couple of weeks ago. She said she went to the staff and asked if they knew the resident had left, and they did not. During an interview on 10/17/17 at 5:51 a.m., CNA E said she worked the 10:00 to 6:00 p.m. shift, and provided care for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455517	A. BUILDING _____ B. WING _____	**10/23/2017**

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 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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) Resident #6. She said the resident sometimes went to the store by himself, and sometimes did not tell anyone that he was going. CNA E said sometimes they did not know t (TRUNCATED)