STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455675	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Amarillo Rehabilitation and Nursing	5601 Plum Creek Drive Amarillo, TX 79124

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave for 1 (Resident #1) of 5 residents reviewed for transfer/discharge rights.The facility failed to allow Resident #1 to return to the facility after he was admitted to a short-term psychiatric hospital following an apparent suicide attempt.This failure could place residents at risk of feelings of instability/insecurity. Findings Included:Record review of Resident #1's admission record dated 05/19/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, type 2 diabetes mellitus (insufficient production of insulin, causing high blood sugar), nicotine dependence, alcohol dependence in remission, major depressive disorder recurrent severe (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), alcoholic hepatitis (liver inflammation caused by heavy or prolonged alcohol use), acquired absence of right leg below knee, and acquired absence of left leg below knee.Record review of Resident #1's quarterly MDS assessment completed on 02/23/26 revealed a BIMS score of 15 which indicated intact cognition. Section D Mood revealed he had little interest or pleasure in doing things 7-11 days of the 14-day look-back period. Section E Behavior revealed Resident #1 had no behaviors during the look-back period. Section GG Functional Abilities revealed he used a walker and limb prosthesis. Resident #1 was independent across all ADLs except bathing where he needed supervision or touching assistance. Section N Medications revealed he was receiving antidepressant medication.Record review of Resident #1's care plan completed on 04/29/26 revealed he had a positive drug screen for marijuana and he used tobacco. He was care planned for having major depressive disorder. Staff were to Monitor/record/report to MD prn risk for harm to self; suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possession or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. This intervention was initiated on 03/21/25. Another intervention was Psychiatric Services [name of provider] discontinued r/t non-adherent with treatment plan.Record review of Resident #1's order summary report dated 05/19/26 revealed the following orders and corresponding order start dates:01/23/26 Discharge for services of [name of psychiatrist's NP] due to resident/responsible party non-adherent with treatment plan05/18/26 Transfer to [name of behavioral health hospital] for inpatient treatment. one time only for 7 DaysRecord review of Resident #1's progress notes revealed the following notes and corresponding authors and dates/times:05/17/26 at 11:50 PM a transfer notification written by CN [Resident #1] was transferred to a hospital on [DATE] 12:15 AM related to Resident was found in his room bleeding from self inflicted wound to left wrist. The resident used a straight razor to slice his wrist. 05/18/26 at 09:13 AM a note written by LVN M Resident continues on one on one supervision no s/s of discomfort or distress noted.05/18/26 at 12:07 PM a note written by SW SW and admin met with patient. Although he indicated he was not trying to self-harm, he was agreeable to go to [name of behavioral (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	hospital] to be evaluated and admitted due to the seriousness of his injury and concern of the facility. [Name of behavioral hospital] has accepted the patient and [name of facility] will transport him at 2pm.05/18/26 at 12:35 PM a note written by LVN M [Resident #1] was transferred to a hospital on [DATE] at 1:48 PM related to Self inflicted wound to left wrist. This is intended to serve as notice of an emergency transfer.Record review of Resident #1's EHR under the MDS tab revealed a Discharge Return Not Anticipated assessment In Progress.Record review of Resident #1's EHR under the MISC tab revealed an Immediate Discharge Notice dated 05/18/26 at 02:05 PM by ADM.Record review of Resident #1's Discharge Notification dated 05/18/26 revealed he was discharged to a behavioral health hospital on [DATE] and the discharge was necessary for his welfare, and his needs could not be met in the facility. The discharge further revealed, Resident has an immediate threat to self harm. Resident lacerated his left wrist with a double edged razor blade. Resident was treated in March 2025 for suicidal ideation at [name of behavioral hospital]. In May 2026, resident was sent to hospital for emergency care after an apparent suicide attempt in facility. Resident is being discharged to acute in-patient psychiatric facility, [name of behavioral hospital].During an interview on 05/19/26 at 08:21 AM OM stated she has received an immediate discharge for Resident #1 and was concerned the facility might not be planning to take him back after he finished his in-patient psychiatric stay.During an interview on 05/19/26 at 02:28 PM CN stated the facility issued an immediate discharge for Resident #1 on 05/18/26 because Resident #1 had not exhibited any signs or symptoms that indicated he was suicidal and the facility did not feel they could keep him safe or meet his needs.During an interview on 05/20/26 at 08:39 AM OM stated she spoke to ADM on 05/19/26 and was informed the facility did not intend to take Resident #1 back after his stay at the behavioral hospital. OM stated ADM told her the decision came from high up in the facility's corporate structure. OM stated, Him (Resident #1) being dumped will likely affect his Medicaid and certainly his NF Medicaid. She stated Resident #1 was enrolled in a program to help him transition to living in the community on his own and that his enrollment could be jeopardized by the facility refusing to take him back.During an interview on 05/20/26 at 10:40 AM ADM stated someone in her corporate structure right below the very top made the decision not to take Resident #1 back. She stated corporate said, We will take the dumping tag.but we are not taking him back. ADM stated she spoke to the behavioral hospital staff and told them she would help them find placement for Resident #1 after his treatment if she needed to. She stated she spoke to his Medicaid case manager about a possible placement at another facility in town and his case manager was planning to visit that facility today to see if they would accept Resident #1 when he finished his treatment at the behavioral hospital.During an interview on 05/20/26 at 10:50 AM DDC stated the immediate discharge the facility did for Resident #1 did not necessarily mean he could not return to the facility until they could find him a more appropriate placement. DDC reiterated, We are not saying we will never take him back in this building. We were in agreement that this discharge option was safest for him and for us and for our facility. I do think this (surveyor's investigation into the appropriateness of Resident #1's discharge) is a little premature since he has not been discharged from [name of behavioral hospital] yet and we are still working to locate an appropriate placement.During an observation and interview on 05/20/26 at 11:37 AM, DDC was seated in ADM's office and ADM was on the phone. The DDC joined this surveyor in the hallway. DDC stated if Resident #1 was ready to be discharged from the behavioral hospital and did not have an appropriate placement the facility would take him back and work to find him an appropriate placement. ADM hung up the phone and this surveyor leaned into her office doorway and asked her if the facility would be willing to take Resident #1 back if, when he was ready to be discharged from the behavioral hospital, he had no other placement options. DDC walked behind this surveyor into ADM's office and stood facing ADM and nodding. ADM looked at DDC and stated, I guess so if they (gestured to DDC) are saying that, then we will.During an interview on 05/20/26 at 01:17 PM ADON stated there was not a negative outcome to Resident #1 if the facility discharged him to a short-term behavioral hospital unless the behavioral hospital would send them (Resident #1) out on the streets.During an (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	interview on 05/20/26 at 01:29 PM IDPA stated when a facility sent a resident to their behavioral hospital and was unwilling to take the resident back, They (residents) don't have anywhere to go and that leaves us trying to find new placement for them so basically what they (facility) did is dumped him on us. She stated the facility did not let the behavioral hospital know they were not taking Resident #1 back until he was already in the behavioral hospital.During an interview on 05/20/26 at 01:45 PM ADM stated the reason Resident #1 was issued an immediate discharge and not simply transferred to the behavioral hospital was because the facility was not intending to take him back. She stated she did not think there was a negative outcome to Resident #1 because his needs were being met so it is not like I kicked him out on the street.During an interview on 05/20/26 at 01:47 PM DDC stated she did not think there was a negative impact on Resident #1. She stated, In this case when we find him an appropriate, safer level of care after psych (psychiatric hospital) we hope it positively impacts his life.During an interview on 05/20/26 at 02:10 PM DDC stated she thought the decision to issue an immediate discharge for Resident #1 was the right decision for Resident #1 and for the facility.Record review of facility policy titled Discharge or Transfer and dated 12/2017 revealed the following: . In the following limited circumstances, this facility may initiate transfers or discharges: A. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; . Emergent Transfers to Acute Care Residents who are sent emergently to the hospital are considered facility-initiated transfers because the residents return is generally expected. When a resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer. In situations where the facility has decided to discharge the resident while the resident is still hospitalized , the facility will send a notice to a representative of the Office of the State LTC Ombudsman. Permitting Residents to Return This facility will allow residents to return following a hospitalization or leave unless the conditions for discharge are met as explained in this policy. Because this facility was able to care for the resident prior to the hospitalization or therapeutic leave, documentation related to the basis for discharge must clearly show why the facility can no longer care for the resident.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 6 residents reviewed for accidents and hazards.The facility failed to ensure Resident #1 did not have access to a double-sided razor blade. Resident #1 used the razor blade to cut his left wrist, resulting in a 7 cm laceration on the inside of Resident #1's left wrist which required 23-26 stitches on the night of [DATE].The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the investigator entered the facility.This failure could place residents at risk of harm or death. Findings Included:Record review of Resident #1's admission record dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, type 2 diabetes mellitus (insufficient production of insulin, causing high blood sugar), nicotine dependence, alcohol dependence in remission, major depressive disorder recurrent severe (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), alcoholic hepatitis (liver inflammation caused by heavy or prolonged alcohol use), acquired absence of right leg below knee, and acquired absence of left leg below knee.Record review of Resident #1's quarterly MDS assessment completed on [DATE] revealed a BIMS score of 15 which indicated intact cognition. Section D Mood revealed he had little interest or pleasure in doing things 7-11 days of the 14-day look-back period. Section E Behavior revealed Resident #1 had no behaviors during the look-back period. Section GG Functional Abilities revealed he used a walker and limb prosthesis. Resident #1 was independent across all ADLs except bathing where he needed supervision or touching assistance. Section N Medications revealed he was receiving antidepressant medication.Record review of Resident #1's care plan completed on [DATE] revealed he had a positive drug screen for marijuana and he used tobacco. He was care planned for having major depressive disorder. Staff were to Monitor/record/report to MD prn risk for harm to self; suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possession or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. This intervention was initiated on [DATE]. Another intervention was Psychiatric Services [name of provider] discontinued r/t non-adherent with treatment plan.Record review of Resident #1's order summary report dated [DATE] revealed the following orders and corresponding order start dates:[DATE] Discharge for services of [name of psychiatrist's NP] due to resident/responsible party non-adherent with treatment plan[DATE] Sugical [sic] incision to left wrist: clean with wound cleanser/NS.[DATE] Transfer to [name of behavioral health hospital] for inpatient treatment. one time only for 7 Days[DATE] Duloxetine HCl Oral Capsule Delayed Release Sprinkle 60 MG.give 2 capsule by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE .Record review of Resident #1's MAR for [DATE] revealed he received his Duloxetine HCl as ordered from [DATE]st to [DATE]th.Record review of Resident #1's progress notes revealed the following notes and corresponding authors and dates/times:[DATE] at 11:50 PM a transfer notification written by CN [Resident #1] was transferred to a hospital on [DATE] 12:15 AM related to Resident was found in his room bleeding from self inflicted wound to left wrist. The resident used a straight razor to slice his wrist.[DATE] at 12:10 AM a note written by RN K This shift nurse was going to assess the resident and check BG level this evening due to low levels found the previous day and a lower level today. This is only a concern due to levels trending out of the norm. Upon entering the residents room, there appeared to be a mess on the floor when the light was turned on it was quickly identified as blood. This shift nurse approached the resident and asked if he was bleeding and pulled covers aside (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	and identified laceration or lacerations to left wrist. This shift nurse grabbed some gauze to apply pressure and called CNA for assistance and called upon other staff members to aide in care. Management and Physicians on call notified as documented. 911 called and awaiting ambulanceXXX[DATE] at 01:40 AM a note written by RN K The ambulance arrived about 0128 (01:28 AM). The paramedic asked about the situation which was addressed by this shift nurse. The resident was loaded onto a granny/gurney. And paperwork given to Paramedic/EMT. The resident was wheeled out and loaded onto ambulance and transported to [initials of hospital].[DATE] at 04:35 AM a note written by RN K [Initials of hospital] representative called facility and stated that the resident was being transferred back. When asked why and why is not being committed to the [name of psychiatric care facility] or such. And the [initials of hospital] representative stated that due to the residents denial of suicidal ideologythat [sic] they had no grounds to commit him for psychiatric evaluation. The resident was transported back by [initials of hospital] transport. Upon arrival he was met in drop off zone by front doors with staff and wheelchair. The resident was returned to his room by wheelchairand [sic] accompanied by staff. Will monitor the resident and await further orders. The resident is in bed resting, bed lowered, bed brakes locked, call light in reach, equal fall and rise chest bilaterally, RR at 17, and denies pain or further needs at this time.[DATE] at 06:08 AM a note written by LVN M Ressident [sic] alert and orientd [sic] very pleasant denies any pain or discomfort, denies any SI, dressing to left wrist intact no new drainage noted. Resident on one on one for supervision .[DATE] at 07:52 AM a note written by RN K This statement is in regards of [Resident #1]. On the night of [DATE] this shift nurse went to check on the resident around 11:30. The reason being is the day before ([DATE]) when BG was checked, it was 62. This was not consistent for the resident. When assessed the evening of [DATE] the residents BG was at 141. So I decided that I would do a check later in the evening to make sure BG wasn't dropping to a critical level. When I entered the room to assess the resident BG level I seen something on the floor. I turned on the residents light and the mess on the floor appeared to be blood. I spoke with a loud tone, ?[Resident #1] are you bleeding?' I approached the resident and uncovered him and I could see the resident was bleeding from his left wrist. I said, ?[Resident #1] did you cut yourself?' He stated, ?Yes.' I said, ?Why?' He stated, ?Because I'm a fucking dumb ass.' I mediately [sic] went to the cart and grabbed some gauze, returned and applied pressure. At this time the cut did not appear to be bleeding profusely but still needed to apply pressure. I had staff CNA's [sic] assist me' [sic] then called other shift nurses to come help. Together we called management to notify of the situation. Physician was notified and orders were to send out which at this time 911 was called. Family on resident profile was notified. When CNA's [sic] asked the resident what happened he stated, ?I was throwing away the razor blades and slipped and I guess that's when I cut myself. I didn't even notice I cut myself. I just went to bed.' This was the same thing he told the Paramedic, EMT, [initials of hospital] staff and the police. When staff CNA's [sic] were cleaning the resident to transfer out. The CNA's found a metal box with barbers razors and a marijuana vape pen. This was removed, bagged up and placed away for the administrator to inspect. Paramedics had arrived and the resident was taken to the hospital. When the paramedics/EMT asked what happened the resident stated, ?I fell when trying to throw away the razers [sic].' The resident left by ambulance and report was called into the [initials of hospital] ER. [Initials of hospital] representative called and stated they were bringing the resident back. This staff nurse asked. ? Why are they not going to admit him to the [names of two psychiatric units] for help.' The representative stated, ? The resident denied suicidal ideology.' Due to the denial, [initials of hospital] treated the incident as an accident as stated by the resident. Upon arrival I told the resident, ? I understand you told everyone that this was an accident. But from mypoint [sic] of view you were in bed like you do when going to sleep. Prosthetics off, shirt off and in your boxers. But before this you slip, cut your wrist, don't feel it or see yourself bleeding. You don't call for help ring the call light come out of your room for help but manage to undress and get ready for bed. It just doesn't make since [sic]. But if you need help, know that we're here for you.' The resident stated, ? Okay, but I'm (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	good I have [name of friend] why would I kill myself.' On this day the resident didn't show signs of suicidal tendencies. When this staff nurse arrived to work, the resident was sitting in the chair he's always in watching T.V. in the units day room. I walked by and said what's up [Resident #1], gave him a fist bump, and asked, ?You good.' He stated, ?Yeah.' And when asked if he was good it was not because he was giving me signs to be concerned. I generally ask everyone upon arrival if they are ok. And as stated above my only concern was to check BG level because he was trending low. That was my reason for checking on him. Maybe an act of God and good I didn't wait till the morning.[DATE] at 09:13 AM a note written by LVN M Resident continues on one on one supervision no s/s of discomfort or distress noted.[DATE] at 12:07 PM a note written by SW SW and admin met with patient. Although he indicated he was not trying to self-harm, he was agreeable to go to [name of behavioral hospital] to be evaluated and admitted due to the seriousness of his injury and concern of the facility. [Name of behavioral hospital] has accepted the patient and [name of facility] will transport him at 2pm.Record review of Resident #1's hospital discharge instructions revealed he arrived at the hospital on [DATE] at 01:54 AM with a laceration to his left wrist. He was to return in 7-10 days for suture removal.Record review of Resident #1's Discharge Notification dated [DATE] revealed he was discharged to a behavioral health hospital on [DATE] and the discharge was necessary for his welfare, and his needs could not be met in the facility. The discharge further revealed, Resident has an immediate threat to self harm. Resident lacerated his left wrist with a double edged razor blade. Resident was treated in [DATE] for suicidal ideation at [name of behavioral hospital]. In [DATE], resident was sent to hospital for emergency care after an apparent suicide attempt in facility. Resident is being discharged to acute in-patient psychiatric facility, [name of behavioral hospital].During an interview on [DATE] at 05:22 AM CNA A stated she had worked with Resident #1 and had never noted any signs of depression or suicidality. She stated it was not normal for residents to have razor blades in their rooms. CNA A stated if residents wanted to be shaved the CNAs did that for them. She stated a possible negative outcome of a resident having razor blades in their room was they could cut or hurt themselves. She stated since Resident #1 cut himself she had been trained on what was allowed in a resident's room as well as how to recognize and report s/s of depression, anxiety, and suicidal ideation.During an interview on [DATE] at 05:27 AM LVN B stated she had worked with Resident #1 and had never noted any signs of depression or suicidality. She stated it was not normal for residents to have razor blades in their rooms. She stated a possible negative outcome of a resident having razor blades in their room was they could accidentally or intentionally cut themselves. She stated since Resident #1 cut himself she had been trained on what was allowed in a resident's room as well as how to recognize and report s/s of depression, anxiety, and suicidal ideation.During an interview on [DATE] at 05:30 AM CNA C stated residents should not have razor blades in their rooms. She stated they could hurt or cut themselves or step on the razor blades. CNA C stated since Resident #1 cut himself she had been trained on what was allowed in a resident's room as well as how to recognize and report s/s of depression, anxiety, and suicidal ideation.During an interview on [DATE] at 05:36 AM LVN D stated she had worked with Resident #1 and had not noticed any suicidal ideation or depression. She stated Resident #1 interacted with the other residents really well. LVN D stated it was not normal for residents to have razor blades in their rooms. She stated a possible negative outcome of a resident having razor blades in their room was cuts and/or infections. LVN D stated since the incident with Resident #1 she was trained on what was allowed in a resident's room as well as how to recognize and report s/s of depression, anxiety, and suicidal ideation.During an interview on [DATE] at 05:38 AM CNA E stated it was not normal for residents to have razor blades in their rooms. He stated a possible negative outcome of a resident having razor blades in their room was what happened with Resident #1. He stated since the incident he was trained on what was allowed in resident rooms and how to recognize and report s/s of depression, anxiety, and suicidal ideation.During an interview on [DATE] at 05:40 AM CNA F stated it was not normal for residents to have razor blades in their rooms. She stated a possible negative outcome of a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	resident having razor blades in their room was they could slice somebody's throat or wrist. She stated after the incident with Resident #1 she was trained on what was allowed in resident rooms and how to recognize and report s/s of depression, anxiety, and suicidal ideation.During an interview on [DATE] at 05:42 AM CNA G stated residents should not have razor blades in their rooms. She stated, They are not to have any sharp objects in their rooms. CNA G stated residents could hurt themselves or others. She stated she had been trained on what was allowed in a resident's room and how to recognize and report s/s of depression and suicidal ideation since the incident with Resident #1.During an interview on [DATE] at 05:48 AM DON stated residents were not allowed to have razor blades in their rooms because they could hurt themselves.During an interview on [DATE] at 05:52 AM LVN H stated residents were not to have razor blades in their rooms lest they hurt themselves. She stated she worked occasionally with Resident #1 and never noticed s/s of depression or suicidal ideation from him. She stated following the incident of him cutting himself with a razor blade she was trained on what was allowed in a resident room and on recognizing and reporting s/s of depression and suicidal ideation.During an interview on [DATE] at 05:53 AM CNA I stated residents were not to have razor blades in their rooms lest they hurt themselves. She stated CNAs shaved residents who desired to be shaved. CNA I stated since the incident with Resident #1 she had been trained on recognizing and reporting s/s of depression, anxiety, and suicidal ideation as well as what was allowed in a resident's room.During an interview on [DATE] at 05:57 AM DON stated she provided training to all staff on rotation on [DATE] on recognizing and reporting s/s of anxiety, depression and suicidal ideation as well as what was and was not allowed in a resident's room. She stated a new rotation came on [DATE] and she would train that whole rotation at that time.During an interview on [DATE] at 06:09 AM CNA F stated she was on shift on the evening of [DATE] when Resident #1 cut himself. She stated she and her nurse, LVN J, were on a different unit but when RN K called LVN J to assist him with Resident #1 she (CNA F) went as well. She stated LVN J stopped by a supply closet and got a bandage and the two of them ran to RN K's unit. CNA F stated RN K was holding gauze to Resident #1's left wrist when she and LVN J arrived in Resident #1's room. She stated LVN J began to bandage Resident #1's wrist and she (CNA F) told RN K they could take care of Resident #1 if he (RN K) wanted to start making calls and charting. She stated after LVN J bandaged Resident #1's wrist, she (LVN J) left Resident #1's room to help RN K with notifications and calling 911. She stated she began to clean the blood on Resident #1's floor and table. She stated Resident #1 had his head covered by the blankets. She stated she looked in his drawer and inside the seat of his walker and did not see anything he could have cut himself with. She stated when she took the trash bag out of his trash can it seemed heavy and she prodded around on the bottom of the bag and felt something hard. She stated she discovered a marijuana vape pen and a small metal box of razor blades in the bottom of Resident #1's trash can. She showed the two items to LVN J and after the blood was cleaned off the two items LVN J took a picture for ADM. CNA F stated the blood on Resident #1's floor was beginning to dry around the edges, and it was approximately 8 inches around. She described the blood on his table as just a few inches and oval. CNA F described the blood on Resident #1's bedding as approximately 12 inches in an elongated oval.During an interview on [DATE] at 06:43 AM LVN J stated RN K called for her to assist him after he found Resident #1's cut wrist. She stated she and RN K watched Resident #1 until the ambulance arrived. She stated she had worked with Resident #1 many times and never seen any warning signs of depression or suicidal ideation. She stated, I never seen anything, he is always very friendly. It caught me off guard that that happened.During an interview on [DATE] at 06:49 AM ADM stated Resident #1 had a cut from one side to the other on the inside of his wrist. She stated it was 7 cm long and required 23-26 stitches at the hospital.During an interview on [DATE] at 07:42 AM RN K stated when he arrived on shift on the evening of [DATE] Resident #1 was acting normal. He stated, I didn't notice anything different with him. He stated he had some concern about Resident #1's blood glucose level as it has been low during his last shift on [DATE]. RN K stated at about 11:30 PM on [DATE] he entered Resident #1's room to check his blood (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455675	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Amarillo Rehabilitation and Nursing	5601 Plum Creek Drive Amarillo, TX 79124

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	glucose and he noticed a mess on the floor of the room. When he turned on the light, he saw it was blood. RN K stated he asked Resident #1 if he was bleeding and he could see blood dripping from Resident #1's bed. RN K stated he pulled the covers back and asked Resident #1 if he cut himself and Resident #1 said he did. RN K stated he asked Resident #1 why he cut himself and Resident #1 stated, Because I am a freaking idiot. RN K stated later when the CNAs asked Resident #1 what happened he told them he was trying to put the razor blades away and he slipped and fell and did not realize he cut himself. RN K stated, That is the story he is sticking with and I don't buy it. He would have had to take off both legs (Resident #1 had two prosthetic legs) and take his shirt and his shorts off all while not noticing he was cut. RN K stated of Resident #1 cutting himself, It really caught me off guard. It really shocked me. I have had rapport with him for a while. RN K stated he had worked with Resident #1 for 3 years. He stated in that three years Resident #1 had shown no s/s of suicidality. RN K stated the size of the pool of blood on Resident #1's floor was approximately 6 inches round with wavy edges. He stated the blood in the bed had soaked into the blanket and sheets and Resident #1 had moved around a lot so it was a mess. RN K stated it was not normal for residents to have razor blades in their rooms. He stated, I have no idea where those came from. RN K stated residents could accidentally cut themselves. He stated the cut on Resident #1's wrist was all the way across the inside of his wrist. RN K stated he had not been back to work since the incident and had not received any trainings regarding the incident, but he expected to be trained before his next shift.During an interview on [DATE] at 08:12 AM CN stated the facility did not have an accidents/hazards policy. She stated the resident's rights policy would cover part of accidents/hazards.During an interview on [DATE] at 09:15 AM CNA L stated she was working on the unit with RN K on the evening of [DATE]. She stated Resident #1 did not show any s/s of depression or act any differently than usual. CNA L stated residents were not supposed to have razor blades in their rooms. She stated they could cut themselves. CNA L stated she had been trained after the incident with Resident #1 regarding recognizing and reporting s/s of depression or suicidal ideation as well as what was allowed in a resident room.During an interview on [DATE] at 09:21 AM FM N stated Resident #1 had always lived with family members and had been in rehabilitation for drugs and alcohol. She stated she did not believe Resident #1 tripped and fell on the razor blade. Family member N stated Resident #1 told her, I didn't try to kill myself, but I want to go home to my [family member]. She stated Resident #1's family member died of cancer in 2012.During an interview on [DATE] at 09:37 AM SW stated when she and ADM performed a trauma screening on Resident #1 on [DATE] after he returned to the facility from the hospital, he kept indicating to her that he did not try to kill himself. She stated he did agree to go the psychiatric hospital. SW stated when she was speaking to the psychiatric hospital to refer him for placement, they told her he had been there before for similar reasons.During an interview on [DATE] at 09:44 AM FM O stated in March of 2025 she and several other family members received a text message from Resident #1 saying he wished he was dead. She stated she alerted the facility and the facility had Resident #1 transferred to the psychiatric hospital where he stayed for 7-10 days. She stated he had never harmed himself before but had talked about it a lot all of his life.During an interview on [DATE] at 09:56 AM LMSW, Resident #1's counselor, stated she had been seeing him weekly since October of 2025. She stated he often declined sessions. LMSW stated Resident #1 did not ever show s/s of suicidal ideation or depression during their sessions. LMSW stated the last time she saw Resident #1 was [DATE] and during that session he did not show any s/s of depression or suicidal ideation.During an interview on [DATE] at 11:03 AM HSK P stated she had been recently trained on recognizing and reporting s/s of depression and suicidal ideation and what was allowed in resident rooms.During an interview on [DATE] at 03:09 PM Resident #1's friend stated she did not have any idea he was planning to hurt himself. She stated they did not have a fight or argument.During an interview on [DATE] at 03:56 PM ADON stated residents were not to have razor blades in their rooms because they could hurt themselves or others. She stated she was trained on recognizing and reporting s/s of depression and suicidal ideation and on what was allowed in resident rooms.Record (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	review of an undated facility policy titled Resident Rights revealed no mention of a safe environment or accidents/hazards. Record review of undated sheet from facility titled Items Not Allowed in Resident Room: revealed the following: . SAFETY HAZARDS: . Razors and blades .Record review of Ad Hoc QAPI meeting revealed it was held on [DATE] and attended by ADM, DON, ADON, MD, BOM, Director of Rehab, CN, Human Resources, MDS nurse, and Housekeeping.Record review of an in-service by DON for all staff dated [DATE] revealed staff were trained on items allowed in a resident's room. Record review of the information covered during this inservice revealed that staff were provided a list of items that were not allowed in a resident's room , which included razors and blades. Record review of an in-service by DON for all staff dated [DATE] revealed staff were trained on recognizing depression and suicide warning signs in residents and how to immediately report said signs. This failure was identified as past noncompliance IJ as the facility had instituted adequate corrective measures to prevent recurrence of the non-compliance.