

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675851 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/20/2024 |
| NAME OF PROVIDER OR SUPPLIER Georgia Manor Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 2611 W 46th Ave Amarillo, TX 79110 | |

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) |
|--|---|
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48221</p> <p>Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse,</p> <p>neglect, exploitation, or mistreatment, including injuries of unknown source are reported immediately, but not later than 24</p> <p>hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the residents to the</p> <p>Administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where</p> <p>state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for</p> <p>1 (Resident #1) of 5 residents reviewed for abuse/neglect.</p> <p>The facility failed to report an injury of staff inflicted injury (fingernail wound marks to Resident #1's right hand) on 4/16/24 to</p> <p>the Administrator and to the state within 24 hours.</p> <p>This failure could place residents at risk of not having incidents of possible abuse and neglect reviewed and investigated in a</p> <p>timely manner by the facility and state survey agency. This could place residents at risk of continued and/or unrecognized</p> <p>abuse or neglect.</p> <p>Findings included:</p> <p>Record review of Resident #1's admission record dated 05/20/2024 revealed a [AGE] year-old female admitted to the facility on</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675851 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/20/2024 |
| NAME OF PROVIDER OR SUPPLIER Georgia Manor Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 2611 W 46th Ave Amarillo, TX 79110 | |
| 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) | | |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>11/22/2023 with diagnoses that included, but were not limited to, Schizoaffective Disorder Bipolar Type (experience psychotic symptoms like hallucinations or delusions and mood disorder of mania and depression), Metabolic Encephalopathy (neurological disorder caused from systemic illness like kidney failure, diabetes, liver disease, and heart failure), Acute Kidney Failure with Tubular Necrosis (a condition causing lack of oxygen blood flow to kidneys damaging them), Essential Hypertension abnormally high blood pressure), Unspecified Dementia (a group of thinking and social symptoms that interferes with daily functioning), Dyspnea ((difficulty breathing or shortness of breath), and Acute Respiratory Failure with Hypoxia (not enough oxygen in the tissues of your body).</p> <p>Record review of Resident #1's Annual MDS completed on 04/11/24 revealed a BIMS of 03 which indicated severely impaired cognitive functioning. Resident #1 was noted to have impaired cognition due to dementia.</p> <p>Section GG revealed Resident #1utilized a wheelchair for mobility and is totally dependent for toileting, rolling in bed right and left, Section H revealed Resident #1 is always incontinent of bowel and bladder.</p> <p>Record review of Resident #1's care plan with a last review/revision date of 05/01/24 revealed Resident #1 continues to have bladder and bowel incontinence with intervention to check resident every two hours and assist with toileting as needed and provide peri care after each incontinent episode.</p> <p>Record review of Resident #1's orders dated 04/02/24 through 5/02/24 revealed no mention of Right hand wound or alleged abuse.</p> <p>Record review of facility's investigation of Resident #1's incident revealed it was reported to State authorities on 04/24/24 at 10:45AM. Staff interviews attached to the facility's investigation revealed on 4/16/24 CNA A and CNA B were at Resident 1's</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675851 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/20/2024 |
| NAME OF PROVIDER OR SUPPLIER Georgia Manor Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 2611 W 46th Ave Amarillo, TX 79110 | |
| 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) | | |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>bedside to change her. CNA A turned resident towards CNA B. CNA A saw CNA B 'clawing her fingernails into the skin of</p> <p>Resident #1. CNA A reported hearing Resident #1 yelling, Let me go you black bitch. I'm going to report you. It will show</p> <p>up on my skin. CNA A told CNA B she was going to report her. CNA A reported to the Night Charge LVN C.</p> <p>Record review of facility's in-service for staff on reporting following the failure to report Resident #1's bruise revealed a sign-</p> <p>in sheet attached to facility's Abuse/Neglect policy. This policy did include information regarding reporting of abuse and/or</p> <p>neglect. The policy dated 3/29/2018 on page 3, Section E. Reporting.3. a & b states:</p> <p>a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation.</p> <p>b. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.</p> <p>Facility Administrator also included that all incidents are to be reported immediately to the Charge Nurse and the</p> <p>Administrator is to be called.</p> <p>During an interview on 5/20/24 at 5:25AM CNA A stated she received an in-service on 4/24/24 ANE and Reporting in a</p> <p>Timely manner.</p> <p>During an interview by phone on 5/20/24 at 12:01PM with CNA E, she stated she had attended Inservice on ANE, Reporting</p> <p>in a Timely Manner, and Resident Rights.</p> <p>During an observation and interview on 5/20/24 at 900AM Resident# 1 was lying on her left side in her bed with Head of Bed</p> <p>(HOB) raised. 45 degrees watching TV. Alert and friendly, wearing gown and covered with two blankets. Cup of apple juice</p> <p>with straw on bedside table next to resident. When questioned Resident #1 stated she does remember a CNA 'poking' her with</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675851 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/20/2024 |
| NAME OF PROVIDER OR SUPPLIER Georgia Manor Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 2611 W 46th Ave Amarillo, TX 79110 | |
| 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) | | |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>her fingernails on the Right hand. Stated she is happy that she doesn't see that CNA anymore. She stated the other CNAs are</p> <p>nice to her. Resident allowed inspection of her Right hand. No wounds or scabs present. Skin is clean, clear, and dry. Resident</p> <p>stated she has no complaints about her care.</p> <p>During an interview on 5/20/24 at 126PM the Administrator was asked about the ANE allegation of Resident #1 which occurred</p> <p>on 4/16/24 but wasn't reported until 4/26/24, why she waited eight days to report from date of the incident. She stated, I</p> <p>wasn't told about it until 4/26/24 by LVN C when we were meeting in my office. She said forgot to tell me. I reported it, got</p> <p>written statements from CNA A and LVN C and started Inservice's on ANE and Reporting in a Timely Manner.</p> <p>During an interview on 5/21/24 at 105PM return phone call from LVN C. She confirmed she was working night shift on</p> <p>4/16/24 at about 9:00PM CNA A came up to her and told her Resident #1 stated she didn't want CNA B in her room because</p> <p>she was mean. LVN C wrote a statement to verify this interaction with CNA A. She said during the phone interview, she had</p> <p>forgotten about the incident until she was talking with the Administrator on 4/26/24 and told her at that time.</p> <p>During an interview on 5/20/24 at 515AM CNA A was asked what a negative outcome could be for not reporting injuries or</p> <p>incidents from known or unknown sources, she stated, someone could get really sick or hurt badly and no one would know</p> <p>what happened.</p> <p>During an interview on 5/20/24 at 252PM Regional Compliance RN D was asked if the facility has its own policy for reporting</p> <p>ANE. She stated the reporting incident guidelines the facility uses are the State Guidelines. They had an Inservice to train staff</p> <p>to notify Charge Nurses and Administrator immediately if any incidents occur on 4/24/24.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675851 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/20/2024 |
| NAME OF PROVIDER OR SUPPLIER Georgia Manor Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 2611 W 46th Ave Amarillo, TX 79110 | |

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) |
|--|--|
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Employee Record Review of CNA B shows a hire date of 4/12/24. She was out sick since incident on 4/16/24. Administrator called to suspend her employment. She was incarcerated and was in jail. She has not been in the building since 4/16/24.</p> <p>Record review of facility policy titled Abuse/Neglect and dated 3/29/2018 revealed the following:</p> <p>Definitions of and descriptions of various types of Abuse and Neglect .B. Training through orientation and Inservice's on</p> <p>issues related to abuse/neglect C. Prevention 1. The facility will post in public areas .how to report concerns, incidents,</p> <p>and grievances without fear of retribution.E. Reporting-3. Facility employees must report all allegations of abuse,</p> <p>neglect, exploitation, mistreatment of Resident a. If allegations involve abuse or result in serious bodily injury, the report is</p> <p>to be made within 2 hours of the allegation.b. If the allegation does not involve abuse or serious bodily injury, the report</p> <p>must be made with 24 hours of the allegation.</p> |