

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  06/28/2024
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46534</p> <p>Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 (Resident #2 and Resident #5) of 6 residents reviewed for reporting of abuse, neglect, exploitation or mistreatment.</p> <p>The facility failed to report to the state within 2 hours when Resident #5 hit Resident #2.</p> <p>This failure could place residents at risk of continued abuse.</p> <p>Findings Included:</p> <p>Record review of Resident #2's admission record dated 06/27/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, major depressive disorder, and anxiety disorder.</p> <p>Record review of Resident #2's quarterly MDS revealed a completion date of 04/24/24. Section C indicated a BIMS score of 11 which indicated moderately impaired cognition.</p> <p>Record review of Resident #2's care plan completed on 04/18/24 indicated Resident #2 had depression and was receiving antidepressant medication.</p> <p>Record review of Resident #2's progress notes revealed in part:</p> <p>A note written by SW on 05/23/24 SW met with res as she was tearful and upset. Res said she was upset with several people that recently frustrated her. She proceeded to say she was 'flipped off' by another res. When she asked him to put his finger down he swung and hit her arm. Res said she was not in pain and it did not bother her, but another res around her witnessed and became upset at what happened. SW notified ADON and Admin.</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #5's admission record dated 06/27/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it, stroke), schizoaffective disorder bipolar type (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), schizoaffective disorder depressive type (a mental health disorder that is marked by a combination of schizophrenia symptoms such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), bipolar disorder (serious mental illness characterized by extreme mood swings such as extreme excitement or extreme depressive feelings), major depressive disorder with psychotic symptoms (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), mood disorder, generalized anxiety disorder (inability to control constant worrying), hemiplegia and hemiparesis following cerebral infarction (partial paralysis following stroke) affecting right dominant side, cognitive communication deficit, and aphasia (a disorder that affects the ability to communicate, read, write, and understand language caused by damage or injury to the specific area of the brain responsible for language).</p> <p>Record review of Resident #5's quarterly MDS revealed a completion date of 04/09/24. Section C indicated no BIMS score. The staff assessment for mental status revealed Resident #5 had moderately impaired cognition. Section E indicated Resident #5 refused care 1-3 days of the 7-day look back period. No other behaviors were noted in Section E. Section N revealed Resident #5 was receiving antidepressant and antipsychotic medications.</p> <p>Record review of Resident #5's care plan completed on 04/22/24 revealed Resident #5 had potential to demonstrate physical behaviors toward staff and other residents. Interventions included notifying the doctor of any danger to self or others and notifying the charge nurse of any physically abusive behaviors. The care plan indicated Resident #5 was sent to a psychiatric facility for evaluation and treatment. Resident #5 was care planned for receiving antidepressant and antipsychotic medications.</p> <p>Record review of Resident #5's progress notes revealed in part:</p> <p>A note written on 05/23/24 at 03:47 PM by SW another Res reported [Resident #5] 'flipped her off'. When she asked him to put his finger down he swung and hit her arm. SW notified ADON and Admin.</p> <p>A note written on 05/23/24 at 03:59 PM by ADON Res punched another res, after flipping off another res and that res asking this res not to flip her off. Res punched at res, barely touched res. Res redirected at this time. Will cont. to monitor. Called [name of psychiatrist]'s office and spoke with [name] concerning res and situation and n/o received to send to psych unit at this time. [First name of previous ADM] administrator notified at this time.</p> <p>A note written on 05/23/24 at 5:25 PM by SW Referral was faxed to [name of behavioral hospital] for treatment due to aggressive behaviors. Per psychiatrist, [name of psychiatrist], request.</p> <p>A note written by SW on 05/24/24 Res unable to consent for inpatient psych treatment due to being non-verbal. SW completed emergency detention paperwork and submitted to [Name of County] county court per Admin. request.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A note written by MDS LVN on 06/13/24 Report called from [name of nurse] at [name of behavioral hospital]. [Resident #5] is expected to admit back to facility today around 11. [name of nurse at behavioral hospital] states . that [Resident #5] has not been aggressive with staff, how ever he has flipped off all staff regularly. Informed ADON and Charge nurse of report received.</p> <p>During an interview on 06/26/24 at 09:10 AM ADON stated Resident #5 was not really interviewable. She stated, He will probably flip you off.</p> <p>During an observation and interview on 06/26/24 at 09:11 AM Resident #2 was seated at a table in the dining room with Resident #3 and another resident. Resident #5 was seated at a table near them. Resident #2 stated she remembered the incident when Resident #5 flipped her off and hit her. She said she was not hurt. Of Resident #5 flipping her off, Resident #2 stated, That is how he talks to us. She stated on 05/23/24 she had just returned from a smoke break and Resident #5 flipped her off. Resident #2 stated she approached Resident #5 to tell him to 'stop that' and he went for her. She stated she saw him coming and pulled her arm back so Resident #5 just grazed her arm with his hand. Resident #2 stated it was no big deal.</p> <p>During an observation and interview on 06/26/24 at 09:14 AM Resident # 5 was seated in his w/c at a table in the dining room. When asked how he was doing he raised his left hand with only the middle finger pointing up.</p> <p>During an observation and interview on 06/26/24 at 09:36 AM Resident #3 was seated at a table in the dining room. She stated she remembered the incident when Resident #5 flipped off Resident #2 and hit Resident #2. Resident #3 stated, He just slapped at her lightly, didn't hurt her at all.</p> <p>During an interview on 06/26/24 at 12:44 PM SW stated she remembered Resident #2 telling her about Resident #5 flipping her off hitting her. SW stated Resident #2 was crying when she was speaking with SW but that she was not upset about the incident with Resident #5, she was crying about other things that had transpired that day. SW stated Resident #2 did not even seem that upset about it happening. SW stated Resident #2 just mentioned it (Resident #5 flipping her off and attempting to hit her) to me in passing. SW stated the facility responded to the incident by referring Resident #5 to a behavioral hospital for evaluation and treatment. SW stated she told ADON and the previous ADM about the incident the day of the incident.</p> <p>During an interview on 06/28/24 at 08:12 AM Resident #5's family member stated it was normal behavior for Resident #5 to flip people off. She stated Resident #5 lived on the streets for years and had a bunch of mental issues. She stated Resident #5 had hit people in the past and had been hit by others. She stated, I mean, when you get a bunch of people like that in there it is bound to happen.</p> <p>During an interview on 06/28/24 at 08:52 AM RN G stated if suspected abuse of a resident was not reported timely it could continue to happen.</p> <p>During an interview on 06/28/24 at 09:12 AM ADON stated if suspected abuse of a resident was not reported timely, It can happen again.</p> <p>Record review of facility Incident by Incident Type report revealed Resident #2 and Resident #5 were listed under Behavior Incidents on 05/23/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility report to HHSC regarding the incident of Resident #5 hitting Resident #2 on 05/23/24 revealed a report date of 05/29/24.</p> <p>Record review of facility investigation into the incident with Resident #2 and Resident #5 revealed Resident #3 was a witness to the incident.</p> <p>Record review of facility in-service taught by previous ADM on 05/23/24 revealed in part:</p> <p>. Abuse, neglect must be reported immediately. The abuse coordinator is [name of previous ADM] and if she isn't available you can report to the DON or ADON.</p> <p>Record review of facility policy Abuse/Neglect dated 03/29/18 revealed in part:</p> <p>. Residents should not be subjected to abuse by anyone, including, . other residents, . E. Reporting 3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. a. If allegations involve abuse or result in serious bodily injury, the report must be made within 24 hours of the allegation.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46534</p> <p>Based on observation, interview, and record review the facility failed to, based on the comprehensive assessment of a resident, ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident # 1) of 6 residents reviewed for quality of care.</p> <p>The facility failed to enter physician's orders in the EHR which resulted in Resident #1 missing an appointment on 05/21/24 to have an ILR placed.</p> <p>This failure could place residents at risk of not receiving necessary care and/or treatment.</p> <p>Findings Included:</p> <p>Record review of Resident #1's admission record dated 06/27/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, chronic congestive heart failure (a progressive heart disease that affects the pumping action of the heart muscles resulting in shortness of breath and fatigue), acute respiratory failure with hypoxia (below-normal level of oxygen in your blood, specifically in the arteries. Hypoxemia is a sign of a problem related to breathing or circulation, and may result in various symptoms, such as shortness of breath), anemia (lower than normal amount of healthy red blood cells), and unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).</p> <p>Record review of Resident #1's quarterly MDS revealed a completion date of 04/30/24. Section C indicated intact cognition with a BIMS score of 14. Section I indicated active diagnoses which included heart failure and respiratory failure. Section N indicated Resident #1 was receiving anticoagulant (blood thinning) and diuretic (increases urine output and decreases fluid retention medication).</p> <p>Record review of Resident #1's care plan completed on 06/24/24 revealed Resident #1 was to be given her cardiac medications as ordered to remain free of s/s of congestive heart failure. The care plan indicated Resident #1 had potential for fluid deficit r/t diuretic use. Resident #1's care plan indicated she was receiving anticoagulant therapy and had a heart monitor r/t atrial fibrillation.</p> <p>Record review of Resident #1's progress notes revealed in part:</p> <p>A note written by SW on 05/21/24 at 11:07 AM SW went to remind res of appt today. She stated she was unaware of her procedure with [name of cardiology office] to have Loop recorder implanted. SW had previously spoke with RN, [first name of RN F] regarding the appt. SW contacted [name of cardiology office] to follow up and clarify appt for res. They (cardiology office) stated orders were sent to stop specific meds and all eating for a specific time frame. They also reported ot have spoken with RN, [first name of RN F] to inform her. SW went to get ADON to have her speak with [name of cardiology office]. ADON, [first name of ADON] requested they speak with charge nurse [first name of LVN B] as she is the nurse. SW notified [name of cardiology office] and they (cardiology office) requested the admin come and speak. Admin. [first name of previous ADM] met with Nurse (from cardiology office) via phone and gathered information. Appt will be rescheduled at a later date. [Name of cardiology office] will notify nursing facility of new appt. time.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A note written by ADON on 05/21/24 at 11:40 AM [Name of cardiology office] called to notify that his res did not have blood thinners placed on hold and procedure could not be done.</p> <p>A note written by CRN on 06/06/24 Appointment with [name of cardiology office] rescheduled for June 11th at 800 am for pre procedure appt. Procedure to be done on June 17th. Pre op instructions will be given to nurse at appointment on June 11th.</p> <p>A note written by ADON on 06/12/24 Called [sic] received from [initials of cardiology office], res will have a [sic] implanted loop recorded procedure done 6/17/24. Res is to be NPO at midnight on 6/17/24. [Brand name of anticoagulant medication] to be held beginning 6/15/24-6/17/24. [Brand name of diuretic medication] to be held the morning of the procedure.</p> <p>Record review of Resident #1's order summary dated 06/27/24 revealed in part:</p> <p>The following phone order with order date of 06/12/24 and start date of 06/14/24: Res (resident) will have a implanted loop recorder procedure done 06/17/24. 1) NPO @ midnight Monday 6/17/24. 2) [Brand name of anticoagulant medication] to be held 6/15/24-6/17/24. 3) [Brand name of diuretic medication] to be held 6/17/24 The morning of the procedure.</p> <p>The following phone order with order and start date of 12/25/23: [Brand name of anticoagulant medication] Oral Tablet 5 MG Give 1 tablet by mouth two times a day .</p> <p>The following verbal order with order and start date of 02/12/23: [Brand name of diuretic medication] Oral Tablet 20 MG Give 1 tablet by mouth one time a day for edema.</p> <p>During an observation and interview on 06/26/24 at 09:00 AM Resident #1 was lying on her back in bed. She stated she had the procedure she needed and still had staples in her chest from the procedure. She did not seem to remember she was originally scheduled to have the procedure 27 days earlier than it was done. She stated she did not think she experienced any negative outcome from missing the original appointment.</p> <p>During an interview on 06/27/24 at 02:57 PM SW stated she spoke to RN F regarding Resident #1's appointment on 05/21/24. SW stated RN F put a sticky note on her (SW's) door. SW stated after the appointment was missed she reminded RN F that she (RN F) put the sticky note on her (SW's) door.</p> <p>During an interview on 06/27/24 at 03:00 PM RN F stated she no longer worked for the facility. She stated she remembered the incident with Resident #1 missing her cardiologist appointment/procedure. She stated she was at lunch when the cardiologist office called with the verbal orders regarding Resident #1's pre-procedure. RN F stated an agency nurse named [first name of LVN A] took the orders over the phone and wrote them on a sticky note. RN F stated when she came back from lunch LVN A handed her the sticky note and told RN F she (LVN A) would put the orders in as soon as she received the fax. RN F stated she placed the sticky note on the door of SW's office because SW was responsible for arranging transportation to and from appointments. RN F stated the fax did not come in during that shift and she briefed the on-coming nurse, LVN C, about the orders, the sticky note, and to be watching for the fax. RN F stated she did not think about the orders again because they were the responsibility of LVN A, as she was the one who answered the phone and took the orders. RN F stated it was a few weeks later when the previous ADM asked her about the orders, and she (RN F) told ADM that LVN A had taken the orders and she (RN F) had briefed on-coming LVN C to be watching for the fax.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/27/24 at 03:26 PM LVN C stated she did not remember a conversation with RN F about orders for Resident #1, a sticky note, and a fax.</p> <p>During an interview on 06/28/24 at 08:52 AM RN G stated the nurse who answered the phone and received orders was the one responsible to enter the orders into the EHR. He stated, Because if you give it to someone else it might be miscommunicated and the resident might not get the treatment needed.</p> <p>During an interview on 06/28/24 at 09:12 AM ADON stated it was the responsibility of nurses to enter orders into the EHR. She stated if a nurse received an order over the phone that nurse was the one who should enter the order into the EHR. She stated a resident might not receive the care they need if orders are not entered into the EHR. ADON stated the procedure Resident #1 missed was for an ILR. She stated an ILR helps with the rhythm of her heart. ADON stated Resident #1 did not experience any issues between missing her procedure and receiving the rescheduled procedure 27 days later.</p> <p>On 06/28/24 at 10:43 AM and at 10:45 AM attempts were made to contact LVN A via telephone. She did not answer or respond to text messages.</p> <p>During an interview on 06/28/24 at 11:58 AM MD D stated the procedure Resident #1 missed was for long term monitoring of her heart rhythm. He stated the ILR was just a recording device, not for treatment, but for diagnosis.</p> <p>Record review of facility's investigation into Resident #1's missed appointment revealed a typed sheet of paper signed by the previous ADM. The previous ADM noted a nurse from the cardiologist's office told the previous ADM that she (nurse from cardiologist office) spoke to RN F on 05/14/24 and relayed the orders regarding NPO and holding of anticoagulant and diuretic medication. The nurse from the cardiologist office told the previous ADM that she faxed the orders to the facility on [DATE] as well.</p> <p>Record review of facility in-service taught on 05/21/24 to RN F revealed in part:</p> <ol style="list-style-type: none"> <li>1. If you are given orders by any physician, it is your responsibility to make sure the orders are processed and followed through. If the orders require follow through past your shift, it is your responsibility to pass the information on and put it on your communication board in PCC.</li> <li>2. You are to document in pcc (a kind of EHR software) under progress notes anytime a physician rounds in facility, if your resident goes out to any appointment, or if a physician office calls with any concerns.</li> </ol> <p>Record review of facility policy Physician's Orders dated 2015 revealed in part:</p> <p>. Verbal or Telephone Orders by the Physician or Nurse Practitioner 1. Nurse will receive the order and read the order back to the prescriber to ensure it is correct. 3. The nurse will enter the order into PCC for the resident and select either verbal or telephone, depending on how the nurse received the order. Preventing Verbal or Telephone Order Errors: . 5. Immediately transcribe verbal/telephone orders into the patient's medical record or onto a prescription pad as they are being communicated.</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46534</p> <p>Based on observation, interview, and record review the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 (Resident #4) of 6 residents reviewed for pain management.</p> <p>The facility failed to allow sufficient time for pain medication to take effect prior to changing Resident #4's wound vac on 05/30/24.</p> <p>This failure could place residents at risk of pain and/or anxiety related to pain.</p> <p>Findings Included:</p> <p>Record review of Resident #4's admission record dated 06/27/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, acquired absence of unspecified leg above knee, polyneuropathy (malfunction of many peripheral nerves throughout the body), and atherosclerosis of native arteries of extremities (fats, cholesterol, and other substances collected on the inner walls the arteries) with rest pain right leg.</p> <p>Record review of Resident #4's admission MDS revealed a completion date of 06/04/24. Section C noted a BIMS score of 12 which indicated moderately impaired cognition. Section GG indicated use of a w/c. Section J indicated use or offer of PRN pain medication as well as pain experienced frequently. Resident #4 rated her pain at an 8 out of 10. Section M indicated Resident #4 had a surgical wound.</p> <p>Record review of Resident #4's care plan completed on 06/13/24 indicated Resident #4 was at risk for falls due to AKA. Resident #4 was at risk for uncontrolled pain. The interventions listed were initiated on 05/31/24 and included: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. The care plan indicated Resident #4 had a surgical site to: right stump (AKA). An intervention to address the surgical site was, Observe for s/s pain during treatment and medicate PRN per physician's order.</p> <p>Record review of Resident #4's progress notes revealed in part:</p> <p>A note from 05/30/24 written by ADON Went into res room to do wound care on res. Introduced myself and explained what I would be doing. Res asked if she was in pain and res stated no Res transferred self into bed began wound care. Res dressing taken off and once packing taken out res began to yell. Wound care stopped and this nurse asked charge nurse to medicate res. Nurse called pcp to get an order for [NAME] #3 d/t hydrocodone not in e-kit. Order received for Tylenol #3 one tab po Q4hrs prn and Tylenol #3 taken from e-kit. Res medicated at this time. This nurse began cutting packing to wound size while medication took effect. Wound care completed on res, Res asked for television to be turned on and res resting with eyes closed.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A note from 05/31/24 written by SW SW met with res to complete Social history. Res reported her wound care was painful and she felt mistreated by nursing. Admin notified.</p> <p>Record review of Resident #4's active orders dated 06/27/24 revealed the following order: Nurse to call PCP if pain level not controlled with pain medication. Notify DON/Administrator immediately. four times a day for PAIN TO WOUND TO RIGHT BKA.</p> <p>Record review of Resident #4's discontinued orders revealed the following:</p> <p>An order for Tylenol with Codeine #3 oral tablet 300-30 MG one tablet given by mouth every 4 hours as needed for pain. The order had a start date of 05/30/24 and an end date of 05/31/24.</p> <p>An order for Tylenol with Codeine #3 oral tablet 300-30 MG two tablets given by mouth every 4 hours as needed for pain. The order had a start date of 05/31/24 and an end date of 06/03/24.</p> <p>An order for resident to ensure wound vac flowing at 125mg and be changed weekly on Friday. The order had an order date of 05/30/24.</p> <p>An order for surgical wound to be cleaned with wound cleanser and wound vac to wound bed to be set at -125mmHg continuously and to be changed weekly on Friday. The order had a start date of 06/05/24 and an end date of 06/14/24.</p> <p>Record review of Resident #4's MAR for May of 2024 revealed no record of Resident #4 receiving any medication for pain on 05/30/24. The MAR revealed Resident #4 had an order for Tylenol with Codeine #3 which was ordered as 1 tablet by mouth every 4 hours as needed for pain.</p> <p>During an observation and interview on 06/26/24 Resident #4 was seated on the side of her bed dressed in a hospital gown with her left leg hanging toward the floor and her right leg which had been amputated above the knee lying on the bed with a bandage on the end of the stump. She stated when she got to the facility on [DATE] and the nurse was attaching the wound vac to her stump it was pain like she had never experienced. Resident #4 stated she started hollering and at that time the nurse who was attaching the wound vac told her they had given her some pain medication earlier that should have been kicking in. Resident #4 stated the pain medication did not seem to help at all. Resident #4 stated she did not know the name of the staff person who was attaching the wound vac, but she did know the staff person was still working in the facility because she knew the face. Resident #4 stated she did not feel like the staff person listened to her and took her pain into consideration during the application of the wound vac.</p> <p>During an interview on 06/27/24 at 01:51 PM OTR stated she was in the therapy clinic which was around a corner and down the hall from Resident #4's room on 05/30/24 during the application of Resident #4's wound vac. OTR stated she could hear Resident #4 crying out in agony and at one point she heard Resident #4 say, I just can't take this anymore. OTR stated, What I thought was so sad was I could hear her from her room, around the corner, and into our gym. OTR stated she thought nursing staff tried to give Resident #4 pain medication prior to the procedure. She added, But I don't think they gave it enough time to kick in. OTR stated ADON told her the medication did not have enough time to take effect. OTR stated she had witnessed wound vacs being applied in other settings and she had never heard anyone express the kind of pain Resident #4 was expressing.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Georgia Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  2611 W 46th Ave Amarillo, TX 79110	
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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/27/24 at 03:41 PM MDS LVN stated her office is across the hall from the therapy clinic. She stated she did not hear Resident #4 crying during her wound vac change on 05/30/24 until OTR came into her office to notify her of Resident #4 crying. MDS LVN stated at that point she stepped out of her office into the hall and I did hear some crying. She stated, I heard her crying, I couldn't make out what she was saying. I could tell it was to do with pain. That she was having pain.</p> <p>During an interview on 06/27/24 at 03:49 PM LVN B stated she was the charge nurse who called Resident #4's PCP to get an order for pain medication the facility had on hand in the e-kit. She stated she gave Resident #4 the pain medication before the wound vac was applied.</p> <p>During an interview on 06/28/24 at 09:05 AM MD E stated, Some patients are more sensitive to the wound vacs than others. She stated some of Resident #4's pain was stemming from anxiety. MD E stated, She was a lot more sensitive on the stump area, even just touch sensitive. I think there was some neuropathy going on there. MD E stated she was not a witness to the first wound vac change on 05/30/24 but ADON called and told her everything they had done during the procedure. MD E stated ADON told her wipes were used to get the adhesive to loosen. MD E stated, The only thing I think they could have done differently was maybe call primary (PCP) for other/different meds for pain or anxiety. MD E stated she was in the facility for the next wound vac change and Resident #4 was very anxious to receive care.</p> <p>During an interview on 06/28/24 at 09:12 AM ADON stated she was the nurse changing Resident #4's wound vac on 05/30/24. She stated she knew Resident #4 was in pain because she was screaming. She stated she asked Resident #4's charge nurse LVN B to give her a pain pill but the charge nurse stated because Resident #4 was a new admit her hydrocodone was not in the facility. ADON stated she told LVN B to call the PCP and get an order for something we have in e-kit. ADON stated she told previous DON to walk with LVN B to the e-kit as they were calling the PCP to get the order so the process could be accomplished quickly. ADON said, We administered 2 Tylenol 3s (a medication consisting of acetaminophen and codeine). ADON stated LVN B was the nurse who administered the medication. She stated the medication did not seem to work. ADON stated they waited 15 minutes after the medication was administered to begin working on the wound vac application. When asked if she thought that was long enough for the medication to take effect, ADON answered, She (Resident #4) said it was okay. ADON stated as she continued with the procedure Resident #4 was waving her arm in the air and crying Lord Jesus.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/28/24 at 09:53 AM previous DON stated ADON was the facility wound care nurse and the facility policy was if a resident was admitted with a wound vac the facility would change the wound vac so it was compatible with the equipment the facility owned. DON stated she was in the room with ADON as the wound vac was being changed. She stated she was on standby. DON stated Resident #4 was immediately in pain when ADON began the procedure. DON stated she asked ADON if they should get Resident #4 something for the pain. DON stated she asked repeatedly if we should stop and give her time or find another way to do things. DON stated, It was hurting her (Resident #4) so bad. She was screaming and saying, 'Please help me Jesus, make the pain stop!' DON stated ADON did not use antiadhesive wipes to get the adhesive to loosen. She stated, I'm not sure she realized at that point that we had them (antiadhesive wipes). DON stated, I have never seen a patient have this much pain with removal (of a wound vac). DON stated at that point she told ADON they were going to give Resident #4 a break and she (DON) was going to call the PCP for pain medication. DON stated she left the room to get the medication from the e-kit and when she returned with the medication ADON had already pulled the packing from Resident #4's wound and was cutting the new packing to insert into the wound. DON stated she told ADON they had to give Resident #4 some time for the medication to work. DON stated ADON waited about 10 minutes and started repacking the wound. DON stated Resident #4 started to scream and holler again at that point. DON stated she told ADON they needed to give Resident #4 more time and ADON said, The faster we get it over the faster she will stop hurting and continued the procedure. DON stated she stayed with Resident #4 after the procedure and tried to verbally console her. She stated Resident #4's pain began to subside 30-45 minutes after the procedure was finished. DON stated, Everything [ADON] did was appropriate to the procedure. What she failed to do was properly assess the patient's pain, call the doctor, and see if there was anything else we could do. DON stated 10 minutes was not long enough to wait for the pain medication to take effect. She stated, I think we should have waited at least 45 minutes to an hour.</p> <p>During an interview on 06/28/24 at 11:58 AM MD D stated 15 minutes was not long enough to wait for pain medication to take effect. He stated, It has to be absorbed and it takes longer than that. He stated the time varies for everybody but there is typically not much of an effect for 30-40 minutes.</p> <p>Record review of facility investigation into incident of Resident #4's wound vac being applied revealed a written statement by OTR detailing her concerns regarding Resident #4's pain.</p> <p>Record review of facility wound care, abuse/neglect, pain management in-service taught by CRN on 05/31/24 to DON and ADON revealed the following subject matter:</p> <ol style="list-style-type: none"> <li>1. Before performing wound care, offer pain medication to the resident.</li> <li>2. While performing wound care if the resident is in pain, offer pain medication and give resident time for the medication to work.</li> <li>3. If you are in the middle of wound care and the resident is in pain, cover the wound with a loose dressing, administer pain medication, and document.</li> <li>4. If pain medication is not helping, call MD and have medication scheduled, increased, or changed if not working for the pain.</li> <li>5. Always make sure resident is comfortable, call light within reach, and ask about pain after completing wound care.</li> </ol> <p>(continued on next page)</p>		

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F 0697  Level of Harm - Actual harm  Residents Affected - Few	Record review of facility policy Pain Management, Assessment Scale dated 05/25/16 revealed in part:  Pain is a subjective sensation of discomfort derived from multiple sensory nerve interactions generated by physical, chemical, biological, or psychological stimuli. Complaints of pain will be assessed accordingly by the nurse and effectively managed through prescribed medications, and comfort measures, and all available resources of the facility. Goals . 3. Resident expresses a feeling of comfort and relief from pain. 1. Assess resident's physical symptoms of pain, . 2. Perform comfort measures to promote relaxation. 9. Have the resident rate pain on a scale of one to ten with one being the least pain and ten being the worst pain experienced. The nurse may use pain rating scale when assessing effectiveness of medications and assessing for pain intensity. 12. Talk with the resident about pain and assess for pain relief after interventions. 13. Monitor for effectiveness of pain interventions.		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46534</p> <p>Based on observation, interview and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for one (Resident #4) of 6 residents reviewed for accuracy of records.</p> <p>The facility failed to document the administration of pain medication on 05/30/24 to Resident #4.</p> <p>This failure could place residents at risk of receiving medications in doses other than those ordered.</p> <p>Findings Included:</p> <p>Record review of Resident #4's admission record dated 06/27/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, acquired absence of unspecified leg above knee, polyneuropathy (malfunction of many peripheral nerves throughout the body), and atherosclerosis of native arteries of extremities (fats, cholesterol, and other substances collected on the inner walls the arteries) with rest pain right leg.</p> <p>Record review of Resident #4's admission MDS revealed a completion date of 06/04/24. Section C noted a BIMS score of 12 which indicated moderately impaired cognition. Section GG indicated use of a w/c. Section J indicated use or offer of PRN pain medication as well as pain experienced frequently. Resident #4 rated her pain at an 8 out of 10. Section M indicated Resident #4 had a surgical wound.</p> <p>Record review of Resident #4's care plan completed on 06/13/24 indicated Resident #4 was at risk for falls due to AKA. Resident #4 was at risk for uncontrolled pain. The interventions listed were initiated on 05/31/24 and included: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. The care plan indicated Resident #4 had a surgical site to: right stump (AKA). An intervention to address the surgical site was, Observe for s/s pain during treatment and medicate PRN per physician's order.</p> <p>Record review of Resident #4's progress notes revealed in part:</p> <p>A note from 05/30/24 written by ADON Went into res room to do wound care on res. Introduced myself and explained what I would be doing. Res asked if she was in pain and res stated no Res transferred self into bed began wound care. Res dressing taken off and once packing taken out res began to yell. Wound care stopped and this nurse asked charge nurse to medicate res. Nurse called pcp to get an order for [NAME] #3 d/t hydrocodone not in e-kit. Order received for Tylenol #3 one tab po Q4hrs prn and Tylenol #3 taken from e-kit. Res medicated at this time. This nurse began cutting packing to wound size while medication took effect. Wound care completed on res, Res asked for television to be turned on and res resting with eyes closed.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #4's discontinued orders revealed the following:</p> <p>An order for Tylenol with Codeine #3 oral tablet 300-30 MG one tablet given by mouth every 4 hours as needed for pain. This order had a start date of 05/30/24 and an end date of 05/31/24.</p> <p>Record review of Resident #4's MAR for May of 2024 revealed no record of Resident #4 receiving any medication for pain on 05/30/24. The MAR revealed Resident #4 had an order for Tylenol with Codeine #3 which was ordered as 1 tablet by mouth every 4 hours as needed for pain.</p> <p>During an observation and interview on 06/26/24 Resident #4 was seated on the side of her bed dressed in a hospital gown with her left leg hanging toward the floor and her right leg which had been amputated above the knee lying on the bed with a bandage on the end of the stump. She stated when she got to the facility and the nurse was attaching the wound vac to her stump it was pain like she had never experienced. Resident #4 stated she started hollering and at that time the nurse who was attaching the wound vac told her they had given her some pain medication earlier that should have been kicking in. Resident #4 stated she did not remember receiving any medication prior to or during the wound vac application.</p> <p>During an interview on 06/27/24 at 03:49 PM LVN B stated she was the charge nurse who called Resident #4's PCP to get an order for pain medication the facility had on hand in the e-kit. She stated she gave Resident #4 the pain medication before the wound vac was applied. LVN B stated she did not know why the MAR did not reflect Resident #4 receiving Tylenol #3 on 05/30/24. She stated, It should be on there.</p> <p>During an interview on 06/28/24 at 08:52 AM RN G stated the nurse who administered a medication was responsible for documenting in the MAR. He stated the documentation should happen at the time the medication was administered. He stated if he had to use medication from the e-kit he would retrieve the medication using his personal passcode and return to this computer to enter the medication into the MAR of the resident. He said if a medication was administered and not documented it might be given by someone else and it is just false documentation.</p> <p>During an observation and interview on 06/28/24 at 09:12 AM ADON stated she was the nurse changing Resident #4's wound vac on 05/30/24. She stated she knew Resident #4 was in pain because she was screaming. She stated she asked Resident #4's charge nurse LVN B to give her a pain pill but the charge nurse stated because Resident #4 was a new admit her hydrocodone was not in the facility. ADON stated she told LVN B to call the PCP and get an order for something we have in e-kit. ADON stated she told previous DON to walk with LVN B to the e-kit as they were calling the PCP to get the order so the process could be accomplished quickly. ADON said, We administered 2 Tylenol 3s. ADON stated LVN B is the nurse who administered the medication. ADON searched her computer and was unable to find any documentation of Resident #4 being given Tylenol #3 on 05/30/24. ADON stated a possible negative outcome not documenting medication administration was the resident could receive too much medication.</p> <p>During an interview on 06/28/24 at 09:53 AM previous DON stated on 05/30/24 she was in the room when ADON was changing Resident #4's wound vac. She stated Resident #4 was expressing pain and she (DON) told ADON they were going to give Resident #4 a break and she (DON) was going to call the PCP for pain medication. DON stated she left the room to get the medication from the e-kit. DON stated after the medication was administered to Resident #4 she (DON) told ADON they had to give Resident #4 some time for the medication to work.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility policy Purpose and Requirements Medical Records dated 2015 revealed in part:</p> <p>THE MEDICAL RECORD IS A LEGAL DOCUMENT THAT SERVES THE PURPOSE OF: 1. Providing an accurate assessment of each resident's condition.</p> <p>3. Proof of care, treatments, medications, diet, etc. as ordered by the attending physician.</p>