STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676347	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amarillo Center for Skilled Care	6641 W Amarillo Blvd Amarillo, TX 79106

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on interview and record review, the facility failed to report an alleged violation of injury of unknow origin immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation resulted in serious bodily injury, to officials in accordance with State law, including to the State Survey Agency for one (Resident #1) of 8 residents reviewed for injury of unknow origin. The facility failed to report that resident #1 had a fall on 2-27-2024 resulting in a right intertrochanteric fracture (right hip fracture) for 38 days after the fracture occurred. This failure could affect residents by resulting in a delay of identification of injuries and lack of timely follow-up on recommended interventions to prevent serious bodily harm, or lasting physical impairment. Findings include: Record review of Resident #1 face sheet dated 4-17-2024 revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include displaced intertrochanteric (extracapsular (outside a capsule or capsular thing) fractures of the proximal femur) fracture of the right femur (onset 2-28-2024), malnutrition(lack of proper nutrition), anxiety disorder(a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), Alzheimer's(a progressive disease that destroys memory and other important mental functions), hypertension(a condition in which the force of the blood against the artery walls is too high), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), and displaced intertrochanteric (extracapsular (outside a capsule or capsular thing) fractures of the proximal femur) fracture of the left femur (onset 2-20-2024). Record Review of Resident #1's last MDS was an admission completed 2-23-2024 with a BIMS of 4 indicating she was severely cognitively impaired, and she had a functionality of requiring partial/moderate assistance with most activities of daily living. Section C-Cognitive Patterns: C0400 Recall Resident #1 was listed 0 - No-could not recall. Record review of the facility provided Hospital Discharge Summary with date of service 2-29-2024 revealed the following: (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted : 2-27-2024 Admission Diagnoses: Fall, Right Intertrochanteric Fracture Record review of Resident #1's Progress Notes dated 2-27-2024 3:13 AM revealed the following: Per LVN A - Note Text: CNA notified this nurse that resident was on the floor. Upon entering the room resident was on the floor laying on her right-side. Her upper body and head laying on a pile of blankets. resident was near the bottom of the bed. Assessed ROM and c/o pain to Right upper thigh. Denies no other pain. resident denies hitting head. No other injuries noted at this time. x 2 assist to bed. Educated resident to use call light. Notified RP and DON. Also notified NP new order for Xray to right femur and right hip 2 view. Record review of neuro assessments (completed by LVN A) for Resident #1 with effective dates 2-27-2024 at 02:45 AM, 3:00 AM, 3:30 AM, 4:00 AM, and 4:30 AM revealed the following: b. Best Verbal Response 4) Confused - not oriented, but communication is coherent. During an interview on 4-16-2024 at 09:50 AM a family member reported that her mother did have dementia and would often become confused, that on the night of the fall Resident #1 was confused and thought that she had an appointment to get her teeth looked at and that her mother got out of bed thinking that she had an appointment. During an interview on 4-17-2024 at 08:07 AM the Administrator reported that the DON was not in the facility today, would not be available, and did not give a reason why. During an interview on 4-17-2024 at 08:27 AM the administrator reported that the incident with Resident #1 did not become an issue until the resident was discharged and, on the way, out of the facility a family member reported to a staff member that she was going to sue the facility for letting her mother fall resulting in her fracturing her hip. The Administrator reported that the incident/fall occurred on 2-27-2024 and that the CNA (who no longer works for the facility) found Resident #1 on the floor. Resident #1 was assessed, x-rays were ordered, and the original x-rays did not indicate a fracture but due to the residents continued pain Resident #1 was sent to the hospital were a second x-ray did find the fracture and surgery was completed to correct the fracture. The Administrator reported that the staff fallowed protocol and the resident's condition was addressed timely, all staff have been trained on ANE and have been retrained with this new report. When asked why the fall with fracture was not reported the Administrator reported that due to the resident making a specific statement that she was returning from the bathroom and that she would no longer wear socks because she fell , the facility felt the resident was able to explain what occurred and therefore the incident was not and injury of unknow origin. The Administrator stated, If there is any question or if the resident appears confused in any way, then we will report it but if the resident is clear then we determine that the resident is oriented and able to report what happened. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4-17-2024 at 12:33 PM MDS C verified that she completed all section of Resident #1's 2-23-2024 MDS. MDS C verified that Resident #1 did have a BIMS of 4 and a 0 on all short-term memory questions, that Resident #1pretty much did not have any short term recall every time Resident #1 was interview meaning that Resident #1's short-term memory was poor. MDS C reported that Resident #1 often refused care to include therapy due to poor short-term memory leading to not being able to achieve any of her goals and not qualifying for skilled care because Resident #1 could not remember any of the tasks. When asked if Resident #1 could remember why she fell on [DATE] MDS C stated, Probably not. Her short-term memory was so poor she could be standing on the end of the bed or coming from the bathroom, and she would not remember. During an interview on 4-17-2024 at 1:04 PM the SW reported that Resident #1 had poor short-term memory and that she did agree with the MDS Coordinator that Resident #1 did not have the memory capability to recall why she fell on [DATE]. The SW reported that she interviewed Resident #1 on another incident that occurred on 3-9-2024 and she interviewed the Resident #1 again on 3-11-2024 and Resident #1 had no memory of that incident. During an interview on 4-17-2024 at 1:37 PM LVN C (nurse who assessed Resident #1 post the fall on 2-27-2024) confirmed that the CNA found the resident on the floor with the blankets under her head and reported that Resident #1 had a poor memory and history of forgetting immediately instructions that Resident #1 had been given by staff such as using the call light, where to put her laundry, or meal delivery. LVN A reported that she notified the Dr, family, and the DON, that reporting the fall and fracture were definitely something the facility needed to follow protocols and that is why she notified the Dr, family, and DON. During an interview on 4-17-2024 at 1:55 PM the Administrator (the Abuse/Neglect Coordinator) reported that due to Resident #1 making a very specific statement concerning not wearing socks and her fall the facility felt like the resident explained why she fell and that is why they determined that the fall was not an injury of unknown origin and therefore was not reportable. The Administrator reported that she felt like there were no negative consequences because they fallowed their facility ANE policy reporting guidelines. Record review of the facility provided policy titled Abuse/Neglect revised 3-29-2018, revealed the following: E Reporting 3. Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment, misappropriation of resident property, injury of unknown origin to the facility administrator. The facility administrator or designed will report to HHSC . a. If the allegations involve abuse or result in serious bodily harm, the report is to be made within 2 hours of allegation.