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	04/01/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47159 Based on observations, interviews, and record reviews the facility failed to treat each resident with respect, dignity, and care for each resident, in a manner and environment that promotes the maintenance or enhancement of his or her quality of life, while respecting each resident's individuality. The facility failed to protect and promote the rights of 3 of 8 residents (Residents #1, #2, and #3) reviewed for resident rights. The facility failed to ensure Resident #1 was served a meal with napkins, dinnerware and cutlery which were non-disposable. Resident #1 was served a meal with a Styrofoam plate and cup and plastic cutlery as a form a convenience for facility staff. The facility failed to ensure the full visual privacy of catheter bag contents for two residents (Residents #2 and #3) by using privacy covers. These failures could cause residents to feel uncomfortable, embarrassed and disrespected. Findings included: Record review of Resident #1's clinical record reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of Mild Cognitive Impairment of Uncertain or Unknow Etiology (brain changes occurring in the very early stages of Alzheimer's or other neurodegenerative diseases that cause dementia), and Major Depressive Disorder, Single Episode, Mild (a mental health condition that causes a persistent feeling of sadness and loss of interest in activities that were once enjoyable). Resident #1 had a BIMS score of 15 indicating she was cognitively intact. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #1 on 04/01/2025 at 9:47AM revealed she had awoken the morning of 03/27/2025 to find her breakfast tray on her bedside table. Resident #1 stated she wanted some hot coffee and tried to locate her call light. Resident #1's call light had fallen off her bed in the night and she was unable to reach it to summon a CNA. Resident #1 is ambulatory but was experiencing hip pain the morning of 03/27/2025 and had chosen to stay in bed. Resident #1 stated she took the cover off her breakfast plate and used her knife to tap on the side of the plate to get someone's attention. CNA B came into the room and asked Resident #1 why she was banging on the plate and not using her call light, like she was supposed to. CNA B told Resident #1 she was going to break the plate and get glass in her eyes if she kept doing that. CNA B retrieved the call light and clipped it onto Resident #1's blanket and then proceeded to write on the dining slip on the breakfast tray that Resident #1 could no longer have regular plates, cups, and silverware. She was to have only Styrofoam and plastic. Resident #1 stated CNA B put the slip back on her tray and left the room to get her some coffee. When CNA B returned with the coffee, Resident #1 asked if she were being punished. CNA B told her eating on a foam plate and using plastic utensils was for her own safety. Resident #1 stated her RR came to visit her shortly after breakfast and her breakfast tray was still sitting on her bedside table. She told her RR what happened, and the RR immediately took the dining slip with the written request for Styrofoam and plastic dinnerware and told Resident #1 she would take care of the situation. Resident #1 thought her RR had spoken with LVN A after the incident. Resident #1 stated she had received all meals since the lunch meal on 03/27/2025 on regular China with regular utensils but felt embarrassed receiving her lunch on a Styrofoam plate with plastic utensils. An interview with LVN A on 04/01/2025 at 10:00AM reflected on 03/27/2025 CNA B had written on the breakfast dining slip that Resident #1 was to have only Styrofoam and plastic dinnerware. LVN A stated she questioned CNA B on who told her to request the foam and plastic dinnerware for Resident #1. CNA B told LVN A no one had told her to put in the request; she had done it on her own to keep Resident #1 from banging on her plate with her knife and possibly becoming injured. LVN A stated she told CNA B she should have come to her first as the Charge Nurse to discuss the incident, before deciding to make the request to the kitchen on her own. LVN A asked CNA B what she had done with the dining slip and CNA B told her she left it on Resident #1's tray so the kitchen staff would see it before lunch. LVN A stated she spoke with Resident #1's RR who was still visiting at that time, about the incident, and was asked by the RR if Resident #1 was being punished for some reason. Resident #1's RR asked LVN A not to say anything to administration and told LVN A she would take care of the situation on her own. An interview with the DON on 04/01/2025 at 11:00AM reflected she was unaware of the incident between CNA B and Resident #1. The DON stated she had not been at work on Thursday or Friday, March 27th and 28th of prior week and no one had come to talk to her about the incident. She stated she would call CNA B immediately to find out the details of the incident and what disciplinary steps needed to be taken against CNA B. She stated she would also speak with Resident #1, her RR and LVN A. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #1's RR on 04/01/2025 at 5:13PM revealed she felt as if Resident #1 had been embarrassed by CNA B. The RR verified CNA B had written on the breakfast slip from 03/27/2025 Resident #1 was to have only Styrofoam and plasticware. The RR stated Resident #1 was served the lunch meal on a Styrofoam plate with plastic utensils on 03/27/2025, but all other meals since that time had been served on regular China with regular utensils. The RR stated she spoke with LVN A about the situation and asked her not to say anything to administration for fear of pushing too hard and causing problems. Record review of Resident #2's clinical record revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (dementia which presents with behaviors which are more mild and less aggressive and can present a disconnect between actual life circumstances and the person's state of mind or feelings), Major Depressive Disorder, Recurrent, Severe without Psychotic Features (an episode of depression in which loss of self-esteem, worthlessness and guilt are present), Charcot's Joint, Right Ankle and Foot (a rare condition caused by complications of diabetes-related neuropathy which causes bone and joint fragmentation), and Type 2 Diabetes without Complications (a condition where the body cannot use insulin correctly and sugar builds up in the blood). Resident #2 had a BIMS score of 00, indicating she was severely cognitively impaired. An observation of Resident #2 on 04/01/2025 at 10:10AM revealed she was sitting in her wheelchair by the nurse's charting station while CNA C was charting. Resident #2's catheter bag contents were clearly visible, and no privacy cover was in place. An attempt to interview Resident #2 was not successful due to her level of cognition. Record review of Resident #2's physician orders dated 03/21/2024 revealed the following: Ensure foley bag is in privacy bag while in bed or wheelchair, every shift. An interview with CNA C on 04/01/2025 at 10:12AM reflected he was not sure if Resident #2 minded if her privacy bag was not covering her catheter bag contents, but stated, It must have fallen off! [Resident #2] had it at breakfast; I don't know what happened. CNA C immediately went to Central Supply to replace Resident #2's privacy bag. CNA C stated the negative outcome of not having a privacy bag would be Resident #2 might become embarrassed or feel bad about herself. Record review of Resident #3's clinical chart revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of Sepsis, Unspecified Organism (a serious condition in which the body responds improperly to infection), Addison's Disease (a condition where the body doesn't make enough of the hormones cortisol and aldosterone), Multiple Sclerosis (a disease that causes breakdown of the protective covering of the nerves), [NAME] (an intestinal bleed involving black, tarry stools from the upper gastrointestinal tract), Systemic Lupus Erythematosus, Unspecified (an auto-immune disease where the body mistakenly attacks healthy tissue, skin, joints, kidney, brain and other organs), and Neuromuscular Dysfunction of Bladder, Unspecified (the nerves of the brain or spinal cord are damaged and the sphincter muscles of the bladder can no longer work correctly). An observation of Resident #3 on 04/01/2025 at 1:30PM revealed she was laying in her bed with her catheter bag clipped close to the end of the bed. There was no privacy cover, and the bag was able to be seen from the hallway, when the door to the room was open. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #3 was unsuccessful due to her unresponsiveness and end-of-life circumstances. An interview with Resident #3's RR on 04/01/2025 at 1:33PM reflected Resident #3 had not had a cover on her catheter bag since Friday, March 28th when she started Hospice services. The RR stated Resident #3 would be so embarrassed if she knew the bag was hanging from the bed with no covering. Resident #3's RR stated the communication in the facility had been less than helpful. She had asked 2 unnamed CNAs if they could get privacy covers for the bag over the weekend, but neither had returned with the covers. Record review of Resident #3's physician orders dated 03/16/2025 revealed the following: Resident to be bed bound due to pain/end-of-life, two times a day for Hospice/end-of-life related to Sepsis, Unspecified Organism. Ensure Foley bag is in privacy bag while in bed or wheelchair every shift related to Neuromuscular Dysfunction of Bladder, Unspecified. Record review of the facility's undated policy for Resident Rights did not reflect written policy for the use of regular China and utensils or privacy bags over catheter bags.