STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676100	A. Building B. Wing	05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Angelo Nursing and Rehab	5455 Knickerbocker Rd San Angelo, TX 76904

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44766 Based on observation, interview, and record review the facility failed to ensure necessary treatment and services consistent with professional standards of practice to promote healing of a pressure injury was provided based on the comprehensive assessment for 4 of 4 residents reviewed for pressure injury. (Resident's #1, #2, #3, and #4) The facility failed to implement interventions to prevent pressure wounds for 4 Residents. Resident #1 acquired 3 wounds, wound #1 was to the left gluteal stage 3, Wound #2 was to the sacrum, stage 2, and wound #3 was to the right gluteal stage 2. Resident #2 acquired a stage 2 wound to the right gluteal. Resident #3 acquired a stage 2 wound to the right gluteal. Resident #4 acquired a stage 2 wound to the sacrum. The facility failed to turn and reposition Resident #4 daily. This failure could place residents at risk for developing pressure injuries and worsening pressure injuries. Findings included: Record review of Resident #1's electronic face sheet, dated 4/27/2023 revealed he was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses to include Spinal Stenosis (happens when the spaces in the spine narrow and create pressure on the spinal cord and nerve roots) Muscle weakness, and Constipation. Record review of Resident #1's most recent Quarterly MDS dated [DATE] revealed BIMS of 10, which indicated no cognitive impairment. Record review of Resident #1's care plan revised on 2/23/23 regarding ADL care indicated Resident #1 required total assistance of two staff for transfers and extensive physical assistance of two staff for repositioning. The care plan does not notate refusal of repositioning. Record review of Resident #1's care plan initiated 4/27/23 regarding impaired skin integrity indicated Encourage and assist with frequent positioning to prevent pressure to injuries. Record review of the Weekly Non-pressure log dated 4/10/23 indicated that Resident #1 had shearing to the right gluteal. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of the Weekly Skin assessment dated [DATE] indicated that Resident #1 has current skin issues with ongoing treatment, no new areas of breakdown noted. Completed by LVN-C (wound care nurse). Record review of the Weekly Skin assessment dated [DATE] indicated that Resident #1 has current skin issues with ongoing treatment, no new areas of breakdown noted. Completed by LVN-C. Record review of the weekly skin assessment dated [DATE] revealed that Resident #1 had no new skin issues. Completed by LVN-C. Record review of WCP-A wound care notes dated 4/25/23 indicated: Resident #1 had 3 wounds, wound #1 (new) was to the left gluteal stage 3, Wound #2 (new) was to the left back stage 2, and Wound #3 (new) was to the right gluteal stage 2. Record review of the Weekly Skin assessment dated [DATE] indicated that Resident #1 has 3 NEW areas of breakdown, Stage 2 to left back, Stage 3 to left buttock, and Stage 2 to right buttock. Completed by LVN-C Record review of the shower log dated 4/18/23 revealed for Resident #1 bed bath was given with pressure sore notated for sacral area. Record review of the progress notes for March, April, and May 2023 did not contain documentation of Resident #1 refusing care. Orders: Cleanse stage II to left back with wc or ns, pat dry, apply collagen ag and cover with silicone foam one time a day and as needed (order date 4/26/23, start date 4/26/23) Cleanse stage III to left glut with wc or ns, pat dry, apply collagen ag and cover with silicone foam one time a day and as needed (order date 4/26/23, start date 4/26/23) Cleanse stage II to right glut with wc or ns, pat dry, apply collagen ag and cover with silicone foam one time a day and as needed (order date 4/26/23, start date 4/26/23) LAL mattress every shift for multiple pressure injuries (order date 4/26/23, start date 4/26/23) Pressure reducing mattress to bed (order date 9/18/20) Wound Consult by Advantage Surgical and Wound Care as needed (order date 12/15/22) Vitamin C 500 MG (Ascorbic Acid) give 1 tablet by mouth one time a day for wound healing (order date 12/08/22, start date 12/09/22) Measurements from facility notes in cm: L glut 2.5x2x0.1 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R glut 3.5x0.5x0.1 Lower back 0.7x0.5x0.1 During an observation on 4/28/23 at 10:47 a.m. Resident #1 was lying on his left side. During an observation on 4/28/23 at 12:19 p.m. Resident #1 was lying on his left side. During an observation on 4/28/23 at 1:46 p.m. Resident #1 was lying on his left side. During an interview on 5/5/2023 at 2:05 PM, LVN-C (Wound care nurse) stated that Resident #1 was a difficult case. She stated that he moved a lot in his bed and does not like to stay in the same position for long at all. She stated that he would refuse repositioning but that was not the biggest issue. She stated that he will reposition himself back to his one side right after being repositioned from the other side to help wound healing. She stated that all 3 of Resident #1's wounds happened very fast. She stated he had some shearing to the back sides of his buttocks upper legs that she had been working on. She stated that the wounds were pretty much healed. She stated that the weekly skin assessment on 4/19/23 and the resident was pretty much healed. She stated on 4/24/23 CNA-D called her to Resident #1's room and the wounds were much worse than they were on 4/19/23. She stated Resident #1 did not just have shearing he had open wounds. She stated she called the wound care physician immediately and staged the wounds over the phone with her based on her observations. She stated she looked at the shower log for that past weekend and the skin evaluation form dated 4/22/23 did not indicate any shearing, redness, or sores to the left or right buttock. During an interview on 5/5/2023 at 11:45 AM FM-L stated based on everything she believes Resident # 1 was not repositioned as much as he should have been. She stated that there were a couple of days when staffing seemed a little short to get to him to do repositioning. She stated he only really likes to lay on one side. She stated so there has been times where the staff had repositioned him and within about 30 mins, he would wiggle himself back to his other side. She stated he would also remove the pillow between his legs that they put there; it takes some time, but he would ultimately remove the pillow. She stated she has never heard facility staff offer education on him repositioning himself or the importance of why not to do it. Resident #2 Record review of Resident #2's electronic face sheet, dated 5/3/2023 revealed she was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses to include Type 2 Diabetes, Difficulty in Walking, and Constipation. Record review of Resident #2's most recent MDS dated [DATE] revealed BIMS of 12, which indicated no cognitive impairment. Record review of Resident #2's care plan revised on 4/17/21 regarding ADL care indicated Resident #2 required assistance of one staff for transfers and extensive physical assistance of one staff for repositioning. The care plan did not notate refusal of repositioning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #2's care plan revised on 4/17/21 regarding limited physical mobility related to weakness indicated Monitor/document/report PRN any signs or symptoms of immobility: contractures forming or worsening, thrombus formation, skin-breakdown . Record review of Resident #2's care plan revised 4/17/21 regarding impaired circulation indicated to follow facility policies/protocols for prevention of skin breakdown (initiated date 10/26/21) Record review of the progress notes for March, April, and May 2023 did not contain documentation of Resident #2 refusing care. During an interview on 5/1/2023 at 12:00 PM, Resident #2 stated she used to have two wounds on the bottom part of her buttocks on both sides. She stated that one side had fully healed and the other was almost done healing. She stated she really was not sure how or why she got the wounds. She stated the only thing she figures was both wounds from sitting 24/7. She stated she doesn't like a bed and doesn't want one, so she sleeps in her recliner. She stated when she wakes up, she goes directly to her wheelchair. She stated that she was told that she has those wounds on her legs because she sits way too much. She stated she only started getting the wounds when her PT ran out and she sits all the time. She stated no nurses or CNA's come by to ask her if she needed help to reposition or just stand for a little bit. She stated she would if she was asked to or got a little help to do so. She stated the staff seems very rushed or busy to help her though. She stated that the changes by the facility after the wounds were discovered was a cushion for her wheelchair, which she uses all the time. Orders: Resident #2 Cleanse stage II to right glut with wc or ns, pat dry, apply zinc oxide every shift and as needed after incontinent episode or showers (order date 04/05/23, start date 04/05/23) Pressure reducing cushion to wheelchair (order date 03/11/20) Pressure reducing mattress to bed (order date 3/11/20) ROHO cushion to WC every shift for ppx (order date 08/17/22, start date 8/17/22) Wound Consult by Advantage Surgical and Wound Care as needed (order date 8/9/22) Measurements from facility notes in cm: R glut 1x1x0.1 During an observation on 5/3/2023 at 10:36 AM, Resident #2 was sitting in same position in her wheelchair, pressure fully on butt and both upper thighs. During an observation on 5/3/2023 at 12:28 PM, Resident #2 was sitting in same position in her wheelchair, pressure fully on butt and both upper thighs. During an observation on 5/3/2023 at 2:37 PM, Resident #2 was l sitting in same position in her wheelchair, pressure fully on butt and both upper thighs. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #3 Record review of Resident #3's electronic face sheet, dated 5/3/2023 revealed he was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses to include Type 2 Diabetes, Dementia, and Dysphagia (medical term for swallowing difficulties). Record review of Resident #3's most recent Quarterly MDS dated [DATE] revealed BIMS of 13, which indicated no cognitive impairment. Record review of Resident #3's care plan revised on 12/11/19 regarding ADL care indicated Resident #3 required assistance of two staff for transfers. It does not notate refusal of repositioning. Record review of Resident #3's care plan revised 9/8/21 regarding at risk for skin integrity impairment indicated Follow facility policies/protocols for skin/wound prevention/treatment. Record review of Resident #3's care plan revised 3/8/23 regarding impaired skin integrity indicated Encourage/assist frequent re-positioning avoiding pressure to injury sites. (initiated 12/20/18) Record review of the progress notes for March, April, and May 2023 did not contain documentation of Resident #3 refusing care. During an interview on 5/3/2023 at 12:15 PM, Resident #3 stated that he can't really reposition in his chair on his own. He stated that the couple times he had tried he has fallen out of the chair. He stated he has requested for help to reposition in his chair, but he was either told they would get to him shortly or they never come back to him. He stated he does feel the wound should have been prevented if he didn't sit in his chair all day long and got a little help from the staff. Orders: Resident #3 A+D to bilateral lower legs and buttocks Q shift and PRN incontinent care every shift for dry skin red buttocks (order date 12/21/21, start date 12/22/21) Cleanse stage II to sacrum with wc or ns, pat dry, apply collagen and cover with silicone with foam as needed if comes off or becomes soiled (order date 4/18/23, start date 4/18/23) Cleanse stage II to sacrum with wc or ns, pat dry, apply collagen and cover with silicone with foam one time a day (order date 4/18/23, start date 4/19/23) Low air mattress to help prevent further skin breakdown (order date 7/9/22) Pressure reducing cushion to wheelchair (order date 12/21/21) Wound consult by Advantage Surgical and Wound Care as needed (order date 8/9/22) Measurements from facility notes in cm: Sacrum 0.2x0.2x0.1 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 5/5/2023 at 10:14 AM Resident #3 was sitting in the same position in his wheelchair, pressure fully on butt and both upper thighs. During an observation on 5/5/2023 at 11:48 AM Resident #3 was sitting in the same position in his wheelchair, pressure fully on butt and both upper thighs. During an observation on 5/5/2023 at 1:03 PM Resident #3 was sitting in the same position in his wheelchair, pressure fully on butt and both upper thighs. Resident #4 Record review of Resident #4's electronic face sheet, dated 5/3/2023 revealed he was an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses to include Type 2 Diabetes, Pulmonary Disease, and Osteoarthritis. Record review of Resident #4's most recent Quarterly MDS dated [DATE] revealed BIMS of 15, which indicated no cognitive impairment. Record review of Resident #4's care plan initiated on 4/17/20 regarding ADL care indicated Resident #4 required assistance of one to two staff for transfers (revised 7/25/20) and extensive physical assistance of one staff for repositioning. Record review of Resident #4's undated care plan regarding ADL care indicated Resident #4 does not notate refusal of repositioning. Record review of Resident #4's care plan initiated on 4/17/20 regarding limited physical mobility related to weakness indicated to monitor/document/report PRN any signs and symptoms of immobility: contractures forming or worsening, thrombus formation, skin-breakdown. Record review of Resident #4's care plan initiated on 9/23/22 regarding potential for further alteration in skin integrity impairment indicated to Check resident for incontinence frequently and provide peri care as needed. Keep skin clean and dry, Record review of the progress notes for March, April, and May 2023 did not contain documentation of Resident #4 refusing care. During an interview on 4/28/2023 at 11:45 AM Resident #4 stated he stayed in his wheelchair pretty much all the time. He stated he probably got his wounds from sitting on his butt all day. He stated he wouldn't mind if staff were to help him get up a little each day or work with him in his chair to reposition. He stated staff does not come and ask him if he wants to be repositioned. Orders: Resident #4 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Cleanse stage II to right glut with wc or ns, pat dry, apply collagen sheet and hydrocolloid drsg one time a day every other day and PRN if comes off or becomes soiled (order date 4/12/23, start date 4/13/23) Pressure reducing cushion to wheelchair every shift (order date 12/24/19, start date 12/24/19) Wound Consult by Advantage Surgical and Wound Care as needed (order date 9/13/23) Multivitamins-Minerals Tablet give 1 tablet by mouth one time a day for wound care (order date 11/09/21, start date 11/09/21) Vitamin C Tablet 500 MG (Ascorbic Acid) Give 1 tablet by mouth one time a day for wound healing (order date 03/01/23, start date 03/02/23) Measurements from facility notes in cm: R glut 0.4x0.6x0.2 During an observation on 5/12/2023 at 11:14 AM Resident #4 was sitting in the same position in his wheelchair, pressure fully on butt and both upper thighs. During an observation on 5/12/2023 at 12:48 PM Resident #4 was sitting in the same position in his wheelchair, pressure fully on butt and both upper thighs. During an observation on 5/12/2023 at 2:03 PM Resident #4 was sitting in the same position in his wheelchair, pressure fully on butt and both upper thighs. During an interview on 4/27/2023 at 10:45 AM, the DON stated that some of the residents do refuse to be turned or repositioned. She stated that any time this occurs, the nurse/aid was to notate refusal in progress notes of the nursing system. She stated Resident #1 has been known to refuse being repositioned as well as Resident #4. She stated she was not exactly sure how residents were getting wounds. She stated that the wound care nurse (LVN-C) was outstanding and did a great job. She stated the facility has more of a preventative care to wounds issue then a restorative care issue. She stated that once the wounds are discovered they are healed. She stated that Resident #1 was also known to reposition himself after being repositioned. She stated he does not like to lay on his right side. During an interview on 4/27/2023 at 12:25 AM NP-B stated that she has been monitoring all residents and Resident #1 has been one on her radar. She stated that Resident #2, Resident #3, and Resident #4's wounds could have been prevented through repositioning. She stated those residents need to move more and not be in their wheelchairs all day. She stated she doesn't really offer to reposition the residents in wheelchairs because she feels they should be able to reposition themselves. She stated that the expectation is that all residents are to be repositioned every two hours. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/27/2023 at 5:30 PM LVN-C stated as far as the wounds go, she believes that Residents #2, #3, and #4 were all completely preventable. She stated that the residents can be put on all the supplements in the world but if the staff don't reposition them or turn them, help them get up, whatever, it won't make a difference. She stated that when she is around it looks like the staff is doing their jobs but she is technically in a management position so she knows that might make them act busy around her. She stated that as the wound care nurse she has done education with staff about turning/repositioning residents and in-services on skin, but she is not sure what the DON and Administrator have done. She stated the expectation is residents are to be repositioned every two hours. She stated she doesn't really do a lot of reposition rounding because she works on the wounds in the facility pretty much all day long. During an interview on 4/28/2023 at 6:10 AM CNA-D stated that there are a few residents she works very hard to keep cleaned, repositioned and no skin break down. She stated but when the other aid works or staff call in and there is not enough, residents are laying on their backs instead of repositioned, soaked from head to toe in urine and form wounds. She stated the expectation is to reposition residents every 2 hours. She stated this really doesn't always happen. She stated that she may just get to busy to be able to get to all of the residents. She stated she knows she needs to get to every resident because it can cause wounds but sometimes is just not possible. During a phone interview on 5/5/2023 at 10:30 PM WCP-A stated that the Residents #1-4 wounds could have been prevented. She stated that even though Resident #1's wounds came on rapidly, they also could have been prevented. She stated Residents #2-4 need to be moved out of their wheelchairs to really help from getting the wounds on their buttocks and back of thighs. She stated that on multiple occasions, when she was at the facility to do wound care rounds, she had to wait for a good while before anyone could be tracked down to come help her move a resident or help her with a resident in general. She stated this could explain some of the facility acquired wounds within the facility. stated that all wounds were a case-by-case basis. She stated Residents #2, #3, and #4 wounds could have been prevented by repositioning or getting the residents up and moving them. She stated in the care of Resident #1, 4/25/23 was the first time she had ever seen the resident. She stated that LVN-C did call her on the 4/24/23 to discuss the new wounds found on Resident #1, the wounds described over the phone to her by LVN-C were two stage 2 wounds and one stage 3 wound. She stated that on 4/25/23 when she went to the facility to assess the resident, she did confirm that the resident had 2 stage two wounds and one stage three. During an interview on 5/16/23 at 3:15 PM, DPT-G stated that Residents #1-4 were on PT. She stated Resident #2 was on PT but it ended on 4/14/23. She stated that all residents do need assistance. She stated that Resident #3 can maybe wiggle but he needed assistance to adjust and reposition. She stated that Resident #2 was roughly the same probably could wiggle or reposition but really should have assistance to do so. She stated that Resident #1 was a full assist to move and reposition. She stated that Resident #4 would need assistance to move or reposition in his wheelchair. She stated that the wounds were all associated to the lack of movement in general. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/16/23 at 2:55 PM, the DON stated that she was not exactly sure where the wounds were coming from. She stated that there does seem to be an issue in the preventative care vs the restorative care. She stated that the facility's restorative care was perfect, but the prevention of the wounds seems to be an issue. She stated she was not sure if it really comes down to staffing or employees not doing tasks. She stated that when she was at the facility staff seemed very busy and things were getting done, but the residents were still getting wounds. She stated that Residents #2, #3, #4 were all in their wheelchairs pretty much all day long. She stated that she was not sure if staff were assisting them with repositioning or not. She stated that all residents whose care plans state repositioning were to be repositioned every two hours. She stated that this even includes residents who were in their wheelchairs all day long. During an interview on 5/5/23 at 2:20 PM, the ADMIN stated that he feels the wounds within the facility were more related to newer staff that complete everything they were supposed to do but maybe don't do it as well as they should be doing it or as thoroughly. He stated he was not sure if they were rushing through their task. He stated repositioning concerns would be a nursing staff issue and the DON would handle this issue. Record review of the facility's Un-dated Wound Prevention Program Policy: The purpose of this program is to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure as well as, non-pressure related wounds. 4. All residents will have the following nursing care procedures implemented: b. Activity- i. As tolerated by the resident encourage ambulation and out of bed activity c. Pressure Relief- ii. As tolerated by the resident encourage mobility iii. As needed position and reposition the resident with pillows and other supportive devices,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44766 Based on interview and record review, the facility failed to ensure the physician reviewed Review the resident's total program of care, including medications and treatments to write, sign, and date progress notes at each visit for three (Resident #6, Resident #7, and Resident #8) of 60 residents reviewed for physician services. The facility failed to ensure Residents #6, #7 and #8 was documented to be seen by facility's attending physician at least once within the first 30 days of admission. The failure could place residents at an increased risk of not receiving appropriate and adequate medical care. Findings included: Review of Resident #6's quarterly MDS assessment dated [DATE] reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #6's active diagnoses included sclerosis, hyperlipidemia, hypoxemia, and injury of nerve root of cervical spine. Review of Resident #6's Face Sheet dated 5/16/23 reflected his attending physician was PHY-I. There was no documentation found in the clinical record of a physical done in the first 30 days for Resident #6 Review of Resident #7's quarterly MDS assessment dated [DATE] reflected she was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #7's active diagnoses included Dementia, hyperlipidemia, and epilepsy Review of Resident #7's Face Sheet dated 4/27/2023 reflected his attending physician was PHY-I. There was no documentation found in the clinical record of a physical done in the first 30 days for Resident #7 Review of Resident #8's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #8's active diagnoses included type 2 diabetes, hypokalemia, UTI, and anxiety disorder. Review of Resident #8's Face Sheet dated 4/28/2023 reflected his attending physician was PHY-I. There was no documentation found in the clinical record of a physical done in the first 30 days for Resident #8 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676100	A. Building B. Wing	05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Angelo Nursing and Rehab	5455 Knickerbocker Rd San Angelo, TX 76904

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 5/16/23 at 4:15 PM, PHY-I stated that he had gone and seen Resident #6 at the facility but does not have the exact date. He stated that he does not document these visits because he did not want to charge the resident for a visit. He stated he usually goes into the facility after hours when no one was there. He stated that he knew better and should have all documentation available and given to the facility and had a running record of all visits. He stated he will change that immediately and start documenting all visit and getting all documentation to the facility. He stated that he understood he is to visit every new resident to the facility within the first 30 days of being admitted to the facility. During a phone interview on 5/16/23 at 3:15 PM, NP-B stated that she believes PHY-I does come to the facility and see's each resident. She stated she was not sure when he does come and sees the residents. She stated that she has no documentation of his visits. She stated she would have to reach out to him if she ever needed any documentation. She stated that as far as she knows the residents were being seen by PHY-I but she has no records to show that he has. She stated that PHY-I does not upload or give any documentation but knows he visits with them because they discuss the residents together over the phone weekly. During an interview on 5/16/23 at 2:55 PM, the DON stated PHY-I does come to the facility and see's the residents. She stated she does not know when he comes in and she does not know where he documents any of his visits. She stated that NP-B would have all that information. She stated that if the facility ever needed anything NP-B would have it. She stated the NP for PHY-I should have all documentation of his visits and how often he comes to the facility. She stated the NP-B is great about uploading all her visits to the residents, but she never see's PHY-I upload any documents about his visits to the facility. Facility's policy for physician visits/documentation was requested on 5/16/23 at 12:25 PM from the DON. No document was provided by time of exit on 5/16/23 at 5:15 PM. During an interview on 5/16/2023 at 4:45 PM, the DON stated she could not find a policy related to physician visits.