STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675814	A. Building B. Wing	08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S Henderson Blvd Kilgore, TX 75662

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41656 Based on interview and record review, the facility failed to ensure a baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was implemented for 8 of 14 residents reviewed for new admissions (Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, and Resident #11). The facility did not develop a baseline care plan within 48 hours of admission for Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, and Resident #11. These failures could place residents at risk of not receiving care and services to meet their needs. Findings included: 1. Record review of Resident #4's face sheet indicated she was [AGE] years old, admitted on [DATE], and had diagnoses including arthritis, high blood pressure, skin cancer, and osteoporosis (weak and brittle bones that easily break). Record review of Resident #4's orders, dated for 07/01/22 - 08/31/22, indicated she had orders for pureed meat, wound care to her right calf, occupational and physical therapies, observe for pain with interventions, Clindamycin (an antibiotic), and tramadol (a pain medication). Record review of Resident #4's Baseline Care Plan revealed the care plan, with an effective date of 05/27/22, was incomplete and had not been signed by facility staff, the resident or her family. Record review of Resident #4's MDS assessment, dated 06/06/22, indicated she had minimal difficulty hearing with use of a hearing aid, had clear speech, understood and was understood by others, and had impaired vision with the use of corrective lenses. She had mildly impaired cognition and required supervision and set up help with all ADLs and used a walker for ambulation. She was occasionally incontinent of the bladder and had occasional pain that she rated as mild. 2. Record review of Resident #5's face sheet indicated he was [AGE] years old, admitted on [DATE], and had diagnoses including Alzheimer's, heart failure, bipolar disorder (extreme mood swings), schizoaffective disorder (a combination of hallucinations/delusions and mood symptoms such as depression or mania), depression, kidney failure, heart disease, left foot amputation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's orders, dated for 07/01/22 - 08/31/22, indicated he had orders for speech, occupational and physical therapies. Record review of Resident #5's Baseline Care Plan, with an effective date of 06/16/22, revealed the care plan was incomplete and had not been signed by facility staff, the resident, or her family. Record review of Resident #5's MDS assessment, dated 06/24/22, indicated he had minimal difficulty hearing, had clear speech, usually understood and was usually understood by others. He was totally dependent on 2 staff with bed mobility and transfers. He was totally dependent on 1 staff with toilet use and personal hygiene. He used a wheelchair for ambulation. He was always incontinent of bowel and bladder. He had difficulty swallowing food and coughed or choked during meals. He was also at risk for pressure wounds. 3. Record review of Resident #6's face sheet indicated she was [AGE] years old, admitted on [DATE], and had diagnoses including Alzheimer's, high blood pressure, kidney disease, and depression. Record review of Resident #6's orders, dated for 07/01/22 - 08/31/22, indicated she had orders for mechanical soft texture foods, zinc oxide to her buttocks, offload heels while in bed, physical and occupational therapies, amlodipine (a blood pressure medication), citalopram (an antidepressant), donepezil (an Alzheimer's medication), doxycycline (an antibiotic), mirtazapine (an appetite stimulant), and Tylenol #4. Record review of Resident #6's Baseline Care Plan, with an effective date of 08/03/22, revealed the care plan was blank and contained no information. The care plan had not been signed by facility staff, the resident or her family. Record review of Resident #6's admission MDS assessment, dated 08/03/22 , had been completed. 4. Record review of Resident #7's face sheet indicated she was [AGE] years old, admitted on [DATE], and had diagnoses including dementia, heart failure, Parkinson's (brain disorder causing unintended movements), pacemaker, high blood pressure, anxiety, arthritis, hallucinations and depression. Record review of Resident #7's orders, dated for 07/01/22 - 08/31/22, indicated she had orders for nectar thick liquids, labs related to coumadin (a blood thinner) use, coumadin, Ativan (anti-anxiety medication), and trazadone (a sleep aide). Record review of Resident #7's chart on 08/15/22 revealed no baseline care plan. Record review of Resident #7's admission MDS assessment, dated 06/29/22, had been completed. 5. Record review of Resident #8's face sheet indicated he was [AGE] years old, admitted on [DATE], and had diagnoses including stroke, dementia with behaviors, anxiety, atrial fibrillation (an irregular and rapid heartbeat), seizures, weakness, and high blood pressure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's orders, dated for 07/01/22 - 08/31/22, indicated he had orders for blood sugar checks, Depakote (a medication used to treat seizures and psychiatric disorders), behavior/mood monitoring, psychological services, observation for pain and non-pharmacological interventions, occupational and physical therapies, Tylenol, Ativan, Eliquis (a blood thinner), lorazepam (an anti-anxiety), metoprolol (a blood pressure medication), Remeron (an appetite stimulant), Record review of Resident #8's Baseline Care Plan, with an effective date of 07/09/22, revealed the care plan contained no resident information and had not been signed by facility staff, the resident or her family. Record review of Resident #8's MDS assessment, dated 07/15/22, indicated he had unclear speech, was rarely understood and rarely understood others, and had impaired vision. He had severely impaired cognition and continuous disorganized thinking. He had physical behavioral symptoms directed towards others 1 to 3 days and verbal behavioral symptoms directed towards others every day. He required the extensive assist of two staff members with bed mobility and was totally dependent on 2 staff members with transfers. He was totally dependent on one staff member with personal hygiene, toileting, eating, and dressing. He used a wheelchair for ambulation and was always incontinent of bowel and bladder. He was also at risk for pressure wounds. 6. Record review of Resident #9's face sheet indicated he was [AGE] years old, admitted on [DATE], and had diagnoses including dementia, psychosis, high blood pressure, and weakness. Record review of Resident #9's orders, dated for 07/01/22 - 08/31/22, indicated he had orders for blood work every 6 months, behavior monitoring, pain observation with non-pharmacological interventions, physical and speech therapies, and required a pressure relieving device in his wheelchair. Record review of Resident #9's chart on 08/15/22 revealed no baseline care plan. Record review of Resident #9's MDS assessment, dated 08/08/22, indicated he had adequate hearing and vision and clear speech. He usually understood and was usually understood by others. He was cognitively intact and was totally dependent on two staff members with bed mobility and transfers. He required the extensive assistance of one staff member with dressing and personal hygiene. He used a wheelchair for ambulation and was always incontinent of bowel and bladder. He was also at risk for pressure wounds. 7. Record review of Resident #10's face sheet indicated she was [AGE] years old, admitted on [DATE], and had diabetes. Record review of Resident #10's orders, dated for 07/01/22 - 08/31/22, indicated she had orders for physical and speech therapies, Coreg (a medication for high blood pressure), Furosemide and torsemide (diuretics used to flush extra fluids out of the body). Record review of Resident #10's chart on 08/15/22 revealed no baseline care plan. Record review of Resident #10's admission MDS assessment, dated 08/11/22, had been completed. (continued on next page)

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Record review of Resident #11's face sheet indicated she was [AGE] years old, admitted on [DATE], and had diagnoses including schizophrenia (a psychological condition that can cause hallucinations and delusions), anxiety, high blood pressure, depression, and right shoulder joint replacement. Record review of Resident #11's orders, dated for 07/01/22 - 08/31/22, indicated she had orders for behavior monitoring, occupational and physical therapies, psychological evaluation, Depakote, gabapentin (used to treat nerve pain), melatonin (a sleep aide), hydrocodone (a pain reliever), tramadol (a pain reliever), and ziprasidone (an antipsychotic). Record review of Resident #11's chart on 08/15/22 revealed no baseline care plan. Record review of Resident #11's MDS assessment, dated 06/09/22, indicated she had clear speech, understood and was understood by others, and had impaired vision with the use of corrective lenses. She had intact cognition and had verbal behaviors directed at others one to 3 days. She required the supervision of one staff member with bed mobility, transfers, walking, eating, toilet use, and personal hygiene. She used a cane for ambulation. She reported frequent pain and was a smoker. During an interview on 08/16/22 at 4:10 p.m. the DON said to her knowledge the old DON was the one who initiated care plans. She said they had work to do on the care plans. She said she had asked the corporate RN if the LVNs could initiate care plans. The corporate RN said the LVNs can, but the DON still must go in and sign off on the care plans since she was the RN. She said she wanted to get all her staff together for training on care plans so they could start getting the care plans started, but they had not done it yet. During an interview on 08/19/22 at 3:21 p.m. the administrator said they had been without an MDS nurse for quite a while. She said the new MDS nurse would be starting on 09/12/22 and would begin doing care plans for them. During an interview on 08/19/22 at 2:15 p.m. the DON said they were aware of the care plan issue and had been aware of it, but it had taken time to see who oversaw them and who was able to complete them. She said the expectation for care plans was that they be completed for each resident. She said they did hold care plan meetings but said if there was not a care plan in the computer, then there was not a care plan. Record review of a facility Care Plans - Baseline policy, with a revision date of March 2022, indicated: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight hours of admission .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41656 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet residents' medical needs for 8 of 14 residents reviewed for care plans. (Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, and Resident #11). The facility failed to develop a care plan with measurable objectives and timeframes to address Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, and Resident #11's needs. This failure could place residents at risk of receiving inadequate individualized care and services. Findings included: 1. Record review of Resident #4's face sheet indicated she was [AGE] years old, admitted on [DATE], and had diagnoses including arthritis, high blood pressure, skin cancer, and osteoporosis (weak and brittle bones that easily break). Record review of Resident #4's orders, dated for 07/01/22 - 08/31/22, indicated she had orders for pureed meat, wound care to her right calf, occupational and physical therapies, observe for pain with interventions, Clindamycin (an antibiotic), and tramadol (a pain medication). Record review of Resident #4's Baseline Care Plan revealed the care plan, with an effective date of 05/27/22, was incomplete and had not been signed by facility staff, the resident or her family. Record review of Resident #4's chart on 08/15/22, revealed no care plan. Record review of Resident #4's MDS assessment, dated 06/06/22, indicated she had minimal difficulty hearing with use of a hearing aid, had clear speech, understood and was understood by others, and had impaired vision with the use of corrective lenses. She had mildly impaired cognition and required supervision and set up help with all ADLs and used a walker for ambulation. She was occasionally incontinent of the bladder and had occasional pain that she rated as mild. 2. Record review of Resident #5's face sheet indicated he was [AGE] years old, admitted on [DATE], and had diagnoses including Alzheimer's, heart failure, bipolar disorder (extreme mood swings), schizoaffective disorder (a combination of hallucinations/delusions and mood symptoms such as depression or mania), depression, kidney failure, heart disease, left foot amputation. Record review of Resident #5's orders, dated for 07/01/22 - 08/31/22, indicated he had orders for speech, occupational and physical therapies. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's Baseline Care Plan, with an effective date of 06/16/22, revealed the care plan was incomplete and had not been signed by facility staff, the resident, or her family. Record review of Resident #5's chart on 08/15/22 revealed no care plan. Record review of Resident #5's MDS assessment, dated 06/24/22, indicated he had minimal difficulty hearing, had clear speech, usually understood and was usually understood by others. He was totally dependent on 2 staff with bed mobility and transfers. He was totally dependent on 1 staff with toilet use and personal hygiene. He used a wheelchair for ambulation. He was always incontinent of bowel and bladder. He had difficulty swallowing food and coughed or choked during meals. He was also at risk for pressure wounds. 3. Record review of Resident #6's face sheet indicated she was [AGE] years old, admitted on [DATE], and had diagnoses including Alzheimer's, high blood pressure, kidney disease, and depression. Record review of Resident #6's orders, dated for 07/01/22 - 08/31/22, indicated she had orders for mechanical soft texture foods, zinc oxide to her buttocks, offload heels while in bed, physical and occupational therapies, amlodipine (a blood pressure medication), citalopram (an antidepressant), donepezil (an Alzheimer's medication), doxycycline (an antibiotic), mirtazapine (an appetite stimulant), and Tylenol #4. Record review of Resident #6's Baseline Care Plan, with an effective date of 08/03/22, revealed the care plan contained no information and had not been signed by facility staff, the resident or her family. Record review of Resident #6's chart on 08/15/22 revealed no care plan. Record review of Resident #6's admission MDS assessment, dated 08/03/22, had been completed. 4. Record review of Resident #7's face sheet indicated she was [AGE] years old, admitted on [DATE], and had diagnoses including dementia, heart failure, Parkinson's (brain disorder causing unintended movements), pacemaker, high blood pressure, anxiety, arthritis, hallucinations and depression. Record review of Resident #7's orders, dated for 07/01/22 - 08/31/22, indicated she had orders for nectar thick liquids, labs related to coumadin (a blood thinner) use, coumadin, Ativan (anti-anxiety medication), and trazadone (a sleep aide). Record review of Resident #7's chart on 08/15/22 revealed no baseline care plan. Record review of Resident #7's chart on 08/15/22 revealed no care plan. Record review of Resident #7's admission MDS assessment, dated 06/29/22, had been completed. 5. Record review of Resident #8's face sheet indicated he was [AGE] years old, admitted on [DATE], and had diagnoses including stroke, dementia with behaviors, anxiety, atrial fibrillation (an irregular and rapid heartbeat), seizures, weakness, and high blood pressure. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's orders, dated for 07/01/22 - 08/31/22, indicated he had orders for blood sugar checks, Depakote (a medication used to treat seizures and psychiatric disorders), behavior/mood monitoring, psychological services, observation for pain and non-pharmacological interventions, occupational and physical therapies, Tylenol, Ativan, Eliquis (a blood thinner), lorazepam (an anti-anxiety), metoprolol (a blood pressure medication), Remeron (an appetite stimulant), Record review of Resident #8's Baseline Care Plan, with an effective date of 07/09/22, revealed the care plan contained no resident information and had not been signed by facility staff, the resident or her family. Record review of Resident #8's chart on 08/15/22 revealed no care plan. Record review of Resident #8's MDS assessment, dated 07/15/22, indicated he had unclear speech, was rarely understood and rarely understood others, and had impaired vision. He had severely impaired cognition and continuous disorganized thinking. He had physical behavioral symptoms directed towards others 1 to 3 days and verbal behavioral symptoms directed towards others every day. He required the extensive assist of two staff members with bed mobility and was totally dependent on 2 staff members with transfers. He was totally dependent on one staff member with personal hygiene, toileting, eating, and dressing. He used a wheelchair for ambulation and was always incontinent of bowel and bladder. He was also at risk for pressure wounds. 6. Record review of Resident #9's face sheet indicated he was [AGE] years old, admitted on [DATE], and had diagnoses including dementia, psychosis, high blood pressure, and weakness. Record review of Resident #9's orders, dated for 7/1/22 - 8/31/22, indicated he had orders for blood work every 6 months, behavior monitoring, pain observation with non-pharmacological interventions, physical and speech therapies, and required a pressure relieving device in his wheelchair. Record review of Resident #9's chart on 08/15/22 revealed no baseline care plan. Record review of Resident #9's chart on 08/15/22 revealed no care plan. Record review of Resident #9's MDS assessment, dated 08/08/22, indicated he had adequate hearing and vision and clear speech. He usually understood and was usually understood by others. He was cognitively intact and was totally dependent on two staff members with bed mobility and transfers. He required the extensive assistance of one staff member with dressing and personal hygiene. He used a wheelchair for ambulation and was always incontinent of bowel and bladder. He was also at risk for pressure wounds. 7. Record review of Resident #10's face sheet indicated she was [AGE] years old, admitted on [DATE], and had diabetes. Record review of Resident #10's orders, dated for 07/01/22 - 08/31/22, indicated she had orders for physical and speech therapies, Coreg (a medication for high blood pressure), Furosemide and torsemide (diuretics used to flush extra fluids out of the body). Record review of Resident #10's chart on 08/15/22 revealed no baseline care plan. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #10's chart on 08/15/22 revealed no care plan. Record review of Resident #10's admission MDS assessment, dated 08/11/22, had been completed. 8. Record review of Resident #11's face sheet indicated she was [AGE] years old, admitted on [DATE], and had diagnoses including schizophrenia (a psychological condition that can cause hallucinations and delusions), anxiety, high blood pressure, depression, and right shoulder joint replacement. Record review of Resident #11's orders, dated for 07/01/22 - 08/31/22, indicated she had orders for behavior monitoring, occupational and physical therapies, psychological evaluation, Depakote, gabapentin (used to treat nerve pain), melatonin (a sleep aide), hydrocodone (a pain reliever), tramadol (a pain reliever), and ziprasidone (an antipsychotic). Record review of Resident #11's chart on 08/15/22 revealed no baseline care plan. Record review of Resident #11's chart on 08/15/22 revealed no care plan. Record review of Resident #11's MDS assessment, dated 06/09/22, indicated she had clear speech, understood and was understood by others, and had impaired vision with the use of corrective lenses. She had intact cognition and had verbal behaviors directed at others one to 3 days. She required the supervision of one staff member with bed mobility, transfers, walking, eating, toilet use, and personal hygiene. She used a cane for ambulation. She reported frequent pain and was a smoker. During an interview on 08/16/22 at 4:10 p.m. the DON said to her knowledge the old DON was the one who initiated care plans. She said they had work to do on the care plans. She said she had asked the corporate RN if the LVNs could initiate care plans. The corporate RN said the LVNs can, but the DON still must go in and sign off on the care plans since she was the RN. She said she wanted to get all her staff together for training on care plans so they could start getting the care plans started, but they had not done it yet. During an interview on 08/19/22 at 3:21 p.m. the administrator said they had been without an MDS nurse for quite a while. She said the new MDS nurse would be starting on 09/12/22 and would begin doing care plans for them. During an interview on 08/19/22 at 2:15 p.m. the DON said they were aware of the care plan issue and had been aware of it, but it had taken time to see who oversaw them and who was able to complete them. She said the expectation for care plans was that they be completed for each resident. Record review of a facility Care Plans, Comprehensive Person-Centered policy, with a revision date of March 2022, indicated: .The comprehensive, person-centered care plan is developed withing 7 days of the completion of the required MDS assessment and no more than 21 days after admission .

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41656 Based on observation, interview, and record review, the facility failed to ensure that residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 3 of 5 residents reviewed for pressure ulcers. (Resident #1, Resident #2, and Resident #3) 1. The facility failed to assess Resident #1's skin weekly which led to the resident being diagnosed with a stage 4 pressure wound (a very deep wound involving skin, muscle, and bone) to her sacrum (the bone between the spine and tailbone). The resident required hospitalization due to sepsis (the body's extreme reaction to an infection), and osteomyelitis (an infection of the bone) of the sacrum due to the wound. 2. The facility failed to assess Resident #3's skin weekly and failed to provide Resident #2 and Resident #3 with consistent wound care to prevent further wound deterioration. These failures placed residents with skin breakdown at risk of pain, worsening of wounds, infection, emotional distress, harm, or death. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 4:50 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at the severity of actual harm that is not immediate jeopardy with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems. Findings included: 1. Record review of Resident #1's face sheet, with a print date of [DATE], indicated she was [AGE] years old, admitted on [DATE], discharged on [DATE] and had diagnoses including an unstageable pressure wound to the sacrum, right side hemiplegia (lack of control in one side of the body), diabetes, Alzheimer's, high blood pressure, and aphasia (inability to communicate effectively). Record review of Resident #1's orders, with a print date of [DATE], indicated an order with a start date of [DATE] for cleansing the resident's buttocks with wound cleanser, pat dry, apply Dakin's solution, and gauze daily. Also noted was an order for a weekly skin assessment on Saturday nights, with a start date of [DATE]. Record review of Resident #1's care plan, indicated a focus area, with an initiation date of [DATE] , of alteration to her skin integrity due to her history of pressure wounds. Interventions included a pressure relief cushion in her wheelchair, weekly skin assessments, monitoring for skin breakdown, performing treatments as ordered, conducting Braden scales, and keeping skin clean and dry. A focus area, with an initiation date of [DATE], indicated she was considered at risk for UTIs and skin breakdown due to her incontinence with interventions including weekly skin assessments, pressure relieving devices, monitor every 2 hours for incontinent episodes and appropriate care after each incontinent episode. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's MDS assessment, dated [DATE], indicated she had minimal hearing difficulty, unclear speech, usually understood and was understood by others, and had mild cognitive impairment. She was totally dependent on one staff member for bed mobility and toilet use. She was totally dependent on two staff members for transfers and required the extensive assistance of two staff members with personal hygiene. She used a wheelchair for ambulation. The MDS indicated she was at risk for developing pressure ulcers but had no pressure wounds present. Record review of Resident #1's most recent Braden scale, dated [DATE], indicated a score of 13, meaning the resident was at moderate risk of developing pressure wounds. Record review of Resident #1's most recent skin assessment, dated [DATE], indicated she had no skin issues. Record review of Resident #1's July MAR indicated she had skin assessments performed on [DATE], [DATE], [DATE], [DATE], and [DATE]. Record review of Resident #1's August MAR indicated she had a skin assessment on [DATE]. Record review of Resident #1's skin assessments through July and August revealed no documented skin assessments for dates [DATE], [DATE], [DATE], [DATE], or [DATE]. Record review of a nurse's note, completed by LVN A, dated [DATE] at 3 p.m., indicated LVN A was notified by CNA B about Resident #1 needing wound care to her buttocks. LVN A assessed the resident's wound and described it as being foul smelling with drainage, slough, and eschar (dry, dead tissue). LVN A notified the resident's family member, the wound care physician and the medical director and received treatment orders for the wound. Record review of a nurse's note, completed by LVN C, dated [DATE] at 5:29 p.m. indicated Resident #1 had an open area to her bottom with a treatment in place. She was to follow up with the wound care physician on [DATE]. LVN C said the resident refused to lay back down after her 10:00 a.m. smoke break. She said she attempted to educate the resident on the importance of laying back down so her wound would not worsen. The resident refused, saying she did not like to lay down and liked to roll around in her chair. Record review of a nurse's note, completed by an agency nurse , dated [DATE] at 1:37 p.m. indicated Resident #1 had an ulcer to her coccyx with treatments tolerated well. Resident #1 was non-compliant with relieving pressure off her wound and demanded to stay up in her chair all day. The agency nurse indicated the resident was given encouragement to lie down, but she would not. Record review of the wound care physician's note dated [DATE] indicated Resident #1 had an unstageable pressure wound to her sacrum measuring 8cm x 12cm x 4cm with 80% slough (dead bacteria, skin cells, and white blood cells) and 20% granulation tissue (new tissue and blood vessels). The wound was present for greater than 5 days and had light drainage. Record review of a nurse's note, completed by LVN C, dated [DATE] at 4:10 p.m., indicated Resident #1 was up in her wheelchair in her room, watching tv. The resident tolerated her wound treatment well but was still refusing to lay down. (continued on next page)

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	675814	A. Building B. Wing	08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S Henderson Blvd Kilgore, TX 75662

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a nurse's note, completed by an agency nurse, dated [DATE] at 5:37 p.m., indicated Resident #1 was seen by the medical director and found to have altered mental status. The medical director ordered the resident be sent out for further evaluation and treatment on [DATE]. Record review of Resident #1's hospital records indicated she admitted on [DATE] with sepsis and a large wound. She was not a candidate for surgical intervention and hospice was suggested as the best option for her. Wound examination described the sacral bone as crumbling and necrotic (dead). Imaging conducted concluded the resident had air in her lower chest that had possibly entered through the wound. The infectious disease physician indicated the resident would not survive her wound with or without surgery and palliative care should be discussed. She discharged from the hospital to a different facility on [DATE]. During an observation on [DATE] at 11:10 a.m. of Resident #1's room contained a low air loss mattress and a pressure relieving cushion in her wheelchair. During an observation on [DATE] at 4:50 p.m. Resident #1 was seen in the ICU. She had been intubated (tube inserted through the mouth to keep the airway open so oxygen can be delivered to the lungs via a machine) earlier in the day and was on a ventilator (life support machine). The resident's wound was dressed and packed. After removal of the dressing and packing, the wound was noted to have a strong odor. The wound bed had white slough, dark colored eschar , and drainage. The resident's sacrum bone was visible. The wound was very large and very deep, larger than a softball, and displayed some granulation tissue. During a phone interview on [DATE] at 10:31 a.m., Resident #1's family member said she was at the hospital when the resident was turned over and she saw the resident's bottom for herself. She said it was a very large wound and was a stage 4. She said one of the physicians at the hospital said the wound to the resident's bottom was very bad and would need surgery, but he did not believe it was fixable. She said the hospital staff were trying to determine if the wound went down to the bone. She said she did not know if the facility had a wound care nurse on staff and did not know if the staff were showering the resident regularly. She said the resident had a colostomy bag (a piece of the colon is surgically placed externally to allow for waste collection in a bag) and she believed staff were not cleaning the resident's bottom since she doesn't poop. She said she had a care plan meeting with the activity director, and she was not sure who else, but she said they never mentioned anything about a wound to the resident's bottom. She said she was called by the facility and notified the medical director had ordered the resident be sent to the hospital. She said she went to the hospital and the medical director arrived as well. He told her the resident had been very lethargic at the facility, did not look like herself and was not behaving like herself. During attempted interviews calls were placed to CNA B on [DATE] at 10:38 a.m. and [DATE] at 2:48 p.m. Voice messages were left both times asking for a return call, but no return call was received. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 12:00 p.m. the administrator said she had implemented an immediate plan of correction, dated [DATE], regarding skin assessments and wound care. She said they identified there were issues with both. She said the plan addressed nurses completing skin assessments as indicated or at least weekly and CNAs to complete skin assessments per CNA protocol and upon showers. The DON, ADON, and administrator were to monitor this weekly and review shower sheets and skin assessment sheets. Wound treatments were also to be addressed by the nurses per orders from the wound care physician and medical director until the wound care nurse started on [DATE]. The DON, ADON, and administrator were to monitor weekly for treatment orders. During a phone interview on [DATE] at 1:39 p.m. hospital RN D said she was the nurse taking care of Resident #1 during her stay in the hospital. She said the resident's wound was a stage 4 and measured 10cm length x 14cm width x 5cm depth. She said there was no way the wound appeared on [DATE] and was as bad as it was by [DATE] when the resident admitted to the hospital. She said once the resident's wound was cleaned out, her sacrum was visible in the wound. She said the resident had osteomyelitis in her pelvis and was on vancomycin (an antibiotic use to treat complicated infections). She said the resident was admitted due to altered mental status, fast heart rate, and a worsening of her wound. She said to her knowledge, the medical director of the facility was the person who sent the resident out and he was concerned about sepsis. She said the resident had 2 units of blood transfused after admission as well. She said they were hoping the resident could have surgery on her wound, but they were not sure if she would be a candidate for that. During a phone interview on [DATE] at 2:49 p.m. LVN A said she worked in the facility for a short amount of time, but Resident #1 was her resident. She said she was asked on [DATE] by CNA B if she was going to do the treatment to Resident #1's bottom before the aide got her up. She said she had no orders to do the treatment to the resident's bottom and was not told about a wound in shift change report. She said at that point she looked at the resident's bottom and noted slough, necrotic (dead) tissue, and a foul odor but she could not give the stage of the wound. She said she notified the administrator, who did not know the resident had the wound. She said she notified the doctor so she could get treatment orders and asked him what to do. She said she asked the other nurse working with her, LVN C, if she knew about the resident's bottom wound, and she said she did not. She said LVN C looked through the resident's chart and said RN E should have done the resident's skin assessment the night before, [DATE]. She said she showed RN E a picture of the wound and when RN E saw it, she said, I don't know what that is. She told RN E that was Resident #1's wound, and she should have seen it on her skin assessment the night before . She said RN E said, I've never seen that. She said the aides she worked with over the weekend, [DATE]-[DATE] were turning their residents every 2 hours like they should, but she could not say if other aides were turning the residents timely. She said she looked in the resident's nurse's notes for at least the previous month of care and saw nothing about the resident's wound. She said one of the aides tried to say they had bathed her the night before, but she was not sure how they could have not noticed the wound, or even the smell of it. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on [DATE] at 4:10 p.m., the medical director said he did not realize Resident #1's wound was as big as it was until he saw it on [DATE]. He said when he saw the wound, he was shocked at the size of it. He said he had known the resident for many years, and he knew from looking at her that day that she was not her usual self. He said the resident had a previous stroke and had issues with communication, but she always knew who he was and was always happy to see him. He said when he saw her the morning of [DATE], she appeared very confused and did not know who he was. He knew then that she needed to be sent out. He said she had some tachycardia (high heart rate) as well and he was unsure if the resident may have had another stroke, was septic, or some other condition. He said he went to the hospital to see the resident that day and had been following her since. He said she was septic, and they were treating her with vancomycin. She also had osteomyelitis to her sacrum and her sacrum was visible once the wound had been cleaned out. He said he could not say definitively if the wound could have occurred and progressed to the point it was at on [DATE] with no one noticing it. He said he did see Resident #2 and Resident #3 as well. They both had wounds that he was aware of. He did not realize the residents were not having regular skin assessments and said that it was problematic they were not receiving them. During an interview on [DATE] at 10:20 a.m. the corporate RN said she saw Resident #1's wound for herself through pictures taken of it, and it looked as if the wound had not healed properly. She said the wound appeared to have healed over the top instead of the wound healing from the inside out. She said she believed there had been a wound in that area prior to this happening and it may have been old. During a phone interview on [DATE] at 10:39 a.m. LVN F said she was the treatment nurse for the facility until [DATE] but left. She was now a PRN employee and had not worked in a month. She said when she left, Resident #1 only had a small abrasion to her left glute (the large muscle of the buttock) from the brief. She said she did the weekly skin assessments for the residents when she was the treatment nurse. She said she went from wound care to the floor as a regular nurse. She said when she went back to the floor, the resident's skin assessments were to be passed off to the nurses caring for the residents. She said she worked in the facility for about a year and had not ever seen a wound to Resident #1's coccyx or sacrum. She said she made a conscious effort to turn the residents if the aides did not. She said she could not speak for everyone on if the residents were being turned and repositioned. She said Resident #1 was very adamant about going to all smoke breaks and not laying back down between the breaks. She said she asked for policies and procedures regarding wound care and skin assessments, but she was never given them. During an interview on [DATE] at 10:52 a.m. CNA G said she had not taken care of Resident #1 in about 3 or 4 weeks. She said she was not aware the resident had a wound on her bottom until around the time it was seen by the wound care physician. She said they work so understaffed, but there was no reason her bottom should have looked like that and there was no excuse for it. She said LVN C reported to her that it was a bad wound. She said the resident required brief changes and she did not understand how anyone didn't see or identify it. She said it was impossible to turn the residents every 2 hours and it was not being done like it should be. She said they have shower sheets and they're supposed to report any wounds or skin alterations they identify. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:18 a.m. CNA H said she did not see Resident #1's wound to her bottom when she was getting her ready for a shower and did not see it during her shower on [DATE] as she was laying on the shower chair. She said the resident kept pushing back on her and swatting her hands away when she would try to wash the resident's bottom. She said she was not told the resident had a wound on her bottom by the off going shift. She said she did not smell anything, and the resident had no complaints of pain. She said she tried her best to reposition the resident and turn her when she could. She said she was to notify the nurse when she identified a resident skin issue or alteration. During an interview on [DATE] at 12:48 p.m. LVN J said she had worked in the facility since [DATE]. She said resident skin assessments used to pop up in the EMAR, but it had not been doing that lately and she wasn't sure why. She said 100 hall had a skin assessment book that told the nurses what room to do, but they still had to do it in PCC (Point Click Care, an electronic charting system) She said no other hall had a skin assessment book. She said they used to have a treatment nurse that handled the skin assessments and wound care. She said when she was told by an aide there was a skin issue with a resident, she would go see the resident and assess. She said she was told a wound was found on Resident #1's bottom, but she did not know how anyone could have missed it. She said she had to tell agency staff that they were expected to do their own wound care and skin assessments because they did not know or were not told. She said she did not believe her residents were being turned every 2 hours as they were supposed to be. She said they seemed to have several high acuity and totally dependent residents clustered together, and she did not believe it would be possible for all residents to be turned every 2 hours. During an interview on [DATE] at 1:25 p.m. CNA K said she had not taken care of Resident #1 in a long while. She said she was in the facility the day the wound was identified though. She said she did not understand why anyone did not see the wound before then because from what she was told, it was very big and had tunneled. She said the resident was very adamant about going to smoke and refused to lay back down. She said the resident would say she was not wet, and a lot of the aides would take her word for it. She said she personally would not take the resident's word for it and would check the resident regardless. She said sometimes the resident would be dry as she said and other times she would be soaking wet. She said she did not understand how the resident's wound was so bad off and yet no one saw it. She said she did not think the aides were cleaning the resident's bottom as they were supposed to. She said she was supposed to report to the nurse whenever she saw a skin issue with the residents. She said she had seen agency aides not turning their residents every 2 hours as they were supposed to. She said she reported this to her nurse every time she saw it. She said she told the agency nurses that they must dress the resident's wounds after she bathed them. She said the RN supervisor did not do treatments on Saturday [DATE] because the key was locked in the cart, and she was not able to get into it. During an interview on [DATE] at 5:27 p.m. the DON said she told nurses who had asked her about the outstanding skin assessments to complete the assessments. She said she had no other way of communicating these things since she was not at the facility at night. She said there was a book on the 100 hall that outlined which skin assessments to do on what day but that was the only book she knew of. She said the wound care nurse was to start on [DATE], but the other floor nurses would still be responsible for their own skin assessments on residents not being seen by the wound care nurse. She said her in-service book was at the nurse's station, but she could not guarantee an agency nurse would look at it or sign it. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on [DATE] at 6:41 p.m. the medical director said the nurse he spoke with on [DATE] portrayed the wound to be smaller than it was when he saw it on [DATE] He said the staff told him the wound had worsened over the past 2 days. He said had he known the wound was in the condition it was, he would have had the staff call the wound care physician instead of him. During an interview on [DATE] at 2:01 p.m. LVN C said she was not aware of Resident #1's wound because the wound was in a place where the only way to see it would have been during incontinent care. She said the aides did not often tell the nurses about Resident #1 refusing to lay down or wanting to stay in her chair. She said CNA B saw the resident's bottom and assumed, with how bad it was, the resident's bottom needed treatment. When CNA B asked if the nurse needed to do the treatment, the nurse was not aware there was a wound. She said the skin assessment reminders appeared in PCC with the options of yes or no. If staff clicked yes, the reminder went away. Staff then had to go into the skin assessment tool themselves and do the skin assessment. If staff clicked no, the reminder would stay active. She said there were skin treatments missed many times due to agency not wanting to do their own wound care. She said her residents were probably not getting turned every two hours because the aides were bogged down with all the high acuity and totally dependent residents. She said RN E was asked why she had not done the skin assessment on Resident #1 on [DATE] and RN E said, I don't know. During a phone interview on [DATE] at 2:50 p.m. RN E said she did not remember if she worked the night before Resident #1's wound was found. She said she performed her skin assessments at night as she was supposed to, and she documented them in PCC. She later said she assessed her resident's skin but did not document it. She denied seeing the resident's wound to her sacrum. She said when they did not have a wound care nurse the nurses were supposed to do the skin assessments themselves. She said she may have been overlooking the PCC documentation part of the assessments, but she did them. She said they had been putting zinc oxide on a wound on Resident #1's left buttock, but she did not see the wound to the sacrum, and she was very surprised to hear about it. She said she had not been educated on wound care or skin assessments. She said they just got the order for wound care and then did whatever the order said. She said they just assessed whoever PCC said to for skin assessments that night. During a phone interview on [DATE] at 4:44 p.m. LVN L said she did not always do skin assessments when she was supposed to because there was no list available to look at. She said when she saw the reminders pop up in PCC, she did the skin assessments. She said the reminders did not always pop up. She denied knowing about Resident #1's wound before it was identified. During an interview on [DATE] at 9:45 a.m. the administrator said she was notified by Resident #1's family on [DATE] at 9:00 p.m. that Resident #1 had expired at the hospital. During an interview on [DATE] at 10:50 a.m. the administrator said she had just been made aware Resident #1 had not expired and was living at a different facility. She said they received a call from the other facility's business office manager requesting payment information for the resident. She said she did not know why the resident's family members would have reported she expired when she had not. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 9 a.m . with the admitting facility's wound care nurse indicated Resident #1 was now residing there. She said the most recent wound measurements were recorded as 17cm x 15cm x 7cm during her admission on [DATE]. Facility staff said she transferred to them on [DATE] from the hospital and was sent back to the hospital on [DATE] due to her being a full code and her oxygen saturation falling to 77% on room air and only increasing to 88% with oxygen. 2. Record review of Resident #2's face sheet, with a print date of [DATE], indicated she was [AGE] years old, admitted on [DATE], and had diagnoses including multiple sclerosis (disease of the brain and spinal cord caused by the immune system), early onset Alzheimer's, high blood pressure and stage 4 wounds to both of her buttocks. Record review of Resident #2's orders, with a print date [DATE], indicated an order with a start date of [DATE] to cleanse the open area to her right calf with wound cleanser, pat dry, apply calcium alginate and cover with a dry dressing. Another order, with an initiation date of [DATE], indicated to cleanse the open area to her left calf with wound cleanser, pat dry, and apply calcium alginate, then cover with a dry dressing. She was to have a skin assessment every Thursday on day shift and a pressure relieving mattress. Record review of Resident #2's care plan, with a focus area of potential for impaired skin integrity, with an initiation date of [DATE], indicated she had a pressure injury related to decreased mobility. Interventions included keeping her clean and dry, positioning with pillows, a pressure relief mattress and pressure relief cushion in her wheelchair, skin assessments every week and turn and reposition her every two hours. Another focus area of current skin concerns and at risk for further breakdown, with an initiation date of [DATE], included interventions of administer wound care as ordered, keep skin clean and dry monitor for increase in breakdown, position with pillows, pressure relief mattress and cushion, and weekly skin assessments. Record review of Resident #2's most recent MDS assessment, dated [DATE] indicated she had clear speech, understood and was understood by others, and had mild cognitive impairment. She was totally dependent on one staff member for toileting and personal hygiene. She required the assistance of two staff members for transfers. She used an electric wheelchair for ambulation. She had documented wounds and was at risk of developing pressure ulcers. Record review of Resident #2's most recent Braden scale, dated [DATE] indicated a score of 9, meaning the resident was at very high risk of developing pressure wounds. Record review of Resident #2's skin assessment, dated [DATE], was incomplete and had no measurements for her right calf wound. Record review of a nurses note by LVN F, dated [DATE] at 7:56 p.m. indicated Resident #2 had an old wound to her calf reopen. The wound care physician was notified, and an order was put in place. Record review of the wound care physician's note dated [DATE] indicated an old ulcer reopened to Resident #2's right calf and measured 7cm x 3cm x .1cm with moderate drainage and 100% slough. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the wound care physician's note dated [DATE] indicates Resident #2's right calf wound had deteriorated and measured 14cm x 3cm x.1cm with moderate drainage. The physician indicated the wound was 30% slough, 40% granulation, 10% muscle/fascia, 20% skin. During an observation and interview on [DATE] at 11:15 a.m. Resident #2 was laying in her bed, she was awake and alert, watching tv. She had a low air loss mattress and a pressure relieving cushion in her electric wheelchair. She said she had a wound to her bottom and a wound to her right leg. She said she did not know when the wound to her right leg occurred, and the facility had to find it. She did not know how long the wound was there before it was found as she cannot feel her legs. She said she was sometimes turned, and needed help with turning and repositioning herself, but she did not frequently get turned and repositioned. She said it was rarely every 2 hours. She was laying on her back with no noted support. She said the nurse's provided wound care daily, but it had not been completed yet that day. During an interview on [DATE] at 11:40 a.m. agency LVN M said she was told to do wound care on her residents for the day. She said she knew to do skin assessments on her residents for the day but was not told by anyone to do them. She said she had not done wound care yet, but she would. During an interview on [DATE] at 11:50 a.m. agency LVN N said he knew where to look in PCC for resident skin assessments and he was sure to do them whether he was told to or not. He said he had already done his wound care on his residents and was also made aware they had wounds and treatments in place in shift report. During an observation and interview on [DATE] at 12:30 p.m. Resident #2 said her dressings were not changed on Saturday [DATE]. She said the dressing were changed on Sunday [DATE]. She said they were still not turning her like they should. She was laying on her back with no positioning devices. Her wounds had dressings, but they were not dated or initialed. During an observation and interview on [DATE] at 2:33 p.m. Resident #2 said her dressings had still not been changed. She was still laying on her back with no positioning devices in place. 3. Record review of Resident #3's face sheet, with a print date of [DATE], indicated she was [AGE] years old, admitted on [DATE] and had diagnoses including quadriplegia (inability to move any of the extremities due to damage to the spinal cord), stroke, high blood pressure, and dystonia (involuntary muscle contractions). Record review of Resident #3's orders, with a print date of [DATE], indicated she had a pressure reducing mattress with an order date of [DATE]. She had an order, with an initiation date of [DATE], to cleanse her left knee with normal saline, pat dry, apply collagen and place a dry dressing daily until resolved. Another order, with an initiation date of [DATE], indicated she had a wound to her left inner lower calf with a treatment of wound cleanser, pat dry, apply collage, and cover with a dressing. No order was noted for weekly skin assessments. Record review of Resident #3's care plan, with a focus area of alteration in skin integrity, with an initiation date of [DATE], indicated she had pressure ulcers and was at risk for skin breakdown due to immobility. Interventions included turning her every two hours, weekly skin assessments, a pressure reducing mattress, positioning with pillows, and monitoring for breakdown. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's most recent MDS assessment, dated [DATE], indicated she had no speech, never understood others and was never understood. She had short and long-term memory problems, severely impaired decision-making skills, continuous inattention and was totally dependent on one staff member for bed mobility, dressing, and eating. She was totally dependent on two staff members for toilet use and personal hygiene. The MDS indicated she had pressure wounds and was at risk for pressure wounds. It also indicated she had a pressure device for bed, nutrition interventions and treatments for her wounds. Record review of a nurse's note, dated [DATE] at 4:06 p.m. and completed by an agency nurse, indicated Resident #3 had a treatment administered to her left inner calf. Her left knee was noted to have an open wound measuring 2.5cm x 5cm with drainage noted. The physician was notified, and orders were received to cleanse the wound with normal saline, pat dry, apply collagen, and apply a dry dressing. The wound care physi [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675814	A. Building B. Wing	08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Guest Care Center	2700 S Henderson Blvd Kilgore, TX 75662

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41656 Based on interview and record review, the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented and systematically organized for 2 of 5 residents reviewed for clinical documentation. (Resident #1 and Resident #3) Nursing staff documented on Resident #1 and Resident #3's ETARs that weekly skin assessments were performed, when they had not been done. These failures could place residents at risk for incomplete and inaccurate clinical records which could lead to miscommunication, a delay in services or a potential decline in resident's health. Findings included: 1. Record review of Resident #1's face sheet, with a print date of 08/23/22, indicated she was [AGE] years old, admitted on [DATE], and had diagnoses including an unstageable pressure wound to the sacrum, right side hemiplegia (lack of control in one side of the body), diabetes, Alzheimer's, high blood pressure, and aphasia (inability to communicate effectively). Record review of Resident #1's orders, with a print date of 08/23/22, indicated an order for a weekly skin assessment on Saturday nights, with a start date of 05/14/22. Record review of Resident #1's care plan, indicated a focus area, with an initiation date of 06/07/19, of alteration to her skin integrity due to her history of pressure wounds. Interventions included a pressure relief cushion in her wheelchair, weekly skin assessments, monitoring for skin breakdown, performing treatments as ordered, conducting Braden scales, and keeping skin clean and dry. A focus area, with an initiation date of 03/25/18, indicated she was considered at risk for UTIs and skin breakdown due to her incontinence with interventions including weekly skin assessments, pressure relieving devices, monitor every 2 hours for incontinent episodes and appropriate care after each incontinent episode. Record review of Resident #1's MDS assessment, dated 06/07/22, indicated she had minimal hearing difficulty, unclear speech, usually understood and was understood by others, and had mild cognitive impairment. She was totally dependent on one staff member for bed mobility and toilet use. She was totally dependent on two staff members for transfers and required the extensive assistance of two staff members with personal hygiene. She used a wheelchair for ambulation. The MDS indicated she was at risk for developing pressure ulcers but had no pressure wounds present. Record review of Resident #1's July MAR indicated she had skin assessments performed on 07/02/22, 07/09/22, 07/16/22, 07/23/22, and 07/30/22. Further review of the resident's chart revealed the resident was in the hospital on 07/02/22 and was not available for the documented skin assessment. The MAR had a Chart Codes key which indicated number codes for staff to choose in the event a task was not performed. The resident not being in the facility would have been coded as a 6. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's August MAR indicated she had a skin assessment on 08/06/22. Record review of Resident #1's skin assessments revealed no documented skin assessments for dates 07/09/22, 07/16/22, 07/23/22, 07/30/22, or 08/06/22. 2. Record review of Resident #3's face sheet, with a print date of 08/23/22, indicated she was [AGE] years old, admitted on [DATE] and had diagnoses including quadriplegia (inability to move any of the extremities due to damage to the spinal cord), stroke, high blood pressure, and dystonia (involuntary muscle contractions). Record review of Resident #3's orders, with a print date of 08/23/22, indicated she had a pressure reducing mattress with an order date of 08/11/22. She had an order, with an initiation date of 07/31/22, to cleanse her left knee with normal saline, pat dry, apply collagen and place a dry dressing daily until resolved. Another order, with an initiation date of 04/14/22, indicated she had a wound to her left inner lower calf with a treatment of wound cleanser, pat dry, apply collage, and cover with a dressing. No order was noted for weekly skin assessments. Record review of Resident #3's care plan, with a focus area of alteration in skin integrity, with an initiation date of 06/24/21, indicated she had pressure ulcers and was at risk for skin breakdown due to immobility. Interventions included turning her every two hours, weekly skin assessments, a pressure reducing mattress, positioning with pillows, and monitoring for breakdown. Record review of Resident #3's most recent MDS assessment, dated 06/17/22, indicated she had no speech, never understood others and was never understood. She had short and long-term memory problems, severely impaired decision-making skills, continuous inattention and was totally dependent on one staff member for bed mobility, dressing, and eating. She was totally dependent on two staff members for toilet use and personal hygiene. The MDS indicated she had pressure wounds and was at risk for pressure wounds. It also indicated she had a pressure device for bed, nutrition interventions and treatments for her wounds. Record review of Resident #3's July MAR indicated she had skin assessments on 07/07/22, 07/14/22, 07/21/22, and 07/28/22. Record review of Resident #3's August MAR indicated she had a skin assessment on 08/04/22. Record review of Resident #3's skin assessments revealed no documented skin assessments on 07/07/22, 07/14/22, 07/21/22, 07/28/22 or 08/04/22. During an interview on 08/15/22 at 2:45 p.m. 2:45 p.m. the DON said she expected the staff in the facility to do their wound care as ordered and skin assessments as ordered. During a phone interview on 08/19/22 at 11:34 a.m. LVN P said she no longer worked in the facility and only worked there for a short time. She said during her time in the facility, she was not told to do skin assessments for the residents on her hall. She said she was never given a schedule regarding what skin assessments to do on what day. She said if someone was not in the facility, she knew she should not chart on them, but other than that she did not know about the codes to apply if the resident was not in the facility or refused. She said she was behind on charting a lot of the time, and she would just click off on her MAR without paying attention to what she was clicking. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/19/22 at 11:45 a.m. LVN J said on days where she checked she had done skin assessments with no skin assessment documentation, it was a click it off kind of day where she did not look at what she was checking off. She said if she did not do something, she should choose the code as to why the task was not performed. She clicked on a resident MAR to provide a demonstration and said if a resident was not in the facility, or an event did not occur, she should choose a code such as 9 which meant other and she would be prompted to enter in a reason for the event that did not occur. During an interview on 08/19/22 at 2:15 p.m. the DON said the risks of staff not doing skin assessments were what they were currently dealing with; residents with wounds and problems that must be fixed. She said she believed her staff were doing skin assessments but were not charting it and giving themselves credit for it. She said her expectations for staff were that they accurately document, and if they did not complete a task, they document as such. Record review of a facility Charting and Documentation policy, revision date of July 2017, indicated: . documentation in the medical record will be objective, complete and accurate .