STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676179	A. Building B. Wing	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midland Medical Lodge	3000 Mockingbird LN Midland, TX 79705

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** 45411 Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice to promote healing and prevent infection for 1 of 8 residents (Resident #2) reviewed for pressure ulcers. The facility failed to follow physician orders and monitor Resident #2's skin under her right leg immobilizer between the evening of 08/01/2022 and the afternoon of 08/04/2022, resulting in the development of an unidentified pressure ulcer to her right knee requiring hospitalization . This failure placed residents at risk for the development or worsening of pressure ulcers, infection, pain, decreased quality of life, and/or hospitalization . The findings included: Resident #2 Record review of Resident #2's Admission Record dated 08/06/22 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included congestive heart failure, local infection of the skin and subcutaneous tissue, reduced mobility, pain, rheumatoid arthritis, age-related osteoporosis, unspecified vitamin deficiency, and edema. Review of Resident #2's Significant Change MDS assessment dated [DATE] documented: She scored a 7 of 15 on her mental status exam, indicating severe cognitive impairment, exhibited physical behaviors directed towards others for 1 - 3 days of the previous 7, was totally dependent on one or two staff for all Activities of Daily Living. She had upper and lower range of motion impairment on one side and used a wheelchair and was frequently incontinent of bladder and always incontinent of bowel. MDS indicated diagnoses of heart failure, hypertension, wound infection, hyperlipidemia, arthritis, osteoporosis, other fractures, and dementia. MDS indicated Resident #2 had chronic pain, had a life expectancy of less than 6 months and was as at risk for the development of pressure ulcers. Review of Resident #2's Care Plan, revised 07/11/2022, indicated, in part: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #2 had an ADL self-care performance deficit related to unspecified dementia without behavioral disturbance. The Goal was: the resident will maintain current level of function in ADL's/ care daily through the review date. Identified Approaches included: a mechanical lift for all transfers, providing a sponge bath when a full bath or shower cannot be tolerated, the resident required assistance by staff to turn and reposition in bed per doctor's order and/or nursing home protocol. Notify doctor and responsible party of significant abnormalities and document findings. The resident required assistance by staff to eat; the resident required skin inspection during all ADL;'s/care per resident request and as necessary. Observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. Review of Resident #2's Care Plan, revised on 6/21/22, indicated, in part: Problem: Resident #2 had a pathological bone fracture due to other specified disorders of bone density and structure. The identified goal was Resident #2 will be free from signs or symptoms of pain or will express/exhibit relief of pain after administration of ordered medications, alternative comfort measures. Identified interventions included: wound care: daily monitor edema/swelling right knee with immobilizer, one time a day. Remove immobilizer to right lower leg and assess skin every shift, then reapply immobilizer. Notify doctor if any changes to skin. In an interview on 8/6/22 at 12:15 PM, DON stated Resident #2 was admitted to the hospital on 8/4/22 after being taken to a follow up appointment with her orthopedic doctor. Record review of Resident #2's Emergency Department note, dated 8/4/22, revealed Chief Complaint: BIBA from skilled nursing facility after Resident #2 was seen for a follow up doctor appointment to check on dislocated knee. Resident #2 was sent by orthopedic doctor due to right knee being swollen, a 1-inch pressure ulcer and drainage., Physical Exam: Skin: circular 3 cm purulent ulcer to right knee, stage 1 erythematous ulcer to mid anterior right shin, Medical Decision-Making Process: [Resident #2] arrived via EMS. She has a chronic appearing wound of the right patellar region with obvious deformity . Orthopedic doctor would like the patient admitted to the hospital with infectious disease consultation and wound care until further plan has been established. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 8/6/22 at 12:15 PM DON stated that on 8/5/22, Resident #2's son came to the facility to meet with the Administrator and herself regarding a wound found on Resident #2's right knee during Orthopedic physician follow-up appointment yesterday (08/04/22). DON stated that Resident #2's son showed pictures of Resident #2's right knee which showed a round wound with pus and brown drainage and what appeared to be a 4-inch by 4-inch foam pad held in place by a single strip of tape above the right knee. DON stated the dressing showed drainage on it too. DON stated Resident #2's son told them the wound was discovered when the orthopedic doctor removed the immobilizer to examine her right knee. DON stated that the facility immediately began investigating the situation with the DON stating the Treatment Nurse had documented a head-to-toe skin assessment for Resident #2 on 8/1/22. DON stated that the only documented wound at the time of the skin assessment on 8/1/22 was an existing skin tear to Resident #2's left 2nd toe. DON stated that Resident #2 was on hospice, that her baths were done by hospice aides and the last bath was documented on 8/4/22, with no documentation of a wound to right knee noted. DON stated that no one from facility or Hospice had reported a wound or skin breakdown regarding Resident #2's right knee to her. DON stated that the Treatment Nurse did identify an abrasion to Resident #2's right shin immediately before Resident #2 left the facility for her Orthopedic appointment on 8/4/22 but the Treatment Nurse denied seeing any wounds or dressing on Resident #2's right knee. DON stated that she questioned the Treatment Nurse about the type of dressing shown in the pictures Resident #2's son showed. DON stated that the Treatment Nurse reported she did have that type of dressing (seen in photo), but Treatment nurse stated she did not use them and did not keep these dressings on her treatment cart. DON stated that the facility was continuing their investigation into the incident. In an interview with on 8/6/22 at 12:15 AM, Administrator stated that Resident #2's son came to the facility on [DATE] and requested to meet with him and the DON. Administrator stated they were shown the pictures of Resident #2's right knee by Resident #2's son. The Administrator stated he instructed the DON to report the incident to State Office and begin a facility investigation. Record review of Resident #2's, MAR's-TAR's revealed the documented physician orders: 9/14/21 (date order written by physician)-Remove immobilizer to right lower leg and assess skin every shift, then reapply immobilizer. Notify MD if any changes to skin. Every Shift. With review, day shift nurses and night shift nurses initialed they completed the physician order (above) while resident was in the facility. 6/17/22 (date order written by physician) Resident #2 has a brace/splint to right knee remove and assess skin every day. Report any adverse findings. Resident is to be moved with extreme caution. Every shift to assess for knee joint dislocation. Instruct aides to use extreme caution while providing resident care. With review, day shift nurses and night shift nurses initialed they completed the order while resident was in the facility. Record review of Resident #2's, Order Summary dated 08/08/2022 revealed the following physician orders: 6/29/22-Arginaid (liquid vitamin supplement) two times a day for wound care protocol, 1 packet mixed in 4-6 ounces water. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/13/22-Wound Care protocol: Pre-Albumin every month. 4/24/19-May apply skin protectant/barrier cream to affected/reddened areas every shift and/or prn as preventative. 5/11/22-Protective tent to foot of bed to prevent pressure on feet every shift. 9/14/21 Remove immobilizer to left lower leg and assess skin every shift, then reapply immobilizer. Notify MD if any changes to skin. 6/17/22-Resident has a brace/splint to right knee, remove and assess skin every day, report any adverse findings. Resident to be moved with extreme caution. 4/24/19-Skin assessments: skin assessments on admission for three days and then weekly, weekly assessments for all identified wounds and Braden risk assessments on admission then weekly times three weeks and then quarterly. 6/20/22 Wound Care: daily monitor edema/swelling right knee with immobilizer. Record review of Resident #2's Skin Assessments, revealed the following documentation by Treatment nurse: 7/25/22 at 2:02 PM revealed no documented wounds. 8/1/22 at 6:22 PM revealed skin tear to left 2nd toe. Record review of Resident #2's Orthopedic Progress Note (during hospital admission), dated 8/5/22, revealed: Assessment/Plan: continued drainage; patient and family have 2 options, wound care, antibiotics for this wound over the anterior knee, I do not know if the TKA is septic but it may be, the other and really only reasonable surgical option is an above knee amputation which the family for good reason is hesitant; reduction with wound care is likely not a good answer as this was attempted in June, this knee has been unstable for at least 6 months and she does not ambulate, I attempted a reduction yesterday but the knee did not move, even if I was able to reduce it, we have no way to keep it reduced which is why the only surgical option would be AKA; recommend ID consult; Wound care consult Record review of Resident #2's Infectious Disease Consultation Note (during hospital admission), dated 8/6/22 revealed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Chief Complaint: BIBA from local skilled nursing facility after a doc appt to check on dislocated knee. Sent by Orthopedic physician d/t knee being swollen, a 1-inch pressure ulcer and drainage., History of Present Illness: ID consultation is requested for [AGE] year-old female with MRSA infection of the right knee and chronic dislocation. She has been non ambulatory for 3 years .Orthopedic physician could not reduce the dislocated knee. He recommended right AKA. Patient is on hospice at skilled nursing facility. She has been started on Vancomycin and Zosyn., Physical Exam: Musculoskeletal: right knee with dislocation and quarter sized ulcer on right knee, the knee is not warm to touch or erythematous., Assessment/Plan: 1. Open knee wound: Patient has a MRSA infection of the knee, a prosthetic knee. I agree with Orthopedic physician and have recommended right AKA for cure. If the goal is chronic suppression, I would treat her with 4 weeks of Vancomycin or Daptomycin and then daily Bactrim for chronic suppression (Clindamycin and Doxycycline will not work for MRSA). I spoke to Resident #2's son and he said that he and his family would like a couple weeks to think about it. I told him that I could place a PICC line and send her to rehab while they decide; it wouldn't be an option to stay here for 2 weeks while they decide. Record review of Resident #2's Hospitalist Progress Note (during hospital admission), dated 8/7/22, revealed: Assessment /Plan: 1. Right knee infected wound/dislocation: continue IV Vancomycin and Zosyn; wound culture grew out MRSA; Infectious Control physician in agreement with Orthopedic physician that AKA would be the correct treatment; Infectious Disease physician offered family that patient can be sent to SNF with IV antibiotics in the mean time until family makes decision about AKA; talked to patient's son who is in agreement with Infectious Control physician and wants IV antibiotics set up until family has come to a consensus about whether they want to pursue surgery or not In an interview on 8/8/22 at 12:28 PM, LVN A stated that Resident #2 had been fragile since she started working in the facility 4 months ago. LVN A stated that Resident #2 recently had a dislocation of her right knee and wore a brace to keep it straight. LVN A stated that she did not remember what the brace looked like exactly and that we did not touch her immobilizer at all. LVN A then stated that sometimes she would unstrap the immobilizer but not take it all the way off. LVN A stated that on the morning of 8/4/22 she saw the brace on Resident #2's leg and signed the order on the MAR's-TAR's but she did not remove the brace to visualize the leg. LVN A stated that she did not notice anything abnormal about the immobilizer on 8/4/22 before Resident #2 left for Orthopedic appointment. LVN A stated that she was not aware of any wounds to Resident #2's right knee/leg until after the Resident #2 was admitted to the hospital on 8/4/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 8/8/22 at 1:04 PM, RN B stated she had been the facility Treatment Nurse since February of 2022. RN B stated Resident #2 was very angry and resistant to care. RN B stated she did an unavoidable pressure ulcer risk assessment on Resident #2, but the physician was on vacation and had not signed it. RN B stated Resident #2 got the brace in June 2022 because she had osteoporosis. RN B described the brace as going approximately 6 inches above the right knee to right above the ankle. RN B stated the brace was a true immobilizer and would force the leg not to bend and the fabric holding it together was solid (no hole for the kneecap) with Velcro straps around it. RN B stated there were metal ridges on the sides covered in fabric preventing Resident #2 from bending her leg. RN B stated all she did was check for circulation at the top and bottom of the brace and make sure it was not too tight. RN B described the process as physically putting two fingers down the immobilizer to make sure it was not too tight (RN B showed surveyors by pantomiming). RN B stated she did not feel very far down the immobilizer to check for edema or to see if Resident #2's extremity was puffy. RN B stated she usually took the immobilizer off on Mondays when she did her full skin assessment, or when she noticed the immobilizer was too loose or too tight. She stated she did not usually take it off more than that. RN B stated she did Resident #2's skin assessment on 8/1/22 and did not find any new wounds when she removed immobilizer to perform weekly full skin assessment. RN B stated she remembered on 8/4/22 she got to the building around 1:45 p.m. and Resident #2 had not left for her Orthopedic physician appointment. RN B stated she did not realize Resident #2 did not have her wound care done that day until she saw the medical transport company going down Resident #2's hallway. RN B asked the personnel of the company who they were taking, and they told her Resident #2. RN B stated she asked them if she could do the wound care on Resident #2 really quick before they took Resident #2 to doctor appointment, transportation personnel waited while RN B provided wound care to Resident #2's left toe. RN B stated while she did the wound care to Resident #2's left toe she noticed the brace looked sloppy and tangled and did not want the orthopedic physician to see the brace looking this way. RN B stated she opened the bottom of Resident #2's brace and noted a new abrasion to the right shin that measured approximately 1. 9 cm x 3 cm. RN B stated there was a dressing on the leg that was not one of hers. RN B stated she took off the dressing, cleaned the wound and put a xero-foam dressing on it and then wrapped the leg in the immobilizer and placed the Velcro correctly. RN B stated she did not open the part of the immobilizer that circled Resident #2's knee. RN B said she did not see any swelling over the top of the brace, and she did not have time to check for edema. RN B stated the transport company took Resident #2 to her appointment. RN B stated she expected Resident #2 to be back around 6 p.m. but the charge nurse told her (RN B) that Resident #2 was sent to the hospital. RN B stated she called the shin injury an abrasion but the corporate nurse told her it should be a Stage II pressure ulcer because of the location. RN B stated she initially thought Resident #2 went to the hospital because the knee was dislocated but the charge nurse told her it was because Resident #2 had a wound to the right knee, and it was infected. RN B stated, nothing was infected that I know of. RN B stated the charge nurse called Resident #2's hospice nurse and then put her on the phone with the treatment nurse (RN B). RN B stated the hospice nurse told her it was because of the wound being infected but did not say which wound. RN B stated she had more personal appointments and had to leave the facility and when she came back from her appointments, the administrator called her (RN B) into his office. RN B stated the DON asked the Hospice agency for the shower and skin sheets. RN B stated another nurse worked with Resident #2 and stated she put lotion on Resident #2's leg because the skin was scaly and flakey. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	RN B stated the family had pictures of the wound and when they showed the pictures to her, she asked what kind of dressing is that? RN B described the picture as showing a 4 cm x 4cm foam dressing that was taped across the wound at the top only. RN B clarified that the 4 cm x 4cm dressing was attached on one side but not the others. RN B stated the DON asked her if she had any dressings (like the ones that were seen in the photographs from son) and she said yes, but they were not in the cart because she did not like to use that type of dressing. RN B stated the dressing was just a non-adherent dressing because whoever put the dressing on used tape. RN B stated she had a hard time wrapping her head around why anyone would put a dressing on like that. RN B was asked to get a 4 cm by 4 cm dressing the facility used. RN B returned with the 4 cm x 4 cm dressing, and she ran her finger across the top, pointing. RN B stated, someone put tape just at the top. RN B stated the dressing absorbed drainage but held the drainage against the skin. RN B stated the only time she would use a 4 cm x 4 cm foam dressing like the one she showed surveyors was on a heal or as a protection of some kind, but not as a dressing. RN B stated the wound care company the facility used kept sending them to her, but she never used it. RN B stated there was a storage closet that held wound care supplies that anyone could get in because it was the same code as all the other doors in the facility. RN B stated the night nurses knew the code. RN B stated the aides should not know it because taking dressings on and off were outside their scope of practice. RN B described Resident #2's leg as the bone at the knee making a pyramid shape and the skin moved funny. RN B stated the new wound on Resident #2's knee appeared to be approximately quarter sized and round. She stated it looked like it might be a stage III wound. RN B stated the picture showed drainage on the foam pad that would match up where the knee was. RN B stated she did not know if there was eschar or drainage to the wound. RN B stated on 8/4/22 she did not notice any drainage. RN B stated she only slid her fingers on the inside at the top of the immobilizer because she was afraid of Resident #2 pulling her hair or something. RN B repeated there were no wounds on Resident #2's leg on Monday (8/1/22) when she opened the whole thing up. RN B stated the hospice company Resident #2 used had a shower aide who came in two or three times a week. RN B stated, a bath aide would be cleaning that leg. RN B stated the facility bath aides used shower sheets. RN B stated no one informed her Resident #2 had a wound on her knee. RN B stated, someone was supposed to let her know about the wound - the charge nurse or the DON. RN B stated, word of wounds traveled so it did not matter who was told first. RN B said she was guessing that when the hospice aides found a wound, they would notify their charge nurse and their charge nurse would notify the facility. RN B stated she never had anyone from that hospice company come to her and report there was a new wound. RN B stated: our facility policy is I look at new wounds. I let the DON know, I communicate with the hospice and the family and the doctor. RN B admitted the charge nurses were not removing Resident #2's immobilizer prior to the discovery of the wound. Surveyors read the physician's order to remove and check skin every day. RN B stated, Really? Ok. I didn't know that. In an Interview on 8/8/22 at 2:48PM CNA C stated that Resident #2 could be resistant to care and that it would normally take 2 to 3 people to provide care. CNA C stated that she had never seen anyone remove or open the immobilizer. CNA C stated that she had seen the treatment nurse open the immobilizer one time when Resident #2 first came back to the facility after the dislocation was found (June 2022) and that the treatment nurse told her not to remove the immobilizer. CNA C stated that the CNAs were not supposed to open or remove the immobilizer. CNA C stated that since Resident #2 was on hospice the facility aides did basic care and the hospice aides did her bed bathes. CNA C stated that she did not know if the hospice aides removed the immobilizer during care. CNA C stated the hospice aides were last in the facility on 8/4/22 and they gave Resident #2 a bed bath that day. CNA C stated that she did not know if or how often the nurses were supposed to remove the immobilizer. CNA C stated she thought the staff had been in-serviced on proper care for the immobilizer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an Interview on 8/8/22 at 7:57 PM, LVN D stated that she had been employed at the facility since March 2022. LVN D stated that since she started working in the facility Resident #2 had been confused and could be very aggressive. LVN D stated that if Resident #2 was resting she (LVN D) would not wake Resident #2 up for care because she did not want to disturb her or make her become agitated. LVN D stated that Resident #2 had a brace or protective thing on her right leg. LVN D stated she did not perform any type of care for it. LVN D stated that the last time she personally removed the brace to do a skin check was the last weekend of July 2022, but she could not remember what day. LVN D stated that at that time she did not see any wounds to Resident #2's right leg or knee. LVN D stated that she checked Resident #2's leg for abrasions or contusions by removing the brace as often as possible if the resident would allow it. LVN D stated she was not aware that she should document if the resident refused care, but she did know how to make a note in the chart to do so. LVN D stated that if there was an order to remove the brace and check the resident's skin, but the resident refused to allow her to do it she would not document that it had been done. LVN D stated that if she saw any dressing present, she would chart about the condition of the dressing, but she would never mess with it. In an Interview on 8/8/22 at 8:18 PM CNA E stated that she had worked in the facility for about one month. CNA E stated that she trained on Resident #2's hall when she started working with Resident #2. CNA E stated she had not worked with Resident #2 since training, but she did assist in providing care at some point the previous week because it took four staff to get Resident #2 cleaned up and the bed changed. CNA E stated the immobilizer was never removed from Resident #2's right leg and that she did not notice anything unusual about the immobilizer or the leg. CNA E stated that Resident #2 could be combative at times. CNA E stated that Resident #2's right leg had to be supported during care and it always took at least three staff to change her. In an Interview on 8/8/22 at 8:32 PM CNA F stated she had worked at the facility for 6 months and that she rotated the halls she worked. CNA F stated that Resident #2's mood was very unpredictable, and staff had to approach her in different ways to provide care depending on her mood. CNA F stated it always took 2 or 3 people to provide care for Resident #2. CNA F stated the last time she worked with Resident #2 was probably the last week of July 2022, but she was not certain. CNA F stated that Resident #2's right leg was sensitive. CNA F stated she had never seen the brace open or heard of anyone opening or removing the brace from Resident #2's right leg. CNA F said she could not remember seeing or being told about any sore/wound on the leg. CNA F stated the most important thing about caring for Resident #2 was that she was always a 2 person assist at least and one person could not provide care for her alone. In an Interview on 8/8/22 at 8:43 PM, CNA G stated that she started working at the facility on 8/1/22. CNA G stated she only worked with Resident #2 on 8/3/22 and she refused care and tried to hit her. CNA G stated she reported the refusal to the nurse. CNA G stated that Resident #2 had blankets covering her, so she did not see her legs. CNA G stated that she was not told that Resident #2 was fragile or that she had a brace on her leg. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an Interview on 8/9/22 at 9:42 AM, Hospice RN stated she last saw Resident #2 on 8/1/22. Hospice RN stated she only saw Resident #2 once a week on Mondays. Hospice RN stated that during her visits she checked vital signs, assessed pain and comfort levels, completed a head-to-toe skin assessment, made sure the resident had all the medications she needed, got any updates/changes from facility nurses, and spoke with the family to provide an update. Hospice RN stated that she did not ever remove the immobilizer from Resident #2's right leg because of the knee dislocation. Hospice RN stated that her skin assessment was done based on the skin surrounding the immobilizer and that she had never seen what Resident #2's leg looked like underneath the immobilizer. Hospice RN stated that she relied on the facility's treatment nurse to give her information regarding Resident #2's skin and that each time she came to the facility she would sit with the treatment nurse and go over the weekly skin assessments and any issues for all the hospice company's residents. In an interview on 8/9/22 at 10:00 AM, The Hospice Administrator stated that hospice staff based their care for residents on what they were told by the treatment nurse regarding skin issues or wounds. The Hospice Administrator stated that hospice nurses did not provide wound care supplies to the facility and hospice aides only brought wipes and briefs when they went to the facility. The Hospice Administrator stated that her aides went to the facility to do baths on Monday, Wednesday and Friday. The Hospice Administrator said recently the facility requested additional help with meals and basic care on Tuesday and Thursday as well but that they should have only been giving baths if it was necessary on those days. The Hospice Administrator stated the hospice aides did not remove Resident #2's immobilizer. The Hospice Administrator stated when the facility sent Admission Orders for Resident #2 there was no order to remove the immobilizer to assess the skin. The Hospice Administrator stated that they do not use the type of dressing that was seen in the pictures taken of Resident #2's right knee. Observation on 8/9/22 at 10:08 AM of pictures sent by the Hospice Administrator revealed box labeled Optifoam Gentle EX Silicone Faced Foam & Border dressing. Dressing was 4-inchx4-inch square in total size with 2.55-inchx2.55-inch square foam pad surrounded by adherent border. In an Interview on 8/9/22 at 10:55 AM, Hospice CNA 1 and Hospice CNA 2 both stated they had worked with Resident #2 since June 2022 and that she was funny and did not refuse care from them. Hospice CNA 1 stated that Resident #2 never complained of pain during care, only discomfort at being moved around. Hospice CNA 1 and Hospice CNA 2 stated that they last saw Resident #2 on 8/4/22 and provided basic care for her. Hospice CNA 1 stated Resident #2 required 2 staff for all care. Hospice CNA 1 stated they last bathed Resident #2 on 8/3/22. Hospice CNA 2 stated that they never removed Resident #2's immobilizer during care and that they were trained to clean around it when bathing her. Hospice CNA 1 and Hospice CNA 2 stated they had never seen the immobilizer removed or opened and both denied seeing any dressing on Resident #2's right leg. Hospice CNA 1 and Hospice CNA 2 denied seeing any drainage on the immobilizer or seeing any signs or symptoms of infection to the surrounding skin. Hospice CNA 2 stated there was a dressing on Resident #2's left foot that she first noticed a couple of weeks ago and that they had not been told about any other wounds. Hospice CNA 1 and Hospice CNA 2 both stated if they discovered a new wound or skin issue, they informed the hospice nurse and the facility nurse. Hospice CNA 1 and Hospice CNA 2 stated that they communicated with their nurse every day regarding the hospice residents and that they were notified of any changes with residents by their nurse. Hospice CNA 1 stated they had only found one new wound on a resident since she started work with the facility and it had been communicated to everyone. Hospice CNA 2 stated that when they brought supplies to the facility it was soap, wipes, briefs, lotions and that they do not carry wound care supplies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676179	A. Building B. Wing	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midland Medical Lodge	3000 Mockingbird LN Midland, TX 79705

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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 - Actual harm Residents Affected - Few	In an Interview on 8/9/22 at 11:30 AM, DON stated that the hospital sent Resident #2's records to the facility. DON stated wound cultures were done on Resident #2's right knee with admission to the hospital and revealed an MRSA infection. DON stated the hospital had started Resident #2 on IV antibiotics. The DON stated the orthopedic doctor recommended an above the knee amputation of the right leg due to the dislocation because it would never be stable again. DON stated that Resident #2's family planned to take some time to decide what course of action they wanted to take and that the hospital doctors agreed to do antibiotics to treat the infection until a decision was made. The DON stated she did not see anything in the hospital records to indicate if a wound care consultation was done. The DON stated the paperwork documented the wound to Resident #2's right knee was a 3-centimeter purulent (pus) ulcer. In an interview on 8/9/22 at 11:30 AM, The administrator stated that he could not say specifically say what caused the system breakdown regarding skin issues in the facility. The administrator stated that there has been quite a bit of turnover in staff and leadership, and they have been dealing with things as they come up. In an interview on 8/9/22 at 2:32 PM, DON stated that at the last skin meeting she thought there were around 40 treatments for wounds but was unable to say how many were pressure ulcers. DON stated that she thought the matrix the facility provided was not correct but that the MDS nurses are the ones responsible for that data. DON stated she did not know how the matrix was populated. The DON stated that when she first began working in the facility there were some issues with how skin issues were labeled such as red areas being called moisture associated skin damage when that was not an accurate description. She stated that she had discussed this with staff and explained the difference. Observation of wound care supply closet with Treatment Nurse on 8/9/22 at 3:10 PM revealed large box of individually packaged dressings labeled SiliGentle Self Adherent Silicone Foam Dressing. Upon opening single dressing, it was noted to be the same color and texture as the dressing shown in the photos sent by Resident #2's son. In an Interview on 8/9/22 at 3:30 PM, Resident #7 (Resident #2's roommate) stated that the day before Resident #2 was admitted to the hospital, Resident #2 and Resident #2's son was visiting in their shared room, when Resident #7 overheard the treatment nurse working with Resident #2 on the other side of the privacy curtain. Resident #7 stated Resident #2 kept sounding like she was in pain and telling the nurse to leave her alone and calling her a fool. Resident #7 stated that the treatment nurse apologized to Resident #2 and said she was almost done, that she just had to put the dressing on and [TRUNCATED]