STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455642	A. Building B. Wing	03/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dayton Nursing and Rehabilitation	310 E Lawrence St Dayton, TX 77535

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 47879 Based on observation, interview and record review, the facility failed to ensure the physician was consulted for a change of condition for 1 of 10 residents reviewed for notification of changes. (Resident #2) Resident #2 returned to the facility from the hospital on 01/30/24. Hospital discharge records included a blister to Resident #2 left heel. The facility did not consult or notify the physician of the blister to left heel for treatment orders after the resident returned from the hospital on 01/30/2024. This failure could place residents at risk for delay in treatment and decreased quality of life. Findings included: Record review of Resident #2's face sheet dated 01/30/24 indicated she was a [AGE] year-old female, initially admitted on [DATE], and her diagnoses included dementia (the impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and high blood pressure. Resident #2 was readmitted on [DATE] with diagnosis of fracture of the femur (broken thigh bone). Record review of Physician orders for Resident #2 dated March 2024 indicated an order to elevate, off load right heel and monitor blister, report changes to MD with a start date of 2/2/24. Another order was to apply hydrogel to the right heel and cover with dry dressing daily with a start date of 3/22/24. Record review of Resident #2's admission MDS assessment dated [DATE] indicated she had severely impaired cognition with BIMS of 04. She was dependent on one staff for transfer and showers. Section M (skin): indicated no wounds, no issues with feet and no areas were noted. Record review of Resident #2's Care plan dated 1/30/24 to 3/23/24 indicated on 3/23/24 there was an unstageable pressure ulcer on r heel with eschar, there was no mention of the blister on the r heel the resident admitted on [DATE]. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's admission assessment dated [DATE] at 6:52 p.m., indicated she was readmitted with a quarter size blister on her right heel that was covered with bandage from the hospital. The orders noted on 02/02/24 elevate, offload right heel, and monitor blister and notify physician of any changes. Record review of weekly skin assessments for Resident #2 as follows: On 2/2/24, other: intact blister to right heel; offloading; On 2/9/24, other: intact blister to right heel; offloading; On 2/16/24, other: intact blister to right heel; offloading; On 2/23/24, other: N/A; On 3/1/24, other: N/A; On 3/8/24, other: N/A; and On 3/15/24, other: N/A. During an interview and observation on 3/23/24 at 9:30 a.m., the DON said during the wound sweep Resident #2 wound was identified as an unstageable wound as we observed Resident #2 right heel. During an interview and observation on 3/23/24 at 10:40 a.m., the MD E removed Resident #2's sock exposing her right heel with an wound with escar approximately in size of 3 cm by 3 cm and he said Resident #2 would need an appointment with wound care specialist for treatment. He said the facility notified him of the area yesterday (3/22/24). He said normally the facility would notify his nurse practitioner and receive orders to treat or referral to wound care. He said he was not told about the wound before 3/22/24. He stated, I will ask my Nurse Practitioner if she was aware of the wound. He said if the facility failed to notify him that failure could cause a delay in care. He said he felt responsible too. During an interview on 3/23/24 at 11:30 a.m., the NP D said she was not notified about Resident #2 having a blister on her right heel since readmission on 01/30/24 or having eschar on her right heel. She said the routine order for a blister would be to elevate, offload the heel, monitor the blister, and notify the physician of any changes. She said then on her next onsite visit, she would have assessed the area and order specific treatment, pain management, referral to wound care and make a progress note. During an interview on 3/23/24 at 12:30 p.m., the ADON said the weekly skin assessments for Resident #2 were not correct for 2/23/24 to 3/15/24 and should have included the blister on the right heel. She said there was no documentation of the physician being notified on the weekly skin assessments. Record review of podiatry note dated 2/21/24 indicated Resident #2 was seen and treated for trimming of the nails and no documentation about the blister. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the nurse's note dated 03/16/24 indicated Resident #2 had a blister on right heel and was an unstageable wound do to wound was covered with eschar (a thick layer attached to the wound bed and often requires medical intervention from wound care specialist for debridement). There was no documentation of the physician being notified of Resident #2's blister on right heel had changed from a blister to eschar tissue on the right heel. During an interview on 3/23/24 at 2:00 p.m., the DON said her expectations was for the nurses to notify her, ADON, Physician and the Administrator and obtain treatment orders. She said all weekly skin assessments will be performed per the list at the nurse's station and followed up on as needed. The policy titled Change in condition of status dated February 2021 indicated Our facility promptly notifies the resident, his or hers attending physicians and the resident representative of all changes in medical/mental condition or status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 10 residents reviewed for care plans. (Resident #4) The facility failed to develop a comprehensive person-centered care plan including an active problem of pressure injuries for Resident #4. Resident #4 was not care planned for new pressure injuries identified on 03/01/2024. These failures could place residents at risk of not having individual needs met, a decreased quality of life, and cause residents not to receive needed services. Findings included: Record review of a face sheet dated 03/14/2024 indicated Resident #4 was [AGE] years old male and was admitted on [DATE] with diagnoses including anoxic brain damage (process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning), Cerebrovascular disease (condition that affects blood flow to the blood vessels in the brain), urinary tract infection, sepsis due to pseudomonas (medical emergency in which your immune system stops fighting an infection and starts to attack your healthy tissues and organs), hypertension (condition in which the force of the blood against the artery walls is too high), bed confinement status, Dysphagia and dysarthria following a stroke (difficulty swallowing and difficulty speaking following a stroke) Record review of the most recent MDS dated [DATE] indicated Resident #4 was usually understood and understood others. The MDS indicated a BIMS score of 11 showing that Resident #4 was moderately impaired cognitively. Record review shows that Resident #4 MDS section V care area assessment summary was triggered for Pressure Ulcers. Record review of a care plan dated 3/18/2024 indicated Resident #4 was not care planned for new pressure injuries identified on 03/01/2024. Record review of nursing progress notes dated 03/01/2024, CN received notice that Resident #4 had skin issues on his buttocks. New shear/friction wounds found to right upper buttocks and right medical buttocks, attending NP notified new orders obtained and Resident #4 was placed on the schedule for wound care physician to visit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of skilled wound care consult note dated 03/07/2024, authored by wound care physician, indicated that wound consult for opinion on how to manage Resident #4's wounds located on the right upper buttocks and right medial (cleft area separating the two buttocks) buttocks. Wound location: right upper buttock; caused from shear/friction (wound occurs when an object was dragged or rubbed across skin); no sign of infection, dressing used: collagen (wound treatment applied to support new blood vessel formation) and skin prep (protective wipe/spray that forms a barrier to the skin) or betadine, cover with foam dressing. Wound Description: odor: none, exudate (drainage): scant, serosanguinous (combination of serous fluid and blood); peri (area around wound) wound stable; wound edge: normal; pain 3/10. Size: length 3.1 centimeters x width 2.7 centimeters x depth 0.1 centimeters and wound area 8.37 centimeters. Wound location: right medial (cleft area separating the two buttocks) buttock; caused from moisture associated skin damage with erosion (partial loss of the top layer of skin); no sign of infection, dressing used: collagen (wound treatment applied to support new blood vessel formation) and skin prep or betadine, cover with foam dressing. Wound Description: odor: none, (drainage): none; peri (area around wound) wound stable; wound edge: normal; pain 3/10. Size: length 2.8 centimeters x width 1.3 centimeters x depth < 0.1 centimeters and wound area 3. 64 centimeters. Record review of orders dated 03/07/2024 indicate Resident #4 wound care orders for wound 1 and wound 2 - cleanse wounds with SP or betadine, apply collagen and cover with foam dressing once a day. During an observation of wound care being provided to Resident #4 on 03/14/2024, Resident #4 continues to have shear/friction/pressure injuries to right upper buttocks and right medial buttocks. Interview on 03/20/2024 at 12:05 p.m. with the ADON said Resident #4's care plan should have been updated when new pressure injuries/wounds occurred. ADON stated that she expects that resident's care plans are accurate and up to date. She said staff who take care of a resident may not know their needs if all care for them was not documented in the resident's file. She stated that new wounds and treatment ordered should be care planned and that Resident #4 had a doctor's order for the wound care to be completed. She said all the residents' care should be documented in their care plan. She stated that she did not know why Resident # 4's care plan had not been fully developed/updated. Interview on 03/21/2024 at 2:05 p.m., the Administrator said she would have expected for a comprehensive care plan to have been updated on Resident #4, she said with the change in staff it must have been missed. She said the new MDS Coordinator was responsible for initiating the comprehensive care plan and it was the charge nurses and nurse managers' responsibility to update care plans. She said Resident #4 had new wounds/injuries and risks that must be monitored. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Care Planning - Interdisciplinary Team policy dated March 2022 indicated, Policy Statement: The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation and Implementation: 1. Resident care plans are developed according to the timeframes and criteria established by S483.21. 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). 3.The IDT includes but is not limited to: a. the resident's attending physician; b. a registered nurse with responsibility for the resident; c. a nursing assistant with responsibility for the resident ; d. a member of the food and nutrition services staff; e. to the extent practicable , the resident and /or the resident's representative; and f. other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. 4. The resident, the resident's family and/or the resident ' s legal representative /guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 5. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47879 Based on observation, interview and record review, the facility failed to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment or no more than 21 days after admission for 1 of 10 residents reviewed for comprehensive plans of care. (Resident #3) The facility did not develop a comprehensive care plan within 7 days of the completion of the comprehensive assessment or no more than 21 days after admitted on [DATE] and readmitted on [DATE] for Resident #3. Resident # 3 had no comprehensive care plan from 02/02/2024 to 03/20/204. Resident # 3's care plan should have been completed by no later than 2/17/2024. Resident #3 has cardiac issues and risk that must be monitored. This failure could place residents at risk of not receiving appropriate care and services. Findings included: Record review of Resident #3's face sheet dated 03/14/2024 indicated she was an [AGE] year-old female initially admitted on [DATE] and readmitted on [DATE]. Her diagnoses included right femur fracture (broke hip), Hypertensive chronic kidney disease (a long-standing kidney condition that develops over time due to persistent or uncontrolled high blood pressure), kidney disease (a disease or condition impairs kidney function, causing kidney damage), heart failure (condition that develops when the heart doesn't pump enough blood for the body's needs), atherosclerotic heart disease (a condition where the blood vessels become narrowed and hardened due to buildup of fats in the blood vessel wall), and atrial fibrillation (a type of irregular heartbeat). Record review of Resident #3's admission MDS assessment dated [DATE] indicated Resident #3 was usually understood and understood others. The MDS indicated a BIMS of 15 which indicated cognitively intact. The MDS indicated the resident was admitted for orthopedic rehabilitation care, history of cardiac disease and was taking a diuretic, which was a high-risk drug. The MDS indicated the resident had a pressure ulcer upon admission to the facility which required treatment. Record Review and observation on 3/14/2024 and 3/20/2024, Resident #3 observed with 2+ edema to both lower extremities. Record review of skilled nurses note date 3/14/2024 authored by LVN A, indicated Edema present to left and right lower extremities, left and right leg edema: 2+ pitting (how deep the pits are and how long they last after you press swollen area 2+ pit that goes away with 15 seconds). Record review of skilled nurses note date 3/20/2024 authored by LVN B, indicated Edema present to left and right lower extremities, left and right leg edema: 2+ pitting (how deep the pits are and how long they last after you press swollen area 2+ pit that goes away with 15 seconds). Cardiologist and attending NP aware and new orders obtained. Record Review of Nurse Practitioner Progress Note dated 02/06/2024 indicated that Resident #3 has had episodes of asymptomatic hypotension (low blood pressure) down into systolic blood pressure of 60s. Cardiologist and attending NP aware and new orders obtained. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/13/2024 at 9:00 a.m. and 3/20/2024 at 5:00 p.m. with Resident #3, she says that she was admitted to the facility for rehabilitation services following a fractured hip, she said she does have cardiac issues that causes the swelling in her lower extremities and her B/P to drop low. She said she has recently seen her cardiologist and that the attending NP/MD at facility and her cardiologist are communicating and trying to adjust her medications to remove the fluid and keep her B/P in an acceptable range. Resident #3 pleased with care being provided by facility staff. Record review of the clinical record from 02/02/2024 to 03/20/2024 for Resident #3 indicated no comprehensive care plan. Interview on 03/20/2024 at 12:05 p.m. with the ADON said Resident #3's comprehensive care plan was not completed and said, must have missed it. The ADON said that the previous MDS Coordinator should have completed the comprehensive care plan and/or notified ADON or DON that the comprehensive care plan was not completed. ADON said this MDS coordinator resigned with last day being 02/29/2024 and she was told that all required MDS assessments and comprehensive care plans had been completed. ADON said this comprehensive care plan must have been missed. She said the care plan was not completed and available to staff. She said the facility nursing staff (ADON, DON, or CN) usually reviewed and completed the care plans after they were initiated in the computer by the MDS Coordinator. The ADON said when a resident admitted to the facility there was a basic care plan in the computer. She said once the MDS/Comprehensive Assessment was completed then an IDT/care plan meeting was scheduled, and a comprehensive care plan was developed and should happen within 7 days of the compressive assessment completion. She said Resident #3's comprehensive care plan should have been completed by no later than 02/17/2024. The ADON said not having a comprehensive care plan could put residents at risk for not receiving care, missing care, or appropriate/adequate care. Interview on 03/21/2024 at 2:05 p.m., the Administrator said she would have expected for a comprehensive care plan to have been developed on Resident #3, she said with the change in staff it must have been missed. She said the new MDS Coordinator was responsible for initiating the comprehensive care plan and it was the charge nurses and manager's responsibility to update care plans. She said Resident #3 has cardiac issues and risks that must be monitored. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Care Plan, Comprehensive Person-Centered policy dated March 2022 indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. Record review of the mds-3.0-rai-manual-v1.18.11_October_2023 indicated The care plan completion date must be no later than 7 calendar days after the comprehensive assessment completion date (CAA(s) completion date = 7 calendar days).

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on interview and record review , the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (Resident #1) of 10 residents reviewed for quality of care. The facility failed to coordinate care with the orthopedic surgeon and attending NP/MD of Resident #1's change in skin condition to RLE surgical area, addressing a scab, dark or discolored skin on top of resident's right foot identified in 02/14/2024. No documentation of an assessment or treatment performed to Resident #1's pressure injury/wound to top of right foot and/or no coordination or communication with orthopedic surgeon or attending physician/NP regarding pressure injury/wound identified on 02/14/2024 by orthopedic surgeon. The facility failed to coordinate with orthopedic surgeon or attending NP/MD documented of right dorsal foot pressure injury when it deteriorated to an unstageable wound with eschar and resident had to be hospitalized and area required surgical debridement and graft application. An Immediate Jeopardy (IJ) was identified on 03/21/2024. The IJ template was provided to the facility on [DATE] at 5:09 p.m. While the IJ was removed on 03/23/2024 at 1:00 p.m., the facility remained out of compliance at a scope of isolated and severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems that were put in place. This failure could place residents at risk for diminished quality of care, untreated medical issues, and death. Findings included: Record review of Resident #1's electronic face sheet dated 03/13/2024 indicated she was originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: displaced trimalleolar fracture of right lower leg (fracture of lower leg bone, connected to foot/ankle area), Other acute osteomyelitis (infection of the bone), left ankle and foot, Encounter for surgical aftercare following surgery on the skin and subcutaneous tissue-Right ankle ORIF (surgical procedure to replace bones with hardware or attach hardware to fix broken bone), Need for assistance with personal care, Muscle weakness (generalized), End stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to need for a regular course of long-term dialysis or a kidney transplant to maintain life), Cognitive communication deficit, metabolic encephalopathy (another health condition, such as diabetes, liver disease, kidney failure, or heart failure, makes it hard for the brain to work), hypertension condition in which the force of the blood against the artery walls was too high, Diabetes mellitus (chronic condition that affects the way the body processes blood sugar). Record review of Resident #1's MDS dated [DATE] indicated she had no pressure injuries. She scored a 15/15 on her BIMS which signified she was cognitively intact. She was incontinent of bowel and bladder and went to dialysis 3 x week for hemodialysis for her end stage renal disease. She required substantial/maximal assistance with her ADL's. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's comprehensive care plan date initiated 12/15/2023 and revised on 03/01/2024 indicated Problem .has surgical wound to right ankle with pins in place .Approach . Assess condition of surrounding skin. Report emergence of skin excoriation. Observe and report signs of localized infection (localized pain, redness, swelling, tenderness, loss of function, heat at the infected area.) Further review indicated Problem . potential for impaired skin integrity related to impaired mobility. Approach . Assess feet Q shower day & PRN, noting color, peripheral pulses, sensory reflexes, temperature, presence of edema or verbalizations of pain. Assess skin weekly & PRN & document changes. Record review of Resident #1's Braden Skin assessment dated [DATE] indicated she scored a 19 which signified she was at a low risk for skin breakdown. The was no o current Braden Skin Assessment noted in medical records. Record review of Resident #1's Orders As of: 12/14/2023 to 02/27/2024 indicated: Treatments .to provide weekly skin assessment once a day on Monday 6:00 a.m. - 6:00 p.m. Dated 11/09/2023. Further review indicated Treatments . check skin surrounding splint to right leg. Check for capillaries refill to lower extremity every shift and as needed . Notify MD of any abnormalities or changes in skin condition. Every Shift: day shift 06:00 a.m. - 06:00 p.m., night shift 06:00 p.m. - 06:00 a.m. Dated 11/23/2023 Ended 02/26/2024. Wound Treatments: cleanse pin site to right ankle surgical site with peroxide once a day every other day 06:00 a.m. - 06:00 p.m. Dated 12/15/2023. Ended 02/27/2024. Record review of Resident #1's Skin - Dignity Weekly Skin assessment dated [DATE] authored by RN C indicated Resident #1 did not have a pressure, diabetic, venous, arterial ulcer, or incision. Other: Surgical incision with pins to the inner and outer right ankle, wound care in place. Record review of Resident #1's Orthopedic progress note dated 02/14/2024 authored by orthopedic MD indicated that Resident #1 was being seen status post right ankle fusion with hardware removal with external fixator and pins placement on 12/11/2023. The external fixator frame was in place to RLE, swelling was mild, incision healed. Mild redness on the proximal medial and lateral pins. Abrasion with some black scabbing proximally 2 centimeters x 2 centimeters on the top of right foot. Record review of Resident #1's facility medical record dated 01/24/2024 to 02/25/2024 does not indicate facility was coordinating with orthopedic surgeon after follow-up visits provided. No orthopedic office visit notes identified in the medical records at the time of orthopedic office visits and no communication regarding continued treatment or orders noted from orthopedic office. Two orthopedic notes identified in the medical records were requested and received by facility on 02/29/2024 after the deterioration of RLE external pin site and black/dark area to top of right foot. Record review of Resident #1's Skin - Dignity Weekly Skin assessment dated [DATE] authored by LVN A indicated Resident #1 did not have a pressure, diabetic, venous, arterial ulcer, or incision. Other: Surgical incision with pins to the inner and outer right ankle, wound care in place. Record review of Resident #1's Skin - Dignity Weekly Skin Assessment due 02/26/2024 not found in medical records. (continued on next page)

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	455642	A. Building B. Wing	03/23/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress notes from 02/14/2024 to 02/27/2024 revealed no documentation of an assessment or treatment performed to Resident #1's pressure injury/wound to top of right foot and/or no coordination or communication with orthopedic surgeon or attending physician/NP regarding pressure injury/wound identified on 02/14/2024 by orthopedic surgeon. Record review of resident #1's TAR dated February 2024 did not have an assessment or treatment for pressure injury/wound on top of right foot. Record review of Resident #1's Progress Note dated 02/23/2024 authored by LVN A, indicated that CN was made aware by CNA that resident's right foot dressing had blood leaking. CN noted resident's right foot with dried blood on skin and pins, with white spots with clear drainage on side of foot too. CN cleaned wound per wound care order, DON, ADON, Administration, and MD notified of findings, no new orders given. Record review of Resident #1's Progress Note dated 02/25/2024 authored by LVN A, indicated that CN nurse cleaned residents' Right foot per wound care order, right foot had purulent drainage, with dried blood, RP notified, MD was already made aware upon first finding on 02/23/24. DON notified, ADON notified. Will monitor. Vital signs were within normal limits . Resident denies any pain or discomfort at this time. Record review of Resident #1's Progress Note dated 02/26/2024 authored by DON G indicates that the facility NP was notified regarding skin integrity and pictures were sent to NP. New orders for stat labs to be obtained and schedule an ortho visit as soon as possible . Record review of Resident #1's image of RLE dated 02/25/2024 and 02/26/2024 indicated that resident has a dark area to top of right foot with redness noted around wound. Record review of Resident #1's Progress Note dated 02/27/2024 authored by NP indicated that Resident #1 was seen today after having hemodialysis (a machine filters waste, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) session this morning. She continued to have drainage from RLE hardware x 5 days, the entry points in the heel, middle, and upper portions of the hardware have purulent drainage. She is complaining of significant pain. She has an appointment with Ortho scheduled for tomorrow, but labs from 02/26/2024 show leukocytosis of 17.9 which is concerning. Spoke with orthopedic MD on the phone and he advised transferring Resident #1 to affiliated hospital for evaluation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's hospital record dated 02/27/2024, indicated Diagnosis: Chronic osteomyelitis (infection in the bone) of the right ankle, has external fixator, infection at sites of external fixator pins and right dorsal foot wound (pressure injury). Resident #1 underwent manipulation of external fixature, pin exchange and irrigation and debridement with application of integra graft to right dorsal foot (pressure injury site) on 02/29/2024. Skin head to toe assessment completed in hospital ER dated 02/27/2024 indicated Resident #1 was found to have pressure injury to right lateral buttock, measuring 2 cm x 2cm - images indicate site missing top layer of skin, pink in color, and a pressure injury to right dorsal foot measuring 2 cm x 4 cm - images indicate black/eschar tissue with redness around wound site. Plan: The patient has had some issues with the pin sites, we recommend surgery to evaluate exchange of pins. The resident was admitted for IV antibiotics, pain management and surgical intervention. Recommend compression of the ankle fusion through the frame as well as debridement of the dorsal midfoot wound that is worsening. Resident #1 underwent surgical intervention of right ankle manipulation of external fixator pin exchanged and wound irrigation, debridement, and graft application to right dorsal foot pressure injury/wound on 02/29/2024. Resident #1 was discharged on [DATE] to another nursing facility with orders to continue IV antibiotics for 8 weeks and to provide care to pressure injury/wound to right dorsal foot and pin sites daily and to follow up with infectious disease and orthopedic physicians. Interview on 03/13/2024 at 2:30 p.m. with LVN A, indicated that she cared for Resident #1, she was a CN nurse on 06:00 a.m. - 06:00 p.m. shift and she provided pin site care, cleansed each site with hydrogen peroxide, and wrapped RLE/external fixator with ace wrap during her shift. LVN A said that Resident #1 had an external fixator/halo device to RLE status post hardware removal following ankle fracture and CN was responsible to provide pin site care every other day. LVN A said her pin sites started looking red, macerated, and purulent drainage on 02/23/2024 and reported the findings to DON, ADON, Administration, and MD notified of findings, no new orders given. LVN A does not recall assessing or providing treatment to an area on top of Resident #1's right foot. LVN A indicates that she took a photo of the resident's right lower extremity/foot and sent it to the DON due to her concerns with the external fixator pin sites. LVN A said the care provided and concerns was focused on the external fixators pin sites, does not recall scab, dark area, or discoloration to top of right foot. LVN A said it is the CN's responsibility to collect new orders or office visit notes/progress notes when resident goes to outside appointments. LVN A said she tries to call to get notes or new orders when residents go to outside appointments but may not have time to follow up if not obtained. LVN A said that DON and/or ADON will follow up with outside appointments if aware. Interview on 03/13/2024 at 4:40 p.m. with LVN B, indicated that she cared for Resident #1, she was a CN on 06:00 a.m. - 06:00 p.m. shift and she provided pin site care and wrap RLE/external fixator with ace wrap during her shift. LVN said that resident had an external fixator/halo device to RLE and CN was responsible to provide pin site care every other day. LVN said that she did recall seeing a dark or discolored skin on top of resident's right foot but was not providing care or treatment to the area to her knowledge, no orders. LVN B said she has only been employed with the facility for about 1 month and follows her MAR/TAR to provide required treatments and medications. LVN B said that if residents go out to outside appointments that she thinks DON or ADON does follow up regarding new orders or treatments. LVN B said Resident #1 was cognitive and she could tell you what the doctor said. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 03/13/2023 at 6:18 p.m. with Resident #1's family member indicated she went to the hospital emergency room to meet the Resident #1 on 02/27/2024. She stated she saw Resident #1 right lower extremity and told the ER staff that she had concerns regarding the care the resident was receiving at the current nursing facility. The FM stated she had redness and purulent drainage from her external fixator pin sites on right foot, a large black round wound to the top of her right foot, and a pressure sore to her right buttock. She stated she was in shock, the right foot looked horrible since she had last seen it at the orthopedic office on 02/14/2024. She stated the hospital diagnoses was infection at site of external fixator pin, cellulitis, and right foot wound. She stated the area on top of her right foot had dead tissue that had to be surgically removed and a graft placed. She said that the facility staff improper placement of ace wrap caused the wound on top of foot. FM said she was unaware of the pressure injury on right buttocks until she saw it at the hospital ER. FM said resident will not be returning to this facility due to the neglect and inadequate care provided to Resident #1. Interview on 03/14/2024 at 5:22 p.m. with RN C indicated that she works as the RN supervisor usually on weekends but does pick up days during the week if needed. RN C recalls Resident #1's right foot with external fixator device and CN had to provide pin site care using hydrogen peroxide and Q-tip every other day and then wrap RLE/external fixator with ace wrap for protection. RN C does not recall the last time she cared for Resident #1 and has no recollection of resident having any wounds or discolored area to top of right foot area that she assessed or provided care for. RN C said each resident was scheduled a day and shift for weekly skin assessments to be performed by CN. Skin assessment should identify any new wounds, skin tears, abrasions, lacerations, rash, skin impairment/damage, discoloration, bruises, pressure, diabetic, venous, arterial ulcer, or incisions. Interview on 03/18/2024 at 11:27 a.m. with LVN A acknowledges that she took the photographs of Resident #1's RLE and provided a copy to DON. LVN A reviewed the photo previously taken on 02/25/2024 and does identify a dark/discolored area to top of right foot. LVN A said that the dark/discolored area on top of right foot should have been identified on the weekly skin assessments and the orthopedic MD or attending physician should have been made aware so assessment and treatment could have been ordered. LVN A does not recall when the dark/discolored area on top of right foot occurred or was first identified. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 03/18/2024 at 1:41 p.m. with DON G, said she was familiar with Resident #1, she said she had to do a write up/medication error on an LVN because she used Dakin's solution (mixture of bleach or chlorine bleach, boric acid diluted in water) for pin site care instead of hydrogen peroxide on 02/22/2024. DON G communicated with LVN A on 02/23/2024 regarding Resident #1's external fixator pin sites with redness and purulent drainage and told her to contact orthopedic surgeon with report. DON G said she received a text message and image/photo of Resident #1's RLE on 02/25/2024 with concerns that pin sites continue to have drainage and redness noted during wound care. DON G said on 02/26/2024 she contacted orthopedic surgeon's office for an earlier appointment and notified attending NP/MD. DON G said she forwarded the attending NP the photos she had received from LVN A and NP gave new orders for stat labs to be obtained. DON G said that she had not physically observed Resident #1's RLE only the images sent to her. DON G said she reached out to orthopedic surgeon several times trying to get the resident an earlier appointment. DON G said that labs came back on 2/27/2024 indicating elevated white blood count and attending NP notified. She said attending NP consulted with orthopedic surgeon and resident was sent to affiliated hospital for evaluation and treatment. DON G does not recall facility staff mentioning Resident #1 having a dark/discolored area to top of foot but once she reviews the image/photo she acknowledges that image from 2/25/2024 does show a dark/discolored area to top of right foot. DON G said skin assessment should be performed weekly and as needed, DON G said areas like this should be documented and monitored. DON G said that she was no longer employed as the DON with this facility and was terminated at the end of February 2024. Interview on 03/20/2024 at 3:27 p.m. with LVN B, she acknowledges that the ace wrap being too tight could have caused the area to Resident #1's right dorsal foot, she said that she placed a non-adherent pad to area for protection at times. LVN B said that the dark/discolored area on top of right foot should have been identified on the weekly skin assessments and the orthopedic MD or attending physician should have been made aware so assessment and treatment could have been ordered. LVN B does not recall when the dark/discolored area on top of right foot occurred or was first identified. Interview on 03/14/2024 at 3:45 p.m. with DR E., who supervised NP D, he stated that he has seen Resident #1 with the external fixator and pin sites when he was visiting the roommate, approx. 1 week prior to hospitalization , while care was being provided to site, he does not recall seeing a dark/discolored area to top of right foot but says he was focus more on the pin sites which had a little redness but looked ok. DR E said that Resident #1 was seen by orthopedic surgeon routinely and he provided care/orders to RLE. DR E observed a photo of the RLE taken at the hospitalER on [DATE] and said no RLE did not look like that when he saw it, he said that NP D had been notified of the pin sites having drainage and redness on 02/26/2024 and she ordered labs and later consulted with orthopedic surgeon for hospital transfer and evaluation. DR E denied being notified or aware of dark/discolored area on top of right foot. Interview on 03/19/2024 at 8:00 a.m. with NP D indicated that she was notified by facility staff on 02/26/2024 that Resident #1 was having purulent drainage and redness at fixator pin sites, she ordered labs to be collected and for orthopedic appointment to be scheduled ASAP. NP D acknowledges that she received a picture of the Resident #1's RLE on 02/26/2024. NP D said that the focus at the time was the change in the pin site insertion sites, redness and purulent drainage, NP D reviews the photo provided to her on 02/26/2024 and does acknowledge the resident had a dark/discolored area to top of right foot but unable to assess due to poor quality of picture. NP said that Resident #1 was routinely being seen by orthopedic doctor for care, interventions, and treatment to RLE. NP said Resident #1 was sent to affiliated hospital on 02/27/2024 due to abnormal lab values (elevated WBC count) and redness, and purulent drainage from fixator pin sites. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 03/20/2024 at 12:05 p.m. with the ADON indicated initially Resident #1 admitted to facility with cast/splint due to fractured ankle, but due to hardware failure, resident had to have hardware removed and eternal fixator placed back in December 2023. ADON states that Resident #1 was seen by therapy services at first and has remained non-weight bearing. Resident #1 was being seen by orthopedic surgeon weekly, then biweekly then every three weeks. Resident #1 was non- weight bearing to RLE and facility staff was to provide pin site care to external fixator pins every other day using hydrogen peroxide and wrap RLE/external fixature with ace wraps. Resident was transported to orthopedic surgeon appointments and dialysis 3 x week by facility transport. ADON said that resident was cognitive and that she would report to facility what happened during her orthopedic appointments because family members would meet them at appointment and take office visit paperwork. ADON said that the charge nurse was responsible for following up when resident had outside appointment and getting the paperwork or new orders, ADON said that she or the DON was available to assist with getting office visit paperwork if needed assistance. ADON said that she contacted orthopedic surgeon for office visit notes for investigation related to medication error (staff applied wrong treatment to RLE pin sites) and had received and reviewed the documents on 02/29/2024. ADON said she had observed Resident #1's RLE with redness and purulent drainage to pin sites, recalls a dark/dried scab area to top of foot day prior to resident being transferred to hospital for evaluation. ADON said she also spoke with resident on 02/26/2024 regarding pin sites redness and drainage and resident said that orthopedic surgeon was aware of the pin sites redness and drainage during last orthopedic appointment and that they were scheduling surgery for pin sites to be exchanged. ADON denied that she contacted orthopedic surgeon to verify resident statement. ADON said that said that the dark/discolored area on top of right foot should have been identified on the weekly skin assessments and the orthopedic MD or attending physician should have been made aware so assessment and treatment could have been ordered if needed. Attempted to contact the Orthopedic Surgeon 03/20/2024 and 03/21/2024, office staff reports that he was in surgery on Thursday mornings and he would return the call. No return call, called office multiple times and left message, no return call received from the Orthopedic Surgeon. Interview on 03/21/2024 at 2:05 p.m. with the Administrator, she said Resident #1 had a scab on the top of her foot, but the main focus was on her fixator pin sites. Administrator observed images from hospital ER assessment on 02/27/2024 and said that the wound on top of the right foot did not look like that at time of transfer to hospital ER. Administrator acknowledges that she did not observe the RLE prior to transfer to hospital ER but pictures or images she received days prior did not look like the hospital ER images. Administrator was aware that facility staff were not receiving or contacting outside appointment staff for office visit records or new orders and have put a new process in place that CN was to contact and obtain office visit notes and orders from outside appointments. The administrator said she has a perform improvement plan in place for skin assessments not being completed weekly. Resident # 1's skin assessment was completed weekly over the last month except for 02/26/2024 but the skin assessment did not indicate or acknowledge that resident had a dark/discolored area to top of right foot as identified in images/photos taken by facility and hospital staff. Administrator reluctantly agrees that a skin impairment (dark/discolored area, scab, redness) should be assessed and identified on weekly skin assessment and the orthopedic MD or attending physician should have been made aware for treatment plan or intervention. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility policy and procedure titled Prevention of pressure injuries revised April 2020, indicated Skin Assessment 1. Conduct a comprehensive scan assessment upon (or soon after) admission, with each risk assessment as indicated according to the resident's risk factors and prior to discharge. 2. During the skin assessment, inspect a. presence of erythema; b. Temperature of skin and soft tissue; and c. edema. 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) . Prevention Skin Care 4. Use a barrier product to prevent skin from moisture. 6. Do not rub or otherwise cause friction on skin that is at risk of pressure injuries. Device-Related Pressure Injuries 1. Review and select medical devices with consideration to the ability to minimize tissue damage, including size shape and its application and ability to secure the device. 2. monitor regularly for comfort and signs of pressure related injury. The Administrator was notified of an Immediate Jeopardy on 03/21/2024 at 5:09 p.m. and was given a copy of the IJ template and a Plan of Removal (POR) was requested. The POR was accepted on 3/22/24 at 4:48 pm. Plan of Removal Problem: F684- Quality of Care Interventions: 1.DON/Designees will review all residents on resident roster to identify all residents receiving care from outside providers by 3/22/2024. 2.DON/Designees will provide updated clinical information to outside providers (MDs) on residents which pertain to their specific type of care; Ortho, cardiac, GI, urology, dental, podiatrist, etc. by 03/22/2024. DON/designee will pull information from residents' chart, including progress notes, all orders, medications, vital signs. This documentation will accompany the resident to their outside provider appointments. 3. The following in-services were initiated and conducted by Administrator and DON on 3/21/2024. All available staff will begin being in-serviced on 3/21/2024, to be completed on or before 3/22/2024. Any clinical staff member not present or in-serviced by this time will not be allowed to assume their duties until they have been in-serviced. Administrator/designee will ensure that all in-service training has been done for all clinical staff by checking off the clinical staff roster, check off being completed by HR coordinator. All clinical staff Care Coordination with all physicians involved in residents care and change of condition policy reviewed. CNA/CMA- Reporting changes in residents skin conditions when noticed immediately to charge nurse. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Records review of 6 current residents indicated the clinical face sheet had been reviewed and updated as needed. No changes were noted for the 6 reviewed. All residents were assessed for any change of condition and a complete skin assessment was completed by RNs and 1 of the 6 residents had unstageable on her heel. The RN immediately reported to the physician and treatments were provided as ordered. The documentation indicated a coordination of care per notification of physician, nurse, and the facility administration. The care plan was updated, and the physician came to the facility and assessed the resident and ordered a referral and treatment. The primary physician was documenting on the wound and the referral orders. The referral for the wound care physician was being obtained and the charge nurses faxed needed items to the wound care physician. During an interview on 3/23/24 at 2:00 p.m., the DON said her expectations was for the nurses to notify her, ADON, Physician and the Administrator any new skin impairments/wounds and obtain treatment orders. She said all weekly skin assessments will be performed per the list at the nurse's station and followed up on as needed. On 03/23/24 at 1:00 p.m., the Administrator was informed the Immediate Jeopardy was lifted; however, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems that were put in place. [TRUNCATED]

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Dayton Nursing and Rehabilitation	310 E Lawrence St Dayton, TX 77535

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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** 47879 Based on observation, interview, and record review, the facility failed to ensure residents received care, consistent with professional standards of practice to prevent pressure injury and does not develop pressure injury unless the individual's clinical condition demonstrated that they were unavoidable; and a resident with pressure injury receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new pressure injuries from developing for 2 (Resident #1 and Resident #2) of 10 residents reviewed for pressure injuries in that: 1.The facility failed to provide assessments, treatment for pressure injuries and notify physican to Resident #1's right dorsal foot pressure injury when it deteriorated to an unstageable wound with eschar from 02/14/2024 to 2/27/2024 where it declined to requiring wound irrigation, debridement, and graft application during her hospitalization on [DATE]. 2. The facility failed to provide assessments, treatment for pressure injuries and notify physican to Resident #2's blister to right heel when it deteriorated to an unstageable wound with eschar from 3/16/24 to 3/22/24. An Immediate Jeopardy (IJ) was identified on 03/21/2024. The IJ template was provided to the facility on [DATE] at 5:09 p.m. While the IJ was removed on 03/23/2024 at 1:00 p.m., the facility remained out of compliance at a scope of a pattern and severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems that were put in place. This facility failure could place residents at risk of untreated wounds, infection, a decline in health, further surgeries with associated complications leading to death. Findings included: Record review of Resident #1's electronic face sheet dated 03/13/2024 indicated she was originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: displaced trimalleolar fracture of right lower leg (fracture of lower leg bone, connected to foot/ankle area), Other acute osteomyelitis (infection of the bone), left ankle and foot, Encounter for surgical aftercare following surgery on the skin and subcutaneous tissue-Right ankle ORIF (surgical procedure to replace bones with hardware or attach hardware to fix broken bone), Need for assistance with personal care, Muscle weakness (generalized), End stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to need for a regular course of long-term dialysis or a kidney transplant to maintain life), Cognitive communication deficit, metabolic encephalopathy (another health condition, such as diabetes, liver disease, kidney failure, or heart failure, makes it hard for the brain to work), hypertension condition in which the force of the blood against the artery walls is too high, Diabetes mellitus (chronic condition that affects the way the body processes blood sugar). (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 dated [DATE] indicated she had no pressure injuries. She scored a 15/15 on her BIMS which signified she was cognitively intact. She was incontinent of bowel and bladder and went to dialysis 3 x week for hemodialysis for her end stage renal disease. She required substantial/maximal assistance with her ADLs. Record review of Resident #1's comprehensive care plan date initiated 12/15/2023 and revised on 03/01/2024 indicated Problem .has surgical wound to right ankle with pins in place .Approach . Assess condition of surrounding skin. Report emergence of skin excoriation. Observe and report signs of localized infection, (localized pain, redness, swelling, tenderness, loss of function, heat at the infected area.) Further review indicated Problem . potential for impaired skin integrity R/T impaired mobility. Approach . Assess feet every shower day & as needed, noting color, peripheral pulses, sensory reflexes, temperature, presence of edema or verbalizations of pain. Assess skin weekly & as needed & document changes. Record review of Resident #1's Braden Skin assessment dated [DATE] indicated she scored a 19 which signified she was at a low risk for skin breakdown. No current Braden Skin Assessment noted in medical records. Record review of Resident #1's Orders As of: 12/14/2023 to 02/27/2024 indicated: Treatments .to provide weekly skin assessment once a day on Monday 6:00 a.m. - 6:00 p.m. Dated 11/09/2023. Further review indicated Treatments . check skin surrounding splint to right leg. Check for capillaries refill to lower extremity Q shift and PRN. Notify MD of any abnormalities or changes in skin condition. Every Shift: day shift 06:00 a.m. - 06:00 p.m., night shift 06:00 p.m. - 06:00 a.m. Dated 11/23/2023 Ended 02/26/2024. Wound Treatments: cleanse pin site to right ankle surgical site with peroxide once a day every other day 06:00 a.m. - 06:00 p.m. Dated 12/15/2023. Ended 02/27/2024. Record review of Resident #1's Skin - Dignity Weekly Skin assessment dated [DATE] authored by RN C indicated Resident #1 did not have a pressure, diabetic, venous, arterial ulcer, or incision. Other: Surgical incision with pins to the inner and outer right ankle, wound care in place. Record review of Resident #1's Orthopedic progress note dated 02/14/2024 authored by orthopedic MD indicated that Resident #1 was being seen status post right ankle fusion with hardware removal with external fixator and pins placement on 12/11/2023. The external fixator frame was in place to RLE, swelling was mild, incision healed. Mild redness on the proximal medial and lateral pins. Abrasion with some black scabbing proximally 2cm x 2cm on the top of right foot. Record review of Resident #1's Skin - Dignity Weekly Skin assessment dated [DATE] authored by LVN A indicated Resident #1 did not have a pressure, diabetic, venous, arterial ulcer, or incision. Other: Surgical incision with pins to the inner and outer right ankle, wound care in place. Record review of Resident #1's Skin - Dignity Weekly Skin Assessment due 02/26/2024 not found in medical records. Record review of Resident #1's progress notes from 02/14/2024 to 02/27/2024 revealed no documentation of an assessment or treatment performed to Resident #1's pressure injury/wound to top of right foot and/or pressure injury to right buttocks. (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 TAR dated February 2024 did not have an assessment or treatment for pressure injury/wound on top of right foot or pressure injury to right buttocks. Record review of Resident #1's Progress Note dated 02/23/2024 authored by LVN A, indicated that CN was made aware by CNA that resident's right foot dressing had blood leaking. CN noted resident's right foot with dried blood on skin and pins, with white spots with clear drainage on side of foot too. CN cleaned wound per wound care order, DON, ADON, Administration, and MD notified of findings, no new orders given. Record review of Resident #1's Progress Note dated 02/25/2024 authored by LVN A, indicated that CN nurse cleaned residents' Right foot per wound care order, right foot had purulent drainage, with dried blood, RP notified, MD was already made aware upon first finding on 02/23/24. DON notified, ADON notified. Will monitor. V/S WNL limits. Resident denies any pain or discomfort at this time. Record review of Resident #1's Progress Note dated 02/26/2024 authored by DON G indicates that the facility NP was notified regarding skin integrity and pictures were sent to NP. New orders for stat labs to be obtained and schedule an ortho visit ASAP. Record review of Resident #1's image of RLE dated 02/25/2024 and 02/26/2024 indicated that resident has a dark area to top of right foot with redness noted around wound. Record review of Resident #1's Progress Note dated 02/27/2024 authored by NP indicated that Resident #1 was seen today after having hemodialysis (a machine filters waste, salts and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) session this morning. She continued to have drainage from RLE hardware x 5 days, the entry points in the heel, middle, and upper portions of the hardware have purulent drainage. She is c/o significant pain. She has an appointment with Ortho scheduled for tomorrow, but labs from 02/26/2024 show leukocytosis of 17.9 which is concerning. Spoke with orthopedic MD on the phone and he advised transferring Resident #1 to affiliated hospital for evaluation. Record review of Resident #1's hospital record dated 02/27/2024, indicated Diagnosis: Chronic osteomyelitis (infection in the bone) of the right ankle, has external fixator, infection at sites of external fixator pins and right dorsal foot wound (pressure injury). Resident #1 underwent manipulation of external fixature, pin exchange and irrigation and debridement with application of integra graft to right dorsal foot (pressure injury site) on 02/29/2024. Skin head to toe assessment completed in hospital ER dated 02/27/2024 indicated Resident #1 was found to have pressure injury to right lateral buttock, measuring 2 cm x 2cm - images indicate site missing top layer of skin, pink in color, and a pressure injury to right dorsal foot measuring 2 cm x 4 cm - images indicate black/eschar tissue with redness around wound site. Plan: The patient has had some issues with the pin sites, we recommend surgery to evaluate exchange of pins. The resident was admitted for IV antibiotics, pain management and surgical intervention. Recommend compression of the ankle fusion through the frame and debridement of the dorsal midfoot wound. Resident #1 underwent surgical intervention of right ankle manipulation of external fixator pin exchanged and wound irrigation, debridement, and graft application to right dorsal foot pressure injury/wound on 02/29/2024. Resident #1 was discharged on [DATE] to another nursing facility with orders to continue IV antibiotics for 8 weeks and to provide care to pressure injury/wound to right dorsal foot and pin sites daily and to follow up with infectious disease and orthopedic physicians. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/13/2024 at 2:30 p.m. with LVN A, indicated that she cared for Resident #1, she was a CN on 06:00 a.m. - 06:00 p.m. shift and she provided pin site care, cleansed each site with hydrogen peroxide, and wrapped RLE/external fixator with ace wrap during her shift. LVN said that resident had an external fixator/halo device to RLE status post hardware removal following ankle fracture and CN was responsible to provide pin site care every other day. LVN said her pin sites started looking red, macerated, and purulent drainage on 02/23/2024 and reported the findings to DON, ADON, Administration, and MD notified of findings, no new orders given. LVN A does not recall assessing or providing treatment to an area on top of Resident #1's right foot. LVN A indicates that she took a photo of the resident's right lower extremity/foot and sent it to the DON due to her concerns with the external fixator pin sites. LVN A said the care provided and concerns was focused on the external fixators pin sites, does not recall dark area, scab, or discoloration to top of right foot. LVN A said it is the CN's responsibility to collect new orders or office visit notes/progress notes when resident goes to outside appointments. LVN A said she tries to call to get notes or new orders when residents go to outside appointments but may not have time to follow up if not obtained. LVN A said that DON and/or ADON will follow up with outside appointments if aware. Interview on 03/13/2024 at 4:15 p.m. with orthopedic surgeon indicated that Resident #1 had been seen by orthopedic for several months due to fractured ankle, osteomyelitis, hardware failure/removal, and back in December 2023 resident had right ankle fusion with an external fixator device applied. Orthopedic surgeon denies that the use of Dakin's solution rather than hydrogen peroxide could have caused any damage or further skin impairment to Resident #1's external pin sites. The surgeon acknowledges that Resident #1 had upcoming surgery for external fixator pins to be exchanged. Interview on 03/13/2024 at 4:40 p.m. with LVN B, indicated that she cared for Resident #1, she was a CN nurse on 06:00 a.m. - 06:00 p.m. shift and she provided pin site care and wrap RLE/external fixator with ace wrap during her shift. LVN said that resident had an external fixator/halo device to RLE and CN was responsible to provide pin site care every other day. LVN said that she did recall seeing a scab, or dark or discolored skin on top of resident's right foot but was not providing care or treatment to the area to her knowledge, no orders. LVN B said she has only been employed with the facility for about 1 month and follows her MAR/TAR to provide required treatments and medications. LVN B said that if residents go out to outside appointments that she thinks DON or ADON does follow up regarding new orders or treatments. LVN B said Resident #1 was cognitive and she could tell you what the doctor said. Interview on 03/13/2023 at 6:18 p.m. with Resident #1's FM indicated she went to the hospital ER to meet the resident on 02/27/2024. She stated she saw Resident #1 right lower extremity and told the ER staff that she had concerns regarding the care the resident was receiving at the current nursing facility. The FM stated she had redness and purulent drainage from her external fixator pin sites on right foot, a large black round wound to the top of her right foot, and a pressure sore to her right buttock. She stated she was in shock, the right foot looked horrible since she had last seen it at the orthopedic office on 02/14/2024. She stated the hospital diagnoses was infection at site of external fixator pin, cellulitis, and right foot wound. She stated the area on top of her right foot had dead tissue that had to be surgically removed and a graft placed. She said that the facility staff improper placement of ace wrap caused the wound on top of foot. FM said she was unaware of the pressure injury on right buttocks until she saw it at the hospital ER. FM said resident will not be returning to this facility due to the neglect and inadequate care provided to Resident #1. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/14/2024 at 5:22 p.m. with RN C indicated that she works as the RN supervisor usually on weekends but does pick up days during the week if needed. RN C recalls Resident #1's right foot with external fixator device and CN had to provide pin site care using hydrogen peroxide and Q-tip every other day and then wrap RLE/external fixator with ace wrap for protection. RN C does not recall the last time she cared for Resident #1 and has no recollection of resident having any wounds or discolored area to of right foot or to right buttocks area that she assessed or provided care for. RN C said each resident was scheduled a day and shift for weekly skin assessments to be performed by CN. Skin assessment should identify any new wounds, skin tears, abrasions, lacerations, rash, skin impairment/damage, discoloration, bruises, pressure, diabetic, venous, arterial ulcer, or incisions. Interview on 03/18/2024 at 11:27 a.m. with LVN A acknowledges that she took the photographs of Resident #1's RLE and provided a copy to DON. LVN A reviewed the photo previously taken on 02/25/2024 and does identify a dark/discolored area to top of right foot. LVN A said that the dark/discolored area on top of right foot should have been identified on the weekly skin assessments and the orthopedic MD or attending physician should have been made aware so assessment and treatment could have been ordered. LVN A does not recall when the dark/discolored area on top of right foot occurred or was first identified. LVN A denies being notified by CNA that resident had a new skin impairment to right buttock. Interview on 03/18/2024 at 1:41 p.m. with DON G, said she was familiar with Resident #1, she said she had to do a write up/medication error on an LVN/CN because she used Dakin's solution for pin site care instead of hydrogen peroxide on 02/22/2024. DON G communicated with LVN A on 02/23/2024 regarding Resident #1's external fixator pin sites with redness and purulent drainage and told her to contact orthopedic surgeon with report. DON G said she received a text message and image/photo of Resident #1's RLE on 02/25/2024 with concerns that pin sites continue to have drainage and redness noted during wound care. DON G said on 02/26/2024 she contacted orthopedic surgeon's office for an earlier appointment and notified attending NP/MD. DON G said she forwarded the attending NP the photos she had received from LVN A and NP gave new orders for stat labs to be obtained. DON G said that she had not physically observed Resident #1's RLE, only the images sent to her. DON G said she reached out to the orthopedic surgeon several times trying to get resident an earlier appointment. DON G said that labs came back on 2/27/2024 indicating elevated white blood count and attending NP notified. She said attending NP consulted with orthopedic surgeon and resident was sent to affiliated hospital for evaluation and treatment. DON G does not recall facility staff mentioning Resident #1 having a dark/discolored area to top of foot but once she reviews the image/photo she acknowledges that image from 2/25/2024 does show a dark/discolored area to top of right foot. DON G said skin assessment should be performed weekly and as needed, DON G said areas like this should be documented and monitored. DON G said that she was no longer employed as the DON with this facility, was terminated at the end of February 2024. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/20/2024 at 3:00 p.m. with CNA F, said she works 06:00 a.m. to 06:00 p.m. shift and provides personal care and assistance to residents. CNA F said she recalls Resdient#1 and her halo device to her right foot, she recalls that she reported to the CN once that the ace wrap had blood on it and pin sites appeared to be bleeding, she said CN assessed the right foot after reporting the incident. CNA F said she recalled providing care to Resident #1 days before or day of her being transferred to hospital, can't remember exact day, and when she place her hand on right hip area resident said ouch that hurt, CNA said she saw a fluid filled area to right hip/buttocks area, she completed her care and notified CN of her findings of fluid filled blister to right hip/buttocks area. CNA said I usually work with LVN B, but I cannot remember who I reported it to, but I remember reporting it to the CN. Interview on 03/20/2024 at 3:27 p.m. with LVN B, she acknowledges that the ace wrap being too tight could have caused the area to Resident #1's right dorsal foot, she said that she placed a non-adherent pad to area for protection at times. LVN B denies being notified by CNA that resident had a new skin impairment to right buttock. LVN B said that the dark/discolored area on top of right foot should have been identified on the weekly skin assessments and the orthopedic MD or attending physician should have been made aware so assessment and treatment could have been ordered. LVN B does not recall when the dark/discolored area on top of right foot occurred or was first identified. Interview on 03/14/2024 at 3:45 p.m. with DR E., who supervised NP D, he stated that he has seen Resident #1 with the external fixator and pin sites when he was visiting the roommate, approx. 1 week prior to hospitalization , while care was being provided to site, he does not recall seeing a dark/discolored area to top of right foot but says he was focus more on the pin sites which had a little redness but looked ok. DR E said that Resident #1 was seen by orthopedic surgeon routinely and he provided care/orders to RLE. DR E observed a photo of the RLE taken at the hospitalER on [DATE] and said no RLE did not look like that when he saw it, he said that NP D had been notified of the pin sites having drainage and redness on 02/26/2024 and she ordered labs and later consulted with orthopedic surgeon for hospital transfer and evaluation. DR E denied being notified or aware of dark/discolored area on top of right foot or fluid filled blister to right hip/buttocks area. Interview on 03/19/2024 at 8:00 a.m. with NP D indicated that she was notified by facility staff on 02/26/2024 that Resident #1 was having purulent drainage and redness at fixator pin sites, she ordered labs to be collected and for orthopedic appointment to be scheduled ASAP. NP D acknowledges that she received a picture of the Resident #1's RLE on 02/26/2024. NP D said that the focus at the time was the change in the pin site insertion sites, redness and purulent drainage, NP D reviews the photo provided to her on 02/26/2024 and does acknowledge the resident had a dark/discolored area to top of right foot but unable to access due to poor quality of picture. NP said that Resident #1 was routinely being seen by orthopedic doctor for care, interventions, and treatment to RLE. NP said Resident #1 was sent to affiliated hospital on 02/27/2024 due to abnormal lab values (elevated WBC count) and redness, and purulent drainage from fixator pin sites. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/20/2024 at 12:05 p.m. with the ADON indicated initially Resident #1 admitted to facility with cast/splint due to fractured ankle, but due to hardware failure, resident had to have hardware removed and eternal fixator placed back in December 2023. ADON states that Resident #1 was seen by therapy services at first and has remained non-weight bearing. Resident #1 was being seen by orthopedic surgeon weekly, then biweekly then every three weeks. Resident #1 was non- weight bearing to RLE and facility staff was to provide pin site care to external fixator pins every other day using hydrogen peroxide and wrap RLE/external fixature with ace wraps. Resident was transported to orthopedic surgeon appointments and dialysis 3 x week by facility transport. ADON said that resident was cognitive and that she would report to facility what happened during her orthopedic appointments because family members would meet them at appointment and take office visit paperwork. ADON said that the charge nurse was responsible for following up when resident had outside appointment and getting the paperwork or new orders, ADON said that she or the DON was available to assist with getting office visit paperwork if needed assistance. ADON said that she contacted orthopedic surgeon for office visit notes for investigation related to medication error (staff applied wrong treatment to RLE pin sites) and had received and reviewed the documents on 02/29/2024. ADON said she had observed Resident #1's RLE with redness and purulent drainage to pin sites, recalls a dark/dried scab area to top of foot day prior to resident being transferred to hospital for evaluation. ADON said she also spoke with resident on 02/26/2024 regarding pin sites redness and drainage and resident said that orthopedic surgeon was aware of the pin sites redness and drainage during last orthopedic appointment and that they were scheduling surgery for pin sites to be exchanged. ADON denied that she contacted orthopedic surgeon to verify resident statement. ADON said that said that the dark/discolored area on top of right foot should have been identified on the weekly skin assessments and the orthopedic MD or attending physician should have been made aware so assessment and treatment could have been ordered if needed. Attempted to contact the Orthopedic Surgeon 03/20/2024 and 03/21/2024, office staff reports that he was in surgery on Thursday's mornings and would have return the call. No return call, called office multiple times and left message, no return call received from orthopedic surgeon. Interview on 03/21/2024 at 2:05 p.m. with the Administrator, she said Resident #1 had a scab on the top of her foot, but the focus was on her fixator pin sites. Administrator observed images from hospital ER assessment on 02/27/2024 and said that the wound on top of the right foot did not look like that at time of transfer to hospital ER. Administrator acknowledges that she did not observe the RLE prior to transfer to hospital ER but pictures or images she received days prior did not look like the hospital ER images. Administrator was aware that facility staff are not receiving or contacting outside appointment staff for office visit records or new orders and have put a new process in place that CN is to contact and obtain office visit notes and orders from outside appointments. The administrator said she has a PIP in place for skin assessments not being completed weekly. Resident # 1's skin assessment was completed weekly over the last month except for 02/26/2024 but the skin assessment did not indicate or acknowledge that resident had a dark/discolored area to top of right foot as identified in images/photos taken by facility and hospital staff. Administrator reluctantly agrees that a skin impairment (dark/discolored area, scab, redness) should be assessed and identified on weekly skin assessment and the orthopedic MD or attending physician should have been made aware for treatment plan or intervention. (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 facility policy and procedure titled Prevention of pressure injuries revised April 2020, indicated Skin Assessment 1. Conduct a comprehensive scan assessment upon (or soon after) admission, with each risk assessment as indicated according to the resident's risk factors and prior to discharge. 2. During the skin assessment, inspect a. presence of erythema; b. Temperature of skin and soft tissue; and c. edema. 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.). Prevention Skin Care 4. Use a barrier product to prevent skin from moisture. 6. Do not rub or otherwise cause friction on skin that is at risk of pressure injuries. Device-Related Pressure Injuries 1. Review and select medical devices with consideration to the ability to minimize tissue damage, including size shape and its application and ability to secure the device. 2. monitor regularly for comfort and signs of pressure related injury. The Administrator was notified of an Immediate Jeopardy (IJ) on 03/21/2024 at 5:09 p.m. and was given a copy of the IJ template and a Plan of Removal (POR) was requested. 2. Record review of Resident #2's face sheet dated 01/30/24 indicated she was a [AGE] year-old female, initially admitted on [DATE], and her diagnoses included dementia (the impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and high blood pressure. Resident #2 was readmitted on [DATE] with diagnosis of fracture of the femur (broken thigh bone). Record review of Physician orders for Resident #2 dated March 2024 indicated an order to elevate, off load right heel and monitor blister, report changes to MD with a start date of 2/2/24. Another order was to apply hydrogel to the right heel and cover with dry dressing daily with a start date of 3/22/24. Record review of Resident #2's admission MDS assessment dated [DATE] indicated she had severely impaired cognition with BIMS of 04. She was dependent on one staff for transfer and showers. Section M (skin): indicated no wounds, no issues with feet and no areas were noted. Record review of Resident #2's care plan dated 1/30/24 to 3/23/24 indicated on 3/23/24 there was an unstageable pressure ulcer on right heel with eschar (dead tissue), there was no mention of the blister on the right heel the resident admitted on [DATE]. Record review of Resident #2's admission assessment dated [DATE] at 6:52 p.m., indicated she was readmitted with a quarter size blister on her right heel that was covered with bandage from the hospital. The orders noted on 02/02/24 to elevate, offload right heel, and monitor blister and notify physician of any changes. Record review of weekly skin assessments for Resident #2 as follows: On 2/2/24, other: intact blister to right heel; offloading; On 2/9/24, other: intact blister to right heel; offloading; On 2/16/24, other: intact blister to right heel; offloading; (continued on next page)

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	455642	A. Building B. Wing	03/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dayton Nursing and Rehabilitation	310 E Lawrence St Dayton, TX 77535

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/23/24, other: N/A; On 3/1/24, other: N/A; On 03/08/24, other: N/A; and On 3/15/24, other: N/A. During an interview and observation on 3/23/24 at 10:40 a.m., MD E observed Resident #2's right heel and MD E said Resident #2 would need an appointment with wound care specialist for treatment. He said the facility notified him of the area yesterday (3/22/24). He said normally the facility would notify his nurse practitioner and receive orders to treat or referral to wound care. He said he was not told about the wound before 3/22/24. He stated, I will ask my Nurse Practitioner if she was aware of the wound. He said if the facility failed to notify him that failure could cause a delay in care. He said he felt responsible too. During an interview on 3/23/24 at 11:30 a.m., the NP D said she was not notified about Resident #2 having a blister on her right heel since readmission on 01/30/24 or having eschar on her right heel. She said the routine order for a blister would be to elevate, offload the heel, monitor the blister, and notify the physician of any changes. She said then on her next onsite visit, she would have assessed the area and order specific treatment, pain management, referral to wound care and make a progress note. During an interview on 3/23/24 at 12:30 p.m., The ADON said the weekly skin assessments for Resident #2 were not correct for 2/23/24 to 3/15/24 and should have included the blister on the right heel. She said there was no documentation of the physician being notified on the weekly skin assessments. Record review of podiatry note dated 2/21/24 indicated Resident #2 was seen and treated for trimming of the nails and no documentation about the blister. Record review of the nurse's note dated 03/16/24 indicated Resident #2 had a blister on right heel and was an unstageable wound do to wound was covered with eschar (a thick layer attached to the wound bed and often requires medical intervention from wound care specialist for debridement). There was no documentation of the physician being notified of Resident #2's blister on right heel had changed from a blister to eschar tissue on the right heel. The POR on 3/22/24 at 6:22 pm was accepted. Plan of Removal Problem: F686- Pressure Injuries Interventions: 1.DON/Designee will conduct a facility wide skin sweep to verify accuracy of documented wounds to be completed by 3/22/2024. 2.Registered Nurse consultant completed DON check off on staging and wound care 3/22/2024. 3.DON checked off registered nurses on wound staging and wound care on 3/22/2024. 4.DON initiated checked off on assessing and documenting changes in wounds and wound care with LVNs on 3/22/2024. Nurses will not be allowed to work the floor until education and in-service is completed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Education: 1.The following in-services were initiated by DON/designee on 3/21/2024: All available staff will begin being in-serviced on 3/21/2024, to be completed on or before 3/22/2024. Any staff member not present or in-serviced by this time will not be allowed to assume their duties until they have been in-serviced. 2. Administrator/designee to ensure that all in-service training has been done for all staff (nurses, CNAs, Medication Aides, dietary, housekeeping, and maintenance} by checking off the employee staff roster; tracking for completion of education and in servicing being completed by HR coordinator. All staff Change of Condition/Documenting the differentiation and identification of wounds. Nurses- In-service on wound care

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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** 47879 Based on interview and record review, the facility failed to maintain medical records on each resident that are accurately documented for 1 (Resident #5) of 10 residents reviewed for accurate medical records in that: 1.LVN H failed to complete the initial admission assessment documentation on Resident #5 when he was admitted to the facility on [DATE]. 2.LVN H failed to document on the MAR/TAR indicating what medication Resident #5 admitted with and whether any of the medications were administered during Resident #5's short stay in the facility on 03/4/2024 to 03/05/2024. This failure could place residents at risk for misinformation about professional care provided. Findings included: Record review of Resident #5's electronic face sheet dated 03/13/2024 indicated the resident was admitted to the facility on [DATE]. His diagnoses included: Acute respiratory failure with hypoxia (condition where you don't have enough oxygen in the tissue in your body), Pneumonia due to coronavirus disease (an infection in your lungs caused by covid 19), Hypertension (condition in which the force of the blood against the artery walls is too high), myocardial infarction (blood flow decreases or stops in one of the blood vessels of the heart causing tissue death) and pulmonary embolism (sudden blockage in your pulmonary arteries, the blood vessels that send blood to your lungs). Record review of Resident #5's chart reflected there was no care plan/baseline care plan documentation. Record review of Resident #5's admission MDS assessment reflected it was not started. Record review of nurse's progress notes reflected there was no documentation indicating any assessment done, the time of admission on Resident #5. ADON made entry in EMR under progress note dated 3/8/2024, that LVN H acknowledged she admitted resident to facility on 03/04/2024 at 7:30 p.m. from hospital, resident was in facility approximately 5 hours when he was complaining of chest pain, and she received orders to send resident to local ER. Record review of Resident #5's hospital medical records indicate Resident #5 was being admitted to nursing facility for rehabilitation services following hospital stay and debilitation. Record review of Resident #5's MAR revealed no documentation of medications entered or administered on 03/04/2024. The MAR was blank, and no medications that Resident #5 came with from hospital were documented. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/14/2024 at 3:01 p.m. with LVN H revealed she was the CN on 03/04/2024 and did begin the process of admitting Resident #5, she said resident did not get to facility until after 07:00 p.m. and she and the CNA did the admission introduction, greeting, explained call light, bed control, etc. LVN H said that resident started complaining about shortness of breath, and she started resident on oxygen by concentrator, relief of shortness of breath noted after oxygen applied. LVN H said around 11:00 - 11:30 p.m. resident began complaining of chest pain and attending physician notified, interventions of oxygen, and nitroglycerin protocol unsuccessful, resident became sweaty and clammy, so EMS contacted for emergency services for resident to be transferred back to hospital for chest pain. She said EMS arrived at the facility and was reluctant to take the resident back to hospital. EMS transferred resident to hospital of choice with complaints of chest pain and shortness of breath. LVN H said that Resident #5 left the faciity on [DATE] between 12:01 am and 1:00 am. LVN H said she did not complete her documentation on Resident #5's facility admission prior to leaving her shift. LVN H said she had two emergencies that night and 30 + residents to provide care too, she was unable to document and had plans to return to facility to complete the documentation, but she became ill and was unable to return to facility. Interview on 3/18/2024 at 9:45 a.m. with the Administrator revealed her expectation was that when new residents were admitted to the facility, staff should put as much documentation as possible. She stated Resident #5 was admitted later in the evening on 03/04/2024, when she became aware that admission was not documented for Resident #5, she requested the DON at the time, to contact LVN H regarding completing her paperwork and learned that LVN H was ill and unable to return to facility. She stated she addressed the issue with LVN H over the phone, but she had not been scheduled to return to the facility by the agency staff. She stated she expected the staff to document the status for the resident on admission and care given but she noticed on 03/05/2024 LVN H did not finish the initial assessment or putting the medications on the MAR. She said that she received a return call from LVN H on 03/08/2024, discussed with LVN H the requirements for documenting on admissions, LVN H expressing she was ill and unable to return to facility to complete documentation at that time. She also stated she had the ADON reach out to LVN H and data entry any statement information provided into Resident #5's medical records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Charting and Documentation policy, dated revised July 2017, reflected: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record: objective observations; medications administered; treatments or services performed; changes in the resident's condition; events, incidents or accidents involving the resident; and progress toward or changes in the care plan goals and objectives. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 4. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified nursing assistants may only make entries in the resident's medical chart as permitted by facility policy. 5. Information documented in the resident's clinical record is confidential and may only be released in accordance with state law, the Health Insurance Portability and Accountability Act (HIPAA) and facility policy. Refer all requests for information to the director of nursing services, nurse supervisor/charge nurse or to the business office. 6. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records. 7. Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment; whether the resident refused the procedure/treatment; notification of family, physician or other staff, if indicated; and the signature and title of the individual documenting.