STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observations, interviews, and record reviews the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 out of 6 residents (Resident #1) reviewed for quality of care. 1. The facility failed to ensure Resident #1's wounds were measured weekly on (9) occasions. 2. The facility failed to ensure wound care treatments/dressings were provided to Resident #1 as ordered by the physician on (2) occasions. This deficient practice could place residents at risk for worsening wounds and/or infections. Findings included: 1. Record review of Resident #1's Admission Record, dated 2/14/25, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Acquired absence of left leg below knee, Type 2 diabetes (chronic condition that affects the way the body processes blood sugar), Gangrene (death of tissue due to lack of blood flow or infection) , Atherosclerosis (The build-up of fats, cholesterol, and other substances in and on the artery walls) of arteries of left leg with ulceration (an open wound or sore in the skin) of ankle, and Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #1's comprehensive MDS assessment, dated 11/15/24, revealed Resident #1 had a BIMS of 11, suggesting moderate cognitive impairment. Further record review of this document revealed, under Section M - Skin Conditions, the resident had (4) venous or arterial ulcers and infection of the foot. Treatments included application of dressing to feet. Record review of Resident #1's Care Plan, dated 12/11/24, revealed the resident had potential for complications related to surgical wound to the left lower extremity. Interventions included: wound vac, treatments as ordered, assessment of wound appearance and documentation of appearance and measurements. Further review of Care Plan, dated 2/17/25, revealed Resident #1 had potential for complications related to surgical wound related to BKA. Interventions included: treatments as ordered, assessment of wound appearance and documentation of appearance and measurements. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Wound Progress Evaluations revealed LVN K (Wound Care Nurse) documented the same measurements previously documented by the wound care physician for the following dates: 10/13/24 - measurements documented by LVN K for left lateral ankle arterial wound were 3.1 x 2.2 x 0.3 cm, which were the same measurements documented by the WC MD on 10/10/24. 10/21/24 - measurements documented by LVN K for left lateral ankle arterial wound were 2.8 x 2.1 x 0.4 cm, which were the same measurements documented by the WC MD on 10/17/24. 10/30/24 - measurements documented by LVN K for left lateral ankle arterial wound were 2.5 x 2.2 x 0.3 cm, which were the same measurements documented by the WC MD on 10/24/24. 11/7/24 - measurements documented by LVN K for left lateral ankle arterial wound were 1.7 x 1.2 x 0.3 cm, which were the same measurements documented by the WC MD on 11/14/24. 12/23/24 - measurements documented by LVN K for left lateral ankle arterial wound were 2.2 x 2.5 x 0.3 cm, which were the same measurements documented by the WC MD on 12/16/24. 1/2/25 - measurements documented by LVN K for left lateral ankle arterial wound were 2.5 x 2.2 x 0.3 cm, which were the same measurements documented by the WC MD on 12/30/24. 1/3/25 - measurements documented by LVN K for left lateral ankle arterial wound were 2.9 x 1.8 x 0.3 cm, which were the same measurements documented by the WC MD on 1/2/25. 1/15/25 - measurements documented by LVN K for left lateral ankle arterial wound were 3.3 x 3.7 x 0.3 cm, which were the same measurements documented by the WC MD on 1/13/25. 1/22/25 - measurements documented by LVN K for left lateral ankle arterial wound were 4.1 x 3.5 x 0.2 cm, which were the same measurements documented by the WC MD on 1/20/25. During a telephone interview on 2/23/25 at 4:58 pm, LVN K said she used the WC MDs measurements of Resident #1's wound because the WC MD saw the resident weekly. LVN K said on the days Resident #1 was not seen by the WC MD she did not measure the wound during her assessment of the wound because she did not need to. LVN K further stated she was expected to measure resident wounds on a weekly basis, so she measured them with the WC MD when the physician visited Resident #1. 2. Record review of Resident #1's Order Summary, dated 2/20/25, revealed an order cleanse incision of left BKA with normal saline, apply oil emulsion gauze, cover with large pad, secure with kerlix, apply stockinette, and monitor site daily one time a day, dated 2/15/25 - 2/19/25. Review of Resident #1's February TAR revealed LVN K initialed for 2/17/25 and 2/18/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 2/18/2025 at 4:00 pm revealed dressing to Resident #1's left BKA was clean, dry, and dated 2/16/25. LVN K confirmed the date on the dressing was 2/16/2025 and confirmed she had not changed Resident #1's dressing in two days (2/17/25 and 2/18/25). LVN K further stated she checked off the wound care as completed in PCC. LVN K said she did that because she did not like when the color changed to red in PCC (indicating the treatment was late). LVN K said she intended to return and complete Resident #1's wound care but got busy because the WC MD was making rounds and forgot. LVN K further stated the WC MD had not seen Resident #1 on 2/18/25. During an interview on 2/18/2025 at 5:43 pm, LVN K said the WC MD was in the facility on 2/18/25 and this was why she documented Resident #1's wound care treatment as completed without providing treatment. LVN K further stated on 2/17/25 she worked the floor, and the nurses were supposed to do Resident #1's wound care. LVN K said she did not know why she documented Resident #1's wound care as completed on 2/17/25 when it was not done, adding she just told herself she would get to him today (2/18/25). During an interview on 2/20/25 at 1:30 pm, the DON said LVN M was currently responsible for wound care when LVN K was unavailable but before 2/1/25 the charge nurses were responsible for wound care when LVN K was not available. The DON further stated the TARs were reviewed for treatment completion during the morning meetings. The DON said if a blank was identified on the TARs, the nurse responsible for the treatment was contacted to determine whether it was a failure to document and if so, the nurse was to document the treatment as soon as possible. The DON further stated if it was a missed treatment, the treatment was completed as soon as possible, and education provided to the nurses that were responsible for the treatments. The DON said lack of documentation could affect the residents because someone else could repeat the treatment and disrupt the healing process by removing a dressing too early, as well as discomfort to the resident. The DON further stated missed treatments put the residents at risk for potential infection and delayed healing. The DON said she expected the wound care nurse to always follow physician orders. The DON said she was not aware of missed treatments for Resident #1. During an interview on 2/20/25 at 12:38 pm, the ADON said the facility had a meeting every weekday morning, and assessment and TARs were reviewed, the weekend supervisors reviewed them on the weekends. The ADON further stated the DON also reviewed the assessments and TARs. The ADON said when treatments were missed the charge nurse and physician were notified and the missed treatment was provided as soon as possible. The ADON said when the treatment nurse was unavailable to complete wound care, the charge nurses completed their own wound care. The ADON further stated treatments were to be documented before the end of the day the treatment was completed on. The ADON said it was important to provide wound care as ordered for healing. The ADON said verbal orders were to be documented the same day they were was received. The ADON further stated nurses were expected to review orders before providing care so they knew what to do. The ADON said she was not aware of Resident #1 missing treatments. During an interview on 2/20/25 at 1:30 pm, the DON said the expectation was for verbal orders to be documented by the end of the shift to update the residents' care. The DON further stated nurses were expected to review orders prior to treatment to ensure orders were carried out as ordered because the residents might not get the appropriate treatments, which may delay the healing process. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/25 at 11:26 am, RN H said he provided wound care from time to time. RN H further stated the facility had a wound care nurse but if he assessed an area that required treatment, he provided it. RN H said he was expected to provide wound care when the treatment nurse was not available. RN H said he was expected to document all treatments in the residents' wound care records. RN H further stated the facility's policy was that any time a treatment was completed or not completed for any reason it was to be documented. RN H said if a treatment was not documented it wasn't done. RN H further stated documentation needed to be completed that everyone knew that the resident received the treatment, when it was done, and that it was completed. RN H said treatments were scheduled because they were needed and if something was missed it was important so that the next nurse knew that it was not done and needed to be completed. RN H further stated it would be important to notify the physician of missed treatment because orders were based on what the provider thought would provide the best benefit to the residents and that he would want to bring that to the attention of the provider to avoid possible complications. RN H further stated when he provided treatments, he documented them. RN H said he was expected to document any treatments he provided. Attempted interview on 2/21/25 at 12:01 pm with LVN B was unsuccessful. Attempted interview on 2/21/25 at 12:19 pm with LVN G was unsuccessful. Attempted interview on 2/21/25 at 12:21 pm with RN J was unsuccessful. During an interview on 2/23/25 at 1:45 pm, the DON said she was responsible for ensuring treatments were completed as ordered and according to professional standards of practice. During an interview on 2/23/25 at 2:18 pm, the Regional Nurse said the facility did not have a Quality of Care/Treatment policy. Attempted interview on 2/23/25 at 4:58 pm with LVN K was unsuccessful. Attempted interview on 2/24/25 at 12:15 pm with the WC MD was unsuccessful. Attempted interview on 2/25/25 at 11:06 am with the WC MD was unsuccessful. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/25/25 at 12:17 pm, the DON said nurses were expected to provide treatments as ordered so that treatments were consistent, and they were able to evaluate if treatments were effective or not. The DON further stated deviating from physician orders could delay wound healing. The DON said if treatments were missed due to resident refusal it was to be documented in the progress notes. The DON said she was responsible for ensuring all treatments were provided as ordered by the physician and documented. The DON further stated she was responsible for ensuring any missed treatments were documented and notifications made. The DON said nurses were expected to measure resident wounds on a weekly basis to show the progress of the wounds. The DON further stated it was only acceptable to use the WC MD's measurements when rounding with the WC MD. The DON said when not rounding with the WC MD, she expected the nurses to re-measure the wounds. The DON said obtaining wound measurements was important to assess the progress of the wounds. The DON further stated if measurements were not obtained, they could not keep up with the progress of the wound and gage the progress, she added this was also important for continuity of care. The DON said obtaining wound measurements weekly was the facility's policy. The DON further stated she was responsible for ensuring resident wounds were measured on a weekly basis. The DON said she expected a wound assessment to be completed on 2/13/25 for Resident #1 when he returned from the hospital. The DON further stated the wound care nurse or floor nurse assigned to Resident #1 was responsible for completing the assessment by the end of the shift to obtain orders for treatment and follow-up. The DON said she was responsible for ensuring assessments were completed. The DON further stated there was a potential for negative outcomes due to lack of assessment/measurements and orders. Attempted interview on 2/25/25 at 1:00 pm with the WC MD was unsuccessful. During an interview on 2/25/25 at 5:54 pm, the Administrator said if a resident missed/refused a treatment, it should be documented, the RP and the Physician/NP notified. The Administrator said notifications were made so that everyone was on the same page and there was communication among staff, family, and providers. Record review of the facility's Wound Treatment Competency Assessment, undated, revealed .Reviews and verifies physician's orders for wound care .Cleanse the wound as ordered .Applies and secures dressing as ordered . Record review of the facility's policy titled Skin Integrity Management System, undated, revealed: .Wound progress is to be documented each week with measurements and wound descriptions. 1. Treatment for an identified area is documented on the Treatment Administration Record (TAR). a .Assignments for skin evaluations will be scheduled. These assignments are to be monitored for completion .Facility DONs are responsible to establish a system to monitor and assure Skin Integrity Management System Compliance . Record review of the facility's policy titled Documentation in Medical Record, dated 10/24/22, revealed: .3. Principles of documentation include but are not limited to .i. False information shall not be documented .ii. Record desc1iptive and objective information based on first-hand knowledge of the assessment, observation, or service provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review the facility failed to ensure 1 of 1 (Resident #2) resident reviewed for pressure ulcers received necessary treatment and services, consistent with profession standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing. 1. The facility failed to provide wound care treatments/dressing to Resident #2 as ordered by the physician on (22) occasions. 2. The facility failed to ensure LVN K followed physician orders during observed wound care for Resident #2's right lateral foot on 02/19/2025. 3. The facility failed to ensure LVN K documented a verbal order for wound care for the right lateral foot on 02/18/2025. This deficient practice could place residents at risk for worsening wounds and/or infections. Record review of Resident #2's Admission Record, dated 2/18/25, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Contact Dermatitis (skin inflammation caused by friction or contact with substances), and Corns and callosities (thickened skin caused by repeated friction and pressure). Record review of Resident #2's comprehensive MDS assessment, dated 2/6/25, revealed Resident #2 had a BIMS of 12, suggesting intact cognition. Further record review of this document revealed, under Section M - Skin Conditions, Resident #2 had one or more unhealed pressure ulcers/injuries, two unstageable pressure injuries presenting as deep tissue injury. Treatments included pressure injury care, and applications of ointments/medications. Record review of Resident #2's Care Plan, 2/10/25, revealed the resident had an alteration in skin integrity related to the presence of an unstageable pressure ulcer/injury on the right lateral midfoot. Interventions included: treatments as ordered, assessment and document status weekly, evaluation of the status of the dressing, and weekly assessments, measurements, and description. Record review of Resident #2's Order Summary, dated 2/20/25, revealed an order for prophylactic care to apply skin prep to left heel, right heel, and right lateral foot, and wrap with kerlix daily, dated 10/19/24 - 11/4/24. Review of Resident #2's November 2024 TAR revealed a blank for 11/2/24. Record review of Resident #2's Order Summary, dated 2/20/25 revealed an order to apply iodine swab to right heel and right lateral foot, and wrap right foot with kerlix every other day, dated 11/9/24 - 11/29/24. Review of Resident #2's November 2024 TAR revealed blanks for 11/17/24, 11/19/24, and 11/27/24. Record review of Resident #2's Order Summary, dated 2/20/25, revealed an order to apply betadine and leave open to air daily for left ankle suspected DTI, dated 1/10/25 - 1/23/25. Review of Resident #2's January 2025 TAR revealed blanks for 1/11/25, 1/12/25, 1/16/25, 1/17/25, 1/18/25, and 1/19/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Order Summary, dated 2/20/25, revealed an order to apply betadine and leave open to air daily for left lateral foot suspected DTI, dated 1/10/25 - 2/4/25. Review of Resident #2's January 2025 TAR revealed blanks for 1/11/25, 1/12/25, 1/16/25, 1/17/25, 1/18/25, 1/19/25, 1/24/25, and 1/30/25. Record review of Resident #2's Order Summary, dated 2/20/25, revealed an order to apply layers of gauze to bilateral heel and secure with kerlix every other day, dated 2/6/25. Review of Resident #2's February 2025 TAR revealed blanks for 2/6/25 and 2/12/25. Record review of Resident #2's Order Summary, dated 2/20/25, revealed an order to apply betadine and wrap bilateral feet every other day, dated 2/6/25. Review of Resident #2's February 2025 TAR revealed blanks for 2/6/25 and 2/12/25. During an interview on 2/18/2025 at 2:56 pm, LVN K said she worked as the wound care nurse Monday - Friday 9:00 am - 6:00 pm and rotated on the weekends. LVN K further stated the weekend supervisors completed wound care on the weekends. During observation and interviews on 2/18/25 at 5:15 pm, Resident #2 was lying in bed. Resident #2 was talkative and pleasant but confused. Observation of Resident #2's feet revealed neither foot had a dressing. Further observation of Resident #2's feet revealed there was no observable betadine residual on any of the wounds. During an interview on 2/18/2025 at 5:33 pm, LVN B said she was the nurse assigned to care for Resident #2. LVN B further stated she was not aware of Resident #2's wounds on the feet until the observation with the state investigator on 2/18/25. LVN B further stated LVN K was responsible for wound care and if the LVN K was not at the facility the nurses had to provide wound care. LVN B confirmed Resident #2 did not have any dressings to either feet or wounds and said she did not see any betadine residual. During an interview and record review on 2/18/2025 5:43 pm, LVN K said Resident #2's wounds had been evaluated on 2/17/25. Review of Resident #2's wound evaluation, dated 2/17/25, revealed the wound to the right lateral foot appeared almost healed. LVN K said she did not apply kerlix dressing to the wound because Resident #2 did not get out of bed. LVN K acknowledged applying betadine but not applying the kerlix dressing to Resident #2's feet. LVN K further stated the kerlix dressing was for padding and she had not received an order to omit the kerlix dressing. LVN K said she omitted the kerlix dressing since 2/14/25. During an interview on 2/19/25 at 3:29 pm, LVN K said Resident #2 just required iodine for the wound to the right lateral foot. LVN K further stated the order was not coming up and she did not know why. During observation of wound care for Resident #2 on 2/19/25 at 3:50 pm, LVN K did not cleanse the wound to Resident #2's right lateral foot prior to applying betadine treatment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/19/25 at 4:22 pm, LVN K said Resident #2 originally had an order for iodine and dressing to the right lateral foot. LVN K said she had not checked if Hospice A RN had left orders for Resident #2's right lateral foot wound. LVN K further stated last night (2/18/25) Hospice A RN said wound care wound be completed daily for the right foot. LVN K said she did not check Resident #2's orders prior to wound care. She further stated she was expected to check orders prior to wound care to see if there were any changes. During an interview on 2/19/25 at 4:49 pm, LVN K said Hospice A RN told her she expected LVN K to enter Resident #2's orders for wound care on 2/18/25 but she had not entered the orders and was now locked out of the computer. LVN K further stated she received a verbal order on 2/18/25 to cleanse Resident #1's wound to the right lateral foot with normal saline, apply iodine and wrap with kerlix. LVN K said it was Important to document orders in a timely manner, so that the orders were followed, and wound care was provided. LVN K further stated not following wound care orders or cleaning wounds could hinder the wound healing process. During a telephone interview on 2/20/25 at 11:06 am, Hospice A RN said she gave LVN K a verbal order for Resident #2's wound to the right lateral foot on 2/18/25 to cleanse, apply iodine and wrap. Hospice A RN further stated that she expected the wound to be cleansed with normal saline prior to applying treatment. Attempted interview on 2/20/25 at 11:49 am with LVN B was unsuccessful. Attempted interview on 2/20/25 at 12:06 pm with LVN K was unsuccessful. During an interview on 2/20/25 at 1:30 pm, the DON said LVN M was currently responsible for wound care when LVN K was unavailable but before 2/1/25 the charge nurses were responsible for wound care when LVN K was not available. The DON further stated the TARs were reviewed for treatment completion during the morning meetings. The DON said if a blank was identified on the TARs, the nurse responsible for the treatment was contacted to determine whether it was a failure to document and if so, the nurse was to document the treatment as soon as possible. The DON further stated if it was a missed treatment, the treatment was completed as soon as possible, and education provided to the nurses that were responsible for the treatments. The DON said lack of documentation could affect the residents because someone else could repeat the treatment and disrupt the healing process by removing a dressing too early, as well as discomfort to the resident. The DON further stated missed treatments put the residents at risk for potential infection and delayed healing. The DON said she expected the wound care nurse to always follow physician orders. The DON said she was not aware of missed treatments for Resident #1 and Resident #2. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/20/25 at 12:38 pm, the ADON said the facility had a meeting every weekday morning, and assessment and TARs were reviewed, the weekend supervisors reviewed them on the weekends. The ADON further stated the DON also reviewed the assessments and TARs. The ADON said when treatments were missed the charge nurse and physician were notified and the missed treatment was provided as soon as possible. The ADON said when the treatment nurse was unavailable to complete wound care, the charge nurses completed their own wound care. The ADON further stated treatments were to be documented before the end of the day the treatment was completed on. The ADON said it was important to provide wound care as ordered for healing. The ADON said verbal orders were to be documented the same day they were was received. The ADON further stated nurses were expected to review orders before providing care, so they knew what to do. The ADON said she was not aware of Resident #1 and Resident #2 missing treatments. During an interview on 2/20/25 at 1:30 pm, the DON said the expectation was for verbal orders to be documented by the end of the shift to update the residents' care. The DON further stated nurses were expected to review orders prior to treatment to ensure orders were carried out as ordered because the residents might not get the appropriate treatments, which may delay the healing process. During an interview on 2/21/25 at 11:26 am, RN H said he provided wound care from time to time. RN H further stated the facility had a wound care nurse but if he assessed an area that required treatment, he provided it. RN H said he was expected to provide wound care when the treatment nurse was not available. RN H said he was expected to document all treatments in the residents' wound care records. RN H further stated the facility's policy was that any time a treatment was completed or not completed for any reason it was to be documented. RN H said if a treatment was not documented it was not done. RN H further stated documentation needed to be completed that everyone knew that the resident received the treatment, when it was done, and that it was completed. RN H said treatments were scheduled because they were needed and if something was missed it was important so that the next nurse knew that it was not done and needed to be completed. RN H further stated it would be important to notify the physician of missed treatment because orders were based on what the provider thought would provide the best benefit to the residents and that he would want to bring that to the attention of the provider to avoid possible complications. RN H said he did not remember missing treatments on 1/11/25, 1/12/25, 1/18/25 for Resident #2. RN H further stated when he provided treatments, he documented them. RN H said he was expected to document any treatments he provided. Attempted interview on 2/21/25 at 12:01 pm with LVN B was unsuccessful. Attempted interview on 2/21/25 at 12:19 pm with LVN G was unsuccessful. Attempted interview on 2/21/25 at 12:21 pm with RN J was unsuccessful. During an interview on 2/22/25 at 4:16 pm, LVN I said he remembered providing wound care treatments for Resident #2 on 11/2/24, 1/11/25, 1/12/25, 1/18/25, 1/19/25 but must have forgotten to document them. During an interview on 2/23/25 at 1:45 pm, the DON said she was responsible for ensuring treatments were completed as ordered and according to professional standards of practice. During an interview on 2/23/25 at 2:18 pm, the Regional Nurse said the facility did not have a Quality of Care/Treatment policy. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Attempted interview on 2/23/25 at 4:58 pm with LVN K was unsuccessful. During an interview on 2/25/25 at 12:17 pm, the DON said nurses were expected to provide treatments as ordered so that treatments were consistent, and they were able to evaluate if treatments were effective or not. The DON further stated deviating from physician orders could delay wound healing. The DON said if treatments were missed due to resident refusal it was to be documented in the progress notes. The DON said she was responsible for ensuring all treatments were provided as ordered by the physician and documented. The DON further stated she was responsible for ensuring any missed treatments were documented and notifications made. The DON said nurses were expected to measure resident wounds on a weekly basis to show the progress of the wounds. The DON further stated it was only acceptable to use the WC MD's measurements when rounding with the WC MD. The DON said when not rounding with the WC MD, she expected the nurses to re-measure the wounds. The DON said obtaining wound measurements was important to assess the progress of the wounds. The DON further stated if measurements were not obtained, they could not keep up with the progress of the wound and gage the progress, she added this was also important for continuity of care. The DON said obtaining wound measurements weekly was the facility's policy. The DON further stated she was responsible for ensuring resident wounds were measured on a weekly basis. The DON said she expected a wound assessment to be completed on 2/13/25 for Resident #1 when he returned from the hospital. The DON further stated the wound care nurse or floor nurse assigned to Resident #1 was responsible for completing the assessment by the end of the shift to obtain orders for treatment and follow-up. The DON said she was responsible for ensuring assessments were completed. The DON further stated there was a potential for negative outcomes due to lack of assessment/measurements and orders. During an interview on 2/25/25 at 5:54 pm, the Administrator said if a resident missed/refused a treatment, it should be documented, the RP and the Physician/NP notified. The Administrator said notifications were made so that everyone was on the same page and there was communication among staff, family, and providers. Record review of the facility's Wound Treatment Competency Assessment, undated, revealed .Reviews and verifies physician's orders for wound care .Cleanse the wound as ordered .Applies and secures dressing as ordered . Record review of the facility's policy titled Skin Integrity Management System, undated, revealed: .1. Treatment for an identified area is documented on the Treatment Administration Record (TAR). a . Assignments for skin evaluations will be scheduled. These assignments are to be monitored for completion . Facility DONs are responsible to establish a system to monitor and assure Skin Integrity Management System Compliance .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interviews, and record review the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 out of 4 residents (Resident #6) reviewed for pain management. The facility failed to adequately assess and treat Resident #6's pain prior to or during wound care. This failure could place residents at risk for unnecessary pain, discomfort, and decreased quality of life. Findings included: Record review of Resident #6's Admission Record, dated 2/22/25, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (disease affecting memory and other important mental functions) , Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) , chronic pain, Dementia (group of thinking and social symptoms that interferes with daily functioning), and Cognitive Communication Deficit (difficulty with thinking and language) . Record review of Resident #6's quarterly MDS assessment, dated 12/18/24, revealed she had a BIMS score of 5, severe cognitive impairment. Further review of the assessment revealed Resident #6 received Opioids (medications used to treat moderate to severe pain) and received scheduled pain medication in the last 5 days. Record review of Resident #6's Order Summary, dated 2/22/25, revealed an order for Triple Antibiotic Ointment to right posterior lower leg every other day; cleanse with wound cleanser, pat dry, apply ointment, and wrap with kerlix from foot to below the knee, dated 2/20/25. Record review of Resident #6's Order Summary, dated 2/22/25, revealed Resident #6 had orders for acetaminophen 650 mg PRN for pain, dated 5/15/23; hydrocodone-acetaminophen 5-325 mg every 4 hours PRN for pain, dated 1/31/25; and Morphine 20 mg/mL, give 10 mg every 2 hours PRN for pain, dated 1/27/25. Record review of Resident #6's Change of Condition Communication Form, dated 2/23/25, revealed Resident #6 had redness around skin tear to right leg; possible cellulitis (common bacterial skin infection), soft tissue, or wound infection; possible problem - Skin infection/wound infection; new orders received for Bactrim twice a day for 10 days. During an interview on 2/20/25 at 12:14 pm, the Administrator said the facility did not have wound care procedures but did have a checklist. The Administrator provided Wound Treatment Competency Assessment. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 2/22/25, beginning at 3:39 pm, of RN L's wound care, assisted by LVN M, to Resident #6's right calf revealed the resident was not assessed or treated for pain prior to the procedure. Further observation revealed Resident #6's wound had some purulent drainage residue on steri-strips and dressing, redness, and edema to the peri-wound area. Further observation revealed Resident #6 seemed to express pain during the procedure by repeatedly saying ay, ay and reached for her right calf. RN L continued with treatment and Resident #6 continued to complain of pain and reached for her right calf. RN L said she did not know if Resident #6 was complaining of pain or was scared and continued with the treatment. RN L completed the treatment and Resident #6 continued to complain of pain, repeatedly saying ay, ay. At 3:48 pm, RN L asked Resident #6 if she had pain and needed pain medication, Resident #6 said yes. During an interview on 2/22/25 at 4:00 pm, RN L said Resident #6 was not medicated for pain prior to wound care treatment. During an interview on 2/22/25 at 4:07 pm, RN L said she assessed Resident #6 for pain when she explained the procedure and the resident said no and then said no se (I do not know). RN L further stated she did not know if Resident #6 was saying I don't know because she did not know what RN L was asking or if she had pain. RN L said she normally stopped treatments if a resident knew what she was saying. RN L further stated she tried to be gentle because she did not know if Resident #6 was hurting, and she offered pain medication after she was done with the treatment. RN L said Resident #6 was not saying ouch, she was saying ay as in pain or ahi as in there, in Spanish. RN L further stated she did not stop the treatment because she was very gentle and knew that she was not causing the resident pain. RN L said Resident #6 was saying ay, ay but she did not see any frowning or gestures suggesting Resident #6 was hurting, RN L further stated resident #6 kept putting her hand near the wound area, and it seemed like the resident wanted to scratch, not stop RN L. RN L said normally residents say they were in pain or she could see that they were hurting. RN L said Resident #6 could not have been in pain during wound care because she was being gentle during the treatment to Resident #6's right calf and the resident was not frowning. RN L further stated signs expressed by residents unable to use words to express their feelings included: frowning, moaning, and guarding the affected area. RN L further stated that she only stopped treatments when residents specifically said stop. RN L further stated Resident #6 was reaching for her right calf but thought she reached to scratch more than protecting the area. During an interview on 2/24/25 at 2:19 pm, LVN M said she did not know Spanish but every time Resident #6 was moved she said ay. LVN M further stated it was hard to tell when Resident #6 was in pain but thought when the resident said ay she was in pain. LVN M said when Resident #6 reached down for her leg she probably wanted the treatment to be stopped, did not want to be touched. LVN M further stated some non-verbal pain cues included guarding, grimacing, pushing, striking out, and tensing up. LVN M said Resident #6 expressed the tension, guarding, and she was trying to push RN L's hand away while she assisted RN L with wound care on 2/22/25. LVN M said the facility's expectation was to medicate prior to wound care if needed. LVN M further stated the nurse was asked to medicate Resident #6, but this was done after the treatment was completed. LVN M said she would have stopped the treatment and asked the nurse to medicate Resident #6 when she seemed to be in pain. LVN M further stated it was important to medicate resident prior to wound care when needed to decrease pain and the resident did not suffer or experience distress during treatments. LVN M said she did not think Resident #6 had pain medication ordered to be administered prior to treatments but added she had PRN Tylenol ordered for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/25 at 4:59 pm, the DON said the facility policy stated to assess residents for pain when treatments were provided but it did not address when the assessment should be completed. The DON further stated that ideally residents should be assessed for pain before the treatment began, maybe an hour before to allow the medication to work. The DON said it was important to assess residents for pain before wound care treatments for the residents' comfort. Record review of the facility's policy titled Skin Integrity Management System, undated, revealed: .a. Assess residents for pain and act accordingly during treatments . Record review of the facility's Wound Treatment Competency Assessment revealed: .Assesses resident before, during and after treatment for pain. Provide pain relief measures if indicated. Pre-medicate if ordered .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39251 Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments for 1 of 6 medication carts (Treatment Cart) reviewed for medication storage. The facility failed to ensure the Treatment Cart was locked when unattended on (3) occasions. This failure could place residents at risk of medication misuse and drug diversion. Findings included: Observation on 2/22/25 beginning at 3:19 pm, RN L entered Resident #2's room, closed the door, and prepared to provide wound care leaving the treatment cart unlocked. Further observation revealed the treatment cart was unlocked when RN L opened Resident #2's room door after the treatment was completed. Observation revealed there were two CNAs on the hall when RN L exited the room. Further observation revealed RN L re-entered Resident #2's room, leaving the treatment cart unlocked. RN L was observed entering the resident's room to wash her hands, leaving the treatment cart unlocked. Further observation revealed a nurse at the far end of the hall preparing medications, a resident and unlicensed staff on the hall at the time of observation. During an interview on 2/22/25 at 4:00 pm, RN L said she was not allowed to leave the treatment cart unlocked because it was a risk, and anyone can access the cart including residents. RN L further stated residents could get hurt because they did not know what it was, and they can get into it. RN L said the cart contained treatments, such as betadine, alcohol pads, triple antibiotic ointment, and other treatments. RN L further stated there were ambulatory residents on hall the treatment cart was on. RN L said the facility policy was that the carts were locked whenever her back was turned to it. RN L said she guessed she overlooked locking the cart. During an interview on 2/25/25 at 12:17 pm, the DON said she expected medication/treatments carts to be locked when unattended. The DON further stated leaving carts unlocked when unattended was a safety issue because the facility had confused residents that could gain access to what is stored in the carts, such as, medications and treatments. The DON said it was the facility's policy that carts were locked when unattended. Record review of the facility's policy titled Medication Carts and Supplies for Administering Meds, dated 10/1/19, revealed: .2. The medication cart is locked at all times when not in use. 3. Do not leave the medication cart unlocked or unattended in the resident care areas .The medication cart must remain in your line of sight when it is not locked .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39251 Based on interview and record review the facility failed to ensure medical records were kept in accordance with professional standards and practices and were complete and accurately documented for 4 of 6 residents (Resident #1, Resident #3, Resident #4, and Resident #6) reviewed for accuracy of records. 1. The facility failed to ensure Resident #1's treatments were documented per facility policy on (5) occasions. 2. The facility failed to ensure Resident #3's treatments were documented per facility policy on (17) occasions. 3. The facility failed to ensure Resident #4's treatments were documented per facility policy on (13) occasions. 4. The facility failed to ensure Resident #6's wound assessment was documented per facility policy. These deficient practices could place residents at risk for improper care due to inaccurate records. Findings included: 1. Record review of Resident #1's Admission Record, dated 2/14/25, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Acquired absence of left leg below knee, Type 2 diabetes (chronic condition that affects the way the body processes blood sugar), Gangrene (death of tissue due to lack of blood flow or infection) , Atherosclerosis (The build-up of fats, cholesterol, and other substances in and on the artery walls) of arteries of left leg with ulceration (an open wound or sore in the skin) of ankle, and Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #1's Order Summary, dated 2/20/25, revealed an order to assess for pain and medicate prior to wound care daily, dated 12/17/24 - 1/7/25. Review of Resident #1's January TAR revealed a blank for 1/1/25. Record review of Resident #1's Order Summary, dated 2/20/25, revealed an order to assess for pain and medicate prior to wound care Monday, Wednesday, and Friday, dated 1/8/25 - 1/29/25. Review of Resident #1's January TAR revealed a blank for 1/27/25. Record review of Resident #1's Order Summary, dated 2/20/25, revealed an order to cleanse wound to left proximal lateral foot with normal saline, apply skin prep, apply negative pressure wound therapy on Monday, Wednesday, and Friday, secure with kerlix and tubular elastic dressing, dated 1/6/25 - 1/29/25. Review of Resident #1's January TAR revealed a blank for 1/27/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Order Summary, dated 2/20/25, revealed an order to cleanse left distal lateral foot surgical incision with normal saline, apply skin prep, apply negative pressure wound therapy on Monday, Wednesday, and Friday, secure with kerlix and tubular elastic dressing, dated 1/6/25 - 1/29/25. Review of Resident #1's January TAR revealed a blank for 1/27/25. Record review of Resident #1's Order Summary, dated 2/20/25, revealed an order for wound vac to left proximal lateral foot with green foam dressing every Monday, Wednesday, and Friday, dated 1/20/25 - 1/29/25. Review of Resident #1's January TAR revealed a blank for 1/27/25. Record review of Resident #1's progress notes revealed there were no progress regarding the reason for the blanks in the TAR for the above-mentioned dates. During an interview on 2/14/25 at 2:00 pm, Resident #2 said the staff had been providing wound care daily before he left to the hospital (2/2/25 - 2/13/25). Resident #1's family member said Resident #1 was getting his treatments. During interview on 2/21/25 the NP said that Resident #1 refused care at times due to pain or not wanting to be bothered. The NP further stated she might have been notified of missed treatment but did not remember if she had been notified. 2. Record review of Resident #3's Admission Record, dated 2/20/25, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Spina Bifida (a defect that occurs when the neural tube that develops into the spinal cord and brain does not close properly), Cellulitis (common bacterial skin infection) of right lower limb, and open wounds on feet. Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to cleanse left dorsal foot with normal saline, pat dry, apply leptospermum honey, apply collagen powder to wound, and cover with gauze dressing daily, dated 11/23/24 - 12/23/24. Review of Resident #3's December 2024 TAR revealed blanks for 12/3/24 and 12/8/24. Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to cleanse left dorsal foot with normal saline, pat dry, apply medi-honey, apply calcium alginate, and cover with gauze dressing daily, dated 12/22/24 - 1/21/25. Review of Resident #3's December 2024 TAR revealed a blank for 12/28/24. Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to cleanse right dorsal foot with normal saline, pat dry, apply leptospermum honey, apply collagen to wound, and cover with gauze dressing daily, dated 11/23/24 - 12/23/24. Review of Resident #3's December 2024 TAR revealed blanks for 12/3/24 and 12/8/24. Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to cleanse right dorsal foot with normal saline, pat dry, apply medi-honey, apply calcium alginate, and cover with gauze dressing daily, dated 12/22/24 - 1/21/25. Review of Resident #3's December 2024 TAR revealed a blank for 12/28/24. Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to apply betadine to left foot 4th toenail bed daily, dated 1/8/25 - 1/20/25. Review of Resident #3's January 2025 TAR revealed a blank for 1/17/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to apply betadine to left dorsal foot wound daily, dated 1/29/25 - 2/10/25. Review of Resident #3's January 2025 TAR revealed a blank for 1/31/25. Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to cleanse left foot wound with normal saline, pat dry, apply collagen powder, cover with calcium alginate, and cover with dressing daily, dated 1/15/25 - 2/14/25. Review of Resident #3's January 2025 TAR revealed blanks for 1/17/25 and 1/28/25. Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to cleanse left dorsal foot wound with normal saline, pat dry, apply medi-honey, calcium alginate, and cover with dressing daily, dated 12/22/24 - 1/21/25. Review of Resident #3's January 2025 TAR revealed a blank for 1/1/25. Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to cleanse right dorsal foot wound with normal saline, pat dry, apply collagen powder, cover with calcium alginate, and cover with dressing daily, dated 1/15/25 - 2/14/25. Review of Resident #3's January 2025 TAR revealed blanks for 1/17/25, 1/28/25, and 1/31/25. Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to cleanse right dorsal foot wound with normal saline, pat dry, apply medi-honey, calcium alginate, and cover with dressing daily, dated 12/22/24 - 1/21/25. Review of Resident #3's January 2025 TAR revealed a blank for 1/1/25. Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to apply betadine to right foot 2nd and 4th toenail bed daily, dated 1/8/25 - 1/20/25. Review of Resident #3's January 2025 TAR revealed a blank for 1/17/25. Record review of Resident #3's Order Summary, dated 2/20/25, revealed an order to apply betadine and skin prep to left dorsal medial foot wound daily, dated 1/29/25. Review of Resident #3's February 2025 TAR revealed a blank for 2/4/25. Record review of Resident #3's progress notes, from 12/3/24 to 2/4/25, revealed there were no progress regarding the reason for the blanks in the TAR for the above-mentioned dates. During observation and interview on 2/18/2025 at 4:15 pm, Resident #3 said she had wounds to the top of both her feet. Observation revealed small healing superficial wounds to the tops of both feet which were scabbed and not covered with a dressing. Resident #3 said she received wound care daily by the wound care nurse. Resident #3 further stated sometimes on the weekend no one did her wound care. She stated she would tell the weekend nurses the wound care was not done and they would say they would get to it but never did. Resident #3 said she could not remember the dates this occurred or who she told. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #4's Admission Record, dated 2/23/25, revealed the resident was readmitted to the facility on [DATE], with diagnoses that included: Alzheimer's Disease (disease affecting memory and other important mental functions) , Dementia (group of thinking and social symptoms that interferes with daily functioning) , Type 2 diabetes (chronic condition that affects the way the body processes blood sugar), and Lymphedema (swelling in the extremities caused by a lymphatic blockage). Record review of Resident #4's Order Summary, dated 2/23/25, revealed an order for compression wraps to bilateral lower extremities daily and PRN for aide circulation and reduce swelling, dated 9/2/24 - 1/23/25. Review of Resident #4's December 2024 TAR revealed a blank for 12/2/24. Record review of Resident #4's Order Summary, dated 2/23/25, revealed an order to apply clean kerlix and ace bandage to bilateral lower legs daily for history of lymphedema, dated 1/29/25. Review of Resident #4's January 2025 TAR revealed a blank for 1/30/25. Record review of Resident #4's Order Summary, dated 2/23/25, revealed an order for compression wraps to bilateral lower legs daily and PRN for aide circulation and reduce swelling, dated 9/2/24 - 1/23/25. Review of Resident #4's January 2025 TAR revealed blanks for 1/1/25, 1/9/25, 1/11/25, 1/12/25, 1/16/25, 1/17/25, 1/18/25, 1/19/25, 1/21/25, and 1/22/25. Record review of Resident #4's Order Summary, dated 2/23/25, revealed an order to apply clean kerlix and ace bandage to bilateral lower legs daily for history of lymphedema, dated 1/29/25. Review of Resident #4's February 2025 TAR revealed a blank for 2/12/25. Record review of Resident #4's Progress Note, dated 1/9/25, revealed Resident #4 refused wound care and explained that the wound care nurse would be providing the treatment until further notice. Further review of Resident #4's Progress Notes revealed there were no additional progress regarding the reason for the blanks in the TAR for the above-mentioned dates. During an interview on 2/19/25 at 11:16 am, Resident #4 said she received wound care as ordered. Resident #4 further stated she did not allow other nurses to provide her treatment when LVN K was not at the facility. During an interview on 2/18/2025 at 3:05 pm, Resident #4 said she often refused care including wound care because she only wanted LVN K to provide wound care because she was the only one who did it right. 4. Record review of Resident #6's Admission Record, dated 2/22/25, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (disease affecting memory and other important mental functions) , Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) , chronic pain, Dementia (group of thinking and social symptoms that interferes with daily functioning), and Cognitive Communication Deficit (difficulty with thinking and language). Record review of Resident #6's Progress Note, dated 2/7/25, revealed a skin tear was noted to Resident #6's right calf. The wound was cleaned with wound cleanser, patted dry, and steri-strips applied. Further review revealed the DON, family, and hospice were notified. The progress note was authored by LVN I. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's EMR revealed the wound to the right calf was discovered on 2/7/25. Further review revealed no Wound Progress Evaluations or wound measurements until 2/18/25. Record review of Resident #6's Skin and Wound Evaluation, dated 2/18/25, revealed skin tear measuring 1.7 cm x 2.3.cm x 1.1.cm. Record review of Resident #6's Care plan, dated 2/20/25, revealed the resident had impaired skin integrity related to injury as evidenced by skin tear to right lower extremity. Interventions included: weekly skin assessment by licensed nurse. During an interview on 2/20/25 at 1:30 pm, the DON said LVN M was currently responsible for wound care when LVN K was unavailable but before 2/1/25 the charge nurses were responsible for wound care when LVN K was not available. The DON further stated the TARs were reviewed for treatment completion during the morning meetings. The DON said if a blank was identified on the TARs, the nurse responsible for the treatment was contacted to determine whether it was a failure to document and if so, the nurse was to document the treatment as soon as possible. The DON said lack of documentation could affect the residents because someone else could repeat the treatment and disrupt the healing process by removing a dressing too early, as well as discomfort to the resident. The DON said she was not aware of the treatments that were not documented. During an interview on 2/20/25 at 2:16 pm, the ADON said she did not know if she was focused on something else during the meetings and missed the lack of documentation. During an interview on 2/21/25 at 3:18 pm, the ADON said when LVN K was unavailable, the charge nurses were responsible for completing wound care for their assigned residents. During an interview on 2/22/25 at 5:30 pm, the facility's Regional Nurse verified there were no Wound Progress Evaluations for Resident #6 until 2/18/25. During an interview on 2/25/25 at 12:17 pm, the DON said she was responsible for ensuring all treatments were documented. The DON said she was responsible for ensuring assessments were completed. The DON further stated there was a potential for negative outcomes due to lack of assessment and orders. During an interview on 2/25/25 at 12:17 pm, the DON said when treatments were missed due to resident refusal it was to be documented in the progress notes. The DON further stated there was a potential for negative outcomes due to lack of assessments. Record review of the facility's Wound Treatment Competency Assessment, undated revealed: .Documents treatment procedure . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Documentation in Medical Record, dated 10/24/22, revealed: .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation .1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred .i. False information shall not be documented .Documentation shall be .complete .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39251 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents (Resident #2 and Resident #3) reviewed for infection control. LVN K and RN L did not perform hand hygiene appropriately when providing wound care to Resident #2 and Resident #3. This deficient practice could affect all residents who require wound care and place them at risk for infection. Findings included: Interview and observation of wound care to Resident #3's feet, on 2/19/25 beginning at 3:11 PM, revealed LVN K gathered supplies for wound care donned gown and removed Resident #3's socks without performing hand hygiene; LVN K completed wound care to Resident #3's feet and washed her hands for 9 seconds. During an interview on 2/19/15 at 3:24 pm, LVN K said she did not perform hand hygiene prior to providing wound care for Resident #3 and was nervous with the state investigator present. LVN K further stated she was expected to perform hand hygiene between glove changes for infection control purposes. Interview and observation of wound care to Resident #2's feet, on 2/22/25 beginning at 2:07 PM, revealed RN L touched the outside of the mask she was wearing with ungloved hands and donned a new mask without performing hand hygiene. RN L removed the dressing to Resident #2's right lateral foot and washed her hands for 13 seconds. Further observation revealed RN L washed her hands for 14 seconds after cleansing the wound to Resident #2's right ankle then proceeded to cleanse the wound to the right lateral foot and washed her hands for 13 seconds. After applying betadine to the wounds, RN L washed her hands for 10 seconds. Further observation revealed RN L washed her hands for 10 seconds before removing the dressing to Resident #2's left foot. RN L cleansed wounds to Resident #2's left foot (toe, lateral foot, and ankle) and washed her hands for 13 seconds, 10 seconds, and 12 seconds after cleansing each wound, respectively. Further observation revealed RN L washed her hands for 11 seconds after applying betadine to Resident #2's left toe, removed gloves, grabbed gown from the front to access her pocket. RN L retrieved keys to the treatment cart from her pocket, retrieved additional betadine and a pair of gloves from the treatment cart without performing hand hygiene, she then sanitized her hands and donned the gloves she retrieved from the treatment cart. RN L said she donned the gloves she retrieved from the treatment cart. Further observation revealed RN L applied betadine to Resident #2's wound and washed her hands for 15 seconds. After applying the dressing to Resident #2's foot she washed her hands for 12 seconds. Further observation revealed RN L washed her hands for 8 seconds once the procedure was completed, and trash was disposed. RN L said she thought she had performed hand hygiene before she retrieved additional items from the treatment cart because she could not go from dirty to clean without sanitizing her hands because that would put the resident at risk for infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/22/25 at 4:00 pm, RN L said she started working at the facility approximately 3 weeks prior and worked Saturday and Sunday. RN L said hand hygiene training included when to perform hand hygiene, such as in between glove changes and before handling clean items. RN L further stated she was expected to wash her hands for at least 20 seconds. RN L said it was important to perform hand hygiene as recommended because that was enough time for the antibacterial soap to kill germs. RN L further stated when hand hygiene was not performed as recommended there could be cross contamination to wounds which can lead to infections. RN L said she received training to include infection control. RN L further stated the hand hygiene in-service included: washing hands upon entering a resident's room, when the room was exited, every time gloves were changed, when hands were visibly contaminated/soiled, and when she handled clean items. RN L said she was expected to wash hands for 20 seconds and this was important because that was enough time for the antibacterial soap to kill germs. RN L further stated not performing hand hygiene as recommended could affect the residents by contamination of whatever we were doing, like wound care or incontinent care and this may lead to infection. During interview on 2/23/25, the DON said she was responsible for ensuring the nursing staff had the appropriate training and competency evaluations. Record review of email from the facility Administrator, dated 2/23/25, revealed the facility did not have a policy regarding nurse training and competency evaluations. Record review of the facility's policy titled Infection Prevention and Control Program, dated 5/13/23, revealed: .16. Staff Education: a. All staff shall receive, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. b. All staff shall demonstrate competence in relevant infection control practices. c. Direct care staff shall demonstrate competence in resident care procedures established by our facility .

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 39251 Based on observations, interviews, and record reviews the facility failed to include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at S483.80(a)(2). 18 of 28 nurses (LVN B, LVN D, RN G, RN H, LVN K, RN L, LVN P, LVN Q, LVN T, RN U, LVN V, LVN W, RN X, RN Y, LVN AA, LVN DD, LVN EE, and LVN FF) reviewed for hand hygiene training, 18 of 28 (LVN B, LVN F, RN G, RN H, RN J, LVN P, LVN Q, LVN T, RN U, LVN V, LVN W, RN Y, LVN AA, LVN BB, LVN DD, LVN EE, LVN FF, and ADON) reviewed for hand hygiene competency, and 28 of 28 (LVN B, LVN D, LVN F, RN G, RN H, LVN I, RN J, LVN K, RN L, LVN M, LVN P, LVN Q, LVN R, RN S, LVN T, RN U, LVN V, LVN W, RN X, RN Y, LVN Z, LVN AA, LVN BB, LVN CC, LVN DD, LVN EE, LVN FF, and ADON) reviewed for wound care training. 26 of 28 (LVN B, LVN D, LVN F, RN G, RN H, LVN I, RN J, LVN K, LVN P, LVN Q, LVN R, RN S, LVN T, RN U, LVN V, LVN W, RN X, RN Y, LVN Z, LVN AA, LVN BB, LVN CC, LVN DD, LVN EE, LVN FF, and ADON) reviewed for wound care competency. The facility failed to train and verify competencies for all licensed nursing staff regarding hand hygiene and wound care. This failure could place residents at risk of not being provided care by staff who have the appropriate skills necessary. Findings included: Record review of the facility's training related to hand hygiene and wound care revealed the following: the facility employed a total of 28 nurses, 18 nurses had not completed hand hygiene training (LVN B, LVN D, RN G, RN H, LVN K, RN L, LVN P, LVN Q, LVN T, RN U, LVN V, LVN W, RN X, RN Y, LVN AA, LVN DD, LVN EE, and LVN FF), 18 nurses had not completed hand hygiene competency evaluations (LVN B, LVN F, RN G, RN H, RN J, LVN P, LVN Q, LVN T, RN U, LVN V, LVN W, RN Y, LVN AA, LVN BB, LVN DD, LVN EE, LVN FF, and ADON), 28 nurses had not completed wound care training (LVN B, LVN D, LVN F, RN G, RN H, LVN I, RN J, LVN K, RN L, LVN M, LVN P, LVN Q, LVN R, RN S, LVN T, RN U, LVN V, LVN W, RN X, RN Y, LVN Z, LVN AA, LVN BB, LVN CC, LVN DD, LVN EE, LVN FF, and ADON), and 26 nurses had not completed wound care competency evaluations (LVN B, LVN D, LVN F, RN G, RN H, LVN I, RN J, LVN K, LVN P, LVN Q, LVN R, RN S, LVN T, RN U, LVN V, LVN W, RN X, RN Y, LVN Z, LVN AA, LVN BB, LVN CC, LVN DD, LVN EE, LVN FF, and ADON). Interview and observation of wound care to Resident #3's feet, on 2/19/25 beginning at 3:11 PM, revealed LVN K gathered supplies for wound care donned gown and removed Resident #3's socks without performing hand hygiene; LVN K completed wound care to Resident #3's feet and washed her hands for 9 seconds. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/19/15 at 3:24 pm, LVN K said she did not perform hand hygiene prior to providing wound care for Resident #3 and was nervous with the state investigator present. LVN K further stated she was expected to perform hand hygiene between glove changes for infection control purposes. During interview on 2/19/25 at 4:22 pm, LVN K (Wound Care Nurse) said she had received wound care training from a regional staff member but did not remember when this was or if it was documented. Attempted interview on 2/20/25 at 11:47 am, with LVN C, was unsuccessful. Attempted interview on 2/20/25 at 11:49 am, with LVN B, was unsuccessful. Attempted interview on 2/21/25 at 12:01 pm, with LVN B, was unsuccessful. Attempted interview on 2/21/25 at 12:04 pm, with LVN C, was unsuccessful. Interview and observation of wound care to Resident #2's feet, on 2/22/25 beginning at 2:07 PM, revealed RN L touched the outside of the mask she was wearing with ungloved hands and donned a new mask without performing hand hygiene. RN L removed the dressing to Resident #2's right lateral foot and washed her hands for 13 seconds. Further observation revealed RN L washed her hands for 14 seconds after cleansing the wound to Resident #2's right ankle then proceeded to cleanse the wound to the right lateral foot and washed her hands for 13 seconds. After applying betadine to the wounds, RN L washed her hands for 10 seconds. Further observation revealed RN L washed her hands for 10 seconds before removing the dressing to Resident #2's left foot. RN L cleansed wounds to Resident #2's left foot (toe, lateral foot, and ankle) and washed her hands for 13 seconds, 10 seconds, and 12 seconds after cleansing each wound, respectively. Further observation revealed RN L washed her hands for 11 seconds after applying betadine to Resident #2's left toe, removed gloves, grabbed gown from the front to access her pocket. RN L retrieved keys to the treatment cart from her pocket, retrieved additional betadine and a pair of gloves from the treatment cart without performing hand hygiene, she then sanitized her hands and donned the gloves she retrieved from the treatment cart. RN L said she donned the gloves she retrieved from the treatment cart. Further observation revealed RN L applied betadine to Resident #2's wound and washed her hands for 15 seconds. After applying the dressing to Resident #2's foot she washed her hands for 12 seconds. Further observation revealed RN L washed her hands for 8 seconds once the procedure was completed, and trash was disposed. RN L said she thought she had performed hand hygiene before she retrieved additional items from the treatment cart because she could not go from dirty to clean without sanitizing her hands because that would put the resident at risk for infection. During an interview on 2/22/25 at 4:00 pm, RN L said she started working at the facility approximately 3 weeks prior and worked Saturday and Sunday. RN L further stated she received wound care training on 2/21/25, which included assessment for signs and symptoms of infection and pain, infection control, and notification to the physician and the residents' family if there were a change in condition. RN L said hand hygiene training included when to perform hand hygiene, such as in between glove changes and before handling clean items. RN L further stated she was expected to wash her hands for at least 20 seconds. RN L said it was important to perform hand hygiene as recommended because that was enough time for the antibacterial soap to kill germs. RN L further stated when hand hygiene was not performed as recommended there could be cross contaminated to wounds which can lead to infections. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/25 at 12:38 pm, the ADON said she thought the DON was responsible for training LVN K. The ADON further stated LVN K should have completed a Wound Care Skills assessment when she was hired. The ADON said when LVN K was unavailable, the charge nurses were responsible for completing wound care for their assigned residents. During an interview on 2/21/25 at 4:53 pm, the DON said LVN K was already employed by the facility when the DON was hired. The DON further stated she had not reviewed LVN K's competencies for wound care and infection control. The DON said when LVN K was unavailable the charge nurses were responsible for wound care. During an interview on 2/22/25 at 4:00 pm, RN L said she received wound care training on 2/21/25 that included assessing for signs/symptoms of infection, infection control, pain, notifying the MD/family of any changes in condition and any new orders. RN L further stated the hand hygiene in-service included: washing hands upon entering a resident's room, when the room was exited, every time gloves were changed, when hands were visibly contaminated/soiled, when she handled clean items. RN L said she was expected to wash hands for 20 seconds and this was Important because that is enough time for the antibacterial soap to kill germs. It can affect the resident by contamination of whatever we were doing, like wound care or incontinent care. This can lead to infection. During interview on 2/23/25, the DON said she was responsible for ensuring the nursing staff had the appropriate training and competency evaluations. Record review of email from the facility Administrator, dated 2/23/25, revealed the facility did not have a policy regarding nurse training and competency evaluations. Record review of the facility's policy titled Infection Prevention and Control Program, dated 5/13/23, revealed: .16. Staff Education: a. All staff shall receive, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. b. All staff shall demonstrate competence in relevant infection control practices. c. Direct care staff shall demonstrate competence in resident care procedures established by our facility .