STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455871	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Nursing and Rehabilitation LP	803 S Alamo Levelland, TX 79336

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 04033 Based on observation, interviews and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 6 residents (Resident #1 and Resident #2) reviewed for care plans. The facility failed to have a care plan in place to accurately address Resident #1's wound care. The facility failed to have a care plan in place to accurately address Resident #2's oxygen use. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included: Resident #1 Record review of Resident #1's Face Sheet revealed she was an [AGE] year-old female admitted to the facility on [DATE]. Resident #1's diagnoses included Stroke (damage to brain from interruption of blood supply), Traumatic Brain Dysfunction (a disruption in the normal function of the brain), Amputation (surgical removal of a limb), Diabetes Mellitus (a metabolic disease involving inappropriately elevated blood glucose levels), Hypertension (persistently elevated blood pressure), Non-Alzheimer's Dementia (impaired cognition not related to Alzheimer's Disease). Record review of Resident #1's Admission MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating Resident #1 was cognitively intact. Section M-Skin Conditions indicated she had surgical wounds and open lesions and requiring wound care, dressings and application of ointments and medications. Record review of Resident #1's Care Plan dated 06/20/24 indicated wound care was not included on this plan. Record review of Resident #1's Physician's Orders dated 06/20/24 revealed order to cleanse bilateral labial (skin folds on each side of vagina) wounds with wound cleanser and apply silver alginate and cover with abdominal pad daily. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/15/24 at 2:30 p.m., the hospital's Registered Nurse, indicated Resident #1 was diagnosed with vaginal cancer upon her admission to the hospital on 08/13/24, and was scheduled for wound debride on 08/15/24. Observation on 08/15/24 at 3:01 pm of Resident #1, who was awake, revealed she was lying in her bed. Resident #1's wounds were not observed because she was waiting to go to surgery for wound debride. During an interview on 08/15/24 at 3:01 p.m., Resident #1 indicated she responded to the questions asked of her by nodding her head but did not seem to understand the questions . During an interview on 08/16/24 at 12:55 p.m., LVN A indicated Resident #1 upon admission (06/18/24) completed a skin assessment, which included an unstageable wound to her labial that was covered with slough. Resident #1 was seen at the wound care clinic on 06/25/24, 07/03/24, 07/09/24, 08/05/24, and 08/06/24. This clinic referred Resident #1 to the oncologist on 08/12/24 who sent her to the hospital. LVN A said Resident 1's wounds were addressed through the wound care clinic, wound care at the facility, and an air mattress was offered to this resident; however, her family refused. During an interview on 08/16/24 at 2:36 p.m., LVN B indicated she assessed and measured Resident #1's wound and provided wound care per physician's orders; however, the wounds did not improve. During a phone interview on 08/16/24 at 3:48 PM, the DON indicated she did not know why the care plan did not address wound care and that she or the MDS Coordinator was responsible for initiating and updating care plans. She stated a potential negative outcome for failure to ensure accuracy of care plans was missing the goal for informed care of residents. During an interview on 08/16/24 at 5:03 PM, the Clinical Resource RN indicated any resident condition or change of condition should have been included in Resident #1's care plan. The RN said the order for wound care, should have been added to the care plan. Resident #2 Record review of Resident #2's Face Sheet she was [AGE] year-old female admitted to the facility 11/28/22. Resident #2's diagnoses included Dementia (thinking and social symptoms that interferes with daily functioning), chronic obstructive pulmonary disease (lung diseases that blocks airflow and makes it difficult to breathe), pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), shortness of breath, altered mental status (changes in awareness, and movement) systolic heart failure (left ventricle is weak and can't contract normally when the heart beats). Record review of Resident #2's Physician Order Report dated 07/22/24 - 08/22/24 indicated the order was changed on 06/18/24 to nasal cannula (continuous) with oxygen at 2 liters a minute on every shift day and night. Record review of Resident #2's Quarterly MDS dated [DATE] revealed she scored a 12 on her BIMS. Section E-Behavior of this MDS indicated she had not displayed behaviors of rejecting her care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Care Plan dated 06/27/24 and reviewed/revised by the DON on 07/22/24 revealed oxygen therapy via nasal cannula was not included on this plan. Observation and attempted interview on 08/15/24 at 10:34 a.m., indicated Resident #2 was sitting in her wheelchair in her room, she was not wearing her nasal cannula, because she was sitting on the tubing. Resident #2 could not respond to questions asked her about her nasal cannula. During an interview on 08/15/24 at 11:21 a.m., CNA D indicated she assisted Resident #2 from her bed where she was wearing her nasal cannula from the oxygen concentrator. After, she transferred Resident #2 to her wheelchair she switched her to the nasal cannula from her e-tank (aluminum tank that stores supplemental oxygen) that was on her wheelchair. CNA D said Resident #2 had a history of removing her nasal cannula. During an interview on 08/15/24 at 11:51 a.m., CNA E indicated Resident #2 had a history of removing her nasal cannula. During an interview on 08/15/24 at 12:07 p.m., CNA G indicated Resident #2 had a history of removing her nasal cannula. During an interview on 08/16/24 at 3:45 p.m., the DON indicated upon admission of a resident using oxygen, this would be care planned, but if the oxygen was ordered after admission, she would add it to the plan. The DON said she was not sure why it had not been added to the plan. During an interview on 08/16/24 at 3:51 p.m., the Clinical Resource RN, indicated Resident #2's order for using oxygen, should have been added to the care plan. Review of the facility's policy and procedure for Comprehensive Care Plans dated 01/26/24 indicated it was the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment. Qualified staff responsible for carrying out the interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. The services provided or arranged by the facility, as outlined in the comprehensive care plan, will meet professional standards of quality, and will be provided by qualified persons in accordance with each resident's written plan of care. Review of the facility's policy and procedure for Care Plans, Comprehensive Person-Centered dated 2001 indicated The care planning process will: describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; incorporate risk factors associated with identified problems; incorporate identified problem areas and incorporate risk factors associated with identified problems. The Interdisciplinary Team must review and updated the care plan: when there has been a significant change in the resident's condition and when the desired outcome is not met.