STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455891	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Park Multi Care Center	4252 Bryant Irvin Rd Fort Worth, TX 76109

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 - 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** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #1) of 4 residents reviewed for care plans. The facility failed to assess and care plan for Resident #1' s primary diagnosis of sickle call pain crisis. This placed residents at risk for not receiving proper care and services due to inaccurate care plans. Findings included: Record review of Resident #1 ' s face sheet dated 06/11/2025 reflected a [AGE] year-old woman admitted to the facility on [DATE] with primary diagnosis of Sickle-Cell/HB-C Disease (genetic blood disorder of abnormal hemoglobin, resulting in blockage of blood vessels and reduced oxygen delivery in the blood. Outcomes include anemia-low hemoglobin, pain-blockage of blood flow, and risk of infection) with Crisis (characterized by painful episode caused by blockage of blood flow), with admitting diagnoses of alcoholic cirrhosis of liver without ascites (scarring of liver due to alcohol, without abnormal fluid buildup), idiopathic aseptic necrosis of bone, multiple sites (loss of blood supply to bone resulting in dying bones), fracture of right pubis (pubic bone, part of pelvis), sacrum (bone that forms base of spine, connecting the pelvis), left hip joint, and left femur (thigh bone), muscle weakness (generalize), abnormalities of gait and mobility (abnormal pattern of walking due to underlying medical condition or injury), lack of coordination, anemia, cerebral infarction (stroke), and end stage renal disease (chronic kidney failure, loss of kidney function). Record review of Resident #1 's MDS dated [DATE] reflected a BIMS score of 15, indicating cognitively intact. The resident ' s primary medical condition was indicated as Medically Complex Conditions, ICD Code: D57.219 (SICKLE-CELL/HB-C DISEASE WITH CRISIS, UNSPECIFIED). Record review of Resident #1's paper chart binder dated 05/21/25 reflected: Admitting Diagnosis: Sickle Cell Pain Crisis. Record review of Resident #1's baseline care plan initiated 05/22/25, reflected no focus, no interventions, and no goals for dx of sickle cell disease with crisis. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's order summary report dated 06/11/2025 reflected: Physician has reviewed and agrees with the plan of care (see signature); order date: 05/22/2025. Pt may be sent out to ER for higher level of care; order date: 05/30/2025. Record review of Resident #1's hospital history records (2/17/2025; 2/25/2025) reflected: Hemoglobin levels- 02/11/2025 - 7.8 g/dL 02/13/2025 - 8.2 g/dL 02/14/2025 - 8.7 g/dL 02/15/2025 - 8.4 g/dL 02/16/2025 - 8.7 g/dL 02/17/2025 - 8.1 g/dL 2/20/2025 - 7.8 g/dL 2/21/2025 - 7.8 g/dL 2/22/2025 - 7.4 g/dL 02/23/2025 - 7.0 g/dL 2/24/2025 - 7.1 g/dL 2/25/2025 - 6.6 g/dL History of multiple blood transfusions Record review of Resident #1 ' s hospital history records 05/14/2025) reflected: 05/14/2025- 7.3 g/dL (reference range 12.0-16.0 g/dL) Flag: L (low). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/02/2025 with Resident #1 ' s family member revealed that on 05/30/2025, she had to call EMS and have Resident #1 transported to the ER because the resident was experiencing heart palpitations. Upon arrival to the ER, Resident #1 ' s hemoglobin level was 4.9 g/dL; the resident was admitted to the hospital ' s cardiac intensive care unit (specialized unit of hospital for various cardiac conditions that requires continuous monitoring and treatment). The family member stated that the resident was no longer in the cardiac intensive care unit, but the resident was still in the hospital and did not have a discharge date . An interview on 06/12/2025 with Resident #1 ' s family member revealed that the resident had not been discharged from the hospital since being admitted on [DATE]. Interview with LVN C on 06/11/2025 at 2:44PM revealed she provided care to Resident #1 prior to being discharged to the hospital. She stated that on 05/30/2025, Resident #1 ' s family called the paramedics, and she did not initially know why. LVN C was aware of Resident #1 ' s dx of sickle cell disease. She stated that when the paramedics arrived and asked what was going on, the family said the resident was having heart palpitations. LVN C discussed the physician recently changed Resident #1 ' s anxiety medications from PRN to a scheduled regimen because the resident ' s heart rate was high. She further stated the physician said the resident ' s tachycardia (heart rate over 100 beats per minute) was due to her anxiety. There was no change of condition prior to family calling EMS. LVN C was not aware of any orders for monitoring Resident #1 ' s hemoglobin levels or blood labs being ran once a week. LVN C was unable to provide examples of signs and symptoms in those with sickle cell disease. LVN C stated tiredness, fatigue, shortness of breath, pale skin, and tachycardia were the symptoms of someone with low hemoglobin. Interview with the ADON on 6/11/2025 at 3:10PM revealed Resident #1 was sent to the ER on [DATE] due to pain from sickle cell crisis. The ADON explained prior to the resident being sent out, she talked with the resident and there were no complaints of pain. A few hours later the resident said she was in a sickle cell crisis. The ADON stated orders were put into the resident ' s charts as the physician told the staff; labs were done with dialysis but that the resident should have had a lab upon admission to facility. The surveyor asked the ADON to describe signs and symptoms of someone with low hemoglobin level of 4.9 g/dL and she stated weakness, the resident wouldn ' t be very alert, cold, pale, in pain, low blood pressure, increased heart rate, shock, and blood count low. The ADON stated the importance of monitoring blood labs in someone with sickle cell disease was the hemoglobin can be low and need to make sure that blood cell count is where it should be. She stated she would have contacted the doctor to get orders if these symptoms were present. The ADON stated the importance of care plans was for staff to know how to take care of residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/11/2025 at 3:59PM with the Regional Compliance Nurse revealed she was asked why Resident #1 ' s sickle cell disease was not care planned. She stated it depends on what their care is, and the disease process; she would recommend someone's most serious condition be in their care plan. The Regional Compliance Nurse was asked how Resident #1 ' s labs would be checked for low hemoglobin, and she stated they would need to talk with the physician to get the order because nurses cannot order labs. The Regional Compliance Nurse stated dialysis had Resident #1 ' s labs and dialysis would send the resident ' s labs to the facility. She further explained all residents had paper charts, and dialysis labs were kept in those charts. She stated the charge nurses are responsible to look at labs and physicians will look at the labs, she assumed dialysis staff looked at labs. The surveyor asked how staff know if labs are abnormal, and she stated the staff would just have to look at the dialysis labs. The Regional Compliance Nurse stated signs and symptoms of low hemoglobin include a bleeding episode, lethargy, and increased confusion. She stated it was important that there was lab work for the facility to monitor for low hemoglobin and to see if the resident needed a transfusion and to notify the physician if the hemoglobin was low. Record review of Resident #1 ' s paper chart binder dated 05/21/25 did not reflect dialysis lab work. An interview 06/11/2025 at 4:27PM with the ADM revealed that every nurse should show about sickle cell disease and the symptoms associated. She stated that the facility did not provide training specifically regarding sickle cell disease, but the facility had resources for nurses, and they could reach out to the physician if needed. The ADM stated the staff did not reach out about sickle cell disease. She further explained the risk of staff not using resources or the physician can result in a sickle cell episode. Record review of the facility ' s Resident Assessment Instrument and Care Plan Development policy and procedure, reviewed 09/05/2024, reflected: The information identified using the MDS and Care Area Assessment process is used to develop an individualized person-centered Care Plan that includes the patient ' s voice, the patient ' s goals while residing in the facility and for discharge that assist the patient to attain and/or maintain their highest practicable level of well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #4) of 4 residents reviewed for quality of care. The facility failed to provide treatment to Resident #4 ' s burns on both her thighs according to physician orders. This failure placed residents of risk for not receiving appropriate care and treatment and a decreased quality of life. Findings included: Record review of Resident#4 ' s face sheet, dated 06/18/2025, reflected a [AGE] year-old woman admitted on [DATE] with primary diagnoses of burns involving 10-19% of body surface with 10-19% third degree burns, burn of third-degree right hand, right thigh, left thigh, and right lower leg; other diagnoses include generalized anxiety disorder, major depressive disorder, pain in unspecified hip. Record review of Resident #4 ' s care plan dated (no date) reflected the Focus/Problem of: The resident has actual impairment to skin integrity. burn bilateral (left and right) thighs right arm surgical wound to left and right thigh; date initiated 05/16/2025. One of nine interventions included treatment as ordered. With the goal of The resident will have no complications related to skin through the review date (06/11/2025). Record review of Resident #4 ' s MDS dated [DATE] reflected a BIMS score of 13, indicating cognitively intact. Record review of Resident #4 ' s outpatient surgical specialist for wound care dated 05/21/2025 reflected: Instructions: Please bathe her and wash her bilateral lower extremities with soap and water gently washing with hands daily. Her bilateral (left and right) lower extremity wounds should be moisturized twice a day with quality lotion. Record review of Resident #4 ' s orders dated 06/11/2025 reflected: Aquaphor Advanced Therapy External Ointment (Emollient) Apply to BILATERAL (left and right) THIGHS topically two times a day for PREVENTION; order date 05/22/2025. Record review of Resident #4 ' s TAR dated 06/11/2025 reflected: Aquaphor Advanced Therapy External Ointment: Administered by LVN E Time: 06/09/25 08:44; Location: Thigh - front (left) Administered by LVN E Time: 06/09/25 08:44; Location: Thigh - front (right) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administered LVN I Time: 06/09/25 23:36[11:36 PM]; Location: Thigh - front (left) Administered by LVN I Time: 06/09/25 23:36[11:36 PM]; Location: Thigh - front (right) Administered by LVN H Time: 06/10/25 10:43; Location: Leg - both Administered by RN G Time: 06/10/25 20:07 [8:07 PM]; Location: Leg - both Administered by RN F Time: 06/11/25 10:52; Location: Leg - both. An observation and interview with Resident #4 on 06/11/2025 at 11:10AM revealed the resident had not been receiving Aquaphor treatment on her thighs for burns. The resident stated staff had not been applying Aquaphor treatment twice a day for 2 weeks. The resident showed the surveyor her burns. The burns covered both thighs, the skin had various spots including redness, fresh pink scarring, and brown peeling/flaky skin. The skin did not have a greasy or glossy coat and did not appear moisturized. She stated she takes itching medication because the burns on her legs were dry and itchy. The resident stated she saw a specialist doctor every other week for her burns. An interview on 06/11/2025 at 1:59PM with RN F revealed she was asked if she could show the surveyor Resident #4 ' s Aquaphor in the medication cart. RN F had been excused from the interview and returned at 2:09PM with a tube of Aquaphor. RN F stated that she left the Aquaphor in the resident ' s room in a bedside table drawer. The RN further discussed that the resident wants the Aquaphor that was in a tub (container with a lid that twists on and off) and not in the (squeeze) tube like the facility had and that she explained to the resident that it's the same product. RN F stated that she went to apply it that morning, but someone distracted her, and she left it there due to providing care to another resident in another room. The RN stated someone else applied the Aquaphor. When asked specifically who applied it, she proceeded to call a staff member to confirm. She then stated the ADON applied it, and she had asked the ADON to apply it. The surveyor asked RN F where the Aquaphor was to be applied and how often and she stated on the resident ' s legs for dryness, twice a day. RN F stated it was important to know residents ' orders and make sure they receive treatment, so staff know if treatment was working or to follow up with the doctor if it was not working. The surveyor asked RN F to describe what can happen to untreated burned skin and she stated the skin can crack and become infected; the body would be prone to infection. An interview with Resident #4 on 06/11/2025 at 2:57PM revealed the resident had received Aquaphor treatment after the surveyor was in her room. The resident explained someone in gray scrubs applied the Aquaphor, but she did not know who it was. She further stated the staff member did not wash her skin before applying Aquaphor treatment; they applied it all over her legs, not specifically to her thighs. She said the staff came into her room while she was sleeping, and she heard staff at the bedside table. She was unsure if staff put the tube of Aquaphor into the bedside table drawer or if they got the Aquaphor from the drawer. The surveyor asked Resident #4 if she cares if the Aquaphor was in a tube or a tub and she stated No, it doesn ' t make a difference to me. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with the ADON on 06/11/2025 at 3:10PM revealed the ADON stated she applied Aquaphor to Resident #4 around noon on 06/11/2025 because RN F asked her to. She stated that she had not applied it previously and that it was for her burns on her legs, so they didn ' t dry out. The surveyor asked the procedure for applying the Aquaphor, and the ADON stated to put on gloves and apply to the top of the legs bilaterally; she asked the resident and the resident showed her where to apply; then she applied. The ADON was asked if she washed the area before treating, and she stated the order did not say to wash her legs first. The surveyor asked the ADON who puts orders in residents ' charts, and she stated orders go straight to the nurses, where they review orders and put them into the chart. The ADON stated it was important to apply Aquaphor as ordered to prevent drying of the skin and reopening of wound, and for healing. An interview on 06/11/2025 at 3:59PM with the Regional Compliance Nurse revealed she was aware of Resident #4 ' s burns on her legs and stated they were scared and healed. The surveyor asked who told her they were healed, and she stated she was not sure but was told the resident had healed and dried skin but had not seen the resident. The Regional Compliance Nurse was asked what the expectation was for applying the Aquaphor treatment and she stated the nurses should follow the order. The Regional Compliance Nurse stated when residents had a doctor ' s appointment outside of the facility, the nurse who received the resident back from the appointment, the DON, or ADON were responsible to review the doctor ' s notes to determine what new orders the resident had; and if orders are not transcribed like prescribed, residents will not receive treatment like prescribed. Interview with the ADM on 06/11/2025 at 4:27PM revealed the ADON and DON were expected to monitor and transcribe orders correctly in resident ' s charts. She further explained it was important to make sure when that the facility ' s orders match outside provider ' s orders so that they do not miss anything for treatment for the resident. The ADM stated that the purpose of an order was so the resident can be cared for based on their condition. Record review of the facility's Documentation of New or Changed Physician/Prescriber Orders policy, revised 07/01/24 did not address following physician orders.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to assess the risks and benefits of bed rails and grab bars with the resident or resident representative or obtain informed consent prior to installation for two (Resident #2 and Resident #3) of four resident rooms observed and reviewed for bed rails/enabler bars. 1.The facility failed to have evidence of informed consent, a physician's order, a side rail assessment, and a care plan of the resident's risk of entrapment for bed rails or grab bars for Resident #2. 2.The facility failed to have evidence of informed consent, a side rail assessment, and a care plan of the resident's risk of entrapment for bed rails or grab bars for Resident #3. These failures could place residents who used bed rails/grab bars at risk of the resident not being assessed for bed rails or grab bars, resident/responsible party not being aware of the risks, and informed consent not being obtained from the resident or responsible party which could place the resident at risk of harm. Findings included: Resident #2 Record review of Resident #2 face sheet, dated 06/11/25, revealed a 61-year male who was admitted to the facility on [DATE]. His primary diagnosis was dysphagia following cerebral infarction (difficulty swallowing after having a stroke). His secondary diagnoses included uncontrolled blood sugars, heart failure, blood clot in left upper leg, and muscle weakness. Record review of Resident #2's admission MDS dated [DATE], did not reflect Resident #2's BIMS score, and it did not indicate ADLs needs. Record review of Resident #2's PIR dated 06/5/25 reflected a BIMS of 10 indicating moderate cognitive impairment. Observation and interview with Resident #2's in his room on 06/11/2025 at 11:57 a.m., revealed Resident #2 was out of bed in his high back wheelchair with family at his side. The grab/mobility bar on both the left and right side of the bed were raised. Resident #2 said that when he first admitted to the facility, he had no grab bars, but after he fell, he and his family asked for them for repositioning and mobility when getting out of bed . Resident #1 said he had been asking for bed rails and he was told that they were considered a restraint and informed of the risks, but after he fell, they put them on his bed which he was happy about it. Record review of Resident #2's physician's active order for June 2025 reflected there was no orders for use of bed rails/ grab bars. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Care Plan initiated on 06/06/25 reflected a focus area of an actual fall with minor injury to the left eyebrow area related to poor balance. The goal was the resident would resume usual activities without further incident through the review date. The interventions were floor mats as tolerated, high back wheelchair when up in bed, and PT consult for strength and mobility. The care plan did not reflect use of bedrails or grab bars for mobility. Record review of Resident #2's completed assessments from 06/04/25 to 06/11/25 reflected a fall risk evaluation completed on 06/04/25. The completed assessments did not reflect a completed assessment of side rails use. Review of Resident #2's medical record revealed no signed bed rail/grab bar consent form signed by the resident or resident's responsible party or noted to have verbal permission for the bed rails/grab bars. Record review of the Incident and Accident Tracking logs for 04/01/25 through 06/11/25, revealed Resident #2 had a fall on 06/04/25. Resident #3 Record review of Resident #3's face sheet dated 06/11/25 revealed a [AGE] year-old female with an admission of 03/01/25. Her primary diagnosis was pressure ulcer of left buttock. Her secondary diagnoses included urinary tract infection, muscle weakness, lack of coordination, back pain, and mild cognitive impairment. Record review of Resident #3's comprehensive MDS assessment, dated 05/21/25, revealed a BIMS of 00 indicating Resident #3 had severe cognitive impairment. Further review of MDS reflected Resident #3 required substantial/maximal assistance rolling left to right in the bed. The MDS reflected Resident #3 did not use bed rail. Observation of Resident #3's room and bed on 06/11/25 at 11:25 a.m., revealed a grab/mobility bar on the left side and right side of the bed were raised . Resident #3 was not in the room. Record review of Resident #3's physician's active order for June 2025 reflected use of ¼ side rails at head to enable independent bed mobility. Order start date 03/01/25. Record review of Resident #3's Care Plan, last updated on 06/11/25, reflected focus areas Combative Behavior during Incontinent Care and at Risk for Injury. Resident #3 exhibits combative behavior during incontinent care resulting in increased risk of injury hitting head on side rails. The goal was for Resident #3 remained free from further injury during care. The interventions included proved (padded) low bed with blosters (thick pillows) or floor mat and ensuring 2 people assist during incontinent care. The care plan did not reflect bedrails or grab bars for mobility. Record review of Resident #3's completed assessments from 03/01/25 to 06/11/25, did not reflect a completed assessment of side rail use. Review of Resident #3's medical record revealed no signed bed rail/grab bar consent form signed by the resident or resident's responsible party or noted to have verbal permission for the bed rails/grab bars. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/11/25 at 1:35 p.m., LVN C said Resident #2 was able to use a bed rail for bed mobility and transfers. LVN C said she expected the side rail assessment to accurately reflect the use of the side rail. LVN C said she did not know the risk to Resident #2 because he could use of a side rail since his he had the ability to use it safely for mobility. She said she had not worked with Resident #3, and she was not familiar with her mobility. During an interview on 06/11/25 at 3:09 p.m., the ADON revealed Resident #2 fell out of his wheelchair because he was unable to hold his upper trunk of his body when he seats rail. She said one of Resident #2's interventions were a high back wheelchair. The ADON said Resident #3 was on hospice and it was likely that her bed came with side rails from hospice. The ADON said she believed that bed rail assessments were completed for both residents. The ADON said the side rail assessment should be completed with the care plan. The ADON said nursing was responsible for obtaining bed rail orders, consents, and updating the assessment to accurately reflect the use of a side rail as an enabler. The ADON said Resident #2 and Resident #3 could be injured without an accurate assessment of the use of side rail. ADON said nurse managers were responsible for ensuring the side rail assessment, orders, and care plans were completed and completed accurately. The ADON said it was considered a restraint if they did not have the required assessments, care plans, consents , and orders in place. During an interview on 06/11/25 at 4:26 p.m., the Administrator said she expected the side rail assessment to be updated with changes in condition, as a part of the care planning process. The Administrator said nursing was responsible for getting physician's orders and completing the side rail assessment. She said the DON and ADON were responsible for monitoring that orders, care plans, and assessments were completed. The Administrator said her facility did not have consents for bedrails because it was not in their policy. She said the risk to the residents was that the residents could hurt themselves when turning. Review of facility policy titled: Bed Rails-Safe and Effective Use of Bed Rails revision date 11/16/2021, reflected Bed rails should only be used when identified need outweighs the potential risk. 1. Residents will be assessed upon admission, readmission or upon initiation utilizing use of Bed rails. 3 the facility should use Med-Pass Consent for use of Bed Rails. 5. A person- centered care plan will be developed within 48 hours of admissions to address the bed rail (s), if indicated 7 a physician's order and signed restraint physical assessment is required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455891	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Park Multi Care Center	4252 Bryant Irvin Rd Fort Worth, TX 76109

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized for 2 (Resident #1 and #4) of 7 for accuracy of records. The facility failed to accurately transcribe orders for the admitting diagnoses for Resident #1 and #4. The failure can affect residents by putting them at risk for physical pain, decline in current health condition(s), and negative psychosocial impact. Resident #1 Record review of Resident #1 ' s face sheet dated 06/11/2025 reflected a [AGE] year-old woman admitted to the facility on [DATE] with primary diagnosis of Sickle-Cell/HB-C Disease (genetic blood disorder of abnormal hemoglobin, resulting in blockage of blood vessels and reduced oxygen delivery in the blood. Outcomes include anemia-low hemoglobin, pain-blockage of blood flow, and risk of infection) with Crisis (characterized by painful episode caused by blockage of blood flow), with admitting diagnoses of alcoholic cirrhosis of liver without ascites (scarring of liver due to alcohol, without abnormal fluid buildup), idiopathic aseptic necrosis of bone, multiple sites (loss of blood supply to bone resulting in dying bones), fracture of right pubis (pubic bone, part of pelvis), sacrum (bone that forms base of spine, connecting the pelvis), left hip joint, and left femur (thigh bone), muscle weakness (generalize), abnormalities of gait and mobility (abnormal pattern of walking due to underlying medical condition or injury), lack of coordination, anemia, cerebral infarction (stroke), and end stage renal disease (chronic kidney failure, loss of kidney function). Record review of Resident #1 ' s MDS dated [DATE] reflected a BIMS score of 15, indicating cognitively intact. Record review of Resident #1 ' s paper chart binder dated 05/21/25 reflected: Admitting Diagnosis: Sickle Cell Pain Crisis. Record review of Resident #1 ' s order summary report dated 06/11/2025 reflected: Physician has reviewed and agrees with the plan of care (see signature); order date: 05/22/2025 OXYcontin RF 60mg give 2 tabs to =120mg every 8 hours for sickle cell disease; order date: 5/28/2025 Record review of Resident #1 ' s physician orders for May 2025, reflected no physician orders for monitoring Resident #1 ' s hemoglobin levels or lab work. Record review of Resident #1 ' s baseline care plan initiated 05/22/25, reflected no focus, no interventions, and no goals for dx of sickle cell disease with crisis. (continued on next page)

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	455891	A. Building B. Wing	06/11/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN C on 06/11/2025 at 2:44PM revealed she provided care to Resident #1. LVN C was not aware of any orders for monitoring Resident #1 ' s hemoglobin levels or blood labs being ran once a week for the resident ' s sickle cell disease condition. LVN C was asked to describe signs and symptoms of someone with a low hemoglobin level of 4.9 g/dL, she stated tiredness, fatigue, shortness of breath, pale skin, tachycardia (fast heart rate) Interview with the ADON on 6/11/2025 at 3:10PM revealed orders were put into the residents ' charts as the physician told the staff; and labs were done with dialysis but that the resident should have labs upon admission to facility. The ADON was asked to describe signs and symptoms of someone with a low hemoglobin level. She stated weakness, the resident wouldn ' t be very alert, cold, pale, in pain, low blood pressure, increased heart rate, shock, and the blood count low. The ADON stated the importance of monitoring blood labs in someone with sickle cell disease was the hemoglobin could be low and need to make sure that blood cell count is where it should be. She stated she would have contacted the doctor to get orders if those symptoms were present. Interview with the ADM on 06/11/2025 at 4:27 PM revealed the ADON and DON were expected to monitor and transcribe orders correctly in resident ' s charts. The ADM discussed that it was important that a resident ' s orders were transcribed correctly to care plan for their admitting diagnosis and to get the right order to the doctor. She further explained the purpose of an order is so a resident can be cared for. Resident #4 Record review of Resident #4 ' s face sheet, dated 06/18/2025, reflected a [AGE] year-old woman admitted on [DATE] with primary diagnoses of burns involving 10-19% of body surface with 10-19% third degree burns, burn of third-degree right hand, right thigh, left thigh, and right lower leg; other diagnoses include generalized anxiety disorder, major depressive disorder, pain in unspecified hip. Record review of Resident #4 ' s care plan dated (no date) reflected the Focus/Problem of: The resident has actual impairment to skin integrity. burn bilateral (left and right) thighs right arm surgical wound to left and right thigh; date initiated 05/16/2025. One of nine interventions included treatment as ordered. With the goal of The resident will have no complications related to skin through the review date (06/11/2025). Record review of Resident #4 ' s MDS dated [DATE] reflected a BIMS score of 13, indicating cognitively intact. Record review of Resident #4 ' s outpatient surgical specialist for wound care dated 05/21/2025 reflected: Instructions: Please bathe her and wash her bilateral lower extremities with soap and water gently washing with hands daily. Her bilateral lower extremity wounds should be moisturized twice a day with quality lotion. Record review of Resident #4 ' s orders dated 06/11/2025 reflected: (continued on next page)

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	455891	A. Building B. Wing	06/11/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Aquaphor Advanced Therapy External Ointment (Emollient) Apply to BILATERAL THIGHS topically two times a day for PREVENTION; order date 05/22/2025 The orders did not mention the instructions to bathe and wash Resident #1 ' s bilateral lower extremities with soap and water prior to applying the Aquaphor. Interview with Resident #4 on 06/11/2025 at 2:57PM revealed the resident had received Aquaphor treatment after the surveyor was in her room. The resident explained someone in gray scrubs applied the Aquaphor, but she did not know who it was. She further stated the staff member did not wash her skin before applying Aquaphor treatment; they applied it all over her legs, not specifically to her thighs. She said the staff came into her room while she was sleeping, and she heard staff at the bedside table. She was unsure if staff put the tube of Aquaphor into the drawer if they got it from the drawer. An interview with the ADON on 06/11/2025 at 3:10PM revealed the ADON stated she applied Aquaphor to Resident #4 around noon on 06/11/2025 because RN F asked her to. She stated that she had not applied it previously and that it was for Resident #4 ' s burns on her legs, so they didn ' t dry out. The surveyor asked the procedure for applying the Aquaphor, and the ADON stated to put on gloves and apply to the top of the legs bilaterally; she asked the resident, and the resident showed her where to apply; then she applied. The ADON was asked if she washed the area before treating, and she stated the order did not say to wash her legs first. The surveyor asked the ADON who puts orders in residents ' charts, and she stated orders go straight to the nurses, where they review orders and put them into the chart. The ADON stated it was important to apply Aquaphor as ordered to prevent drying of the skin and reopening of wound, and for healing. An interview on 06/11/2025 at 3:59PM with the Regional Compliance Nurse revealed she was aware of Resident #4 ' s burns on her legs and stated they were scared and healed. The surveyor asked who told her they were healed, and she stated she was not sure but was told the resident had healed and dried skin but had not seen the resident. The Regional Compliance Nurse was asked what the expectation was for applying the Aquaphor treatment, and she stated the nurses should follow the order. The Regional Compliance Nurse stated when resident had a doctor ' s appointment outside of the facility, the nurse who received the resident back from the appointment, the DON, or ADON were responsible to review the doctor ' s notes to determine what new orders the resident had; and if orders were not transcribed like prescribed, residents would not receive treatment like prescribed. An interview with the ADM on 06/11/2025 at 4:27PM revealed the ADON and DON were expected to monitor and transcribe orders correctly in residents ' charts. She further explained it was important to make sure the facility ' s orders match outside provider ' s orders so that they do not miss anything for treatment for the resident. Record review of the facility ' s Documentation of New or Changed Physician/Prescriber Orders policy, revised 07/01/24 reflected: 6. Authorized facility staff should enter new electronic medication orders in the electronic medication ordering system as soon as they are received . 6.3 Once the drug is chosen, staff should carry on with the order process by completing the directions, administration schedule, reason for use, and any other information required to complete the order.