STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675035	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Healthcare Center	406 E Seventh St Burkburnett, TX 76354

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45437 Based on observation, interview, and record review, the facility failed to consult with the resident's physician, or the resident's representatives regarding a change in condition for 1 (Resident #1) of 3 residents reviewed for notification of changes. The facility did not consult with Resident #1's Physician or Resident Representative regarding a pressure ulcer that was identified on 03/04/2024 and re-assessed on 04/07/2024. This failure could place residents who presented with pressure ulcers at risk for not receiving appropriate care and interventions. Findings were: Record review of Resident #1's admission record revealed she was [AGE] years old. She was admitted to the facility on [DATE] with a primary diagnosis of dementia with other behavioral disturbances (loss of memory, language, problem solving and other thinking abilities that occurs with agitation and aggressive behaviors), senile degeneration of the brain (mental deterioration), bipolar (mood swings ranging from depressive lows to manic highs), Post-traumatic stress disorder (disorder that results in the person having difficulty recovering after experiencing or witnessing an event), and anxiety (feeling of fear, dread and uneasiness). Record review of Residents #1's Significant Change MDS dated [DATE], revealed the following: -Section C (Cognitive Patterns) reflected a BIMS (Brief interview of Mental Status) score of 07, which was indictive of severe cognitive impairment. -Section M (Skin Conditions) The resident was a high risk for developing a pressure injury but did not have a pressure injury. Record review revealed Resident #1's care plan dated 02/02/2024 revealed the following: (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: 675035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Evergreen Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 406 E Seventh St Burkburnett, TX 76354	

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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 0580 Level of Harm - Actual harm Residents Affected - Some	-Pressure Ulcer/Injury- Resident was at risk for skin breakdown related to incontinence and thin fragile skin. Goal- Prevent/heal pressure sores and skin breakdown. Approach- Follow facility skin care protocol, preventative measures: area blank, report to charge nurse any redness or skin breakdown immediately and turn while repositing per resident request. -Cognitive loss/dementia- Resident has dementia. Goal- Resident will be alert and oriented as possible. Approach- Anticipate needs and observe for non-verbal cues, approach in a calm manner, explain what you intend to do while providing care, introduce yourself and orient to person, place, and time. -Delirium- Resident has difficulty focusing, easily distracted, and has disorganized thinking. Goal- Resident will be as alert and oriented as possible. Approach- Assess for pain, minimize distraction, and orient PRN. Record review of Resident #1's Weekly skin assessments indicated on: 03/04/2024 - The right heel was a 6 cm x 6 cm, stage 1, no exudate amount, and the tissue were closed and resurfaced. Assessment was completed by LVN #1. 04/07/2024- The right heel was a 1.4 cm x 1.7 cm, unstageable, moderate bloody amount of exudate and the tissue was granulated, with 95% granulated and 5% slough. Assessment was completed by LVN #1. Record review of Resident #1's Nursing Documentation from 02/01/2024 to 04/08/2024 revealed 04/08/2024 at 9:49 PM., by LVN #1, resident was assessed in house by Hospice RN. Received the following wound care orders: Right Heel. cleanse with wound cleanser then pat dry with gauze. Apply hydrogel to wound bed. cover with hydro cellular foam dressing. change daily and PRN. No documentation of Physician, Resident Representative or Hospice Services notification of pressure injury identification or decline prior to this date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Evergreen Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 406 E Seventh St Burkburnett, TX 76354	

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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 0580 Level of Harm - Actual harm Residents Affected - Some	During an observation and interview on 04/08/2024 at 11:00 AM., the ADON uncovered Resident #1's right foot bandage and completed a skin assessment on the resident. She revealed that she reviewed the resident's chart and that there showed to be no ongoing skin integrity issues on the resident's right foot, as well as orders or treatments. She measured the right foot and reported that the foot had a 5cm x 5cm unstageable ulcer on it. There was a large ring around wound that had dry white pealing skin, small amount of eschar (black tissue) around some edges of the dry peeling skin. In the central portion of the right heal wound was a smaller open area with red beefy appearance and small amount of yellow tissue. Resident had yellow staining on foot that extended through the arch of her foot. She guessed it was unstageable since there was eschar on the border of the heel wound. She said that this was the first time she was made aware that the resident had any pressure related injuries on her right foot and that if she had been made aware, she would have made sure it was assessed weekly, orders were entered, and treatments were completed daily. She stated that she was responsible for the skin care assessments and the weekly observations were missed because she had not checked to see if they were completed by the nurse's that worked the floor. She stated that this task had been delegated to her by the DON since she started in 2023. She stated that Resident #1 should have had orders entered on 03/04/2024 and that the DON, physician, family, and hospice provider should have been notified. She revealed that she was not aware that an initial observation of the wound was documented on 03/04/3024 or that a subsequent observation was completed on 04/07/2024. She performed Resident #1's wound care by cleaning the area and patting it dry, she then covered the area with the bandage and said that she was going to notify the physician and hospice immediately. During an interview on 04/08/2024 at 11:45 AM., the Medical Director revealed that he saw the resident over the weekend when he was completing his rounds and that he did not document the wound or observe the wound, since he was not made aware that the resident had a wound on her right foot. He stated that his expectations were to be notified anytime there was a change in condition, or for another physician to be notified, as well as hospice and the family. He stated that orders and treatment should have been completed and conducted since it was identified on 03/04/2024. He stated that Resident #1 was frequently confused. He stated that this failure could result in the pressure injury worsening from lack of treatment. During an interview on 04/08/2024 at 1:30 PM., RN#1 (hospice nurse for Resident #1) revealed that they did not have anything in their records that reflected any type of skin integrity issues or pressure ulcers on foot. She reported that there was no documentation in their records that revealed a call from the facility to let them know that a wound had been identified until that date. She reported that she was going to send an RN out to the facility to access wounds and obtained orders and treatments. During an interview on 04/08/2024 at 1:45 PM., with Resident #1's representative revealed that that she was not notified in March 2024 or up to this date in April 2024, that the resident had a pressure ulcer on her right foot. During an interview on 04/08/2024 at 1:50 PM., Resident #1's second representative revealed that he was not notified in March 2024 or April 2024, that the resident had a pressure ulcer on her right foot. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Evergreen Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 406 E Seventh St Burkburnett, TX 76354	

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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 0580 Level of Harm - Actual harm Residents Affected - Some	During an interview on 04/10/2024 at 2:30 PM., LVN #1, she stated that she was the one who initially identified the wound on her right heel, and she told the nurse who was taking over that day. She revealed that she did not tell the DON, call the Physician, call the family, call the ADON, or call the hospice agency. She stated that even thought she had not notified the physician or hospice to obtain orders, she was cleaning it thoroughly and provided dressing changes when she worked. She stated that she had not completed items because she got busy. She revealed that this failure could result in her pressure ulcers getting worse. A policy titled Change in a Resident's Condition or Status revised on 04/20/2023, revealed the following: Policy Statement: Our facility promptly notifies the resident, his or her attending physician, healthcare provider and the resident's representative of changes in the resident's medical mental condition and or status. Policy interpretation and implementation: 1) The nurse will notify the resident's attending physician, health care provider or physician on call when there has been an: d. significant change in the residence physical, emotional, mental condition. e. Need to alter the residence medical treatment significantly. 2) a significant change of condition is a major decline and improvement in the resident status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. b. Impacts more than one area of the resident's health status. c. Requires interdisciplinary review and or revisions to the care plan. 3) The nurse will notify the resident's representative when: b. there is a significant change in the residence physical, mental, or psychosocial status.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45437 Based on interviews, and record reviews, the facility failed to complete a comprehensive assessment within 14 days after a significant change in the physical condition for 1 of 2 residents (Resident #1) whose records were reviewed for assessments. The facility failed to recognize and re-assess Resident #1 after a pressure ulcer was identified, a fall with major injury occurred and aggressive behaviors presented. This failure placed residents at risk for not developing interventions to meet their needs for care assistance and treatments. Findings include: Record review of Resident #1's admission record revealed she was [AGE] years old. She was admitted to the facility on [DATE] with a primary diagnosis of dementia with other behavioral disturbances (loss of memory, language, problem solving and other thinking abilities that occurs with agitation and aggressive behaviors), senile degeneration of the brain (mental deterioration), bipolar (mood swings ranging from depressive lows to manic highs), Post-traumatic stress disorder (disorder that results in the person having difficulty recovering after experiencing or witnessing an event), and anxiety (feeling of fear, dread and uneasiness). Record review of Resident #1's progress notes revealed the following: -On 02/01/2024 at 6:22 AM., LVN #1 documented that she was alerted to resident by sound of her voice calling out for help. upon entering room observed resident lying face down on the floor mat beside her bed. Resident's speech was slurred and there was a moderate amount of bleeding from the right side of her head. it appears resident's head hit the bed railing when she fell . assessed for any further injury @ that time. - On 02/01/2023 at 3:33 PM., the DON documented that Resident was transported to the Hospital for further evaluation and treatment. Resident received treatment and returned to the facility the same day with 5 staples to frontal area. - On 02/22/2024 at 1:27 PM., RN #2 documented that 5-staples removed from wound on right side of forehead. - On 03/12/2024 at 3:00 PM., DON documented that she was notified that this resident engaged in a physical altercation with another resident on the west hall near the nurse's station. Per witnesses in area, this resident was yelling at other residents to shut up when they responded this resident became upset and struck a fell ow resident on their neck giving them an abrasion. That resident retaliated with a return physical strike causing this resident to have a skin tear to the left side of her neck. Residents were immediately separated by staff and kept separated. - On 03/14/2024 at 9:24 AM., The SW documented he was informed that Resident #1 had been involved in an altercation where she struck another resident. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 03/28/2024 at 3:52 PM., ADON documented that new order received from NP with psych services, Seroquel 25mg po q day prn x 14 days (1 extras dose during the day if needed daily in addition to scheduled nightly dose. Record review of Resident #1's Significant Change MDS dated [DATE] revealed the following: -Section C (Cognitive Patterns) reflected a BIMS (Brief interview of Mental Status) score of 07, which is indictive of severe cognitive impairment. Disorganized Thinking - The behavior is present and fluctuates, the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject. -Section E (Behavior) reflected that: Resident #1 did not have behaviors that put them at significant risk for physical illness or injury. -Section J (Health Conditions- Falls) reflected that the resident did not have a fall with Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma. -Section M (Skin Conditions) reflected that resident did not have a pressure injury or skin injury. Record review of Resident #1's Weekly skin assessments indicated on: 03/04/2024 - The right heel was a 6 cm x 6 cm, stage 1, no exudate amount, and the tissue were closed and resurfaced. Assessment was completed by LVN #1. 04/07/2024- The right heel was a 1.4 cm x1.7 cm, unstageable, moderate bloody amount of exudate and the tissue was granulated, with 95% granulated and 5% slough. Assessment was completed by LVN #1. In an interview on 04/09/2024 at 2:00 PM., the DON revealed that the resident did have a change of condition from her last MDS, with additional areas that should have been identified and addressed with a new comprehensive assessment. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/10/2024 at 3:00 PM, the MDS coordinator revealed the resident had a pressure ulcer that was identified on March 04, 2024 , decline in behaviors, and a fall with major injury occurred. She revealed that resident had a significant change since the last MDS in February due to the resident's aggression, falls and pressure ulcer. She revealed that this failure could cause the resident to miss care areas such as the wound care that was not care planned or completed and other care areas that were not being identified and/or a comprehensive care plan being completed. Record review of the facility's policy covering MDS inaccuracies was requested to the MDS coordinator on 04/10/2024. She revealed that she uses the RAI manual for guidance.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45437 Based on interview and record review, the facility failed to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment for 1 of 3 residents (Resident #1) whose records were reviewed for assessments and care plans, as well as having an IDT team present at the care conference. The facility failed to ensure that Resident #1 had an Intradisciplinary Team care conference after Residents #1's Significant Change MDS dated [DATE]. This failure could place residents at risk of not have having their care plans completed accurately and timely. Findings included: Record review of Resident #1's admission record revealed she was [AGE] years old. She was admitted to the facility on [DATE] with a primary diagnosis of dementia with other behavioral disturbances (loss of memory, language, problem solving and other thinking abilities that occurs with agitation and aggressive behaviors), senile degeneration of the brain (mental deterioration), bipolar (mood swings ranging from depressive lows to manic highs), Post-traumatic stress disorder (disorder that results in the person having difficulty recovering after experiencing or witnessing an event), and anxiety (feeling of fear, dread and uneasiness). Record review of Residents #1's Significant Change MDS dated [DATE] revealed the following: -Section C (Cognitive Patterns) reflected a BIMS (Brief interview of Mental Status) score of 07, which is indictive of severe cognitive impairment. Disorganized Thinking - The behavior is present and fluctuates, the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject. -Section J (Health Conditions- Falls) reflected that the resident did not have a fall with Major injury - bone -Section M (Skin Conditions) The resident was a high risk for developing a pressure injury but did not have a pressure injury. Record review of Resident #1's electronic Care Conference record did not have an IDT care plan after the Significant Change MDS on 02/01/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/08/2024 at 1:45 PM., with Resident #1's representative revealed she was not invited to a care plan in a while, it has been at least since 2023. The family would like to attend by phone and be involved in the care plan process and resident care areas. In an interview on 04/09/2024 at 2:00 PM, the DON revealed that she was not responsible for the care plans, the MDS was after completion of the MDS assessment. She revealed even though the care plan meetings were not completed timely By the IDT, she still ensured residents received the care and there were no issues with quality of care. In an interview on 04/10/2024 at 1:00 PM., the SW revealed that he was not aware the Resident #1 had a Comprehensive MDS completed in February. He stated he was responsible for scheduling the care conference and he did not schedule one. He revealed the last one was completed was on 08/30/2023. He stated it was missed and he was just capturing the Quarterly and Annual assessments that he was notified of. He revealed he was never notified of the resident having a Significant Change. He revealed this failure could cause a care conference not being completed. In an interview on 04/10/2024 at 3:00 PM, the MDS coordinator revealed that she was unsure how why the IDT meeting got missed. She said this failure would place the residents at risk for inaccurate care plans and assessments which could cause a quality-of-care issue. She revealed that even though the care plans were not completed correctly, they still took care of the residents. Record review of the facility's policy titled: Care Plan, Comprehensive Person-Centered dated January 26, 2024, revealed the following: 5) The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MSDS assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45437 Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice, to prevent development of pressure injuries for 1 of 7 (Residents #1) residents reviewed for pressure injuries. The facility failed to notify Resident #1's Physician, Resident Representative and Hospice services after identification of wound on Resident #1's right heel. The facility failed to obtain orders for wound care for Resident #1's right heel. The facility failed to perform routine wound care for Resident #1's right heel. The facility failed to complete weekly skin assessments for Resident #1. This failure could place residents who had pressure injuries at risk for new development or worsening of existing pressure injuries. Findings included: Record review of Resident #1's admission record revealed she was [AGE] years old. She was admitted to the facility on [DATE] with a primary diagnosis of dementia with other behavioral disturbances (loss of memory, language, problem solving and other thinking abilities that occurs with agitation and aggressive behaviors), senile degeneration of the brain (mental deterioration), bipolar (mood swings ranging from depressive lows to manic highs), Post-traumatic stress disorder (disorder that results in the person having difficulty recovering after experiencing or witnessing an event), and anxiety (feeling of fear, dread and uneasiness). Record review of Residents #1's Significant Change MDS dated [DATE] revealed the following: -Section C (Cognitive Patterns) reflected a BIMS (Brief interview of Mental Status) score of 07, which is indictive of severe cognitive impairment. -Section M (Skin Conditions) The resident was a high risk for developing a pressure injury but did not have a pressure injury. Record review of Resident #1's care plan dated 02/02/2024 revealed the following: -Pressure Ulcer/Injury- Resident is at risk for skin breakdown related to incontinence and thin fragile skin. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Some	Goal- Prevent/heal pressure sores and skin breakdown. Approach- Follow facility skin care protocol, preventative measures: area blank, report to charge nurse any redness or skin breakdown immediately and turn while repositing per resident request. -Cognitive loss/dementia- Resident has dementia. Goal- Resident will be alert and oriented as possible. Approach- Anticipate needs and observe for non-verbal cues, approach in a calm manner, explain what you intend to do while providing care, introduce yourself and orient to person, place and time. -Delirium- Resident has difficulty focusing, easily distracted, and has disorganized thinking. Goal- Resident will be as alert and oriented as possible. Approach- Assess for pain, minimize distraction, and orient PRN. Record review of Resident #1's Weekly skin assessments under Wound Management for Resident #1 indicated on: 03/04/2024 - The right heel was a 6 cm x 6 cm, stage 1, no exudate amount and the tissue were closed and resurfaced. Assessment was completed by LVN #1. 04/07/2024- The right heel was a 1.4 cm x1.7 cm, unstageable, moderate bloody amount of exudate and the tissue was granulated, with 95% granulated and 5% slough. Assessment was completed by LVN #1. There were no documented weekly skin assessments for the week of 03/11/2024, 03/18/2024, 03/25/2024 or 04/01/2024. Record review of Resident #1's Nursing Documentation from 02/01/2024 to 04/08/2024 revealed 04/08/2024 at 9:49 PM., by LVN #1, resident was assessed in house by Hospice RN. Received the following wound care orders: . Right Heel. cleanse with wound cleanser then pat dry with gauze. Apply hydrogel to wound bed. cover with hydro cellular foam dressing. change daily and PRN. No documentation of Physician, Resident Representative or Hospice Services notification of pressure injury identification or decline prior to this date. Record review of Resident #1's Physician Orders dated 04/08/2024 revealed 04/08/2024 at 11:27 AM revealed the following: call placed to hospice. informed need order for wound to right foot. new order received clean with NS, pat dry cover with foam dressing may wrap with gauze if need for comfort. Hospice stated new orders will be given when res is seen by hospice nurse this week, signed ADON. No orders for wound care prior to this date regarding Resident #1's pressure injury to right heel. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Some	During an observation and interview on 04/08/2024 at 10:00 AM., Resident #1 was sitting in her wheelchair with socks on both of her feet. She was unsure how long she had the pressure injury in her right foot. She had a gauze wrap around the foot, and she said she wrapped it herself. It was loose and twisted. There was no time, date or initials located on the dressing. She said it had been cleaned yesterday by LVN #1, but that was the first time she had received treatment. She said she has been cleaning it and rewrapping it herself. During an observation and interview on 04/08/2024 at 11:00 AM., the ADON uncovered Resident #1's right foot bandage and completed a skin assessment on the resident. She revealed that she reviewed the resident's chart and that there showed to be no ongoing skin integrity issues on the resident's right foot, as well as orders or treatments. She measured the right foot and reported that the foot had a 5cm x 5cm unstageable ulcer on it. There was a large ring around wound that had dry white pealing skin, small amount of eschar (black tissue) around some edges of the dry peeling skin. In the central portion of the right heal wound was a smaller open area with red beefy appearance and small amount of yellow tissue. Resident had yellow staining on foot that extended through the arch of her foot. She guessed it was unstageable since there was eschar on the border of the heel wound. She said that this was the first time she was made aware that the resident had any pressure related injuries on her right foot and that if she had been made aware, she would have made sure it was assessed weekly, orders were entered, and treatments were completed daily. She stated that she was responsible for the skin care assessments and the weekly observations were missed because she had not checked to see if they were completed by the nurse's that worked the floor. She stated that this task had been delegated to her by the DON since she started in 2023. She stated that Resident #1 should have had orders entered on 03/04/2024 and that the DON, physician, family, and hospice provider should have been notified. She revealed that she was not aware that an initial observation of the wound was documented on 03/04/3024 or that a subsequent observation was completed on 04/07/2024. She performed Resident #1's wound care by cleaning the area and patting it dry, she then covered the area with the bandage and said that she was going to notify the physician and hospice immediately. During an interview on 04/08/2024 at 11:45 AM., the Medical Director revealed that he saw the resident over the weekend when he was completing his rounds and that he did not document the wound or observe the wound, since he was not made aware that the resident had a wound on her right foot. He stated that his expectations were to be notified anytime there is a change in condition, or for another physician to be notified, as well as hospice and the family. He stated that orders and treatment should have been completed and conducted since it was identified on 03/04/2024. He stated that Resident #1 was frequently confused. He stated that this failure could result in the pressure injury worsening from lack of treatment. During an interview and observation on 04/08/2024 at 12:15 PM., Resident #1 stated that she could do most things herself and that she did not need help with things. She did keep her foot clean, and she wore the pressure reducing boot that the facility provided for her. Resident was wearing a pressure reducing boot, blue in color and appeared clean. Resident stated that when she needed wound stuff done or she did not have a bandage, she would use toilet paper to make a pad and just wrap it back up with the gauze that was on it. The gauze appeared clean and not reused multiple times. Resident reported that she was often confused but she knows about her feet. Resident stated that she did not have any other foot issues. Resident stated the orange colored (betadine) stain on her right foot was due to it being cleaned by her. She was unsure and could not remember where she kept or stored the cleaner and that it must be locked up at her nurses' station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Healthcare Center	406 E Seventh St Burkburnett, TX 76354

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0686

Level of Harm - Actual harm

Residents Affected - Some

During an interview and observation on 04/08/2024 at 1:15 PM., Resident #1 had a pressure reducing boot on her right foot. She reported that the orange that was on her right foot was from when the ADON took off the bandage and put a cleaning solution on it. She did not remember where the cleanser came from or how she obtained it, she thought a nurse gave it to her. She said that she sometimes used tissue paper for the bandage, but she was not sure when. She said that the facility provided her a boot to wear on her feet, but she was unsure who gave it to her or when she wore it.

During an interview on 04/08/2024 at 1:30 PM., RN#1 (hospice nurse for Resident #1) revealed that they did not have anything in their records that reflected any type of skin integrity issues or pressure ulcers on foot. She reported that there was no documentation in their records that revealed a call from the facility to let them know that a wound had been identified until that date. She reported that she was going to send an RN out to the facility to access wounds and obtained orders and treatments.

During an interview on 04/08/2024 at 2:00 PM., CNA #1 revealed that she was a CNA that provided care for Resident #1. She stated that she knew that Resident #1 had a wound on her foot, but that it had been scabbed over. She revealed that the scab had just come off and that she believed it was being treated, but did not know who was treating it, or how it was treated or when it is treated. She believes had notified the nurse, but she could not remember which one or when she did. She revealed that she has not been treating it.

During an interview on 04/08/2024 at 1:20 PM., Resident #2 revealed that she was the roommate of Resident #1. She said that Resident #1 wore a pressure reducing boot at times, but she was unsure who brought it. She stated that the moon boot just appeared one day. She reported that the resident would get up at times and walk. She said that she had seen a nurse provide care for her foot a few times, but she did not know her name.

During an interview on 04/08/2024 at 2:10 PM., Resident #2 stated that she had not seen Resident #1 perform wound care on her own feet.

During an interview on 04/09/2024 at 4:00 PM., CNA #2 from Hospice revealed she has been giving Resident #1 showers three times a week. She stated she had not been performing wound care on her feet, but that she had been keeping them clean. She stated that she was unaware if there was or was not orders for wound care.

During an interview on 04/10/2024 at 2:00 PM., the ADON stated that she was the one that contacted hospice on Monday, 04/08/2024. She revealed that she was responsible for the weekly skin checks on all the residents, including Resident #1. She revealed that she previously had the black area but that it came off the around the 5th, 6th or 7th. She stated that she assumed that the DON was notified initially that Resident #1 had a pressure ulcer injury on 03/04/2024. She revealed that the resident was often confused and unaware of her limitations. She stated that Resident #1 had worn a pressure reducing moon boot for a few weeks, but she was unsure where it came from, she assumed it was from hospice.

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NAME OF PROVIDER OR SUPPLIER: Evergreen Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 406 E Seventh St Burkburnett, TX 76354	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 04/10/2024 at 2:30 PM., LVN #1, revealed that she had been providing wound care on the days she worked. She stated that there were no orders for wound care, so she just guessed and did what she thought it needed. She stated that she was the one who initially identified the wound on her right heel, but that she told it to the nurse who was taking over. She revealed that she did not tell the DON, call the DR, call the family, call the ADON, or call the hospice agency, and that she knew of the process of notification once a change of condition had been identified. She stated that she had not completed the weekly skin assessments, as ordered, because she got busy. She revealed that this failure could result in her pressure ulcers getting worse. Record review of the facilities policy titled Pressure Injury/Skin Breakdown- Clinical Protocol, dated May 2022, revealed the following: Assessment and Recognition: 1) The nursing staff or practitioner will assess and document an individual significant risk factors for developing pressure injuries; for example, immobility, recent weight loss, and a history of pressure injuries. 2) In addition, the nurse shall describe and document/report the following: A) Full assessment of pressure injury including location, stage, link, width and depth, presence of exudates or necrotic tissue. B) Pain assessment. C) Resident's mobility status. D) Current treatments, including support services and E) All active diagnosis. Treatment: 1) The staff will request physicians orders pertinent to wound treatments in medical interventions. Monitoring: 1) during resident visits, the physician will evaluate and document the progress of wound healing especially for those with complicated, extensive, or poorly killing wounds. 2) The interdisciplinary team will update the care plan as appropriate.

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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** 45437 Based on observation, record review and interview, the facility failed to maintain wound care records on each resident that are accurately documented for 1 of 3 residents (Resident #1) reviewed for records. The facility failed to document that Resident #1 had wound care. This failure to maintain accurate records could affect Residents by receiving inadequate care and services. Findings include: Record review of Resident #1's admission record revealed she was [AGE] years old. She was admitted to the facility on [DATE] with a primary diagnosis of dementia with other behavioral disturbances (loss of memory, language, problem solving and other thinking abilities that occurs with agitation and aggressive behaviors), senile degeneration of the brain (mental deterioration), bipolar (mood swings ranging from depressive lows to manic highs), Post-traumatic stress disorder (disorder that results in the person having difficulty recovering after experiencing or witnessing an event), and anxiety (feeling of fear, dread and uneasiness). Record review on 04/08/2024 at 9:40 AM revealed that Resident #1's care plan dated 02/02/2024 revealed the following: -Pressure Ulcer/Injury- Resident is at risk for skin breakdown related to incontinence and thin fragile skin. Goal- Prevent/heal pressure sores and skin breakdown. Approach- Follow facility skin care protocol, preventative measures: area blank, report to charge nurse any redness or skin breakdown immediately and turn while repositing per resident request. Record review on 04/08/2024 at 9:50 AM revealed that Residents #1's Significant Change MDS dated [DATE] revealed the following: -(Cognitive Patterns) reflected a BIMS (Brief interview of Mental Status) score of 07, which is indictive of severe cognitive impairment. -(Skin Conditions) The resident was a high risk for developing a pressure injury but did not have a pressure injury. Record review of Resident #1's Weekly skin assessments indicated on: 03/04/2024 - The right heel was a 6 cm x 6 cm, stage 1, no exudate amount and the tissue were closed and resurfaced. Assessment was completed by LVN #1. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/07/2024- The right heel was a 1.4 cm x1.7 cm, unstageable, moderate bloody amount of exudate and the tissue was granulated, with 95% granulated and 5% slough. Assessment was completed by LVN #1. Record review of Resident #1's Nursing Documentation from 02/01/2024 to 04/08/2024 revealed the only documented wound care was on 04/08/2024 at 9:49 PM., by LVN #1, when the resident was assessed in house by Hospice RN. Wound care orders were provided at that time No documentation of wound care orders or treatments provided to right heel prior to this date. Record review of Resident #1's Physician Orders dated 04/08/2024 revealed 04/08/2024 at 11:27 AM revealed the following: call placed to hospice. informed need order for wound to right foot. new order received clean with NS, pat dry cover with foam dressing may wrap with gauze if need for comfort. Hospice stated new orders will be given when res is seen by hospice nurse this week, signed ADON. No orders for wound care prior to this date regarding Resident #1's pressure injury to right foot. During an observation and interview on 04/08/2024 at 10:00 AM., Resident #1 had a gauze wrap around the foot. There was no time, date or initials anywhere on the outside of it. She said that it had been cleaned yesterday by LVN #1, but that was the first time she had cleaned her wound. She said that she has been cleaning it and rewrapping it herself. During an observation and interview on 04/08/2024 at 11:00 AM., the ADON uncovered Resident #1's right foot bandage and completed a skin assessment on the resident. She revealed that she reviewed the resident's chart and that there showed to be no ongoing skin integrity issues on the resident's right foot, as well as orders or treatments. She was unsure why the foot was even bandaged without orders and who bandaged it. During an interview on 04/08/2024 at 11:45 AM., the Medical Director revealed orders and treatment should have been completed and conducted since it was identified on 03/04/2024. During an interview on 04/08/2024 at 1:20 PM., Resident #2 revealed she had seen a nurse provide care for Resident #1's foot a few times, but she did not know her name. During an interview on 04/10/2024 at 2:30 PM., LVN #1, revealed that she remembered that she has been providing wound care. She stated there were no orders for wound care, so she just guessed and did what she thought it needed. She revealed that this failure could result in resident's care areas getting worse. Record review of the Facilities Policy and Procedure titled: Guidelines for Charting and Documentation dated April 2012 revealed the following: The purpose of charting A documentation is to provide: 1) a complete account of the resident's care, treatment, responses to the care, signs, symptoms, etcetera., and the progress of the resident's care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) The facility, as well as other interested parties, with the tool for measuring the quality of care provided to the resident. Treatment Orders: Specify what is to be done, location and frequency, and duration of the treatment.