STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675053	A. Building B. Wing	08/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chisolm Trail Nursing and Rehabilitation Center	107 N Medina Lockhart, TX 78644

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for one (Resident #1) of three residents reviewed for pressure injuries. The facility failed to reinstate Resident #1's wound treatment orders after she was readmitted from the hospital on 07/11/24 until 07/16/24. Her wounds worsened and a new pressure injury was acquired during that timeframe. These failures resulted in an identification of an Immediate Jeopardy (IJ) on 08/30/24 at 1:44 PM. While the IJ was removed on 08/31/24 at 12:55 PM, the facility remained at a level of actual no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of improper wound management, the development of new pressure injuries, deterioration in existing pressure injuries, infection, and pain. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pressure ulcers, diabetes, history of sepsis (a serious condition in which the body responds improperly to an infection), adult failure to thrive, and muscle wasting and atrophy (wasting away). Review of Resident #1's readmission MDS assessment, dated 07/18/24, reflected a BIMS of 14, indicating she was cognitively intact. (Section M) Skin Conditions reflected she was at risk of developing pressure ulcers/injuries and had one stage II, one stage III, and one stage IV pressure injury. Review of Resident #1's quarterly care plan, dated 07/02/24, reflected she was at risk of developing pressure ulcers with interventions of conducting weekly skin inspections and providing treatments as ordered. Review of Resident #1's hospital discharge paperwork from her hospitalization from [DATE] - 07/11/24, reflected 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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	PTWC consulted for management of CAPIs to L buttocks and sacrum. [Resident #1]'s CAPI to L buttocks measures 1x1.5 cm and appears to be a stage 2. Wound consists of 100% red viable tissue. CAPI to coccyx measures 1x0.5 cm and consists of 50% slough and 50% red viable tissue after selective debridement with cotton tip applicator. No drainage or malodor noted from wounds. Wounds appear stable at this time . Review of Resident #1's wound assessments conducted by the WCD, dated 07/16/24, reflected the following: Stage 3 pressure wound of the left buttock full thickness: 6.0 cm x 3.0 cm x 0.2 cm Stage 2 pressure wound of the right buttock partial thickness: 2.3 cm x 1.1 cm x 0.1 cm Stage 4 pressure wound coccyx full thickness: 1.5 cm x 1.0 cm x 0.2 cm Review of Resident #1's physician order, dated 07/16/24, reflected stage 3 pressure wound of left buttock: Cleanse with NS, pat dry, apply alginate calcium with silver, cover with border gauze, one time a day for wound care. Review of Resident #1's physician order, dated 07/16/24, reflected pressure wound to coccyx, full thickness: cleanse with NS, pat dry, apply alginate calcium with silver, cover with border gauze, one time a day for wound care. Review of Resident #1's physician order, dated 07/16/24, reflected pressure wound of the right buttock, partial thickness: cleanse with NS, pat dry, apply zinc one time a day for wound care. Review of Resident #1's TAR, dated July 2024, reflected no treatment orders from 07/11/24 - 07/16/24. The first treatments for the wounds were completed after returning from the hospital on 07/11/24 on 07/17/24. During a telephone interview on 08/15/24 at 12:24 PM, Resident #1's WCD stated he was not aware she went without treatment orders after her readmission from the hospital on 07/11/24 until after his weekly assessment on 07/16/24. He stated he would have expected her old treatment orders to have been reinstated or to implement new treatment orders from the hospital. He stated a negative outcome of not having treatment orders in place would depend on the situation of the wounds and it could just be minimal negative outcomes. He stated he was unaware her wounds worsened after her hospitalization . During an interview on 08/15/24 at 12:36 PM, the DON stated it was the responsibility of the admitting nurse to reinstate all orders when a resident was readmitted from the hospital. She stated they also sat down as an IDT and went over the orders together. She stated going several days without treatment orders could lead to sepsis, worsening of wounds, or rehospitalization . Review of the facility's Skin Care Guidelines Policy, dated July of 2018, reflected the following: Purpose: To provide a system for evaluation of skin to identify risk and identify individual interventions to address risk and a process for care of changes/disruption to skin integrity. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Process: - All those admitted will be observed for baseline skin condition and evaluated for risk of skin breakdown within 24 hours of admission. The findings will be documented in the electronic medical record. - Patients/Residents will be observed by the nurse aide team members daily for changes in skin condition. These changes will be reported to the licensed nurse and documented in the electronic medical record. The ADM and DON were notified on 08/30/24 at 1:44 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was approved on 08/30/24 at 6:31 PM: 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. Completion Date: August 30, 2024 - The DNS and designee(s) conducted skin assessments on all residents by August 30, 2024. - An audit was conducted to ensure all treatments, supplies, and equipment were readily available for ordered wound treatments by Nursing Supervisors and designee on August 30, 2024. - A medical records review was completed on all residents by Nursing Supervisors and designee(s) to ensure weekly skin assessments were completed and treatment recommendations/orders were in place by August 30, 2024. - A care plan audit was conducted by the MDS coordinator to ensure that treatment recommendations/orders were on the care plan and that the care plan was being followed . 2. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. Completion Date: August 30, 2024. - All facility policies and procedures related to skin care, wound care, and pressure injury prevention were reviewed by the Senior Director of Clinical Operations and revised as needed . - An audit of all pressure relieving devices and support surfaces was conducted by the Nursing Supervisor(s) to ensure proper use according to manufacturer's instructions. - DNS/Director of clinical operations provided education to all licensed nurses present have been educated and any further team members will be educated before working next shift on facility policies and procedures related to skin/wound care, as well as appropriate wound treatment measures. This included ensuring residents had necessary support surfaces and pressure relieving devices, and that staff was following the manufacturer's recommendations for use on August 30, 2024. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- DNS/Director of Clinical Operations provided education to all licensed nurses present have been educated and any further team members will be educated before working next shift on appropriate documentation which included transcription and entering of treatment orders on the physician's order sheet in the EHR and the resident's TAR on August 30, 2024. - DNS/ Director of Clinical Operations educated all nurse aides present have been educated and any further team members will be educated before working next shift on preventative skin care on August 30, 2024. - DNS/Director of Clinical Operations conducted daily treatment record and nursing documentation audits to ensure accurate and complete documentation of skin related treatments and preventative measures starting on August 30, 2024. - For residents returning from the hospital, treatment recommendations/orders and wound care appointments will be transcribed and overseen by the treatment nurse and DNS. - A QAPI PIP has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented at the monthly QAA meeting. Monitoring/auditing and reporting will continue for a minimum of three months. The Surveyor monitored the POR on 08/31/24 as followed: During interviews on 08/31/24 from 11:01 AM - 12:42 PM, five CNAs and one MA from different shifts all stated they were in-serviced prior to their shifts . All were able to give examples as to when they would report to their nurse regarding skin integrity issues such as redness, bruising, discoloration, skin tears, or abrasions. They stated it was important to notify the nurse of any skin changes so they could assess the skin and be aware of any possible issues. They all stated it was important to reposition residents every two hours to help prevent skin breakdown. During interviews on 08/31/24 from 11:01 AM - 12:42 PM, two RNs and three LVNs from different shifts all stated they were in-serviced prior to their shifts . They all stated that a head-to-toe assessment was to be conducted immediately upon every new admission and any wounds were to be documented and the NP , DON, and WCD should be notified. They all stated if the resident was admitted without treatment orders, they would enter a standard order until the WCD gave them alternate orders. They all stated negative outcomes of a resident missing wound care treatments could be wounds deteriorating and risk of infection. All nurses stated their expectations were that nursing aides notify them immediately of any new skin issues such as discoloration, redness, open areas, bruising, rashes, or anything abnormal. The Nurses all stated if the WCN was not working it was their responsibility to provide wound care. Review of the facility's QAPI meeting, dated 08/30/24, reflected the ADM, AIT, DON, ICP, WCN, and MD were in attendance. Review of an in-service entitled Wound Care, dated 08/30/24 - 08/31/24 and conducted by the DON, reflected all nurses were in-serviced on pressure injury staging, protocols for wound care, entering wound care orders immediately upon admission, and their Skin Care Guidelines policy. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an in-service entitled Caring for Skin, dated 08/30/24 - 08/31/24 and conducted by the DON, reflected all nursing assistants were in-serviced on ensuring pressure relieving devices were being used properly and the following: Skin Changes In Elderly o Normal skin functions decline o Elderly more prone to skin disease, infection, problems in wound healing. o Pigmentation(color). Skin is of pale color o Moisture. Skin becomes dry, flaky&rough Pressure Ulcer Prevention o Change position frequently o Use positioning devices to float heels & relieve skin pressure o Pressure reducing cushions in wheelchairs o Keep skin clean and dry o Encourage fluids, hydration o Lotion and use barrier cream as needed o Report to charge nurse any bruise, red or broken skin o Report to charge nurse any refusals of care What To Report To Charge Nurse o Any bruise or discoloration of skin o Any rash or raised skin area o Any cut or laceration o Any red or open area o Any warm or cool skin area. o Any unusual bumps o Any report of pain (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Procedure For Reporting o Look and touch skin during AM and PM cares everyday. o Report anything unusual to charge nurse right away or as soon as possible after cares o Charge nurse to assess resident, measure and document. Review of all residents' skin assessments, completed 08/30/24 by the DON, reflected no new skin integrity issues. Review of all residents' EMRs who required pressure relieving devices, on 08/31/24, reflected they all had appropriate physician orders and were care planned for the devices. Review of three residents' EMRs that had recently been readmitted from the hospital, on 08/31/24, reflected their wound treatment orders had been reinstated the same day as their readmission. Review of two residents' EMRs that had current wounds, on 08/31/24, reflected no wound care treatments had been missed during the month of August 2024. While the IJ was removed on 08/31/24 at 12:55 PM, the facility remained at a level of actual no actual harm at a scope of pattern that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.