

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Chisolm Trail Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of three residents reviewed for quality of care. The facility failed to complete an accurate skin assessment on Resident #1 on 07/17/25 which did not include multiple red small scratches underneath both of her eyes. This failure could place residents at risk of skin integrity issues not being addressed, infection, and hospitalization. Findings included: Review of Resident #1's undated face sheet reflected [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit, history of falling, and dementia. Review of Resident #1's quarterly MDS assessment, dated 05/07/25, reflected a BIMS score of 99, indicating she was unable to complete the interview due to her severe cognitive deficit. Section M (Skin conditions) reflected she was at risk of developing pressure ulcers/injuries. Review of Resident #1's quarterly care plan, dated 04/29/25, reflected she had a self-care deficit related to impaired cognition/dementia with an intervention of observing her skin for alterations in skin integrity. Review of Resident #1's Weekly Skin Assessment, dated 07/17/25 at 9:03 AM and documented by the TN, reflected she had no new skin integrity issues. Observation on 7/17/25 at 9:56 AM revealed Resident #1 in her wheelchair in the hallway. She was not able to be interviewed. She had multiple small red scratch-like marks under each eye. During an observation and interview on 07/17/25 at 10:34 AM, this surveyor brought LVN A to Resident #1 and asked what she saw on her face. She stated there appeared to be little scratch marks under her eyes. She stated she would expect to see them on a skin assessment because anything on the resident such as redness, bruising, or open skin should be documented. During an interview on 07/17/25 at 11:12 AM, the TN stated she completed weekly skin assessments on the residents. She stated she did complete Resident #1's assessment that morning and did not see any skin integrity issues. She stated she had been shown Resident #1's face by LVN A (prior to the interview). She stated she normally would not document something like the teeny openings on her face. She stated she normally only documented something she would need to treat, such as skin tears or open areas. During an interview on 07/17/25 at 11:52 AM, the DON stated skin assessment should include a head-to-toe observation. He stated skin integrity issues he would expect to be on a skin assessment would be redness, wounds, open areas, excoriation, and any abnormalities. He stated he would expect scratches to be documented because they were a break in the skin and could turn into something else. He stated the importance for accurate skin assessments was to ensure the nurses were ensuring skin issues were not worsening. Review of the facility's Skin Assessment Policy, dated 2021, reflected the following: It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions.</p>

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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