STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675489	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devine Health & Rehabilitation	104 Enterprise Ave Devine, TX 78016

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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 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** 48753 Based on interview, observation, and record review, the facility failed to ensure that the comprehensive person-centered care plan described services that are to be furnished to maintain the resident's highest practicable physical, mental and psychosocial well-being for one of 14 residents (Resident #5) reviewed for care plans in that: The facility failed to ensure Resident #5's care plan indicated that Resident #5 had abrasions on her left 2nd, 3rd and 4th toe and her right 2nd and 3rd toe that required a daily wound treatment, when the care plan record was reviewed on 10/21/2024. This deficient practice could place residents who had wounds at risk for not receiving treatment and services. The findings included: Review of Resident #5's undated face sheet revealed Resident #5 was a 77- year-old female who admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes (a condition resulting from insufficient production of insulin, causing high blood sugar) , Chronic Obstructive Pulmonary Disease (a group of lung diseases causing constriction of the airways and difficulty breathing), Cirrhosis of Liver (scarring of the liver typically caused by hepatitis viruses or chronic alcohol abuse), Chronic Pain, Hemiplegia (paralysis of one side of the body), and Vascular Dementia (brain damage typically caused by multiple strokes). Review of Resident #5's quarterly MDS assessment, dated 09/12/2024, reflected Resident #5 had a BIMS score of 13, indicating no cognitive impairment. Section GG, titled Functional Abilities and Goals, reflected Resident #5 was dependent on staff for rolling left and right in bed and dependent for chair/bed transfers. Section M, titled Skin Conditions, reflected Resident #5 was at risk for developing pressure ulcers/injuries and had a pressure relieving mattress. Record review of Resident #5's care plan, date initiated 06/30/2022 and revised 05/08/2024, reflected Resident #5 had the potential for pressure ulcer development, refused preventative measures and heel protectors, and was non-compliant with treatment. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's October 2024 TAR reflected the following orders scheduled for a.m.: A) Wound-cleanse left foot 2nd toe with ns, pat dry, paint with betadine, one time a daily for wound healing. Start date 10/12/2024. B) Wound-cleanse left foot 3rd toe with ns, pat dry, paint with betadine, one time a daily for wound healing. Start date 10/12/2024. C) Wound-cleanse left foot 4th toe with ns, pat dry, paint with betadine, one time a daily for wound healing. Start date 10/12/2024. D) Wound-cleanse right foot 2nd toe with ns, pat dry, paint with betadine, one time a daily for wound healing. Start date 10/12/2024. E) Wound-cleanse right foot 3rd toe with ns, pat dry, paint with betadine, one time a daily for wound healing. Start date 10/12/2024. Record review of a Wound Care Consult Note for Resident #5, dated 10/15/2024, the Wound Care NP described Resident #5's toe wounds as abrasions and the wound bed as dry scab and said to cleanse with normal saline or wound cleanser, dry, apply betadine and leave open to air. During an observation and interview with Resident #5, 10/21/2024 at 2:14 p.m., Resident #5 was observed in her room lying in bed with a low air loss mattress. The left side of the bed was up against the room wall. Resident #5's toes were exposed at the end of the bed and Surveyor A observed Resident #5 had abrasions/dried scabs to her 2nd, 3rd and 4th toes on her right foot and on her 2nd and 3rd toes on her left foot. Resident #5 said she had diabetes and could not feel her toes and sometimes would hit them on the wall or scraped them together. Resident #5 said the facility had offered interventions to prevent further abrasions that included moving her bed away from the wall and wearing preventative boots or other items to protect her feet. Resident #5 said the staff pull her bed away from the wall when turning and repositioning her, but she would not allow them to leave her bed away from the wall. Resident #5 also stated she did not like wearing other things on her feet. Resident #5 said staff were good about providing treatments and her scabs were healing. During an interview with the Wound Care NP, 10/23/2024 at 12:37 p.m., the Wound Care NP stated Resident #5 had dry abrasions to her toes that were healing and stated the current treatment of betadine was an appropriate treatment. During as interview with the MDS Coordinator, 10/24/2024 at 11:49 a.m., the MDS Coordinator stated care plans were completed by the MDS Coordinator, DON, or ADON, and care plans should be updated at the time of a change in a resident's plan of care. The MDS Coordinator stated it was important to update the care plan at the time of the change in a resident's plan of care, so everyone was aware of the changes for that resident. During an interview with the DON, 10/24/2024 at 11:56 a.m., the DON said during the morning meeting daily, the DON, ADON or MDS Coordinator would update resident care plans when reviewing new orders or changes in resident care. The DON said a resident's care plan should be updated as soon as a change was identified, and new interventions were put in place to address the change. The DON said it was important for resident care plans to be up to date and accurate because it is the care that the patient is needing, and it is a way for staff members to be aware of the type of care that we are providing to that specific resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an undated facility policy titled Comprehensive Care Planning (Nursing Policy and Procedure Manual GP MC 03-18.0) reflected the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights 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. The policy also reflected residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and the resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring and administering of all drugs to meet the needs of the residents for 1 (Resident #5) of 14 residents reviewed for controlled medication use, in that: The facility failed to ensure LVN A, LVN B, and LVN C failed to follow facility policy to ensure all controlled medications were accurately reconciled at the start and end of the shift which resulted in a controlled medication discrepancy. This failure could place residents at risk for medication overdose, medication under-dose, ineffective therapeutic outcomes, and drug diversion. The findings included: Review of Resident #5's undated face sheet revealed Resident #5 was a 77- year- old female who admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes (a condition resulting from insufficient production of insulin, causing high blood sugar), Chronic Obstructive Pulmonary Disease (a group of lung diseases causing constriction of the airways and difficulty breathing), Cirrhosis of Liver (scarring of the liver typically caused by hepatitis viruses or chronic alcohol abuse), Chronic Pain, Hemiplegia (paralysis of one side of the body), and Vascular Dementia (brain damage typically caused by multiple strokes). Review of Resident #5's quarterly MDS assessment, dated 09/12/2024, reflected Resident #5 had a BIMS score of 13, indicating no cognitive impairment. Section J Health Conditions reflected Resident #5 received a pain medication regimen. Resident was interviewed about her pain and stated she rarely/not at all experienced pain or hurting, pain rarely/not at all made it hard for her to sleep at night, pain rarely/not at all limited her participation in rehabilitation therapy sessions and rarely/not at all limited her day-to-day activities. On a scale of 1 to 10, Resident #5 stated 3 was the worst her pain had been over the previous 5 days. Review of Resident #5's care plan, dated initiated 06/30/2022 and revised 09/23/2022, reflected Resident #5 had the potential for uncontrolled pain and the interventions included administering medications as ordered and anticipate need for pain relief and respond immediately to any complaints of pain. Review of Resident # 5's October 2024 MAR reflected an order for Norco oral Tablet 10-325mg (Hydrocodone-Acetaminophen) Give 1 tablet by mouth four times a day related to chronic pain syndrome. The medication was scheduled for 5:00 a.m., 12 p.m., 6 p.m. and 11 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's-controlled medication count sheet log revealed a space for a licensed nurse to log the date, time, amount of medication given, amount of medication remaining and signature. The log reflected Resident #5 received 1 tab of her Norco medication on 10/15/24 at 11 p.m. with 11 pills remaining and administered 1 tab on 10/16/2024 at 5 a.m. with 10 pills remaining. The medications were initialed as administered by LVN C. Review of Resident #5 controlled drug audit record reflected a log for the oncoming and outgoing nurse to sign at each shift change to validate that the controlled medications were reconciled before the next nurse took possession of the medication cart and keys. The audit log was blank on 10/16/2024 for the 10 p.m. - 6 a. m. shift nurse and the 6 a.m.- 2 p.m. nurse. During an interview with Resident #5, 10/21/2024 at 2:14 p.m., Resident #5 stated she had been receiving her pain medications as scheduled, her pain was controlled and stated she did not have any issues with getting her pain medication on time when it was due, stating they do a good job with it. During an interview with LVN A, 10/24/2024 at 10:28 a.m., LVN A stated she arrived for her 6 a.m. shift on 10/16/2024 a few minutes before 6 a.m. and stated LVN C asked LVN A to count the controlled medications and take report on 400/500 hall since LVN B was running late for the shift, and LVN A agreed. LVN A stated LVN C called out the number of pills remaining listed on the audit sheet and LVN A called out the number of controlled medications remaining on each resident's blister pack that contained the controlled medication. LVN A said the purpose was to ensure the number of remaining pills in the blister pack and the number of remaining pills listed on the audit sheet matched. LVN A said Resident #5 had 9 pills remaining in her blister pack and said LVN C also said 9 when reading off of the audit sheet. LVN A said she remembered it so clearly because she thought to herself that LVN A would need to get a triplicate to reorder the medication since the count dropped below 10 pills. LVN A said when they were finished counting the controlled medications, LVN C left the facility. LVN A said when LVN B arrived, LVN B asked LVN A if she counted with LVN C and LVN A said yes. LVN A said she then gave the keys to LVN B without counting the medications with LVN B. LVN A stated a short time later LVN B came to the nurse's station and told LVN A that Resident #5 only had 9 pills in her blister pack and her count sheet said she should have had 10. LVN A said LVN A and LVN B completed a cart audit for any other discrepancies and to see if there were any loose pills in the bottom of the cart and did not find any loose medication or discrepancies with other resident counts. LVN B stated she had received training on counting narcotics and stated the facility protocol was LVN A should have looked at the controlled count sheets when LVN C was calling out the numbers to verify the accuracy. LVN B said she had been trained that both nurses should visually check the blister pack and audit sheet to validate the numbers the other nurse was reciting was accurate. LVN A also stated when LVN B arrived to take over the shift, LVN A and LVN B should have completed a controlled medication count together before LVN A gave the keys and the cart to LVN B. LVN A stated LVN A and LVN B notified the DON around 6:40 a. m. of the controlled medication discrepancy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN B, 10/24/2024 at 11:32 a.m., LVN B stated she arrived at the facility around 6:14 a.m. and was told by LVN A that LVN C left and counted the controlled medications with LVN A. LVN B said she did not count the controlled medications with LVN A when she arrived and said she had received training on counting controlled medications before taking the keys from another nurse and said she was just thrown off because she was running late and didn't do the count. LVN B said a few minutes into her shift, she opened the controlled medication cart to pull a medication and noticed that Resident #5 only had 9 pills in her blister pack and her audit sheet said 10 pills should still be remaining. LVN B said she asked LVN A about the count and LVN A told her LVN C said there were 9 pills still remaining on the audit sheet. LVN B said she audited the rest of her controlled medications on her cart and then notified the DON of the discrepancy around 6:40 a.m. During an interview with the DON, 10/24/2024 at 11:56 a.m., the DON stated he was notified of a medication count discrepancy by LVN B around 6:46 a.m. The DON stated LVN B said she did not count with LVN C or LVN A, but LVN B had been counting the controlled medications independently and told the DON Resident #5's blister pack had 9 pills in it and the audit sheet stated she should have had 10 pills left. The DON stated he asked LVN A and LVN B to remain at the facility, and the DON and Administrator began an investigation into the discrepancy. The DON said he audited Resident #5's-controlled audit count sheet and did not identify a discrepancy with the audit log sheet and the medication administration record. However, the blister pack only contained 9 pills and should have contained 10 according to the audit and administration record. The DON said all facility residents on controlled medications were audited and no further discrepancies were identified. The DON stated Resident #5 was interviewed by the ADON on the morning of 10/16/2024 and Resident #5 stated she had received her medication on time and had no complaints of unresolved pain. LVN C was contacted on 10/16/2024 and asked to return to the facility to provide a statement for the investigation and participate in a drug test. The DON said LVN C said she lived 40 miles away and was not feeling well and could not come back. LVN C was told she would need to drug test prior to her shift on the evening of 10/16/2024. LVN C called in for her shift and did not comply with the drug test. LVN A and LVN B were both drug tested and the test results were negative. The DON stated the expectation for managing controlled medications was the nurse with possession of the medication cart and the nurse taking possession of the medication cart was to complete the controlled medication reconciliation together by both nurses visualizing the number of medications remaining on the audit sheet and the number of medications in the blister pack. The DON said both nurses should then sign the controlled drug audit record to validate the count was completed. The DON said staff received re-education on the facility protocol for counting controlled medication. During an interview with the Administrator, 10/24/2024 at 1:21 p.m., the Administrator stated LVN C provided a statement to the facility but did not return to work or participate in a drug test and was no longer employed at the facility. The Administrator stated the incident was reported to the city police department, Ombudsman, and Health and Human Services, and stated staff had received re-education on expectations for reconciling controlled medications. The Administrator stated the DON and ADON would be responsible for auditing the system to ensure accuracy. During an interview with the Consultant Pharmacist, 10/24/2024 at 2:20 p.m., the Consulting Pharmacist stated she was notified of the medication discrepancy by the administrator on 10/16/2024 and stated Resident #5's medication would be re-ordered timely so Resident #5 did not miss a dose related to the medication discrepancy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a statement dated 10/19/2024, and signed by LVN C, stated LVN C counted the med cart with LVN A because LVN B was late and LVN C said there was no discrepancy. LVN C when she got home, she received a call from the DON and said she explained to him that when LVN C left the building every single narcotic was accounted for. Review of an in-service titled Narcotic Documentation, dated 03/18/2024, stated narcotics must be counted at the beginning and end of your scheduled shift. Never assume the cart without counting and signing the chain of custody shift to shift count. Never leave the cart keys with another nurse without counting. The in-service is signed by 7 nurses including LVN A and LVN B. Review of an in-service titled Narcotic Counts; Medication Management, dated 08/24/2024, stated narc count oncoming nurses counts actual medication and off going nurse reads out the number to the oncoming nurse to ensure accuracy. The in-services was signed by 12 nurses including LVN C. Review of facility policy titled Medication Administration Procedures (Pharmacy Policy and Procedure Manual 2003 revised 10/25/2017), stated there shall be a narcotics audit at each change of shift to ensure against any discrepancy. Upon a correct audit, the nurses or med aides involved will sign the narcotic check list at the time of the audit, the nurses are to observe for both the correct count and the correct medication. Review of facility policy titled Storage and Documentation of controlled Medications (Pharmacy Policy and Procedure Manual 2003), stated All controlled medications will be stored under double lock and checked for accountability at each change of shift by the nurse going off duty and the nurse coming on duty. Documentation of the audit will be completed on the appropriate form. Review of facility policy titled Controlled Drugs Audit and Accountability (Pharmacy Policy and Procedure Manual 2003), stated the change of shift audit sheets is where nursing staff will sign to indicate that the controlled drugs were audited and that the responsibility of accountability of the controlled drugs is being changed to a different nursing staff. This form has columns to indicate the total number of controlled drug audit sheets present at each shift change audits.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48753 Based on observation, interviews and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 meal (lunch 10/21/24) observed, in that; The facility failed to identify a food item held below proper holding temperature prior to surveyor intervention This failure could place residents, who consumed food prepared in the facility kitchen, at risk of reduced meal satisfaction, diminished nutritional intake, food borne illness and weight. The findings were: An observation, 10/21/2024 at 11:40 a.m., in the facility dining room revealed a posted lunch menu that included BBQ beef on a bun, tater tots, onion, pork beans, apple cobbler and drink of choice. The alternate food items included a bologna sandwich, chef salad, and grilled cheese sandwich. An observation, 10/21/2024 at 12:20 p.m., of the serving line revealed [NAME] A taking temperatures of the food on the steam table. The tater tot's temperature was 130 degrees, and all of the other food items temperatures were above 140 degrees. [NAME] A was observed telling staff she was ready to start serving the food and began serving resident plates. During an interview with the Dietary Manager, 10/21/2024 at 12:23 p.m., the Dietary Manager said she was not sure what temperature the hot food had to be held at in order to be safely served to the residents and said she would be right back. She returned in less than a minute and said the temperature should be above 140 degrees. She was notified the tater tots temperature was 130 degrees and [NAME] A was starting to serve the residents. The Dietary Manager said the tater tots would need to be reheated until they were at the correct temperature before being served to the residents. The Dietary Manager said serving food below the correct temperatures could cause a resident to get a bacteria and said that her staff had received training on safe food temperatures. During an interview with [NAME] A, 10/21/2024 at 12:26 p.m., [NAME] A stated hot food should be served above 140 degrees and the tater tot temperature was 130. [NAME] A said she should not have started the food service until all the food temperatures were over 140 degrees and she was going to reheat the tater tots in the oven until they reach a safe temperature before serving to the residents. During an interview with the Administrator, 10/24/2024 at 1:21 p.m., the Administrator stated her expectation was for hot food to be served above 140 degrees. The Administrator said if the temperature was not 140 degrees prior to the meal service, the food item should be heated on the stove or oven until it reached the safe temperature. The Administrator said the staff had received training on food temperatures and said the importance of servicing food at the correct temperature was for the safely and enjoyment of the resident. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of document titled, Certificate of Completion, certified that [NAME] A successfully completed a Food Handler Course on March 21, 2022. The certificate stated the certificate was valid for 3 years from the date of completion. Record review of a document titled, [Company Name] Food Manager Certification Program, certified that the Dietary Manager had successfully completed a Texas Food Safety Manager Certification Examination, effective date 09/09/2024. Record review of facility document titled in-service training attendance roster listed the topic as Charts/Temps and dated 04/09/2024. The attached undated in-service policy titled Food Service stated potentially hazardous food shall be maintained at: 41 degrees or less or 140 degrees or above. The in-service attendance sheet revealed 6 signatures including [NAME] A and the Dietary Manager. Record review of an undated facility policy titled, Daily Food Temperature Control stated we will assure that food is served at a safe temperature. Temperatures of all hot and cold food shall be taken prior to every meal service and recorded on the temperature log. This is done to help ensure that food is safe and served within acceptable ranges. The procedures included all hot foods shall be cooked and held for service at a temperature of 140 degrees F or above.

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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** 48753 Based on interview, observation, and record review, the facility failed to maintain clinical records in accordance with accepted professional standard and practices that are complete and accurately documented for 1 (Resident #5) of 4 residents reviewed for treatment administration. The facility failed to ensure the treatment administration records (TAR) for Resident #5 reflected that the administration of the treatment orders was accurately documented evidenced by the lack of documentation of Resident #5's wound treatments provided on 10/21/2024. This deficient practice could place residents receiving treatments at risk for not receiving appropriate care. The findings were: Review of Resident #5's undated face sheet revealed Resident #5 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes(a condition resulting from insufficient production of insulin, causing high blood sugar) , Chronic Obstructive Pulmonary Disease (a group of lung diseases causing constriction of the airways and difficulty breathing), Cirrhosis of Liver (scarring of the liver typically caused by hepatitis viruses or chronic alcohol abuse), Chronic Pain, Hemiplegia (paralysis of one side of the body), and Vascular Dementia (brain damage typically caused by multiple strokes). Review of Resident #5's quarterly MDS assessment, dated 09/12/2024, reflected Resident #5 had a BIMS score of 13, indicating no cognitive impairment. Section GG, titled Functional Abilities and Goals, reflected Resident #5 was dependent on staff for rolling left and right in bed and dependent for chair/bed transfers. Section M, titled Skin Conditions, reflected Resident #5 was at risk for developing pressure ulcers/injuries and had a pressure relieving mattress. Review of Resident #5's October 2024 TAR, 10/23/2024 at 10:05 a.m., reflected the following orders scheduled for a.m.: A) Wound-cleanse left foot 2nd toe with ns, pat dry, paint with betadine, one time a daily for wound healing. Start date 10/12/2024. B) Wound-cleanse left foot 3rd toe with ns, pat dry, paint with betadine, one time a daily for wound healing. Start date 10/12/2024. C) Wound-cleanse left foot 4th toe with ns, pat dry, paint with betadine, one time a daily for wound healing. Start date 10/12/2024. D) Wound-cleanse right foot 2nd toe with ns, pat dry, paint with betadine, one time a daily for wound healing. Start date 10/12/2024. E) Wound- cleanse right foot 3rd toe with ns, pat dry, paint with betadine, one time a daily for wound healing. Start date 10/12/2024. The TAR for each order was not initialed by a nurse as completed on 10/21/2024. Record review of the facility staffing schedule dated, Monday 10/21/2024, revealed LVN B was assigned to Resident #5's hall on 6 a.m.- 2 p.m. shift then ADON was assigned to the hall at 10:00 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675489	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devine Health & Rehabilitation	104 Enterprise Ave Devine, TX 78016

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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	During an observation and interview with Resident #5, 10/21/2024 at 2:14 p.m., Resident #5 was observed in her room lying in bed with a low air loss mattress. The left side of the bed was up against the room wall. Resident #5's toes were exposed at the end of the bed and Surveyor A observed Resident #5 had abrasions/dried scabs to her 2nd, 3rd and 4th toes on her right foot and on her 2nd and 3rd toes on her left foot. Resident #5 said she had diabetes and could not feel her toes and sometimes would hit them on the wall or scrape them together. Resident #5 said the facility had offered interventions to prevent further abrasions that included moving her bed away from the wall and wearing preventative boots or other items to protect her feet. Resident #5 said the staff pulled her bed away from the wall when turning and repositioning her, but she would not allow them to leave her bed away from the wall. Resident #5 also stated she did not like wearing other things on her feet. Resident #5 said staff were good about providing treatments and her scabs were healing. During an interview with the ADON on 10/23/2024 at 10:30 a.m., the ADON stated she did not perform wound care for Resident #5 on Monday 10/21/2024. The ADON said wound care would have been completed by the charge nurse and she did not know who the charge nurse was on that day. During an interview with the Wound Care NP, 10/23/2024 at 12:37 p.m., the Wound Care NP stated Resident #5 had dry abrasions to her toes that were healing and stated the current treatment was appropriate. The Wound Care NP stated if a wound treatment was missed for one day, it would not have negatively affected Resident #5's healing process. During an interview with LVN B on 10/23/2024 at 2:52 p.m., LVN B stated she worked on 10/21/2024 from 6 a.m. until the ADON took over the shift at 10 a.m. LVN B stated she did not perform wound care for Resident #5 on 10/21/2024 and said she did not tell ADON that wound care had not been completed on Resident #5. LVN A said treatments scheduled for a.m. on the TAR were usually completed before 10 a.m. or 11 a.m. each day. Record review of Resident #5's October 2024 TAR, 10/23/2024 at 3:17 p.m., reflected the ADON had initialed all the blank wound orders for 10/21/2024, marking them as completed. During an interview with Resident #5, 10/23/2024 at 3:35 p.m., Resident #5 said she could not recall if her wound care was completed or not on Monday, 10/21/2024, but stated the nurses were good about doing it daily. During an interview with the ADON, 10/23/2024 at 3:45 p.m., the ADON stated she did not realize she worked as the Charge Nurse on 10/21/2024. The ADON said she recalled doing the treatments for Resident #5 on 10/21/2024 so she completed a late entry on 10/23/2024 and initialed the treatments as completed. The ADON stated she did not document on the TAR when she completed wound care on 10/21/2024 and stated she had been trained on the importance of documenting at the time the care was provided. During an interview with the DON, 10/24/2024 at 11:56 a.m., the DON stated the Charge Nurse assigned to each hall was responsible for providing wound care according to the physician orders on the resident TARS. The DON stated wound care documentation should have been completed at the time the wound care was provided and said the importance of timely documentation was to make sure the physician orders and care was provided as indicated and in a timely manner. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator, 10/24/2024 at 1:21 p.m., the Administrator stated the Charge Nurses were responsible for providing wound care and the nurse managers were to spot check the documentation daily. The Administrator also stated wound care documentation should be completed in a resident's TAR as soon as it is done, on the same shift. Record review of facility policy titled Nursing Facility Medication Administration (Pharmacy Policy and Procedure Manual 2003 PA 03-6.14a), included 3. Medications shall be administered only to the resident for whom they are prescribed, given in accordance with directions on the prescription or the physician's order and recorded on the resident's medication record. Record review of a facility in-service training attendance roster, dated 01/29/2024, titled Medication Administration, contained 6 signatures including the ADON. The facility policy attached to the training attendance roster was titled Medication Administration Procedures (Pharmacy Policy and Procedure Manual 2003 revised 10/25/2017 PA 03-4.02) included all nurses administering medication must sign and initial the designated area of each resident's medication/treatment administration record or resident specific master signature log for identification of all initials used in charting.