STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675792	A. Building B. Wing	11/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansfield Nursing & Rehabilitation Center	1402 E Broad St Mansfield, TX 76063

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one (Resident #1) of three residents reviewed for pressure ulcers. 1. The facility failed to ensure there were PRN wound care orders for Resident #1's Stage 4 sacral pressure ulcer per professional standards of care. 2. The facility failed to ensure Resident #1's dressing was replaced when it became dislodged, allowing the wound to become contaminated with feces. This failure could place residents at risk of developing infections to wounds. Findings included: Record review of Resident #1's undated face sheet reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of Stage 4 pressure ulcer of sacrum. Record review of Resident #1's quarterly MDS, dated [DATE], reflected his BIMS score was not calculated due to his medical condition. His Functional Status assessment indicated he required total assistance from staff for all of his ADLs. His Skin Conditions did not reflect any pressure ulcers. Record review of Resident #1's care plan, dated 09/27/24, indicated he had a Stage 4 pressure ulcer to his coccyx that was being treated by the wound care physician. Record review of Resident #1's physicians orders reflected an order, dated 11/19/24, which reflected: Wound Treatment Order: Location: (sacrum and right buttock) Clean with Normal Saline/Wound Cleanser. Apply:(Dilute 1/4 of Dakins solution onto kerlix). Cover with Primary Dressing:(optiform/bordered dressing). Once A Day 06:00 AM - 06:00 PM Observation on 11/23/24 at 11:00 AM of Resident #1 revealed he was on his back in bed, tracheostomy in place, feeding tube in place with feeding infusing, and a urinary catheter draining amber colored urine. The resident was not responsive to verbal stimulation. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 11/23/24 at 11:40 AM with LVN A revealed Resident #1's pressure ulcer did not have dressing in place. The dressing was not present in the resident's brief, and the pressure ulcer was covered with loose bowel movement. LVN A stated she did not know when the dressing had come off. She stated this was her first assessment of the resident this shift. Observation and interview on 11/23/24 at 12:00 PM with the ADON revealed she agreed the dressing for Resident #1's pressure ulcer was not present in the resident's brief. The ADON stated if the dressing had been removed while providing care because it was soiled or dislodged. She stated the nurse should have been notified immediately, so the dressing could be replaced. Interview on 11/23/24 at 12:05 PM with CNA B revealed she had changed Resident #1's brief, with CNA C assisting, between 7:30 AM and 8:00 AM. CNA B stated the dressing was in place at that time. CNA B stated the resident's brief was only wet, not soiled when she changed it. When CNA B was asked if she had reported the wetness to the nurse, since the resident had a urinary catheter, she stated she did not notify LVN A. She stated LVN A had been assisting her with Resident #1. Interview on 11/23/24 at 12:15 PM with CNA C revealed he had not helped CNA B change Resident #1. Follow-up interview on 11/23/24 at 12:18 PM with LVN A revealed she had not assisted CNA B with changing Resident #1. Observation on 11/23/24 at 12:24 PM with LVN A revealed Resident #1's pressure ulcer had been cleansed of bowel movement. The resident's skin did not appear red or irritated, and the wound measured 10 cm x 15 cm x 4.5 cm. LVN A provided Resident #1 with wound care per the physician order. Telephone interview on 11/23/24 at 1:40 PM with the Wound Care Nurse revealed Resident #1 had returned to the facility from an LTAC facility in September 2024. The Wound Care Nurse stated he had gone to the LTAC after having his tracheostomy placed, with the wound to his coccyx. Prior to his hospital admission and treatment at the LTAC, Resident #1 had no wounds. The Wound Care Nurse stated the Wound Physician thought the wound was healing slowly due to the resident's medical conditions. The Wound Care Nurse stated the nurses knew they were responsible for wound care when she was not present in the facility, and they knew to follow the physician's order for the procedure. Record review of the facility's Wound Care policy, dated June 2022, reflected the policy did not address what to do when the dressing had been dislodged or if the wound had been contaminated with bodily fluids.