STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675797	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER: Weston Inn Nusring and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 2505 S 37th St Temple, TX 76504	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on record review and interview, the facility failed to develop a base line care plan that included the instructions needed to provide effective and person-centered care of the resident for three (Resident #6, Resident #7, and Resident #8) of six residents reviewed for baseline care plans. The facility failed to timely complete a baseline care plan within 48 hours of admission for Residents #6, #7, and #8. This failure could place residents at risk for not receiving care and services to meet their needs. Findings included: Review of Resident #6's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with no documented diagnoses. Review of Resident #6's EMR, on 01/29/25, reflected an admission MDS assessment had not been completed. Review of Resident #6's EMR, on 01/29/25, reflected an admission/baseline care plan had not been completed. Review of Resident #7's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of altered mental status. Review of Resident #7's EMR, on 01/29/25, reflected an admission MDS assessment had not been completed. Review of Resident #7's EMR, on 01/29/25, reflected an admission/baseline care plan had not been completed. Review of Resident #8's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including hypotension (low blood pressure), repeated falls, dementia, and acute respiratory failure. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's EMR, on 01/29/25, reflected an admission MDS assessment had not been completed. Review of Resident #8's EMR, on 01/29/25, reflected an admission/baseline care plan had not been completed. During an interview on 01/30/25 at 4:12 PM, LVN A stated she had done resident assessments but never a baseline care plan. She stated care plans should address the type of transfer assistance the resident required, basic daily needs and goals, or if they had a feeding tube or IV. She stated if a resident did not have a care plan, it would be hard for the nurses to know if they had a peg tube or wound vac. During an interview on 01/30/25 at 5:05 PM, the DON stated admitting nurses were responsible for baseline care plans once the initial assessment was done. She stated areas such as baseline ADLs should be on the baseline care pan. She stated if they were not completed in a timely manner, they would not know how to take care of the resident. During an interview on 01/30/25 at 5:25 PM, the ADM stated the charge nurse was responsible for completing the residents' baseline care plans from their admission assessment, and they should be completed within 48 hours. She stated the baseline care plans should address any basic information to take care of the resident such as their code status, medications, or skin issues. She stated if not done timely, something vital could be missed that could contribute to the care of the resident. Review of the facility's Baseline Care Plans Policy, revised March 2022, reflected the following: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident, including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendation, if applicable.

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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 44317

Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical and nursing needs that are identified in the comprehensive assessment for 2 (Resident #1 and Resident #9) of 4 residents reviewed for comprehensive care plans.

The facility failed to ensure Resident #1's comprehensive care plan included interventions for NPWT to a stage 4 pressure ulcer.

The facility failed to ensure Resident #9's comprehensive care plan included her ADL status, indwelling urinary catheter, stage 4 pressure ulcer to sacrum, communication deficit, and CPAP.

These failures could affect residents by placing them at risk of not receiving necessary care or services to address their specific needs.

Findings included:

Review of Resident #1's face sheet printed on 01/28/25 reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included pressure ulcer of sacral region (between the buttocks) - stage 4, chronic pain, neuromuscular dysfunction of bladder (lack of bladder control due to a nerve problem), paraplegia (paralysis), and type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar).

Review of Resident #1's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 11 indicating moderately impaired cognition.

Section H (Bladder and Bowel) reflected she had an indwelling catheter.

Section M (Skin Conditions) reflected she had an unhealed stage 4 pressure ulcer.

Review of Resident #1's current clinical physician orders reflected an order dated 07/29/24, Change wound vac dressing every MWF and as needed. After removing dressing, apply [cleanser] soaked gauze for 3 minutes, apply topical iodine over wound bed, apply adaptic dressing to wound bed then apply wound vac foam at 150mmHg continuous. Apply Eakin ring around peri wound to prevent stool into wound. Use skin prep to protect skin from dressing. Another order dated 07/29/24 reflected, If wound vac is unable to hold a seal or turned off for 2 hours, remove entire dressing and replace with alginate packing.

Review of Resident #1's Wound Care Progress note, from the wound clinic physician, dated 01/22/25, reflected in part, Resident #1 stated that her wound vac had been changed once weekly. I contacted the ADON at the facility. Resident had a wound vac change that was not done on Friday 01/18/25 but otherwise had her dressing changed 3x/week . Initial sacral wound began April 2022 .She was off NPWT from 06/13/24-07/26/24 . Continue NPWT 125mmHg.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's comprehensive care plan reflected, Problem: The resident has a pressure ulcer stage four to buttocks. NPWT Wound vac is in place (continuous 150mmHg) to promote healing process. Date initiated: 03/24/24 Revision on: 10/18/24. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date. [sic] Date Initiated:03/24/24 Revision on: 09/25/24 Target Date: 04/06/25. Interventions: Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage. Date initiated: 03/24/24. The care plan did not address care or maintenance of the NPWT wound vac. During an observation and interview on 01/27/25 at 10:30 AM, Resident #1 was lying in bed with the head of the bed elevated. She stated she had a bed sore and was supposed to get wound care on Mondays, Wednesdays, and Fridays. The wound vac machine was observed at the bedside. The display on the machine indicated it was powered on and functioning. Review of Resident #9's admission MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility on [DATE]. Section B (Hearing, Speech, and Vision) reflected resident had no speech, was rarely/never understood, and rarely/never understands. Section GG (Functional Abilities) reflected she was dependent on staff for eating, oral hygiene, toileting, bathing, personal hygiene, bed mobility and transfers. She required substantial/maximal assistance for dressing. Section H (Bladder and Bowel) reflected an indwelling urinary catheter. Section I (Active Diagnoses) reflected diagnoses including aphasia (difficulty using or comprehending language), cerebrovascular accident (stroke), chronic lung disease, and other tracheostomy complications. Section M (Skin Conditions) reflected she was at risk for developing pressure ulcers , had no unhealed pressure ulcers/injuries and no venous or arterial ulcers. Section O (Special Treatments, Procedures, and Programs) reflected the use of CPAP. Review of Resident #9's current clinical physician orders reflected the following orders: 01/22/25 Clean stage 4 to sacrum with normal saline, apply calcium alginate, then foam adhesive dressing daily. 01/22/25 Turn every 2 hours for wound healing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/28/24 Pressure reducing cushion to wheelchair and Pressure reducing mattress to bed. O1/28/25 Change urinary catheter and drainage bag monthly. 12/28/24 CPAP at bedtime. Revie of Resident #9's comprehensive care plan reflected in part, Problem: The resident has an ADL self-care performance deficit r/t ___. Date Initiated: 12/28/24. Goal: The resident will improve current level of function in (SPECIFY ADLs) through the review date. Resident will be able to: (SPECIFY) Date Initiated: 01/28/25. Target Date: 03/28/25 Interventions: ORAL CARE: The resident has (SPECIFY: own teeth, upper/lower dentures, broken teeth, carious teeth, sore gums, bridgework). The resident requires oral inspection (SPECIFY FREQ) Report changes to the nurse. Date Initiated: 12/28/24. Problem: The resident has a behavior problem (SPECIFY) r/t__. Date Initiated: 12/28/24. Goal: The resident will have no evidence of behavior problems (SPECIFY) by review date. Date Initiated: 12/28/24 Target Date 03/28/25. Interventions: None. Problem: The resident is/has potential to be (physically/verbally) aggressive (SPECIFY) r/t___. Initiated 12/28/24. Goal: The resident will not harm self or others through the review date. Date Initiated: 12/28/24 Target Date 03/28/25, Interventions: None. The care plan did not address ADL status, the indwelling urinary catheter, the stage 4 pressure ulcer, the CPAP, or the aphasia/communication deficit. During an observation and interview on 01/27/25 at 10:41 AM, Resident #9 was observed lying in bed with the head of the bed elevated. A urinary catheter drainage bag was observed at the bedside. Cartons of tube feed formula were observed at the bedside. Resident was unable to verbalize but family member at bedside confirmed that the resident received tube feeding and that she had a pressure sore on her back side. During an interview on 01/27/25 at 11:42 AM, the ADM stated the MDS Nurse was responsible for care plans. She stated the MDS Nurse was on vacation last week, so the SW was helping with care plans. She stated if they needed something nurse-wise, they should have called the regional nurse for help. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/27/25 at 11:44 AM, the SW stated she scheduled the care plan meetings but did not initiate nursing care plans. She stated the ADON or DON was responsible for the care plans. During an interview on 01/27/25 at 11:56 AM, the MDS Nurse stated the BOM and regional nurse assisted with care plans while she was out last week. She stated the company has a prn MDS person that assists with care plans and MDSs. She stated the previous DON assisted with care plans and sometimes some of the nurses completed care plans. She stated she expected there to be a baseline care plan on everyone within 24 hours of admission. The baseline care plan carried over to the comprehensive care plan once signed off by the RN. She stated she would go back and fill in the blanks on the care plans when she had a chance. During an interview on 01/27/25 at 4:00 PM, the DON stated she expected admission assessments and baseline care plans to be initiated upon admit. She stated she expected comprehensive care plans to be completed timely. She expected the care plans would reflect the needs of the residents. She stated she had been in the building for 6 days and had begun to conduct audits to determine the status and needs of the facility. During an interview on 01/30/25 at 12:09 PM, the MDS Nurse stated the resident's abilities, 1 or 2 person assist, ADLs, chronic pain, fall risk, admission diagnosis, nutrition , wounds, any lines, or ostomy, just about everything should be included on the care plan. She stated it was important to care plan everything so the next shift will know how to care for the resident. She stated there could be many complications if care plans were not accurate. During an interview on 01/30/25 at 12:50 PM, the ADON stated it was her expectation that care plans included a problem, goal, and interventions. She stated everything should be on the care plan, refusals of care, preferences for nail care or wounds, everything. She stated the care plan supports how to take care of the resident. The care plan helps the CNAs know how to care for the residents. During an interview on 01/30/25 at 5:05 PM, the DON stated the care plan contains the information needed to care for the residents. She stated it was her expectation that the comprehensive care plan contained all the stuff needed to care for the resident. During an interview on 01/30/25 at 5:25 PM, the ADM stated comprehensive care plans contained a vast amount of information. She stated she was not clinical and relied on the clinical staff to complete care plans. She stated it was her expectation that anything that contributed to the care of the resident's physical, psychosocial, or mental wellbeing was included. She stated it painted a picture of the whole resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plans, Comprehensive Person-Centered policy revised March 2022, reflected in part, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; e. reflects currently recognized standards of practice for problem areas and conditions. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS 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 - 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** 44317 Based on observations, interviews, and record reviews, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 (Resident # 1 and Resident #9) of 5 Residents reviewed for pressure ulcers. 1. The facility failed to perform wound care to Resident #9's Stage 3 pressure ulcer to right buttock, as ordered, on 01/06/25, 01/09/25, 01/11/25, 01/12/25, 01/14/25, 01/20/25, 1/21/25 and 1/22/25 . Resident #9's wound was infected on 01/16/2025 and got worse from a stage 3 to a stage 4. 2. The facility failed to perform wound care on Resident #9's sacral wound per orders for Resident #9 dated 1/16/2025 until 1/23/2025. Resident #9's wound was infected on 01/16/2025 and got worse from a stage 3 to a stage 4. An Immediate Jeopardy (IJ) was identified on 02/11/25. The template was provided to the facility on [DATE] at 2:30 PM. While the IJ was removed on 02/12/25 at 3:36 PM, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents with pressure wounds at risk of the wound worsening, leading to increased pain, infection, delayed healing, serious complications including sepsis (a serious condition in which the body responds improperly to an infection, causing the organs to work poorly), reduced mobility, and a lower quality of life. 3. The facility failed to change a wound vac dressing to Resident #1's Stage 4 pressure ulcer, as ordered, on 01/12/25 and 01/17/25. Findings included: Review of Resident #9's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of Cerebral infarction (also known as ischemic stroke, occurs as a disruption of blood floor to the brain due to problems with blood vessels that supply it), non-traumatic intracerebral hemorrhage in the brain stem (focal bleeding from a blood vessel in the brain) Review of Resident #9's admission MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility on [DATE]. Section GG (Functional Abilities) reflected she was dependent on bed mobility and transfers. Section I (Active Diagnoses) reflected diagnoses including aphasia (difficulty using or comprehending language), cardiovascular accident (stroke), chronic lung disease, and other tracheotomy (surgically created hole, also called a stoma in your windpipe) complications. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Section M (Skin Conditions) reflected she was at risk for developing pressure ulcers/injuries, had no unhealed pressure ulcers/injuries and no venous or arterial ulcers. Review of Resident #9's Comprehensive Care Plan, initiated 12/28/24 and revised on 01/28/25 reflected it did not address the pressure injury/ulcer ., meaning, Resident #9 was not admitted with pressure injury. Review of Resident #9's skin assessment dated [DATE] reflected the resident had excoriation (wear of the skin often caused by scratching, rubbing, or friction against the skin surface) at right buttock measuring 3 x 6 cm. Review of Resident #9's TAR reflected: Wound Care Consult as indicated, one time only for skin breakdown for 7 Days -Start Date- 12/29/2024. Review of Resident #9's NP's progress notes dated 01/03/2025 reflected: Chief Complaint/Reason for this Visit - wound. New wound to buttocks presents today, stage 3. Wound care referral provided. Stage 3 pressure ulcer: Wound care referral, continue wound care as prescribed. Review of Resident #9's Physician orders dated 01/03/2025 reflected a referral to be seen by wound care doctor. Clean stage 3 to right buttock with normal saline, apply hydrocolloid dressing daily one time a day Supplementary. Key: Drainage: Saturated/Moist/Dry General Appearance: Red/Yellow/Pink/Black/Green/Whit e/Tan/Purple/Brown/Gray Surrounding Skin: Macerated/Reddened/Firm/Normal -Start Date- 01/04/2025 Review of Resident #9's January 2025 MAR/TAR reflected an order dated 01/04/25 and discontinued on 01/20/25, Clean stage 3 to right buttock with normal saline, apply hydrocolloid dressing daily. The dressing change was not documented on 01/06/25, 01/09/25, 01/11/25, 01/12/25, 01/14/25 , and 01/20/25 . It was also reflected there was no wound care order in place for 01/21/25 and 01/22/2025. Review of Resident #9's skin assessment dated [DATE] reflected pressure at right buttocks. Review of Resident #9's clinical records reflected Resident #9 was not seen by the Wound Doctor until 1/16/2025 since the referrals were made on 12/29/2024 and 1/03/2025. Review of Resident #9's Wound Doctor's notes dated 1/16/2025 reflected: LOCATION: Sacro coccyx Extending to Bilateral Buttocks ETIOLOGY: Pressure Injury/Ulcer - Wound Stage: 4 - Pressure Injury PREOPERATIVE INDICATIONS: Necrotic tissue, infected tissue, slough , and drainage (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	SIGNS OF INFECTION: Pain, foul odor, erythema (redness to the skin), and purulent(pus) drainage WOUND DESCRIPTION: UNDERMINING: 2 cm at 12 o'clock EXUDATE: Copious, purulent, and sanguineous PERIWOUND: Erythematous (redness to the skin due to the accumulation of blood in dilated capillaries) WOUND EDGE: Friable (thin skin) DRESSING USED: Calcium Alginate and Bordered Gauze Review of Resident #9's MAR/TAR for January 2025 reflected Resident #9 was treated with the following antibiotics for wound infection: Doxycycline Hyclate Tablet 100 MG Give 1 tablet via PEG-Tube (a medical device use to provide nutrition and hydration directly to the stomach, also known as G-tube) two times a day for wound infection for 14 Days -Start Date- 01/16/2025 -D/C Date- 01/22/2025. Cipro Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet via G-Tube two times a day for wound infection for 7 Days -Start Date- 01/22/2025. Clindamycin HCl Oral Capsule 300 MG (Clindamycin HCl) Give 2 capsule via G-Tube every 8 hours for wound infection for 7 Days -Start Date- 01/22/2025. Review of Resident #9's TAR reflected orders from Wound Doctor's visit from 01/16/2025 for Resident #9's wounds were not implemented until 1/23/2025. Review of Resident #9's clinical physician orders reflected an order dated 01/22/25 , Clean stage 4 to sacrum with normal saline, apply calcium alginate, then foam adhesive dressing daily. During an observation and interview on 01/27/25 at 10:30 AM, Resident #1 was lying in bed with the head of the bed elevated. The wound vac machine was observed hanging at the bedside. She stated she had a bed sore and was supposed to get wound care on Mondays, Wednesdays, and Fridays but they did not always change the wound vac dressing when they were supposed to. She stated the nurse had just changed the wound vac dressing a short time ago. During an observation and interview on 01/27/25 at 10:41 AM, Resident #9 was observed lying in bed with the head of the bed elevated. Resident was unable to verbalize but family member at bedside confirmed that the resident had a pressure sore on her back side and was dependent on staff for repositioning. The family member stated she had not seen the wound and did not know if it was worsening. During a telephone interview on 01/27/25 at 3:36 PM, the Medical Director stated the nurses should, follow up on wound care. He stated he was familiar with NPWT, usually the settings come from the hospital or wound care doctor. He expected orders to be followed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/27/25 at 4:00 PM, the DON stated she expected wound vacs to be maintained, and she expected that staff had been trained. She stated she was not sure if there were any competencies for the wound vacs. The DON stated she had been in the building for only 6 days and was not yet familiar with everything. She stated she did not know if agency nurses had been trained on the wound vac. She stated she expected wound care to be completed as ordered and documented. She stated not performing wound care as ordered could lead to infection or delay healing. During an interview on 01/28/25 at 12:04 PM the ADON stated she had observed RN B change a wound vac dressing but she had not received hands-on training on actual wound vac device. She stated it was her expectation that wound care was provided as ordered. If it was not documented, it did not happen. She stated it did not meet her expectations that dressing changes were missed. She stated she had talked with Resident #1's wound care doctor about one missed dressing change. During an interview on 01/30/25 at 12:09 PM, the MDS Nurse stated it was her expectation that all treatments were documented when given. She stated if it was not documented, it did not happen. She stated everything had to be documented to give a picture of what is going on with the resident. She stated documentation was important because the doctor needed to know, if it went to court you needed to know, so you had to document everything. During an interview on 01/30/25 at 12:50 PM, the ADON stated it was her expectation that residents were assessed, and it was documented. She stated regarding wound care, she expected the old dressing was assessed, the wound was assessed, and the resident's response to the treatment was assessed and all of that was documented. She stated wounds should be measured and wound vac settings documented. She stated there needed to be a paper trail to inform the doctor and the insurance of the resident's status. She stated not providing wound care could cause wounds to worsen. During an interview on 01/30/25 at 3:07 PM, LVN E stated it was important to follow the physician orders, such as wound care. She stated treatments were ordered for a reason. She stated wound care was documented when the care was provided. Not providing wound care could cause worsening or more wounds. During an interview on 02/11/2025 at 10:11 am the Wound Doctor stated that he has been seeing Resident #9 for wound care to the sacral wound. He stated he first saw Resident #9 on 1/16/2025, at which point he described the wound as a fairly large sacral wound that was fairly necrotic and draining pus, unstageable (a pressure ulcer that is cover with necrotic tissue or eschar making it hard to stage or treat), necrotic, once the necrotic tissue was removed over the wound bed, it was immediately a Stage IV pressure ulcer due to the depth of the wound. The Wound Doctor stated, following his assessment of the wound, he started Resident #9 on antibiotics (Doxycycline) for the infection, initially, which was later changed by the primary doctor. The wound Doctor stated, missing wound care can cause problems, like worsening of the wound. The Wound Doctor stated it was his expectation that wound care be done daily as ordered, unless otherwise specified. The Wound Doctor stated Resident #9's comorbidities that might affect wound healing were right hemiparesis, weakness, less mobility, and offloading was a big deal with her wound, less able to feel pain. He also stated nutritional wise, Resident #9 was good. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weston Inn Nusring and Rehabilitation	2505 S 37th St Temple, TX 76504

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interview on 2/11/25 at 11:38 am, RN B stated she was ADON for the period in question from 12/28 2024 through 1/23/2025 and made rounds with the Wound Doctor on his visits. She stated the ADON was responsible for monitoring wound progress. She stated it was the expectation that wound care orders be put in the Resident's chart right after the wound Doctor's visit. She stated she did not know why the Wound Doctor was not notified between 1/3/25 to 1/16/25 of the wound consultation for Resident #9. She stated she did not know why the new wound care orders for Resident #9 from the Wound Doctor visit on 1/16/25 were not updated in Resident #9's chart until 1/23/25. She stated that if wound care consult was not given to the Wound Doctor when he was in the building, they would have to wait until the following week as they did not have a way to contact the Wound Doctor between visits. RN B stated if the residents were not seen by the wound doctor timely and the wound care orders were not implement as ordered, the resident's wounds would get worse. RN B stated Resident #9 was not able to move herself from side to side without assistance from staff. RN B stated she worked with Resident #9 on 1/22/2025 but could not state why wound care for Resident #9 was not done on 01/22/2025. Attempts made on 02/11/2025 at 12:37 PM to contact LVN M, the nurse assigned to Resident # 9 on 1/9/2025 but to no avail , a voice message was left. During a phone interview on 02/11/2025 at 12:39 PM, LVN N, the nurse assigned to Resident #9 on 1/21/2025, stated she worked with an agency and only worked 1 shift at the facility. LVN N stated she could not remember Resident #9, but she did a couple of wound cares on the day that she worked at the facility. LVN N stated if she didn't sign or document on the MAR/TAR that means the treatment was not done. During a phone interview on 2/11/2025 at 01:37 PM, LVN A, the nurse assigned to Resident #9 on 01/06/2025, 1/11/2025, 1/12/2025, 01/14/2025 and 1/20/2025, stated she worked with Resident #9, and Resident #9 required daily wound care and the need to be repositioned every two hours. LVN A stated she was responsible for wound care on her shift as a nurse. LVN A stated she performed wound care on Resident #9 on the days she worked with the Resident except for when the Wound Doctor was making his rounds but was unable to recall the dates, she worked with Resident #9 or the dates wound care was completed for the resident. LVN A stated that without documentation of care, it wound suggest the wound care was not done. LVN A stated that providing necessary care to residents and documenting their care was part of quality nursing care and could be neglect if it was not done. Resident #9 was not seen by the Wound Doctor until 1/16/2025 and the Wound Doctor did not visit the facility on 1/20/2025. During an interview on 02/11/2025 at 3:20 PM the Nurse Consultant stated the DON was out sick and she was in place of the DON. she stated that her expectations for physician orders were that they would be implemented and followed. The Nurse Consultant stated wound care orders should be implemented as soon as possible, at the latest, the following morning to enable the resident to receive care ordered by the following morning. The Nurse Consultant stated the Residents could have a negative outcome, such as worsening of a wound, if new orders were not implemented timely. The Nurse Consultant stated that Residents could have negative outcome, such as worsening of a wound, if wound care was not performed as ordered. The Nurse Consultant stated that if a nurse does not document care, then it was not done. (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 the facility's Charting and Documentation policy, revised July 2017, reflected in part, Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation: 2. The following information is to be documented in the resident medical record: 2. a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 7. Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided, b. The name and title of the individual(s) who provided the care, c. The assessment data and/or any unusual findings obtained during the procedure/treatment, d. How the resident tolerated the procedure/treatment, e. Whether the resident refused the procedure/treatment; f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting. Review of the facility's Pressure Ulcers/Skin Breakdown - Clinical Protocol revised April 2018, reflected in part, Assessment and Recognition: 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses. The policy did not address providing wound care as ordered. The Administrator was notified on 02/11/2025 at 2:30 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 02/12/2025 at 12:41 PM: Plan of Removal Immediate Jeopardy On 01/27/2025 an abbreviated survey was initiated at the facility. On 02/11/2025 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. Date Initiated: 02/11/2025. The notification of Immediate Jeopardy states as follows: F686 - The facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Statement of Deficient Practice: All residents who require wound care could be at risk for potential negative effects. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Upon learning the facility failed to ensure residents with pressure ulcers received necessary treatment and services facility had wound physician complete rounds on resident who have consented. All other wound treatments not ref erred or consented to wound care physician will be directed by primary care until otherwise directed by primary physician. Nurse Consultant and Director of Clinical Services have conducted an audit to ensure all wounds identified have a current treatment in place. Responsible Party: DON/ADON, Target date: 2/11/2025 Follow up: Monitor for completion through morning meeting process. 2. Nurse Consultant and Director of Clinical Services provided in- service education to all nursing staff currently on shift regarding following physician ordered wound care and documentation of wound care. Responsible Party: DON/ADON, Target date: 2/11/2025 Follow up: Provide ongoing education to all new hires, agency, prn leave of absence prior to first shift worked and Follow WE CARE meeting process to ensure compliance. 3. All nursing staff will be provided with in-service following physician ordered wound care and documentation of wound care prior to next shift worked, including new hires, PRN, Vacation, Agency and Leave of Absence staff. Responsible Party: DON/ADON or Designee Target date: 2/11/2025 and ongoing Follow-up: Follow WE CARE meeting process to ensure compliance. 4. Identify any new wounds through orders, weekly skin assessments and admission assessments review completed during clinical morning meeting will be referred to primary care physician and wound care physician if ordered by primary care physician. Responsible Party: IDT Team Target date: 2/11/2025 and ongoing Follow-up: Follow WE CARE meeting process to ensure compliance. 5. Wound care physician will be notified via telephone by DON or designee when wound care consultation is ordered. Responsible Party: IDT Team (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/12/2025 at 2:54 PM the Administrator stated she was in-serviced by the Nurse Consultant on 02/12/2025 and she was in-servicing nurses at the beginning of their shifts on treatment orders, what to do if they identify new wounds. The Administrator stated the facility already identified all the wounds in the facility, they made sure the new wounds identified by the facility staff were seen by the Wound Doctor on 2/11/2025, made sure there were treatments in place and accurate, was verified by the Nurse Consultant and the Regional Director. The Administrator stated the facility would monitor through their daily morning meeting and the weekly WE Care meeting . The DON stated part of the morning meeting process, they would check the clinical dashboard to make sure treatment had been completed. The Administrator stated the Wound Doctor's contact was in PCC in the Resident's chart. The Administrator stated the DON was responsible to ensure treatments were done and she would designate someone in her absence of the DON. Review of Wound Doctor's visit orders dated 2/11/2025 reflected all new orders were in the Residents charts. Review of facility's in-services reflected in-services were initiated on 02/11/2025 at 5:35 PM with attached documents of: Medication orders, Pressure Ulcers/Skin breakdown-clinical Protocols: Receiving and Transcribing physician orders-Treatment Orders Physician Referrals-Wound assessment and Management Wound treatment documentation-Complete documentation and monitoring Review of facility's Quality Assurance Performance Improvement Committee document reflected QAPI had a meeting on 02/11/2025 to discuss IJ regarding wound care treatment orders. The Administrator was notified on 02/12/2025 at 3:36 PM that the IJ had been removed. While the IJ was removed on 02/12/25 at 3:36 PM, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. 3. Review of Resident #1's face sheet printed on 01/28/25 reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] after an overnight stay in the emergency room . Her diagnoses included pressure ulcer of sacral region (between the buttocks) - stage 4, chronic pain, neuromuscular dysfunction of bladder (lack of bladder control due to a nerve problem), paraplegia (paralysis), and type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar). Review of Resident #1's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 11 indicating moderately impaired cognition. Section GG (Functional Abilities) reflected she required substantial/maximal assistance with bed mobility. Section M (Skin Conditions) reflected she had an unhealed stage 4 pressure ulcer. (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 Resident #1's current clinical physician orders reflected an order dated 07/29/24, Change wound vac dressing every MWF and as needed. After removing dressing, apply [cleanser] soaked gauze for 3 minutes, apply topical iodine over wound bed, apply adaptic dressing to wound bed then apply wound vac foam at 150mmHg continuous. Apply Eakin ring around peri wound to prevent stool into wound. Use skin prep to protect skin from dressing. Another order dated 07/29/24 reflected, If wound vac is unable to hold a seal or turned off for 2 hours, remove entire dressing and replace with alginate packing. Review of Resident #1's January 2025 MAR and TAR reflected the wound vac dressing was not changed on 01/13/25 and 01/17/25 . Review of Resident #1's comprehensive care plan reflected in part: Problem - Last revised 10/18/24 - The resident has a pressure ulcer stage four to buttocks. NPWT wound vac is in place (continuous 150mm Hg) to promote healing process. Goal - The residents pressure ulcer will show signs of healing and remain free from infection. Interventions - Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage. The care plan was not revised to reflect the current order for 125mmHg. Review of Resident #1's Wound Care Progress note, from the wound clinic physician, dated 01/22/25, reflected in part, Resident #1 stated that her wound vac had been changed once weekly. I contacted the ADON at the facility. Resident had a wound vac change that was not done on Friday 01/18/25 but otherwise had her dressing changed 3x/week . Initial sacral wound began April 2022 .She was off NPWT from 06/13/24-07/26/24 . Continue NPWT 125mmHg. During a brief interview on 01/27/25 at 3:30 PM with the ADM, a policy for wound vacs and nursing competencies for wound vacs were requested. A policy for wound vacs was not received prior to exit.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #5) of six residents reviewed for pain. The facility failed to provide effective pain management for Resident #5 while she resided at the facility from 01/17/25 - 01/27/25. She had a recently acquired amputation that caused her to be in excruciating pain. The facility did not adjust her pain medication or notify her NP. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 01/29/25 at 4:04 PM and an IJ template was given. While the IJ was removed on 01/30/25 at 6:15 PM, the facility remained out of compliance at a level of 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 placed residents at risk for prolonged and unnecessary pain and suffering and a decreased quality of life. Findings included: Review of Resident #5's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including type II diabetes, major depressive disorder, chronic pain, and acquired absence of left leg above the knee. Review of Resident #5's EMR, on 01/29/25, reflected her Admission MDS assessment had not been completed. Review of Resident #5's admission care plan, dated 01/17/25, reflected she had acute pain related to left AKA and sacroiliitis (a painful condition which affects both sacral joints) with an intervention of monitoring/documenting for side effects of pain medication and notifying the physician if interventions were unsuccessful. Review of Resident #5's physician order, dated 01/17/25, reflected Hydrocodone-Acetaminophen Oral Tablet-325 MG - Give 1 tablet by mouth every 8 hours as needed for pain. Review of Resident #5's MAR , dated January 2025, reflected she was administered the medication (Hydrocodone-Acetaminophen) on the following days with the pain level (numerical) and effectiveness documented (pain level from 1-10): 01/17/25 at 10:36 PM - Pain Level 7 - Ineffective 01/18/25 at 4:30 AM - Pain Level 6 - Effective 01/18/25 at 10:03 PM - Pain Level 10 - Unknown if effective (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	01/19/25 at 8:40 AM - Pain Level 8 - Ineffective 01/19/25 at 4:40 PM - Pain Level 10 - Effective 01/20/25 at 10:50 PM - Pain Level 7 - Effective 01/21/25 at 11:25 AM - Pain Level 8 - Effective 01/22/25 at 10:15 AM - Pain Level 6 - Effective 01/26/25 at 3:47 AM - Pain Level 8 - Effective 01/26/25 at 5:55 PM - Pain Level 9 - Effective Review of Resident #5's physician order, dated 01/17/25, reflected Tylenol Oral Tablet - 325 MG - Give 2 tablets by mouth every 6 hours as needed for pain. Review of Resident #5's MAR, dated January 2025, reflected she was administered the medication (Tylenol) on the following days with the pain level (numerical) and effectiveness documented: 01/19/25 at 7:18 PM - Pain Level 8 - Effective 01/20/25 at 7:48 AM - Pain Level 4 - Effective 01/21/25 at 2:07 PM - Pain Level 3 - Effective Review of Resident #5's physician order, dated 01/18/25, reflected Buprenorphine Transdermal Patch Weekly 10 MCG/HR - Apply 1 patch transdermally one time a day every 7 day(s) for pain. Review of Resident #5's MAR, dated January 2025, reflected she only received the patch on 01/18/25. Review of an intake reported to HHSC, dated 01/24/25, reflected the following regarding Resident #5: RP and [Resident #5] report that at night when the CNAs [CNA G and CNA H] come in to provide care that they are rough with her and when she tells them she is hurting they will say we are not hurting you. Review of Resident #5's ER paperwork, dated 01/27/25, reflected the following: Reason for Admission: s/p Lt AKA pain . Left AKA stump wrapped, [Resident #5] intolerable of pain and refused exam on leg . . On exam, [Resident #5] has intractable pain . Patient uncomfortable and histrionic on exam per documentation. Left AKA stump with purulent drainage, mild skin necrosis . (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	. [Resident #5] was discharged on the 17th to a skilled nursing facility and had increasing pain in her AKA site. [Resident #5] gets dialyzed Monday Wednesday Friday but apparently missed Friday's dialysis due to the pain . During a telephone interview on 01/29/25 at 1:12 PM, CNA G stated if a resident was complaining of pain, she would tell the nurse. She stated she remembered providing care to Resident #5 (on 01/23/25) and knew she had a fresh amputation so she understood she would be in pain. She stated she was swinging at us (she and CNA H) because of the pain she was in during peri care . She stated RN J knew how much pain she was in because she had gone in and out of the room. She stated she was not sure if RN J gave her medication or what medication could have been given because she was just a CNA and did not know about medications. She stated it took CNA H and herself at least 30 minutes to provide the care due to the amount of pain Resident #5 was in. She stated they were not purposely trying to hurt her but had to get her clean. Review of Resident #5's progress notes, on 01/29/25, reflected no documentation regarding the pain during peri care on 01/23/25 . Pain medication was not administered to Resident #5 until 01/26/25. During a telephone interview on 01/29/25 at 1:34 PM, Resident #5's NP stated she had never expressed pain to her. She stated she would expect nursing staff to notify her if pain was not being managed or if pain medications were not effective. She stated she could have done something about it. She stated Buprenorphine patch orders should be followed. She stated if the order was for every seven days, it should be changed every seven days as it would no longer be effective. She stated a negative outcome of being in uncontrolled pain could be high blood pressure, heavy breathing, or anxiety. She stated Resident #5 was always anxious. During a telephone interview on 01/29/25 at 2:46 PM, Resident #5's RP stated he believed the staff agreed the pain medication was not sufficient while she was at the facility, but they were just following the orders given. He stated her severe pain never subsided the whole time she was at the facility. He stated she recently (01/28/25) had to have a procedure where they put a tube in her wound (incision site) to drain it due to an infection. He stated the infection had been causing her even more pain. An attempt was made to interview RN J on 01/29/25 at 3:04 PM. A returned call was not received prior to exiting. Review of the facility's Pain Policy, Revised October 2022, reflected the following: . The staff will assess the individual's pain and related consequences at regular intervals, at least each shift for acute pain or significant changes in levels of chronic pain. . If the resident's pain is complex or not responding to standard interventions, the attending physician may consider additional consultative support. The ADM was notified on 01/29/25 at 4:04 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 01/30/25 at 10:47 AM: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The notification of Immediate Jeopardy states as follows: F697 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Statement of Deficient Practice: The facility failed to provide effective pain interventions for Resident #5. CORRECTIVE ACTION: 1. Upon learning of the deficient practice the Regional Director of Clinical Services and Nurse Consultant began a review of residents charts for pain assessment orders . RESPONSIBLE PARTY: RDCS TARGET DATE: 1/29/25 FOLLOW-UP: Monitor for completion through morning meeting process. CORRECTIVE ACTION: 2. DON began inservice education for all nurses currently on shift regarding pain assessments for all resident each shift to include acute pain or significant changes in levels of chronic pain and when to notify the physician regarding pain not being managed by regimen in place and how to conduct a pain assessment properly. Nursing Administration will complete a second pain assessment on 5 residents twice weekly for 3 months to ensure proper assessment of resident pain and level of nurse proficiency. Regional Director of Clinical Services and Nurse Consultant have conducted a pain assessment on each resident currently in the facility and residents will be continued to be assessed q shift ongoing. No residents have been identified at this time for uncontrolled pain. RESPONSIBLE PARTY: DON TARGET DATE: 1/29/25 FOLLOW-UP: Provide ongoing education to all new hires, agency, prn, leave of absence prior to first shift worked. CORRECTIVE ACTION: 3. All licensed nursing staff will be provided with in-service education on regarding pain assessments for all resident each shift to include acute pain or significant changes in levels of chronic pain and when to notify the physician regarding pain not being managed by current regimen prior to next shift worked, including new hires, PRN, Vacation, Agency and Leave of Absence staff. RESPONSIBLE PARTY: DON/ADON or Designee. TARGET DATE: 1/29/25 and ongoing. FOLLOW-UP: Review daily staffing to ensure compliance. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	CORRECTIVE ACTION: 4. Confirm that pain assessment order was placed on the resident chart for all new admissions, readmissions or new complaints RESPONSIBLE PARTY: DON/ADON or Designee TARGET DATE: 1/29/25 and ongoing. FOLLOW-UP: Follow morning meeting process to ensure compliance CORRECTIVE ACTION: 5. Review all residents currently identified for increased or change in pain weekly during WE CARE clinical meeting to confirm ongoing interventions and physician notification. RESPONSIBLE PARTY: IDT Team TARGET DATE: 1/29/25 and ongoing. FOLLOW-UP: Follow WE CARE meeting process to ensure compliance. CORRECTIVE ACTION: 6. AD HOC QAPI meeting conducted to discuss plan of correction for compliance. RESPONSIBLE PARTY: IDT Team TARGET DATE: 1/29/25 FOLLOW-UP: Review any compliance issues in QAPI meetings for 3 months CORRECTIVE ACTION: 7. Medical Director notified of alleged deficient practice. RESPONSIBLE PARTY: Administrator TARGET DATE: 1/29/25 The Investigator monitored the Plan of Removal on 01/30/25 as followed: During interviews conducted on 01/30/25 between 11:13 AM and 6:06 PM, 3 rehab therapists, 2 RNs, 6 LVNs, and 11 CNAs from both shifts stated they were in-serviced on pain. They all stated that if any resident complained of pain during care, they would stop immediately. The CNAs and therapists said they would notify the nurse immediately. The CNAs said they would tell the nurse and give the nurse a written note as a reminder. The nurses stated they would assess the resident every shift and with every complaint of pain. The nurses stated they would provide pain medication and follow up to ensure effectiveness. They stated if the medication was not effective, they would notify the doctor or nurse practitioner. Review of the facility's QAPI agenda, dated 01/29/25, reflected the MD, ADM, DON, ADON , MDS Nurse, SW, and Licensed Nursing Staff were in attendance. Review of an in-serviced entitled Pain, dated 01/29/25, reflected all nursing staff were in-serviced on their pain policy and the following: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Monitor for pain every shift. Document pain/pain levels. Complete pain assessment if resident has pain. Provide medication if needed. If resident does not have pain meds notify MD/NP and document in EMR. CNA and Nurse will stop ADL, wound care, etc. and resident must be assessed and medication for pain. Activity resume with medication. Review of the WE CARE documentation form, revised 04/2023, reflected the form identified the procedure for conducting the meeting and the information to be reviewed. The information included pain and how the ADON or designee would review PRN pain medication documentation in [EMR system] for residents taking pain medications consistently. The facility had not had their weekly WE CARE meeting prior to exit. The ADM was notified the IJ was lowered on 01/30/25 at 6:15 PM. However, the facility remained out of compliance at a level of 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.

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 42949

Based on interviews and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 (Resident #10 and Resident #11) of 6 residents reviewed for medications and pharmacy services.

The facility failed to ensure Resident #10's Calcium, Fluorometholone Ophthalmic Suspension, Lidoderm Patch 5%, Valacyclovir, Carvedilol, Revatio, and levothyroxine were administered according to the physician's orders.

The facility failed to ensure Resident #11's Atorvastatin, Latanoprost Ophthalmic Solution, and Levothyroxine were administered according to the physician's orders.

These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a potential for decreased health status and decreased quality of life.

Findings included:

Review of Resident #10's face sheet printed on 01/28/25, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included effusion left knee (swelling of the tissues around a joint due to extra fluid), Chronic respiratory failure with hypoxia (not enough oxygen in the blood), chronic obstructive pulmonary disease (a lung disease limiting air flow from the lungs), and heart disease.

Review of Resident #10's EMR on 01/27/25, reflected an admission MDS assessment had not been created.

Review of Resident #10's BIMS assessment dated [DATE], reflected a score of 15 indicating intact cognition.

Review of Resident #10's current clinical physician orders reflected:

01/19/25 Calcium 600 mg oral tablet by mouth one time a day with meal

01/19/25 Fluorometholone Ophthalmic suspension 0.1% Instill 1 drop in left eye one time a day for Ophthalmic agent.

01/18/25 Lidoderm Patch 5% Apply to left knee topically in the morning for left knee pain.

01/18/25 Valacyclovir HCl tablet 500 mg give two tablets by mouth one time a day for cold sores, shingles, or genital herpes for 7 days.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/24/25 Biofreeze Cool the Pain External gel 4% apply to right thigh topically two times a day for pain. 01/18/25 Carvedilol tablet 3.125mg give one tablet by mouth two times a day for hypertension with meal. Hold if SBP less than 110 and Heart Rate less than 60. 01/18/25 Revatio Oral Tablet 20mg Give 20 mg by mouth three times a day for pulmonary atrial hypertension. 01/28/25 Levothyroxine 137 mcg give one tablet by mouth one time a day for low thyroid hormone. Review of Resident #10's January 2025 MAR reflected missed administration of the following - Calcium 600mg on 01/19/25. Fluorometholone Ophthalmic suspension on 01/19/25 and 01/20/25. Lidoderm Patch 5% on 01/19/25 and 01/20/25. Valacyclovir HCl on 01/19/25. Biofreeze gel 4%on 01/24/25 and 01/26/25. Carvedilol 3.125mg on 01/20/25. Revatio 20mg twice on 01/19/25 once on 01/20/25 and twice on 01/24/25. Levothyroxine 137 mcg on 01/19/25 and 01/20/25. Review of Resident #10's care plan reflected in part, Problem: Thyroid therapy to treat hypothyroidism is at risk for adverse effects. Date Initiated: 01/28/25. Goal: Will have no adverse side effects related to thyroid therapy until next review date. Date Initiated: 01/28/25. Target Date: 04/28/25. Interventions: Administer medication per physician orders. Date Initiated: 01/28/25. Monitor for signs and symptoms of adverse effects and report any changes to physician. Date Initiated: 01/28/25. Obtain labs as ordered, notify physician of results. Date Initiated: 01/28/25. Problem: The resident has altered respiratory status/difficulty breathing r/t obstructive sleep apnea. Date Initiated: 01/28/25. Goal: The resident will maintain formal breathing pattern as evidenced by normal respirations, normal skin color and regular respiratory rate/pattern through the review date. Date Initiated: 01/28/25. Target Date: 04/28/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions: Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Date Initiated: 01/28/25. Monitor for s/sx respiratory distress . Review of Resident #11's face sheet printed on 01/27/25, reflected an [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Her diagnoses included other diseases of stomach and duodenum (first part of the small intestine), malnutrition, surgical aftercare following surgery on the digestive system, dry eye syndrome, atherosclerosis of aorta (arteries narrowed and hardened due to buildup of plaque), and osteoporosis (brittle bones). Review of Resident #11's admission MDS assessment dated [DATE] Section C (Cognitive Patterns) reflected a BIMS assessment was not completed. Staff assessed resident as no short-term memory impairment, and independent in decision making. Review of Resident #11's clinical physician orders reflected: 12/12/24 Atorvastatin Calcium oral Tablet 10mg give one tablet by mouth at bedtime for hyperlipidemia. 12/12/24 Latanoprost Ophthalmic Solution 0.005% Instill 1 drop in both eyes at bedtime for macular degeneration. 12/12/24 Levothyroxine Sodium Tablet 137mcg give one tablet by mouth one time a day for low thyroid hormone. Review of Resident #11's December 2024 MAR reflected missed administration of the following - Atorvastatin 10mg on 12/12/24. Latanoprost Ophthalmic Solution on 12/12/24. Levothyroxine Sodium 137mcg on 12/13/24. Review of Resident #11's baseline care plan reflected in part, Problem: Thyroid therapy to treat (specify), is at risk for adverse effects. Date Initiated 12/13/24. No goal or interventions. During an observation and interview on 01/27/25 at 10:52 AM, Resident #10 was lying in bed with the HOB elevated. She stated they had a meeting last week and the complaints she had finally got taken care of. She stated she got a new bed, a phone in the room, and little rails to help with turning in bed. She stated she had been getting her meds, but she was not sure if she was getting everything she was supposed to. During an interview on 01/28/25 at 12:04 PM, the ADON stated she expected medications to be administered as ordered. They do have a supply of common medications available if needed. She stated if a medication was not administered, the resident would not get the intended effect. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/30/25 at 12:09 PM, the MDS Nurse stated every med given was documented in the MAR. If the resident had difficulty taking the med the nurse needed to document that in a progress note. She stated if a couple times a med was missed, the doctor or nurse practitioner was notified. She expected effectiveness of prn medications to be documented. She stated missed doses could cause lab levels to be off, or if it were a missed seizure medication, it could cause the resident to have a seizure. She stated if the medication was not documented, it was not given. During an interview on 01/30/25 at 12:50 PM, the ADON stated it was her expectation that medications were documented when administered. If a medication was not given, the reason for not giving it needed to be documented. She stated if it was not documented, it was not given. She stated negative effects from not receiving a medication would depend on the missed med, such as missing blood thinners could cause blood clots, missed antibiotics could cause infection to linger or build resistance to the med. A policy for medication administration was requested. During an interview on 01/30/25 at 5:25 PM, the ADM stated she expected medications to be administered as ordered. Review of the facility's Medication Orders policy revised November 2014, reflected in part, Purpose: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. The policy did not address administration or documentation of the administration. A policy on medication administration was requested from the ADM at entrance on 01/27/25. The policy was not received prior to exit.

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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 - Some	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** 42949 Based on interview and record review, the facility failed to ensure that medical records were accurately documented for three (Resident #6, Resident #7, and Resident #8) of six residents reviewed for accurate medical records. The facility failed to document nursing notes in Residents #6's, #7's, and #8's EMR for multiple days after they were admitted to the facility. This deficient practice could result in errors in care and treatment. Findings included: Review of Resident #6's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with no documented diagnoses. Review of Resident #6's EMR, on 01/29/25, reflected an admission MDS assessment had not been created. Review of Resident #6's EMR, on 01/29/25, reflected an admission/baseline care plan had not been created. Review of Resident #6's progress notes in his EMR, on 01/29/25, reflected no nursing documentation. Review of Resident #7's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of altered mental status. Review of Resident #7's EMR, on 01/29/25, reflected an admission MDS assessment had not been created. Review of Resident #7's EMR, on 01/29/25, reflected an admission/baseline care plan had not been created. Review of Resident #7's progress notes in his EMR, on 01/29/25, reflected no nursing documentation. Review of Resident #8's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including hypotension (low blood pressure), repeated falls, dementia, and acute respiratory failure. Review of Resident #8's EMR, on 01/29/25, reflected an admission MDS assessment had not been completed. Review of Resident #8's EMR, on 01/29/25, reflected an admission/baseline care plan had not been created. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's progress notes in his EMR, on 01/29/25, reflected no nursing documentation. During an interview on 01/30/25 at 4:12 PM, LVN A stated residents should have, at the minimum, a daily skilled note in their EMRs. She stated it would not be okay for there to be no documentation in a resident's chart because the nurses would not know their status, and the resident could go without pertinent care. During an interview on 01/30/25 at 5:05 PM, the DON stated the residents' progress notes should reflect whatever was going on at that time, any changes in medication or condition. She stated it was important so other staff members could look at their documentation and know what was going on with the resident. She stated a negative outcome could be missing information that would be needed to take care of the resident. During an interview on 01/30/25 at 5:25 PM, the ADM stated her expectations were that Medicare residents had nursing documentation in their progress notes every shift as it was best practice, but every 24 hours was a requirement. She stated if the resident was not a skilled resident, they should have at least three days of post-admission notes charted by exception at that point. She stated it would not be acceptable for a resident to go without any nursing documentation as it was important for anyone who read their chart to know what was going on with the resident. She stated if not documented clearly, issues could be missed. Review of the facility's Charting and Documentation Policy, revised July 2017, reflected the following: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42949

Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 5 (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #9) of 7 residents reviewed for infection control.

1. The facility failed to wear PPE when providing high contact resident care (dressing, bathing, transfers, wound care, device) to Residents #1, #2, #3, #4, and #9.

2. The facility failed to have signage on resident doors that reflected PPE was required for high contact care for Residents #1, #2, #3, #4, and #9.

3. The facility failed to educate staff on infection control procedures related to Enhanced Barrier Precautions (EBP).

These failures could place residents at risk for infection, hospitalization , or death.

Findings included:

1. Review of Resident #1's face sheet printed on 01/28/25 reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included pressure ulcer of sacral region (between the buttocks) - stage 4, chronic pain, neuromuscular dysfunction of bladder (lack of bladder control due to a nerve problem), paraplegia (paralysis), and type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar).

Review of Resident #1's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 11 indicating moderately impaired cognition. Section H (Bladder and Bowel) reflected she had an indwelling catheter. Section M (Skin Conditions) reflected she had an unhealed stage 4 pressure ulcer.

Review of Resident #1's comprehensive care plan reflected in part:

Problem - Last revised 10/18/24 - The resident had a pressure ulcer stage four to buttocks. Goal - The residents pressure ulcer will show signs of healing and remain free from infection. Interventions - Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage.

Problem - Resident had suprapubic catheter r/t neuromuscular dysfunction of bladder. Goal - last revised 09/25/24 - The resident will show no s/sx of urinary infection through the review date. Interventions - Position catheter bag and tubing below the level of the bladder. Monitor for s/sx of discomfort on urination and frequency. Monitor/record/report to MD for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's January 2025 MAR reflected the resident received Amoxicillin -Pot Clavulanate Tablet 875-125mg (antibiotic) 1 tablet by mouth every 12 hours for bacterial infection 01/17/25 through 01/21/25 and Doxycycline Hyclate oral tablet 100mg (antibiotic) 1 tablet by mouth two times a day for UTI from 01/17/25 through 01/22/25. Review of Resident #1's Wound Care Progress note dated 01/22/25, reflected she was on two antibiotics, at that time, based on a urine culture that grew P. mirabilis and MRSA. Her sacrum wound culture from 01/13/25 grew E. faecalis. Review of Resident #1's current clinical physician orders reflected in part, Change wound vac dressing every MWF and as needed. After removing dressing, apply [cleanser] soaked gauze for 3 minutes, apply topical iodine over wound bed, apply [dressing] to wound bed then apply wound vac foam at 150mmHg continuous . dated 07/29/24, and Wound care to suprapubic catheter site twice a day and prn. Cleanse around suprapubic ostomy with NS and pat dry with gauze . dated 07/16/24. 2. Review of Resident #2's face sheet printed on 01/30/25 reflected a [AGE] year-old male admitted to the facility on [DATE] His diagnoses included acute osteomyelitis left ankle and foot (infection in the bone), type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar), cellulitis of left lower limb (skin infection), and non-pressure chronic ulcer of left foot with necrosis (death of cells) of bone. Review of Resident #2's MDS assessments reflected they were all, in process. Review of Resident #2's baseline care plan, reviewed by the nurse on 01/18/25 reflected, Problem - The resident has potential/actual impairment to skin integrity of the (specify location) r/t. No goal or interventions reflected. Problem The resident has an AD: self-care performance deficit r/t. No goal or interventions reflected. Problem - The resident has (specify acute/chronic) pain r/t. No goal or interventions reflected. The care plan did not address the wound, the wound vac, or the PICC. Review of Resident #2's current clinical physician orders reflected in part, Change wound vac dressing every MWF and as needed. After removing dressing apply [cleanser] soaked gauze for 3 minutes, apply topical iodine over wound bed, apply dressing to wound bed, then apply wound vac foam at 150mmHg continuous . dated 01/20/25. Vancomycin HCl in NaCl intravenous solution 1.25-0.9Gm/250ml Use 1500 mg intravenously every 12 hours for osteomyelitis /wound (bone infection) to run at 167 ml per hour dated 01/28/25. Review of Resident #2's Admission/ReAdmission Evaluation dated 01/16/25 reflected a PICC in the right antecubital (inside of the forearm) and an unknown wound on the left lower leg. 3. Review of Resident #3's face sheet reflected a [AGE] year-old female initially admitted to the facility 01/04/25 and readmitted on [DATE]. Her diagnoses included acute cystitis without hematuria, type 2 diabetes mellitus, unspecified open wound on right lower leg, and hypertension (high blood pressure). Review of Resident #3's Discharge/Return Anticipated MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 15 indicating intact cognition. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weston Inn Nusring and Rehabilitation	2505 S 37th St Temple, TX 76504

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's care plan, initiated on 01/04/25 and revised on 01/28/25, reflected in part, Problem - The resident has actual impairment to skin integrity of the midline upper abdomen and right inner thigh r/t surgical procedure. Goal - The resident will have no complications r/t laceration of right medial thigh through the review date. Interventions - . Wound/dressing:(specify location and type), observe dressing (specify frequency). Change dressing and record observations of site (specify frequency). The care plan did not address the wounds or the wound vac. Review of Resident #3's current clinical physician orders reflected in part, Change wound vac dressing every T, TH, Sat and as needed. After removing dressing apply [cleanser] soaked gauze for 3 minutes, apply topical iodine over wound bed, apply dressing to wound bed, then apply wound vac foam at 125mmHg continuous . dated 01/23/25, Wound care referral - wound to R thigh dated 01/20/25, and mid abdomen: cleanse with NS, pat dry apply hydrogel, cover with dry adhesive dressing daily and PRN dated 01/09/25. 4. Review of Resident #4's face sheet printed 01/29/25, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included atherosclerosis of native arteries of extremities left leg with rest pain (narrowing of the arteries decreasing blood flow causing pain while resting), sacroiliitis (An inflammation of one or both immovable joints formed by the bones of the pelvis called sacrum and the ilium. This causes stiffness or pain in the lower back, hip, and legs), acquired absence of left leg above knee (amputation), and dependence on renal dialysis (a treatment that helps people with kidney failure keep their body's balance of fluids, electrolytes, and blood pressure). Review of Resident #4's MDS assessments reflected all assessments were in progress. Review of Resident #4's baseline care plan initiated on 01/17/25, reflected in part, Problem - The resident has potential/actual impairment to skin integrity of the (specify location) r/t. Goal - The resident will maintain or develop clean and intact skin by the review date. Interventions - Educate resident/family/caregivers of causative factors and measures to prevent skin injury .The resident needs (specify: assistance, supervision, reminding) to apply protective garments (specify: Geri-sleeves, bunny boots etc.) . The care plan did not address the surgical incision, the dialysis fistula, or the implanted port in the chest. Review of Resident #4's clinical physician orders reflected in part, LLE incision - monitor for s/sx infection. Clean daily with NS, pad dry, leave OTA dated 01/23/25. The orders did not address the dialysis port. Review of Resident #4's Admission/ReAdmission Evaluation, dated 01/17/25, reflected an implanted port in the right upper chest, a dialysis fistula in the left antecubital (a surgical connection made between an artery and a vein for performing dialysis on the left inner arm), and a surgical incision on the left thigh. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's medical record summary from the acute hospital, printed on 01/28/25, reflected the resident presented on 01/27/25, to the hospital, from the vascular clinic, for uncontrolled pain. The record reflected the resident had an above the knee amputation on 01/02/25. The stump had purulent drainage and mild skin necrosis (dead tissue). The resident was transferred to the ER. Resident #4 was admitted to the hospital with a primary diagnosis of cellulitis (skin infection). The surgical progress note written on 01/28/25 reflected a plan' OR tomorrow 01/29 for wound washout and debridement . 5. Review of Resident #9's admission MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses including aphasia (difficulty using or comprehending language), cerebrovascular accident (stroke), chronic lung disease, and other tracheostomy complications. The MDS reflected the resident received tube feedings but did not reflect a pressure ulcer or indwelling catheter. Review of Resident #9's comprehensive care plan last revised 01/28/25 reflected in part, The resident requires tube feeding (specify) r/t. Goal - The resident will be free of aspiration through the review date. The resident will maintain adequate nutritional and hydration status aeb weight stable, no s/s of malnutrition or dehydration through review date. The resident's insertion site will be free of s/sx of infection through the review date. Interventions - The resident needs the HOB elevated 45 degrees during and thirty minutes after tube feed. Administer tube feeding formula . Check for tube placement and gastric contents . Monitor/document/report PRN any s/sx of aspiration, fever, tube dislodged, infection at tube site . The care plan did not address the indwelling catheter or the stage 4 pressure ulcer. Review of Resident #9's clinical physician orders reflected in part, Clean stage 4 to sacrum (large bone at the bottom end of the spine) with normal saline, apply calcium alginate, then foam adhesive dressing daily, dated 01/22/25, Check gastric residual volume (GRV) every 4 hours and hold feedings if residuals are greater than 250 ml ., dated 12/28/24and Change urinary catheter and drainage bag monthly dated 01/28/25. During an observation and interview on 01/27/25 at 10:30 AM, Resident #1 was lying in bed with the head of the bed elevated. She stated she had a bed sore and was supposed to get wound care on Mondays, Wednesdays, and Fridays. The wound vac machine was observed hanging at the bedside. A catheter drain bag was observed at the bedside. The resident moved her sheet and blanket, and an indwelling suprapubic catheter was observed. During an observation and interview on 01/27/25 at 10:41 AM, Resident #9 was observed lying in bed with the head of the bed elevated. A urinary catheter drainage bag was observed at the bedside. Cartons of tube feed formula were observed at the bedside. Resident was unable to verbalize, but a family member at the bedside confirmed that the resident received tube feeding and that she had a pressure sore on her back side. During an observation and interview on 01/27/25 at 10:48 AM, Resident #2 stated the staff changed his wound vac every MWF. A wound vac was observed on his left lower leg/foot, the dressing partially obstructed by his sock. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/28/25 at 9:28 AM, Resident #1 was lying in her bed with her call light on. She stated she was waiting for staff to pull her up in bed so she would be able to eat her breakfast. The surveyor stepped out of the room. Two staff members entered the room. There was no signage on the door and no PPE available outside or inside the room. The two staff members were observed as they left the room. The surveyor re-entered the room and observed the resident sitting up in bed and able to reach her breakfast tray. She stated the staff did not wear PPE except for the one staff wearing a mask. There was no discarded PPE observed in the trash cans. During an observation and interview on 01/28/25 at 9:33 AM, Resident #3 was observed sitting up in a wheelchair in her room. A wound vac was observed hanging from a strap around her neck. Resident #3 requested a different strap to attach the device to the wheelchair. She stated staff had just changed the dressing on her wound vac. There was no PPE observed in the room or in the trash. There was no signage on the door, and no PPE available near the room. During an observation on 10/28/25 from 1:21 PM to 1:24 PM, a walk through the facility was conducted. There were on isolation carts observed in the halls. There were no PPE caddies observed hanging on room doors. There were no isolation or precaution signs observed on any of the room doors. During a telephone interview on 01/28/25 at 9:56 AM, Resident #1's family member stated the resident had a long history of urinary tract infections. She stated the resident was recently on two different antibiotics at the same time due to a UTI. She stated the resident was recently at a doctor's appointment and the doctor recommended the resident go to the emergency room due to the color of the urine in the drainage bag. Resident #1 went to the emergency room . The suprapubic catheter was replaced during that visit on 01/22/24. During a telephone interview on 01/28/25 at 1:28 PM, the Medical Director stated he was familiar with EBP. He stated it was his expectation that the precautions were followed. He stated the staff had all been trained and should have followed the guidelines. He stated there should have been signs on the doors and PPE available. He stated PPE was worn to prevent the spread of infection. During an interview on 01/28/25 at 2:15 PM, the ADM stated she had talked with the medical director, and they needed to get the EBP in place. She stated she was not a nurse and she had relied on her clinical team, mostly the DON, to have the precautions in place. She stated she did not know the depth of what should have been done. She stated RN B was the IP, but she stepped down from the ADON position, so the new ADON was the IP. She stated any resident who had a medical device like catheters or PICC lines, or wound vacs should have been on EBP with a sign on the room door and PPE available. During an interview on 01/28/25 at 2:59 PM, the ADM stated the new ADON did not have her IP certificate but had started the training. She stated she and the administrative team did not find a specific policy that addressed EBP. She stated they were downloading guidance. During an interview on 01/28/25 at 3:31 PM, the DON stated she had been in the building for 6 days. She stated anyone with anything going into a hole, anything artificial that did not come with the body, should have had EBP. She stated it was her expectation that staff followed EBP guidelines. She stated not wearing proper PPE could have caused infection issues. She stated she had an IP certificate, but she could not be the person in that role. She stated it was the expectation of the company that all DONs and ADMs had the IP certificate. She stated she was not sure where they kept the PPE competencies but would look for the documents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/28/28 at 3:55 PM, LVN F stated she had been at the facility only 2-3 times. She stated she had not had any training at this facility about EBP. She stated there was a sign on the door that indicated what PPE to wear. When asked which rooms had the signs, she stated, Oh, there are no signs and there is no PPE. During an interview on 01/28/25 at 6:05 PM, CNA G stated she had not had any training on EBP at that facility. During an interview on 01/28/25 at 6:07 PM, Resident #1 stated staff had worn gloves and sometimes a mask, but never a gown, when they provided wound care or incontinent care. During an interview on 01/28/25 at 6:10 PM, MA I stated she started working at the facility in December 2024. She stated she had not had any training on EBP. During an interview on 01/28/25 at 6:11 PM, Resident #3 stated staff wore gloves when they provided wound care. She stated some staff wore a mask, but staff did not wear gowns or any other protective equipment during care. Review of the facility's infection control tracking reflected there had been on outbreak. Review of the facility's Infection Prevention and Control Program policy, revised September 2022, reflected in part, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . Policy Interpretation and Implementation 2. The program is based on accepted national infection prevention and control standards . 6. Policies and Procedures a. Policies and procedures are utilized as the standards of the infection prevention and control program. b. Policies and procedures reflect the current infection prevention and control standards of practice .11. Prevention of Infection a. Important facets of infection prevention include: (1) identifying possible infections or potential complications of existing infections;(2) instituting measures to avoid complications or dissemination; (3) educating team members and ensuring that they adhere to proper techniques and procedures . Review of the facility's guidelines, Virginia Department of Health - Enhanced Barrier Precautions in Nursing Homes Algorithm, dated 06/2024, reflected in part, EBP are indicated for the following residents who are: Known to be colonized or infected with a multidrug-resistant organism (MDRO) when contact precautions do not otherwise apply; At increased risk of MDRO acquisition (e.g., resident has a wound or indwelling medical device) . In addition to standard precautions, gowns and gloves should be worn during the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care . Steps to Implementation: With implementation, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. 1. Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required personal protective equipment (PPE) (e.g., gown and gloves). For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of a gown and gloves. 2. Make PPE, including gowns and gloves, available immediately outside of the resident room .