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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675820	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lennwood Nursing and Rehabilitation	8017 W Virginia Dr Dallas, TX 75237

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15315 Based on observation, interview and record review, 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 three (Residents #1, #2, and #3) of four residents reviewed for pressure ulcers. 1. Resident #1 was not provided wound care for an unstageable pressure ulcer to the sacrum (a large, triangular bone at the base of the spine) on 03/03/24 and 03/09/24. 2. Resident #2 was not provided wound care for an unstageable pressure ulcer to the coccyx (a small triangular bone at the base of the spine commonly known as the tailbone) on 03/02/24, 03/03/24, and 03/09/24. 3. Resident #3 was not provided wound care for a sacrococcyx (center mid buttock below the sacrum) pressure ulcer (no stage indicated) on 03/09/24. These failures could place residents at risk for worsening of existing pressure ulcers and/or development of new pressure ulcers. Findings included: 1) Record review of Resident #1's physician's orders dated 03/2024, revealed the resident was a [AGE] year-old male, readmitted to the facility on [DATE] with diagnoses to include vascular dementia, heart failure and chronic embolism and thrombosis (thrombosis a blood clot that forms in a blood vessel-embolus is a clot travels that through blood vessels). Record review of nurse's admission notes dated 03/02/24 and time 3:31 p.m. revealed Resident #1 readmitted with an open wound to the coccyx measuring 2.2 centimeters by 3.8 centimeters (length by width). (Wound Care Physician assessment dated [DATE] clarified location as sacrum not coccyx). Record review of Resident #1's nurse's admission assessment notes dated 03/02/24 timed 3:57 p.m. and 7:23 p.m. revealed the resident was forgetful, incontinent of bowel/bladder, required assistance with meals and required the assistance of two staff for all activities of daily living to include transfers. (continued on next page)

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

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Nurse's progress notes dated 03/13/24 reflected the resident transferred to the hospital due to abnormal labs. Record review of Resident #1's physician orders, dated 03/2024, revealed the following active wound care orders: Sacrum wound orders start date 03/02/24-clean with normal saline, pat dry and apply Medi honey, Calcium Alginate and dry dressing daily and as needed. Sacrum wound orders start date 03/06/24-clean with normal saline, pat dry and apply Santyl and Calcium Alginate daily and as needed. Record review of Resident #1's March 2024 MARS/TARS revealed no documentation that wound care was provided for the resident's pressure ulcer on 03/03/24 and 03/09/24. Record review of Resident #1's initial and only WCP assessment/notes dated 03/06/24 revealed the resident was treated for an unstageable 5.5 centimeter by 3-centimeter (length by width) pressure ulcer wound to the sacrum that contained a moderate amount of serous drainage (Serous-a clear to yellow fluid that leaks out of a wound). (Unstageable-full-thickness pressure injuries in which the base is obscured by slough and/or eschar. (Slough-yellow/white material in the wound bed). (Eschar-a collection of dry, dead tissue within a wound). Record review of Resident #1's baseline care plan dated 03/04/24 revealed problems addressed included staff assistance was required for eating, transfers, bathing/hygiene and cueing for turning and repositioning. The resident's wound was not addressed. 2) Record review of Resident #2's physician orders dated 03/24/24, revealed the was a [AGE] year-old male, readmitted to the facility on [DATE]. His diagnoses included type II diabetes mellitus and heart failure. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed the resident's BIMS score was 8 indicating moderately impaired cognition. The assessment reflected the resident required maximum assistance for all activities of daily living, used a wheelchair for mobility and was incontinent of bowel/bladder. Record review of Resident #2's undated care plan revealed the resident's pressure ulcer was addressed. Interventions included administering treatments as ordered. Record review of Resident #2's physician orders, dated 03/2024, revealed the following active wound care orders: Sacrum wound orders start date 03/22/24-clean with normal saline, pat dry and apply Medi honey, Calcium Alginate and dry dressing daily and as needed. (Wound Care Physician assessment dated [DATE] clarified location as coccyx not sacrum). Observation on 03/20/24 at 10:27 a.m. revealed Resident #2 was resting in bed with an open wound to the coccyx. The wound presented as approximately dime sized with red, pink, white colored tissue, and a moderate amount of slough. Interview on 03/20/24 at 10:40 a.m. attempted with Resident #2 was unsuccessful as the resident presented with some cognitive impairment and did not respond to questions about his care in the facility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's March 2024 MARS/TARS revealed no documentation that wound care was provided for the resident's pressure ulcer on 03/02/24, 03/03/24, and 03/09/24. Record review of Resident #2's weekly WCP assessment/notes dated 03/06/24 and 03/13/24 revealed the resident was treated for an unstageable pressure ulcer to the coccyx. The wound's progress was assessed as increased in size on 03/13/24 to 3 by 1.5 (LXW) centimeters from 2 by 2 by 0.3 centimeters on 03/06/24. The assessment notes reflected a debridement procedure was performed on 03/06/24 and 03/13/24. 3) Record review of Resident #3's physician's orders dated 03/2024, revealed the resident was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses to include heart failure, pressure ulcer, and dementia. Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed the resident's cognitive skills for daily decision making were severely impaired. The assessment reflected the resident required maximum assistance all activities of daily living, used a wheelchair for mobility, was incontinent of bowel and utilized an indwelling urinary catheter. Record review of Resident #3's undated care plan revealed pressure ulcers were addressed. Interventions included providing wound care according to orders. Record review of Resident #3's physician orders, dated 03/2024, revealed the following active wound care orders: Sacrococcyx wound start date 12/21/23-clean with normal saline, pat dry, pack with moistened betadine gauze, cover with abdominal pad and dry dressing daily and as needed. (Wound Care Physician assessment dated [DATE] clarified location as sacrococcyx not sacrum). Observation and interview on 03/20/24 at 9:43 a.m. revealed Resident #3 was resting in bed with an open wound to the sacrococcyx area. The wound presented as a large open area with dark red tissue. Attempts to interview the resident at this time were unsuccessful as she did not respond to questions about her care in the facility. Record review of Resident #3's March 2024 MARS/TARS revealed no documentation that wound care was provided for the resident's pressure ulcer on 03/09/24. Record review of Resident #3's weekly WCP assessment/notes dated 03/06/24 and 03/13/24 revealed the resident was treated for an unstageable pressure ulcer to the sacrococcyx. The assessment notes reflected a debridement procedure was performed during each visit. The wound's progress was assessed as decreased in size on 03/13/24. Interview with the Administrator on 03/19/24 at 12:48 p.m. revealed the facility currently had no DON, but one had been hired to start next week. The ADON was new and had been at the facility for one week. Interview on 03/19/24 at 1:25 p.m. The TN stated during the weekend the weekend supervisor and charge nurses provided wound care. The weekend supervisor acted as Treatment Nurse on the weekend and provided wound care, but if there was no wound care nurse on duty charge nurses were responsible for providing wound care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/19/24 at 4:13 p.m. the Weekend Supervisor stated she did not recall what treatments or names of residents she provided wound care for on 03/02/24. She stated wound care she provided would be documented on the TARS. She stated she was the weekend supervisor, but she worked prn (as needed) and provided wound care. She stated she was on duty on Saturday 03/16/24 during the day shift from approximately 9:00 a.m. or 10:00 a.m. but had to leave early due to an emergency. She stated she told the charge nurses what resident wounds needed to be completed. Interview on 03/20/24 at 8:22 a.m. the TN stated she was not sure who provided wound care for Resident #1, #2, and #3 on 03/02/24, 03/03/24, 03/09/24 and 03/16/24. She stated she had been having problems with weekend nursing staff not providing wound care. On 03/20/24 the ADON provided a list of charge nurse assignments for the weekend days of 03/02/14, 03/03/24, and 03/09/24. Record review of the list revealed the TN worked as a charge nurse assigned to Resident #2 on 03/02/24, On 03/03/24 LVN A was the assigned charge nurse for Residents #1 and #2 and on 03/09/24 agency nurse LVN B was the assigned charge nurse for Resident #1, #2, and #3. Interview on 03/20/24 at 12:42 p.m. agency nurse, LVN B stated she worked the day shift from 6:00 a.m. to 2:00 p.m. on 03/09/24 and it was her first shift at the facility. She stated during report she was told there was a weekend TN. She stated sometime around lunch time she received a text message from one of the other nurses reminding her to complete wound care because the weekend supervisor who usually provided wound care had called in. She stated she replied to the text saying she would try her best but there were no guarantees because of the heavy workload as she had been assigned to four halls. She stated it was not her role to provide wound care because the facility hired her as the charge nurse, and she was told there was a TN on duty. LVN B stated she did not provide any wound care on 03/09/24. Interview on 03/20/24 at 2:42 p.m. the TN stated she did not provide care for Resident #2 on 03/02/24. She stated the weekend supervisor was responsible for providing wound care on Saturday 03/02/24. Interview on 03/20/24 at 4:30 p.m. LVN A stated she worked the day shift from 6:00 a.m. to 2:00 p.m. on 03/03/24. She stated she recalled on that Sunday (03/03/24) the weekend supervisor was acting as TN and was to provide wound care. She states she found out at the end of her shift the weekend supervisor had no set hours and was not coming during her shift. She stated she thought the weekend supervisor was coming in later to provide wound care. She stated she provide no wound care on 03/03/24. Interview with the Administrator on 03/20/24 at 2:00 p.m. he stated he was not aware of the omissions in wound care. Interview with the Administrator on 03/21/24 at 1:20 p.m. he stated his expectations were for nursing staff to provide wound care. He stated it was important for wound care to be provided or residents would be at risk of wounds getting worse. Record review of the facility's current Wound Care policy/procedure dated reviewed 12/2023, revealed: The purpose of this procedure is to provide guideline for the care wounds to promote healing. The policy/procedure reflected step-by-step procedure for providing wound care, and the documentation procedure. There was no information related to the treatment and management of pressure/ulcers/wounds.

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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** 15315 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 3 of 3 residents (Residents #1, #2 and #3) reviewed for accuracy of medical records. 1. The facility failed to ensure staff documented Resident #1's wound care on the TAR after performing wound care on 03/04/24. 2. The facility failed to ensure staff documented Resident #2's wound care on the TAR after performing wound care on 03/16/24. 3. The facility failed to ensure staff documented Resident #3's wound care on the TAR after performing wound care on 03/06/24. These failures could place residents at risk for treatment errors and omissions in care. Findings included: 1) Record review of Resident #1's physician's orders dated 03/2024, revealed the resident was a [AGE] year-old male, readmitted to the facility on [DATE] with diagnoses to include vascular dementia, heart failure and chronic embolism and thrombosis (thrombosis a blood clot that forms in a blood vessel-embolus is a clot travels that through blood vessels). Record review of Resident #1's baseline care plan dated 03/04/24 revealed problems addressed included staff assistance was required for eating, transfers, bathing/hygiene and cueing for turning and repositioning. The resident's wound was not addressed. Record review of Resident #1's physician orders, dated 03/2024, revealed the following active wound care orders: Sacrum wound orders start date 03/02/24-clean with normal saline, pat dry and apply Medi honey, Calcium Alginate and dry dressing daily and as needed. Sacrum wound orders start date 03/06/24-clean with normal saline, pat dry and apply Santyl and Calcium date of 1/22/2024. Record review of Resident #1's March 2024 MARS/TARS revealed no documentation that wound care was provided for the resident's pressure ulcer on 03/04/24. 2) Record review of Resident #2's physician orders dated 03/24/24, revealed the was a [AGE] year-old male, readmitted to the facility on [DATE]. His diagnoses included type II diabetes mellitus and heart failure. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed the resident's BIMS score was 8 indicating moderately impaired cognition. The assessment reflected the resident required treatment for pressure ulcer/injury. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's undated care plan revealed the resident's pressure ulcer was addressed. Interventions included administering treatments as ordered. Record review of Resident #2's physician orders, dated 03/2024, revealed the following active wound care orders: Sacrum wound orders start date 03/22/24-clean with normal saline, pat dry and apply Medi honey, Calcium Alginate and dry dressing daily and as needed. (Wound Care Physician assessment dated [DATE] clarified location as coccyx not sacrum). Record review of Resident #2's March 2024 MARS/TARS revealed no documentation that wound care was provided for the resident's pressure ulcer on 03/16/24. Record review of Resident #2's weekly WCP assessment/notes dated 03/06/24 and 03/13/24 revealed the resident was being treated for an unstageable pressure ulcer to the coccyx. 3) Record review of Resident #3's physician's orders dated 03/2024, revealed the resident was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses to include heart failure, pressure ulcer, and dementia. Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed the resident's cognitive skills for daily decision making were severely impaired. The assessment reflected the resident required treatment for pressure ulcer/injury. Record review of Resident #3's undated care plan revealed the resident's pressure ulcer was addressed. Interventions included administering treatments as ordered. Record review of Resident #3's physician orders, dated 03/2024, revealed the following active wound care orders: Sacrococcyx wound start date 12/21/23-clean with normal saline, pat dry, pack with moistened betadine gauze, cover with abdominal pad and dry dressing daily and as needed. (Wound Care Physician assessment dated [DATE] clarified location as Sacrococcyx not sacrum). Record review of Resident #3's March 2024 MARS/TARS revealed no documentation that wound care was provided for the resident's pressure ulcer on 03/06/24. Record review of Resident #3's weekly WCP assessment/notes dated 03/06/24 and 03/13/24 revealed the resident was being treated for an unstageable pressure ulcer to the Sacrococcyx. Interview on 03/19/24 at 4:28 p.m. LVN C stated on 03/16/24 the Weekend Supervisor had to leave early due to an emergency and she performed wound care for the remaining residents according to the Weekend Supervisor's instructions. She stated she thought she had documented the wound care. Interview on 03/20/24 at 2:42 p.m. the TN stated she provided all wound care on 03/04/24 and on 03/06/24. She stated she must have forgotten to document the wound care for Resident #1 and Resident #3. Interview on 03/21/24 at 1:20 p.m. the Administrator stated his expectations were for facility staff to follow policies and procedures related to documentation in the resident's clinical records. He stated it was important to document care provided to be able to tell if the care was provided and enable appropriate reaction. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility's current Wound Care policy/procedure dated reviewed 12/2023 revealed documentation was addressed. The policy/procedure reflected the following information should be recorded in the resident's medical record: The date and time the wound care was provided, the name and title of the individual performing the wound care and the signature and title of the person recording the data. Record review of the facility's current Charting and Documentation policy/procedure dated reviewed 12/2023 revealed 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 should 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.