STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675820	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

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 33552

Based on observations, interviews and records 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 (Resident #1, Resident #2 and Resident #4) of three residents reviewed for quality of care.

1. On 02/01/25 and 02/02/25, the facility failed to provide wound care to Resident #1's sacral wound.

2. On 02/07/25, the facility failed to follow physician orders to cover Resident #1's and Resident #2's wound(s) with a dry dressing as needed for dislodgment of dressing.

3. On 02/05/25 and 02/07/25, the facility failed to follow physician orders or manufacturer instructions to ensure that Resident #1's, Resident #2's and Resident #4's low air loss mattress pump had the correct settings for appropriate pressure redistribution.

These failures placed residents at risk of developing new or worsening pressure ulcers.

Findings included:

RESIDENT #1

Record review of Resident #1's Face Sheet dated 02/05/25 reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1's active diagnoses included hypertensive heart disease (a condition that develops when high blood pressure (hypertension) damages the heart over time), chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products from the blood), pancytopenia (a condition in which the body has low levels of red blood cells, white blood cells, and platelets), acute kidney failure (a sudden and significant decline in kidney function that occurs over a short period (within days or weeks)), type 2 diabetes (a chronic disease characterized by high blood sugar levels), hyperlipidemia (a condition in which there are abnormally high levels of lipids (fats) in the blood), hypertension (a condition where the blood pressure in the arteries is consistently elevated above normal levels), atrial fibrillation (a common heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly and rapidly)and vascular dementia (a type of brain damage that occurs when blood flow to the brain is reduced or blocked, leading to damage to brain cells). Resident #1 did not admit with any pressure ulcers.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675820	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

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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 quarterly MDS assessment dated [DATE] reflected a BIMS score of 14 which indicated no cognitive impairment. Resident #1 had range of motion impairment on both sides of her lower extremities and used a wheelchair for mobility. Resident #1 was at risk of developing pressure ulcers and did not have any pressure ulcers or any other skin issues that required treatments at the time of the assessment.

Record review of Resident #1's care plan dated 12/13/24 and revised 02/05/25 reflected she had an open area near the coccyx area and an unstageable pressure ulcer to the sacrum. Interventions included, Monitor/document location, size and treatment of skin injury, Treatment to coccyx, administer treatments as ordered and monitor for effectiveness, monitor dressing (FREQ) to ensure it is intact and adhering, Monitor/document/report to MD PRN changes in skin status: appearance, color,

wound healing, s/sx of infection, wound size, stage.

Record review of Resident #1's Order Summary Report dated 02/05/25 reflected:

- Order date 01/03/25: Cleanse sacral wound with Dakin solution, apply Santyl ointment, calcium alginate and dry dressing daily and PRN for dislodgment of dressing.

- Order date 01/04/25: Cleanse sacral wound with Dakin solution, apply Santyl ointment, calcium alginate and dry dressing daily and PRN.

Record review of Resident #1's February 2024 TAR revealed the orders were implemented as written for daily care as evidenced by a checkmark and LVN C's initials on 02/03/25 - 02/07/25. The TAR did not reflect a follow up code or nurse initials to indicate that wound care was provided on 02/01/25 or 02/02/25. The TAR did not reflect a follow up code or nurse initials to indicate that PRN wound care was provided on 02/06/25 (10P - 6A shift) when Resident #1's dressing was removed or became dislodged.

Record review of Resident #1's Weight Summary reflected a weight of 103.3 lbs. measured on 01/02/25.

Record review of Resident #1's wound care visit dated 01/29/25 reflected it was an evaluation of the wound on her sacrococcyx. The wound progress was noted to have decreased in size.

An interview with Resident #1 on 02/07/25 at 11:15 AM revealed she was receiving wound care but she was not sure on her bottom where it was located. Resident #1 said she could not feel her wound and was not in any pain with the wound. She stated the nurses did wound care once a day and the wound nurse was really good.

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

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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 - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 02/07/25 at 11:32 AM, Resident #1 rested quietly in bed on a low air loss (LAL) mattress with a control unit placed at the foot of the bed. The pump's power button was lit up and in the ON position and the weight setting in lbs. pressure adjust knob was pointed between 150 - 180 (lbs.). CNA E assisted LVN C to reposition Resident #1 and prepare for wound care. When LVN C removed Resident #1's brief to provide care, the sacral coccyx wound was exposed without a dressing. CNA E denied she removed the dressing or knew how long the wound was uncovered when LVN C inquired why the wound did not have a dressing. The wound had some light pink, thin, and watery drainage. There was no odor or apparent signs of infection. Resident #1 did not verbalize or demonstrate non-verbal cues suggestive of pain during wound care. RESIDENT #2 Record review of Resident #2's Face Sheet dated 02/05/25 reflected he admitted to the facility on [DATE] and readmitted after a hosptial stay on 01/29/25 with a pressure ulcer to the sacrum stage 4. A record review of Resident #2's Admission MDS Assessment, dated 1/17/25, revealed a [AGE] year-old male who admitted on [DATE]. Resident #2 had a history and diagnoses of Retention of urine, unspecified; Osteomyelitis (infection of the bone); Dependence on renal dialysis; Pressure ulcer of sacral region, Stage 4; and Acquired absence of right leg above the knee. A BIMS score of 12 suggested Resident #2 had a moderate cognitive decline. Resident #2 had a suprapubic urinary catheter and was frequently incontinent of bowel. Resident #2 had a recent discharge on 01/22/25 and readmitted to the facility on [DATE]. A record review of Resident #2's comprehensive care plan, initiated 08/29/24, target date 05/01/25, reflected: [Resident #2] have (1) pressure ulcer r/t immobility. Stage 4 to sacrum (Initiated 09/06/24; Revised 10/07/24). Interventions included Administer medications as ordered; Administer treatments as ordered and monitor for effectiveness; Assess/record/monitor wound healing; Monitor dressing daily to ensure it is intact and adhering; and Report loose dressing to Treatment Nurse [LVN C]. A record review of Resident #2's Order Summary Report printed 02/07/25 reflected: - Order date 01/29/25: Low air loss mattress. Adjust ht/wt settings for appropriate pressure redistribution. Apply flat sheet open to length of bed with one disposable pad only. Every shift. - Order date 02/06/25: Cleanse sacral/coccyx wound with Dakin's and pack with Dakin's-soaked gauze and cover with bordered gauze. Cleanse penile shaft and genitals with NS and place thick layer of zinc around genitals. Do not remove previously applied zinc oxide as needed for wound care. - Order date 02/06/25: Cleanse sacral/coccyx wound with Dakin's and pack with Dakin's-soaked gauze and cover with bordered gauze. Cleanse penile shaft and genitals with NS and place thick layer of zinc around genitals. Do not remove previously applied zinc oxide every Monday, Wednesday, and Friday for wound care. If not improvement in 14 days, consider treatment change. - Order date 01/29/25: Weekly weights X 4 weeks every day shift every Friday for 4 weeks. Record review of Resident #2's January 2025 TAR reflected: (continued on next page)

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

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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 - Minimal harm or potential for actual harm Residents Affected - Some	- 01/31/25 - NA in the box to enter a weight, a checkmark, and LVN B's initials that indicated the order to obtain Resident #2's weight was completed. Record review of Resident #2's February 2025 TAR's reflected: - 02/07/25 - The weight measurement was blank. There was no follow up code or nurse initials that indicated the order was completed. - The orders were implemented as written for Low air loss mattress. Adjust ht/wt settings for appropriate pressure redistribution . as evidenced by a checkmark and a nurse's initials every shift. LVN B initialed the TAR on 02/07/25 Day Shift (6A - 2P) as completed. - The February 2025 TAR did not reflect a follow up code or nurse initials to indicate PRN wound care was provided on 02/06/25 (10P - 6A shift) when Resident #2's dressing was removed or became dislodged. Record review of Resident #2's weight summary reflected a post-dialysis weight of 149.1 on 01/17/25 at 8:49 AM. Record review of Resident #2's wound care visit dated 02/05/25 reflected it was an evaluation his wound and indicated the moisture-associated skin damage to his scrotum (extending to his penile shaft) had decreased in size. The wound to his left medial heel had also decreased in size and the wound to his left lateral foot was unable to be determined since it was the first visit with that injury. The wound for his left lateral foot was noted to have a wound etiology from peripheral artery disease. An interview with Resident #2 on 02/07/25 at 10:45 AM revealed he was receiving wound care and they were being dressed every other day and he was not in any pain. During an observation and interview on 02/07/25 at 12:12 PM, Resident #2 was in a semi-side-lying (left lateral and back) position on a LAL mattress with a control unit placed at the foot of the bed. The pump's power button was lit and in the ON position, the weight setting in lbs knob pointed towards the maximum weight (350 lbs.). The mattress presented a fully inflated firm surface. Resident #2 was pleasant and willingly participated in an interview. Resident #2 was alert and oriented to person, place, time of day, and situation. Resident #2 said that his dressing became soiled overnight but was not replaced by the night nurse or the morning nurse. Resident #2 could not say how the status of the mattress settings interfered with his comfort level. Resident #2 denied current pain related to the firmness of the low air mattress. CNA E assisted LVN C to reposition Resident #2 and prepare for wound care. When LVN C removed Resident #2's brief to provide care, the sacral coccyx wound was exposed without a dressing. The wound was not packed per physician orders. CNA E denied she removed the dressing or knew how long the wound was uncovered when LVN C inquired why the wound did not have a dressing. The wound had a small amount of light pink, thin, and watery drainage. There was no odor or apparent signs of infection. Resident #2 did not verbalize or demonstrate non-verbal cues suggestive of pain during wound care. RESIDENT #4 (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #4's Quarterly MDS Assessment, dated 11/29/24, revealed a [AGE] year-old female who admitted on [DATE]. Resident #4 had a history and diagnoses of a Pressure ulcer of sacral region, Stage 4 and Non-Alzheimer's Dementia. Resident #4's cognition was moderately impaired per staff assessment for mental status. Resident #4 had an indwelling catheter and was frequently incontinent of bowel. Resident #4's MDS assessment reflected Resident #4 had a pressure ulcer/injury and at risk of developing pressure ulcers/injuries. The MDS assessment reflected a pressure reducing device for bed, nutrition, or hydration interventions to manage skin problems, pressure ulcer/injury care, application of nonsurgical dressings, and applications of ointments/medications were in place for skin and ulcer/injury treatments. Resident #4 received hospice services. A record review of Resident #4's comprehensive care plan, initiated/revised 04/25/24, reflected: Documented pressure ulcer to Sacrococcyx [Initiated 11/05/24; Revised 04/01/24]. Interventions included require air loss mattress on the bed and make sure it is plugged in at all times and Treatment to sacrococcyx (stage 4). A record review of Resident #4s Order Summary Report reflected: - Order date 07/18/24: Air mattress in use due to impaired skin integrity every shift. - Order date 01/29/25: Weights & Vital signs per facility policy. Record review of Resident #4's weight summary revealed the last weight measured on 01/02/25 at 10:13 AM was 104.2 pounds. An observation on 02/05/25 at 12:34 PM revealed Resident #4 was in bed asleep. She had a low air loss mattress underneath her but it was not turned on. During an observation and interview on 02/07/25 at 12:32 PM, Resident #4 was in a supine (on back) position on a LAL mattress with a control unit placed at the foot of the bed. The pump's power button was lit and in the ON position, the weight setting in lbs knob pointed towards 150 lbs. During an interview on 02/07/25 at 1:45 PM, LVN C said that she was the facility treatment nurse and was responsible for providing wound care as ordered Monday - Friday. LVN C said that the charge nurses were responsible for wound care over the weekends when she [LVN C] was not scheduled. LVN C said that Residents #1, #2, and #4 were last seen by the WMD for wound care on 02/05/25. LVN C said that interventions should reflect on the resident's care plan to turn and reposition every 2 hours, off-load pressure areas, encourage hydration and nutrition to prevent skin breakdown and worsening of wounds. LVN C said that all residents would have either a pressure relieving mattress or a low air loss mattress to prevent and treat pressure ulcers. LVN C said that the low air loss pump settings were based off the resident's current weight to apply the appropriate amount of air to avoid constant pressure under boney surfaces and wounds. LVN C said that she checked that the pumps were on and functioning by feeling the bed to ensure it was inflated but did not check the settings. LVN C said the risk of the bed being too firm or not functioning was development of bed sores or worsened wounds. (continued on next page)

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	675820	A. Building B. Wing	02/07/2025

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/07/25 at 2:00 PM, LVN B said that she checked each resident's low air loss pumps at start of shift and every time she made rounds to make sure the pump was turned on. LVN B said that she felt the mattress to make sure it was inflated. LVN B could not verbalize what the appropriate settings should be for Resident's #1, #2, or #4 low air loss mattresses. During an interview on 02/07/25 at 4:36 PM, RN D said that he was the 2P - 10P nurse assigned to Residents #1, #2, and #4. RN D said that residents had low air loss mattresses to prevent skin breakdown and promote wound healing. RN D said that he did not always check if the settings were correctly set to the residents' weight in pounds. RN D said that he did always check if the bed was on and functioning. Record review of the facility's Wound Care policy, reviewed December 2024, reflected, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Verify that there is a physician's order for this procedure. Review the resident's care plan to assess for any special needs of the resident. Apply treatments as indicated.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on observations, interviews, and records review the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services for 2 of 3 residents (Resident #2 and Resident #4) reviewed for catheter care. 1. On 02/07/25, LVN B failed to provide ongoing monitoring and report any changes in condition to Resident #2's and Resident #4's urinary catheters (a thin, flexible tube that's inserted into the body to drain urine) and urine output. These failures could place residents at risk of improper catheter care and catheter-associated urinary tract infections. Findings included: RESIDENT #2 A record review of Resident #2's Admission MDS Assessment, dated 1/17/25, revealed a [AGE] year-old male who admitted on [DATE]. Resident #2 had a history and diagnoses of Retention of urine, unspecified; Osteomyelitis (infection of the bone); Dependence on renal dialysis; Pressure ulcer of sacral region, Stage 4; and Acquired absence of right leg above the knee. A BIMS score of 12 suggested Resident #2 had a moderate cognitive decline. Resident #2 had a suprapubic urinary catheter and was frequently incontinent of bowel. Resident #2 had a recent discharge on 01/22/25 and readmitted to the facility on [DATE]. A record review of Resident #2's comprehensive care plan, initiated 08/29/24, target date 05/01/25, did not reflect a focus or interventions for a suprapubic urinary catheter. A record review of Resident #2's Order Summary Report printed 02/07/25 reflected: - Order date 01/29/25: Cleanse Foley Catheter per facility protocol every shift. - Order date 01/29/25: Empty Foley bag every shift and PRN as needed. - Order date 01/29/25: Foley catheter 16 Fr with 10 mL balloon to gravity one time a day. - Order date 01/29/25: Keep urinary drainage bag below the level of the bladder at all times every 8 hours as needed. - Order date 01/29/25: Keep urinary drainage bag below the level of the bladder at all times every shift. - Order date 01/29/25: Monitor Foley Catheter leg strap for proper placement every shift and PRN as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Order date 01/29/25: Monitor Foley Catheter leg strap for proper placement every shift and PRN every shift. - Order date 01/29/25: Monitor Foley Catheter for leakage, blockage, sediment buildup, or low output every shift as needed. - Order date 01/29/25: Monitor Foley output every shift. - Order date 01/29/25: Monitor urine every shift. Notify MD for any abnormal findings. Record review of Resident #2's February 2025 TAR's reflected: - The orders were implemented as written to monitor Foley Catheter leg strap for proper placement every shift and PRN as evidenced by a checkmark and a nurse's initials every shift. LVN B initialed the TAR on 02/07/25 Day Shift (6A - 2P) as completed. - The orders were implemented as written to monitor Foley output every shift as evidenced by a measured urine output amount, a checkmark, and a nurse's initials every shift. LVN B initialed the TAR on 02/07/25 Day Shift (6A - 2P) as completed and entered an x as the urine output amount. - The orders were implemented as written to monitor urine every shift, notify MD for any abnormal findings as evidenced by a checkmark and a nurse's initials every shift. LVN B initialed the TAR on 02/07/25 Day Shift (6A - 2P) as completed. During an observation and interview on 02/07/25 at 12:57 PM, Resident #2 was in a semi-side-lying (left lateral and back) position on a LAL mattress. Resident #2 had a SPC in place at the lower left abdominal area above the pubic bone. The SPC insert site was not covered by a gauze dressing. There was a urinary catheter strap that secured the tubing incorrectly and ineffective to preventing pulling or tugging. The SPC tubing laid across Resident #2's right leg connected to a closed system drainage bag, covered by a privacy bag, that hung on the bed rail. There was no urine drainage in the tubing and the drainage bag was empty. Resident #2 was pleasant and willingly participated in an interview. Resident #2 was alert and oriented to person, place, time of day, and situation. Resident #2 said his catheter leaked at times and he would be wet. RESIDENT #4 A record review of Resident #4's Quarterly MDS Assessment, dated 11/29/24, revealed a [AGE] year-old female who admitted on [DATE]. Resident #4 had a history and diagnoses of a Pressure ulcer of sacral region, Stage 4 and Non-Alzheimer's Dementia. Resident #4's cognition was moderately impaired per staff assessment for mental status. Resident #4 had an indwelling catheter and was frequently incontinent of bowel. Resident #4's MDS assessment reflected Resident #4 had a pressure ulcer/injury and at risk of developing pressure ulcers/injuries. The MDS assessment reflected a pressure reducing device for bed, nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, application of nonsurgical dressings, and applications of ointments/medications were in place for skin and ulcer/injury treatments. Resident #4 received hospice services. A record review of Resident #4's comprehensive care plan, initiated/revised 04/25/24, reflected: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Resident #4] have an Indwelling Catheter: Pressure Ulcer of Sacral Region, Stage 4. Interventions included Change catheter and drainage bag based on clinical indications such as infection, obstruction, when the integrity of the closed system is compromised, etc. and Observe/record/report to MD for s/sx UTI. A record review of Resident #4's Order Summary Report reflected: - Order date 01/08/25: Change Foley Catheter 20-22 Fr with 10-30 mL balloon for Sacral Wound one time only for 1 day. [COMPLETED] - Order date 10/22/24: Cleanse Foley Catheter per facility protocol every shift. - Order date 10/22/24: Empty Foley bag every shift and PRN as needed. - Order date 10/22/24: Empty Foley bag every shift and PRN every shift. - Order date 11/25/24: Foley Catheter 20-22 Fr with 10-30 mL balloon for Sacral Wound as needed for Foley Change. - Order date 10/22/24: Keep urinary drainage bag below the level of the bladder at all times every shift. - Order date 10/22/24: Keep urinary drainage bag below the level of the bladder at all times every 8 hours as needed. - Order date 10/22/24: Monitor Foley Catheter leg strap for proper placement every shift and PRN as needed. - Order date 10/22/24: Monitor Foley Catheter leg strap for proper placement every shift and PRN every shift. - Order date 10/22/24: Monitor Foley Catheter for leakage, blockage, sediment buildup, or low output every shift as needed. - Order date 10/22/24: Monitor Foley output every shift. - Order date 10/22/24: Monitor urine every shift. Notify MD for any abnormal findings. An observation of Resident #4 on 02/05/25 at 12:34 PM revealed she was asleep in bed and her indwelling urinary catheter tubing had a cloudy consistency in the urine with a light in color flaky substance floating in it. During an observation and interview on 02/07/25 at 1:21 PM, Resident #4 was in a supine (on back) position on a LAL mattress. Resident #4 had an indwelling urinary catheter in place. There was a urinary catheter strap that secured the tubing to prevent pulling or tugging. The catheter tubing laid across Resident #4's right leg connected to a closed system drainage bag, covered by a privacy bag, that hung on the bed rail. Visible inspection of the indwelling catheter tubing revealed white flakes floating in a small amount of hazy and cloudy urine that drained through the tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/07/25 at 1:45 PM, LVN C said that she was the facility treatment nurse and was responsible for providing wound care as ordered Monday - Friday. LVN C acknowledged that Resident #2's catheter did not have any urine output during rounds with investigator. LVN C said that Resident #2 catheter was leaking earlier in the week (Monday), she notified the nurse, and entered a progress note that there was a urine leak. During an interview on 02/07/25 at 2:00 PM, LVN B said that she changed Resident #2's catheter at the start of shift (02/07/25 7:00 AM) because it needed a drainage bag cover. LVN B said that the drainage bag that was placed by the urologist did not have a drainage bag cover. LVN B said that the drainage bag had a small amount of yellow urine output at the beginning of shift. LVN B said that she did not have a chance to check the urine output since the last time she changed the bag at the start of shift because there was a treatment nurse in the room at the time she was going to do it. LVN B said that Resident #4 catheter was draining clear yellow urine when she checked at the start of shift. LVN B said that the assigned nurses were responsible for performing catheter care to residents with indwelling and suprapubic urinary catheters. LVN B said that catheter care included checking the insert site for trauma, drainage, signs of infection; to check if the tubing dislodged; check for urine color and for any abnormalities that should be reported to the MD. LVN B denied any concerns. During an observation and interview on 02/07/25 at 2:07 PM, LVN B checked the urine output for Resident #4. LVN B said that she did not notice the cloudy urine output or specks in the urine. During an observation of Resident #2's suprapubic catheter, LVN B observed no urine output and an empty drainage bag. LVN B stated that Resident #2 had urine output when she changed the catheter bag in the morning. LVN B said that she would notify the physician about the findings and implement any new orders. Record review of Resident #2's progress notes revealed LVN B sent the NP a message (02/07/25 at 2:27 PM) that Resident #2's catheter was not draining. LVN B entered an Orders Administration Note (at 2:37 PM) that reflected no noted output in the resident's Foley Catheter bag at this time. The resident's NP alerted of the findings. Record review of Resident #4's progress notes revealed LVN B sent the PA a message (02/07/25 at 2:28 PM) regarding the sediment noted in Resident #4's urinary catheter tubing. LVN B entered a progress note at 3:45 PM that indicated new orders were received from the PCP to obtain a UA with C&S for lab pickup. LVN B documented that she notified the hospice RN and the RP. During an interview on 02/07/25 at 4:36 PM, RN D said that he was the 2P - 10P nurse. RN D said that it was the nurse responsibility to provide catheter care and check the urine output of residents with urinary catheters. RN D said a part of catheter care was checking the flow of the urine, check for abdominal distention, odor, and placement of the catheter to avoid trauma and prevent urinary tract infections. RN D said that LVN B notified him of new orders received for Resident #2 that needed to be implemented. RN D said that LVN B reported there was minimal urine output, that Resident #2's brief was wet and there was a new order to flush the catheter with 5 - 10 cc of normal saline. Record review of the facility's Catheter Care, Urinary policy, reviewed December 2024, reflected: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Review the resident's care plan to assess for any special needs of the resident. (continued on next page)

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

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Input/Output 1. Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to the physician or supervisor. 2. Maintain an accurate record of the resident's daily output, per facility policy and procedure. Maintaining Unobstructed Urine Flow 1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.) Complications 1. Observe the resident for complications associated with urinary catheters. a. If the resident indicates that his or her bladder is full or that he or she needs to void (urinate), notify the physician or supervisor. b. Check the urine for unusual appearance (i.e., color, blood, etc.). c. Notify the physician or supervisor in the event of bleeding, or if the catheter is accidently removed. d. Report any complaints the resident may have of burning, tenderness, or pain in the urethral area. e. Observe for other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately. Managing Obstruction 1. If the catheter material is contributing to obstruction, notify the physician and change the catheter if instructed to do so. 2. Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction.

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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** 33552 Based on interview, and record review, 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 one (Resident #2) of five residents reviewed for medications and pharmacy services. The facility failed to administer Resident #2's blood pressure medication Midodrine in accordance with physician orders, by not obtaining his blood pressure prior to administering the medication on seven occasions from 01/12/25 through 01/23/25. The failure 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, including low blood pressure which could cause fainting or dizziness because the brain was not receiving enough blood. Findings included: Record review of Resident #2's Face Sheet dated 02/05/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted from the hospital on 01/29/25. Resident #2's active diagnoses included encephalopathy (a medical condition that affects the brain's function), type 2 diabetes (a chronic disease that affects how the body uses glucose (sugar) for energy), hyperlipidemia (a condition characterized by abnormally high levels of lipids (fats) in the blood, such as cholesterol and triglycerides), hypertension (a condition characterized by abnormally high levels of lipids (fats) in the blood, such as cholesterol and triglycerides), atrial flutter (a type of heart rhythm disorder where the upper chambers of the heartbeat rapidly and irregularly), heart failure (a condition where the heart is unable to pump blood effectively enough to meet the body's needs), end-stage renal disease (a condition in which the kidneys have permanently lost their ability to function properly) and a stage 4 pressure ulcer of the sacral region (a localized area of skin damage that develops when pressure on the skin cuts off blood flow to the area). Record review of Resident #2's admission MDS assessment dated [DATE] reflected a BIMS score of 12, which indicated moderate cognitive impairment. Resident #2 had no behavioral symptoms and no rejection of care. Resident #2 had range of motion impairment on both sides of his lower extremities and use a wheelchair for mobility. Record review of Resident #2's care plan dated 08/29/24 and last updated on 01/23/25 reflected no discussion of his blood pressure medication and related health condition. Record review of Resident #2's January 2025 physician's orders reflected, Midodrine HCl Oral Tablet 5 MG Give 3 tablet by mouth three times a day for low bp- Hold for SBP greater than 110 (start date 01/12/25; dc 'ed 01/23/25). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's January 2025 MAR did not reflect all blood pressure recordings three times a day prior to the administration of his Midodrine on 01/12/25 (all three shifts), 01/13/25 (all three shifts), 01/18/25 (AM and HS shift), 01/19/25 (all three shifts), 01/20/25 (PM shift), 01/22/25 (AM and HS shift) and 01/23/25 (AM shift). Record review of Resident #2's nursing progress notes did not reflect all additional blood pressure readings for January 2025 when there was none documented on the MAR. An interview with ADON A on 02/07/25 at 12:30 PM revealed after investigator intervention, the facility was working with their corporate office to see if there was a template available to see if blood pressure readings were being taken, and if their e-charting system could turn red during a medication pass when an ordered blood pressure reading was not documented. The ADON A stated the charge nurses were taking residents' blood pressure readings on their own personal documentation, But that does not suffice .they have their own little system and how they do things. I told them it doesn't help us, it hurts us. Everything needs to be in [e-charting system]. An interview with the DON on 02/07/25 at 12:56 PM revealed after investigator intervention, nursing management in-serviced nursing staff on the blood pressure reading gaps and expectations going forward. She stated the facility was also going to initiate a PIP and ensure that was a focus. The DON stated she knew the nurses were taking the blood pressure of residents because she witnessed it when she rounded the facility. She said she would go around and randomly ask what residents' blood pressure parameters were to the nursing staff to see if they were getting done. The DON stated the medication aides could also take residents' blood pressure and record them in the MARs. The DON said the charge nurses usually wrote their blood pressure readings down on a piece of paper, I have seen them do it, but then they are supposed to transfer them to the computer. The DON stated because she and ADON A were new, they were catching up on a lot of systems and procedures. The potential negative outcome of no recorded blood pressure readings prior to a hypotensive medication being taken was, Negative. hospitalization or worse. Midodrine is a medication used for high blood pressure. Giving a blood pressure medication when a resident has low blood pressure, they can go into cardiac arrest. An interview with LVN B on 02/07/25 at 1:31 PM revealed she was the charge nurse for Resident #2 and the medication aides were the ones who took the residents' blood pressure and administered the medications. LVN B stated it was important to take a hypotensive resident's blood pressure prior to administering their medication because if their blood pressure was too high and the Midodrine was given, then it could cause a stroke. An interview with the ADM on 02/07/25 at 2:29 PM revealed after investigator intervention, the nursing management did an audit on residents' hypotensive and hypertensive medications to make sure the monitoring was in place and would also place the issue on a PIP to be monitored by the ADON and DON. Review of the facility's policy titled, Medication Administration General Guidelines dated December 2024 reflected, .Medication Administration: .2. Obtain and record any vital signs as necessary prior to medication administration.

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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 33552

Based on interview and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized for three (Residents #1, #2 and #3) of five residents reviewed for pressure ulcers and non-pressure wounds.

1. The facility failed to document wound care was provided for Resident #1 in January 2025 on twelve occasions.

2. The facility failed to document wound care was provided for Resident #2 in January and February 2025 on eight occasions.

3. The facility failed to document wound care was provided for Resident #3 in January 2025 and February 2025 on 28 occasions.

This failure could place residents at risk of not receiving wound care, wounds worsening and a lack of oversight of their clinical records by the nursing staff and nursing management.

Findings included:

1. Record review of Resident #1's Face Sheet dated 02/05/25 reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1's active diagnoses included hypertensive heart and chronic kidney disease, pancytopenia, acute kidney failure, type 2 diabetes, hyperlipidemia, hypertension, atrial fibrillation and vascular dementia.

Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 14 which indicated no cognitive impairment. Resident #1 had range of motion impairment on both sides of her lower extremities and used a wheelchair for mobility. Resident #1 was at risk of developing pressure ulcers and did not have any pressure ulcers or any other skin issues that required treatments at the time of the assessment.

Record review of Resident #1's care plan dated 12/13/24 and revised 02/05/25 reflected she had an open area near the coccyx area and an unstageable pressure ulcer to the sacrum. Interventions included, Monitor/document location, size and treatment of skin injury, Treatment to coccyx, administer treatments as ordered and monitor for effectiveness, monitor dressing (FREQ) to ensure it is intact and adhering, Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/sx of infection, wound size, stage.

Record review of Resident #1's January 2025 physician orders reflected the following treatment orders:

- Cleanse sacral wound with Darkin solution, apply Santyl ointment, calcium alginate and dry dressing

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	daily and prn. as needed for dislodgment of dressing (start 01/03/25) - Cleanse sacral wound with Darkin solution, apply Santyl ointment, calcium alginate and dry dressing daily and prn. every day shift (start date 01/03/25) Record review of Resident #1's January 2025 TAR reflected no documented treatment to her sacral wound on 01/02/25, 01/09/25, 01/11/25, 01/16/25, 01/17/25, 01/18/25, 01/21/25, 01/24/25, 01/25/25, 01/26/25, 01/29/25 and 01/31/25. Record review of Resident #1's nursing progress notes for January 2025 reflected no additional wound treatment documented outside of what was already documented on the TAR. There was no discussion to indicate why the wound care was not performed on the numerous dates. Record review of Resident #1's wound care visit dated 01/29/25 reflected it was an evaluation of the wound on her sacrococcyx. The wound progress was noted to have decreased in size. An interview with Resident #1 on 02/07/25 at 11:15 AM revealed she was receiving wound care but she was not sure on her bottom where it was located. Resident #1 said she could not feel her wound and was not in any pain with the wound. She stated the nurses did wound care once a day and the wound nurse was really good. 2. Record review of Resident #2's Face Sheet dated 02/05/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted from the hospital on 01/29/25. Resident #2's active diagnoses included encephalopathy (a medical condition that affects the brain's function), type 2 diabetes (a chronic disease that affects how the body uses glucose (sugar) for energy), hyperlipidemia (a condition characterized by abnormally high levels of lipids (fats) in the blood, such as cholesterol and triglycerides), hypertension (a condition characterized by abnormally high levels of lipids (fats) in the blood, such as cholesterol and triglycerides), atrial flutter (a type of heart rhythm disorder where the upper chambers of the heartbeat rapidly and irregularly), heart failure (a condition where the heart is unable to pump blood effectively enough to meet the body's needs), end-stage renal disease (a condition in which the kidneys have permanently lost their ability to function properly) and a stage 4 pressure ulcer of the sacral region (a localized area of skin damage that develops when pressure on the skin cuts off blood flow to the area). Record review of Resident #2's admission MDS assessment dated [DATE] reflected a BIMS score of 12 which indicated no cognitive impairment and no rejection of care issues. Resident #2 was dependent on staff for all areas of mobility and required assistance with ADLs. Resident #2 was frequently incontinent of bowel and had an indwelling catheter (a thin, flexible tube that is inserted into the body to drain or deliver fluids). Resident #2 was at risk of developing pressure ulcers and had one unhealed stage 4 pressure ulcer at the time of the assessment. Resident #2 also had an unstageable deep tissue injury and a diabetic ulcer on his foot, a surgical wound and moisture-associated skin damage. He required a Pressure reducing device for his chair, a pressure reducing device for the bed, nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, surgical wound care, application of nonsurgical dressings and applications of ointments/medications. (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 care plan dated 08/29/24 and last revised 01/23/25 reflected he had one stage 4 pressure ulcer to his sacrum (initiated 09/06/24) and had a diabetic ulcer. Interventions included 1) Administer treatments as ordered and monitor for effectiveness, 2) Monitor dressing daily to ensure it is intact and adhering. Report lose dressing to treatment nurse, 3) Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage, 4) Treatment to sacrum-Cleanse with NS, pat dry, apply Calcium Alginate with honey, cover with dry dressing daily and prn, 5) Treat wound as per facility protocol, 6) Treatment to left medial heel, 7) Treatment to right lateral foot. Record review of Resident #2's January and February 2025 physician's orders reflected the following treatment orders: - Cleanse LLE wounds with normal saline and dry, dress with xeroform and dry dressing every day shift every Mon, Wed, Fri for Treatment: If no improvement in 14 days consider treatment change. Notify MD if any changes in wound or any s/s of infection (start date 01/31/25 to open ended). -Cleanse wound with Dakin's and pack with Dakin's-soaked gauze and cover with bordered gauze. Cleanse sacrum with NS and place thick layer of zinc around genitals. every day shift every Mon, Wed, Fri for Wound Care If no improvement in 14 days consider treatment change (Start 01/31/25, discontinued 02/03/25). -Cleanse penile shaft and scrotum area with normal saline and dry area. Apply zinc oxide, daily and during incontinence care. one time a day for Incontinence Associated Dermatitis/Weepy Edema/Intertrigo If no improvement in 14 days consider treatment change (start date 01/15/25, discontinued 01/23/25). -Miconazole External Powder 2% apply topically two times a day for candida infection for ten days (start date 01/12/25). Record review of Resident #2's January 2025 TARs reflected no documented treatment to his penile shaft on 01/16/25, 01/18/25, 01/21/25 and 01/23/25 and no documented treatment for his candida infection on 01/13/25 and 01/16/25 through 01/21/25. Record review of Resident #2's February 2025 TARs reflected no documented treatment to his left lower extremity wound on 02/03/25. Record review of Resident #2's nursing progress notes for January and February 2025 reflected no additional wound/skin treatment documented outside of what was already documented on the TAR. There was no discussion to indicate why the wound and skin care was not performed on the numerous dates. Record review of Resident #2's wound care visit dated 02/05/25 reflected it was an evaluation his wound and indicated the moisture-associated skin damage to his scrotum (extending to his penile shaft) had decreased in size. The wound to his left medial heel had also decreased in size and the wound to his left lateral foot was unable to be determined since it was the first visit with that injury. The wound for his left lateral foot was noted to have a wound etiology from peripheral artery disease. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #2 on 02/07/25 at 10:45 AM revealed he was receiving wound care and they were being dressed every other day and he was not in any pain. 3. Record review of Resident #3's Face Sheet dated 02/05/25 reflected he was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #3's active diagnoses included chronic peripheral venous insufficiency (a condition where the veins in the legs become damaged, leading to poor blood flow back to the heart), non-pressure chronic ulcer (a persistent open sore or a chronic ulcer that doesn't heal properly) and lower leg amputation (a surgical procedure to remove part or all of the leg below the knee). Record review of Resident #3's admission MDS assessment dated [DATE] reflected a BIMS score of 14 which indicated no cognitive impairment and no rejection of care issues. Resident #3 was dependent on staff for all areas of mobility and required assistance with ADLs. He had range of motion impairment on both sides of his lower extremities and used a wheelchair and walker for mobility. Resident #3 was incontinent of bowel and bladder and was at risk of developing pressure ulcers. Resident #3 did not have any unhealed pressure ulcers at the time of the assessment but did have two venous and arterial ulcers present. Resident #3 had skin treatments which included the application of nonsurgical dressings, applications of ointments/medications and application of dressings to feet. Record review of Resident #3's care plan dated 01/17/25 and last revised 01/20/25 reflected he had a venous stasis ulcer related to peripheral vascular disease. Interventions included 1) Document location of wound, amt of drainage, peri-wound area, pain, edema, circumference measurements, 2) Evaluate wound for: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated, 3) I need skin exposure to moisture minimized due to incontinence, wound drainage or perspiration. Place (specify) to absorb moisture. Record review of Resident #3's January and February 2025 physician's orders reflected the following treatments: -Diphenhydramine Acetate External Cream- Apply to area of rash on bilateral arms, chest and abdomen three times a day (start date 01/18/25 through open ended). -Cleanse LLE with dakins and RLE with NS and dry, apply xeroform, Calcium alginate and cover w/ dry dressing, wrap with kerlix and Co Band. Ammonium lactate to remainder of legs, MWF. as needed for wound care (start date 01/23/25 to open ended). Record review of Resident #3's January and February 2025 TAR reflected no documented skin treatment to his rash every day from 01/21/25 through 02/05/25 on 27 occasions throughout the three nursing shifts. Record review of Resident #3's February 2025 TAR reflected no documented treatment to his left lower extremity wound on 02/03/25. (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 #3's nursing progress notes for January and February 2025 reflected no additional wound/skin treatment documented outside of what was already documented on the TAR. There was no discussion to indicate why the wound and skin care was not performed on the numerous dates. Record review of Resident #3's wound care visit dated 01/29/25 reflected it was an evaluation of his wounds found on the right leg, left leg, right 3rd toe, and left 3rd medial toe. The wounds were noted to have decreased in size with the exception of the left 3rd medial toe as it was the first visit, so progress was undetermined. 4. An interview with LVN C on 02/05/25 at 4:28 PM revealed she was the facility's wound care nurse and had been in that position for two months. LVN C stated when she worked as a wound care nurse, there were a number of times she was pulled to the floor to work as a charge nurse. She stated when that happened, then each charge nurse on the floor would do their own residents' wound care. If the charge nurse could not do it, then the oncoming nurse on the evening shift would have to complete it. LVN C stated she did not want any of the charge nurses, however, to do the residents' treatments with stage 3 or 4 pressure ulcers. When asked why there was no documented evidence that wound care was completed two days prior on 02/03/25 for Residents #2 and #3, LVN C stated she had to work the floor that day so the treatments would have been delegated to the charge nurses. LVN C stated when wound care was completed, the TAR was supposed to be completed and the charge nurses knew that. LVN C stated she documented wound care every day, I am not sure why there are blanks. She stated Resident #2 had been hospitalized four times in the last few months for the blanks on the TAR were days he was in the hospital or days he was at dialysis. LVN C stated, If he gets wound care done, it is documented .I can only be responsible for myself and do the best I can do. Regarding Resident #2, LVN C stated he had wound care done every single day and his wound was healing. She surmised the reason his TAR had blanks for treatment completed was that it was on days she was off work our out sick, And maybe they [charge nurses] haven't done it. Regarding Resident #3, LVN C stated he had only been at the facility for three weeks, his right leg had completely healed and she did the wound care to his bilateral extremity wounds every time she was at the facility. She said she did not complete Resident #3's wound care on 02/03/25 because the floor nurse was supposed to it, he was responsible for it. LVN C stated when she cannot do wound care, the DON was made aware and would let the charge nurses know they would need to complete it. LVN C stated she had been auditing all resident wounds for the past week that had been healed but had no treatment discontinued orders, But there is not a need usually because I know what to do and what not to do. LVN C stated she would know if wound care was not being done because she would see a discrepancy in the bandage not being dated to the current date. LVN C stated, If it was the same date as I write it then I know it wasn't done. She said the evidence of wound care being provided was not necessarily documentation, but if the wound was healing and anyone could click on the TAR the treatment was provided when it was not. LVN C stated she did not review the TARs to see if resident wound care was being documented as provided. She stated For things like not clicking off on the TARs, sometimes those minor things on the TAR, I don't think to click them off because I know all their [residents] orders. I can take fault for that. LVN C stated that was why she had asked the ADON/DON permission to discontinue the wound orders for residents who were supposed to have them only for a limited amount of time and their wound had healed. (continued on next page)

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

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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	An interview with ADON A and the DON on 02/05/25 at 5:06 PM revealed the facility had meetings about residents' skin every Tuesday and Thursday and their focus was on residents with open wounds and major wounds. She stated they also did skin sweeps twice a month and did random checks on residents on the 24-horu report for any skin changes. ADON A and the DON stated they had not run an audit for wounds for the past week, but in an audit, they could see what wound treatment had been missed. ADON A stated she did not remember seeing wound care being missed on the TAR for residents in the facility. She stated how she was alerted of a missed medication was if she went to look at it and it was color coded red in the e-charting system, but she only looked back at the last shift. An interview with ADON A on 02/07/25 at 12:30 PM revealed after investigator intervention, the facility nursing management reviewed wound documentation and saw the gaps in documentation. She said the issue was with the 6AM-6PM nurses, so they were going to make some re-adjustments. She said they did an audit of the wounds but did not know what the outcome was. She said they were going to have LVN C adjust the time of the orders so there were no gaps in documentation. ADON A stated, Hopefully that will eliminate the issue when we modify the times, then nothing will be missed. She said they now had the orders on the TAR on 6a-2p shift and 2p-10p shift and no longer on a 12-hour shift. An interview with LVN B on 02/07/25 at 1:31 PM revealed the charge nurses were responsible for wound care if LVN C was not there and they had to document the treatment was done. An interview with the ADM on 02/07/25 at 2:29 PM revealed she stated, It is a documentation issue. Going forward, we educated [LVN C] and nurses for documenting and checks and balances to make sure it is done. The ADM stated ADON A and the DON would oversee the wound documentation on a daily basis. Review of the facility's policy titled, Medication Administration: General Guidelines dated December 2024 reflected, .Documentation: 1. The individual who administers the medication dose, records the administration on the resident's eMAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications; 2. If a dose regularly scheduled medication is withheld, refused, or given at other than the scheduled time, the eMAR for that dosage administration is notated with the appropriate code and an explanatory note is entered in the resident's Progress Notes. If two consecutive doses of a vital medication are withheld or refused, the physician is notified; 3 .Topical Medications used in treatments are listed on the electric treatment administration record (eTAR); .4. The resident's eMAR/eTAR is initialed by the person administering the medication, in the space provided under the date, and on the lone for that specific medication dose administration and time. Initials on each eMAR/eTAR are verified with a full signature in the space provided at the end of the eMAR/eTAR or on the nursing care center's master employee signature log.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675820	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

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

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on interview and record review, the facility failed to obtain the hospice nursing documentation, most recent hospice plan of care specific to each patient, hospice election form, physician certification and recertification of the terminal illness specific to each patient, names and contact information for hospice personnel involved in hospice care of each patient, hospice medications information, hospice physician and attending physician orders for one (Resident #5) of three residents reviewed for hospice services and records. The facility failed to obtain the required hospice documentation for Resident #5 when she was admitted to hospice. This failure could affect residents by placing them at risk for services and treatments not being coordinated for end-of-life care. Findings included: Record review of Resident #5's Face Sheet dated 02/07/25 reflected she was admitted on [DATE]. Her active diagnoses included malignant neoplasm of the lung, secondary hypertension, chronic obstructive pulmonary disorder and chronic kidney disease. Review of Resident #5's admission MDS assessment dated [DATE] reflected a BIMS score of 11 which indicated moderate cognitive impairment. Resident #5 has range of motion impairment on both side of her upper and lower extremities and used a wheelchair for mobility. Resident #5 required substantial/maximum assistance of staff for all ADLs and was always incontinent of bladder and bowel. Resident #5 had a life expectancy of less than six months and received hospice services. Review of Resident #1's care plan dated 01/28/25 reflected she had a terminal illness and received hospice services. Interventions included .The facility/agency will consistent with palliative care, plan and implement to diminish the extent of dehydration experienced; .the facility/agency will plan and implement measures to minimize the development of impactions and discomfort, Gradual or rapid loss of ability to move about independently and/or become bedfast is expected, the facility / agency will plan and implement measures to maintain the activity level as long as possible, Placement of an indwelling catheter may be necessary for comfort and well-being, the facility/ agency will plan and implement measures to ensure the comfort with indwelling catheter and minimize urinary tract infections; Skin breakdown and/or pressure sores are expected with this resident. The facility/agency will, consistent with palliative care, plan and implement measures that will preserve as much skin integrity as possible; Weight loss is expected, The facility/agency will consistent with palliative care, plan and implement measures that diminish this weight loss as much as possible; Will require the frequent use of narcotics/anti-anxiety/hypnotic medications the facility/agency will plan and implement measures to maintain the appropriate levels of medication to ensure comfort. Review of Resident #5's January 2025 Physician Orders reflected she was admitted to hospice on 01/28/25 due to a diagnosis of congestive heart failure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675820	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's e-chart and hospice binder on 02/05/25 revealed no evidence of the physician's determination of terminal illness, a hospice election form and hospice RN nursing progress notes. An interview with the DON and ADON A on 02/05/25 at 5:06 PM revealed the facility was in the process of updating the residents' hospice binders and there had been a lot of change in facility staff recently. They stated there was no facility staff member designated as the hospice coordinator but they had hired a social worker who had just started employment. The DON stated that it was often difficult to get hospice providers to send the facility the resident's hospice documents. An interview with ADON A on 02/07/25 at 12:30 PM revealed after investigator intervention, the nursing management reached out to the hospice provider of Resident #5 and obtained the missing hospice documentation. An interview with the DON on 02/07/25 at 12:56 PM revealed all resident hospice binder had been updated and the potential harm of incomplete documentation could be, she stated, It can be a very bad outcome, most of our hospice, I have seen here that they are full code, so that is a very important aspect of that binder being correct. The DON stated the new SW would monitor the residents on hospice services going forward. An interview with LVN A on 02/07/25 at 1:31 PM revealed the facility had a new social worker who was going to be responsible for monitoring the hospice binders and documentation. LVN A stated hospice documentation was important, So we know what orders we have and they give us a copy of the DNR. An interview with the ADM on 02/07/25 at 2:29 PM revealed typically hospice documentation for the residents was monitored and tracked by the social worker, but the facility had been without a social worker for the past two months. The ADM stated the newly hired social worker would soon be auditing the residents' hospice binders for compliance. Review of the facility's policy titled, Hospice Program, revised December 2024 reflected, .12. Our facility has designated the Social Services Director and Director of Nursing to coordinate care provided to the resident by our facility staff and the hospice staff. He or she is responsible for the following: b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the terminal illness .; d. Obtaining the following information from hospice: .(2) Hospice election form, (3) Physician certification and recertification of the terminal illness specific to each resident .; e. Ensure that out facility staff provide orientation on the policies and procedures of the facility, including resident rights, appropriate forms, and record keeping requirements to hospice staff furnishing care to the residents.