STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675850	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coastal Palms Nursing & Rehabilitation	221 Cedar Dr Portland, TX 78374

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interviews and record reviews the facility failed to immediately inform the physician and/or resident/responsible party when there was a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) for one (Resident #1) of five residents reviewed for physician notification of changes. 1.The facility failed to notify the physician of Resident #1's wounds when she was admitted to the facility on [DATE]. 2.The facility did not consult with Resident #1's physician to reconcile Resident #1's hospital discharge wound treatment orders for specific wound care instructions upon admission on 12/16/23. 3.The facility failed to notify the physician upon the discovery of Resident #1's worsening wound on 12/24/23. An immediate jeopardy was identified on 04/09/24. The IJ template was provided to the facility on [DATE] at 3:15 PM. While the IJ was removed on 04/11/24 at 5:15 PM, the facility remained out of compliance at a scope of pattern with a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to monitor and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not receiving appropriate and timely medical interventions which could result in a decline in resident's condition, the need for hospitalization , or death. The findings included: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's admission record dated 12/16/23 revealed a [AGE] year-old female that was admitted /readmitted to the facility on [DATE] and discharged home on 01/20/24. Diagnoses included displaced intertrochanteric fracture of the right femur (fracture of the right thigh bone), left rib fractures due to fall at home, other abnormalities of gait and mobility, muscle wasting and atrophy- multiple sites, history of falling, spinal stenosis with neurogenic claudication (leg pain, heaviness, and/or weakness when walking), chronic obstructive pulmonary disease, and mild protein-calorie malnutrition. Resident #1 lived alone, had fallen at home on a Tuesday, and remained on the floor until Saturday, 4 days later, when she was able to drag herself to another room to reach a phone to call for help. Record review of Resident #1's Comprehensive MDS dated [DATE] revealed resident had a BIMS score of 15, which indicated she was cognitively intact. Record review of Resident #1's hospital discharge orders dated 12/15/23 revealed an order for dressing changes to wounds on Resident #1's left elbow, left hip, left knee, and left foot to be done daily or as needed if soiled and steri-strips (thin adhesive bandages used to close the surgical incision after staples are removed) to right hip to remain in place. Record review of Resident#1's Admission/ Readmission nurse's notes- head to toe skin assessment dated [DATE] at 03:43 PM and signed by LVN A, indicated resident had non pressure skin impairments of skin tear(s) and an incision/ surgical wound. The nurse's notes also indicated a pressure injury on Resident #1's coccyx (tailbone). Comments were Stage 1 to coccyx. Skin tears to bilateral upper extremities (both arms), left hip, left knee, and left foot 5th digit. In a phone interview on 04/03/24 at 01:43 PM, Resident #1's FM stated Resident #1 fell at home, broke her leg, was on the floor for at least 4 days, and had to drag herself from one room to another to get her phone to call for help. FM stated the hospital put a clear dressing on Resident #1's left outer knee wound on 12/16/23 at 5:00 AM. FM stated she arrived to the facility on [DATE] and found the same dressing was still on the wound with the same date of 12/16/23 5:00 AM marked on the dressing. FM stated that when she brought it to the attention of the nurse, she was told that it was just a skin tear. FM stated she informed the nurse that the wound had green pus under the dressing. FM stated that she had the facility contact the DON for her and once she spoke to the DON, the nurse came in a few minutes later to change the dressing. FM stated when the dressing was taken off, the wound looked nasty and almost necrotic and it was absolutely disgusting and that she took a picture of it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Coastal Palms Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 221 Cedar Dr Portland, TX 78374	

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/05/24 at 12:30 PM, LVN A stated that when she got report on Resident #1 from the hospital, they did not tell her anything about any wounds. When asked about the wound to Resident #1's left knee, LVN A stated she documented it as a skin tear. LVN A stated she did not take the dressing off the wound and that she did not know exactly what it looked like. LVN A stated that she did not want to remove the dressing because she did not want to aggravate the skin tear. When asked about the admission order process, LVN A stated she would read the hospital discharge orders, put the orders into the nursing facility system and contact the provider to verify the orders and accept the admission into the system. LVN A stated that she would contact the provider before doing an assessment and if she had found anything unexpected or unusual, she would call the provider back to let them know about it. When asked about the wounds to Resident #1's left side, LVN A stated she did not contact the provider because they do not usually call them about skin tears. LVN A was shown a photo of Resident #1's left knee dressing that was taken on 12/24/23 before it was removed. LVN A described it as a transparent dressing on a person's leg with some kind of absorbable material under it, but that she could not describe the wound because she could not see it underneath the dressing. LVN A stated that she attempted to contact the on-call physician and it must not have been documented because she was waiting on a call back that she never received. LVN A did not state whether she told the next shift that she was waiting on a call back from the physician. In a phone interview on 04/08/24 at 10:50 AM, LVN B stated she was not aware of Resident #1's wounds until a family member called her into the room and told her about it on 12/24/23. LVN B stated the family member had the dressing in their hand and the dressing appeared soiled. LVN B stated the wound had slough and brownish/greenish drainage that could have indicated infection. LVN B stated she attempted to contact the physician but did not receive a call back. She did work the next day and stated she does not recall attempting to follow up with the physician about the wound. LVN B stated she does not recall documenting her attempt to contact the physician. In an interview with ADMIN and ADON on 04/05/24 at 06:37 PM, ADON stated the facility admitting process was: after receiving the resident, review admitting orders, call physician to notify of resident's admission and review and reconcile the admitting orders, assess resident - if any abnormal assessment finding the nurse must notify the physician to retrieve and or modify orders as necessary. The facility's policy on Changes in Resident Condition dated 05/2017 and reviewed/revised January 2023 stated in part: The resident, assigned medical provider, and resident representative or designated family member should be notified when there is a significant change in the resident's physical, mental or psychosocial status or a need to alter treatment significantly (.a need to commence new treatment) and changes in condition should be communicated from shift to shift in the 24-hour report management system. The policy also stated changes in the resident status that affect the problem(s)/goal(s) or approach(s) on his/her care plan should be documented as revisions and communicated to the interdisciplinary caregivers. Documentation was to be done in the Nursing Progress Notes indicating date, time, and who was notified (physician/resident representative), information communicated, and response and/or orders received. This was determined to be an Immediate Jeopardy (IJ) on 04/09/2024 at 3:15 PM. The administrator was notified. The Administrator was provided with the IJ template on 04/09/2024. The following Plan of Removal was accepted on 04/10/2024 at 5:15 PM and indicated the following: [Facility] Plan of Removal (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Coastal Palms Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 221 Cedar Dr Portland, TX 78374	

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	F684 Quality of Care 04/09/24 It is the policy of this community to provide safe and quality nursing/medication administration practices to minimize and/or prevent less than quality of care provided to the residents we serve. 1. Resident A was properly assessed and there were no adverse effects associated with alleged deficient practice. Treatment order obtained on 12/27/23. Resident A discharged home on 01/20/24. 2. 100% skin assessment completed on all residents. Skin assessments updated. Outcome: There were no negative outcomes identified. Date Completed: 04-10-24 3. Education provided to all licensed nurses related to the process for system management to include Administrative nurses (DNS ADNS & WCN) received re-education by the DCO (regional nurse) ensuring that: a. Upon admission, the day of, or the shift the resident is admitted to facility, the admitting nurse will notify the accepting MD/NP of the resident's condition to include any wounds/skin concerns identified. The nurse will then verify the and/or obtain admission orders and treatment orders at that time. In the event the nurse is unable to reach the accepting PCP (MD/NP) then the nurse will call the medical director and document notification attempts within the medical record. The DNS/ADNS/RN supervisor will review admission on the next day to validate that the appropriate treatment orders are noted within the orders of the medical record. o Upon a resident change in condition the assessing or evaluating nurse will notify the MD/NP of the identified change in condition to include newly identified and/or deteriorating wounds. The notification to the medical provider will be promptly, depending on the nature or severity of the identified change in the resident's status. Urgent condition changes may require immediate emergency response, such as notifying and eliciting 911 for emergency care. The nurse will notify the MD/NP immediately but no later than end of the current shift. The nurse will document the notification to the medical provided within the electronic health record, enter any new orders provided. The nurse on duty of the current shift will implement the new orders as prescribed; accordingly, for example, the nurse will administer the initial dose of the medication or treatment as ordered by the MD/NP per their direction to be started immediately or stat, same day, to initiate new order on the next day, upon arrival of new medication or treatment. o Upon the next business day, during the clinical review meeting that takes place M-F, the clinical leadership (DNS/ADNS/DCE) will review admission/re-admission skin assessment/evaluations, changes in conditions, progress notes to ensure that the required documentation is in place within the electronic health record. The DNS/ADNS/DCE is responsible for validating that the notification has been made, new orders (treatment orders) are carried out as prescribed. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Upon the next business day, during the clinical review meeting that takes place M-F, the clinical leadership (DNS/ADNS/DCE) will review changes in conditions, progress notes to ensure that newly identified wounds or deteriorating wounds have been documented within the electronic health record. The DNS/ADNS/DCE is responsible for validating that the appropriate documentation is in place within the E.H.R. Date Completed: 04-10-24 Administrative nurses (DNS ADNS & WCN) received re-education by the DCO (regional nurse) ensuring that documentation within the electronic health record accurately reflects the wound presentation and status to include but not limited to nursing progress notes, skin assessments and the skilled nurse note assessment form within the medical record. Nursing documentation is expected to be completed prior to the end of the nurse's shift. Date Completed: 04-10-24 Administrative nurses (DNS ADNS & WCN) received re-education by the DCO (regional nurse) on the process of administrative nurses notifying the charge nurses at the start of the shift (or as soon as it has been identified that they wound care nurse will not work that day) of their responsibility to administer wound care/treatments and complete assigned skin assessments for that shift in the event the wound care nurse calls off shift and/or if the designated treatment nurse is absent for any reason, licensed nurse will contact DNS/ADNS. The DNS/ADNS will reassign treatments and verify completion at the end of the shift, by instructing the charge nurse to notify the DNS/ADNS should any treatment not be completed upon the end of their shift. Date Completed: 04-10-24 DNS (director of nurses)/designee educated the licensed nurses on ensuring that identified new admission treatment orders are verified with the accepting MD/NP upon admission/readmission, communicating changes in conditions to the medical provider, to include newly identified and/or deteriorating wounds. If PCP/NP does not call back timely to give orders, contact DNS/Medical Director for orders. Thus, ensuring appropriate documentation of the identified wound status and medical provider's wound care orders are noted within the E.H.R accordingly. o Upon admission, the day of, or the shift the resident is admitted to facility, the admitting nurse will notify the accepting MD/NP of the resident's condition to include any wounds/skin concerns identified. The nurse will then verify the and/or obtain admission orders and treatment orders at that time. In the event the nurse is unable to reach the accepting PCP (MD/NP) then the nurse will call the medical director and document notification attempts within the medical record. The DNS/ADNS/RN supervisor will review admission on the next day to validate that the appropriate treatment orders are noted within the orders of the medical record. Date Completed: 04-10-24 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DNS (director of nurses)/designee educated the licensed nurses on ensuring that documentation within the electronic health record accurately reflects the wound presentation and status to include but not limited to nursing progress notes, skin assessments and skilled nurses' notes/assessment form. Nursing documentation is expected to be completed prior to the end of the nurse's shift. Skilled nurse note assessment form should be completed daily when the resident is noted as under skilled care and services, progress notes are expected to be completed as indicated or upon exception and the skin assessment is expected to be completed at least weekly. All nursing documentation should be completed prior to the end of the assigned nurse's shift. Date Completed: 04-10-24 DNS (director of nurses)/designee educated the licensed nurses on the process of administrative nurses notifying the charge nurses on shift of their responsibility to administer wound care/treatments and complete assigned skin assessments for that shift in the event the wound care nurse calls off shift and/or if the designated treatment nurse is absent for any reason, licensed nurse will contact DNS/ADNS. DNS/ADNS will reassign treatments and verify completion. The administrative nurses will notify the charge nurses at the start of the shift (or as soon as it has been identified that they wound care nurse will not work that day) of their responsibility to administer wound care/treatments and complete assigned skin assessments for that shift in the event the wound care nurse calls off shift and/or if the designated treatment nurse is absent for any reason, licensed nurse will contact DNS/ADNS. The DNS/ADNS will reassign treatments and verify completion at the end of the shift, by instructing the charge nurse to notify the DNS/ADNS should any treatment not be completed upon the end of their shift. Date Completed: 04-10-24 DNS (director of nursing)/designee will monitor this process to validate appropriate communication and to ensure patient care needs are met. Date Completed: 04-10-24 DNS (director of nurses)/designee educated the licensed nurses on clinical documentation review upon admit/readmit noting pressure injury/skin concerns identified. A full body skin assessment - intentionally assessing the resident head to toe for evidence of any pressure injury or skin concerns. If a newly admitted resident has an intact dressing in place, the nurse will remove the dressing to complete the skin assessment unless otherwise order not to remove the dressing by the MD/NP and in this case the will document the given instructions by the MD/NP and assess the skin around the dressing indicated the presentation of s/s of infection to the tissue surrounding the dressing in place. The nurse will document the instructions and skin assessment findings within the medical record at that time. Date Completed: 04-10-24 DNS (director of nurses)/designee educated the licensed nurses on the Braden Risk Assessment to be completed by the assigned nurse upon admission, significant change of condition and quarterly reviews in addition to routine re-assessment the Braden Risk Assessment will be completed upon identifying a new onset of pressure related skin injury. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Date Completed: 04-10-24 DNS (director of nurses)/designee educated the licensed nurses on conducting weekly skin assessments/evaluation shall be completed upon admission/readmit at least every 7 days thereafter and as clinically indicated thereafter. Head to toe skin assessment- consists of conducting a head - to- toe skin assessment to identify actual skin concerns, such as pressure injury or other skin concerns. After completing the assessment, the nurse will document accordingly. PCP and RP notification and follow through with any new orders. Plan of care will be updated. Date Completed:04-10-24 DNS (director of nurses)/designee educated the licensed nurses on completing weekly skin assessment should be conducted by the designated nurse and/or designated wound care nurse and follow up with new communication to PCP and orders accordingly. Signing out for weekly skin assessments on the MAR and signing out the treatments as ordered and administered by licensed nurse . Date Completed: 04-10-24 DNS (director of nurses)/designee educated the licensed nurses on proper documentation of site, staging as indicated, measurement taken and noting wound bed appearance to be completed on the Skin/Wound Module within the E.H.R. Nursing obtaining wound care orders for identified wounds and implementing treatment orders as per MD/NP orders and ensuring that the RP notified. Date Completed: 04-10-24 DNS, ADNS, or Wound Care Nurse will conduct post admission skin assessments within 24 -72 hours post admission/readmit to validate accuracy of documentation of skin condition noting wound type, presentation, appropriate state for pressure ulcer injuries, validation of proper treatment orders is in place and any consultations are made as clinically indicated. Date Completed: 04-10-24 IDT will review and update plan of care at the initial 48-72 baseline care plan, at the time of the comprehensive care plan, not later than day 21, quarterly thereafter, upon significant change and annually in order to ensure appropriate interventions are in place to address the prevention of or minimizing the risks associated with skin injury in relation to the identified resident's clinical complexity and resident care needs. Date Completed: 04-9-24 Adhoc QAPI held with Medical Director on 4-9-24 to review plan of action and plan of removal submitted. The facility will conduct a monthly QAPI meeting going forward with the Medical Director to discuss the status of compliance. Date Completed: 04-9-24 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The admitting nurse will review the hospital discharge paperwork, specifically the hospital discharge orders / instructions and the nurse will review this information with the accepting PCP/NP upon being contacted to verify admission/readmission orders. Date Completed:04-10-24 If PCP/NP does not call back timely (within a reasonable amount of time, during the current shift depending on the urgency of the resident's condition) the nurse should contact the Medical Director to report the resident's condition, verify orders or need for orders before the end of the shift. The nurse will document efforts and any new orders obtained within the medical record. Completed: 04/10/24 4. During the daily clinical review meeting held (5-7 days per week) the DNS/Designee will review new admissions/ readmissions and changes in condition (SBARS) r/t skin/wound concerns in order to ensure accuracy and to ensure appropriate follow up interventions are in place. DNS/ADNS will conduct weekly random audits 3x week x 8 weeks of resident's skin assessments and treatments to verify assessment is correct, orders are in place, and care plan is up to date. Findings of audits and system management will be reported to the Administrator and the QAPI committee during the monthly meetings for the next 2 months, identifying system compliance or need for further education and clinical oversight. Verification of the facility's Plan of Removal consisted of the following: Observations of wound care were conducted on 04/11/24 for Resident #30's non pressure injury and Resident #31's two pressure injuries. No issues were noted with wound care. Interviews with licensed staff (included all three shifts) on 04/11/24 included: 10:34 AM - LVN C 10:40 AM - LVN D 10:52 AM - LVN E 11:02 AM - LVN F 11:08 AM - LVN G 11:21 AM - LVN H 11:25 AM - LVN I 11:28 AM - LVN J 2:46 PM - LVN K (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Nurse Documentation dated 04/05/24 Notification of Changes dated 04/09/24 Skin and Wound Prevention and Management Policy and Procedure dated 03/14/19 -Review of the facility's Resident Wound Line List dated 04/11/24 indicated 20 residents with non-pressure wounds and 16 residents with pressure injury wounds. -Review of the facility's QAPI Agenda/Sign-In Sheet dated 04/09/24 revealed the facility met regarding Skin and Wound System Compliance. The QAPI indicated DNS, ADNS or Wound Care Nurse will conduct post admission skin assessments within 24-72 hours post admission/readmit to validate accuracy of documentation of skin condition noting wound types, presentation, appropriate stage for pressure injuries, validation of proper treatment orders is in place and any consultations are made as clinically indicated, and plan of care updated. -Review of the facility's 100% Skin Assessment Log indicted each resident was provided an updated skin assessment on 04/05/24 and/or 04/06/24. Review of Resident #2's, clinical record/skin assessment revealed skin assessments were completed on 04/05/24 and/or 04/06/24, no concerns identified. Review of the facility's undated Monitoring Tool indicated DNS, ADNS or Wound Care Nurse will conduct post admission skin assessments within 24-72 hours post admission/readmit to validate accuracy of documentation of skin condition noting wound types, presentation, appropriate stage for pressure injuries, validation of proper treatment orders is in place and any consultations are made as clinically indicated, and plan of care updated. Comparison of the Monitoring Tool and the New Admission Log beginning on 04/06/24- 04/10/24 indicted each resident's (Resident #s 27,28,29,30,31,32) Admission Skin Assessment were reviewed and no concerns were noted. The facility was informed the Immediate Jeopardy (IJ) was removed on 04/11/24 at 5:15 PM. The facility remained out of compliance at a scope of pattern with a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to monitor and evaluate the effectiveness of the corrective systems.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs for one (Resident #1) of five residents reviewed for care plans. 1. The facility failed to address and include objectives, goals, and interventions specific to Resident #1's surgical and other wounds, oxygen therapy, fall risk, or pain that were present upon her admission on 12/16/23. 2. The facility failed to immediately update Resident #1's care plan upon a change in condition, specifically when Resident #1's wounds were found to be worse on 12/24/23. This failure could place residents at increased risk of not having their individual needs met and decreased quality of life. The findings included: Record review of Resident #1's admission record dated 12/16/23 revealed a [AGE] year-old female that was readmitted to the facility on [DATE]. Diagnoses included displaced intertrochanteric fracture of the right femur (fracture of the right thigh bone), left rib fracture due to fall at home, other abnormalities of gait and mobility, muscle wasting and atrophy- multiple sites, history of falling, spinal stenosis with neurogenic claudication (leg pain, heaviness, and/or weakness when walking), chronic obstructive pulmonary disease, and mild protein-calorie malnutrition. Record review of Resident #1's Comprehensive MDS dated [DATE] revealed resident had a BIMS score of 15, which indicated she was cognitively intact. Record review of Resident #1's hospital discharge orders dated 12/15/23 revealed an order for dressing changes to wounds on Resident #1's left elbow, left hip, left knee, and left foot to be done daily or as needed if soiled and steri-strips (thin adhesive bandages used to close the surgical incision after staples are removed) to right hip to remain in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coastal Palms Nursing & Rehabilitation	221 Cedar Dr Portland, TX 78374

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Admission/ readmission nurse's notes dated 12/16/23 at 03:43 PM and signed by LVN A revealed Resident #1 had a clinical condition of respiratory disease/condition and the respiratory assessment indicated Resident #1 was receiving oxygen therapy. Resident #1's head to toe skin assessment indicated resident had non pressure skin impairments of skin tear(s) and an incision/ surgical wound. The nurse's notes also indicated a pressure injury on Resident #1's coccyx (tailbone). Comments were Stage 1 to coccyx. Skin tears to bilateral upper extremities (both arms), left hip, left knee, and left foot 5th digit. In the pain section, LVN A documented that Resident #1 had back and right hip pain that was acute (experienced to a severe or intense degree) and frequent, described as aching, stabbing, and sharp and relieved by medication and frequent position change. In the fall risk review section, LVN A documented that Resident #1 had recent falls (one or more between 3 and 12 months ago). LVN A did not document that Resident #1 had one or more falls in the previous 3 months, though the resident was admitted for a fractured leg that occurred as a result from a fall at home one month prior. In the box marked check if the resident is a high risk for falls, the box was checked. Record review of Resident #1's admission care plan dated 12/16/23 and revised on 02/07/23 (after discharge) revealed no focus or interventions for surgical site care and no focus or interventions for skin or wound care. Resident #1's care plan also did not include focus or interventions for oxygen therapy, fall risk, or pain. Resident #1's care plan had a focus of I have a self-care deficit r/t (DX). There was no diagnosis listed. The goals and interventions for the self-care deficit were appropriate. The next focus listed on Resident #1's care plan was I am allergic to Chantix. The goal and interventions were appropriate. The third and final focus on Resident #1's care plan, initiated on 01/02/24 by LVN A and revised on 02/07/24 by RMDS after resident was discharged , was At risk for infection or recurrent/chronic infection r/t compromised medical condition: There was no medical condition listed. In an interview on 04/05/24 at 1:46 PM with MDS, she stated that initial care plans for new admissions were created when the admitting nurse did the assessment and put things in there. MDS stated she would review the clinical record, enter the diagnoses, and adjust the care plan. MDS stated the care plans were usually updated right away if there was a change in condition. MDS explained that the purpose of a care plan was to let everyone know what the resident's needs were based on all aspects of the resident; it was all inclusive and was the totality of care that the resident needed and was specific to that individual. MDS stated that if something didn't get care planned, it could result in a lack of appropriate care. MDS stated that surgical and non- surgical wounds or any type of injuries should be care planned. MDS stated, in total, I'm responsible for care plans, but I suppose it would be an IDT effort. MDS stated she could not recall exactly, but she had been on vacation sometime in December (2023). Record review of the facility's Care Plan Policy dated 02/017, revised 03/2022 stated in part: The community develops a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan: -is developed within seven days of the completion of the comprehensive assessment; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Coastal Palms Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 221 Cedar Dr Portland, TX 78374	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-is prepared by the interdisciplinary team, including the attending physician, a registered nurse with responsibility for the resident, and other appropriate team members in disciplines as determined by the resident's needs. The care plan reflects intermediate steps for each outcome objective if they will enhance the resident's ability to meet his or her objectives. Team members use these objectives to monitor resident progress. Record review of the facility's Changes in Resident Condition Policy dated 05/2017, revised 01/2023, stated in part: Changes in the resident status that affect the problem(s)/goal(s) or approach(s) on his/her care plan should be documented as revisions and communicated to the interdisciplinary caregivers.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on record review and interview, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (Resident #1) of five residents reviewed for quality of care. 1. Upon admission on 12/16/23 at 03:43 PM, the facility failed to perform a thorough, comprehensive head to toe assessment and correctly identify, describe, and document the multiple wounds of Resident #1. 2. Provide Resident #1 with wound care to her wounds as indicated in her hospital discharge orders on 12/16/23. Resident #1 did not receive wound care orders until 11 days later on 12/27/23. 3. The facility did not consult with Resident #1's physician to reconcile Resident #1's hospital discharge wound treatment orders for specific wound care instructions upon admission on 12/16/23. 4. The facility failed to perform and document consistent accurate and detailed assessments of Resident #1's wounds to present accurate wound progress and ensure appropriate treatment was developed. 5. The facility failed to address and include objectives, goals, and interventions specific to Resident #1's surgical and other wounds, oxygen therapy, fall risk, or pain that were present upon her admission on 12/16/23. 6. The facility failed to immediately update Resident #1's care plan upon a change in condition, specifically when Resident #1's wounds were found to be worse on 12/24/23. An immediate jeopardy was identified on 04/09/24. The IJ template was provided to the facility on [DATE] at 3:15 PM. While the IJ was removed on 04/11/24 at 5:15 PM, the facility remained out of compliance at a scope of pattern with a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to monitor and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not receiving appropriate and timely medical interventions which could result in a decline in resident's condition, the need for hospitalization , or death. The findings included: (continued on next page)

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Coastal Palms Nursing & Rehabilitation	221 Cedar Dr Portland, TX 78374

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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 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Record review of Resident #1's admission record dated 12/16/23 revealed a [AGE] year-old female that was admitted /readmitted to the facility on [DATE] and discharged home on 01/20/24. Diagnoses included displaced intertrochanteric fracture of the right femur (fracture of the right thigh bone), left rib fractures due to fall at home, other abnormalities of gait and mobility, muscle wasting and atrophy- multiple sites, history of falling, spinal stenosis with neurogenic claudication (leg pain, heaviness, and/or weakness when walking), chronic obstructive pulmonary disease, and mild protein-calorie malnutrition. Resident #1 lived alone, had fallen at home on a Tuesday, and remained on the floor until Saturday, 4 days later, when she was able to drag herself to another room to reach a phone to call for help.

Record review of Resident #1's Comprehensive MDS dated [DATE] revealed resident had a BIMS score of 15, which indicated she was cognitively intact.

Record review of Resident #1's hospital discharge orders dated 12/15/23 revealed an order for dressing changes to wounds on Resident #1's left elbow, left hip, left knee, and left foot to be done daily or as needed if soiled and steri-strips (thin adhesive bandages used to close the surgical incision after staples are removed) to right hip to remain in place.

Record review of Resident #1's Physician's Order Summary Report dated 12/16/23 revealed an entry that stated, the nurse contacted me as the attending and I reviewed the transfer/admission orders no later than the following day of admission by midnight and made the recommended changes as needed for the plan of care, and, As the PCP I have reviewed, acknowledged and approve all active prescribed orders and plan of care during this residents skilled nursing care stay since the last order review. Both orders were verbal orders dated 12/16/23.

Record review of Resident #1's Physician Order Summary Report dated December 2023 revealed Resident #1's wound care orders were not transcribed into the facility electronic system until 12/27/24 for any of Resident #1's non-surgical wounds and that Surgical site assessment/care was not ordered on Resident #1's right leg.

Record review of Resident #1's Admission/ readmission nurse's notes dated 12/16/23 at 03:43 pm and signed by LVN A revealed Resident #1 had a clinical condition of respiratory disease/condition and the respiratory assessment indicated Resident #1 was receiving oxygen therapy. Resident #1's head to toe skin assessment indicated resident had non pressure skin impairments of skin tear(s) and an incision/ surgical wound. The nurse's notes also indicated a pressure injury on Resident #1's coccyx (tailbone). Comments were Stage 1 to coccyx. Skin tears to bilateral upper extremities (both arms), left hip, left knee, and left foot 5th digit. In the pain section, LVN A documented that Resident #1 had back and right hip pain that was acute (experienced to a severe or intense degree) and frequent, described as aching, stabbing, and sharp and relieved by medication and frequent position change. In the fall risk review section, LVN A documented that Resident #1 had recent falls (one or more between 3 and 12 months ago). LVN A did not document that Resident #1 had one or more falls in the previous 3 months, though the resident was admitted for a fractured leg that occurred as a result from a fall at home one month prior. In the box marked check if the resident is a high risk for falls, the box was checked.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Coastal Palms Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 221 Cedar Dr Portland, TX 78374	

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Admission MDS dated [DATE] revealed Resident #1 was not coded for any pressure ulcers or skin tears which was inconsistent with the nursing admission document dated 12/16/23 which revealed Stage 1 to coccyx; skin tear to bilateral upper extremities, left hip, left knee, left foot 5th digit. Resident #1 was coded for surgical wound(s) and surgical wound(s) care. Record review of Resident #1's Daily Skilled Nursing Notes documented the following for the dates indicated: -12/16/23, 12/18/23, 12/21/23, 12/23/23 revealed Section 1.2. Nursing Observation and Assessment, Assess, Monitor, stabilize medical condition s/p acute illness/ event; Wound care and pressure relief/offloading. Skin: Surgical incision. The notes did not include any mention or assessment of any other wound location or description. -12/24/23-12/28/23 and 01/14/24-01/17/24 revealed no wounds indicated. Which is inconsistent with the admission skin assessment dated on 12/16/23. -12/29/23, 12/30/23, 01/18/24, 01/19/24 revealed Dressing clean/dry/intact and Non pressure injury/ulcer. The notes did not include any wound location or description. -01/07/24-01/09/24 indicated Non pressure injury/ ulcer. The notes did not include any wound location or description. -01/10/24 indicated, Non pressure injury/ ulcer and bruising and discoloration on skin. The notes did not include any wound location or detailed wound description. There were no Daily Skilled Nurses notes documented on 12/17/23, 12/19/23, 12/20/23, 12/22/23, 01/11/24-01/13/24, or 01/15/24. Record review of Resident #1's Physician Order Summary Report dated December 2023 revealed an order that read, Complete the PCC Skin &Wound - Total Body Skin Assessment every day shift every Sat for Skin Integrity that had an order date of 12/16/23 and a start date of 12/23/23. Record review of Resident #1's PCC Skin and Wound- Total Body Skin assessment dated [DATE] at 08:42PM, 01/04/2024 at 09:53AM, 01/12/2024 at 05:03PM, and 01/13/2024 at 08:24AM revealed Resident #1 had good turgor elasticity, normal skin color, warm (normal) temperature, normal moisture, and normal skin condition with no new wounds documented. Record review of Resident #1's Skin and Wound Evaluation dated 01/19/24 at 05:11 PM revealed Resident #1 had a stage 2 pressure injury that was documented as present upon admission but also documented as present for one week. It documented Area as 1.0 cm, Length as 1.8cm, and Width as 0.3cm. The document stated the wound had 40% of wound covered by epithelial cells, 60% wound filled by granulation, and 30% of wound filled by slough. Exudate (drainage) was documented as moderate and seropurulent (clear with pus) and no odor. Edges were documented at rolled with epithelization and surrounding tissue was documented as blanching, dry/flaky, fragile, intact, normal in color, and scarring. The wound was documented as improving. There was, however, no location of this wound documented. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Skin and Wound Evaluation dated 01/19/24 at 5:14 PM revealed Resident #1 had a front Left Lateral Thigh, Proximal (front/side of left thigh, closer to the hip) pressure injury present on admission, that was documented as a Stage 2 (partial-thickness skin loss with exposed dermis). It stated it was unknown how long the wound was present. Area length, and width were left with no actual numerical measurement value. Documented was 100% of wound was covered by epithelial, with 0% slough of wound filled. Documented the wound bed was noted pink or red, no amount of exudate (drainage), but then documented serous (clear) exudate. The surrounding tissue was documented as eczematous (rash), erythema (redness) but also normal in color. This was inconsistent with the admission skin assessment dated [DATE] which documented a stage 1 pressure injury to coccyx and skin tears to both arms, left thigh area, left outer knee area, and left 5th toe. Record review of Resident #1's Skin and Wound Evaluation dated 01/19/24 at 5:18 PM revealed Resident#1 had a front left lateral lower leg, distal (front of the left lower leg toward the outside, closer to the ankle) abscess present on admission. It stated it was unknown how long the wound was present. Documented was 10% of wound was covered by epithelial, with 70% slough of wound filled. Documented area 2.1cm area, 2. 1cm length, and 1.3cm wide; Documented was noted bleeding and fibrin, moderate amount of exudate (drainage) seropurulent (clear with pus), with faint odor. Surrounding tissue was blanching, dry/flaky, erythema (redness of skin), fragile (skin at risk for breakdown) and intact. Documented was non-pitting edema extended to less than 4cm around the wound. This was inconsistent with the nursing admission/ readmission assessment dated [DATE] that did not mention a wound or abscess to this area. Record review of Resident #1's Skin and Wound Evaluations dated 01/19/24 revealed there is no documentation of Resident #1's coccyx wound nor the wound on the knee area. Record review of Resident #1's Discharge MDS dated [DATE] was coded for having an unhealed Stage 2 pressure ulcer that was present upon admission/entry. This was inconsistent with the admission skin assessment dated [DATE] which documented a stage 1 pressure injury to coccyx and skin tears to both arms, left thigh area, left outer knee area, and left 5th toe. Resident #1's Physician Order Summary Report dated 01/20/24 revealed Resident may discharge home with home care on 1/20/24 . Cleanse area to left outer knee with ns. pat dry with gauze. Apply Santyl (used to remove damaged tissue) to wound bed and cover with dry dressing daily. Cleanse left hip area with ns and pat dry with gauze. Apply skin prep and cover with dry dressing every other day. In a telephone interview on 04/03/24 at 01:43pm, Resident #1's FM stated Resident #1 fell at home, broke her leg, was on the floor for at least 4 days, and had to drag herself from one room to another to get her phone to call for help. FM stated the hospital put a clear dressing on Resident #1's left outer knee wound on 12/16/23 at 5:00 AM. FM stated she arrived to the facility on [DATE] and found the same dressing was still on the wound with the same date of 12/16/23 5:00 AM marked on the dressing. FM stated that when she brought it to the attention of the nurse, she was told that it was just a skin tear. FM stated she informed the nurse that the wound had green pus under the dressing. FM stated that she had the facility contact the DON for her and once she spoke to the DON, the nurse came in a few minutes later to change the dressing. FM stated when the dressing was taken off, the wound looked nasty and almost necrotic and it was absolutely disgusting and that she took a picture of it. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/05/24 at 12:00 PM, CNA A stated that she had seen the dressing on Resident #1's left knee but could not recall exactly when she saw it. CNA A stated that one of the nurses patched it up and did something to it, but she really did not remember who or when. CNA A stated that the wound on Resident #1's knee had a rotten smell when one of the nurses peeled back the clear dressing, put a gauze over the wound and pulled the same clear dressing back over it. In an interview on 04/05/24 at 12:30 PM, LVN A stated that when she got report on Resident #1 from the hospital, they did not tell her anything about any wounds. When asked about the wound to Resident #1's left knee, LVN A stated she documented it as a skin tear. LVN A stated she did not take the dressing off the wound and that she did not know exactly what it looked like. LVN A stated that she did not want to remove the dressing because she did not want to aggravate the skin tear. When asked about the admission order process, LVN A stated she would read the hospital discharge orders, put the orders into the nursing facility system and contact the provider to verify the orders and accept the admission into the system. LVN A stated that she would contact the provider before doing an assessment and if she had found anything unexpected or unusual, she would call the provider back to let them know about it. When asked about the wounds to Resident #1's left side, LVN A stated she did not contact the provider because they do not usually call them about skin tears. LVN A was shown a photo of Resident #1's left knee dressing that was taken 12/24/23 before it was removed. LVN A described it as a transparent dressing on a person's leg with some kind of absorbable material under it, but that she could not describe the wound because she could not see it underneath the dressing. LVN A stated that she attempted to contact the on-call physician and it must not have been documented because she was waiting on a call back that she never received. LVN A did not state whether she told the next shift that she was waiting on a call back from the physician. In a phone interview on 04/08/24 at 10:50 AM, LVN B stated she was not aware of Resident #1's wounds until a family member called her into the room and told her about it on 12/24/23. LVN B stated the family member had the dressing in their hand and the dressing appeared soiled. LVN B stated the wound had slough and brownish/greenish drainage that could have indicated infection. LVN B stated she attempted to contact the physician but did not receive a call back. She did work the next day and stated she does not recall attempting to follow up with the physician about the wound. LVN B stated she does not recall documenting her attempt to contact the physician. Resident #1's primary care physician was called but was unavailable and was expected to return approximately 04/09/24. In an interview on 04/05/24 at 03:36 PM, MD stated, I can't defend this. The nurse should have assessed the resident, and the physician or nurse practitioner should have assessed the resident. The nurse should have reviewed the hospital discharge orders and let the physician know about the wound care that was indicated and the physician should have also reviewed the hospital discharge records to be sure that all the orders were reconciled. MD stated he was initially contacted this morning (04/05/24) about this incident. MD stated that if any wound is not assessed or treated, if needed, the resident could acquire an infection, become septic requiring immediate care and hospitalization and/or death could occur. In an interview with ADMIN and ADON on 04/05/24 at 06:37 PM, ADON stated the facility admitting process was: after receiving the resident, review admitting orders, call physician to notify of resident's admission and review and reconcile the admitting orders, assess resident - if any abnormal assessment finding the nurse must notify the physician to retrieve and or modify orders as necessary. (continued on next page)

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

When the ADON was shown a picture dated 12/24/23 of Resident #1's left knee wound she described it as, It does not look like a skin tear at this point, it has maceration [prolonged or excessive exposure to moisture that results in skin damage and softening] and slough [dead tissue] in the middle.

ADMIN stated they had already started their response plan this morning (04/05/24) and had educated all the nurses that were at the facility about assessment and skin/ wound documentation and had educated all of the aides that were at the facility about skin care, what to look for, and to report any wounds or skin issues to the nurse immediately. ADMIN and ADON also stated that they had begun retraining on contacting a provider and documentation of that. ADMIN stated that the facility would be doing education and training with all the staff over the next several days as they came in.

Record review of the facility's policy on Skin and Wound Prevention Management dated 03/14/19, revised January 2023, stated in part that each resident would receive the care and services necessary to retain or regain optimal skin integrity. The guideline within the policy stated that a licensed nurse would document the wound presentation or description of skin issues identified within the electronic health record, the licensed nurse should communicate all newly identified skin concerns as well as the status of current wounds or skin concerns to the attending medical provider then document the notifications and any orders provided within the electronic health record. The licensed nurse will continue to monitor the status and progress of the wound until resolved. Should the wound deteriorate, the nurse should notify the provider and IDT of the change in condition and document the wound assessment/evaluation findings, notifications, new orders, and additional interventions. The plan of care should be reviewed and updated accordingly. The DNS/designee will review the skin and wound data to the QAPI committee to identify compliance of system management, analyze for trends. The policy stated that documentation for abnormal skin conditions should be documented within the electronic health record and should include: 1. Type of injury/ulcer 2. Location, shape, ulcer edges, and wound bed 3. Measurements of wound/skin injury 4. Condition of surrounding tissues 5. Determine the etiology of the wound.

Record review of the facility's Care Plan Policy dated 02/2017, revised 03/2022 stated in part: The community develops a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.

The comprehensive care plan:

-is developed within seven days of the completion of the comprehensive assessment;

-is prepared by the interdisciplinary team, including the attending physician, a registered nurse with responsibility for the resident, and other appropriate team members in disciplines as determined by the resident's needs.

The care plan reflects intermediate steps for each outcome objective if they will enhance the resident's ability to meet his or her objectives. Team members use these objectives to monitor resident progress.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's policy on Changes in Resident Condition dated 05/2017 and reviewed/revised January 2023 stated in part: The resident, assigned medical provider, and resident representative or designated family member should be notified when there is a significant change in the resident's physical, mental or psychosocial status or a need to alter treatment significantly (.a need to commence new treatment) and changes in condition should be communicated from shift to shift in the 24-hour report management system. The policy also stated changes in the resident status that affect the problem(s)/goal(s) or approach(s) on his/her care plan should be documented as revisions and communicated to the interdisciplinary caregivers. Documentation was to be done in the Nursing Progress Notes indicating date, time, and who was notified (physician/resident representative), information communicated, and response and/or orders received. This was determined to be an Immediate Jeopardy (IJ) on 04/09/2024 at 03:15 PM. The administrator was notified. The Administrator was provided with the IJ template on 04/09/2024. The following Plan of Removal was accepted on 04/10/2024 at 5:00 PM and indicated the following: [Facility] Plan of Removal F684 Quality of Care 04/09/24 It is the policy of this community to provide safe and quality nursing/medication administration practices to minimize and/or prevent less than quality of care provided to the residents we serve. 1. Resident A was properly assessed and there were no adverse effects associated with alleged deficient practice. Treatment order obtained on 12/27/23. Resident A discharged home on 01/20/24. 2. 100% skin assessment completed on all residents. Skin assessments updated. Outcome: There were no negative outcomes identified. Date Completed: 04-10-24 3. Education provided to all licensed nurses related to the process for system management to include Administrative nurses (DNS ADNS & WCN) received re-education by the DCO (regional nurse) ensuring that: a. Upon admission, the day of, or the shift the resident is admitted to facility, the admitting nurse will notify the accepting MD/NP of the resident's condition to include any wounds/skin concerns identified. The nurse will then verify the and/or obtain admission orders and treatment orders at that time. In the event the nurse is unable to reach the accepting PCP (MD/NP) then the nurse will call the medical director and document notification attempts within the medical record. The DNS/ADNS/RN supervisor will review admission on the next day to validate that the appropriate treatment orders are noted within the orders of the medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coastal Palms Nursing & Rehabilitation	221 Cedar Dr Portland, TX 78374

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Upon a resident change in condition the assessing or evaluating nurse will notify the MD/NP of the identified change in condition to include newly identified and/or deteriorating wounds. The notification to the medical provider will be promptly, depending on the nature or severity of the identified change in the resident's status. Urgent condition changes may require immediate emergency response, such as notifying and eliciting 911 for emergency care. The nurse will notify the MD/NP immediately but no later than end of the current shift. The nurse will document the notification to the medical provided within the electronic health record, enter any new orders provided. The nurse on duty of the current shift will implement the new orders as prescribed; accordingly, for example, the nurse will administer the initial dose of the medication or treatment as ordered by the MD/NP per their direction to be started immediately or stat, same day, to initiate new order on the next day, upon arrival of new medication or treatment. o Upon the next business day, during the clinical review meeting that takes place M-F, the clinical leadership (DNS/ADNS/DCE) will review admission/re-admission skin assessment/evaluations, changes in conditions, progress notes to ensure that the required documentation is in place within the electronic health record. The DNS/ADNS/DCE is responsible for validating that the notification has been made, new orders (treatment orders) are carried out as prescribed. o Upon the next business day, during the clinical review meeting that takes place M-F, the clinical leadership (DNS/ADNS/DCE) will review changes in conditions, progress notes to ensure that newly identified wounds or deteriorating wounds have been documented within the electronic health record. The DNS/ADNS/DCE is responsible for validating that the appropriate documentation is in place within the E.H.R. Date Completed: 04-10-24 Administrative nurses (DNS ADNS & WCN) received re-education by the DCO (regional nurse) ensuring that documentation within the electronic health record accurately reflects the wound presentation and status to include but not limited to nursing progress notes, skin assessments and the skilled nurse note assessment form within the medical record. Nursing documentation is expected to be completed prior to the end of the nurse's shift. Date Completed: 04-10-24 Administrative nurses (DNS ADNS & WCN) received re-education by the DCO (regional nurse) on the process of administrative nurses notifying the charge nurses at the start of the shift (or as soon as it has been identified that they wound care nurse will not work that day) of their responsibility to administer wound care/treatments and complete assigned skin assessments for that shift in the event the wound care nurse calls off shift and/or if the designated treatment nurse is absent for any reason, licensed nurse will contact DNS/ADNS. The DNS/ADNS will reassign treatments and verify completion at the end of the shift, by instructing the charge nurse to notify the DNS/ADNS should any treatment not be completed upon the end of their shift. Date Completed: 04-10-24 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DNS (director of nurses)/designee educated the licensed nurses on ensuring that identified new admission treatment orders are verified with the accepting MD/NP upon admission/readmission, communicating changes in conditions to the medical provider, to include newly identified and/or deteriorating wounds. If PCP/NP does not call back timely to give orders, contact DNS/Medical Director for orders. Thus, ensuring appropriate documentation of the identified wound status and medical provider's wound care orders are noted within the E.H.R accordingly. oUpon admission, the day of, or the shift the resident is admitted to facility, the admitting nurse will notify the accepting MD/NP of the resident's condition to include any wounds/skin concerns identified. The nurse will then verify the and/or obtain admission orders and treatment orders at that time. In the event the nurse is unable to reach the accepting PCP (MD/NP) then the nurse will call the medical director and document notification attempts within the medical record. The DNS/ADNS/RN supervisor will review admission on the next day to validate that the appropriate treatment orders are noted within the orders of the medical record. Date Completed: 04-10-24 DNS (director of nurses)/designee educated the licensed nurses on ensuring that documentation within the electronic health record accurately reflects the wound presentation and status to include but not limited to nursing progress notes, skin assessments and skilled nurses' notes/assessment form. Nursing documentation is expected to be completed prior to the end of the nurse's shift. Skilled nurse note assessment form should be completed daily when the resident is noted as under skilled care and services, progress notes are expected to be completed as indicated or upon exception and the skin assessment is expected to be completed at least weekly. All nursing documentation should be completed prior to the end of the assigned nurse's shift. Date Completed: 04-10-24 DNS (director of nurses)/designee educated the licensed nurses on the process of administrative nurses notifying the charge nurses on shift of their responsibility to administer wound care/treatments and complete assigned skin assessments for that shift in the event the wound care nurse calls off shift and/or if the designated treatment nurse is absent for any reason, licensed nurse will contact DNS/ADNS. DNS/ADNS will reassign treatments and verify completion. The administrative nurses will notify the charge nurses at the start of the shift (or as soon as it has been identified that they wound care nurse will not work that day) of their responsibility to administer wound care/treatments and complete assigned skin assessments for that shift in the event the wound care nurse calls off shift and/or if the designated treatment nurse is absent for any reason, licensed nurse will contact DNS/ADNS. The DNS/ADNS will reassign treatments and verify completion at the end of the shift, by instructing the charge nurse to notify the DNS/ADNS should any treatment not be completed upon the end of their shift. Date Completed: 04-10-24 DNS (director of nursing)/designee will monitor this process to validate appropriate communication and to ensure patient care needs are met. Date Completed: 04-10-24 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DNS (director of nurses)/designee educated the licensed nurses on clinical documentation review upon admit/readmit noting pressure injury/skin concerns identified. A full body skin assessment - intentionally assessing the resident head to toe for evidence of any pressure injury or skin concerns. If a newly admitted resident has an intact dressing in place, the nurse will remove the dressing to complete the skin assessment unless otherwise order not to remove the dressing by the MD/NP and in this case the will document the given instructions by the MD/NP and assess the skin around the dressing indicated the presentation of s/s of infection to the tissue surrounding the dressing in place. The nurse will document the instructions and skin assessment findings within the medical record at that time. Date Completed: 04-10-24 DNS (director of nurses)/designee educated the licensed nurses on the Braden Risk Assessment to be completed by the assigned nurse upon admission, significant change of condition and quarterly reviews in addition to routine re-assessment the Braden Risk Assessment will be completed upon identifying a new onset of pressure related skin injury. Date Completed: 04-10-24 DNS (director of nurses)/designee educated the licensed nurses on conducting weekly skin assessments/evaluation shall be completed upon admission/readmit at least every 7 days thereafter and as clinically indicated thereafter. Head to toe skin assessment- consists of conducting a head - to- toe skin assessment to identify actual skin concerns, such as pressure injury or other skin concerns. After completing the assessment, the nurse will document accordingly. PCP and RP notification and follow through with any new orders. Plan of care will be updated. Date Completed:04-10-24 DNS (director of nurses)/designee educated the licensed nurses on completing weekly skin assessment should be conducted by the designated nurse and/or designated wound care nurse and follow up with new communication to PCP and orders accordingly. Signing out for weekly skin assessments on the MAR and signing out the treatments as ordered and administered by licensed nurse. Date Completed: 04-10-24 DNS (director of nurses)/designee educated the licensed nurses on proper documentation of site, staging as indicated, measurement taken and noting wound bed appearance to be completed on the Skin/Wound Module within the E.H.R. Nursing obtaining wound care orders for identified wounds and implementing treatment orders as per MD/NP orders and ensuring that the RP notified. Date Completed: 04-10-24 DNS, ADNS, or Wound Care Nurse will conduct post admission skin assessments within 24 -72 hours post admission/readmit to validate accuracy of documentation of skin condition noting wound type, presentation, appropriate state for pressure ulcer injuries, validation of proper treatment orders is in place and any consultations are made as clinically indicated. Date Completed: 04-10-24 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	IDT will review and update plan of care at the initial 48-72 baseline care plan, at the time of the comprehensive care plan, not later than day 21, quarterly thereafter, upon significant change and annually in order to ensure appropriate interventions are in place to address the prevention of or minimizing the risks

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49157

Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs for one (Resident #1) of five residents reviewed for care plans.

1. The facility failed to address and include objectives, goals, and interventions specific to Resident #1's surgical and other wounds, oxygen therapy, fall risk, or pain that were present upon her admission on 12/16/23.

2. The facility failed to immediately update Resident #1's care plan upon a change in condition, specifically when Resident #1's wounds were found to be worse on 12/24/23.

This failure could place residents at increased risk of not having their individual needs met and decreased quality of life.

The findings included:

Record review of Resident #1's admission record dated 12/16/23 revealed a [AGE] year-old female that was readmitted to the facility on [DATE]. Diagnoses included displaced intertrochanteric fracture of the right femur (fracture of the right thigh bone), left rib fracture due to fall at home, other abnormalities of gait and mobility, muscle wasting and atrophy- multiple sites, history of falling, spinal stenosis with neurogenic claudication (leg pain, heaviness, and/or weakness when walking), chronic obstructive pulmonary disease, and mild protein-calorie malnutrition.

Record review of Resident #1's Comprehensive MDS dated [DATE] revealed resident had a BIMS score of 15, which indicated she was cognitively intact.

Record review of Resident #1's hospital discharge orders dated 12/15/23 revealed an order for dressing changes to wounds on Resident #1's left elbow, left hip, left knee, and left foot to be done daily or as needed if soiled and steri-strips (thin adhesive bandages used to close the surgical incision after staples are removed) to right hip to remain in place.

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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 - Few	Record review of Resident #1's Admission/ readmission nurse's notes dated 12/16/23 at 03:43 PM and signed by LVN A revealed Resident #1 had a clinical condition of respiratory disease/condition and the respiratory assessment indicated Resident #1 was receiving oxygen therapy. Resident #1's head to toe skin assessment indicated resident had non pressure skin impairments of skin tear(s) and an incision/ surgical wound. The nurse's notes also indicated a pressure injury on Resident #1's coccyx (tailbone). Comments were Stage 1 to coccyx. Skin tears to bilateral upper extremities (both arms), left hip, left knee, and left foot 5th digit. In the pain section, LVN A documented that Resident #1 had back and right hip pain that was acute (experienced to a severe or intense degree) and frequent, described as aching, stabbing, and sharp and relieved by medication and frequent position change. In the fall risk review section, LVN A documented that Resident #1 had recent falls (one or more between 3 and 12 months ago). LVN A did not document that Resident #1 had one or more falls in the previous 3 months, though the resident was admitted for a fractured leg that occurred as a result from a fall at home one month prior. In the box marked check if the resident is a high risk for falls, the box was checked. Record review of Resident #1's admission care plan dated 12/16/23 and revised on 02/07/23 (after discharge) revealed no focus or interventions for surgical site care and no focus or interventions for skin or wound care. Resident #1's care plan also did not include focus or interventions for oxygen therapy, fall risk, or pain. Resident #1's care plan had a focus of I have a self-care deficit r/t (DX). There was no diagnosis listed. The goals and interventions for the self-care deficit were appropriate. The next focus listed on Resident #1's care plan was I am allergic to Chantix. The goal and interventions were appropriate. The third and final focus on Resident #1's care plan, initiated on 01/02/24 by LVN A and revised on 02/07/24 by RMDS after resident was discharged , was At risk for infection or recurrent/chronic infection r/t compromised medical condition: There was no medical condition listed. In an interview on 04/05/24 at 1:46 PM with MDS, she stated that initial care plans for new admissions were created when the admitting nurse did the assessment and put things in there. MDS stated she would review the clinical record, enter the diagnoses, and adjust the care plan. MDS stated the care plans were usually updated right away if there was a change in condition. MDS explained that the purpose of a care plan was to let everyone know what the resident's needs were based on all aspects of the resident; it was all inclusive and was the totality of care that the resident needed and was specific to that individual. MDS stated that if something didn't get care planned, it could result in a lack of appropriate care. MDS stated that surgical and non- surgical wounds or any type of injuries should be care planned. MDS stated, in total, I'm responsible for care plans, but I suppose it would be an IDT effort. MDS stated she could not recall exactly, but she had been on vacation sometime in December (2023). Record review of the facility's Care Plan Policy dated 02/017, revised 03/2022 stated in part: The community develops a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan: -is developed within seven days of the completion of the comprehensive assessment; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-is prepared by the interdisciplinary team, including the attending physician, a registered nurse with responsibility for the resident, and other appropriate team members in disciplines as determined by the resident's needs. The care plan reflects intermediate steps for each outcome objective if they will enhance the resident's ability to meet his or her objectives. Team members use these objectives to monitor resident progress. Record review of the facility's Changes in Resident Condition Policy dated 05/2017, revised 01/2023, stated in part: Changes in the resident status that affect the problem(s)/goal(s) or approach(s) on his/her care plan should be documented as revisions and communicated to the interdisciplinary caregivers.