STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675884	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Teague Nursing and Rehabilitation	884 Hwy 84 W Teague, TX 75860

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47772 Based on interviews and record review, the facility failed to ensure assessments accurately reflected the status for 1 of 7 residents (Resident #1) reviewed for assessments. The facility failed to ensure Resident #1's weekly skin assessments were performed timely, accurately, and appropriately. This failure could place residents at risk of missing treatment needs. Findings included: Record review or Resident #1's AR, dated 4/2/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with a urinary tract infection (which was the result of bacteria, that caused an infection of the urinary system,) chronic kidney disease, stage 3 (which was a disease of the kidney that disrupted the body's ability to filter impurities,) and diabetes mellitus type 2 (which was a condition of the body that disrupted how the body used sugar for fuel.) Record review of Resident #1's Admission MDS, dated [DATE], reflected Section C., Cognitive Patterns; Resident #1 had a BIMS Score of 15. (A BIMS Score of 15 indicated no cognitive impairment). Section M., Skin Conditions reflected Resident #1 he was not a risk for pressure ulcers; had no unhealed pressure ulcers; had no venous or arterial ulcers; had no infections of the feet; had no diabetic foot ulcers; had no open lesions of the feet; and he had no moisture associated skin damage. The resident did not reflect any skin/ulcer or injury treatments. Section GG., Functional Abilities and (Range of Motion;) Resident #1 had no impairment on either side of his upper extremities (shoulder, elbow, wrist, and hand) and no impairment in either lower extremities (hip, knee, ankle, and foot.) Resident #1 utilized a wheelchair for mobility. Resident #1 was dependent upon staff for toileting hygiene, shower/bathe self, lower body dressing, and putting on/talking off shoes, sitting to standing, chair/bed to chair transfer, and tub/shower transfer. Being dependent upon staff meant the helper did all of the effort, or the assistance of 2 or more helpers was required for the resident, to complete the activity. Record review of discharge paperwork for hospitalization from a 1/28/2024 to 2/2/2024. On 2/2/2024, the resident returned to the nursing facility. (continued on next page)

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

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

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NAME OF PROVIDER OR SUPPLIER: Teague Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 884 Hwy 84 W Teague, TX 75860	

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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 - Few	Record review of a complaint, made on 2/2/2024, reflected Resident #1 was hospitalized on [DATE] through 2/2/2024 for low blood pressure and low urine output. He released from the local hospital on 2/2/2024 to return to the nursing facility. The complainant made allegations that Resident #1 was not receiving appropriate skin care. Record review of Resident #1's CP, initiated on 2/2/2024, reflected a focus area for skin conditions, evidenced by Resident #1 having returned from the hospital on 2/2/2024 with a stage II pressure injury to his coccyx, tailbone, and a scabbed area on top of his bi-lateral feet. The goal, initiated on 2/5/2024, reflected Resident #1 would have intact skin, free from redness, blisters, or discoloration. Resident #1's pressure injury would show signs of healing and remain free from infection. The intervention, initiated 2/2/2024, reflected nursing staff would administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing at least weekly. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report declines to the MD. Avoid positioning the resident on (coccyx). Do not massage over bony prominences and use mild cleansers for peri care/washing. Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning. Record review of Resident #1's WSA performed on WSA 2/15/2024 reflected other skin finding reflected redness r/t friction on inner thigh area- barrier cream applied. Signed 2/28/2024 by the DON. (The WSA was not completed timely as the document was dated to have occurred on 2/15/2024 but was not signed until 13 days later on 2/28/2024.) Record review of discharge paperwork for hospitalization from a 2/18/2024 to 3/3/2024. On 3/3/2024, the resident returned to the nursing facility Record review of Resident #1's WSA performed on 2/22/2024 reflected other skin finding reflected redness r/t friction on inner thigh area-barrier cream applied. Signed 3/04/2024 by the DON. (The WSA was not accurate because Resident #1 was not at the facility on 2/22/2024.) Record review of Resident #1's WSA performed on 2/29/2024 reflected other skin finding reflected redness r/t friction on inner thigh area-barrier cream applied. Signed 3/04/2024 by the DON. (This WSA was not accurate because Resident #1 was not at the facility on 2/29/2024.) Record review of a WSA performed on 3/14/2024 reflected other skin finding reflected redness r/t friction on inner thigh area-barrier cream applied. Signed 3/20/2024 by the DON. (The WSA was not completed timely as the document was dated to have occurred on 3/14/2024 but was not signed until 6 days later on 3/20/2024.) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview on 4/01/2024 at 12:57 PM with the complainant revealed Resident #1 admitted to the local hospital for low urine output and low blood pressure on 1/28/2024. While in the care of the facility, the complainant learned that Resident #1 had skin integrity issues and thought the facility could do more to protect his skin. The hospital treated Resident #1's skin concerns and he discharged back to the nursing facility on 2/2/2024. Interview and observation on 4/02/2024 at 9:40 AM with Resident #1 revealed he had been at the facility since the end of November 2023. He was observed was lying on his back. His feet and ankles were in PU relieving boots with a pillow in between; There was a visible bandage on the resident's right foot/ankle dated 4/01/2024. The visible portions of his feet were observed clean with recently trimmed nails. He denied pain with his wounds. Resident #1 revealed he did not have any pressure ulcers on his body when he came to the facility, but he had developed pressure ulcers and sores on his feet, ankles, and back side since his arrival. Since his return to the facility on [DATE], Resident #1 was receiving skin assessments, ulcer assessments, and VOHRA. He has been provided with pressure relieving boots and staff have been placing a pillow between his legs to provide comfort. He denied physical pain associated with his wounds. Interview on 4/04/2024 at 2:15 PM with LVN B revealed she had been an LVN for [AGE] years and had been working at the facility for the last 3.5 years. She stated that she had been trained to complete accurately and to sign the treatment note once completed. She described timely documentation to be done as soon as possible. She remembered a time when she was 2 days late with accurate and timely documentation and she received a one-on-one counseling. She stated that staff was not allowed to enter documentation for other staff members. She stated late and inaccurate documentation placed residents at [NAME] of meeting treatments, the need for follow up assessments, and worsening health condition. Interview on 4/04/2024 at 2:25 PM with LVN D revealed she had been an LVN for the last 8 years and had been working at the facility for the last 10 months. She stated she had been trained to perform accurate assessments and to make sure they were completed at the time. She explained she had been late one time with an assessment and was counseled by the DON the next day. Timely and accurate documentation helps the team provide care to the resident and inaccurate, or missing information, placed the resident at risk of missing important aspects of care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review on 4/4/2024 at 4:40 PM with the DON revealed WSA were supposed to be performed weekly. The WSAs were supposed to be filled out by the nursing staff and the assessments were supposed to be passed along to the DON and the ADON with any issues or concerns. The DON stated WSA performed on 2/15/2024 was completed by her but was not signed until 2/28/2024, 13 days later. She stated she did not perform the WSA but got the assessment on a piece of paper from a nurse and entered the information for a nurse after the fact. The WSA performed on 2/22/24 was completed by the DON on 2/22/24 but was not signed until 3/04/2024, 13 days later. The DON stated that she had been having trouble with staff not completing their notes on time. She knew she was not supposed to be entering other staff's documentation, but she did it anyway to help them out. If the resident's skin condition did not get identified through assessments, the failure was the first line of defense, who were the CNAs, who did not report skin conditions to the charge nurse. The second line of defense, who were the charge nurses, were supposed to document skin conditions and refer those issues with the ADON and the DON. The third line of defense, who were the ADON and the DON, were at fault for inaccurate assessments because they were not checking behind the nursing staff. There were no safeguards in place to identify documentation errors. If there were, she stated we would have caught them. The DON stated that untimely and inaccurate documentation placed residents at risk of missing treatments, worsening of wounds, missing follow up care, and having their needs go unmet. The DON was the facility's Assessment Coordinator. Interview on 4/4/2024 at 4:40 PM with the ADM revealed he expected his staff to follow facility policy and make sure assessments were accurate, appropriate, and timely. He stated a daily assessment should be completed that day and a weekly assessment should be completed that week. Late documentation, inaccurate, or inappropriate documentation placed the residents at risk of facing barriers to receiving good care. A fail safe in place to catch errors in documentation was the standard of care meeting held each week. Also, the DON and the ADON were supposed to be following up on staff to make sure documentation was being completed correctly. If there were documentation errors committed by the DON, the ADM felt the regional nurse was at fault for not checking up and making sure the DONs documentation was being done correctly. The DON was the facility's assessment coordinator. Record review of the facility's Resident Assessment Policy, dated October 2023, reflected the assessment coordinator was responsible for ensuring timely and appropriate resident assessments. Assessments were completed by staff members who had skills and qualifications to assess relevant care areas and who were knowledgeable about the resident's strengths and areas of decline.