STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood of Grapevine	1500 Autumn Drive Grapevine, TX 76051

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 0684

Level of Harm - Minimal harm or potential for actual harm

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 42859

Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices based on the comprehensive assessment of residents for three of six residents (Residents #1, #2, and #3) reviewed for wound care.

The facility failed to follow physician orders for wound care for Residents #1, #2, and #3.

The failure placed residents at risk of wound deterioration and infection.

Findings included:

1. Review of Resident #1's closed clinical record reflected a face sheet, dated 08/22/24, indicating the resident was an [AGE] year-old female admitted to the facility on [DATE]. Resident #1's diagnoses included unspecified fracture of upper end of left humerus (the bone of the upper arm forming joints at the shoulder and the elbow), metabolic encephalopathy (a brain dysfunction that occurs when a chemical imbalance in the blood affects the brain), and hypertension (high blood pressure).

Review of Resident #1's Admission MDS Assessment, dated 07/18/24, reflected the resident was cognitively intact with a BIMS score of 13.

Review of Resident #1's care plan, dated 07/29/24, reflected: Focus: admitted with a skin tear at left lateral elbow due to fall. Goal: The resident will be free from skin tears through the review date. Interventions: Monitor/document location,size, and treatment of skin tear. Report abnormalities,failure to heal, signs of infection,maceration to medical doctor.

Review of Resident #1's physician orders, dated 07/14/24, reflected: May cleanse small cuts, skin tears, and/or abrasions with normal saline/wound cleanser,apply triple antibiotic ointment, apply Steri-strips, and apply dry dressing daily as needed.

Review of Resident #1's Hospital Discharge Summary, dated 07/14/24, reflected the following: Change dressing daily left arm skin tear.

Review of Resident #1's July 2024 TAR reflected there was no documentation indicating Resident #1's skin tear was treated from 07/15/24- 07/23/24. The TAR reflected Resident #1 was provided with wound care from 07/24/24-08/01/24.

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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: 675905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Birchwood of Grapevine		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Autumn Drive Grapevine, TX 76051	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's physician orders, dated 07/22/24, provided by the orthopedic doctor, reflected an order for the antibiotic Bactrim 800-160 mg, one tablet twice a day for seven days for a skin tear on the resident's upper extremity. Review of Resident #1's July 2024 TAR reflected no order for Bactrim tablets. Review of the Resident #1's weekly skin assessments dated 07/14/24, 07/23/24, and 07/30/24 revealed she had wounds. Review of Resident #1's nurse's progress notes, dated 07/14/24, reflected the resident admitted to the facility with a large open area on her left elbow, with active bright red blood, and dressed with a Xeroform pressure dressing (an absorbent fine mesh gauze) wrapped with Kerlex (a brand of bandage rolls that are used for wound care). Interview on 08/19/24 at 2:09 PM with Resident #1's family member revealed she took Resident #1 to an orthopedic appointment on 07/22/24. Resident #1's family member stated the doctor showed her the dressing on Resident #1's skin tear, which was stuck to the skin tear and dated 07/15/24. She stated the doctor gave orders for daily dressing changes, and the resident was put on an antibiotic, Bactrim. Interview via telephone on 08/22/24 at 12:51 PM with LVN B, who was the previous Treatment Nurse, revealed she was not aware Resident #1 had a skin tear until on 07/24/24, when she was notified about the orthopedic report by Resident #1's family member. She stated she did not see the paperwork from the orthopedic clinic, and she was not aware the resident had wound care orders upon her admission the facility. LVN B stated she was aware Resident #1 had brought some orders from her appointment, but she did not receive them. LVN B stated the orders were supposed to be given to the charge nurse, so the orders could be put on the TAR. LVN B stated on admission the admitting nurse completed the initial skin assessment. If there were skin issues, she would then be notified. LVN B denied being notified of skin issue, she stated she was not responsible for dressing skin tears. She stated it was the responsibility of the floor nurses. She stated the facility had standing orders for skin tear treatment, and all nurses were aware of the orders. LVN B stated the skin tear dressings were supposed to be done daily, and she could not tell why Resident #1 was not getting wound care for the skin tear. LVN B stated she performed wound care from the day Resident #1 returned from her orthopedic appointment to the day she got fired on 07/30/24. LVN B stated she had started an in-service training with the nurses on wound care, but not all nurses had signed the training. She did not know where the records were. She stated failing to perform wound care per physician orders could cause wound infection and delayed wound healing. Interview via telephone was attempted on 08/22/24 at 1:15 PM and at 1:25 PM with the admitting nurse, and a voice message was left; however, the admitting nurse did not contact the surveyor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/22/24 at 3:21 PM with RN A, who was the charge nurse, revealed she remembered Resident #1, but she did not remember performing wound care on the resident or knowing the resident had a skin tear. She stated both the Wound Care Nurse, and the nurses were responsible for the wound care. RN A stated they should document the wound care in the treatment record after it was performed. She stated during Resident #1's stay, they had a full-time treatment nurse, so she expected her to perform all wound care dressings. She stated she had done training on wound care, but she could not remember when it was done. She stated failing to perform wound care could lead to slow wound healing and the wound getting infected. Interview on 08/22/24 at 4:01 PM with the ADON revealed she helped with the admission for Resident #1 remotely. She stated she did not help with orders, and she was not aware Resident #1 came with wound care treatment orders from the hospital. She stated it was her responsibility and the DON to go through the admission orders and ensure all orders from hospital were followed and documented on the resident's treatment administration record. She stated the daily wound care orders from the hospital were missed. She stated after the admitting nurse put the wound care orders in, it was the treatment nurse's responsibility to follow up and ensure that wound care was being provided. That nurse was also to perform an initial skin Assessment. She stated when she looked at the nurse's progress notes it was revealed Resident #1 admitted with a skin tear. She denied knowing about the skin tear. She stated failure to perform wound care could lead to a wound infection. Interview on 08/22/24 at 4:41 PM with the DON revealed she did not know about Resident #1's skin tear or wound care orders. She stated she and the ADONs were responsible for going through the hospital orders to ensure all orders were taken care of. She stated on admission, there was a physician order for wound care, but it was not put on the TAR. Her expectation was the Treatment Nurse performing the wound care for Resident #1. She stated she received weekly wound care reports, but she could not produce the reports. She stated she was responsible for monitoring wound care, and she did spot checks; however, she did not provide documentation for the monitoring/spot checks. She stated failure to perform wound care could lead to wounds getting worse and getting infected. She stated she had not done training on wound care with her staff since she was new to the facility. Interview on 08/22/24 at 5:36 PM with the Medical Records Coordinator revealed she accompanied Resident #1 to the doctor's appointment. She stated she was given paperwork from the doctor's office. She stated she placed the paperwork on the Administrator's desk and left. She stated she did not know whether the Administrator saw the paperwork or not because the Administrator was not at her desk. She stated that was her first time accompanying a resident to a doctor's visit, and she followed the Administrator's instruction to bring all the paperwork from the visit to her office. She stated she was the one, who scanned all the documents into the electronic records, and she was not aware whether the prescription orders were put on Resident #1's TAR. She stated failing to get the orders could lead to the resident missing wound care and medications. Interview on 08/22/24 at 6:13 PM with the Administrator revealed she could not recall receiving any paperwork from Resident #1's visit or whether she passed the orders on to nursing. She stated she had no policy on physician orders from outside doctors' visits. The Administrator stated the nurses were responsible for completing the MARs and the TARS. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Birchwood of Grapevine		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Autumn Drive Grapevine, TX 76051	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #2's face sheet, dated 08/22/24, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included peripheral vascular disease (a chronic disorder that causes blood vessels outside of the heart to narrow, block, or spasm) and multiple sclerosis (a chronic disease of the central nervous system). Review of Resident #2's Quarterly MDS Assessment, dated 08/01/24, revealed the resident had moderate cognitive impairment with a BIMS score of 9. The MDS reflected Resident #2 was at risk for developing moisture associated skin damage. Review of Resident #2's care plan, dated 08/09/24, reflected: Focus: has a potential for pressure ulcer development due to immobility. Goal: will have intact skin, free of redness, blisters, or discoloration by/through review date. Intervention: Administer treatments as ordered and monitor for effectiveness. Review of Resident #2's physician orders, dated 08/16/24. reflected the following wound care orders: Right posterior thigh: cleanse with NS and pat dry, apply calcium alginate, and place in open wounds. Then cover with dry dressing everyday shift for MASD. Review of Resident #2's August 2024 TAR reflected wound care was provided to Resident #2 on 08/21/24; however, there was no documentation reflecting Resident #2 was provided with wound care on 08/11/24, 08/13/24, 08/17/24, 08/18/24, 08/19/24, and 08/20/24. Observation and interview on 08/22/24 at 1:55 PM with Resident #2 revealed she was seated in her wheelchair. Resident #2 stated she was doing well. Resident #2 stated she got wound care but not every day. Resident #2 stated she should have had a dressing on it, but it had come off. Resident #1 stated she did not know when the wound care was last done. Observation on 08/22/24 at 1:59 PM revealed Resident #2 had a bowel movement, and there was no dressing observed on the wound on her left inner thigh prior to the resident receiving incontinence care. There were no obvious signs or symptoms of infection noted at the wound site. Interview on 08/22/24 at 3:11 PM with CNA D revealed he was the CNA assigned to Resident #2. He stated between 10:00 AM-10:30 AM he provided Resident #2 with incontinence care. CNA D stated he noticed the resident did not have a dressing on her wound. He stated he did not notify the nurse because he thought the wound was left intentionally open to air. He stated Resident #2 did not complain of pain. CNA D stated he should have notified the nurse the wound was open after incontinence care. He stated the risk of the wound not being covered was infection. Interview on 08/22/24 at 3:21 PM with RN A, who was the charge nurse, revealed she had not completed Resident #2's wound care today (08/22/24) and was not made aware Resident #2's dressing had come off. She stated the Treatment Nurse had completed wound care yesterday on 08/21/24. She stated her expectation was for the CNA to notify her when the dressing came off during incontinence care. She stated the potential risk if the dressing fell off would be a decline in the wound healing and infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's physician orders, dated 08/16/24, reflected the following wound care order: Left lower leg: cleanse with NS and pat dry apply calcium alginate and cover with dry dressing; mild compression with elastic wrap. Start wrapping at toes and gradually work proximally up to knees. May use two elastic wraps if necessary. Remove elastic wraps at bedtime every day shift for venous stasis disease. Review of Resident #4's August 2024 TAR reflected there was no documentation indicating Resident #4 had been provided with wound care on the following dates: 08/10/24, 08/11/24, 08/13/24, 08/17/24, 08/18/24, 08/19/24, and 08/20/24. Observation and interview on 08/22/24 at 9:55 AM revealed Resident #4 in her bed. Resident #4 stated she was doing well. Resident #4 stated she receive wound care but not all the time. Resident #4 had dressings on both of her legs, dated 08/21/24. Interview on 08/22/24 at 4:01 PM with the ADON revealed she did wound care rounds with the Wound Care Doctor on Thursdays. She stated she helped with wound care on Wednesdays and Thursdays when she was not working as a floor nurse. She denied knowing the wound care was not being provided. She stated she had performed wound care on Resident #2 and Resident #3 on 08/21/24. She stated she expected the nurses to provide wound care daily and when a dressing fell off. She stated she and the DON were responsible for monitoring the MARs and TARs to ensure nurses were providing wound care and documenting it on the TARs. The ADON stated failing to document could lead to residents missing care. Interview on 08/22/24 at 4:41 PM with the DON revealed she expected staff to follow daily and as needed orders. If a dressing came off when completing peri care, the aides were supposed to notify the nurse, so the nurses could apply a new dressing. The DON stated she expected wound care to be performed daily as per doctor's orders, and it needed to be documented on the TAR. She stated she did spot checks on wound care, but she could not tell when she last did the spot checks. The DON stated she was not aware of any physician orders from the doctor's visit for Resident #1. She stated all orders were supposed to be given to nursing, so that they could take action on them. The DON stated Resident #1 was put on Doxycycline (antibiotic) on 07/30/24 before she left the facility. The DON stated she had only been employed at the facility for two months, and she had not completed training on wound care and physician orders. She stated the risk of not having a dressing was that it could lead to infection and failing to follow physician orders could lead to the worsening of wounds or infection. The DON said the concern with staff not documenting on the resident's TAR was that if it was not documented there was no proof the care was provided. Review of the facility's Documentation of Medication Administration policy, with a revision date April 2007, reflected: .1. A nurse or certified medication aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR) 2. Administration of medication must be documented immediately after (never before) it is given . Review of the facility's Wound Care policy, dated July 2010, reflected the following: . 1. Verify that there is a physician order for this procedure. The following information should be recorded in the resident's medical record. 1. The type of wound care given (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The date and time the wound care was given. 3. If the resident refused the treatment and the reason(s) why .