STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675978	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Wellness Center	1241 W Marshall Howard Blvd Littlefield, TX 79339

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 - Few	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** 47159 Based on interview, and record review the facility failed to immediately inform the resident's physician and resident representative of a significant change in the residents' physical status and the need to significantly alter the resident's treatment for 1 of 4 residents (Resident #1) reviewed for Change in Condition. The facility failed to correctly notify the physician and resident representative of the extent of one facility-acquired Stage IV pressure injury for Resident #1, thus delaying proper treatment for 2 days. An Immediate Jeopardy (IJ) was identified on 08/22/2024. The IJ Template was provided to the facility on [DATE] at 4:53PM. While the IJ was removed on 08/26/2024, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy and a scope of Isolated due to the need for implementation of corrective measures and the effectiveness of its corrective plan. This failure could place residents at risk of not having their physician or resident representative informed of changes in their conditions. Findings included: Record review of Resident #1's admission record revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: PRIMARY LATERAL SCLEROSIS (A motor-neuron disease which causes nerves within the brain to slowly break down) DYSPHAGIA, OROPHARYNGEAL PHASE (difficulty swallowing) CHRONIC PAIN SYNDROME PAIN IN UNSPECIFIED SHOULDER OTHER SPEECH DISTURBANCES (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	APHASIA (disorder causing difficulty in verbal communication) MUSCLE WEAKNESS (GENERALIZED) MUSCLE WASTING AND ATROPHY, NOT ELSEWHERE CLASSIFIED, UNSPECIFIED SITE OTHER REDUCED MOBILITY HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE PARKINSON'S DISEASE WITH DYSKINESIA, WITHOUT MENTION OF FLUCTUATIONS OTHER MUSCLE SPASM ENCOUNTER FOR SCREENING FOR COVID-19 PERSONAL HISTORY OF COVID-19 OTHER SEASONAL ALLERGIC RHINITIS OTHER CONSTIPATION Record review of skin assessments on 07/28/2024 revealed Resident #1 had a skin assessment performed by LVN C, which indicated no alterations in skin integrity to any part of Resident #1's body. Progress notes written by LVN I on 7/29/2024 stated Resident #1 had open sores with visible tissue deterioration to the bilateral antecubital. areas (inner elbows), but there was no accompanying skin assessment. A phone order dated 07/29/2024 from the RP indicated the wounds were to be treated with Diflucan 150 milligrams (an anti-fungal), once per day, for 3 days and Nystatin Powder with Inter-Dry until the wounds healed. This order was received and recorded by LVN I for the treatment of topical fungus to the bilateral antecubital areas. There was no mention of open sores to the bilateral antecubital areas in the communication notes, while the progress notes from the same date, indicated open areas with visible skin deterioration. Review of skin assessments for Resident #1 revealed LVN C performed an additional skin assessment on 7/31/2024, which indicated during treatment to Resident #1's bilateral antecubital areas, open sores were noted with tendon exposed. There were no wound measurements or staging of the wound performed. A phone order from the RP indicated Resident #1 was to be sent to the hospital for further evaluation of the wounds. Resident #1 was transported to the hospital via ambulance at approximately 10:45AM. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/02/2024 at 6:30PM an interview with the DON revealed CNAs are supposed to look at the resident's legs, arms, feet, back, buttocks, face, etc. during showers, to detect any skin tears or bruises that had not been detected prior. The DON stated she had not provided any hands-on training to CNAs regarding identification of wounds. The DON stated that the CNAs are often at bedside when wounds are dressed, so they have seen wounds and how to care for them but have not been specifically trained on looking for wounds during showers or resident rounds. The Administrator came into the office while we were speaking and stated there was a notebook that showed the teach-back assessments the CNAs do yearly, but she could not locate the notebook. The Administrator stated when the CNAs came to work, they were trained on showers, but not on assessing skin. She stated they have an in-service scheduled to train the CNAs on hydration and skin in November, but there had been no in-service done when Resident #1's wounds were discovered. The Administrator stated the facility had a shower schedule for each resident and Resident #1's showers were scheduled for MWF. The DON then stated that Resident #1 was very clean and would take a shower every day if they would let him. She was asked by this investigator if Resident #1 was so clean, why were the wounds to the inside of his elbows not detected during his shower on Monday, 07/29/2024. The DON could not provide a response to this question. The DON stated Resident #1 wore protective sleeves on his arms to keep from getting pressure sores due to his contractures. She stated the sleeves were removed prior to the shower in case they were soiled and need to be replaced. When asked by this investigator why the wounds would not have been detected if the CNA took Resident #1's sleeves off prior to his shower on 07/29/2024, the DON could not provide a response. She stated the CNAs were not in-serviced on skin assessments and reporting after Resident #1's wounds were found. The DON stated the negative outcome of not in-servicing the CNAs might have been that they thought it was not their job to deal with the wounds and possibly a nurse already knew about them. The DON stated when the wounds were first found to Resident #1, LVN I described them to the RP as a fungal infection. Nystatin powder and Diflucan were provided to Resident #1, per the physician's order. On 08/02/2024 at 7:29PM and interview with CNA P revealed she had not been trained specifically on looking for wounds but had been a CNA for a long time and knew what to look for during resident showers and rounds. CNA P stated the facility conducted in-services on Abuse and Neglect and reporting of incidents, but she had not been told to report wounds, specifically. She stated the negative outcome of not reporting a wound was the resident could become very sick with an infection. CNA P stated Resident #1 had indicated to her on 07/29/2024, through his communication device, that he had not received a shower on Friday 07/26/2024 and was still wearing the same sleeves from Wednesday. Review of Progress Notes revealed CNA P showered Resident #1 on 07/29/2024 and found the open areas to his inner elbows which had a purulent smell and green drainage. CNA P stated she told LVN I on 07/29/2024 that Resident #1 had open areas to his inner elbows which required his attention. LVN I applied Nystatin Powder to the wounds and left Resident #1's protective sleeves off so air could get to the wounds. Record review of Resident #1's Braden Scale completed on 7/31/24 revealed a score of 14, indicating that the resident was a moderate risk for skin integrity issues. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/02/2024 at 7:44PM an interview with LVN C revealed she could not explain why a Braden Scale which she had completed on 7/31/24 indicated Resident #1 was a Potential Problem for friction and shear, while his Mobility indicated he was Completely Immobile and Bedfast. LVN C stated residents who are bedfast and immobile are usually coded as Problem for friction and shear, due to not making even slight changes in body or extremity position without assistance. LVN C did not note any skin integrity issues for Resident #1 during this evaluation. LVN C stated she performs Braden Scale assessments for all residents in the facility, quarterly. An interview with POA regarding Resident #1 on 8/03/2024 at 1:10PM revealed she had been called by LVN I on 7/29/2024 and was informed Resident #1 had open areas to his inner elbows which were described to her as cuts that were infected. The POA was told by LVN I that Resident #1's wounds were treated with Diflucan and Nystatin Powder. On 7/31/24 the POA was called again by LVN I who stated the cuts had worsened and the facility had contacted the RP to see about transferring Resident #1 to the hospital for further evaluation. The POA stated upon his arrival at the hospital ED, x-rays were performed to ensure there was no bone infection which needed to be addressed. The x-rays were negative for bone infection, but when the POA arrived at the hospital and looked at Resident #1's wounds, they were much worse than what had been described to her on the telephone. She stated she immediately thought that the wounds had been there for more than a day or two. Resident #1 was admitted to the hospital in the early hours of 08/01/2024, where he received IV antibiotics of Vancomycin and Rocephin, until his release in the early hours of 08/03/2024. An interview with the DON on 08/03/2026 at 4:39PM revealed Resident #1 had returned to the facility early this morning with dressings applied to both antecubital areas. When asked if she could show this investigator the wounds, she stated she had been informed not to touch the dressings until Monday due to Resident #1 being scheduled for dressing changes on MWF. The DON stated there was Aquacel packed into the wound and the RP does not want it pulled off until it had a couple of days to heal over the weekend. The DON was asked about the hospital's report of exposed tendon, and she stated that it probably happened when the hospital removed the dressing that the facility put on due to the fact that Resident #1's skin was so thin that it would tear easily. Review of a hospital discharge summary revealed Resident #1 returned from the on hospital 08/03/2024 with new orders to protect wounds and wound dressing with water repellent cover. The dressing was to be removed and replaced if the dressing became wet, every MWF for shower days. Aquacel Ag Foam External Pad (Silver) was to be applied to the bilateral antecubital areas every MWF for wound care. Directions: Cleanse wound with wound cleanser, pat dry with 4x4 gauze, apply Aquacel AG and wrap with kerlix. The hospital discharge summary Quality Measures Documentation on page 8 revealed: Wound 07/32/24: Pressure Injury Right antecubital (active); Would 07/31/24: Pressure Injury Left anterior; upper arm (active). On page 9 of the hospital discharge summary, the following was noted: Musculoskeletal: chronic contracures of bilateral upper extremities. Skin: Chronic wounds to bilateral antecubital fossae, left antecubital fossa wound weeping purulent discharge. An interview with the RP on 08/04/2024 at 12:40PM revealed when she was first called by the facility on 07/29/2024 regarding Resident #1, she was told by LVN I Resident #1 had a rash in his armpits. She prescribed Nystatin Powder and Diflucan thinking Resident #1 had a heat rash due to the extreme heat outside, the fact that Resident #1 sweats a lot and had probably developed a heat rash, due to the inability to move his arms. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The RP stated she received a photo on 07/31/2024, of a wound to Resident #1's left antecubital area which was taken by an unnamed member of facility staff that clearly showed exposed tendon to the antecubital area. She immediately gave orders for Resident #1 to be transported to the hospital, via EMS, for treatment. The RP stated in her professional opinion there was no way the wound presented in the photo could have developed in 2 days' time, unless Resident #1 had been sitting in a tub of water, with elbows submerged for the entire 2 days. The photo of the wound was sent by the RP to this investigator and clearly revealed the infected wound and exposed tendon of Resident #1's inner elbow. On 08/04/2026 at 2:16PM an interview with the Administrator revealed CNAs and LVNs usually report any wounds that they see during showers and rounding to the Charge Nurse, which records indicated on 07/29/2024, was LVN I. The Administrator stated she was aware of the skin integrity issue to Resident #1's antecubital areas on 07/29/2024 but had been told by LVN I that Resident #1 had a rash to his inner elbows, not open wounds. When the Administrator reviewed LVN I's documentation, she discovered LVN I had reported to the RP that Resident #1 had a rash to the armpit, not the inner elbow. The Administrator asked LVN I if he knew the difference between and armpit and an elbow and why the documentation did not match the description of the wounds. LVN I stated he had made a mistake in documentation, and it was an easy fix in charting. The Administrator stated Resident #1's wound had been treated with Diflucan and Nystatin Powder starting on 07/29/2024, after a phone order was received from the RP. Resident #1 was treated with Diflucan and Nystatin Powder from 07/29/2024 through 07/31/2024 when the true extent of the wounds to Resident #1 were revealed and he was transported to the hospital. LVN I was relieved of his duties at the facility on 07/31/2024. An interview with the Administrator and DON on 08/26/2024 at 11:04AM revealed staff were now acutely aware of the importance of correct, concise documentation after an in-service was held on 08/22/2024. In this in-service, the DON emphasized the importance of documenting exactly what has been seen, with regard to wounds, taking concerns, even if thought to already be reported, to the Charge Nurse on duty. If those concerns were not addressed by the Charge Nurse, staff was instructed to move up the chain of command to ensure residents are receiving the proper care and attention they deserve. Record review of a policy provided by the facility titled Pressure Ulcer/Injury Risk Management dated July 2017 revealed: Reporting - Notify attending MD if new skin alteration noted. An Immediate Jeopardy (IJ) was identified on 08/22/2024 at 4:53PM. The Administrator and DON were notified. The Administrator was provided with the IJ template, and a Plan of Removal was requested at that time. The facility's Plan of Removal was accepted on 08/23/2024 at 8:50AM and read as follows: Name of Facility Facility Address August 22, 2024 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The plan of removal represents the center's allegation of compliance. This plan of removal serves as the facility's response to the immediate jeopardy notification the center received during the exit conference on August 22, 2024, at 5:09PM from the Texas Health and Human Services Commission related to identification of changes in skin integrity. The allegation is that staff did not identify changes in skin integrity for Resident #1 and that CNAs (certified nurse's assistants) were not trained to identify changes in skin integrity. The allegation also indicated the physician and resident representative were not informed of skin integrity issues in a timely manner. Immediate Actions 1. A routine skin assessment was completed and documented on in Resident #1's chart, indicating no new concerns on July 28, 2024, at 11:09 AM. On 07/29/2024, during routine shower, the CNA reported the change in skin integrity noted for Resident #1 to the charge nurse. The CNA noted open areas to bilateral antecubital areas. The charge nurse assessed the area, notified the physician, and initiated new orders, including the administration of Diflucan and wound care to both areas. The family was notified at that time as well. The nurse documented in the progress notes that the areas of concern were bilateral antecubital areas. 2. On 7/31/24, the charge nurse noted the areas to the bilateral antecubital areas were not improving and notified the physician. Orders were received at that time to transfer residents to the hospital of the family's choice. Resident #1 was transferred to the emergency room for treatment. 3. On 08/02/2024, Resident#1 returned to the facility with wound care orders. There were no changes in the resident's medications and no antibiotics were ordered. In-Service Education Facility implemented the following action plan that had the potential to affect 39 residents. 1. Facility conducted in person education to all CNAs who were in the facility on August 22, 2024, at 1800 PM. The education included prevention of developing or worsening contractures, proper use of shower/skin monitoring sheets, reporting changes in skin integrity to charge nurses and documentation. All staff will receive this education by Friday. August 23,2024. 2. The facility conducted in person training to all nursing staff who were on the schedule on August 22, 2024, at 1800. The education included identification and documentation of skin integrity as well as completing all associated assessments such as Braden Scale and Skin assessments. The education also included notification of physician and resident representative immediately and the documentation of this. All staff will receive this education by Friday, August 23, 2024. Monitoring The following systems of monitoring have been implemented: 1. DON (director of nursing) or designee, will collect all shower/skin monitor sheets daily and address any changes or concerns. This will be completed for the next 3 months or until substantial compliance is achieved. They will ensure all issues or concerns are addressed, assessed, and all notifications made. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	08/26/2024 at 1:02PM Interview with CNA W regarding what she learned from the in-service that was held on 8/22/24 service that was held on 8/22/24 with regard to Resident Change of Condition; she stated that the main thing that she learned was to report anything that you see on a resident's body, even if you think it's already been reported; asked how this changed what she you see on a resident's body, even if you think it's already been reported; asked how this changed what she was doing and she stated that she is documenting on the shower sheet now and not just in the computer on the shower sheet now and not just in the computer; she was only using the computer and was not using the shower sheets to report; will do a better job now. 08/26/2024 at 1:18PM Phone interview CNA R regarding what she learned at the in-service on 8/22/24 with regard to Resident Change of Condition; she stated that they were told to keep a close eye on all resident's skin and report anything that you see, even if you think it has been reported already; using better documentation; asked how the how the in-service changed what she has been doing and she stated that it didn't change much for her due to being a CNA for so long, but reminded her to report anything that you see and document on paper as well as the computer. 08/26/2024 at 1:22PM Phone interview with CNA M regarding what she learned at the in-service on 8/22/24 and she stated that they talked about skin integrity and watching and reporting anything new or old that you see on a resident's skin; checking your resident's skin, especially after your days off to ensure that there is no new conditions; reporting and documenting are essential and if you don't get the first person to listen to you, go up the chain of command; don't just let it go. 08/26/2024 at 1:28PM Phone interview with CNA T regarding what she learned at the in-service on 8/22/24 with regard to skin integrity and Change in Condition ; she stated that they need to be documenting better; use the paper shower sheet and document in the computer; not just one of the two; report anything that you see to the Charge Nurse and if they don't listen, go up the chain; asked how this changes what she had been doing in the past and she stated that she feels like communication will be better, because a licensed staff member licensed staff member has as to sign off on whatever they find and record on the shower sheet. 08/26/2024 at 1:48PM Phone interview with CNA Y regarding what she learned in the in-service on 8/22/24; she stated that they talked about skin and shower sheets and the importance of filling them out correctly and then having a Charge Nurse sign off on them; document on paper and not just in the computer; this will remind her more attentive to any changes in resident's skin. 08/26/2024 at 1:52PM Interview with CNA N regarding what she learned in the in-service on 8/22/24; she stated that she needs to do a better job of filling out the shower sheets and turning them in so that a Charge can sign off on them; look between toes and fingers, elbows and knees to see if there are any skin changes and then record on the shower sheet and report to a Charge so that they can sign off on your shower sheet. 08/26/2024 at 1:55PM Phone interview with CNA L regarding what she learned in the in-service on 8/22/24; she stated that they need to do a better job of filling out the shower sheet and reporting anything, even if it's small to the Charge Nurse so that they can look at it; fill out the skin assessment sheet as well and make sure that all documentation is on paper and in the computer. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	08/26/2024 at 1:58PM Interview with DON regarding the in-service on the on 8/22/24; she stated that they really pushed to both the CNAs and the licensed staff, the importance of documenting everything; don't let little things go, because they turn into big things; report to herself or [NAME] and if you think we're not listening, bug us until we do. 08/26/2024 at 2:03PM Interview with LVN G regarding what they learned in the in-service on 8/22/24; she stated that they talked about both the shower sheet and the skin assessment sheet and ensuring that they are filled out correctly and turned in; check with your CNAs to see what they have documented on the sheets and if she needs to look at any skin issues; reporting up the chain of command, as well as the family and the MD if you see a problem developing with a resident's skin. 08/26/2024 at 2:06PM Phone interview the ADON who is out sick today regarding what was talked about in the in-service on 8/22/24; she stated that they really emphasized the fact that everyone, not just the CNAs need to be checking their residents for any skin integrity issues; the importance of reporting even if you think someone else has already reported it; she and the DON met to make a system of checking to ensure that shower sheets/skin assessments are done and recorded accurately; informing the family and the MD as soon as you see something. 08/26/2024 at 2:26PM Interview with MDS Nurse regarding the in-service on 8/22/24; she stated that they talked about Change in Condition and reporting anything that you see to a Charge Nurse; documentation of everything, both on paper and in computer; if you're not sure if something that you see has been reported already, report it anyway; all of the licensed staff need to do a better job of following up with their CNAs of following up with their CNAs and fell ow workers 08/26/2024 at 2:58PM Phone interview with LVN E regarding what she learned at the in-service that was held on service that was held on 8/22/24 regarding Change of Condition and reporting; she stated the in-service reminded her to look for anything that might warrant a Change of Condition for a resident and the notification of the MD, family DON, et; making sure that risk management paperwork is completed and documented correctly; any new orders that show up on the dash board-check on that resident and chart according to that order; she stated that the CNAs that are hers are very diligent about the shower sheets and reporting anything that they see as far as a change in skin integrity to her; she stated she checks in with her CNAs every shift to make sure that they have completed documentation correctly. 08/26/2024 at 3:07PM Phone interview with LVN C regarding what was covered in the in-service on 8/22/24; she stated that they talked in depth about Change in Condition and the detailed expectations for both hand-written documentation and electronic documentation; reporting of any changes in a resident to the DON, MD, Family and Administrator; she is going to inform both the DON and the Administrator if she observes anything new with her residents and ensure that there is follow-through on what needs to be done the resident; stated that they received a pocket version of the expectations and reporting that she will carry in her pocket to remind herself of what needs to be done and check it off of the list. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	08/26/2024 at 3:29PM Interview with LVN H regarding what was covered in the in-service on 8/22/24 and how it will change her work within the facility; she stated that they covered the expectations that are on the LVNs and RNs to ensure that documentation is correct and done in a timely manner; if you wait even a few minutes to chart something, you may leave out very important details about the resident; if there is a change in condition they have to update the SBAR, notify the MD, family, DON and administrator immediately, as well; make sure that you are checking your residents daily and checking in with your CNAs to ensure that all the bases have been covered with documentation and notifications. The Administrator was informed the IJ was removed on 08/26/2024 at 4:16PM. The facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy and a scope of Isolated due to the need for implementation of corrective measures and the effectiveness of its corrective plan.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47159 Based on observation, interview, and record review the facility failed to ensure that a resident with a pressure ulcer received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 4 residents (Resident # 1) reviewed for contractures. The facility did not prevent the development of one facility-acquired Stage IV, exposed tendon, pressure injury for Resident #1. This failure could place residents at risk for worsening of an ulcer, infection, and a decreased quality of life. An Immediate Jeopardy (IJ) was identified on 08/04/2024. The IJ Template was provided to the facility on [DATE] at 4:00PM. While the IJ was removed on 08/06/2024, the facility remained out of compliance at a level of more than minimal harm and a severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy and a scope of Isolated due to the need for implementation of corrective measures and the effectiveness of its corrective plan. Findings included: Record review of Resident #1's admission record revealed a [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: PRIMARY LATERAL SCLEROSIS (A motor-neuron disease which causes nerves within the brain to slowly break down) DYSPHAGIA, OROPHARYNGEAL PHASE CHRONIC PAIN SYNDROME PAIN IN UNSPECIFIED SHOULDER OTHER SPEECH DISTURBANCES APHASIA MUSCLE WEAKNESS (GENERALIZED) MUSCLE WASTING AND ATROPHY, NOT ELSEWHERE CLASSIFIED, UNSPECIFIED SITE OTHER REDUCED MOBILITY HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE PARKINSON'S DISEASE WITH DYSKINESIA, WITHOUT MENTION OF FLUCTUATIONS (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	OTHER MUSCLE SPASM ENCOUNTER FOR SCREENING FOR COVID-19 PERSONAL HISTORY OF COVID-19 OTHER SEASONAL ALLERGIC RHINITIS OTHER CONSTIPATION Record review of Resident #1's MDS dated [DATE] indicated no pressure injury over a scar or bony prominence, no current unhealed pressure injury, and no detection of a Stage IV pressure injury. There were also no noted skin conditions. Record review of Resident #1's care plan dated 7/3/24 indicated no pressure injury over a scar or bony prominence, no current unhealed pressure injury and no detection of pressure injuries. There was no documentation of any noted skin conditions. An interview with the DON and Admn. on 08/02/2024 at 6:30PM revealed CNAs had not been formally trained on performing resident skin checks while giving showers. She stated CNAs looked for skin conditions such as scratches, bruises, skin tears and any injury of unknown source, but did not specifically check a resident's contractures for any skin deterioration. The DON stated CNAs were often at bedside when wounds were treated by licensed staff but had not been specifically trained on looking for open wounds during showers or rounding. The Admn. stated there were teach-back assessments done yearly for CNAs regarding showering residents and assessing them for bruises, cuts, skin tears and any skin condition which would require further assessment by a licensed staff member. The Admn. was asked to produce the teach-back documentation for CNAs, but the binder could not be located. The DON stated Resident #1 was extremely clean and would take 2 showers per day, if allowed. She stated his scheduled shower days were MWF. The DON stated she was unsure why CNAs would not have found the open area to Resident #1's left antecubital (inner elbow) area when he was showered on Monday, 7/29/2024. When asked what a negative outcome of not instructing CNAs on proper showering techniques and skin assessment, the DON stated CNAs might think that any wound they found had already been seen by a licensed staff member and therefore were not their responsibility. Review of Resident #1's Progress Notes dated 07/29/2024 indicated an open area to the left antecubital area, which was treated with Nystatin Powder and Diflucan, both of which were ordered by the RP. An observation of Resident #1 on 8/3/2024 at 2:22pm revealed Resident #1 was laying in bed. Resident #1's elbows were loosely wrapped with gauze and there was folded gauze in the crease of both elbows. Resident #1 had a washcloth rolled in the palms of both hands due to contractures. On 08/02/2024 at 7:29PM an interview with CNA P revealed she had not been trained specifically to look for wounds or open areas to resident's skin, while performing showers. She stated the Admn. and DON trained the CNAs at least monthly on Abuse and Neglect of Residents and Reporting of Resident Incidents and Accidents, but she had not been specifically trained on reporting wounds. When asked the negative outcome of not reporting a new or worsening wound to licensed staff, she stated the wound could become infected and the resident could become very sick. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Physician Orders revealed Resident #1 was to have had skin assessments performed every Sunday by licensed staff and CNAs. Review of skin assessments dated 07/04/2024, 07/15/2024, 07/22/2024 and 07/28/2024 indicated no skin breakdown to any part of Resident #1's body. Review of Progress Notes revealed CNA P showered Resident #1 on 07/29/2024 and found the open areas to his inner elbows which had a purulent smell and green drainage. CNA P stated she told LVN I on 07/29/2024 that Resident #1 had open areas to his inner elbows which required his attention. LVN I applied Nystatin Powder to the wounds and left Resident #1's protective sleeves off so air could get to the wounds Record review of a skin assessment completed 7/31/24 on Resident #1 revealed suspected deep tissue injuries to right antecubital and left antecubital. The skin assessment further documented: During treatment to resident's bilateral antecubital, both sites noted open. Contacted physician. New order received to send resident out for further assessment and treatment . An interview with the LVN C on 08/02/2024 at 7:44PM revealed weekly skin assessments were placed in the Treatment Administration Record or Miscellaneous sections of the resident's charts. She stated Resident #1's skin assessments may not have been completed on Sundays specifically, but they were done within the next day. She stated CNAs were supposed to perform skin checks when they gave showers but had not been trained on looking for wounds. An interview with Resident #1's POA on 08/03/2024 at 1:10PM revealed she felt as if the facility had been negligent in finding the open area with exposed tendon, to Resident #1's elbow. She stated she received a call from the facility on 07/29/2024 informing her that a small, open wound had developed on the inside of Resident #1's left elbow. Resident #1's arms are contracted at the elbow, so the skin between his upper arm and forearm were always touching. He did not have any protection from skin deterioration in this area unless the staff put his arm sleeves on him. She stated the facility told her they were treating the area with Diflucan and Nystatin Powder and would continue to keep her informed of any changes in Resident #1's overall health (ie. fever, chills, bleeding in the area). On Wednesday, July 31st the POA received another call from the facility which stated the area to Resident #1's inner elbow had gotten worse, and they were going to transport the resident to the hospital of her choice for further evaluation. He was transferred to a hospital at approximately 11:15AM on 7/31/24. Record review of the hospital discharge summary dated 8/2/24 revealed Resident #1 was admitted to the hospital on 7/31/2024 with a primary diagnosis of Cellulitis (skin infection) of the Left Antecubital (left inner elbow). Resident #1 had received IV antibiotics of Vancomycin and Rocephin for the skin infection. Resident #1's POA stated when she saw the open area to Resident #1's inner elbow it was much worse than what the facility had described on the telephone. The tendon was exposed through a hole in Resident #1's inner elbow and the surrounding skin was red and warm to the touch. Resident #1 remained in the hospital on IV antibiotics until 08/02/2024, when he returned to the facility. The discharge summary indicated the following: Quality Measures Documentation on page 8 - Wound 7/31/24 pressure injury right antecubital and wound 7/31/24 pressure injury left anterior upper arm. Page 9 of the discharge summary indicated muscoskeletal - chronic contractures of bilateral upper extremities and skin - chronic wounds to bilateral antecubital fossae; left antecubital fossa wound weeping purulent discharge. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/03/2024 at 4:39PM during an interview, the DON was asked to show this investigator the wound to the inside of Resident #1's left elbow. She declined taking the dressing off, as the wound had been packed with Aquacel (antibiotic gel dressing) and she was worried the wound site would open again if the dressing were removed. An interview with the RP on 08/04/2024 at 12:40PM revealed when she was first called by the facility on 07/29/2024 regarding Resident #1, she was told that Resident #1 had a rash in his armpit. She prescribed Nystatin Powder and Diflucan thinking Resident #1 had a heat rash due to the extreme heat outside, the fact that Resident #1 sweats a lot and had probably developed a heat rash, due to the inability to move his arms. She received a photo of a wound to Resident #1's left antecubital area which was taken by an unnamed member of facility staff. She immediately gave orders for Resident #1 to be transported to the hospital, via EMS, for treatment. She stated in her professional opinion there was no way the wound presented in the photo could have developed in 2 days' time, unless Resident #1 had been sitting in a tub of water with elbows submerged for the entire 2 days. Record review of the photo of the wound was sent by the RP to this investigator and clearly revealed the infected wound and exposed tendon of Resident #1's inner elbow. An interview with the Admn. on 08/04/2024 at 2:16PM revealed she was aware of the skin integrity issue of Resident #1 on 07/29/2024. She stated LVN I, who has since been relieved of his duties at the facility, told her about the wound and the orders for Nystatin and Diflucan from the RP. When the Admn. reviewed the progress notes entered by LVN I they stated Resident #1 had a rash to his left armpit. She stated she asked the LVN I if he knew the difference between an elbow and an armpit and was given no reason why the call to the RP was made stating Resident #1 had a rash and the charting of the call indicated an open wound to the inner elbow. The LVN I told the Admn. it was a mistake and an easy fix in charting. She stated Resident #1 remained in the facility with the open wound until 07/31/2024 when he was transported to the hospital for further evaluation. Review of facility policy and procedure for Pressure Ulcer/Injury Risk assessment dated [DATE] stated: Purpose: The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing pressure ulcers/injuries. General Guidelines: 1. The purpose of a structured risk assessment is to identify all risk factors and then to determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify. 2. Risk factors that increase a resident's susceptibility to develop or to not heal PU/PIs include, but are not limited to: a. Under nutrition, malnutrition, and hydration deficits; b. Impaired/decreased mobility and decreased functional ability; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. The presence of previously healed pressure ulcers/injuries (Areas of healed Stage 3 or 4 PU/PIs are more likely to have recurrent breakdown.); d. Exposure of skin to urinary and fecal incontinence; e. Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency; f. Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus; g. Drugs such as steroids that may affect healing; h. Cognitive impairment; and i. Resident refusal of some aspects of care and treatment. 3. Once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan can be created to address the modifiable risks for pressure ulcers/injuries. 4. Use only a facility-approved risk assessment tool to obtain risk assessment data. 5. The risk assessment should be conducted as soon as possible after admission, but no later than eight hours after admission is completed. 6. Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition. Steps in the Procedure: 1. Gather assessment tools and documentation and conduct the assessment in the manner most appropriate to the resident's condition and willingness to participate. 2. If necessary, allow the resident to take rest periods during the assessment. 3. Conduct a structured pressure ulcer/injury risk assessment using a facility-approved tool. 4. Conduct a comprehensive skin assessment with every risk assessment. a. When conducting a skin assessment, provide for the resident's privacy. b. Once inspection of skin is completed document the findings on a facility-approved skin assessment tool. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. If a new skin alteration is noted, initiate a (pressure or non-pressure) form related to the type of alteration in skin. Skin and Wound Management: 5. Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin, the resident's overall clinical condition, and the resident's stated wishes and goals. a. The interventions must be based on current, recognized standards of care. b. The effects of the interventions must be evaluated. c. The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate. Documentation: The following information should be recorded in the resident's medical record utilizing facility forms: 1. The type of assessment(s) conducted. 2. The date and time and type of skin care provided, if appropriate. 3. The name and title (or initials) of the individual who conducted the assessment. 4. Any change in the resident's condition, if identified. 5. The condition of the resident's skin (i.e., the size and location of any red or tender areas), if identified. 6. How the resident tolerated the procedure or his/her ability to participate in the procedure. 7. Any problems or complaints made by the resident related to the procedure. 8. If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. Document family and physician notification of refusal. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Areas of impaired circulation due to pressure from positioning or medical devices. 3. Use a screening tool to determine if resident is at risk for under-nutrition or malnutrition. 4. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.); c. Wash the skin after any episodes of incontinence, using pH balanced skin cleanser; d. Moisturize dry skin daily; and e. Reposition resident as indicated on the care plan. Prevention: Moisture I. Keep the skin clean and free of exposure to urine and fecal matter. Nutrition: 1. Monitor the resident for weight loss and intake of food and fluids. 2. Include nutritional supplements in the resident's diet to increase calories and protein, as indicated in the care plan. Mobility/Repositioning: 1. Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences. 2. At least every hour, reposition residents who are chair-bound or bed-bound with the head of the bed elevated 30 degrees or more. 3. At least every two hours, reposition residents who are reclining and dependent on staff for repositioning. 4. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Skin and Wound Management: 5. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions. Support Surfaces and Pressure Redistribution: Select appropriate support surfaces based the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors. Monitoring: 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis. Review of facility policy for Pressure Ulcers/Skin Breakdown-Clinical Protocol dated March 2014 stated: Assessment and Recognition: 1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses. 3. The staff will examine the skin of a new admission for ulcerations or alterations in skin. 4. The physician will assist the staff to determine etiology (for example, arterial or stasis ulcer) and characteristics (necrotic tissue, status of wound bed, etc.) of the skin alteration. Cause Identification: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The physician will help identify factors contributing or predisposing residents to skin breakdown; for example, medical comorbidities such as diabetes or congestive heart failure, overall medical instability, cancer or sepsis causing a catabolic state and macerated or friable skin. 2. The physician will help clarify relevant medical issues; for example, whether there is a soft tissue infection or just wound colonization, whether the wound has necrotic tissue, the impact of comorbid conditions on wound healing, etc. Treatment/Management: 1. The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if indicated for type of skin alteration. a. Although poor nutritional status is associated with increased risk of pressure ulcer development, no specific nutritional interventions have been proven conclusively to prevent or heal pressure ulcers. There are no pressure ulcer-specific nutritional measures that should be provided routinely to those with or at risk for developing a pressure ulcer. Nutritional supplementation should be based on realistic appraisal of need and identification of medical conditions and factors that affect appetite, weight, and overall nutritional balance. 2. The physician will help identify medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etc. 3. The physician will help staff characterize the likelihood of wound healing, based on a review of pertinent factors; for example: a. Healing or Prevention Likely: The resident's underlying physical condition, prognosis, personal goals (continued on next page)

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	675978	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Wellness Center	1241 W Marshall Howard Blvd Littlefield, TX 79339

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and wishes, care instructions, and ability to cooperate with the treatment plan make wound healing and subsequent wound prevention realistic. b. Healing or Prevention Possible: Healing may be delayed or may occur only partially; wounds may occur despite appropriate preventive efforts. c. Healing or Prevention Unlikely: The resident is likely to decline or die because of his/her overall medical instability: wounds reflect the individual's overall medical instability; an existing wound is unlikely to improve significantly; additional wounds are likely to occur despite preventive efforts. 4. As needed, the physician will help identify medical and ethical issues influencing wound healing; for example, because of end-stage heart disease or because cause-specific treatment is not advisable, not feasible, or not desired by the resident or family. a. Advance directives may limit the scope, intensity, duration, and selection of various wound-related or adjunctive treatments such as a choice to forego artificial nutrition and hydration. Monitoring 1. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or non-healing wounds. 2. The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. a. Healing may be delayed or may not occur, or additional ulcers may occur because of other factors which cannot be modified. b. It may be appropriate to maintain some or all of the existing approaches, if they are pertinent to the resident's medical conditions, other relevant factors influencing wound development or healing, and specific treatment choices made by the resident or a substitute decision-maker. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility policy for Pressure Ulcer/Skin Breakdown-Clinical Protocol dated March 2014 stated: Assessment and Recognition: 1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses. 3. The staff will examine the skin of a new admission for ulcerations or alterations in skin. 4. The physician will assist the staff to determine etiology (for example, arterial or stasis ulcer) and characteristics (necrotic tissue, status of wound bed, etc.) of the skin alteration. Cause Identification: 1. The physician will help identify factors contributing or predisposing residents to skin breakdown; for example, medical comorbidities such as diabetes or congestive heart failure, overall medical instability, cancer or sepsis causing a catabolic state and macerated or friable skin. 2. The physician will help clarify' relevant medical issues; for example, whether there is a soft tissue infection or just wound colonization, whether the wound has necrotic tissue, the impact of comorbid conditions on wound healing, etc. Treatment/Management: 1. The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	indicated for type of skin alteration. a. Although poor nutritional status is associated with increased risk of pressure ulcer development, no specific nutritional interventions have been proven conclusively to prevent or heal pressure ulcers. There are no pressure ulcer-specific nutritional measures that should be provided routinely to those with or at risk for developing a pressure ulcer. Nutritional supplementation should be based on realistic appraisal of need and identification of medical conditions and factors that affect appetite, weight, and overall nutritional balance. 2. The physician will help identify medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etc. 3. The physician will help staff characterize the likelihood of wound healing, based on a review of pertinent factors; for example: a. Healing or Prevention Likely: The resident's underlying physical condition, prognosis, personal goals and wishes, care instructions, and ability to cooperate with the treatment plan make wound healing and subsequent wound prevention realistic. b. Healing or Prevention Possible: Healing may be delayed or may occur only partially; wounds may occur despite appropriate preventive efforts. c. Healing or Prevention Unlikely: The resident is likely to decline or die because of his/her overall medical instability; wounds reflect the individual's overall medical instability; an existing wound is unlikely to improve significantly; additional wounds are likely to occur despite preventive efforts. 4. As needed, the physician will help identify medical and ethical issues influencing wound healing; for (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	example, because of end-stage heart disease or because cause-specific treatment is not advisable, not feasible, or not desired by the resident or family. a. Advance directives may limit the scope, intensity, duration, and selection of various wound-related or adjunctive treatments such as a choice to forego artificial nutrition and hydration. Documentation The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. Reporting: 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice. An Immediate Jeopardy (IJ) was identified on 08/04/2024 at 4:00PM. The Administrator and DON were notified. The Administrator was provided with the IJ template, and a Plan of Removal was requested at that time. The facility's Plan of Removal was accepted on 08/05/2024 at 10:18AM and read as follows: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility Name Facility Address August 4, 2024 The plan of removal represents the center's allegation of compliance. This plan of removal serves as {facility} response to the immediate jeopardy notification the center received during the exit conference on August 4, 2024, at 1550 from the Texas Health and Human Services Commission related to identification of changes in skin integrity. The allegation is that staff did not identify changes in skin integrity for resident #1 and that CNAs (certified nurse's assistants) were not trained to identify changes in skin integrity. Immediate Actions 1. A routine skin assessment was completed and documented in Resident #1's chart, indicating no new concerns on July 28, 2024, at 11:09 AM. On 07/29/2024, during routine shower, the CNA reported the change in skin integrity noted for Resident #1 to the charge nurse. The CNA noted open areas to bilateral antecubital areas. The charge nurse assessed the area, notified the physician, and initiated new orders, including the administration of Diflucan and wound care to both areas. 2. On 7/31/24, the charge nurse noted the areas to the bilateral antecubital areas were not improving and notified the physician. Orders were received at that time to transfer residents to the hospital of the family's choice. Resident #1 was transferred to the emergency room for treatment. 3. On 08/02/2024, Resident #1 returned to the facility with wound care orders. There were no changes in the resident s medications and no antibiotics were ordered. In-Service Education Facility implemented the following action plan that had the potential to affect 43 residents. 1. Facility conducted in person education to 9 of 11 CNA staff (82%) on August 4, 2024, at 1745 PM. The education included prevention of developing or worsening contractures, proper use of shower/skin monitoring sheets, reporting changes in skin integrity to charge nurses and documentation. 2. The facility conducted in person training to 100% of nursing staff on August 4, 2024, at 1745 PM. The education included identification and documentation of skin integrity as well as completing all associated assessments such as Braden Scale and Skin assessments. 3. 100 % of residents will receive a skin assessment today, August 4, 2024. These will be documented in the individual charts. The following systems of monitoring have been implemented: DON (director of nursing) or designee, will collect all shower/skin monitor sheets daily and address any changes or concerns. This will be completed for the next 3 months or until substantial compliance is achieved. (continued on next page)

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