STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675995	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Rehabilitation Center	2244 Brinker Rd Denton, TX 76208

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44021 Based on observations, interviews, and record review the facility failed to promote and facilitate resident self-determination through support of resident choice for 1 of 7 residents (Resident #88) reviewed for respect and dignity. The facility staff failed to honor Resident #88 ' s request to stay in bed, put on her slippers, and eat breakfast in the dining area instead of staying in bed and eating in her room. The past noncompliance began on 12/16/24 and ended on 12/18/24. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of diminished quality of life. Findings included: Record review of Resident # 88' s face sheet dated 02/25/25 revealed, admission on 07/30/24. Resident #11 was an [AGE] year-old female diagnosed with Alzheimer's disease, dementia with behavioral disturbance, muscle weakness (no muscle strength), major depressive disorder, and cognitive communication deficit. Record review of Resident # 88' s Quarterly Minimum Data Set (MDS), dated [DATE] revealed that Resident #88 had a BIMS score of 00 signifying the most severe level of cognitive impairment, requiring extensive assistance with daily activities, and was noted to have both physical and verbal behaviors e.g. hitting, kicking, scratching, and screaming at others. Resident #88 required substantial/maximal assistance for putting on/taking off footwear and was found to be independent for walking over 150 feet. Her primary medical condition was notated as progressive neurological conditions. Record review of Resident # 88's Care Plan dated 11/21/24 revealed that under focus The resident has impaired cognitive function/dementia or impaired thought processes with interventions of Communicate with resident/family/caregivers regarding resident's capabilities and needs .Discuss concerns about confusion, disease process nursing home placement with resident/family/caregivers. Under the category Focus, The resident has a communication problem related to cognitive decline, with interventions of Monitor/document for physical/nonverbal indicators of discomfort or distress and follow up as needed .Monitor/document frustration level. Wait 30 seconds before providing additional cares. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675995	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER University Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2244 Brinker Rd Denton, TX 76208	

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility investigation of alleged abuse dated 12/22/24 revealed that in a scheduled care plan meeting on 12/17/24, the resident's representative displayed a video to the staff at the care plan meeting that showed LVN G abruptly waking up Resident #88 who appeared to react in surprise to being woken up and then sat up. LVN G then rushed Resident #88 out of bed. Resident #88 could be heard (on the video) protesting and motioning towards her feet and LVN G could be heard telling Resident #88 that she had to get up and go to breakfast. Further review revealed that 1. Associate suspension, and termination in same day to Human Resources office. 2. Head to toe resident assessment as well as skin checks on all residents in the building and safe surveys to be completed on all alert residents. 3. Police report obtained 4. Associates license was referred to the Texas Board of Nursing 5. Re-education 100 percent for all staff in the facility completed 6. Self-report checklist and audits completed 7. Self-Report to Health and Human Resources Commission within 2 hours. 8. Trauma informed care completed with [Resident #88's resident representative]by social worker at this time. 9. All staff who worked with the individual to be interviewed as well. Upon completion of the investigation and review of all the above audits, interventions, interviews, and skin checks noted that there were no other staff or residents who had any concerns with this specific nurse or any other associate in the building. The associate was terminated on 12/18/24 due to the clear video footage showing the inappropriate nature in which he gave the patient care. In an interview on 02/25/25 at 11:13 AM Resident #88's Representative revealed that she had attended a scheduled care plan meeting on 12/17/24 and she had brought/shown a video that she had recorded from Resident #88's room from earlier that same morning. She stated that the video showed LVN G abruptly waking up Resident #88 who appeared to react in surprise to being woken up and then sat up. LVN G then rushed Resident #88 out of bed Resident #88 could be heard (on the video) protesting and motioning towards her feet. LVN G could be heard telling Resident #88 that she had to get up and go to breakfast. She stated that she had explained to several staff members at the facility, many times, that Resident #88 had to be approached quietly and slowly, and that Resident #88 would eventually follow requests if approached in a calm way. She also stated that Resident #88 would get very upset if she was made to walk on the floors in her bare or socked feet and that if shoes/slippers were put on her feet she would cooperate more fully/easily with the Resident Representative or staff. Review of a video submitted by the Resident Representative of Resident #88 showed LVN G abruptly waking up Resident #88 who appeared to react in surprise to being woken up and then sat up. LVN G then rushed Resident #88 out of bed Resident #88 could be heard (on the video) protesting and motioning towards her feet and LVN G could be heard (on the video) telling Resident #88 that she had to get up and go to breakfast. During an interview on 02/25/24 at 12:30 PM with RN H, she stated that she had not been at the care plan meeting with the Resident Representative of Resident #88, but she had witnessed the video. She stated that in the video she remembered LVN G talking loudly [in the video]. She stated that LVN G had turned the light on and woke Resident #88 up with his voice. She stated that LVN G's goal seemed to have been to get Resident #88 up for breakfast. She stated that she thought there may have been a communication problem, and that his limited English/broken/heavy accent and Resident #88 speaking mostly Spanish may have worsened the incident. RN H stated that she had worked with Resident #88 after that incident and saw no change in her behavior. She stated that the facility had asked speech therapy to help train Resident #88 with the use a communication board; but, that Resident #88 did have advanced dementia, so the training was taking some time. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/25/25 at 3:03 PM with the Social Worker she stated Resident #88 was verbal, she was able to speak both English and Spanish, and she was able to generally speak enough to be able to make her needs known or through gestures. She had a BIMS score of 00, she did have a communication board, most residents in the secure unit usually get communication boards. The incident with LVN G was brought up during a care plan meeting, she was the one that advised that we report the incident and then the termination. We received training for ANE/Dementia Care, we did a staff wide in-service for ANE, Customer /Service, Res/Rights, Proper ways to interact with Residents/De-escalation. Human Resources and the ADM came around after to ascertain if the staff remembered the training, they did that to all of the staff more than once a week for nearly a month. Review of in-services Dated 12/18/24 and 12/19/24 revealed the following in-services were conducted and signed by 54 staff members representing 100% of nursing staff: Abuse, Neglect, and Exploitation, Customer/Service, Resident/Rights, Proper ways to interact, and Residents/De-escalation/Interactions. Review of a document entitled Actual/Alleged Abuse Monitoring Dated 12/28/24 to 01/08/25 stated Ask 15-20 staff members per week, situational questions related to Abuse. i.e. What would you do if . Document Date/Time, the staff members name, if they responded correctly, and any corrective action if needed. Note any corrective actions. The document was signed by the DON, the ADON, and the ADM, and documented 27 different staff members were quizzed on the spot for retention of related in-services. Review of Safe Survey of 68 residents, representing the entire resident population that were able to answer questions, and dated 12/17/24 to 12/18/24 and entitled Staff/Resident/Interactions found no negative findings about staff interactions/supervision. Interviews were conducted with 3 RN's, 4 LVN's, and 12 CNA's on 2/25/25 and 2/26/25. All staff were able to recount all in-service topics, stated that they had been monitored/quizzed for retention and understanding of associated in-services, and the monitoring/quizzes had lasted approximately for 1 month after the incident. Staff were able to identify that residents had the right for when they wanted to get out of bed and when they wanted to eat, as well as dressing preferences. Record review of the facility Resident Rights policy dated 11/28/21 revealed, Exercise of Rights - The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of The United States. Respect and Dignity - The resident has a right to be treated with respect and dignity. Self-Determination - The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice. The resident has a right to choose activities and schedules (including sleeping and waking times) with his or her interests. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on observations, interviews, and record reviews, the facility failed to ensure that the comprehensive person-centered care plan was revised to include the services to be furnished to attain or maintain the resident's highest practicable physical well-being as identified in the comprehensive assessment for two (Resident #13 and Resident #22) of five residents reviewed for care plans. 1. The facility failed to revise Resident #13's care plan to address his diagnosis of dehydration and use of intravenous fluids. 2. The facility failed to revise Resident #22's care plan to address her need for a mechanically altered diet and diagnosis of dysphagia. These failures could place residents at risk of not receiving the services needed to attain or maintain their highest practicable physical well-being. Findings included: 1. Record review of Resident #13's Quarterly MDS assessment dated [DATE] revealed Resident #13 was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of dehydration. Section C of the MDS assessment also revealed Resident #13 had severely impaired cognitive skills and was rarely/never understood. Section GG revealed Resident #13 was dependent with eating and required a helper to do all the work. Section O of the MDS assessment revealed Resident #13 had received IV medications. Record review of Resident #13's care plan with a revision date of 1/17/2025 revealed dehydration and intravenous fluids were not addressed in the care plan. Record review of Resident #13's physician orders revealed: On 12/04/2024 monitoring fluids every shift was ordered. On 1/07/2025 normal saline was ordered to be administered intravenously for dehydration. On 2/18/2025 lactated ringers (fluids to treat dehydration) were ordered to be administered intravenously for dehydration. On 2/19/2025 lactated ringers (fluids to treat dehydration) were ordered to be administered intravenously for dehydration. Record review of Resident #13's treatment administration record revealed fluid intake was monitored every shift from 12/01/2024 to current. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #13's progress note dated 12/03/2024 signed by NP E revealed Resident #13 had previously been hospitalized for dehydration, and NP E had ordered lab work and fluid monitoring to prevent future episodes of dehydration. In an observation on 2/25/2025 at 12:25 p.m., a CNA was assisting Resident #13 with eating and drinking. Resident #13 required full assistance and was unable to use arms to assist. In an interview on 2/26/2025 at 2:05 p.m., NP E reported it was difficult to ensure Resident #13 did not become dehydrated because he was unable to communicate. NP E stated she expected the facility to monitor Resident #13's intake and keep him hydrated. NP E stated she ordered labs and IV fluids to ensure he stayed hydrated. NP E reported Resident #13 had previously been hospitalized for dehydration and required the facility to push fluids. NP E stated the risks to residents if they did not receive enough fluids were that they could become dehydrated. In an interview on 2/26/2025 at 2:09 p.m., LVN F reported Resident #13's fluids were monitored by every shift and documented in PCC (electronic charting system). LVN F reported she personally administered fluids to Resident #13 three to four times during her shift and CNAs also gave fluids to residents. LVN F also reported Resident #13 received fluids at mealtimes and was monitored for signs or symptoms of dehydration. LVN F reported signs of dehydration included poor skin turgor and elevated sodium levels on lab work . LVN F was not interviewed concerning care plans. In an interview on 2/26/2025 at 2:39 p.m., MDS D reported she ensured care plans were updated. MDS D stated IV medications and dehydration should be care planned. MDS D stated if care plans were not updated then staff would potentially not know something about the residents' care. In an interview on 2/26/2025 at 3:22 p.m., the DON reported the treatment nurse, the ADONs, the weekend supervisors, the MDS nurse, the compliance nurse, and the DON were responsible for monitoring the care plans. The DON reported intravenous fluids were ordered and administered to Resident #13 for dehydration. The DON stated care plans should include dehydration and if a resident received intravenous fluids. The DON reported the risks to the residents if their care plans were not updated was that staff would not know if the residents were getting the right care. 2. Record review Resident #22's Quarterly MDS dated [DATE] revealed Resident #22 was an [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of dysphagia (difficulty swallowing). Section C of the MDS revealed Resident #22 had a BIMS score of 03 (indicated severe cognitive impairment), and Section K of the MDS revealed Resident #22 required a mechanically altered diet. Record review Resident #22's care plan with a review date of 2/03/2025 revealed Resident #22's diet and dysphagia were not addressed. Record review of Resident #22's physician order dated 5/22/2024 revealed a mechanical soft texture diet was ordered for Resident #22. In an observation on 2/25/2025 at 12:25 p.m., Resident #22 was sitting in the dining room with a plate of mechanically altered food sitting in front of her. Resident #22 did not cough during observation. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/26/2025 at 2:39 p.m., MDS D reported she ensured care plans were updated. MDS D stated diets should be care planned. MDS D stated if care plans were not updated then staff would potentially not know something about the residents' care. In an interview on 2/26/2025 at 3:22 p.m., the DON reported the treatment nurse, the ADONs, the weekend supervisors, the MDS nurse, the compliance nurse, and the DON were responsible for monitoring the care plans. The DON stated care plans should include diets and diagnoses. The DON reported the risks to the residents if their care plans were not updated was that staff would not know if the residents were getting the right care. Review of the facility's policy titled, Comprehensive Care Planning, undated, revealed The comprehensive care plan will describe the following - the services that are to be furnished to attain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and treatment consistent with professional standards of practice to promote healing and to prevent further development of skin breakdown or pressure ulcers for two (Resident #13 and Resident #87) of four residents reviewed for pressure ulcers. 1. The facility failed to ensure Resident #13 was provided with ordered wound care on 12/6/2024, 12/15/2024, 12/16/2024, 12/30/2024, 1/01/2025, 1/03/2025, 1/06/2025, 1/10/2025, 1/13/2025, 1/17/2025, and 2/06/2025 (11 days). 2. The facility failed to ensure Resident #87 was provided with ordered wound care on 1/09/2025, 1/11/2025, 1/12/2025, 1/13/2025, 1/15/2025, 1/16/2025, 1/18/2025, 1/19/2025, 1/26/2025, 2/01/2025, 2/06/2025, 2/07/2025, 2/08/2025, 2/09/2025, 2/15/2025, 2/16/2025, 2/19/2025, 2/20/2025, 2/21/2025, 2/22/2025, 2/23/2025, and 2/24/2025 (22 days). These failures could place residents at risk for infection and a decline in an existing pressure ulcer. Findings included: 1. Record review of Resident #13's Quarterly MDS assessment dated [DATE] revealed Resident #13 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of progressive intellectual disabilities, dehydration, and vitamin deficiency. Section C of the MDS assessment also revealed Resident #13 had severely impaired cognitive skills and was rarely/never understood. Section M of the MDS assessment revealed Resident #13 was at risk for developing pressure ulcers and had one unhealed pressure ulcer. Record review of Resident #13's care plan with a revision date of 1/17/2025 revealed Resident #13 had a pressure ulcer or had potential for pressure ulcers with multiple interventions including to follow facility policies or protocols for the treatment of skin breakdown. Record review of Resident #13's physician orders on 2/25/2025 revealed: Wound care for the right dorsal hallux (great toe/big toe) was ordered from 12/02/24 to 1/22/2025 and revealed wound care was ordered to be provided every 72 hours and as needed. Wound care for another wound on the right first toe (site 3) was ordered from 12/05/2024 to 1/17/2025 and was ordered to be completed every Monday, Wednesday, and Friday. New orders were entered from 1/17/2025 to 2/02/2025 that revealed wound care was ordered to be provided every Monday, Wednesday, and Friday. New orders were entered from 2/02/2025 to 2/24/2025 that revealed wound care was ordered to be provided every Monday, Wednesday, Thursday, and Saturday. Orders for another wound on the right first toe (site 4) was ordered from 12/05/2024 to 1/17/2025 and was ordered to be completed every Monday, Wednesday, and Friday. This order was discontinued on 1/17/2025 with the reason listed as the wound was resolved. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's treatment administration record for December 2024 revealed: Wound care for the right dorsal hallux was not performed on 12/6/2024 (Friday), 12/15/2024 (Sunday), and 12/30/2024 (Monday). Wound care for the right first toe (site 3) was not performed on 12/6/2024 (Friday), 12/16/2024 (Monday), 12/23/2024 (Monday), and 12/30/2024 (Monday). Wound care for the right first toe (site 4) was not performed on 12/6/2024 (Friday), 12/16/2024 (Monday), 12/23/2024 (Monday), and 12/30/2024 (Monday). Record review of Resident #13's treatment administration record for January 2025 revealed: Wound care for the right dorsal hallux was completed as ordered until the order was discontinued on 1/22/2025. Wound care for right first toe (site 3) was not performed on 1/01/2025 (Wednesday), 1/03/2025 (Friday), 1/06/2025 (Monday), 1/10/2025 (Friday), 1/13/2025 (Monday), and 1/17/2025 (Friday). Wound care for right first toe (site 4) was not performed on 1/01/2025 (Wednesday), 1/03/2025 (Friday), 1/06/2025 (Monday), 1/10/2025 (Friday), 1/13/2025 (Monday), and 1/17/2025 (Friday). Record review of Resident #13's treatment administration record for February 2025 revealed: Wound care for right first toe (site 3) was not performed on 2/06/2025. Record review of Resident #13's weekly wound evaluation summary dated 2/20/2025 revealed wound site 3 was healed and no other wounds were present on 2/20/2025. In an observation on 2/25/2025 at 9:39 a.m., Resident #13 was sitting up in his wheelchair in the activities room. Resident #13 had soft heel protection boots on both feet. No dressings or wounds were observed. Resident #13 was nonverbal and unable to interview. 2. Record review of Resident #87's Quarterly MDS assessment dated [DATE] revealed Resident #87 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of malnutrition, muscle wasting and atrophy (loss of muscle mass and strength), and cognitive communication deficit (difficulty communicating). Section C of the MDS assessment revealed Resident #87 had a BIMS score of 03 (indicated severely impaired cognitive skills). Section M of the MDS assessment revealed Resident #87 was at risk for developing pressure ulcers and had two unhealed pressure ulcers. Record review of Resident #87's care plan with a revision date of 1/17/2025 revealed Resident #87 had a pressure ulcer and interventions included to administer treatments as ordered. Record review of Resident #87's physician orders on 2/25/2025 revealed: Wound care for the pressure sore on the sacrum (site 1) was ordered daily from 1/18/2025 to 2/08/2025. Order was discontinued on 2/08/2025. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound care for the right heel (site 2) was ordered daily from 1/31/2025 to 2/21/2025. Order was changed on 2/21/2025 from daily to Monday, Wednesday, and Friday. Wound care for the deep tissue injury on the left heel was ordered every Monday, Wednesday, and Friday from 1/08/2025 to 1/20/2025. Wound care for the skin tear to the back of the left hand had dressing changes ordered from to 2/19/2025 to 2/24/2025. Order was changed to steri-strips on 2/25/2025. Record review of Resident #87's treatment administration record for January 2025 revealed: Wound care for sacrum (site 1) was not performed on 1/09/2025, 1/11/2025, 1/12/2025, 1/13/2025, 1/15/2025, 1/16/2025, 1/18/2025, 1/19/2025, and 1/26/2025. Wound care for the deep tissue injury on the left heel was not performed on 1/13/2025 and 1/15/2025. Record review of Resident #87's treatment administration record for February 2025 revealed: Wound care for pressure sore on sacrum (site 1) was not performed on 2/06/2025, 2/07/2025, and 2/08/2025. Wound care for right heel (site 2) was not performed on 2/01/2025, 2/06/2025, 2/07/2025, 2/08/2025, 2/9/2025, 2/15/2025, and 2/16/2025. Wound care for the skin tear to the back of the left hand was not performed from 2/19/2025 to 2/25/2025. In an observation on 2/25/2025 at 10:12 a.m., Resident #87 was observed sitting in the TV room with a dressing on the back of her left hand. The dressing was dated 2/20/2025 and the edges of the dressing were peeling away from the skin. In an interview on 2/25/2025 at 11:14 a.m., LVN A stated he was the wound care nurse and did all of the wound care for all of the residents unless he was working the floor or not working that day. LVN A stated if he was not available t o do the wound care then the floor nurses were responsible for completing the wound care. LVN A reported if he was doing wound care then he did all of the residents and did not skip any wound care that was ordered. LVN A reported the wound care doctor rounded and assessed all of the wounds on Thursdays. LVN A denied any concerns that wound care was not being performed, and it should be completed as ordered. LVN A stated he had not seen any wound care that had not been done and had not seen any old dressings. LVN A reported the risk of wound care not being performed was that the wounds could get worse or get infected. LVN A was called away to aid other residents before being asked about Resident #87 and Resident #13's wound care. In an observation on 2/25/2025 at 3:54 p.m., Resident #87 was observed resting in bed. Steri-strips were on the back of the left hand where the dressing dated 2/20/2025 was seen previously. No drainage or foul odor was observed from the left hand. The dressing on the right ankle and right heel was dated 2/24/2025 and appeared clean, dry, and intact. Resident #87 was unable to answer questions and just smiled. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/26/2025 at 2:31 p.m., LVN B stated wound care was performed by the wound care nurse, but if she had not seen him by 10 to 11a.m. then she would do the wound care. LVN B stated she knew the wound care still needed to be completed by looking at the treatment administration record. LVN B reported if the wound care was not done then it would not be charted on the treatment record. LVN B also stated if the wound care was done then it would be charted as completed on the treatment record. LVN B reported that all of the floor nurses were able to see the treatment administration record and were able to see if the wound care needed to be completed. LVN B stated the risk to the residents if wound care was not completed was that the size of the wound could increase, and it could increase the risk for infection. LVN B stated the nurse assigned to the resident was responsible to ensure that wound care was performed as ordered. In an interview on 2/26/2025 at 2:57 p.m., ADON C stated the wound care nurse did all the wound care, and if he was not available then the floor nurses were responsible for doing the wound care. ADON C stated the floor nurses were responsible for monitoring that the wound care was completed for their patients. ADON C stated the ADONs would notify the nurses, or the wound care nurse would notify the nurses if they needed to complete wound care for their patients. ADON C reported the risks to the residents if wound care was not completed was that the wounds could get infected, or the resident could become septic. In an interview on 2/26/2025 at 3:22 p.m., the DON stated he had been at the facility for five days and was still learning the processes at this facility. The DON reported the wound care nurse was responsible for performing the wound care but would have to ask the compliance nurse what the process was if the wound care nurse was not available. The DON stated it would be him at some point that was responsible for monitoring if wound care was completed and that he expected it to be completed as ordered. The DON reported the risks to the resident were that the wounds could get infected. Review of the facility's policy titled Skin Integrity Management, with a revision date of October 5, 2016, revealed, 3. Wound care should be performed as ordered by the physician.