

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024
NAME OF PROVIDER OR SUPPLIER Will-O-Bell		STREET ADDRESS, CITY, STATE, ZIP CODE 412 N Dalton Bartlett, TX 76511	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for two (Resident #1 and Resident #2) of four residents reviewed for quality of care.</p> <p>The facility failed to:</p> <ul style="list-style-type: none"> - Ensure Resident #1 was not sitting in his bed with linens covered in feces and his pants saturated with urine. The staff failed to complete accurate skin assessments to be able to provide appropriate treatment to MASD on his buttocks. - Ensure Resident #2 was getting barrier cream applied to a rash on her buttocks and failed to complete accurate skin assessments. <p>These failures placed residents at risk of improper wound management, the development of new pressure injuries, deterioration in existing pressure injuries, infection, and a decreased quality of life.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Review of resident #1's face sheet dated 08/01/24 reflected an [AGE] year-old male who was admitted to the facility on [DATE], readmitted on [DATE], and readmitted on [DATE] with a with diagnoses that included chronic kidney disease stage 3, cognitive communication deficit, and hereditary and idiopathic neuropathy (when the causes of the nerve damage interferes with the functioning of the peripheral nervous system can't be determined)</p> <p>Review of Resident #1's most recent MDS assessment, dated 07/16/2024 for add new record, reflected a BIMS score of 05, indicating he was severally cognitively impaired. Section GG (Functional Abilities and Goals) were left blank. Section M (Skin Conditions) reflected he was at risk of developing pressure ulcers/injuries and had a pressure reducing device for his bed and chair.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's care plan focus dated 02/24/21, reflected Resident #1 had an ADL self-care performance deficit r/t impaired balance, weakness, hypotension, debility, spinal stenosis (the space inside the backbone is too small with interventions dated 02/24/21 that resident required extensive assistance by 1 staff for toileting, encouraged the resident to use bell to call for assistance, monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function.</p> <p>Review of care plan focus dated 06/22/23 reflected the resident has had a fall (unintentional change in plane) with minor injury r/t poor balance and unsteady gait with interventions dated 02/24/21. That resident required extensive assistance by 1 staff with personal hygiene, the resident required skin inspection Q shower day, and PRN to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. The resident required extensive assistance by 1 staff for toileting, the resident required extensive assist by 1 staff with bathing/showering Q Mon, Wed, Fri 2p-10p, and as necessary.</p> <p>Review of Resident #1's quarterly care plan, dated 06/07/24, reflected he required assistance with ADLs with an intervention of assisting with ADLs as needed.</p> <p>Review of Resident #1's Skin Observation Tool dated 07/11/24 reflected skin warm, dry, and intact. No skin issues noted.</p> <p>Review of Resident #1's Skin Observation Tool dated 07/17/24 reflected skin warm, dry, and intact. No skin issues noted.</p> <p>Review of Resident #1's Skin Observation Tool dated 7/31/24 reflected skin warm, dry, and intact. No skin issues noted.</p> <p>Review of Resident #1's shower sheets dated 07/03/24 reflected no skin concerns, clean linens, and shaved, 07/05/24 reflected clean shaved, changed linen, no skin comment, 07/10/24 reflected no comments, 07/12/24 reflected showered, hair washed, resident shaved, linen changed, no skin issues, 07/15/24 reflected shower, no comments, 07/17/24 reflected showered no skin issues, sheets changed, 07/24/2024 reflected showered, no skin comment, 07/26/24 reflected showered no additional comments, and 07/31/24 reflected showered no additional comments.</p> <p>Review of Resident #1's shower sheets dated 07/16/24 reflected showered, no skin comment, 07/18/24 reflected showered, no skin comment, 07/23/24 reflected, everything look good, 07/25/24 reflected showered everything look good, and 08/01/24 reflected showered, no skin issues.</p> <p>Review of Braden Scale for Predicting Pressure Sore Risk, dated 07/09/24, revealed a score of 21 indicating Resident #1 was a very high risk for pressure sores.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 08/01/24 at 1:18 pm of Resident #1 revealed he was in his room seated on his bed close to the end of the bed. Observed sheets unmade and bunched around Resident #1. Bottom sheet towards the middle of the bed revealed a brown colored circular stain approximately 6 inches in diameter. Resident #1 was Spanish speaking, limited in his English but able to communicate with basic English and gestures. The State Surveyor pointed at his sheets and asked, can I look and Resident #1 nodded. Upon lifting the bunched top flat sheet from the bottom fitted sheet the state surveyor observed, on the bottom fitted sheet, a square shaped brown stain approximately 6 inches in length and 4 inches in width. The flat top sheet was lifted from the fitted lower sheet and revealed a square shaped brown stain approximately 4 inches in length and 2 inches wide. The State Surveyor, with no objection from Resident #1, separated the bunched top flat sheet from the lower fitted sheet to reveal a lump of feces on the lower flat sheet, firm with a stain that secreted around the upper top flat sheet, and the lower fitted sheet. The State Surveyor observed the sweatpants worn by Resident #1 were saturated with urine.</p> <p>Observation on 08/01/24 of a photograph provided by a family member of Resident #1's posterior taken 07/14/24 revealed Resident #1's buttock to be red approximately 6 inches from the bottom of his buttock to the top of his buttock to 3 inches below his buttock on his thighs. The State Nurse investigator traveled to the facility on [DATE] and 08/03/24 for Resident #1's skin assessment but he was on leave with his family and an observation was not conducted but the redness appeared to be MASD.</p> <p>Interview on 08/02/24 at 2:29 pm with LVN revealed Resident #1 needed to be rounded on every hour or every two hours because he needed bathroom assistance. He needed to be constantly looked on because his sheets would be dirty. LVN revealed he could not use the call light and he needed to be checked on to see if he needed help.</p> <p>Attempted interview on 08/01/24 at 2:00 pm with Resident #1, Spanish speaking, through interpreter service was unsuccessful. Resident #1 revealed he could not hear or understand the interpreter, although the resident was on the speaker and the interpreter was asked to speak loudly because of resident hearing issues.</p> <p>Resident #2</p> <p>Review of Resident #2's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified urinary incontinence, need for assistance with personal care, obesity, and unspecified dementia.</p> <p>Review of Resident #2's quarterly MDS assessment, dated 05/01/24, reflected a BIMS score of 8, indicating a severe cognitive impairment. Section GG (Functional Abilities and Goals) reflected she was dependent for toileting hygiene. Section M (Skin Conditions) reflected she was at risk of developing pressure ulcers/injuries and had a pressure reducing device for her bed.</p> <p>Review of Resident #2's quarterly care plan, dated 01/05/24, reflected she had potential for pressure ulcer development related to limited mobility and weakness with an intervention of educating the resident/family/caregivers as to causes of skin breakdown, including: transfer/positioning requirements, importance of taking care during ambulating/mobility, and good nutrition and frequent repositioning. It further reflected she had an ADL self-care performance deficit related to dementia with an intervention of requiring limited assistance by 1 staff for toileting an Q 2-hour checks.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's Skin Observation Tool, dated 07/25/24, reflected her skin was warm, dry, and intact. No issues noted.</p> <p>Review of Resident #2's Skin Observation Tool, dated 07/31/24, reflected her skin was warm, dry, and intact. No issues noted.</p> <p>Interview on 08/01/24 at 4:08 PM, Resident #2 stated she was often left for long periods of time in a soiled, wet brief.</p> <p>Observation and assessment on 08/02/24 at 10:28 am by the State Nurse Investigator revealed Resident #2 gave her permission to observe her skin while CNA A turned her, lifted her clothing, and unfastened her brief. Resident #2's skin was observed head to toe. Observed Resident's skin was clear except for slight rash under bilateral breasts and red area across buttocks which appeared to be irritation from sitting in urine, possibly even the start of Moisture Associated Skin Damage (MASD). Observed Resident #2 was sitting in a urine-soaked brief. No evidence of cream on Resident #2's buttock area. CNA A stated there should have been cream applied to her buttock area.</p> <p>Interview on 08/02/24 at 10:28 am by the State Nurse Investigator with CNA A revealed when they find skin issues, they go tell the nurse, and if the nurse says to, they will put cream on the skin area.</p> <p>Interview on 08/05/24 at 12:51 pm with the DON, when shown the photos of the stains and feces in Resident #1's bed she said it looked like the feces had been there a bit, but she could not tell how long. It was unacceptable. She stated that the Administrator has had conversations with Resident #1's family members about Resident #1 being found with feces on him and in his bed. If residents have feces in their bed or on their bodies, it was a dignity issue, it was an infection control issue, and residents could get sick. She stated that if residents were left in soiled or wet briefs and clothing, they could have skin breakdown. She said she did not know what the issue was with her staff that they did not check on him. When shown the photograph provided by a family member of Resident #1's posterior taken 07/14/24 that revealed Resident #1s buttock, she said that there should have been treatment in place for is skin issues on 07/14/24.</p> <p>Review of facility policy routine resident checks dated 07/2013 reflected staff shall make routine resident checks to maintain resident safety and well-being. Routine resident checks involve entering the residents' room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, and needs toileting assistance, etcetera.</p> <p>Review of facility bath/tub policy dated 02/2018 reflected the purpose of this procedure are to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin.</p>		