| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676026 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Will-O-Bell | 412 N Dalton<br>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) |
|---|---|
| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to conduct a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 1 of 6 residents (Resident #39) reviewed for comprehensive assessments. The facility failed to complete an accurate comprehensive assessment for Resident #39. This failure could place residents at risk of not having their care and treatment needs assessed to ensure necessary care and services were provided.The findings include: Record review of Resident #39's face sheet, dated 05/14/26, documented a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #39 had diagnoses which included: congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs), Alzheimer's disease (a neurodegenerative disease that usually starts slowly and progressively worsens), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and muscle wasting and atrophy (the loss of muscle tissue and strength, typically caused by inactivity, malnutrition, aging (sarcopenia), or diseases affecting nerves or muscles). Record review of Resident #39's Quarterly MDS assessment dated [DATE], reflected that resident had no impairment to upper extremity (shoulder, elbow, wrist, hand). MDS assessment reflected Resident #39 was at risk of developing pressure ulcers/injuries. Resident #39's Quarterly MDS assessment reflected that Resident #39 had a BIMS score of 00 indicating she was severely cognitively impaired. Record review of Resident #39's Physician's Orders, dated 06/26/25, reflected resident had and an order for gauze roll to left hand for prophylactic treatment. Monitor every day shift for prophylactic treatment. Record review of Resident #39's care plan dated 03/09/26 and revised 04/01/26 reflected Resident #39 was dependent on staff for meeting emotional, intellectual, physical, and social needs due to Immobility, physical limitations. Care plan dated 05/18/22 reflected Resident #39 had an ADL self-care performance deficit r/t fatigue, impaired balance, limited mobility, musculoskeletal impairment. Goal: resident will maintain current level of function in all ADLs through the review date. Interventions included: Dressing: The resident requires extensive assistance by 1 staff to dress. Gauze roll to left hand for prophylactic TX. monitor Q day. During an observation on 05/13/26 at 2:29 PM, Resident #39 was observed lying in bed with her left hand laying over her chest area. Resident's left hand appeared impaired and closed. Resident was not able to demonstrate if she could have opened her left hand. During an interview on 05/14/26 at 11:10 AM, LVN A stated she was responsible for completing the MDS assessments. She stated she had been trained on completing the MDS assessments accurately. She stated anytime a resident had a physical limitation to their extremities including their hands, it should have been coded on the MDS assessment. She stated she was aware that Resident #39 had a physical limitation to her left hand. She stated she was not sure why Resident #39's left hand limitation was not coded on her MDS assessment but it should have been. She stated if the MDS assessment had not reflected Resident #39's physical limitations in her left hand it could have caused the care plan to not be completed correctly. She stated the physicians' orders were still in place and she did not feel like it would have affected the resident's care. During an<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | interview on 05/14/26 at 11:16 AM, the DON stated LVN A was responsible for completing the MDS assessments. She stated the MDS nurse had been trained on completing MDS assessments correctly. She stated if a resident had a limitation in their extremities such as their hands it should have been coded on the resident's MDS assessment and it should have been coded on Resident #39's MDS assessment. She stated she did not feel like the resident's MDS assessment being coded incorrectly would have directly affected the resident's care but it could have affected the resident's care plan. During an interview on 05/14/26 at 11:33 AM, the ADM stated LVN A was responsible for completing the MDS assessments. She stated LVN A had been trained on completing MDS assessments correctly. She stated if a resident had a limitation in their extremities such as their hands it should have been coded on the resident's MDS assessment and it should have been coded on Resident #39's MDS assessment. She stated if a resident's MDS assessment had not been completed correctly, it could have caused the facility to not get paid properly and it would not have represented the proper care that was required for the resident. Record review of the facility's policy dated 2001 and revised October 2023, titled Quarterly Assessments, reflected Policy Statement: Quarterly MDS assessments are conducted to track the resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. Record review of the facility's policy dated 2001 and revised March 2022, titled Resident Assessments, reflected Policy Statement: A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements. Policy Interpretation and Implementation: 9. All resident assessments completed within the previous 15 months are maintained in the resident's active clinical record. The results of the assessments are used to develop, review and revise the resident's comprehensive care plan. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 1 (Resident #39) of 6 residents reviewed for quality of care. The facility failed to ensure Resident #39 had her gauze roll placed inside her left hand on 05/13/26 as directed by physician orders. These failures could place residents at risk of not receiving necessary medical care, pain, injury, infection, and hospitalization.Findings included: Record review of Resident #39's face sheet, dated 05/14/26, documented a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #39 had diagnoses which included: congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs), Alzheimer's disease (a neurodegenerative disease that usually starts slowly and progressively worsens), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and muscle wasting and atrophy (the loss of muscle tissue and strength, typically caused by inactivity, malnutrition, aging (sarcopenia), or diseases affecting nerves or muscles). Record review of Resident #39's Quarterly MDS assessment dated [DATE], reflected that resident had no impairment to upper extremity (shoulder, elbow, wrist, hand). MDS assessment reflected Resident #39 was at risk of developing pressure ulcers/injuries. Resident #39's Quarterly MDS assessment reflected that Resident #39 had a BIMS score of 00 indicating she was severely cognitively impaired. Record review of Resident #39's Physician's Orders, dated 06/26/25, reflected resident had and an order for gauze roll to left hand for prophylactic treatment. Monitor every day shift for prophylactic treatment. Record review of Resident #39's care plan dated 03/09/26 and revised 04/01/26 reflected Resident #39 was dependent on staff for meeting emotional, intellectual, physical, and social needs due to Immobility, physical limitations. Care plan dated 05/18/22 reflected Resident #39 had an ADL self-care performance deficit r/t fatigue, impaired balance, limited mobility, musculoskeletal impairment. Goal: resident will maintain current level of function in all ADLs through the review date. Interventions included: Dressing: The resident requires extensive assistance by 1 staff to dress. Gauze roll to left hand for prophylactic Tx. monitor q day. Record review of Resident #39's TAR dated May 2026 reflected gauze roll to left hand for prophylactic Tx. Monitor q day shift for prophylactic Tx. It had been signed as completed for 05/13/26 by LVN B. During an observation on 05/13/26 at 2:29 PM, Resident #39 was observed lying in bed with her left hand laying over her chest area. Resident's left hand appeared impaired and closed. Resident was not able to demonstrate if she could have opened her left hand and there was no ordered gauze roll present in her hand. No gauze hand roll was seen in the area where Resident #39's left hand was laying. During an interview on 05/13/26 at 1:59 PM, LVN C stated he was the nurse that took care of Resident #39 on his shift and he knew resident's left hand was contracted. He stated he was not sure if Resident #39 should have had a gauze roll to her hand, but he was going to go check the physician's order. He stated residents with hand contractures should always have had a gauze roll or something in place to prevent the hand from closing more. He stated he had been trained on ADL care and placing gauze in the hands of those with contractures. He stated if a resident had a hand contracture and the gauze roll was not in place as ordered it could have caused the resident's nails to cut into their hand which could have caused a wound or it could have caused bacteria to grow inside the closed the hand. During an observation on 05/13/26 at 2:00 PM, observed Resident #39's left hand being opened slightly by LVN C. Resident #39's left hand was clean and without skin impairment. Resident #39's left hand did not have ordered hand roll in place. During an interview on 05/13/26 at 2:03 PM, CNA D stated she took care of Resident #39 on her shift. She stated she had not noticed Resident #39's left hand being contracted and she was not aware that resident needed a gauze hand roll to her hand. She stated if a resident's<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | hand was contracted and closing and there was no gauze roll in place to the resident's hand it could have caused sores or open wounds to the resident's hand. She stated she was trained on ADL care and placing gauze rolls in the hands of residents that had hand contractures. During an interview on 05/14/26 at 11:16 AM, the DON stated staff had been trained on quality of care and if a resident had an ordered gauze hand roll, the hand roll should have been put in place. She stated she was aware Resident #39 had a physical impairment and limitations to her left hand. She stated Resident #39's ordered gauze hand roll should have been in place in her left hand as much as possible. She stated resident was able to open her left hand some and the gauze roll could have fallen out. She stated if an ordered gauze hand roll had not been in place, it could have caused the resident's hand to become more contracted and skin breakdown could have occurred. During an interview on 05/14/26 at 11:33 AM, the ADM stated staff had been trained on quality of care and if a resident had an ordered gauze hand roll, the hand roll should have been put in place. She stated she knew Resident #39 had a physical impairment and limitations to her left hand because she saw resident daily. She stated Resident 39's gauze hand roll should have been in place in her left hand as ordered. She stated if an ordered gauze hand roll had not been in place, it could have caused the resident's hand to become more contracted. During an interview on 05/14/26 at 2:14 PM, LVN B stated she was the nurse that signed the TAR which reflected Resident #39's gauze roll had been placed in her left hand. She stated she knew the hand roll had been placed in Resident #39's left hand on 05/13/26 because she made sure of it and she saw it there. She stated she ensured Resident #39's gauze roll was placed in her left hand daily. She stated Resident #39 moved her arms and hands a lot and sometimes the gauze roll would fall out. She stated if Resident #39's gauze roll was not in resident's hand it could have caused residents hand closure to worsen or it could have caused skin issues. Review of facility policy dated 2001 and revised March 2018 and titled Activities of Daily Living (ADL), Supporting reflected Policy Statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation: 1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care); d. dining (meals and snacks); 6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #3) reviewed for infection control. Resident #3 had a Stage 3 Pressure Ulcer to the Left buttock and the facility failed to place him on Enhanced Barrier Precautions.This deficient practice could increase the risk of the spread of infection to other residents.Record review of Resident #3's undated face sheet revealed Resident #3 was a [AGE] year-old male admitted on [DATE] with Encephalopathy, (any disease or damage that alters the brain's structure or function), Muscle wasting and atrophy (the shrinking and loss of muscle mass) and Polyosteoarthritis (a degenerative joint disease characterized by the breakdown of cartilage and bone in five or more joints simultaneously. It causes chronic pain, stiffness and reduced mobility, often affective weight-bearing joints).Record review of Resident #3's Quarterly MDS assessment, dated 04/13/2026, reflected Resident #3 had a BIMS score of 14, no impairments in cognitive function, orientation to time and place, and short-term memory. Section M-Skin Conditions revealed Resident #3 had a pressure ulcer/injury. The MDS listed the following treatments: Pressure reducing device for chair, Pressure reducing device for bed, Nutrition or hydration intervention to manage skin problems, Pressure ulcer/injury care, applications of ointment/medications other than to feet.Review of Resident #3s comprehensive care plan revealed a care plan focus problem of a stage 3 pressure injury related to a history of ulcers, limited mobility, dated 02/11/2026 and revised on 04/10/2026. There was no notation of Enhanced Barrier Precautions on the Care Plan.Review of Resident #3s orders revealed wound care orders dated 04/11/2026 and discontinued 04/20/2026 read, Cleanse wound to L buttock with ns, pat dry, apply honey then calcium alginate, cover with gauze island dressing. Wound care orders for 04/21/2026 and discontinued on 04/29/2026 read, Cleanse wound to L buttock with NS, pate dry, apply honey then calcium alginate, cover with gauze island dressing. Wound care orders beginning 04/30/2026 and discontinued on 05/08/2026 read Cleanse wound to L buttock with ns, pat dry, soak with gauze squares in Dakins solutions wring out most of the way, Pack into wound and cover with gauze island dressing. Wound care orders started 05/09/2026 and still in place at the time of the survey read, Cleanse wound to L buttock with wound cleanser spray to wound bed, pat dry, soak 1 gauze square in Dakins solutions wring out most of the way, pack into wound and cover with gauze island dressing. There were no orders for Enhanced Barrier Precautions.During an observation on 05/13/2026 at 11:18AM, Resident #3's room did not have any posting indicating Resident #3 was on Enhanced Barrier Precautions.During an interview with LVN B, 05/13/2026 at 11:20AM, LVN B stated the need for EBPs would include those residents with chronic wounds, catheters, colostomy, and wound care. LVN B stated EBPs are only required if the wound is considered chronic. LVN B stated the DON and LVN B train staff on EBPs upon new hire and every in-service huddle. LVN B stated the training occurs mostly weekly but definitely monthly. LVN B stated the training is verbal but is also written as in-service material. LVN B stated a possible outcome of not using EBPs would be infection. LVN B stated wounds that are considered acute do not require EBP.During an interview with the DON on 05/14/2026 at 2:03PM she stated it is her expectation that EBPs would be implemented for residents who had ostomies, catheters, chronic wounds (if the wound has been there 4-6 weeks with no or minimal improvement). The DON stated a non-chronic wound does not require EBPs. The DON stated a possible outcome of not using EBPs could be that the care partner and the elder could be placed at risk of infection.During an interview with the Administrator on 05/14/2026 at 2:08PM she stated her expectations for use of EBPs are dependent upon the residents' needs such as wounds and any kind of opening like an ostomy or catheter. The Administrator stated she expected the staff to follow those precautions. The Administrator stated a risk of not following the precautions could be that infection<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | could be spread to another resident.Record review of the Enhanced Barrier Precautions policy in the Nursing Services Policy and Procedure Manual reviewed and approved on 12/10/2025 stated: EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Wounds generally include chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds), not shorter-lasting wounds like skin breaks or skin tears. |