STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676089	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winnie L Ltc Partners Inc	2104 N Karnes Cameron, TX 76520

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 - Minimal harm or potential for actual harm 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** 28689 Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 2 residents (Resident #1) reviewed for change in condition . The facility failed to ensure Resident #1's RP was notified when she developed MASD (Moisture Associated Skin Damage) on her buttocks on 01/15/2025, and when it progressed to a non-pressure open area with drainage on 01/28/2025. This failure could place residents at risk of their responsible party/family members being unaware of their change in condition. Findings include: Record review of Resident #1's, undated, face sheet for Resident #1 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Cocaine dependence, in remission, Major Depression, and Paranoid Schizophrenia . She was readmitted on [DATE] after an unwitnessed fall with diagnoses of Urinary Tract Infection, Hypokalemia (low potassium level in the blood) and Schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly. Characterized by thoughts or experiences that seem out of touch with reality) and adjustment disorder with behavioral disorders. Record review of Resident #1's Quarterly MDS, dated [DATE], reflected she had a BIMS score of 15, which indicated intact cognitive status. Record review of Resident #1's Weekly Skin Assessment, by LVN A, dated 01/15/2025, reflected she did not have any MASD or new areas to her skin to report to the Physician/NP or family . Record review of Resident #1's Care Plan, dated 01/20/2025, reflected she had potential /actual impairment to skin integrity r/t MASD/shearing to bilateral buttocks near coccyx area. Record review of Resident #1's Weekly Skin Assessment, dated 01/22/2025, by LVN A, reflected she had MASD to bottom. Notification: Are there any new areas that have not been communicated to the Physician/NP or family? No. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Initial Wound Evaluation and Management Summary, dated 01/28/2025, by MD A for Resident #1 at the request of the Medical Director reflected Chief Complaint: patient presents with a wound on her buttock. Fecal incontinence and urinary incontinence. Non-pressure wound buttock partial thickness. Etiology: [the cause of a condition] Moisture Associated Skin Damage, Duration greater than 7 days, wound size (L x W x D) 7.5 x 5.5 x 0.1 cm. Exudate [drainage]: Light Serosanguinous [a discharge that contains both blood and serum, the clear yellowish part of the blood] Dermis [the skin]: Open In an interview on 04/30/2025 at 10:37 AM, Resident #1 stated she did not feel well and was not pleased about sitting up in a chair. She stated she had just been assisted into her chair. When asked if she would allow the state surveyor to look at her skin later that day, she stated she would not. In an interview on 04/30/2025 at 11:55 AM, MD A stated Resident #1 had a lot of refusals of care. He stated she refused to let him see her or examine her wound at some visits. He stated she refused to turn in the bed or allow peri care. He stated he had given education to the family twice and then Resident #1 finally let him see her skin. He stated the family was surprised at how bad her wound was during the visit on 04/08/2025. He stated one family member was visibly upset and left the room. He stated he tried to educate the family that the staff needed help getting Resident #1 to cooperate with her care. He could not specify which family members he had contact with. Record review of a weekly skin assessment for Resident #1 on 04/11/2025 at 7:21 PM, by the DON, reflected she had MASD to her right and left buttocks, a pressure ulcer and blisters to both heels. The skin assessment reflected the DON notified the RP at 7:31 PM and the Medical Director at 7:50 PM of her findings. In an interview on 04/30/2025 at 12:10 PM, the RP for Resident #1 stated she was not notified of the resident's MASD prior to the DON calling her about her skin issues on her buttocks and heels on 04/11/2025. In an interview on 04/30/2025 at 2:00 PM, the DON stated the notification of the RP for Resident #1 on 04/11/2025 was the first documented time the RP was notified of a change in condition of the resident's skin . In an interview on 04/30/2025 at 2:27 PM, LVN A stated she performed the skin assessments for Resident #1 on 01/22/2025 and found MASD to her buttocks. She stated she thought it had already been communicated to the family. She stated she had training a long time ago on notification of families and RPs. She stated she did not recall notifying the family of the resident change of condition. She further stated she knew she should have notified the family of a change of condition so there would not be any miscommunication. In an interview on 04/30/2025 at 3:25 PM, the DON stated her expectation was for nursing to notify the family and the physician of any change in condition . She stated the family of Resident # 1 should have been notified when she first had a change of status . In an interview on 04/30/2025 at 3:25 PM, the ADM stated her expectation was if there was a change of condition, the family should be notified as soon as possible. She stated it was important for the family to know what's going on with the resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observation , interview and record review the facility failed to ensure, based on the comprehensive assessment of a resident, the resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one of four (Resident #1) residents reviewed for quality of care. The facility failed to document Resident #1 received all her wound care treatments as ordered by the Physician and failed to note in the progress note if she refused care for those treatments. This failure could place residents at risk of not receiving necessary medical care and lead to worsening wounds, pain, infection and hospitalization . Findings include: Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Cocaine dependence, in remission, Major Depression, and Paranoid Schizophrenia. She was hospitalized on [DATE] after an unwitnessed fall and readmitted to the facility on [DATE], with diagnoses which included Urinary Tract Infection , Hypokalemia (low potassium level in the blood), Schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly. Characterized by thoughts or experiences that seem out of touch with reality) and adjustment disorder with behavioral disorders. Record review of Resident #1's Quarterly MDS, dated [DATE], reflected she had a BIMS score of 15, which indicated intact cognitive status. Section D - Mood reflected she had little interest or pleasure in doing things and felt tired or had little energy almost every day. Section GG - Functional Abilities reflected she required supervision or touching assistance to roll from left and right, sit to lying, sit to stand, chair/bed-to-chair transfer and toilet transfer. She required partial moderate assistance for toileting hygiene and personal hygiene. Record review of Resident #1's Nursing Progress Note, dated 10/18/2024, reflected the resident refused to get out of bed. On 11/07/2024, a progress note reflected she refused to take a bath, refused to change her clothes and refused to leave her room. The resident was seen by Psychiatry on 11/12/2025 and 11/26/2025. On 11/26/2025 the resident refused to take her Risperidone, (atypical antipsychotic medication for symptoms of schizophrenia). On 12/10/2025, Resident #1 was again seen by psychiatry and was noted to have a flat affect, not smiling and was depressed. On 12/11/2024 and 12/31/2024, Progress Notes indicated she did not have any MASD. On 01/06/2025, orders were received for a multivitamin and house shakes twice a day. On 01/08/2025 the resident refused her shakes. She continued to refuse her house shakes in the following days. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan, dated 01/20/2025, reflected Focus: potential/actual impairment to skin integrity r/t MASD/shearing to bilateral buttocks near coccyx area. Goal: The resident will have no complications r/t MASD of the buttocks through the review date. Interventions/Tasks Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Follow facility protocols for treatment of injury. Identify/document potential causative factors and eliminate/resolve where possible. Keep skin clean and dry. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc . to MD. Record review of Physician orders for January and February 2025 reflected Clean MASD to bilateral buttocks with wound cleanser, pat dry, apply (skin protectant paste) every shift until healed. d/c date 02/03/2025. Orders on 02/04/2025 reflected Cleanse buttock with DWC [solution that uses sodium hypochlorite, bleach, as a preservative and is effective against a variety of microorganisms] wound cleanser, pat dry apply hydrocolloid paste, 3X daily and PRN incontinent episode three times a day for MASD. Record review of the TAR for February 2025 reflected there was no documented wound care on 02/03/2025. On 02/04/2025 the night shift wound care 10:00 PM was not documented. On 02/05/2025 two of three treatments were missed or not documented. On 02/07/2025, 02/08/2025 and 02/12/2025, the night shift treatments were not documented. On 02/22/2025 and 02/27/2025 the 2:00 PM wound care was not documented. On 03/06/2025 the 8:00 PM wound care was not documented and on 03/17/2025 the 2:00 PM wound care was not documented . In an interview on 04/30/2025 at 11:55 AM, MD A stated Resident #1 had lot of refusals of care. He stated she refused to let him see her or examine her wound at some visits. He stated she refused to turn in the bed or allow peri care. He stated he had given education to the family twice and then Resident #1 finally let him see her skin. He stated he tried to educate the family that the staff needed help getting Resident #1 to cooperate with her care. He could not specify which family members he had contact with. In an interview on 05/12/2025 at 11:16 AM, MA B stated she worked at the facility since August 2024. She stated Resident #1 used to refuse her treatments and ADL care a lot. She stated when she first came to the facility she did not want to get up or let the staff do anything for her. In an interview on 05/12/2025 at 11:20 AM, CNA C stated she worked at the facility for three months. She stated Resident #1 did not like the staff to do anything for her and would tell the nurse they did not want to help her when they did. She further stated two aides went in to assist her to ensure the care was completed. She stated the resident could be difficult to care for at times as she did not want to be bothered . In an observation and interview on 05/12/2025 at 11:36 AM, LVN D stated she worked at the facility for one month. She stated Resident #1 could get fussy when it was time to do her wound care. She stated she thought the wound had improved since she had been at the facility. Observation of the wound on Resident #1 with LVN D who removed her dressing, revealed two small open areas at the top of the buttock crease on either side. There were no s/sx of infection and there was barrier cream noted all over her buttocks . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/12/2025 at 3:35 PM, RN E stated she used to work at the facility full-time but was now a PRN employee. She stated Resident #1 refused care a lot and did not like to be touched. She stated she normally worked on the secure unit but would come out to assist the staff when Resident #1 would refuse care. She stated Resident #1 did not get her showers or get up to go to the dining room. She stated Resident #1 refused therapy and she thought that it contributed to her skin breakdown. She stated Resident #1 did not like aides to touch her and she had to go to her room many times to try to talk her into accepting care . In an interview on 05/12/2025 at 3:45 PM, LVN F stated he thought he was hired at the facility in late July or early August of 2024 and quit working at the facility at the end of April 2025. He stated Resident #1 would refuse care a lot and would not let aides touch her. He stated she refused showers and would not get out of bed. He stated on some days She would not let us do anything for her. He further stated the staff made multiple attempts to offer her care and notified the family of her refusals. In an interview on 05/12/2025 at 2:46 PM, the DON stated nursing staff should complete all ordered treatments. She stated if there was a refusal, they were supposed to document it in the TAR with the number 2 and write a progress note. She further stated if wound care treatments were missed it could potentially lead to infection, sepsis (blood infection) and hospitalization . In an interview on 05/12/2025 at 4:06 PM, the ADM stated she expected nursing staff to complete all of the ordered treatments and to document all of their treatments. In an interview on 05/12/2025 at 4:18 PM, the VP of Clinical Operations stated staff should document all refusals and put a code in the TAR to indicate the care was refused. He stated the nurse should then put in a progress note which indicated why the resident refused. He further stated if wound care was not completed, the wound could get worse. He further stated the only policy and procedure available was for documentation. . Record review of the facility Policy and Procedure, dated 2003, and titled Documentation reflected Documentation also occurs in Point Click Care (PCC). Goal: 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 6. Document completed assessments in a timely manner and per policy. 7. Complete documentation in the electronic healthcare record in a timely manner. Each entry will be signed with proper signature and title.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observation, interview and record review the facility failed to ensure based on the comprehensive assessment of a resident, a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and did not develop ulcers unless the individual's clinical condition demonstrated that they were unavoidable a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one of four residents (Resident #1) reviewed for pressure ulcers. The facility failed to ensure Resident #1 who had MASD (Moisture Associated Skin Damage) and was at risk for worsening skin breakdown received 8 of her ordered treatments in February 2025 and 2 of her ordered treatments in March 2025. This failure could place residents at risk for developing a worsening pressure ulcer, Cellulitis (skin infection), Osteomyelitis (infection of the bone), Sepsis (infection of the blood), severe pain and hospitalization . Findings include: Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Cocaine dependence, in remission, Major Depression, and Paranoid Schizophrenia . She was readmitted to the facility on [DATE] after an unwitnessed fall with diagnoses which included Urinary Tract Infection , Hypokalemia (low potassium level in the blood) and Schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly. Characterized by thoughts or experiences that seem out of touch with reality) and adjustment disorder with behavioral disorders. Record review of Resident #1's Quarterly MDS, dated [DATE], reflected she had a BIMS score of 15, which indicated intact cognitive status. Section D - Mood, reflected she had little interest or pleasure in doing things and felt tired or had little energy almost every day. Section GG - Functional Abilities reflected she required supervision or touching assistance to roll from left and right, sit to lying, sit to stand, chair/bed-to-chair transfer and toilet transfer. She required partial moderate assistance for toileting hygiene and personal hygiene. Record review of Resident #1's Care Plan, dated 01/20/2025, reflected she had potential /actual impairment to skin integrity r/t MASD/shearing to bilateral buttocks near coccyx area. Goal: The resident will have no complications r/t MASD of the buttocks through the review date. Interventions/Tasks Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Follow facility protocols for treatment of injury. Identify/document potential causative factors and eliminate/resolve where possible. Keep skin clean and dry. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc . to MD. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a nursing progress note, dated 01/13/2025 at 6:32 PM, reflected Late entry therapist in room with resident to assist with ADLS . Resident incontinent of bowel/bladder at this time. Therapist reported to this nurse resident has some open areas to bilateral buttocks. This nurse did assess and resident noted with shearing/MASD to both buttocks near coccyx (tailbone) area on both sides. Resident educated on importance of notifying staff for toileting and keeping skin clean and dry. Resident encouraged not to refuse care nor showers. Area is open, with pink/red tissue exposed. This nurse did cleanse with wc , [wound cleanser] pat dry and applied [barrier] cream to site. Resident states she is unable to keep self-clean, staff educated on checking resident frequently in effort to heal areas and maintain skin integrity. WAR updated with tx as performed above. MD aware, wound care to be notified. Will continue to monitor. Record review of an Initial Wound Evaluation and Management Summary dated 01/28/2025 by MD A for Resident #1 at the request of the Medical Director reflected Chief Complaint: patient presents with a wound on her buttock. Fecal incontinence and urinary incontinence. Non-pressure wound buttock partial thickness . Etiology: [the cause of a condition] Moisture Associated Skin Damage, Duration greater than 7 days, wound size (L x W x D) 7.5 x 5.5 x 0.1 cm. Exudate [drainage]: Light Serosanguinous [a discharge that contains both blood and serum, the clear yellowish part of the blood] Dermis [the skin]: Open. DRESSING TREATMENT PLAN Primary Dressing(s) Hydrocolloid paste (triad) apply Q -shift (3xday) and as needed brief changes for 30 days PLAN OF CARE REVIEWED AND ADDRESSED Recommendations Off-Load Wound; Reposition per facility protocol; Turn side to side in bed every 1-2 hours if able Record review of Physician orders for January and February 2025 reflected Clean MASD to bilateral buttocks with wound cleanser, pat dry, apply (skin protectant paste) every shift every shift until healed. d/c date 02/03/2025. Orders on 02/04/2025 reflected Cleanse buttock with DWC [solution that uses sodium hypochlorite, bleach, as a preservative and is effective against a variety of microorganisms] wound cleanser, pat dry apply hydrocolloid paste, 3X daily and PRN incontinent episode three times a day for MASD. Record review of the TAR for February 2025 reflected there was no documented wound care on 02/03/2025. On 02/04/2025 the night shift wound care 10:00 PM was not documented. On 02/05/2025 two of three treatments were missed or not documented. On 02/07/2025, 02/08/2025 and 02/12/2025, the night shift treatments were not documented. On 02/22/2025 and 02/27/2025 the 2:00 PM wound care was not documented. On 03/06/2025 the 8:00 PM wound care was not documented and on 03/17/2025 the 2:00 PM wound care was not documented . Record review of Progress note by MD A for Resident #1, dated 03/03/2025, reflected she refused to allow the physician to look at her sacrum. Resident #1 refused to allow MD A to assess her wound for the second time in a row on 3/18/2025. MD A stated he would attempt to see her wound again. Record review of a Wound Evaluation and Management Summary, dated 04/8/2025 for Resident #1 at the request of the Medical Director, reflected Chief Complaint: patient has wound on her coccyx; buttock. Non-pressure wound buttock partial thickness. Etiology (quality) Moisture Associated Skin Damage, Duration > 77 days, Objective Healing/Maintain Healing (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound Size (L x W x D): 6.0 x 10.0 x 0.1 cm Surface Area: 60.00 cm^2 Exudate: Light Sero - sanguinous [a discharge that contains both blood and serum, the clear yellowish part of the blood] Dermis: Open areas with exposed dermis [skin] Wound progress: Exacerbated due to patient non-compliant with wound care, refusing CARE AND refusing TO TURN EXPANDED EVALUATION PERFORMED The progress of this wound and the context surrounding the progress were considered in greater detail today. Discussed pain and pain management strategies with patient, family, and/or care providing staff. Patient not allowing dressing changes or hygiene care as recommended and counseling provided. Patient not following repositioning or off-loading recommendations and counseling provided. Impaired nutritional status discussed with patient, family, nursing staff, and/or dietitian. Medications affecting wound healing reviewed and considered. Reviewed off-loading surfaces and discussed surfaces care plan. Discussed signs of atypical ulceration and consideration of biopsy with patient and/or family. Considered patient behavior as factor that is complicating wound healing and discussed it further with staff and/or family. Discussed wound healing trajectory and expectations with patient and/or family. DRESSING TREATMENT PLAN Primary Dressing(s) Hydrocolloid paste (triad) apply Q-shift (3xday) and as needed brief changes for 30 days PLAN OF CARE REVIEWED AND ADDRESSED Recommendations Off-Load Wound; Reposition per facility protocol; Turn side to side in bed every 1-2 hours if able. Focused wound exam Site 2: Etiology (quality) Pressure, Stage 3 Pressure wound coccyx [tailbone] full thickness. Duration > 1 day. Wound size (L x W x D) 1.3 x 0.7 x 0.1 cm [approximately 1/2 long x 1/4 inch wide x .04 inch deep] Dressing treatment plan: Leptospermum honey [medical grade honey] apply daily for 30 days, alginate calcium [absorbent dressing] apply once daily for 30 days. Gauze island dressing once daily for 30 days. MD A then removed a small amount of devitalized (dead) tissue from site 2 to promote healthy granulation tissue (a type of new connective tissue that forms during the healing process of wounds). In an interview on 04/30/2025 at 11:55 AM, MD A stated Resident #1 had a lot of refusals of care. He stated she refused to let him see her or examine her wound at some visits. He stated she refused to turn in the bed or allow peri care. He stated he had given education to the family twice and then Resident #1 finally let him see her skin. He stated the family was surprised at how bad her wound was during the visit on 04/08/2025. He stated one family member was visibly upset and left the room. He stated he tried to educate the family that the staff needed help getting Resident #1 to cooperate with her care. He could not specify which family members he had contact with. In an interview on 05/12/2025 at 11:16 AM, MA B stated she had worked at the facility since August 2024. She stated Resident #1 used to refuse her treatments and ADL care a lot. She stated when she first came to the facility she did not want to get up or let the staff do anything for her. (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 - Few	In an interview on 05/12/2025 at 11:20 AM, CNA C stated she worked at the facility for three months. She stated Resident #1 did not like the staff to do anything for her and would tell the nurse they did not want to help her when they did. She further stated two aides went in to assist her to ensure the care was completed. She stated the resident could be difficult to care for at times as she did not want to be bothered. In an observation and interview on 05/12/2025 at 11:36 AM, LVN D stated she had worked at the facility for one month. She stated Resident #1 could get fussy when it was time to do her wound care. She stated she thought the wound had improved since she had been at the facility. Observation of the wound on Resident #1 with LVN D who removed the dressing from her coccyx (tailbone) area, revealed two small open areas at the top of the buttock crease on either side. There were no s/sx of infection and there was barrier cream noted all over her buttocks. Resident #1 denied any pain. In an interview on 05/12/2025 at 3:35 PM, RN E stated she used to work at the facility full-time but was now PRN. She stated Resident #1 refused care a lot and did not like to be touched. She stated she normally worked on the secure unit but would come out to assist the staff when Resident #1 would refuse care. She stated Resident #1 did not get her showers or get up to go to the dining room. She stated Resident #1 refused therapy and she thought it contributed to her skin breakdown. She stated Resident #1 did not like aides to touch her and she had to go to her room many times to try to talk her into accepting care. In an interview on 05/12/2025 at 3:45 PM, LVN F stated he thought he was hired at the facility in late July or early August of 2024 and quit working at the facility at the end of April 2025. He stated Resident #1 would refuse care a lot and would not let aides touch her. He stated she refused showers and would not get out of bed. He stated on some days She would not let us do anything for her. He further stated the staff made multiple attempts to offer her care and notified the family of her refusals . In an interview on 05/12/2025 at 2:46 PM, the DON stated nursing staff should complete all ordered treatments. She stated if there was a refusal, they were supposed to document it in the TAR with the number 2 and write a progress note. She further stated if wound care treatments were missed it could potentially lead to infection, sepsis (blood infection) and hospitalization . In an interview on 05/12/2025 at 4:06 PM the ADM stated she expected nursing staff to complete all of the ordered treatments and to document all of their treatments. In an interview on 05/12/2025 at 4:18 PM, the VP of Clinical Operations stated staff should document all refusals and put a code in the TAR to indicate the care was refused. He stated the nurse should then put in a progress note which indicated why the resident refused. He further stated if wound care was not completed, the wound could get worse. He further stated the only policy and procedure available was for documentation of care . Record review of the facility's Policy and Procedure, dated 2003, and titled Documentation reflected Documentation also occurs in Point Click Care (PCC). Goal: 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 6. Document completed assessments in a timely manner and per policy. 7. Complete documentation in the electronic healthcare record in a timely manner. Each entry will be signed with proper signature and title.