STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676167	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buckner Westminster Place	2201 Horseshoe LN Longview, TX 75605

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 - Actual harm Residents Affected - Some	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** 49019 Based on interview and record review, the facility failed to consult with the physician when the resident experienced a change in condition for one (Resident #1) of five residents reviewed for a change of condition. The facility failed to notify the physician of changes in surgical incision for Resident #1 after finding surgical incision dressing saturated on 9/14/2024 and 9/16/2024. The facility failed to notify the physician of a change in surgical incision dressing saturation for Resident #1 resulting in infection identified on post-op visit on 9/25/2024 requiring oral antibiotic treatment. The noncompliance was identified as Past Non-Compliance (PNC). The non-compliance began on 9/13/2024 and ended on 9/27/2024. The facility had corrected the noncompliance before the investigation began. This failure could affect residents by placing them at risk for a delay in medical treatment, worsening in condition. Findings included: Record review of a face sheet dated 3/10/2025 indicated Resident #1 was a [AGE] year-old female and admitted on [DATE], with diagnoses including fracture unspecified part of neck of left femur (broken hip), muscle weakness (occurs when your body is not able to contract properly, leading to reduced strength in one or more of your muscles) , cirrhosis of the liver (a condition where the liver is permanently damaged and scar tissue replaces healthy tissue), insomnia (trouble falling asleep or staying asleep on a regular basis), and abnormalities of gait and mobility (medical terms used to describe poor muscle control, altered movement). Record review of an incomplete face sheet dated 3/10/2025 did not indicate Resident #1 had emergency contacts or surgeon listed. (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: 676167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
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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 - Actual harm Residents Affected - Some	Record review of a comprehensive MDS assessment, dated 09/20/2024, indicated Resident #1 was understood and understood others. The MDS indicated Resident #1 had a BIMS score of 15 which indicated she was cognitively intact, and she required substantial/maximal assistance with bathing, dressing lower body and putting on/taking off footwear. The MDS indicated she had a hip fracture with occasional pain that was mild and a surgical wound. Record review of a care plan dated 3/10/2025, with activated problem on 9/23/2024, indicated Resident #1 was at risk for infection related to surgical incision of left hip repair. Interventions included to assess Resident #1 for symptoms of confusion, changes in mental status, delirium, or confusion as these may indicate infection, consult with Physician, Physician's Assistant (PA), Certified Nurse Practitioner (CNP), and dietician as indicated and follow policy for reportable conditions. Record review of a care plan printed on 3/10/2025 and no initiation date indicated a problem for Resident #1 indicating she had potential for signs and symptoms of infection. Interventions included monitoring for increasing/worsening signs and symptoms of infection and notify MD. Record review of Resident #1 's nurse note on 9/14/2024, completed by RN D, dated 9/15/2024 indicated Resident #1 had a saturated dressing on left hip surgical site. RN D noted drainage was serosanguineous (refers to fluid that contain or relate to both blood and the liquid part of blood) with no odor. RN D noted Resident #1 did not have any signs and symptoms of infection. RN D said Resident #1 had occasional pain and was relieved with analgesic. RN D documented she performed dressing care with reinforced non-stick ABD and paper tape to help with drainage absorption and noted drainage was small to moderate. The nursing note did not address if RN D notified the physician to obtain orders for treatment. The hospital discharge instructions dated 9/13/2024 did not address specific incision care orders or to leave dressing intact until post-op follow-up visit. Record review of Resident #1's nurse progress note dated 09/16/2024 at 10:35 AM, completed by LVN C indicated resident reports of post-op dressing coming off. LVN C documented she cleansed with normal saline, patted dry, and applied Mepilex border (an absorbent foam dressing) post-op. She noted scant, serosanguinous (refers to fluid that contain or relate to both blood and the liquid part of blood) drainage observed from lower aspect of surgical wound. LVN C documented no redness, swelling, or warmth was observed. No documentation indicated Resident #1's RP or physician was notified of findings. Record review of a wound assessment dated [DATE] at 10:07 AM, LVN C indicated small amount of serosanguineous drainage, wound edges were distinct and attached and surround tissue was normal. LVN C measured the surgical incision which indicated the measurements were 14 cm x 0.10 cm and unable to determine depth. The wound assessment note did not indicate if there were any treatments, orders, or notification of physician during assessment. Record review of nurse note dated 09/16/2024 at 10:35 AM and documented late on 9/26/2024, LVN C indicated post-op dressing came off. LVN C documented she cleansed surgical incision with normal saline, patted dry, and applied Mepilex border (an absorbent foam dressing) post-op (after a medical operation) to the surgical site. She noted scant, serosanguinous (refers to fluid that contain or relate to both blood and the liquid part of blood) drainage observed from lower aspect of the surgical wound. LVN C documented no redness, swelling, or warmth was observed. The nursing progress note did not address if LVN C notified the physician to obtain treatment orders. (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 0580 Level of Harm - Actual harm Residents Affected - Some	Record review of a wound assessment dated [DATE] at 8:44 AM, LVN C indicated there was no exudate, wound edges were distinct and attached, and surrounding tissue was normal. LVN C measured the surgical incision which indicated measurement were 14 cm x 0.10 cm and unable to determine depth. The wound assessment note did not indicate if there were any treatments, orders, or notification of physician during assessment. During an interview on 3/10/2025 at 2:12 PM, LVN A said the nurse was responsible for entering orders in the resident's chart upon admission. She said the orders would be in the discharge paperwork from the hospital. LVN A said if orders were not in the discharge paperwork, she would complete the skin assessment and talk with the ADON or Physician to obtain an order for incision care. LVN A said she would follow-up with the resident admitted every 4 hours to make sure the surgical dressing remained intact. LVN A said she would clarify the orders to identify if the surgeon wanted the dressing to be changed or obtain orders if a dressing became dislodged or soiled. LVN A said a resident could get an infection if a dressing was saturated or dislodged. The nurse is responsible for ensuring wound care was performed. LVN A said she was agency staff and was not at the facility at the time of this intake report. LVN A said she had been in-serviced. During an interview on 3/10/2025 at 3:10 PM. LVN B said the ADON, DON or charge nurse were responsible for placing admission orders in their system. LVN B said this incident was a long time ago and she could not recall the details. LVN B said she would notify the physician if a surgical dressing was saturated and report signs and symptoms of infection to the MD to obtain orders. LVN B said if the hospital did not send over orders upon admission, she would call the hospital to obtain orders. LVN B said the staff do not remove a dressing and observe the incision if the orders indicate do not remove. LVN B said she had heard the surgical incision got infected. LVN B said if a saturated dressing was in place too long, it could become infected. LVN B said the charge nurse was responsible for ensuring the family and physician was notified of the changes, and it would be documented in the nurse notes and on the 24-hour report. LVN B said she would notify the ADON and DON of changes. LVN B said she had been in-serviced on wound changes, abuse and neglect and notifying the physician of changes. Attempted to contact LVN C on 3/10/2025 at 3:49 PM, unable to leave a voicemail due to mailbox being full. Attempted to contact Resident #1 on 3/10/2025 at 3:53 PM, unable to reach due to phone had been disconnected. Resident #1 discharged on [DATE]. Attempted to contact RP for Resident #1 on 3/10/2025 at 3:53 PM, unable to talk at that time with a promise to return call. No return call was received. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/11/2025 at 9:13 AM, the Physician said Resident #1 had a superficial infection to surgical incision per her post-op follow-up visit notes The Physician said he would want to be notified if a dressing was saturated or if the dressing became dislodged. The Physician said orders were to be sent from the hospital. The Physician said he would have wanted the surgical incision to be covered with a 4 x 4 gauze (surgical sponge, absorbent woven gauze), Abd pad (a large wound dressing, abdominal pad) and a Tagaderm (a clear, transparent, waterproof dressing) as needed if a dressing became soiled or dislodged. He said the facility staff could have changed the dressing 2-3 x daily if there was drainage. The Physician said Resident #1 came in for a follow-up visit with his Physician Assistant 2 weeks post-op and he saw Resident #1 a week following and stated the incision was fine. The Physician said it was not uncommon for a resident to develop an infection after discharge and it was important to keep the surgical incision clean. The Physician said if the infection was not caught in time, the results could be bad. During an interview on 3/11/2025 at 10:15 AM, the DON said the charge nurse was responsible for putting in the admission orders. The DON said she did not know why the nurse did not obtain orders from the physician. The DON said the Physician should have been contacted upon admission for the surgical wound care orders. She said the family and the Physician should have been notified when the saturated dressing was identified. The DON said the surgical incision could have deteriorated and got infected. The DON said she expected the nursing staff to call the Physician. The DON said she expected pain and surgical site incision dressing saturation to be reported to the Physician. The DON said all facility staff were in-serviced on wound changes, abuse and neglect and Physician notification. During an interview on 3/11/2025 at 10:33 AM, the ADM said the nurse or ADON was responsible for putting in the admission orders. He said he expected the nurses to contact the Physician with signs and symptoms of infection. The ADM said some Physicians want the surgical dressing to remain intact until the follow-up appointment. The ADM said he expected an as needed order for surgical or wound dressing changes to be in place if a dressing became dislodged or soiled. The ADM said he expected his staff to document communication to the family and physician with responses. The ADM said he expected the nurses to have an order in place prior to providing care. Record review of the facility in-service titled In-service Abuse/Neglect dated 9/27/2024 indicated abuse was negligent or willful injury, unreasonable confinement, intimidation, or punishment resulting in physical or emotional harm or pain .Neglect .the failure of a facility, its associates or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional stress. Neglect includes cases where indifference or disregard for the resident's care, comfort or safety . Neglect of a resident as demonstrated by a pattern of willfully failing to provide care to a resident .Upon admission .If no orders are written upon admission of a surgical incision, wounds or skin issues .Nurse will notify surgeon/MD to obtain orders for wound care or to leave an existing dressing in place per MD orders . Nurse will ensure upon admission that the orders are clarified if needed .For changes in condition .nurse must notify physician and document response. Nurse manager will review every admit ensuring proper orders and assessments are in chart .Nurse manager will weekly monitor administration of proper orders . Signs and Symptoms of infection .Increased pain, increased edema, redness, warmth/hot to touch, increased drainage and foul odor. Nurse will report to surgeon/MD of any changes in surgical site or wounds to Surgeon/MD for further orders. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	Record review of a facility policy titled Charting and documentation dated 10/11/2021 indicated .services provided to the resident, progress toward care plan goals, or change in the resident's medical, physical, functional, or psychological condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation .1. The following information is to be documented in the resident's medical record .Objective observations, medication administration, treatments or services performed, changes in a resident's condition, events, incidents, or accidents .progress toward or changes in the care plan goals and objectives .9. Documentation of procedures and treatments .a. The date and time the procedure/treatment was provided. b. The name and title of the individual who provided the care. c. The assessment data and/or the unusual findings .d. How the resident tolerated .e. Whether the resident refused . f. Notification of family, physician, or other staff .g. The signature and title of the individual .

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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 - Actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49019

Based on interview and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 2 (Resident #1) residents reviewed for surgical incision.

The facility failed to clarify and obtain surgical incision care orders for Resident #1 upon admission on 9/13/2024.

The facility failed to clarify hospital discharge orders for surgical incision site care upon admission on 9/13/2024 for Resident #1.

The facility failed to assess and identify a change in condition for Resident #1's surgical incision site to left hip on 9/14/2024 resulting in an infection requiring antibiotic on follow-up appointment with surgeon on 9/25/2024.

The noncompliance was identified as Past Non-Compliance (PNC). The non-compliance began on 9/13/2024 and ended on 9/27/2024. The facility had corrected the noncompliance before the investigation began.

This failure could place residents of risk for serious harm, and not receiving appropriate care, treatment with interventions to reach their highest practicable physical, mental, and psychosocial well-being.

Findings included:

Record review of a face sheet dated 3/10/2025 indicated Resident #1 was a [AGE] year-old female and admitted on [DATE], with diagnoses including fracture unspecified part of neck of left femur (broken hip), muscle weakness (occurs when your body is not able to contract properly, leading to reduced strength in one or more of your muscles) , cirrhosis of the liver (a condition where the liver is permanently damaged and scar tissue replaces healthy tissue), insomnia (trouble falling asleep or staying asleep on a regular basis), and abnormalities of gait and mobility (medical terms used to describe poor muscle control, altered movement).

Record review of the hospital discharge orders dated 9/13/2024 at 3:07 PM, indicated Resident #1's primary diagnosis was closed displaced fracture of neck of left femur. The discharge instructions indicated medications to continue and additional discharge instructions to prevent infection as follows:

Clean hands are the best protection to prevent infection.

Your physician will give you specific instructions for changing you bandage or dressing.

Maintain a clean environment.

Avoid submerging incisions or wounds.

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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 - Actual harm Residents Affected - Some	Notify your physician for: fever over 101 degrees, chills or shaking, increased redness of incision or wound, increased drainage or pus from incision or wound, odor from incision or wound, or development of severe diarrhea. Record review of a physician order initiated on 9/12/2024 for Resident #1 by DON and signed by attending Physician on 10/9/2024, indicated the nursing staff to complete weekly skin assessments and did not address an order for treatment of the resident's surgical incision. Record review of a wound assessment for Resident #1 was initiated on 9/13/2024 at 6:57 PM, indicated LVN B assessed Resident #1 and noted surgical wound to left hip with staples. The wound assessment indicated there was no non-removeable device, no infection, no antibiotic. no odor and no measurement were documented. The wound assessment indicated there was a small amount of bloody exudate, wound edges were distinct and attached and surrounding tissue was normal. The wound assessment note did not indicate if there were any treatment discharge orders from the hospital. Record review of the TAR dated September 2024, indicated an order on 9/12/2024 for nurse staff to complete a weekly skin assessment. The treatment administration report indicated a new order dated 9/25/2024 for wound care to left hip to be changed daily with orders to cleanse with wound cleanser and cover with dressing. A new dressing change order was entered on 9/25/2024 indicated wound care was to be performed two times daily starting on 9/25/2024 to left hip surgical incision if soiled as needed. The TAR indicated left posterior hip precautions were initiated on 9/26/2024 and a one-time daily dressing change added to perform wound care to left hip dressing daily to cleanse surgical incision of left hip with wound cleanser, pat dry, cover with a border dressing and assess for signs and symptoms of infection daily. Record review of a comprehensive MDS assessment, dated 09/20/2024, indicated Resident #1 was understood and understood others. The MDS indicated Resident #1 had a BIMS score of 15 which indicated she was cognitively intact, and she required substantial/maximal assistance with bathing, dressing lower body and putting on/taking off footwear. The MDS indicated she had a hip fracture with occasional pain that was mild and a surgical wound. Record review of a care plan dated 3/10/2025, with activated problem on 9/23/2024, indicated Resident #1 was at risk for infection related to a surgical incision of left hip repair. Interventions included to assess and document skin color, moisture, texture, and turgor and report abnormal findings, assess and document temperature every shift and report variations in temperature readings per policy, assess Resident #1 for symptoms of confusion, changes in mental status, delirium, or confusion as these may indicate infection, consult with Physician, Physician's Assistant (PA), Certified Nurse Practitioner (CNP), and dietician as indicated and follow policy for reportable conditions. Record review of a care plan printed on 3/10/2025 and no initiation date indicated a problem for Resident #1 indicating she had potential for signs and symptoms of infection. Interventions included monitoring for increasing/worsening signs and symptoms of infection and notify MD, administer medical intervention as ordered, lab as ordered, take and document vital signs as ordered, implement necessary precautions, i.e., contact isolation/other precautions as ordered, monitor and report adverse effects from antibiotics or other meds as ordered, and practice good hand washing technique. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident #1's nursing note dated 9/14/2024 and documented late on 9/15/2024 completed by RN D, indicated Resident #1's left hip surgical dressing was saturated. RN D noted drainage was serosanguineous (refers to fluid that contain or relate to both blood and the liquid part of blood) with no odor. RN D noted Resident #1 did not have any signs and symptoms of infection. RN D said Resident #1 had occasional pain and was relieved with an analgesic. RN D documented she performed dressing care with a reinforced non-stick ABD dressing and paper tape to help with drainage absorption and noted drainage was small to moderate. The nursing note did not address if RN D notified the physician to obtain orders for treatment. Record review of a wound assessment dated [DATE] at 10:07 AM, LVN C indicated small amount of serosanguineous drainage, wound edges were distinct and attached and surround tissue was normal. LVN C measured the surgical incision which indicated the measurements were 14 cm x 0.10 cm and unable to determine depth. The wound assessment note did not indicate if there were any treatments, orders, or notification of physician during assessment. Record review of nurse note dated 09/16/2024 at 10:35 AM and documented late on 9/26/2024, LVN C indicated post-op dressing came off. LVN C documented she cleansed surgical incision with normal saline, patted dry, and applied Mepilex border (an absorbent foam dressing) post-op (after a medical operation) to the surgical site. She noted scant, serosanguinous (refers to fluid that contain or relate to both blood and the liquid part of blood) drainage observed from lower aspect of the surgical wound. LVN C documented no redness, swelling, or warmth was observed. The nursing progress note did not address if LVN C notified the physician to obtain treatment orders. Record review of a wound assessment dated [DATE] at 8:44 AM, LVN C indicated there was no exudate, wound edges were distinct and attached, and surrounding tissue was normal. LVN C measured the surgical incision which indicated measurement were 14 cm x 0.10 cm and unable to determine depth. The wound assessment note did not indicate if there were any treatments, orders, or notification of physician during assessment. Record review of Resident #1's nurse progress note, dated 9/25/2024 at 6:02 PM, indicated new orders were received following post-op visit on 9/25/2024. New orders received for left hip surgical incision dressing daily and a new order received for Cefadroxil 500 mg (antibacterial medication) twice daily for 2 weeks for infection to the left surgical incision after post-op visit at physician's office. Record review of a telephone physician order for Resident #1 dated 9/25/2024 no time documented, indicated new orders for Cefadroxil (Duricef) 500 mg (antibacterial medication) twice daily for 7 days, daily and PRN Left hip dressing changes, resident may ambulate PRN with walker, left lower extremity ultrasound today, 1-week post-op follow-up, and Eliquis 2.5 mg twice daily for 2 weeks for DVT prophylaxis, left hip x-ray and left posterior hip precautions. Record review of a radiology interpretation dated 2/25/2024, indicated left hip x-ray (a type of electromagnetic radiation, used in medical imagining to create a picture of the inside of the body) was completed due to pain in the left hip. The radiological record was completed with two frontal (relating to the front) and frog-leg lateral view (a special pelvis radiograph to evaluate the hip) of the left hip were submitted. The impression indicated there were no acute fractures or dislocation by plain radiography and an intact appearing total hip arthroplasty hardware (an artificial implant of the damaged part of hip joint) identified. (continued on next page)

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F 0684

Level of Harm - Actual harm

Residents Affected - Some

Record review of a vascular duplex examination (a non-invasive ultrasound test that uses sound waves to visualize blood flow and structure in the veins, helping to detect blood clots and venous insufficiency, and vascular issues) dated 9/27/2024, indicated a venous duplex examination using B-mode (a common imagining technique that displays a two-dimensional cross-sectional image of tissues and organs using grayscale, where brighter areas represent stronger echoes), color flow (a medical imagining technique using ultrasound to visualize blood flow, displaying colors superimposed on a grayscale image, indicating the direction and speed of blood flow) and spectral doppler (a technique that uses Fourier analysis to convert returning sound waves into a series of frequencies, providing graphical representation of blood flow velocity over time) was performed. The finding indicated no evidence of Deep vein thrombosis (DVT) (a blood clot deep in the vein, usually the legs) within visualized venous structures of the left lower extremity.

Record review of Medication Administration order dated 9/25/2025, indicated Resident #1 was started on cefadroxil 500 mg (antibacterial medication) twice daily was started to treat infection to surgical incision of left hip.

Record review of Treatment Administration record (TAR) dated September 2024, indicated Resident #1 was received wound care to left hip for dressing changes to be completed daily by cleansing with wound cleanser and covering with dressing. The treatment administration record (TAR) indicated the order was discontinue and restarted on 9/26/2024 for left hip dressing change to be performed daily as follows: cleanse with wound cleanser, pat dry, cover with border dressing and assess for signs and symptoms of infection daily. The treatment administration record indicated left posterior hip precautions were initiated on 9/26/2024.

Record review of Medication Administration record (MAR) dated 3/10/2025, indicated Resident #1 was started on Eliquis 2.5 mg (a medication used to prevent and treat blood clots) twice daily for 14 days was started on 9/26/2024 for DVT (a blood clot deep in the vein, usually the legs) prophylaxis.

Record review of a wound assessment dated [DATE] at 4:19 PM, LVN B indicated a small amount of bloody exudate, wound edges were distinct and attached, surround tissue was normal. LVN B documented infection and antibiotics and no odor. LVN B indicated surgical incision had staples. The wound assessment did not indicate if new orders were received on 9/25/2024 and if care had been provided.

Record review of Physician progress note on 9/30/2024 at 7:04 AM, indicated Resident #1 was diagnosed with cellulitis to incision at surgeon's office and nurse was changing dressing daily.

Record review of Medication administration report dated October 2024, indicated Resident #1 was started on Vitamin C 500 mg (soluble antioxidant that play a vital role in the body's immune system) twice daily, Zinc 50 mg (a supplement to support the immune system and wound healing) daily for 14 days, and multivitamin daily (a supplement of vitamins that are not taken in through diet).

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F 0684 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/10/2025 at 2:12 PM, LVN A said the nurse was responsible for entering orders in the resident's chart upon admission. She said the orders would be on the discharge paperwork from the hospital. LVN A was not present at the time of this incident. She said if orders were not on the discharge paperwork, she would complete the skin assessment and talk with ADON or Physician to obtain an order for incision care. LVN A said she would follow-up with the resident admitted every 4 hours to make sure the surgical dressing remained intact. LVN A said she would clarify the orders to identify if the surgeon wanted the dressing to be changed or obtain orders if a dressing became dislodged or soiled. LVN A said a resident could get an infection if a dressing was saturated or dislodged. She said the nurse was responsible for ensuring wound care was performed. LVN A said she was agency staff and was not at the facility at the time of this intake report. LVN A said she had been in-serviced. During an interview on 3/10/2025 at 3:10 PM, LVN B said the ADON, DON or charge nurse were responsible for placing admission orders in their system. LVN B said this incident was a long time ago and she could not recall the details. LVN B said she would notify the physician if a surgical dressing was saturated and report signs and symptoms of infection to the MD to obtain orders. LVN B said if a saturated dressing was in place too long, it could become infected. LVN B said if the hospital did not send over orders upon admission, she would call the hospital to obtain orders. LVN B said the staff did not remove a dressing and observe the incision if the orders indicated not to remove. LVN B said she had heard the surgical incision got infected. LVN B said the charge nurse was responsible for ensuring the family, physician was notified of the changes, and it would be documented in the nurse notes and on the 24-hour report. LVN B said she would notify the ADON and DON of changes. LVN B said she had been in-serviced on wound changes, abuse and neglect and notifying the physician of changes. Attempted to contact LVN C on 3/10/2025 at 3:49 PM, unable to leave a voicemail due to mailbox being full. Attempted to contact Resident #1 on 3/10/2025 at 3:53 PM, unable to reach due to phone had been disconnected. Resident #1 discharged on [DATE]. Attempted to contact RP for Resident #1 on 3/10/2025 at 3:53 PM, unable to talk at that time with a promise to return call. No return call received by end of day. During an interview on 3/11/2025 at 9:13 AM, the Physician said Resident #1 had a superficial infection to surgical incision per her post-op follow-up visit noted on 9/25/2024. He said he expected the dressing to be clean and intact while at the facility. The Physician said he would want to be notified if a dressing was saturated or if the dressing became dislodged. The Physician said orders were to be sent from the hospital. The Physician said he would have wanted the surgical incision to be covered with a 4 x 4 gauze (surgical sponge, absorbent woven gauze), ABD pad (a large wound dressing, abdominal pad) and a Tegaderm (a clear, transparent, waterproof dressing) as needed if a dressing became soiled or dislodged. He said the facility staff could have changed the dressing 2-3 x daily if there was drainage. The Physician said Resident #1 came in for a follow-up visit with his Physician Assistant 2 weeks post-op on 9/25/2024. and he saw Resident #1 a week following and stated the incision was fine. The Physician said it was not uncommon for a resident to develop an infection after discharge and it was important to keep the surgical incision clean. The Physician said if the infection was not caught in time, the results could be bad. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Buckner Westminster Place		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 Horseshoe LN Longview, TX 75605	

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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 - Actual harm Residents Affected - Some	During an interview on 3/11/2025 at 10:15 AM, the DON said the charge nurse was responsible for putting in the admission orders. She said the ADON and DON could also put in the orders. The DON said she did not know why Resident #1 did not have wound care orders upon admission and said the hospital did not provide any orders. The DON said she did not know why the nurse did not obtain orders from the physician. The ADON at the time was no longer employed at the facility and she was on vacation at the time Resident #1 admitted to the facility on [DATE]. The DON said the Physician should have been contacted upon admission for the surgical wound care orders. She said the family and the Physician should have been notified when the saturated dressing was identified. The DON said the surgical incision could have deteriorated and got infected. The DON said she expected the nursing staff to call the Physician. The DON said she reviewed and the ADON reviewed all new orders and admission as new orders are received. The DON reviewed the nurse progress note and said it appeared LVN C entered her progress note on 9/26/2024 and was a late documentation for 9/16/2025. She said it was unclear why the progress note was dated 9/26/2024 and said it could have been the date she locked the note. She felt the nurse started the note on 9/16/2024. The DON said she expected pain and surgical site incision dressing saturation to be reported to the Physician. The DON said all facility staff were in-serviced on wound changes, abuse and neglect and Physician notification on 9/27/2024. During an interview on 3/11/2025 at 10:33 AM, the ADM said the nurse or ADON was responsible for putting in the admission orders. The ADM said the facility staff discussed orders in the stand-up meetings and the ADON and DON reviewed the orders. The ADM said the facility currently did not have a performance improvement plan (PIP) in place for this incident. The ADM said the facility completed their investigation and identified the root cause, advised staff on expectations of identifying wounds and medications. He said he expected the nurses to contact the Physician with signs and symptoms of infection. The ADM said some Physicians want the surgical dressing to remain intact until the follow-up appointment. The ADM said he expected an as needed order for surgical or wound dressing changes to be in place if a dressing became dislodged or soiled. The ADM said he expected his staff to document communication to the family and physician with responses. The ADM said he expected the nurses to have an order in place prior to providing care. Record request made to DON on 3/11/2025 at 10:15 AM for a facility policy regarding wound care and admission policy. It was reported on 3/11/2025 at 11:00 AM, the facility did not have policies to provide for wounds or admission. Record review of the facility in-service titled In-service Abuse/Neglect dated 9/27/2024 indicated abuse was negligent or willful injury, unreasonable confinement, intimidation, or punishment resulting in physical or emotional harm or pain .Neglect .the failure of a facility, its associates or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional stress. Neglect includes cases where indifference or disregard for the resident's care, comfort or safety . Neglect of a resident as demonstrated by a pattern of willfully failing to provide care to a resident .Upon admission .If no orders are written upon admission of a surgical incision, wounds or skin issues .Nurse will notify surgeon/MD to obtain orders for wound care or to leave an existing dressing in place per MD orders . Nurse will ensure upon admission that the orders are clarified if needed .For changes in condition .nurse must notify physician and document response. Nurse manager will review every admit ensuring proper orders and assessments are in chart .Nurse manager will weekly monitor administration of proper orders . Signs and Symptoms of infection .Increased pain, increased edema, redness, warmth/hot to touch, increased drainage and foul odor. Nurse will report to surgeon/MD of any changes in surgical site or wounds to Surgeon/MD for further orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
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F 0684 Level of Harm - Actual harm Residents Affected - Some	Record review of a facility policy titled Charting and documentation dated 10/11/2021 indicated .services provided to the resident, progress toward care plan goals, or change in the resident's medical, physical, functional, or psychological condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation .1. The following information is to be documented in the resident's medical record .Objective observations, medication administration, treatments or services performed, changes in a resident's condition, events, incidents, or accidents .progress toward or changes in the care plan goals and objectives .9. Documentation of procedures and treatments .a. The date and time the procedure/treatment was provided. b. The name and title of the individual who provided the care. c. The assessment data and/or the unusual findings .d. How the resident tolerated .e. Whether the resident refused . f. Notification of family, physician, or other staff .g. The signature and title of the individual .