STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676193	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waterton Healthcare & Rehabilitation	2875 Shiloh Road Tyler, TX 75703

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 0684 Level of Harm - 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** Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 2 residents (Resident #1) reviewed for quality of care. The facility did not obtain physician order's for wound care to her post-surgical incision sites during her stay at the facility from 3/28/26 to 4/8/26. LVN A did not obtain physician order's for the betadine (a widely used, non-stinging antiseptic that kills germs) she applied to Resident #1's post-surgical incision sights. The facility did not thoroughly assess and document Resident #1's post-surgical incision sites on 3/29/26 and 3/31/26. The facility did not assess and document Resident #1's post-surgical incision sites on 3/30/26and 4/1/26 through 4/8/26. The facility did not follow up to schedule Resident #1's post operative appointment with the orthopedic surgeon. Resident #1 was sent to the hospital on 4/8/26 and treated for dehiscence (surgical complication where a closed incision reopens) and infection of the left lateral incision ((incision to the outer aspect of the left knee extending above and below the knee). Resident #1 returned to her home with a wound vacuum in place. These failures could place residents at risk for deterioration and infection, complications of chronic health conditions and hospitalization. Findings included:Record review of Resident #1's face sheet indicated she was [AGE] years old admitted to the facility on [DATE] with diagnoses of encounter for orthopedic aftercare and anticoagulants (commonly known as blood thinners, are medications that prevent or reduce blood clot formation by slowing down the body's clotting process). Record review of the admission MDS dated [DATE], indicated Resident #1 made herself understood and understood others. The MDS indicated she had moderate cognitive impairment (BIMS of 12). The MDS indicated Resident #1 had no behavior of rejecting care. The MDS indicated Resident #1 was dependent on staff for toileting, showering/bathing, dressing the upper/lower body, and putting on/taking off footwear. The MDS indicated Resident #1 required supervision with oral hygiene. The MDS indicated Resident #1 required setup or clean-up assistance with eating. The MDS indicated Resident #1 was dependent on staff for all position changes (rolling left to right; sit to lying, lying to sitting, sit to stand) and transfers. The MDS indicated Resident #1 was always incontinent of bowel and bladder. The MDS indicated Resident #1 had surgical wounds. Record review of Resident #1's care plan dated 4/2/26 indicated Resident #1 risk for pressure injury development. The care plan interventions included notifying the nurse of new areas of redness, blisters, bruises/discoloration; weekly head to toe skin assessment. The care plan did not address post surgical care or assessment to her post-surgical incision sites. Record review of the hospital wound/ostomy/assessment/care re-evaluation dated 3/27/26 documented Resident #1 had received an open reduction internal fixation of the tibia/fibula (a surgical procedure used to repair complex or displaced fractures of the shin bone [tibia] and/or the smaller lower leg bone [fibula]) (left leg) on 3/21/26 as well as an open reduction internal fixation of the right femur (thigh bone) on 3/23/26. The hospital wound/ostomy/assessment/care re-evaluation documented the following post-surgical incision sites: *Surgical incision to the left anterior measuring leg 15 cm in length and 1 cm in width closed with sutures. The document described the wound as approximated; moist; red with approximated edges (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(approximated wounds have edges that fit tightly together [e.g., closed by stitches, staples, or glue]) with scant serosanguineous drainage (a thin, watery wound discharge that is pale pink or light red, containing both blood [sanguineous] and serum [serous]). The document described the surrounding skin as edematous (issue that is abnormally swollen due to an excessive accumulation of fluid in intercellular spaces) and ecchymotic (describes a skin discoloration caused by ecchymosis-the medical term for a large bruise). *Surgical incision to the left lateral leg (incision to the outer aspect of the left knee extending above and below the knee) measuring leg 24 cm in length and 1 cm in width closed with sutures. The document described the wound as approximated; moist; purple with approximate edges with scant serosanguineous drainage. The document described the surrounding skin as edematous, ecchymotic and purple. * Surgical incision to the right lateral leg measuring leg 29 cm in length and 1 cm in width closed (with staples). The document described the wound as approximated; moist; with approximated edges with scant serosanguineous drainage. The document described the surrounding skin as edematous, ecchymotic and purple. Record review of the hospital after visit summary dated 3/28/26 for Resident #1 did not list any physician orders for her surgical sites. Record Review of Resident #1's progress note dated 3/29/26 at 9:23 a.m., documented as follows: *Skin issue #001- right lateral thigh- surgical wound- present on admission described as approximated, with no dehiscence, closed with staples, healing ridge, length of 35 cm and width of 1 cm. *Skin issue #002- left shin -noting two incision areas present on admission described as approximated, with no dehiscence, closed with sutures, healing ridge (a normal, firm, or bumpy area that develops beneath a surgical incision or wound as it heals), length of 17 cm and width of 1 cm. Further review revealed there was no measurement was provided for 2nd incision to left shin. Record Review of Resident #1's progress note dated 3/30/26 at 5:02 p.m., indicated .skin issue: #001: skin issue has not been evaluated.skin issue: #002: skin issue has not been evaluated. This note was written by LVN B. Record review of Resident #1's progress note dated 3/31/26 at 9:39 a.m. documented as follows: *Skin issue #001: right lateral thigh - surgical wound- present on admission described as approximated, with no dehiscence, closed with 29 staples, healing ridge, closed with 29 staples. The assessment indicated no measurements were obtained because the incisions were sporadically placed. *Skin issue #002: left shin- two incision areas present.11 sutures to left lower extremity, sutures to under 1st, 2nd and 3rd toes of the left foot, 27 sutures to left outer leg. No further assessment to left leg incisions were documented. This note was written by LVN A. Record Review of Resident #1's progress note dated 3/31/26 at 6:38 p.m., indicated .skin issue: #001: skin issue has not been evaluated.skin issue: #002: skin issue has not been evaluated. This note was written by LVN B. Record Review of Resident #1's progress note dated 4/1/26 at 5:00 p.m., indicated .skin issue: #001: skin issue has not been evaluated.skin issue: #002: skin issue has not been evaluated. This note was written by LVN B. Record Review of Resident #1's progress note dated 4/2/26 at 5:29 p.m., indicated .skin issue: #001: skin issue has not been evaluated.skin issue: #002: skin issue has not been evaluated. This note was written by LVN B. Record Review of Resident #1's progress note dated 4/3/26 at 5:53 p.m., indicated .skin issue: #001: skin issue has not been evaluated.skin issue: #002: skin issue has not been evaluated. This note was written by LVN B. Record Review of Resident #1's progress note dated 4/4/26 at 8:41 a.m., indicated .skin issue: #001: skin issue has not been evaluated.skin issue: #002: skin issue has not been evaluated. This note was written by LVN C.Record Review of Resident #1's progress note dated 4/4/26 at 8:45 a.m., indicated .skin issue: #001: skin issue has not been evaluated.skin issue: #002: skin issue has not been evaluated. This note was written by LVN C. Record Review of Resident #1's progress note dated 4/5/26 at 10:44 p.m., indicated .skin issue: #001: skin issue has not been evaluated.skin issue: #002: skin issue has not been evaluated. This note was written by LVN D. Record review of Resident #1's progress note dated 4/6/26 at 11:27 a.m., documented .Sutures under left 2nd toe and 3rd to came loose. Bleeding noted, bright red in color. (MD) here and observed with order rec. (received) to send to ER.Record review of the hospital after visit summary dated 4/6/26 for Resident #1 did not list any (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	physician orders for her surgical sites.Record Review of Resident #1's progress note dated 4/6/26 at 10:56 p.m., indicated .skin issue: #001: skin issue has not been evaluated.skin issue: #002: skin issue has not been evaluated. This note was written by LVN E. Record Review of Resident #1's progress note dated 4/7/26 at 5:07 p.m., indicated .skin issue: #001: skin issue has not been evaluated.skin issue: #002: skin issue has not been evaluated. This note was written by RN D. Record Review of Resident #1's progress note dated 4/8/26 at 11:34 a.m., documented .maceration (softening and breaking down of skin) noted to the left outer incision line. Record Review of the progress note dated 4/8/26 at 11:42 a.m., documented the MD had been notified of Resident #1's maceration of incision to left outer incision line. The progress note indicated Resident #1 was sent to the hospital at that time. Record review of the progress notes for Resident #1 from 3/28/26 to 4/8/26 revealed no additional assessments for Resident #1 post-surgical incision sites. Record review of the MAR/TAR for Resident #1 from 3/28/26 to 4/8/26 found no documented treatment or monitoring to any of Resident #1's surgical incisions. During an interview on 4/22/26 at 2:22 p.m., CNA F said she regularly took care of Resident #1 on the day shift. CNA F said LVN A was putting betadine on the surgical sites every day. During an interview on 4/23/26 at 9:40 a.m., LVN A said she took care of Resident #1 M-F on the 6:00 a.m. to 2:00 p.m. shift. LVN A said she applied betadine to each post-operative surgical site when she cared for her. LVN A said she could not recall who had given her the orders to apply the betadine. LVN A said she was unable to find documentation of communication with a provider in her phone regarding the betadine application. LVN A said if she had received an order it should have recorded in the EMR. LVN A said Resident #1's surgical incision were open to air when she arrived and there were no dressings. LVN A said Resident #1 was very swollen and her legs were weeping fluid from the incision sites since her admission. LVN A said staff were placing an absorbent pad under the legs and trying to position to keep the area dry. LVN A said the wound did not start looking like it was trying to open until 4/8/26. During an interview on 4/22/26 at 3:46 p.m., the Medical Director said he would not have provided treatment orders for Resident #1's surgical incisions and would expect the nurses to follow the orders from the hospital or from the orthopedic surgeon for those areas. The Medical Director said he was at her bedside and sent her to the ER on [DATE] because sutures on the left foot appeared to been open and the foot was bleeding. The Medical Director said Resident #1 was on anticoagulants and felt he could see tendon at the open area so he sent her out promptly. The Medical Director said he could not say he observed the other sights because the urgent concern was site to the left foot. During an interview on 4/23/26 at 6:09 a.m., RN D said she regularly took care of Resident #1 on the 10 p.m. to 6:00 a.m. shift. RN D said she did not recall Resident #1 having any treatment orders. RN D said she would have only performed treatment as it was needed if she did have orders because the routine care would not scheduled on her shift. RN D Resident #1 sites were open to air to her recollection. During an interview on 4/23/26 at 7:50 a.m., the DON said while the charge nurses were responsible for daily wound care, the facility had a wound manager. The DON said the wound manager role had been combined with the role of staffing coordinator and was being performed by LVN G. The DON said performance issues had been identified with LVN G in regard to failing to obtain treatment orders timely. The DON said it was felt a new person in the role would be essential to correcting these issues. The DON said on 3/18/26 LVN H had her first day in the position wound manager/staffing coordinator in conjunction with LVN G. The DON said LVN H quit without notice on 3/31/26. The DON said LVN G was now prn and had not worked in the facility since 3/23/26. The DON the facility hired a new nurse to fulfil the role of wound manager who started last week but since her first day of work has been out sick. The DON said she started in-services with her nurses regarding skin assessments on 4/2/26. The DON said nurses were in-serviced over obtaining treatment orders on 4/9/26 after finding there had been no treatment orders for Resident #1. The DON said the ADON had attempted to call and get treatment orders and schedule a follow up appointment for Resident #1 with the Orthopedic Surgeon [TT8] on 3/31/26 and could provide documentation. Record review[TT9] of the All Conversations: Appointment document (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	dated 3/31/26 reflected the ADON had called and left a message on 3/31/26 at 12:24 pm with the Orthopedic Surgeon's clinic to schedule surgery follow-up. The document did not reflect a request for treatment orders. The document reflected the clinic attempted to return to the call to the ADON on 3/31/26 at 1:00 pm but received no answer or received a busy signal. Record review [TT10] of the All Conversations: Leg Swelling document dated 4/8/26 reflected the ADON had called and left a message on 4/8/26 at 10:20 a.m., with the Orthopedic Surgeon's clinic regarding Resident #1 leg swelling after surgery and ER advising to reach out to orthopedic surgeon. During an interview on 4/23/26 at 9:53 a.m., the ADON said she had not laid eyes on Resident #1 until 4/8/26. The ADON said she did call and leave a message to schedule her post- operative appointment but was not attempting to get any treatment orders as she was unaware there had been no orders obtained. The ADON said on 4/8/26 a family member was at the bedside and had pulled her into the room wanting to know what was being down for Resident #1's left leg incision (incision to the outer aspect of the left knee extending above and below the knee) because it looked like it was opening up. The ADON said she told the family member she was unfamiliar with what exactly was being done and she would get the nurse caring for her. The ADON said LVN A came into the room and told her she was about to notify the physician regarding Resident #1's leg because it started to look like it was opening up. The ADON said LVN A had also reported to her that Resident #1 had been sent to ER on [DATE] and was sent back to the facility. The ADON said she called the orthopedic surgeon's office again on 4/8/26 to notify the leg appeared to be opening up and Resident #1 was sent to the ER on [DATE] but discharged back to the facility. The ADON said they sent her out before receiving a return call. During[TT11] an interview on 4/22/26 at 2:41 p.m., Resident #1's family member reported she was now at home with a wound vacuum to the left leg (incision to the outer aspect of the left knee extending above and below the knee) and receiving wound care at home. An interview with LVN B was attempted via phone on 4/23/26 at 10:15 a.m. but was unsuccessful with no answer. An interview with LVN C was attempted via phone on 4/23/26 at 10:15 a.m. but was unsuccessful with no answer. [TT12] Record review of the facility policy and procedure titled Skin and Wound Monitoring and Management, revised April of 2025, stated .f. Skin and wound assessment on admission and readmission: A licensed nurse must assess/evaluate a resident's skin on admission. All areas of breakdown, excoriation, or discoloration, or other unusual findings, will be documented.A licensed nurse will assess/evaluate each pressure injury/and or non-pressure injury that exists on the resident. This assessment/evaluation should align with the scope of practice and include but not be limited to: 1) Measuring the skin injury; 2) Staging the skin injury (when the cause is pressure); 3) Describing the nature of the injury (e.g. pressure, stasis, surgical incision); 4) Describing the location of the skin alteration; 5) Describing the characteristics of the skin alteration.(g) Ongoing Skin and wound assessment.A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should align with the scope of practice and include but not be limited to: 1) Measuring the skin injury; 2) Staging the skin injury (when the cause is pressure); 3) Describing the nature of the injury (e.g. pressure, stasis, surgical incision); 4) Describing the location of the skin alteration; 5) Describing the characteristics of the skin alteration; 6) Describing the progress with healing, and any barriers to healing which may exist; 7) Identifying any possible complications or signs/symptoms consistent with the possibility of infection.5. Treatment.b. Re-evaluate existing treatment regimen in connection with the resident's clinical presentation, to include current interventions and care plan considerations, if any wound is non-healing or not showing signs of improvement after 14 days or any time the wound is worsening. 6. Monitoring a. Daily via medication administration and treatment administration records.