STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676406	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trucare Living Centers - Selma	16550 Retama Parkway Selma, TX 78154

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observations, interviews, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, which were complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for documentation. Resident #'1's electronic medical record did not contain complete and accurate documentation that CNA A recorded the resident's toileting activity numerous days in the month of March 2024. This failure could result in residents' records not accurately documenting interventions, monitoring, and information provided to nursing staff and the RP and could lead to the assumption that residents do not receive incontinent care and could develop skin issues and infections. The findings were: Record review of Resident #1's face sheet, dated 3/28/24, revealed the resident was readmitted on [DATE] with diagnoses that included dementia, CVA (stroke), and major depressive disorder. Resident was a female; age 65. RP was listed as a family member. Record review of Resident#1's quarterly MDS assessment dated [DATE], revealed: o BIMS Score was 12 (6-12 indicated a moderate impairment). o ADLs : bowel and bladder incontinent of both. Transfer was listed as dependent and bed mobility was listed dependent. ROM was documented as impairment to upper left arm (contracture). o Record review of Resident# 1's Care Plan, undated, revealed the goals and interventions for incontinent care included: Check resident every two hours and assist with toileting as needed. Record review of Resident #1's POC sheet for the month of March 2024 reflected no incontinent care documented on the following days and shifts [6 A-2P, 2P-10P, and 10P-6A]: 3/8/24-changed 3 times on the evening shift. No documentation for day or night shift. (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: 676406	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER: Trucare Living Centers - Selma		STREET ADDRESS, CITY, STATE, ZIP CODE: 16550 Retama Parkway Selma, TX 78154	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/20/24 2P-10P 3/21/24 2P-10P 3/23/24 10P-6A 3/14/24 2P-10P 3/25/24 2P-10P 3/26/24 2P-10P 3/27/24 6A-2P Record review of Resident #1's ADL sheet for the month of March 2024 revealed: incontinent care was not documented by CNA A on the following days: 3/2 (6A-2P), 3/12 (2P-10P), 3/17 (2P-10P), 3/18 (2P-10P), 3/20 (2P-10P), 3/21 (2P-10P), 3/24 (2P-10P), 3/25 (2P-10P), and 3/27 (6A-2P). Observation and interview on 3/28/23 at 2:15 PM, Resident #1 was in bed watching TV. There was no incontinent odor in the room. The resident was cleaned and groomed and alert and oriented to person, place, and time. There was a camera in the room and a W/C. The resident had a contracture to the left arm. There were no injuries, skin tears, or bruises present. The call light was within reach, room was cleaned, there were no fall hazards, and the room was homelike. The resident stated, .I am not wet or soiled .the staff changes me every two hours . Resident #1 stated that there was usually a delay in staff answering the call light to perform incontinent care. Observation and interview on 4/3/24 at 2:40 PM, Resident #1 was in bed watching TV. The resident stated that she was dry and had no issues with incontinent care on 4/3/24. During an interview on 4/4/24 at 9 AM, the Administrator stated that CNA B was terminated on 4/3/24 for failure to document the ADL sheet for March 2024 when providing incontinent care to Resident #1. During a telephone interview on 4/4/24 at 9:45 AM, CNA B stated, she provided incontinent care to Resident #1 and forgot to document it in the ADL sheet in March 2024 because she did not have a POC log in. CNA B stated that she mentioned to LVN A the log-in issue but did not follow up. CNA B stated that she was terminated for not showing up to work on time and not calling in to nurse management; and not documenting ADLs which could give the impression that Resident #1 did not receive incontinent care services. During an interview on 4/3/24 at 4:45 PM, LVN A stated, there was documentation missing for the date range 3/20/24 to 3/27/24 for Resident #1's toileting care. LVN A stated that best care practice was to check every 2 hours to see whether incontinent care was required. LVN A stated there was no requirement to change Resident #1's brief as long as it was dry. LVN A stated that there was no documentation in the POC sheet and on certain days and she could not provide an explanation. LVN A stated that the responsibility to check on incontinent care every shift was the responsibility of the charge nurse; and not checking could lead to a false allegation that incontinent care was not done for Resident #1. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/03/24 at 4:50 PM, the Corporate RN stated, documentation was lacking as evidenced by blanks in the ADL sheet for March 2024 for Resident# 1. The Corporate Nurse stated the responsibility to check on documentation lied with the charge nurses and the DON. The Corporate RN stated the X marked on the ADL sheet meant the event did not occur and it was not known whether the resident refused incontinent care, or the resident was dry; and lack of documentation could lead to a false allegation that Resident #1 was not changed During a telephone interview on 4/4/24 at 10:00 AM, the Medical Director stated, Resident #1 was resistant to care and at times would refuse incontinent care which could lead to a UTI. The Medical Director stated that he had no information that the resident was ever denied incontinent care or left in a soiled brief. During a telephone interview on 4/4/24 at 10:24 AM, CNA C stated: she provided incontinent care to Resident #1 and the resident triggered her call light every 10 minutes wanting to be changed. CNA C stated the resident sometimes purposely soils the cleaned brief after being changed so as to be changed again CNA C stated the resident has never been left in a soiled brief or denied water. CNA C stated there had been no skin breakdown and the resident sometimes refused barrier cream. CNA C stated she documented episodes of incontinent care or refusal in the ADL POC sheet. CNA C stated not documenting could lead to a false allegation that Resident #1 was not receiving incontinent care. Record review of facility's in-service conducted by LVN A on the topic of POC documentation revealed (4/1-4/2/24) 16 CNAs signed the attendance sheet. Record review of facility's in-service conducted by LVN A on the topic of POC documentation given to the nursing staff other than CNAs revealed: 6 LVNs signatures (4/1-4/2/24) signed the attendance sheet. Record review of facility's Charting and Documentation policy dated 3-1-2022 read: All services provided to the resident .shall be documented in the resident's medical record .