

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/08/2025
NAME OF PROVIDER OR SUPPLIER  Allegiant Wellness and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  724 W. Rendon Crowley Road Crowley, TX 76036	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews and record review, the facility failed to develop a comprehensive person-centered care plan for 1 of 5 residents (Resident #1) reviewed for comprehensive care plans. Resident #1's care plan did not address the resident's wound care needs provided by the facility with goals and interventions. This deficient practice could result in a loss of quality of life due to residents receiving improper care. Findings included: Review of Resident #1's face sheet, dated 7/8/2025, revealed the resident was a [AGE] year-old admitted on [DATE] with diagnoses of dehiscence of surgical wound (opening of wound), injury of right knee tendon, and anemia. Review of Resident #1's hospital record, dated 6/13/2025, revealed Resident #1 was admitted for evaluation of an open wound from knee surgery performed on 5/18/2025. Observation of Resident #1 on 7/8/2025 at 9:10am, revealed Resident #1 had a surgical wound on right knee, covered with dressing and the wound was being suctioned using a wound vacuum (a machine used to suction wound fluid). Review of Resident #1's physician order [surgical center name], dated 6/24/2025, revealed there was an order for Negative Pressure Wound Therapy (NPWT) three times per week, with care instructions provided in the order. Review of Resident #1's comprehensive care plan, dated 7/8/2025, reflected no care plan for the wound was developed. Interview with the treatment nurse on 7/8/2025 at 3:45pm revealed that the treatment nurse was responsible to develop a wound care plan for residents with wounds. She confirmed that there was no care plan developed for Resident #1's knee wound. She stated that the risk of not having care plans updated was the resident could receive improper care or lack of care quality. Interview with the DON on 7/8/2025 at 4:00pm revealed that the interdisciplinary team met weekly to develop and/or update residents' care plans. She stated that wound care should be included in the care plan. She stated that she was not aware Resident #1's care plan did not include wound care. Review of facility's Care plans, Comprehensive Person-centered policy, dated 12/2016, revealed that the interdisciplinary team must review and update the care plan when there has been a significant change in the resident's condition. The policy also stated that assessments of residents are ongoing and care plans are revised as information about the resident's condition change. The comprehensive care plan will describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p>

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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