STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676048	A. Building B. Wing	11/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center G	1201 Fm 2685 Gladewater, TX 75647

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interviews, and record review, the facility failed to ensure 1 of 20 residents reviewed received reasonable accommodation of needs. (Resident #60) The facility failed to ensure Resident #60 had a functioning call light. This failure could place residents at risk of injury that could lead to possible falls, major injuries, hospitalization , and unmet needs. Findings include: Record review of an undated face sheet indicated Resident #60 was an [AGE] year-old female admitted on [DATE] with diagnoses of muscle weakness, high blood pressure, dementia (memory loss), and had a history of falling. Record review of the most recent quarterly MDS dated [DATE] indicated Resident #60 was understood and understood others. The MDS revealed Resident #60's BIMs (Brief Interview for Mental Status) score was an 11 indicating moderate impaired cognition. The MDS indicated Resident #60 required supervision with bed mobility, transfers, walking, dressing, eating, toileting, personal hygiene, and bathing. The MDS revealed Resident #60 had no falls since admission/entry, reentry, or prior assessment. Record review of an undated care plan revealed Resident #60 was at risk for falls related to history of falling, psychotropic and cardiac medication use, and weakness. The interventions included to ensure the call light was within reach and encourage her to use it to call for assistance as needed. During an observation and interview on 11/06/22 at 9:28 a.m., Resident #60 indicated her call light had not been working since Thursday, 11/03/22. Resident #60 indicated the Maintenance Supervisor was aware and had ordered the parts to get it fixed. During an observation and interview on 11/07/22 at 08:05 a.m., call light was pushed and it did not work. Resident #60 indicated she did not have any other means to call for assistance if needed. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/22 at 08:28 a.m., RN B indicated he had notified the Maintenance Supervisor on Thursday, 11/03/22, as soon as he noticed Resident #60's call light was not working. He indicated he assumed the call light was fixed and was unaware it was not functioning. RN B indicated the risks for Resident #60 not having a functioning call light were that Resident #60 could fall, become dizzy or need medical attention and not have the means to ask for help. During an interview on 11/07/22 at 8:30 a.m., CNA C indicated she was unaware of Resident #60's call light not working. During an interview on 11/07/22 at 8:39 a.m., the Maintenance Supervisor indicated he was aware that Resident #60's call light did not work and had ordered the part that morning. He indicated there was nothing in place for Resident #60 that she could use if she was to need help and was unsure of the risks of not having a functioning call light. During an interview on 11/07/22 at 08:44 a.m., the DON indicated she was not aware of Resident #60's call light not functioning, so no interventions had been put in place. She indicated this placed Resident #60 at risk for falling, becoming injured and not be able to notify anyone. During an interview on 11/07/22 at 8:45 a.m., the Administrator indicated he was unaware of Resident #60 call light not working. He not having a functioning call light could place Resident #60 at risk for not being able to call for help if needed. During an interview on 11/08/22 at 1:40 p.m., the ADON indicated she expected when a call light was malfunctioning for it to be reported to the charge nurse. The charge nurse would then place a call to the Maintenance Supervisor and place a work order in the electronic system to alert maintenance. The ADON indicated they could have provided Resident #60 with something that would make noise, for example a bell, or move her to another room with a functioning call light. The ADON indicated Resident #60 could be at risk of not being able to call for assistance. Record review of the facility's policy and procedure titled Call Light/Bell revised on 5/2007 indicated . to provide the resident a means of communication with nursing staff . if the call light/bell is defective, immediately report this information to the unit supervisor .

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review the facility failed to ensure that residents with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 5 residents reviewed for pressure ulcers. (Resident #52) *The facility failed to prevent the sacral wound from deterioration from a Stage 2 to a Stage 4 (over a 7-day period) of time. *The facility failed to notify the physician of the wound decline between the visits on 10/04/22 and 10/11/22. *The facility failed to obtain #52's recommended lab orders (WBC, ESR, and CRP) from the wound care consultant on 11/01/22. *The facility failed to ensure Resident #52's low air loss mattress was functioning for 5 hours and 47 minutes on 11/06/22 from 9:15 a.m. to 3:02 p.m. *The facility failed to provide treatment for Resident #52's sacral wound for 4 days after admission starting on 08/30/22. *The facility failed to provide #52's wound care consultant evaluation for the sacral wound, indicated on 08/26/22 admission assessment until 9/27/22. An Immediate Jeopardy (IJ) situation was identified on 11/07/22 at 4:40 p.m. While the IJ was removed on 11/08/22, the facility remained out of compliance at the severity of actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed residents with skin breakdown at risk of pain, worsening of wounds, wound infection, emotional distress, harm, or even death. Findings included: Record review of Resident #52's face sheet with a printed date of 11/07/22, indicated she was a [AGE] year-old-female, admitted on [DATE] and readmitted on [DATE] with the diagnoses of diabetes, difficulty swallowing, protein-calorie malnutrition, and anxiety. Resident #52's hospital assessment indicated she admitted to the local hospital on 9/11/22. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an Initial Admission Record dated 08/26/22 indicated Resident #52 was admitted with a weight of 225.4 pounds and was 65 inches tall. The assessment indicated Resident #52's skin was normal, pale, not flushed or blueish colored, warm and not cold. The admission assessment indicated Resident #52 had a 1/2 inch stage 2 ulcer on her left buttock. The additional documentation indicated Resident #52 had non-blanchable open area to the sacrum that was to be evaluated by the wound consultant. The admission record indicated Resident #52 was not provided an alternating air mattress, or a pressure re-distributing overlay mattress. Record review of an Admission MDS dated [DATE] indicated Resident #52 was admitted from an acute hospital, was rarely understood, and rarely understands. The MDS indicated Resident #52's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident #52 did not reject care. The MDS indicated Resident #52 required extensive assistance with two staff for bed mobility, dressing and toilet use. She required limited assistance of two staff with transfers. Resident #52 required extensive assistance with eating and personal hygiene and total assistance of two staff for bathing. The MDS indicated Resident #52 was always incontinent of bowel and bladder. The MDS indicate Resident #52 was 65 inches tall and her weight was 225 pounds. The MDS indicated she had no weight loss of the last month. Section M of the MDS indicated Resident #52 had a pressure ulcer, a formal assessment tool, and a clinical assessment. The MDS indicated Resident #52 was at risk for pressure ulcers. The MDS indicated she had one or more unhealed pressure ulcers. The MDS indicated Resident #52 had a Stage 2 pressure ulcer (some of the outer surface of the skin or the deeper layer was damaged). The MDS indicated Resident #52 did not have any other pressure injuries. Record review of a medication administration record dated September 2022 indicated an order for the application of collagen powder to a pressure wound on sacrum and cover with a dry dressing daily starting on 08/30/22 ending on 09/06/2022. Record review of the September 2022 medication administration record indicated Resident #52 had an order for the application of barrier cream to bilateral buttocks daily and as needed for MASD (moisture associated skin damage) starting 09/14/22. The medication administration record indicated the first application occurred on 09/14/22 Record review of a Braden Scale for Predicting Pressure Sore Risk dated 08/30/22 indicated Resident #52's score was a 7 indicating very high risk to develop a pressure sore. Record review of a Braden Scale for Predicting Pressure Sore Risk dated 09/06/22 indicated Resident #52's score was a 9 indicating she was at a very high risk to develop a pressure sore. Record review of a hospital History and Physical dated 09/11/22 indicated Resident #52 was admitted and assessed by the physician on 09/11/22 and noted to have a sacral pressure ulcer, and excoriations (removal of skin) in the perineum (area between anus and vulva) and thigh suggestive of incontinence associated dermatitis (diaper rash like). The History and Physical indicated a wound consult recommendation. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an Initial Admission assessment dated [DATE] indicated Resident #52 was readmitted after a hospital stay for cystitis (bladder infection). Resident #52 was 65 inches tall, and her weight was 220.8 pounds. The admission assessment indicated Resident #52 did not have a pressure re-distributing mattress but had an alternating air mattress. The general skin condition of Resident #52 was indicated to be normal and warm. The skin integrity indicated she had moisture associated skin damage on her buttocks but no pressure ulcers. Record review of the EMR (electronic medical record) dated October 2022 indicated Resident #52 was ordered a low air loss mattress initiated on 09/26/22. Record review of a skin evaluation dated 09/27/22 indicated Resident #52 had MASD (moisture associated skin damage) to her buttocks completed by the treatment nurse . The note did not reflect a pressure injury. Record review of an Initial Wound Evaluation and Management Summary (documented by the wound care consulting physician) dated 9/27/22 indicated Resident #52 had a Stage 2 pressure ulcer to the sacrum for at least 1 day duration. The note indicated there was moderate serous exudate (thin watery drainage). The note indicated the wound to Resident #52's sacral region measured 7 cm x 8 cm x 0.1 cm with moderate exudate. The treatment plan included to apply calcium alginate once daily for 30 days and collagen powder once daily for 30 days and cover with a gauze sponge once daily. The note indicated a recommendation for a Prealbumin (protein monitoring) and a hemoglobin AIC (blood sugar monitoring). Record review of a facility wound care report dated October 2022 indicated Resident #52 had a pressure ulcer to her sacrum (a shield shaped bony structure located at the base of the lumbar vertebrae and that was connected to the pelvis). The facility wound report indicated Resident #52's pressure wound was obtained in-house on 9/27/22. The wound stage was classified as unstageable due to slough and eschar. Resident #52 was high risk due to the results of the last Braden score completed on 09/12/22. The wound care report indicated in the month of October 2022 Resident #52's sacral wound reflected the following: Week #1 measured 6 cm x7.0 cm 0.1 cm; Week #2 measuring 6 cm x 5 cm x 1 cm; Week #3 measuring 6 cm x 9 cm x 1.4 cm; Week #4 measuring 10 cm x 12 cm x 2 cm; and week #5 measuring 10 cm x 12 cm x 5 cm. Record review of a Wound Evaluation and Management Summary dated 10/04/22 indicated Resident #52 had a stage 2 pressure ulcer to her sacrum for at least 7 days. The note indicated the wound had moderate serous exudate. The wound measurements were 6 cm x 7 cm x 0.1 cm with moderate exudate and 10% skin. The treatment plan included collagen powder application once daily, calcium alginate application once daily cover with gauze sponge once daily. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a Wound Evaluation and Management Summary dated 10/11/22 indicated Resident #52 now had an unstageable wound due to necrosis (dead) tissue to her sacrum. The note indicated there was moderate serous exudate and was now a full thickness wound (tissue loss of the epidermis and dermis). The note indicated Resident #52's wound measured 6 cm x 9.5 cm x 1 cm. The note indicated the wound had 40% slough, 50% granulation tissue, and 10% skin with the deteriorated wound status. The wound was surgically debrided (removal of dead tissue with a blade) devitalized tissue including slough, biofilm, and non-viable tissue at a depth of 1 cm. The treatment for Resident #52's wound was calcium alginate twice daily with a gauze sponge twice daily. Record review of the progress notes from 10/04/22 through 10/11/22 did not reflect a decline in Resident #52's sacral wound from a Stage 2 to a Stage 4 during this time nor any documentation of the notification of her physician or responsible party. Record review of laboratory results dated [DATE] indicated WBC (white blood cells measuring infection) resulted at 15.7 with the normal range of 4.0-9.6, ESR Erythrocyte sedimentation rate of 90 indicated a high level of inflammation. The normal ESR range was 0-20. Record review of a wound culture dated 10/13/22 and resulted on 10/15/22 indicated Resident #52's sacral wound had a moderate gram-positive coccus. The wound had many groups A streptococcus isolated (infections range from minor to illness to very serious and deadly diseases) and moderate proteus mirabilis (can cause serious infections in humans). Record review of a physician's order dated 10/18/22 indicated Resident #52 was ordered Amoxicillin 500 milligrams by mouth three times daily for 10 days. (Although Resident #52's wound culture was resulted on 10/15/22 the order for the antibiotic therapy was not provided or initiated until 10/18/22 when Resident #52 received two doses). Record review of a Wound Evaluation and Management Summary dated 10/18/22 indicated Resident #52 continued to have an unstageable sacral wound with moderate serous exudate. The note indicated the wound measured 6 cm x 9 cm x 1/4 cm with 30% being slough, 60 % granulation tissue, and 10% skin. The treatment plan was calcium alginate twice daily and a gauze sponge twice daily. The wound was again debrided using a surgical blade. The physician surgically excised devitalized tissue including slough, biofilm, and non-viable subcutaneous level tissues at a depth of 1/4 cm. Record review of a Wound Evaluation and Management Summary dated 10/25/22 indicated Resident #52 had a Stage 4 pressure wound (wound extending to the ligaments, muscle, and bone) with moderate serous exudate. The wound measurements were 10 cm x 12 cm x 2 cm with undermining at 4 cm. The treatment plan was sodium hypochlorite solution and calcium alginate with a second dressing. Record review of a nurse practitioner no te dated 10/31/22 at 9:00 a.m., indicated Resident #52 was currently being treated for a sacral pressure ulcer stage 4 (the most severe form of a bedsore, a deep wound reaching the muscles, ligaments, or bones. Often cause extreme pain infection, invasive surgeries, or even death). The note indicated she was non-distressed in appearance. The note indicated the NP was increasing her pain medication to Tramadol 100 milligrams by mouth every 6 hours routinely. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a Wound Evaluation and Management Summary dated 11/01/22 indicated Resident #52 had a Stage 4 pressure ulcer to the sacrum. The wound had moderate serous exudate. The wound measurement was 10 cm x 12 cm x 5 cm with undermining of 4 cm at 3 o'clock. The wound had 20% slough and 60% granulation tissue and 20% muscle tissue with the wound deteriorated since last visit. Again, the wound was debrided using a surgical blade. The excision of 24.0 cm^2 squared of devitalized tissue including slough, biofilm and non-viable muscle level tissues were removed at a depth of 5 cm. The physician recommended a CRP (measuring protein in the blood), WBC (lab for white blood cells indicating infection), ESR (lab level of measuring inflammation) and a culture of the sacral wound. Record review of the Resident #52's laboratory results did not indicate laboratory results for the CRP, WBC, and ESR recommended by the wound care physician on 11/01/22. During an interview on 11/07/22 at 12:38 p.m., the DON indicated Resident #52's labs ordered on 11/01/22 was not completed because they were only suggested. The DON indicated she was unsure why the wound culture was obtained and not the laboratory levels. During an interview on 11/07/22 at 1:20 p.m., the wound care consulting physician indicated Resident #52's wound care started with a Stage 2 sacral wound on 9/27/22 which had declined now to a large Stage 4 sacral wound. The physician indicated he had made the recommendation for labs to determine if Resident #52 had osteomyelitis (bone infection). The physician indicated he had not seen bone in the wound and therefore required the labs to help determine if Resident #52 required intravenous antibiotic therapy instead of antibiotics through the gastrostomy tube. During an observation on 11/06/22 at 9:15 a.m., Resident #52's low air loss mattress cord was not plugged in to the electrical outlet. The mattress cord was lying on the floor underneath her bed. The lights on the monitoring box were not on. During an observation on 11/06/2022 at 3:02 p.m., Resident #52's low air loss mattress cord was not plugged in to the electrical outlet. The mattress cord was lying on the floor underneath her bed. The lights on the monitoring box were not on. During an observation on 11/07/22 at 7:50 a.m., Resident #52's low air loss mattress was now plugged into the electrical outlet and the lights were on the monitor box. Resident #52 was facing the right side toward the wall. Resident #52 had a scabbed area to her left [NAME] (ear). Record review of a comprehensive care plan indicated Resident #52 had a pressure ulcer to sacral area initiated on 10/14/22 with a revision on 11/07/2022 there was no goal for the pressure wound. The interventions included pressure relieving devices per orders, wound consultant visits, and weekly had to toe skin at risk assessments. A potential for pressure ulcer development care plan indicated the goal was to have intact skin, free of redness, blisters, or discoloration with the interventions of administer treatments as ordered and monitor the effectiveness, notify the nurse immediately of any new areas of skin breakdown such as redness, blisters, bruises, discoloration noted during bathing or daily care, obtain and monitor lab and diagnostic work reporting results to the medical director, and weekly head to toe skin at risk assessments. Record review of a wound culture dated 11/04/22 and resulted on 11/06/22 indicated Resident #52 continued to have a sacral wound infection with proteus mirabilis and moderate group A streptococcus. The physician ordered to complete the oral antibiotic Augmentin. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of a November 2022 medication administration record indicated Resident #52 was ordered Augmentin 600-125 milligrams one tablet every 12 hours for 7 days starting on 11/5/22 until 11/11/22. Record review of Resident #52's clinical record indicated the CRP, WBC, ESR, was not obtained until after surveyor intervention on 11/07/22. The WBC, CRP, ESR, and a wound culture were recommended on the 11/01/22 wound consultant report. The records indicated the wound care consultant physician obtained Resident #52's wound culture was obtained during the wound care. The WBC count was 10.3 with the normal level of 4.0 - 9.6. The CRP result was high at 25.9 indicating inflammation the normal range was 0.1 - 0.8. The ESR result was high indicating inflammation at a result of 109 with the normal range of 0-20. Record review of a medication administration record dated November 2022 indicated Resident #52 was administered Piperacillin Sod-Tazobactam solution 3-0.375 grams intravenously three times daily for wound infection for three weeks. Resident #52 received her first dose on 11/08/22 at 4:00 a.m. Record review of Resident #52's consolidated physician's orders dated 11/07/22 indicated Resident #52 had an ordered to cleanse the sacrum wound with wound cleanser, dry with gauze, pack with Dakin's-soaked gauze, cover with calcium alginate and dry dressing twice daily and as needed for a pressure wound initiated on 10/13/2022. Augmentin tablet 500-125mg administer 1 tablet via the gastrostomy every 12 hours for wound infection initiated on 11/05/22 with an end date of 11/12/22 for a wound infection. Dakin's (1/4 strength) Solution 0.125% (Sodium hypochlorite) apply to sacrum topically every shift for pressure wound. Record review of a care plan dated 11/07/22 indicated Resident #52 was on intravenous antibiotics for osteomyelitis and the goal was not to have any complications. The interventions included to monitor and document any symptoms of infection such as drainage, inflammation, swelling, redness, or warmth. Provide PICC line care every 7 days and flush the PICC line prior to the medication administration was the other interventions for Resident #52. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 11/07/22 at 9:16 a.m. to 9:49 a.m., the treatment nurse performed wound care for Resident #52's Stage 4 sacral wound. The treatment nurse removed the top dressing and revealed a large and deep sacral wound with necrotic (dead) tissue at the noon to 3'oclock portion of the wound. The dressing was saturated in a copious amount of serosanguineous (blood-tinged drainage), and the wound was odorous. The treatment nurse indicated he was assisted by the staffing coordinator because she had a stronger stomach and could handle the odor. During the wound care Resident #52 began grimacing, groaning, and moving her face to the right imbedding her face in her pillow. Resident #52 was encouraged by the staffing coordinator to squeeze her hand. The staffing coordinator indicated Resident #52 was displaying pain. The staffing coordinator indicated Resident #52 displayed this behavior each time during the actual wound care procedure. The treatment nurse indicated Resident #52 was medicated earlier this morning. The treatment nurse indicated he had even mentioned to the family about hospice care to have more effective pain management. During the wound care neither the treatment nurse nor the staffing coordinator stopped the wound care process to ensure adequate pain relief was achieved prior to finishing the treatment. Resident #52 made a grimacing face as the treatment nurse initiated the cleaning of the wound. The staffing coordinator indicated the cleaning must hurt by the face Resident #52 was making. The treatment nurse stated he was unsure if the moaning was pain or how Resident #52 was positioned. During the repositioning of Resident #52 the surveyor noticed two skin concerns. The treatment nurse indicated he was unaware of these two areas. Resident #52 had a 2.5 cm x 0.5 cm x 0.1 cm stage 2 pressure injury, and a 0.5 cm x 0.5 cm fluid filled blister to the right heel. The treatment nurse indicated Resident #52 should have had some heel protection boots on. During an interview after the wound care the treatment nurse indicated Resident #52's grunting, moaning, and grimacing was demonstration of pain. The treatment nurse indicated he should have stopped the procedure and obtained pain medication. The treatment nurse indicated he did not stop the wound care, assess Resident #52 because he was in a hurry to finish. The treatment nurse indicated even though Resident #52's wound looked bad it was actually better in his opinion. The treatment nurse indicated the antibiotic therapy and the Daiken's wound solution was helping the odor. During a telephone interview on 11/07/22 at 6:32 p.m., the MD indicated he was aware Resident #52 had a Stage 4 pressure injury but had not seen the wound himself. The MD indicated he was not made aware the wound declined in a 7-day period from a Stage 2 to a Stage 4. The MD indicated he had not been made aware Resident #52 had two new wounds today nor had he been informed Resident #52 had increased pain with her wound care. The MD indicated he expected the wound care nurse to stop the wound care when any resident demonstrated pain. The MD indicated a low air mattress being unplugged was not ideal for wound healing. The MD indicated he allowed the wound care physician to make recommendations for the wound needs. During an interview on 11/07/22 at 1:51 p.m., CNA F indicated she was the CNA providing care to Resident #52. CNA F indicated she had not noticed Resident #53's two new wounds on her right heel. During an interview on 11/07/22 at 4:16 p.m., the DON indicated Resident #52 was admitted on a Friday evening. The DON indicated the treatment nurse did not work the weekend and was not made aware of the wound care referral therefore Resident #52 was not seen by the wound care physician, and the DON indicated Resident #52's wound was not open on 08/26/22 therefore the wound care consulting physician wound not have seen Resident #52's wound. The DON indicated Resident #52's wound declined from a Stage 2 to a Stage 4 only after the wound care consultant physician debrided the wound. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 11/08/22 at 6:06 p.m., the wound consultant physician was questioned about the debridement of a stage 2 pressure wound. The wound consultant physician stated he would never debride a Stage 2 wound to any resident. He stated he would debride a Stage 3, Stage 4, or an unstageable pressure ulcer. The wound care physician indicated he had never debrided a Stage 2 wound on Resident #52. Record Review of a Wound Evaluation and Management Summary dated 11/08/22 indicated Resident #52 had a stage 4 pressure wound to the sacrum. There was a light serous drainage. The wound measured 11 cm x 14 cm x 5 cm with undermining at 3 o'clock measuring 4 cm. The wound was 20 % slough, 60% granulation tissue, and 20% muscle with the wound deteriorated. The note included additional wound details of now the wound has osteomyelitis (inflammation of the bone caused by an infection). The physician recommended to start Zosyn (antibiotic) for 4 weeks for a maximum of 8 weeks if indicated. The wound dressing continues to be sodium hypochlorite solution apply twice daily and with a gauze sponge dressing twice daily. The note indicated Resident #52's wound was debrided using a surgical blade excising 30.8 cm^2 squared of devitalized tissue including slough, biofilm, and non-viable muscle tissue was removed at a depth of 5 cm. Record review of a chest x-ray dated 11/08/22 for a PICC (peripherally inserted central catheter) line placement verification. Resident #52 received a PICC Line for the administration of intravenous antibiotic therapy. Record review of a Skin and Wound Monitoring and Management policy and procedure dated 03/2015 and revised date of 01/2022 indicated It was the policy of this facility that 1. A resident who enters the facility without a pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable; and 2. A resident having pressure injury (s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. The purpose of this policy was that the facility provides care and services to 1. Promote interventions that prevent pressure injury development; 2. Promote the healing of pressure injuries that are present (including prevention of infection to the extent possible); and 3. Prevent the development of additional, avoidable pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are no visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage. Stage 4 pressure injury: full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an unstageable pressure injury. 7. Communication of Changes a. any changes in the condition of the resident's skin as identified daily, weekly, monthly or otherwise, must be communicated to the resident/responsible party, resident physician, and others as necessary to facilitate healing. The Administrator and DON were notified 11/07/22 at 5:02 p.m. that an Immediate Jeopardy (IJ) was identified due to the above failures. The IJ template was provided on 11/07/22 at 5:05 p.m. The following Plan of Removal submitted by the facility was accepted on 11/08/22 at 8:34 p.m. and included the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676048	A. Building B. Wing	11/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center G	1201 Fm 2685 Gladewater, TX 75647

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediate action: The Medical Director was notified of IJ on 11/7/22 at 5:45pm. Review of all pressure ulcer treatments orders was initiated and will be completed 11/08/22 by the DON. Review/Identification/Interventions will be completed to assure all residents at high risk for pressures ulcers (as determined via Braden scale) will be completed by DON/ADON by 11/07/22. Review of all residents with current pressure ulcers to assure appropriate treatment in place. Education initiated with Nurses and CNAs that included change in condition procedures for wounds, change in behaviors, refusal of care, notification of changes in condition, wound identification, and documentation. This education will be included in the new hire orientation and to including agency staff. Identification of Others Affected Currently there are 67 residents residing in the facility. The facility initiated a skin sweep on 11/07/22 of all residents and will complete 11/08/22. Systemic Change to Prevent Re-occurrence DON started in-service on 11/07/22 with facility charge nurses and CNAs on documentation and monitoring skin integrity system along with skin assessments. The training includes use of shower sheets by the CNAs as well as the Stop and Watch Program, reporting new areas to nurses, nurse documentation / treatment / notification of new areas, new admission assessments to occur once a week for four weeks, quarterly, and with any change of condition. In-services included: documenting skin assessments, timely follow up and notification to RP, DON and MD, wound treatments and reporting until all applicable personnel complete education. In-services will be completed prior to accepting assignments for all charge nurses, nursing assistants, including agency, new hires, and PRN staff. This education will be included in the new hire orientation to include agency - will be completed by 11/08/22. Nurses will complete education for skin assessment prior to the start of their next shift. CNAs will also receive education on shower sheets and Stop and Watch program prior to the start of their shift will be completed by 11/08/22. Shower sheets to be completed by CNA and any new areas to be communicated to Charge Nurse. Skin assessments to be completed by Treatment Nurse, document and communicate any new skin changes to physician, responsible party, and place on 24 hr. report for DON notification. Monitoring: Interviews on 11/08/22 from 12:58 p.m. until 3:18 p.m. the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews with 8 CNAs indicated they had received a written in-service regarding monitoring low air loss mattresses for functioning properly, reporting of all new alterations in skin integrity to the licensed nurse immediately upon discover. Utilization of the shower sheets to document and identify all skin alterations found on a resident while providing care. Interviews with 6 LVNs indicated to monitor a low air loss mattress every shift to determine whether functioning properly. Reporting of skin alterations to the physician, DON, and responsible party. A treatment for alteration must be received and documented when reporting to the physician. The use of shower sheets for monitoring new skin issues. Interviews with 5 RNs indicated to monitor a low air loss mattress every shift to determine whether functioning properly. Reporting of skin alterations to the physician, DON, and responsible party. A treatment for alteration must be received and documented when reporting to the physician. The use of shower sheets for monitoring new skin issues. During an interview on 11/08/22 at 12:58 p.m., the DON indicated she reviewed all pressure ulcer treatments and did not change any treatments. She said a full skin sweep was completed and all identified skin alteration had a treatment in place even if it was a healing scratch. She in-serviced all staff on change of condition on wounds, change in behaviors, refusal of care, notification of changes, wound identification, and documentation. The DON indicated she in-serviced night shift last night and day shift today and including PRN (as needed) nurses. The DON indicated she in-serviced regarding skin integrity, shower sheets with every shower for CNA's, stop and watch for CNA's (doc anything new or new to that CNA), new admission assessment weekly for 4 weeks, doc skin assessment, timely follow up, notifying the responsible party, MD, and the DON. The in-services included reporting all new treatments to the DON, ADON, and treatment nurse. The DON indicated all staff not having the in-services would be in-serviced prior to accepting assignments. Record review of a written in-service dated 11/07/22 indicated the policy of the facility was if a resident has a low air loss mattress it must be assessed every shift to determine if it is function properly. When in a resident's room and notice a mattress unplugged, first plug it back in and you must report to the nurse. Record review of a written in-service dated 11/07/22 indicated unlicensed staff were required to report all new alterations in skin integrity which includes bruises, skin tears, abrasions, scratches, discolored areas, etc. to licensed nurse immediately upon discovery. Licensed staff were required to report alterations of skin integrity to the physician, DON, and the resident's responsible party. A treatment for the alteration must be received and documented at the time of the reporting to the physician. The treatment ordered must be reported to the responsible party and notification must be documented. Record review of a written in-service dated 11/07/22 indicated the unlicensed staff would utilize shower sheets to document and identify all skin alterations found on a resident at any point while providing care. The shower sheet must be turned into the treatment nurse at the end of the shift, with signatures of the nurse indicating understanding of alterations and copy of new order received from the physician. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator and DON were informed the Immediate Jeopardy was removed on 11/08/22 at 8:34 a.m. The facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review the facility failed to ensure respiratory care was provided with professional standards of practice for 1 of 20 residents reviewed for respiratory care and services. (Resident #33) The facility failed to administer oxygen at 2 liters via nasal cannula as prescribed by the physician for Resident #33. This failure could place residents who receive respiratory care at risk for developing respiratory complications. Findings included: 1. A record review of an undated face sheet indicated Resident #33 was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses of acute and chronic respiratory failure (not enough oxygen in blood), congestive heart failure (heart is unable to pump enough force to push enough blood into circulation), stroke, and diabetes (chronic condition that affects the way the body processes blood sugar). Record review of the most recent quarterly MDS dated [DATE] indicated Resident #33 was understood and understood others. The MDS revealed Resident # 33's BIMs (Brief Interview for Mental Status) score was a 15 indicating cognition intact. The MDS indicated Resident #33 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. Resident #33 was totally dependent on transfers and bathing. The MDS revealed under Section O (special treatments, procedures, and program), oxygen therapy had been checked. Record review of the order summary report dated 11/08/22, revealed an order for oxygen at 2 liters per minute continuously per nasal cannula for the diagnosis of acute and chronic respiratory failure. Record review of an undated care plan indicated Resident #33 required oxygen via nasal cannula with interventions to administer oxygen as ordered. During an observation on 11/06/22 at 08:45 a.m., Resident #33's oxygen was set at 3 liters per minute via nasal cannula. During an observation on 11/06/22 at 03:06 p.m., Resident #33's oxygen was set at 3 liters per minute via nasal cannula. During an observation on 11/07/22 at 07:59 a.m., Resident #33's oxygen was set at 3 liters per minute via nasal cannula. During an observation on 11/07/22 at 09:44 a.m., Resident #33's oxygen was set at 3 liters per minute via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/07/22 at 12:59 p.m., Resident #33's oxygen was set at 3 liters per minute via nasal cannula. Record review of the medication administration record for November 2022, indicated nurses had signed off the oxygen was set at 2 liters per min via nasal cannula on 11/6/22, on day and night shift, and 11/7/22, on day shift. During an interview on 11/09/22 at 1:15 p.m., RN D indicated oxygen was to be set per physician orders. RN D indicated the charge nurse was responsible for checking oxygen daily and checked off on the medication administration record. RN D indicated oxygen set at 3 and not at 2 liters per min as prescribed indicated not following physicians' orders. RN D indicated by not setting the oxygen at the prescribed rate could cause residents to become short of breath if not receiving the adequate amount or cause harm if they receive too much oxygen. During an interview on 11/08/22 at 1:40 p.m., the ADON indicated she expected oxygen to be set at the ordered flow rate. The ADON indicated the nurse on the floor caring for the resident was responsible for ensuring the oxygen was set at the correct flow rate. The ADON indicated by not setting the oxygen at the prescribed rate could cause residents to receive too much or too little oxygen. During an interview on 11/08/22 at 4:15 p.m., the DON indicated she expected the nurses to follow the orders as prescribed by the physician. The DON indicated Resident #33 could be at risk for retaining carbon dioxide, which could lead to respiratory issues. During an interview on 11/08/22 at 04:46 p.m., the Administrator indicated he expected the nurses to follow the physicians' orders due to being part of the residents' care. He indicated he was unsure of the risks but believed the residents' breathing could be affected. The Administrator indicated he expected the DON or ADON to follow up and ensure the nurses were following physician's orders. Record review of the facility's policy and procedure titled Oxygen Administration (Mask, Cannula, Catheter) revised on 05/2007 indicated .oxygen therapy is administered, as ordered by the physician.

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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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review the facility failed to ensure pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 20 residents reviewed for pain management. (Resident #52) The facility failed to ensure Resident #52 had effective pain management by evaluating Resident #52's by prior to wound care, during wound care, and post wound care. The facility failed to acknowledge or provide any pain relief medications for Resident #52's pain when she was grimacing and groaning during wound care. The facility failed to notify the physician of Resident #52's pain with wound care. These failures could place residents who received wound care, who had chronic pain conditions, who received as needed pain medication, or who received routine pain medications at risk for not having had their pain addressed causing undo suffering. An Immediate Jeopardy (IJ) situation was identified on 11/07/22 at 4:40 p.m. While the IJ was removed on 11/08/22, the facility remained out of compliance at the severity of actual harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. Findings included: Record review of Resident #52's face sheet with a printed date of 11/07/22, indicated she was a [AGE] year-old-female, admitted on [DATE] and readmitted on [DATE] with the diagnoses of diabetes, difficulty swallowing, protein-calorie malnutrition, and anxiety. Record review of an Initial Admission Record dated 08/26/22 indicated Resident #52 was admitted with a weight of 225.4 pounds and was 65 inches tall. The admission record indicated Resident #52 was not provided an alternating air mattress, or a pressure re-distributing overlay mattress. The assessment indicated Resident #52's skin was normal, pale, not flushed or blueish colored, warm and not cold. The admission assessment indicated Resident #52 had a 1/2 inch stage 2 ulcer on her left buttock. The additional documentation indicated Resident #52 had non-blanchable open area to the sacrum that was to be evaluated by the wound consultant. The assessment indicated Resident #52 smiles occasionally and was very quiet, indicating Resident #52's baseline. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an Admission MDS dated [DATE] indicated Resident #52 was admitted from an acute hospital, was rarely understood, and rarely understands. The MDS indicated Resident #52's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident #52 did not reject care. The MDS indicated Resident #52 required extensive assistance with two staff for bed mobility, dressing and toilet use. She required limited assistance of two staff with transfers. Resident #52 required extensive assistance with eating and personal hygiene and total assistance of two staff for bathing. The MDS indicated Resident #52 was always incontinent of bowel and bladder. The MDS indicated in the section J0100 Pain Management Resident #52 received no scheduled pain medications, received no as needed pain medication, nor any non-medication pain interventions. The MDS indicate Resident #52 was 65 inches tall and her weight was 225 pounds. Section M of the MDS indicated Resident #52 had a pressure ulcer, a formal assessment tool, and a clinical assessment. The MDS indicated Resident #52 was at risk for pressure ulcers. Section M0210 indicated had one or more unhealed pressure ulcers. The MDS indicated in Section M0300 Resident #52 had a Stage 2 pressure ulcer (some of the outer surface of the skin or the deeper layer was damaged). The MDS indicated Resident #52 did not have any other pressure injuries. The MDS did not reflect a pain assessment. The comprehensive care plan dated 8/26/22 with a revision on 11/07/22 indicated Resident #52 had a potential for pain with a goal of Resident #52 would voice a level of comfort or will not have an interruption in normal activities due to pain. The interventions included to administer analgesia medication as per orders; give 1/2 hour before treatments or care, anticipate need for pain relief and respond immediately to any complaint of pain, monitor, and document any side effects, monitor and report any symptoms of non-verbal pain, changes in breathing, grunting, moaning, and even silence. Also report grimacing, clenched teeth, tense body, and face appearing worried. Pain assessment each shift and observe and report any changes in normal routine. Record review of the October 2022 Medication Administration Record revealed Resident #52 had ordered 10/11/22 Tramadol 50 mg administer one tablet every 8 hours as needed for pain. The medication record indicated Resident #52 received only 8 doses in the month of October. Record review of the October 2022 Medication Administration Record revealed Resident #52 was assessed for pain using the PAINAID tool and the assessments indicated she had no pain the entire month of October. Record review of the November 2022 consolidated physician orders printed on 11/07/22 indicated on 10/31/22 Resident #52 was ordered Tramadol 100 mg per the gastrostomy tube 4 times a day routinely. This medication was on scheduled for administration at 6:00 a.m., 12:00 p.m., 6:00 p.m., and 12:00 a.m. Resident #52 was ordered Acetaminophen 325 mg 2 tablets every 4 hours as needed for pain/temperature. Record review of the October 2022 electronic medication administration record indicated Resident #52 had no pain documented in the entire month. The record indicated Resident #52 had acetaminophen 325 mg give 2 tablet every 4 hours as need for pain ordered on 9/12/22. The record indicated Resident #52 received acetaminophen administration a total of 4 times in the entire month of October. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the November 2022 electronic medication administration record indicated Resident #52 had pain on the day shift on November 5th, 6th, and 7th and the 4th and 6th on the night shift. The record indicated Resident #52 received acetaminophen 325 mg 2 tablets every 4 hours on 11/05/22. The electronic medication administration record did not reflect any as needed medications were administered for 11/04/22, 11/96/22, and 11/07/22. Record review of the November 2022 electronic medication administration record indicated Resident #52 had pain on these days: 11/04 /22 rated at a 2; 11/05/22 rated at a 6, 11/06/22 rated at a 2 on the day shift and a 3 on the night shift, and 11/07/22 pain at a 3 on the day shift. The November EMAR indicated Resident #52 received Tramadol 100 mg by gastrostomy tube four times daily 6:00 a.m., 12:00 p.m., 6:00 p.m., and 12:00 a.m. The EMAR indicated Resident #52 had acetaminophen 325 mg two tablets administered on 11/5/22 for a pain level of a 6. The EMAR indicated the medication was effective. During an observation and interview on 11/7/22 at 9:16 a.m. to 9:49 a.m., the treatment nurse performed wound care on Resident #52's Stage 4 sacral wound. The treatment nurse removed the top dressing and revealed a large and deep sacral wound with necrotic (dead) tissue at the noon to 3'oclock portion of the wound. The dressing was saturated in a copious amount of serosanguineous (blood-tinged drainage), and the wound was odorous. The treatment nurse indicated he was assisted by the staffing coordinator because she had a stronger stomach and could handle the odor. During the wound care Resident #52 began grimacing, groaning, and moving her face to the right imbedding her face in her pillow. Resident #52 was encouraged by the staffing coordinator to squeeze her hand. The staffing coordinator indicated Resident #52 was displaying pain. The staffing coordinator indicated Resident #52 displayed this behavior each time during the actual wound care procedure. The treatment nurse indicated Resident #52 was medicated earlier this morning. The treatment nurse indicated he had even mentioned to the family about hospice care to have more effective pain management. During the wound care neither the treatment nurse nor the staffing coordinator stopped the wound care process to ensure adequate pain relief was achieved prior to finishing the treatment. Resident #52 was noted to be making a grimacing face as the treatment nurse initiated the cleaning of the wound. The staffing coordinator indicated the cleaning must hurt by the face Resident #52 was making. The treatment nurse stated he was unsure if the moaning was pain or how Resident #52 was positioned. During the repositioning of Resident #52 the surveyor noticed two skin concerns. The treatment nurse indicated he was unaware of these two areas. Resident #52 had a 2.5 cm x 0.5 cm x 0.1 cm stage 2 pressure injury, and a 0.5 cm x 0.5 cm fluid filled blister to the right heel. The treatment nurse indicated Resident #52 should have had some heel protection boots on. During an interview after the wound care the treatment nurse indicated Resident #52's grunting, moaning, and grimacing was demonstration of pain. The treatment nurse indicated he should have stopped the procedure and obtained pain medication. The treatment nurse indicated he did not stop the wound care, assess Resident #52 because he was in a hurry to finish. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/07/22 at 12:17 p.m., the nurse practitioner indicated she had not actually visualized the Stage 4 pressure ulcer to Resident #52's sacrum. She indicated she ordered the tramadol in anticipation the wound would cause discomfort and she indicated she had not been advised the pain medication was not effective. The nurse practitioner also indicated she expected the nursing staff to monitor and notify her of ineffective pain management. The Nurse Practitioner indicated she expected the pain medication to be administered 1-2 hours prior to wound care. During an interview on 11/07/22 at 12:46 p.m., LVN E indicated she had been completing the wound care for Resident #52 and had noticed the facial grimacing and some moaning . LVN E indicated she had notified the nurse practitioner of the pain and the tramadol order was provided. During an interview on 11/07/22 at 1:20 p.m., the wound care consulting physician indicated Resident #52 had a rather large Stage 4 sacral wound. The physician indicated he had made the recommendation for labs to determine if Resident #52 had osteomyelitis (bone infection). The physician indicated he had not seen bone in the wound and therefore required the labs to help determine if Resident #52 required intravenous antibiotic therapy instead of antibiotics through the gastrostomy tube. The wound care consultant indicated Resident #52 had not displayed pain during his wound care, but he had used a topical anesthesia with wound debridement. During a telephone interview on 11/07/22 at 6:32 p.m., the MD indicated he was aware Resident #52 had a Stage 4 pressure injury but had not seen the wound himself. The MD indicated he had not been made aware Resident #52 had two new wounds today nor had he been informed Resident #53 had increased pain with her wound care. The MD indicated he expected the wound care nurse to stop the wound care when any resident demonstrated pain. During an interview on 11/08/22 at 1:15 p.m., the treatment nurse indicated he should have premedicated Resident #52 prior to the wound care on 11/07/22. The treatment nurse indicated he should have then waited for the medication to be effective prior to starting the wound care for Resident #52. The treatment nurse indicated the PAINAID tool was used to indicated pain for non-verbal residents. During an interview on 11/08/22 at 5:25 p.m., the DON indicated Resident #52 had been medicated two hours prior to her treatment and this was in the time frame of an effective pain management criteria. Record review of a pain policy dated 05/2007 with a revision on 01/2022 indicated the policy of this facility to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Purpose Identify circumstances when pain can be anticipated. Procedure 3. For the resident who was unable to communicate verbally or understand abstract concepts, the PAINAD scale for the cognitively impaired will be used and documented in the residents HER. . The Administrator and DON were notified on 11/07/22 at 5:02 p.m. an Immediate Jeopardy (IJ) was identified due to the above failures. The IJ template was provided on 11/07/22 at 5:05 p.m. The following Plan of Removal submitted by the facility was accepted on 11/08/22 at 8:34 p.m. and included the following: Immediate action: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center G	1201 Fm 2685 Gladewater, TX 75647

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediate Action The Medical Director was notified of IJ on 11/7/22 at 5:45pm. Review of all residents with pressure ulcers to assure current orders are in place for pain management to be completed by DON by 11/07/22 Education provided to all licensed nurses to assure pain assessment is completed prior to all wound care. New pain medication orders received for affected resident from physician for Methadone 5mg/5ml - give 5 ml via gastrostomy tube daily for pain. Tramadol 100mg via gastrostomy tube Q 6 as needed for pain and Tylenol 500mg 2 tabs via gastrostomy tube every 8 hours as need for pain. Identification of Others Affected Currently there are 67 residents residing in the facility. The facility will assure pain assessments for all residents with pressure ulcers are completed prior to treatment. Systemic Change to Prevent Re-occurrence DON started in-service on 11/07/22 with facility charge nurses on documentation and pain assessments prior to wound care treatments. The training includes use of pain assessment prior to any wound care and post pain assessment after treatment is completed will be completed by 11/08/22. Nurses will complete education for pain assessment prior to the start of their next shift - date of completion 11/08/22. Education provided to charge nurses to notify physician if pain management plan is ineffective based on assessment of the resident. Monitoring: Interviews on 11/08/22 from 12:58 p.m. until 3:18 p.m. the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Interviews with 8 CNAs indicated they had received a written in-service regarding monitoring reporting pain to the nurses. Referencing pain is whatever the person says it is, existing whenever the experiencing person say it does. Also referencing, Pain is an unpleasant sensory and emotional experience, associated with, or potential tissue damage. Pain is an unpleasant sensory and emotional experience, associated with actual or potential tissue damage. Interviews with 6 LVNs indicated the in-services included: *Pain assessment was a broad concept involving clinical judgement based on observation of the type, significance, and context of an individual's pain experience. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Provide analgesia 30 to 60 minutes before dressing change. Assess the patient for pain before, during, and after dressing changes. *If no order available for analgesia please notify physician prior to performing the treatment. *Pain assessment to be documented in the resident's medical record, before, during, and after the dressing changes. Interviews with 5 RNs indicated the in-services included: *Pain assessment was a broad concept involving clinical judgement based on observation of the type, significance, and context of an individual's pain experience. *Provide analgesia 30 to 60 minutes before dressing change. Assess the patient for pain before, during, and after dressing changes. *If no order available for analgesia please notify physician prior to performing the treatment. *Pain assessment to be documented in the resident's medical record, before, during, and after the dressing changes. During an interview on 11/08/22 at 12:58 p.m., the DON indicated the nursing staff would be in-serviced prior to accepting their assignments regarding pain. The DON indicated the nurse would assess pain prior, during, and after wound care or ADL care. The DON indicated the nurses will notify the physician if there were no analgesics to administer for pain needs. During an interview on 11/08/22 at 4:41 p.m., the Administrator indicated he was under the understanding the facility had done all the appropriate interventions regarding Resident #52's Stage 4 pressure ulcer. The administrator indicated he expected the residents to have their pain managed. The Administrator indicated education had been provided to the staff and the skin and pain issues will be taken to on-going scheduled QAPI meetings. The Administrator and DON were informed the Immediate Jeopardy was removed on 11/08/22 at 8:34 a.m. The facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46310 Based on observations, interviews, and record review, the facility failed to provide the appropriate treatment and facility servicess to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for a resident with Post Traumatic Stress Disorder (PTSD) for 1 of 17 residents reviewed for behavioral health care services (Resident #40). This failure could place a resident with PTSD at risk of not receiving specialized services which would enhance their highest level of functioning and could contribute to residents decline in physical, mental, and psychosocial well-being. Findings included: A record review of the undated face sheet indicated Resident #40 admitted on [DATE] and was [AGE] year-old male. A record review of the physician's orders dated 11/8/22 indicated Resident #40 had diagnoses that included: Vascular Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance mood disturbance, and anxiety, (a medical classification as listed by WHO under the range - Mental, Behavioral and Neurodevelopmental disorders) with an onset date of 11/7/22 (during stay), Cognitive Communication Deficit (an inclusive term used to describe the impairment of different domains of cognition) with an onset of 12/31/21 (during stay), Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) with an onset date of 12/27/21 (admission), and PTSD (Post Traumatic Stress Disorder is a mental and behavioral disorder that can develop because of exposure to a traumatic event including symptoms of disturbing thoughts, mental or physical distress, and alterations in the way a person thinks or feels) with an onset date of 12/27/21 (admission). The physician's orders dated 11/8/22, indicated Resident #40 was ordered: 5/23/22 Sertraline HCl Tablet, 50 MG, 1 tablet by mouth one time a day for depression A record review of the undated care plan indicated Resident #40 was at risk for impaired cognitive function/dementia or impaired thought processes. Goals for this focus were to remain orientated to (person, place, situation, time) through the review date and maintain current level of cognitive function through the review date. The interventions for these goals were to administer medication as ordered, communicate with family/caregivers regarding resident's capabilities and needs, report to nurse any changes in cognitive function, specifically changes in: decision making ability, memory, recall, awareness to surroundings, and other, difficulty expressing self, difficulty understanding others, sleepiness/lethargy, confusion, and social services to provide psychosocial support as needed. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #40 has potential for psychosocial well-being problem with a history of Post-Traumatic Stress Disorder (PTSD). The goal for this focus was to have no indications of psychosocial well-being problem by/through review date. The interventions for that goal were to allow time to answer questions and to verbalize feelings perceptions, and fears, assist/encourage/support to set realistic goals, encourage participation from resident who depends on others to make own decision, and observe for side effects and adverse reactions to psychoactive medication. Resident #40 was at risk for re-traumatization with history of PTSD. The goal for that focus was for resident to not have any evidence of emotional, physical, and psychological problems by review date. The interventions for that goal were to administer medication as ordered and monitor for side effects and effectiveness, anticipate and meet the needs, approach in a calm manner, document behaviors, and residents responses to interventions, explain all procedures to before starting, attempt to de-escalate and implement coping strategies, monitor behavior episodes and attempt to determine underlying cause, observe for side effects of psychoactive medication, praise any indication of progress/improvement in behavior, and stop and talk with resident when passing by. Resident #40 received psychotropic medications used for depression. The goal for that focus was to remain free of drug related complications. The interventions for that goal were to administer medication as ordered, consult with pharmacy, to consider dosage reduction when clinically appropriate, monitor/record/report to physician as needed for side effects and adverse reactions to psychoactive medications. A record review of the most recent MDS dated [DATE] indicated Resident #40 had clear speech, usually understood others, and was usually understood by others. BIMS score of 9 indicated Resident #40 had moderately cognitive impairment. The MDS indicated Resident #40 had little to no interest or pleasure in doing things 2 to 6 days, felt down, depressed, or hopeless 2 to 6 days, and felt tired or having little energy 2 to 6 days. No behavior concerns or signs and symptoms of delirium were present. No psychological therapy services provided. During interview and observation on 11/7/22 at 9:49 AM with Resident #40, he said he had PTSD from a time he would not like to discuss. He said he did not think most staff know he had PTS because he did not have any triggering episodes. He said he had only had behavioral issue when he had a urinary tract infection and had to go to the emergency room for that. He said he was unsure of when that was. He said none of the nursing staff treated him in a way that made him feel uncomfortable. He said had not received in-house and no one from another agency did not provide him any mental health services. He said he was not familiar with what the process for Medicaid and mental health services. He said that none of the services would be offered to him. He said that he was interested in learning about what was available to him. During an interview on 11/8/22 at 4:12 PM with RN D, she said she was aware of Resident #40's diagnosis of PTSD. She said Resident #40 received services from physical therapy and occupational therapy. She indicated she had not noticed any behaviors and did not have any triggers related to PTSD that she was aware of. She said she was not aware if Resident #40 was supposed to or needed to have mental health services. She said she had trauma informed care training. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/8/22 at 4:19 PM with CNA A, she said she was unaware of any new services Resident #40 was receiving. She stated that she had not noticed any behaviors and was unaware of any triggers. She said she was not aware that Resident #40 had PTSD. She said she had trauma informed care training. During an interview on 11/8/22 at 4:28 PM with LVN E, she indicated Resident #40 received physical and occupational therap. She indicated she was unsure if Resident #40 had a diagnosis of PTSD and stated Resident #40 had no behavioral concerns. She said she was not aware of any triggers Resident #40 may have related to PTSD. She stated she had trauma informed care training during the hiring process. During an interview on 11/8/22 at 4:32 PM with CNA P, she stated she sometimes assisted with care to Resident #40. She indicated Resident #40 attended physical therapy but not she was unsure of times and day. She said she was aware of a PTSD diagnosis for Resident #40 or if he had any triggers. She stated he has had no behavioral concerns. During an interview on 11/8/22 at 4:44 PM with the licensed social worker, she said she did not receive any information from the MDS nurse regarding Resident #40. She said she did not typically obtain any information on a resident unless she is informed by the resident or the MDS nurse that the resident may need additional services. She said she would offer services to Resident #40 and if he desired any mental health services, she would schedule that for him. Social worker said that she was unsure what exactly what services Resident #40 may need but therapeutic approach would be a start and then she would follow any recommendation thereafter. She said she was not aware of his PTSD diagnosis and thus was unaware of any triggers he may have had. She said that she had training on trauma informed care. She said the risk for a resident who had not received any mental health services with a diagnosis of PTSD would be the resident could have an adverse reaction to care received and facility staff could cause harm to the resident's mental health unknowingly. During an interview on 11/8/22 at 4:52 PM with the MDS nurse, she said while she had been trained on trauma informed care, she was not aware of any triggers that Resident #40 may have. She said Resident #40 was not receiving any mental health services at this time. She said the risk to the resident was he could be triggered by something staff are unaware of and that could cause behavioral issues. During an interview on 11/8/22 at 5:02 PM with DON, she said she does not complete any requests for mental health services or any MDS tasks. She said the facility had a social worker and MDS nurse who completed things like this. She said she was not aware that Resident #40 had a diagnosis of PTSD and that she had not been made aware of any behavioral concerns. She said that if a resident had a diagnosis of PTSD, they should be at least offered mental health services. She said if the resident declined, it should be followed up on during the quarterly care plan reviews. She said the risks to a resident if they are not receiving mental health services could be that he would be triggered unknowingly and cause emotional harm. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/8/22 at 5:15 PM with the administrator, he said that he was not aware that any of the residents admitted had a diagnosis of PTSD. He said that it was an uncommon diagnosis for the population the facility services. He said that the expected MDS nurse and social worker would work together to ensure all residents received any services they needed. He said he was confused as to why Resident #40 would need mental health services if he was not PASARR positive. He said that Resident #40 also had a diagnosis of Dementia. He said that he was not aware of any triggered or behavioral concerns for Resident #40. He said he could not think of any risks of harm to the Resident #40 related to not receiving mental health services for PTSD. Record review of facility policy titled Behavioral Health Services dated 8/17 indicated 1. on admission, the nursing staff will review the resident's medical history for any diagnosis or history of mental and psychological adjustment difficulty, trauma and/or post-traumatic stress disorder (PTSD) and physician's orders for treatment and referral recommendation 3. The social services designee will also meet with resident and/or resident's representative and attempt to identify possible psychosocial issues and needs that may be causing behaviors or having an impact on resident's function, mood, or cognition. 4. The inter-disciplinary team (IDT) will ensure that the residents who display or is diagnosed with a mental disorder or psychosocial adjustment difficulty, history of trauma, or post-traumatic stress disordered (PTSD) receives appropriate treatment and services to attain the highest practicable mental or psychosocial well-being and will have an individualized plan of care that addresses the needs of hethe resident, based on comprehensive MDS assessment of the resident. 5. The plan of care will include non-pharmacological interventions and individualized, person-centered care approached as well as trauma-informed approaches in accordance with resident's customary routines, with input from the resident and/or resident representative. 7. Social services will make the appropriate professional services referral, if needed, the following the agreement from the resident and/or resident representative. 10. The facility will provide appropriate training to staff, to ensure skills and competencies that include but not limited to the following: a. caring for residents with mental and psychosocial disorders, b. implementing non-pharmacological interventions, c. trauma-informed care.

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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** 46928 Based on interview and record review the facility failed to in accordance with accepted professional standards and practices, maintain medical records on each resident that was accurately documented for 1 of 20 residents (Resident #54) reviewed for accuracy of medical records. The facility failed to obtain a physician order for dialysis for Resident #54. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. Findings included: 1. A record review of an undated face sheet indicated Resident #54 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses of diabetes (chronic condition that affects the way the body processes blood sugar), end stage renal disease (kidneys cease functioning on a permanent basis), high blood pressure and dependence on renal dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Record review of the most recent annual MDS dated [DATE] indicated Resident #54 was understood and understood others. Resident #54's BIMs (Brief Interview for Mental Status) score was a 15 indicating intact cognition. The MDS indicated Resident #54 required limited assistance with bed mobility and dressing. Resident #54 required supervision with transfers, locomotion and personal hygiene and he required extensive assistance with toileting and bathing. The MDS revealed under Section O (special treatments and procedures), dialysis was checked. Record review of the comprehensive care plan created on 10/19/20 and revised on 05/09/22 indicated Resident # 54 needed hemodialysis related to renal failure. The care plan indicated Resident #54 attended the dialysis center (establishment which provides treatment to remove waste products and excess fluid from the blood) on Monday, Wednesday, and Friday. Interventions included to encourage resident to go to scheduled dialysis appointments, check arteriovenous fistula daily, and not to draw or take blood pressure in arm with graft. Record review of the order summary report dated 11/7/22 did not reveal an order for hemodialysis three times a week. During an interview on 11/08/22 at 1:15 p.m., RN D indicated she was unsure if the order for dialysis was needed. She indicated Resident #54 was already on dialysis prior to admitting to the facility. She indicated she had not obtained an order for dialysis before. (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 11/8/22 at 2:41 p.m., the ADON indicated an order for dialysis should be in Resident #54 electronic medical record. The ADON indicated the admitting nurse was responsible of ensuring the order was placed in electronic medical record. The ADON indicated she was responsible of ensuring all orders were correctly inputted in the electronic medical record. The ADON indicated she reviewed the physician's orders the day of admission or the day after admission. The ADON indicated Resident #54 did not have an order for dialysis which placed him at risk for new staff to be unaware that he required dialysis treatments. During an interview on 11/08/22 at 4:12p.m., the DON indicated Resident #54 should have an order for dialysis. The DON indicated Resident #54 not having a physician's order for dialysis placed him at risk for new staff and physicians to not know he required dialysis treatments. The DON indicated the ADON was responsible of reviewing the hospital records and ensuring all orders were correct. The DON indicated the order for dialysis for Resident #54 was somehow missed. During an interview on 11/08/22 at 4:44 p.m., the Administrator indicated he expected Resident #54 to have an order for dialysis. He indicated Resident #54 was at risk of missing a dialysis treatment which could therefore lead Resident #54 to retain more fluid and cause fluid overload. Record review of the facility's policy and procedure titled Medication and Treatment Orders revised on 05/2007 indicated . medications and treatments are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, the facility failed to establish and maintain an Infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 2 of 20 residents (Resident #220 and resident #13) reviewed for infection control, in that: The facility failed to ensure CNA H did not contaminate wipes, changed gloves, or performed hand hygiene after providing incontinent care and touching linen for Resident #220. The facility failed to ensure CNA A changed gloves or performed hand hygiene after providing incontinent care to Resident #13. These deficient practices could place residents at risk for infection due to improper care practices. Findings include: 1.Record review of Resident # 220's face sheet dated 11/08/22 revealed she was admitted to the facility on [DATE] with diagnoses which included fracture of lumbar spine, rheumatoid arthritis and high blood pressure. Record review of Resident # 220's care plans for the problem area of ADL (Activities of Daily Living) self-care deficit related to second lumbar vertebra. Goal: maintain current level of function. Interventions: encourage to participate to the fullest extent possible with each interaction. Record review of Resident #220 indicated she was admitted [DATE], she had only been at facility 6 days and an MDS was not required prior to exit. During an observation on 11/08/22 at 10:23 a.m., CNA H washed her hands and explained to Resident # 220 what she was going to do. CNA H opened the wipes and placed several individual wipes on residents' uncleaned bed side table and started peri care. CNA H assisted Resident #220 to turn over, using same dirty gloves while touching resident and bed linen. CNA H then proceeded with peri-care wiping from front to back and back to front attempting to clean BM off residents' buttock. CNA H placed brief on Resident # 220, replaced comforter and used remote control to raise head of bed without changing glove and sanitizing her hands. CNA H gathered all equipment, washed her hands, and exited the room. During an interview on 11/08/22 at 10:40a.m., CNA H said she had been checked off on handwashing and incontinent care skills and realized she did not perform peri-care properly after exiting the room. CNA H said she placed wipes on residents' bed side table which cross contaminated her wipes. CNA H said she wiped front to back and back to front during incontinence care and did not wash her hands or change gloves as often as needed for prevention of infection. Record review of skills check offs titled Incontinent Care and Handwashing revealed CNA H was checked off on 09/30/22 with skill being met. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/08/22 at 1:15 p.m., RN D indicated she expected hand hygiene be performed between glove changes. She indicated the risks for not performing hand hygiene between glove changes could cause infection. She indicated hand hygiene was important for infection control. During an interview on 11/08/22 at 1:40 p.m., the ADON indicated she expected her staff to perform hand hygiene when changing gloves. She indicated not performing hand hygiene between glove changes could place the residents at risk for infection. During an interview on 11/08/22 at 4:22 p.m., the DON said medical records was responsible to check off all nurse aides and she was the overseer of all nursing staff. The DON said staff should perform hand hygiene between changing gloves and place a barrier between clean and dirty to prevent cross contamination and infection. During an interview on 11/08/22 at 4:48 p.m., the Administrator said he expected staff to follow the procedure set forth when providing incontinence care. The administrator said he expected the ADON and DON to be responsible for making sure staff was preforming incontinent care correctly. The administrator said gloves should be changed after care was provided to a resident, when the gloves were soiled and before applying new gloves. The Administrator stated the risk of not changing gloves during care could lead to the spread of germs and infection. 46928 2. A record review of an undated face sheet indicated Resident #13 was an [AGE] year-old female who was admitted on [DATE] with diagnoses of dementia (memory loss), high blood pressure, and protein-calorie malnutrition (lack of protein and calories in diet). Record Review of the most recent annual MDS dated [DATE] indicated Resident #13 was usually understood and understood others. The MDs indicated resident #13's BIMs (Brief Interview for Mental Status) score was a 10 indicating moderately impaired cognition. The MDS indicated Resident #13 required extensive assistance with bed mobility, locomotion off unit, dressing and personal hygiene. Resident #13 was totally dependent on transfers, toileting, and bathing. During an observation on 11/06/22 at 09:54 a.m., CNA A and CNA G entered Resident #13's room to provide incontinent care. CNA A cleaned Resident #13 by wiping from front to back and only using one disposable wipe. CNA A took off gloves and reapplied new gloves. CNA A did not use hand sanitizer between glove changes. CNA A proceeded in applying new brief to Resident #13 and applied barrier cream. CNA A and CNA G removed gloves, washed hands, and new gloves reapplied by both CNAs. After removing Resident #13 dirty clothes, CNA A removed her gloves and reapplied clean gloves without hand sanitizing between glove changes. CNA A finished assisting Resident #13 in getting dressed. During an interview on 11/06/22 at 11:29 a.m., CNA A indicated she had not been instructed to use hand sanitizer between glove changes. Therefore, she was unaware of needing to perform hand hygiene after changing gloves. She indicated there was not any hand sanitizers in Resident #13's room but she could carry one in her pocket if she needed. She indicated the risks of not performing hand hygiene between glove changes could place Resident #13 at risk for infection. Record review of skills check offs titled Incontinent Care and Hand Hygiene revealed CNA A was checked off on 8/18/22 with skill being met. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/08/22 at 1:15 p.m., RN D indicated she expected hand hygiene be performed between glove changes. She indicated the risks for not performing hand hygiene between glove changes could cause infection. She indicated hand hygiene was important for infection control. During an interview on 11/08/22 at 1:40 p.m., the ADON indicated she expected her staff to perform hand hygiene when changing gloves. She indicated not performing hand hygiene between glove changes could place the residents at risk for infection. Record review of facility policy Infection Prevention and Control Program dated 11/23/16, indicated, The goal of the infection control program is to decrease the risk of infection ., recognize infection control practices ., identify and correct problems related to infection control practices. Record review of facility policy Perineal Care dated May 2007, Indicated, It is the policy to cleanse the perineum, wash from the cleanest area to the dirtiest area. Record review of facility policy Hand hygiene dated August 2014, indicated, This facility considers hand hygiene the primary means to prevent the spread of infection.