STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676143	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansfield Medical Lodge	301 N Miller Rd Mansfield, TX 76063

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for one (Resident #2) of five residents reviewed for care plans. The facility failed to ensure Resident #1's comprehensive care plan addressed a stage three sacral wound and pacemaker interventions. This failure could place residents at risk of receiving inadequate interventions not individualized to their health care needs. Findings included: Record review of Resident #2's Face Sheet dated 06/04/25 reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #2's active diagnoses included mechanical complication of internal right knee prosthesis, dysphagia (difficulty swallowing), morbid obesity, neuropathy (nerve damage that can lead to pain, weakness, numbness, or tingling in one or more parts of the body), spinal stenosis (a condition where the spaces within the spinal column narrow, potentially compressing the spinal cord or nerve roots), fibromyalgia (a chronic condition causing widespread pain, fatigue, and other symptoms like sleep disturbances and cognitive difficulties), chronic kidney disease (a progressive condition where the kidneys gradually lose their ability to filter waste and excess fluid from the blood, leading to a buildup of these substances in the body), presence of pacemaker and presence of artificial knee joint. Resident #1's face sheet did not include any presence of skin problems or pressure ulcers. Record review of Resident #2's admission MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated no cognitive impairment. Resident #2 had no signs/symptoms of delirium, no potential indicators of psychosis and no rejection of care issues. Resident #2 required staff assistance for ADL's and was frequently incontinent of bowel and bladder. Resident #2 was at risk of developing pressure ulcers/injuries and had a stage 3 pressure wound upon admission (A stage 3 pressure wound is characterized by full thickness loss of skin where the wound has broken through the top two layers of skin and extends into the fatty tissue below, resembling a hole or crater), surgical wounds, required a pressure reducing device for bed, nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, surgical wound care and applications of ointments/medications. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's care plan initiated 05/11/25 and last revised 05/23/25 revealed it did not address her sacral (triangular bone at the base of the spine) wound or any other skin integrity issues. For her pacemaker, the care plan identified it as a care area on 05/12/25, however, under the interventions section, it was incomplete and reflected, The resident's Pacemaker information: Manufacturer:(SPECIFY) Model: (SPECIFY) Serial #: (SPECIFY) Date implanted: (SPECIFY) Name of cardiologist: (SPECIFY). Record review of Resident #2's order summary dated 06/04/25 reflected the following treatment orders: -Cleanse pressure injury to sacrum with normal saline, pat dry, apply collagen and cover with a dry dressing daily and as needed for soilage or dislodgement as needed for wound care and everyday shift for wound care (start date 05/20/25). Additionally, record review of Resident #2's order summary did not include a order for a pacemaker or pacemaker monitoring. It only reflected under the diagnoses section, Presence of cardiac pacemaker. Record review of Resident #2's nursing progress note dated 05/09/25 reflected, Patient was admitted with right knee surgical repair enclosed by brace and ace wrap, right buttock skin breakdown, left buttock skin breakdown and bruises to bilateral (both sides) arms and right thigh, treatment order is in place. Record review of Resident #2's May 2025 TAR reflected no documented evidence that wound care was provided to her sacrum as ordered on the weekend of 05/24/25, 05/25/25 and 05/31/25. On those dates, the TAR was blank with no initial or check mark. Record review of Resident #2's initial wound evaluation dated 05/12/25 by MD B reflected she had one stage three pressure wound on her sacrum that measured 1.5 cm x 0.6 cm x 0.3 cm with a surface area of 0.9 cm2, a wound base with 90% granulation (the appearance of new tissue during wound healing) , 10% slough (dead tissue that needs to be removed from a wound to promote healing), light serosanguineous (clear fluid that leaks out of wounds) and no signs of infection. Resident #2 was noted to be at high risk of wound incidence due to impaired mobility, co-morbid conditions and incontinence. MD B's recommendations included, Implement pressure relieving measures and offloading as tolerated; Low air loss mattress-alternating pressure (group 2 mattress) - verify appropriate function and setting as per manufacturer guidelines; Continue to reposition the patient regardless of the support surface in use; Implement pressure relieving measures, offloading and repositioning as tolerated; Establish turning frequency based on the characteristics of the support surface and the patient's response. An interview with ADON C on 06/03/25 at 3:54 PM revealed she was currently standing in as the wound care nurse for the past three weeks. She stated that care planning wounds was the responsibility of the MDS nurses, which included new wounds acquired in the facility as well as residents who admitted with wounds. ADON C stated it was important to care plan wounds because the care plan tells you about the patient. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation with Resident #2 on 06/04/25 at 9:55 AM revealed she was in bed in her room, but she did not have a low air loss mattress on her bed. Resident #2 stated she used to have one but a couple weeks ago a staff member accidentally dislodged the control unit at the foot of the bed and after that, it would not work so the staff removed it from her bed. Resident #2 stated she could not feel the difference in her comfort leave and was not in any pain because the wound on her sacrum was almost healed. Resident #2 felt her wound was still healing after the low air loss mattress was removed so she was okay with it. Resident #2 was asked if she had received wound care the past two weekends and she said she could not remember for sure, but on the weekends, there is not much of any care happening. Resident #2 assumed she did not get wound care the past two weekends and said every now and then she would get physical therapy on a Saturday, but that was it. Resident #2 stated she was not tended to as well on the weekends and felt the staff provided much less care than during the weekdays. An interview with MDS LVN G on 06/04/25 at 10:32 AM revealed when a resident admitted to the facility with wounds, the admitting nurse was responsible for care planning the wound(s) and each department was responsible for care planning their focus areas. She stated since wounds fell under the nursing department's responsibility, the ADONs as well as the MDS nurses could also care plan wounds if they had the wound care doctor's notes to reference. MDS LVN G stated care planning a resident's wounds was very important as it helped show the guidelines for maintaining the skin's integrity and was a plan that was created for the resident to have a good outcome. With pacemakers, MDS LVN G stated the MDS nurse could care plan those when they did the comprehensive care plans but the baseline care plan which covered the resident's first 14 days at the facility but could be done by anyone in the nursing department. MDS LVN G stated when care planning issues that were generated by a CAA, she tried to ensure it was checked off and care planned, but no system is perfect. MDS LVN G stated when the management had daily clinical staff meetings, they discussed skin integrity changes and any new wounds. If there was a new wound identified, the nursing staff could care plan the wound at that time on the care plan meeting if the DON requested it. Review of the facility's policy titled, Comprehensive Care Plans, revised January 2025 reflected, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, . (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. Review of the facility's policy titled, Baseline Care Plans, revised 11/13/23 reflected, .2. The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. Initial goals based on admission orders; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendation, if applicable.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and records review, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for two (Resident #1 and Resident #2) of five residents reviewed for quality of care. 1. The facility failed to follow physician's order to cover Resident #1's wound with a dry dressing as needed for dislodgement of dressing on 06/03/25. 2. The facility failed to ensure Resident #1's had a low air loss mattress pump with the correct settings for appropriate pressure redistribution on 06/03/25. 3. The facility failed to provide wound care to Resident #2's sacral wound on 05/24/25, 05/25/25, 05/31/25 and 06/01/25. 4. The facility failed to ensure Resident #2 had a functioning low air loss mattress available to use to promote healing of her sacral wound on 06/03/25 and 06/04/25. These failures placed residents at risk of developing new or worsening pressure ulcers. Findings included: 1. Record review of Resident #1's Face Sheet dated 06/04/25 reflected she was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #1's active diagnoses included memory deficit following cerebral infarction, dysphagia (difficulty swallowing), aphasia (loss of ability to understand speech), heart failure, kidney disease, Parkinson's disease (a progressive movement disorder of the nervous system) and overactive bladder. Resident #1 did not admit with any pressure ulcers. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 03 which indicated severe cognitive impairment. Resident #1 had no signs or symptoms of delirium, no negative mood issues, no potential indicators of psychosis and no rejection of care. Resident #1 used a wheelchair for mobility, had no range of motion impairment, required staff assistance for all ADLs and was occasionally incontinent of bowel and bladder. Resident #1 weighed 111 pounds and was five foot four inches tall. Resident #1 was at risk of developing pressure ulcers/injuries and one stage four pressure ulcer which the assessment reflected was present upon admission to the facility. Resident #1 had a pressure reducing device for bed, nutrition or hydration interventions to manage skin problems and pressure ulcer/injury care. Record review of Resident #1's care plan dated 07/02/24 and last revised 03/28/25 reflected no specific discussion of her sacral (triangular bone at the base of the spine) wound. The care plan reflected only that she was at risk potential/actual impairment to skin integrity related fragile skin and she was at risk for enhanced barrier precautions related to wound/wound care and increased risk of multi-drug resistant organism acquisition. The care plan did not reflect her current wound identification or treatment needs. The care plan also did not reflect Resident #1 was receiving hospice services. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Order Summary Report dated 06/03/25 did not include any orders for a low air loss mattress and reflected: -Cleanse pressure injury to sacrum with normal saline or wound cleaner, pat dry, apply [brand name-wound dressing impregnated with sodium chloride specifically designed for heavily draining and discharging wounds], cover with dry dressing daily and as needed for soilage or dislodgement for wound care (start date 05/20/25) -Enhanced Barrier Precautions for the following: Wounds every shift (start date 05/14/25) Record review of Resident #1's June 2025 TAR revealed the orders were implemented as written for daily care as evidenced by a checkmark and LVN A's initial on 06/03/25 (no time was indicated). The PRN TAR did not reflect any PRN wound care was done on 06/03/25 (6A-2P shift) when Resident #1's dressing was removed or became dislodged. Record review of Resident #1's online e-chart reflected no weights recorded under the vitals section for the past 90 days. Record review of Resident #1's most recent nutrition progress note dated 05/27/25 reflected a weight of 111 pounds and indicated her stage 4 sacral wound was improving (Stage 4 is the most severe and deepest stage of pressure ulcers. It is characterized by extensive tissue damage that extends beyond the skin, exposing muscle, tendon, or bone). The assessment stated, Resident continues on hospice care, no recent weight available. Wound noted as improving. Goal for comfort care. Record review of Resident #1's most recent wound care visit dated 06/02/25 reflected it was an evaluation of the wound on her Sacro coccyx (an injury or ulceration in the sacral (lower back) or coccygeal (tailbone) region) The wound measurements at that time were 2.0 cm x 1.3 cm x 0.7 cm with a surface area of 2.6 cm. There was tunnelling (a type of wound where a narrow channel extends from the main wound site into deeper tissues, forming a passageway under the skin) at 12 o'clock of 1.5 cm. The wound was noted to be acquired on 06/27/24 and was improving. There was 90% granulation (the process of new tissue and blood vessel formation within a wound during healing) and 10% slough . Resident #1's sacral wound required a daily dry dressing. An observation and interview on 06/03/25 at 10:39 AM of Resident #1 along with the charge nurse LVN A was conducted to check placement of her dressing and check for the date and initial of the staff who last changed it. Resident #1 was not interviewable or responsive to investigator questions. Resident #1's low air loss mattress was present with a control unit placed at the foot of the bed. The pump's power button was lit up and in the ON position and the weight setting pressure adjust knob was pointed between 280-300 pounds. When LVN A turned Resident #1 to look at the dressing, the sacral wound was exposed without a dressing on it. There was an open wound bed with a small piece of rolled up wound dressing gauze inside the wound. There was no drainage observed coming from the wound, it appeared clean with no redness or inflammation observed. LVN A stated she did not know the dressing was off and no one had told her it had come off on her shift that morning. LVN A stated there was no wound care nurse at the facility and they were in-between hiring a new one. She stated presently, ADON C did the wound care on the weekdays and weekends and the charge nurses who worked the floors did wound care as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DON on 06/03/25 at 12:40 PM revealed Resident #1 was on hospice services and they probably came out and gave her a bath and the dressing came off and they did not tell the nurse. With missing treatment not documented as being provided on the TAR, the DON stated she would look into it and see what happened. An interview with ADON C on 06/03/25 at 3:54 PM revealed she was standing in as the wound care nurse since their wound care nurse quit three weeks ago. ADON C stated, The main thing is to make sure the wound care gets done and nothing gets infected. Regarding Resident #1, ADON C stated when a dressing was not on a resident, there was a PRN order to change it and put a new one on. She said the charge nurse on duty could do it and did not need to wait for herself or ADON D to change it. ADON C stated it was important to do a dressing change when it came off or was dislodged because the resident would be at risk for infection, you don't know what kind of microbes she was sitting on. When a dressing is not on a resident, it is a matter of reporting it, whoever sees it should report it to the charge nurse if they know it is not on. With Resident #1, ADON C stated the nurse was capable of looking in the resident chart to see what their current weight was to ensure the low air loss mattress was at the correct setting. ADON C stated when she rounded, she looked to see if the low air loss mattresses were set correctly. She said she did not do it every day, but she did glance at them. She stated once a resident was on hospice, they no longer got routinely weighed. ADON C stated if Resident #1's pressure was offset too much, meaning her weight was set too high for her body, it made the mattress firmer versus where it needed to be for optimized healing. ADON C stated she did not do wound care for residents on the weekends and that was the responsibility of the weekend charge nurses on duty. An interview with ADON D on 06/04/25 at 10:17 AM revealed she did not do wound care for Resident #1 the day prior on 06/03/25 but wanted to find out why there was no dressing on her sacrum during the investigator's observation at that time. ADON D stated she talked to the overnight CNA who told her the dressing was on Resident #1's sacrum when she did her last peri care on 06/03/25 before her shift was over at 6:00 AM. Then the 6A-2P CNA told ADON D that Resident #1's dressing was off when she saw it in the morning (time unknown). ADON D stated she then called Resident #1's hospice provider and they verified it was the hospice aide who removed the dressing because it was soiled when she came for her routine visit the early morning of 06/03/25. ADON D stated the hospice aide apparently left the dressing off because she was used to ADON C being at the facility every morning who would come in an do wound care after the hospice aide bathed Resident #1, so she left it off thinking ADON C would be coming in to dress imminently. However, ADON D said ADON C did not come into the facility that morning and was offsite. ADON D stated the hospice aide did not notify the charge nurse (LVN A) that the dressing was off, again, assuming [ADON C] was going to do it soon. So the charge nurse did not know the dressing was off, or she would have done it. A follow up observation of Resident #1 on 06/04/25 at 10:33 AM (after investigator intervention) revealed she was in bed awake but not responsive to questions. Her low air loss mattress setting had been changed to a weight of 120 pounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #2's Face Sheet dated 06/04/25 reflected was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #2's active diagnoses included mechanical complication of internal right knee prosthesis, dysphagia (difficulty swallowing), morbid obesity, neuropathy (nerve damage that can lead to pain, weakness, numbness, or tingling in one or more parts of the body), spinal stenosis (a condition where the spaces within the spinal column narrow, potentially compressing the spinal cord or nerve roots), fibromyalgia (a chronic condition causing widespread pain, fatigue, and other symptoms like sleep disturbances and cognitive difficulties), chronic kidney disease (a progressive condition where the kidneys gradually lose their ability to filter waste and excess fluid from the blood, leading to a buildup of these substances in the body), presence of pacemaker and presence of artificial knee joint. Resident #1's face sheet did not include any presence of skin problems or pressure ulcers. Record review of Resident #2's admission MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated no cognitive impairment. Resident #2 required staff assistance for ADLs and was frequently incontinent of bowel and bladder. Resident #2 weighed 254 pounds and was five foot six inches tall . Resident #2 was at risk of developing pressure ulcers/injuries and had one stage three pressure ulcer that was noted to be present upon admission. Resident #2's MDS also noted that she had surgical wounds, required a pressure reducing device for bed, nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, surgical wound care and applications of ointments/medications. Resident #2's care plan initiated 05/11/25 and last revised 05/23/25 revealed it did not address her sacral wound or any other skin integrity issues. Record review of Resident #2's order summary dated 06/04/25 reflected the following treatment orders: -Cleanse pressure injury to sacrum with normal saline, pat dry, apply collagen and cover with a dry dressing daily and as needed for soilage or dislodgement as needed for wound care and everyday shift for wound care (start date 05/20/25) -Turn and reposition per policy or as appropriate, monitor every shift related to decreased mobility, incontinence, High Risk breakdown and skin integrity (start date 05/09/25) -May have pressure reducing mattress unless otherwise indicated (start date 05/09/25). Record review of Resident #2's nursing progress note dated 05/09/25 reflected, Patient was admitted with right knee surgical repair enclosed by brace and ace wrap, right buttock skin breakdown, left buttock skin breakdown and bruises to bilateral (affecting both sides) arms and right thigh, treatment order is in place. Record review of Resident #2's May 2025 TAR reflected no documented evidence that wound care was provided to her sacrum as ordered on the weekends of 05/24/25, 05/25/25 and 05/31/25 . On those dates, the TAR was blank with no initials or check marks. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's initial wound evaluation dated 05/12/25 by MD B reflected she had one stage three pressure wound on her sacrum that measured 1.5 cm x 0.6 cm x 0.3 cm with a surface area of 0.9 cm2, a wound base with 90% granulation , 10% slough, light serosanguineous (a type of wound drainage that is thin, watery, and pale red or pink in color) and no signs of infection. Resident #2 was noted to be at high risk of wound incidence due to impaired mobility, co-morbid conditions and incontinence. MD B's recommendations included, Implement pressure relieving measures and offloading as tolerated; Low air loss mattress-alternating pressure (group 2 mattress) - verify appropriate function and setting as per manufacturer guidelines; Continue to reposition the patient regardless of the support surface in use; Implement pressure relieving measures, offloading and repositioning as tolerated; Establish turning frequency based on the characteristics of the support surface and the patient's response. Record review of Resident #2's subsequent wound care visits by MD B on 05/19/25, 05/26/25 and 06/02/25 revealed her wound was improving at each visit. MD B continued to recommend that Resident #2 have a pressure relieving low air loss mattress at each visit. Record review of Resident #2's June 2025 TAR reflected no documented evidence that wound care was provided to her sacrum as ordered on Sunday 06/01/25 . On that date, the TAR was blank with no initial or check mark. An interview and observation with Resident #2 on 06/04/25 at 9:55 AM revealed she was in bed in her room but she did not have a low air loss mattress on her bed. Resident #2 stated she used to have one but a couple weeks ago a staff member accidentally dislodged the control unit at the foot of the bed and after that, it would not work so the staff removed it from her bed. Resident #2 stated she could not feel the difference in her comfort leave and was not in any pain because the wound on her sacrum was almost healed. Resident #2 felt her wound was still healing after the low air loss mattress was removed so she was okay with it. Resident #2 was asked if she had received wound care the past two weekends and she said she could not remember for sure, But on the weekends, there is not much of any care happening. Resident #2 assumed she did not get wound care the past two weekends and said every now and then she will get physical therapy on a Saturday, but that was it. Resident #2 stated she was not tended to as well on the weekends and felt the staff provided much less can that during the weekdays. 3. An interview with LVN E on 06/04/25 at 10:13 AM revealed ADON C currently did all wound care in the facility, unless a dressing was soiled or dislodged, then the charge nurses could do it as needed, but everything else, the wound care nurse completes. An interview with central supply staff (CS F) on 06/04/25 at 10:49 AM revealed she was responsible for ordering a resident's low air loss mattress and had a company she rented them from who could usually supply them to the facility on the same day once ordered. CS F stated Resident #2's low air loss mattress pump got dislodged and the facility had ordered her another one but claimed Resident #1 did not want it and said it was uncomfortable. CS F stated, With the mattress, they [residents in general] don't like that they can't have all the extra bedding on it. With setting a low air loss mattress to the correct setting, CS F stated that was determined by the weight of the resident and the nurse was the one who usually set it. CS F stated, I can do it, but most of the time I go plug them up and then the nurse or treatment nurse will adjust it to the correct setting. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow up interview with the DON on 06/04/25 at 11:36 AM revealed for Resident #2, the missing TAR documentation of wound care being provided was part of the reason why the previous wound care nurse had to go. The DON stated the previous wound care nurse was clicking and signing off on the pain section of the TAR which was right above the box to indicate wound care was provided. She said the previous wound care nurse was clicking that she was assessing the resident's pain but was not going back into the TAR to indicate that she completed the wound care. The DON stated on the weekends, usually there was a nurse weekend supervisor who did the wounds, but that nurse had taken time off due to a family issue, so the charge nurses were having to complete it. She said, We make sure they do it because we check the dressings to see that they are dated with a signature since they did not click it off [chart on e-TAR]. We do run audits in [e-chart] and I address it with the nurses and med aides every morning. The DON stated she was always in the facility halls rounding and did not stay in her office a lot. She stated in the mornings, she checked her documentation at home to see what was not done as the e-charts had a system in place to audit missed medications/treatments. She stated on the weekends, I call up to the facility and check in on them. The DON stated for the past four days, ADON C (who currently does wound care) had been out of the facility because she was currently in school and was off on the mornings. With low air loss mattresses, the DON stated the charge nurses needed to know settings as well as the wound care nurse, they need to check to make sure because family members come around and fiddle with it. The DON stated the purpose of a low air loss mattress was to give the resident support and that whatever they were lying on was not preventing blood flow to boney areas. The DON stated she knew about Resident #2 not wanting a low air loss mattress and said her wound was still healing. The DON stated if a resident did not want a low air loss mattress, the protocol was to let the family member know and then educate the resident and family to let them know the risks and benefits of not using one. The DON stated, I am sure they told the [family member] but you know these days, if people don't want it, that's okay, but we explain why they need it. 4. Record review of the facility's policy titled, Wound Care, last revised November 2017 reflected, Steps in the Procedure- . 11. Remove dry gauze. Apply treatments as indicated; 12. Dress wound. Pick up sponge and apply directly to area. [NAME] tape with initials, time, and date and apply to dressing. Documentation-The following information should be recorded in the resident's medical record: 1) The type of wound care given; 2)The date and time the wound care was given; 3) The name and title of the individual performing the wound care; 4) Any change in the resident's condition; 5) All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound; 6) Any problems or complaints made by the resident related to the procedure; 7) If the resident refused the treatment and the reason(s) why; 8) The signature and title of the person recording the data.