STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676372	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines North Nursing and Rehabilitation Center	1301 Mallette Drive Victoria, TX 77904

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26481 Based on interview and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 5 residents (Resident #5) reviewed for accuracy and completeness of clinical records, in that: The facility failed to accurately document Resident #5's wound care status in her wound administration record. This failure placed facility residents at risk for lack of wound care or incorrect wound care due to misinformation by incomplete and inaccurate medical records. Findings included: Record review of Resident #5's face sheet, dated 08/19/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: heart failure, end-stage renal disease with dialysis (kidney failure which required blood to be filtered several times a week by a special machine), protein-calorie malnutrition (insufficient intake to meet required body's nutritional needs for protein and calories causing weight loss and muscle loss), atherosclerotic heart disease (hardening of the arteries), atrial fibrillation (irregular heart beat), peripheral vascular disease (narrowing of the arteries to the hands and/or feet), cirrhosis of liver (liver disease that can lead to organ failure), and cardiac defibrillator (mechanical device implanted in the body to assist the heart with beating). Record review of Resident #5's Admission MDS, dated [DATE], revealed a BIMS score of 12 out of 15, which indicated the was independent in making decisions, and the resident was admitted to the facility with a skin tear and 3 unstageable DTIs (form of pressure-induced damage to underlying tissues, which include muscles and bones while the skin surface remains intact). Record review of Resident #5's care plan revealed the resident had a skin tear to her left lower leg, and DTI to left lateral (outer) heel, right heel, and sacrum. Under interventions was listed, Administer treatments as ordered and monitor for effectiveness. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's Weekly-Ulcer Assessment, dated 07/19/24, for the Skin Tear on the resident's left lower extremity (leg) revealed she was admitted with skin tear, the physician was notified and gave an order to cleanse the skin tear to the left lower extremity with wound cleanser, pat dry with gauze, apply Therahoney to wound bed, cover with dressing, and wrap with kerlix every other day or as needed until resolved. Record review of Resident #5's Weekly-Ulcer Assessment, dated 07/19/24, for the DTI on the resident's right heel revealed she was admitted with DTI, the physician was notified and gave an order to cleanse the DTI to the right heel with wound cleanser, pat dry with gauze, apply skin prep, and leave open to air till resolved. Record review of Resident #5's Weekly-Ulcer Assessment, dated 07/19/24, for the DTI on the resident's left lateral heel revealed she was admitted with DTI, the physician was notified and gave an order to cleanse the DTI to the left heel with wound cleanser, pat dry with gauze, apply skin prep, and leave open to air till resolved. Record review of Resident #5's Weekly-Ulcer Assessment, dated 07/19/24, for the DTI on the resident's sacrum (area between the two hip bones to the lowest vertebra of the spine) revealed she was admitted with DTI, the physician was notified and gave an order to cleanse the DTI to the sacrum with wound cleanser, pat dry with gauze, apply skin prep, and leave open to air till resolved. Record review of Resident #5's Physician Order Summary report, dated 08/19/2024, revealed the following wound orders: - Cleanse skin tear to left lower extremity with wound cleanser, pat dry, pat dry with gauze, apply Therahoney to wound bed, cover with pad, wrap with kerlix every other day and as needed until resolved, with a start date of 07/19/2024. - Cleanse DTI to left lateral heel with wound cleanser, pat dry with gauze, apply skin prep, leave open to air every day until resolved, with a start date of 07/19/2024. - Cleanse DTI to right heel with wound cleanser, pat dry with gauze, apply skin prep, leave open to air every day until resolved, with a start date of 07/19/2024. - Cleanse DTI to sacrum with wound cleanser, pat dry with gauze, apply skin prep, leave open to air every day until resolved, with a start date of 07/19/2024. Record review of Resident #5's July 2024 WAR revealed wound care to the resident's skin tear to her left lower extremity, wound care to the DTIs on her left heel, right heel and sacrum were not documented as provided on 07/22/2024 and 07/28/2024. Further review revealed there was no documentation of if attempts to provide wound care to the resident were made on 07/22/2024 or 07/28/2024. During a telephone interview on 08/20/2024 from 12:17 p.m. to 12:40 p.m., LVN B stated she worked on 07/22/2024 and 07/28/2024. LVN B stated she only provided wound care to Resident #5 on 07/28/2024, could not remember if she documented the wound care was done on 07/28/2024 and did not know why she did not document on the WAR that wound care was provided to Resident #5 on 07/28/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 08/20/2024 at 2:29 p.m., the Interim DON stated she was the Interim DON from 06/01/2024 to 08/09/2024. The Interim DON stated she assisted LVN B with her workload by providing wound care to Resident #5 on a Monday (07/22/2024) and forgot to document that wound care was provided due to being so busy. During an interview on 08/20/2024 at 1:43 p.m., the Administrator stated wound care should be documented in the WAR after it had been completed. The Administrator stated just because wound care was not documented as being completed did not indicate that wound care was not provided to the resident. The Administrator stated that the nurse could have been busy and forgot to document that wound care was done and she could not think of any harm to the resident. During an interview on 08/20/2024 at 2:00 p.m., the Regional Compliance Nurse, who was the acting Interim DON, reviewed Resident #5's July 2024 WAR and verified wound care was not documented as provided to the resident on 07/22/2024 and 07/28/2024. The Regional Compliance Nurse stated wound care should be documented in the WAR after it was provided to residents and there would be no harm to the resident by not documenting it completed on the WAR. Record review of the undated Dressing Change Checklist policy revealed verifies orders for wound treatment from .chart documents procedures per facility policy.