STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745021	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindale Specialty Care Center	13905 Fm 2710 Lindale, TX 75771

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interviews and record review, the facility failed to ensure the necessary treatment and services, in accordance with comprehensive assessment and professional standards of practice, to prevent development of pressure injuries was provided for 1 of 4 Residents (Resident #1) reviewed for pressure injuries. The facility failed to prevent deterioration for Resident #1 of MASD of bilateral buttock to a necrotic unstageable pressure ulcer. The facility failed to ensure wound care was provided twice a day as ordered to Resident #1's MASD of the bilateral buttocks to prevent deterioration. Resident #1 did not receive 6 of 10 wound care treatments to his bilateral buttocks. The facility failed to follow their policy by not assessing Resident #1's deteriorating wound. The facility failed to have a system in place to ensure treatments and assessments were being performed per orders and policy. This failure resulted in an identification of an Immediate Jeopardy (IJ) On 5/31/24 at 3:30 p.m. While the IJ was removed on 6/01/24, the facility remained out of compliance with a scope identified at a pattern and a severity of no actual harm with a potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk for new development or worsening of existing pressure injuries, pain, and decreased quality of life. Findings included: 1. Record review of the face sheet dated 6/4/24 indicated Resident #1 was an [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including chronic kidney disease, diabetes, hypertension (elevated blood pressure), and congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should). (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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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS score of 13 and was cognitively intact. The MDS indicated Resident #1 required substantial/maximum assistance with toileting hygiene, showering/bathing, rolling to the left and right, moving from sitting to lying, and moving from lying to sitting on the side of the bed. The MDS indicated Resident #1 was dependent with transfers. The MDS indicated Resident #1 was at risk for developing pressure ulcers/injuries. The MDS indicated Resident #1 had 1 stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bones, tendon, or muscle is not exposed. Slough (any yellowish material noted in the wound bed) may be present but does not obscure the depth of tissue loss) pressure ulcer and 2 unstageable pressure ulcers. The MDS indicated the 1 stage 3 pressure ulcer, and 2 unstageable pressure ulcers were present upon admission to the facility. Record review of the care plan last revised on 5/23/24 indicated Resident #1 had a potential risk for impairment to skin integrity related to fragile skin and decreased mobility with interventions including monitor/document location, size, and treatment of skin injury and report abnormalities, failure to heal, signs and symptoms of infection, maceration (a softening and breaking down of the skin resulting from prolonged exposure to moisture), etc. to the physician. The care plan indicated Resident #1 required a foley catheter (type of urinary catheter). Record review of the physician orders dated 6/4/24 indicated Resident #1 had an order to clean bilateral buttocks with normal saline or wound cleanser then apply barrier cream every shift for MASD starting 5/23/24. The physician orders indicated Resident #1 had an order to cleanse the open area to the sacrum with normal saline or wound cleanser, apply collagen, and cover with a dry dressing starting 5/29/24. The physician orders indicated Resident #1 had an order to cleanse open area to the sacrum with normal saline or wound cleanser, apply calcium alginate (a highly absorptive dressing composed of calcium sodium alginate that creates a comfortable protective gel when in contact with drainage and helps maintain a moist wound environment), and cover with dry dressing every day shift starting 5/30/24. Record review of the TAR for May 2024 indicated Resident #1 was scheduled to have wound care to his bilateral buttocks as ordered during the day shift on 5/24/24, 5/25/24, 5/26/24, 5/27/24, and 5/28/24 and during the night shift on 5/23/24, 5/24/24, 5/25/24, 5/26/24, and 5/27/24. The TAR indicated Resident #1 did not have wound care performed to his bilateral buttocks on the day shift on 5/26/24 and on the night shift on 5/23/24, 5/24/24, 5/25/24, 5/26/24, and 5/27/24. The TAR indicated Resident #1 was scheduled to have wound care performed to the open area to his sacrum on 5/29/24 and 5/30/24. The TAR indicated he did not have wound care performed to the open area to his sacrum on 5/29/24. Record review of the skin assessment dated [DATE] indicated Resident #1 had discoloration to his buttocks. The skin assessment indicated Resident #1's buttocks previously had fragile scar tissue now with purple discoloration and some noted partial thickness (wounds that extend into the first two layers of skin) opening. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the skin assessment dated [DATE] indicated Resident #1 had MASD to his buttocks. The skin assessment indicated Resident #1 had treatments in place to his wounds. The skin assessment indicated Resident #1 had a low air loss mattress (mattress designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown). The skin assessment indicated Resident #1 had frequent loose bowel movements (bowel movements that may be watery, mushy, or shapeless). The skin assessment indicated Resident #1 was unaware of bowel movements. Record review of the Wound assessment dated [DATE] indicated Resident #1 had MASD to the sacrum starting 5/20/24 measuring 9cm x 5cm with partial thickness scattered 0.1cm. Record review of a nursing progress note dated 5/23/24 indicated upon getting Resident #1 ready for an appointment it was noted he had MASD with open areas to his bilateral buttocks. The progress note indicated the area was cleansed and the progress note indicated a new order was obtained for barrier cream to the bilateral buttocks for MASD and to cover with a dressing as needed. Record review of the Wound assessment dated [DATE] indicated Resident #1 had a pressure ulcer to his sacrum that was reclassified from MASD to unstageable (type of pressure ulcer that is unstageable due to being covered by necrotic tissue and occurs when prolonged pressure on the skin prevents blood flow and oxygen from reaching the tissue). The Wound Assessment indicated the pressure ulcer to Resident #1's sacrum measured 11cm x 10cm x 0.1cm. The Wound Assessment indicated contributing factors to Resident #1's pressure ulcer included immobility, increased bowel incontinence, diabetes, hospitalization , and worsening since re-admission. Record review of the progress note from the wound care physician dated 5/30/24 indicated Resident #1 had an unstageable (due to necrosis) full thickness pressure ulcer to his sacrum measuring 11cm x 10cm x 0. 1cm with 40% slough in the wound bed. The progress note indicated the wound care physician recommended to off load the wound by turning side to side in the bed every 1-2 hours, limit sitting to 60 minutes, and utilizing a low air loss mattress. During an interview on 5/31/24 at 12:02 p.m. Resident #1 was needing something for his bottom. said he had a wound on his bottom, and it hurt. Resident #1 said he had a round cushion to sit on but still need something to aid with the pain. Resident #1 said he was being seen by the wound care doctor, but his wound was not getting any better. Resident #1 said the facility staff were treating his wound, but he did not know how often. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/31/24 at 1:02 p.m. the Wound Care Doctor said when Resident #1 came out of the hospital, he had MASD to his bilateral buttocks that was not over a bony prominence. The Wound Care Doctor said the wound now covered both Resident #1's buttocks and the sacrum. The Wound Care Doctor said the wound was necrotic and had slough in the wound bed. The Wound Care doctor said several factors could have contributed to the deterioration of Resident's #1's wound including incontinent care not being performed in a timely manner, lack of turning and repositioning, and decreased nutrition. The Wound Care Doctor said he originally ordered wound care for the MASD twice a day due to the amount of drainage the MASD to Resident #1's wound had. The Wound Care Doctor was not aware wound care for Resident #1 had not been performed to the MASD on the day shift of 5/24/24 or on the nights shifts of 5/23/24 through 5/27/24. The Wound Care Doctor said he could not say for sure if the lack of wound care had contributed to the deterioration to the bilateral buttocks and sacrum. The Wound Care Doctor said if the drainage had subsided once daily may have been sufficient. The Wound Care Doctor did say he expected his orders to be followed and when the order was written for twice daily it was due to drainage and to prevent deterioration of the wounds. Record review of the facility's Documentation of Wound Treatments dated 7/2022 indicated, The facility completes accurate documentation of wound assessment and treatments, including response to treatment, change in condition, and changes in treatment. Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates .Wound treatments are documented at the time of each treatment. If no treatment is due, an indication on the status of the dressing shall be documented each shift (i.e., clean, dry, intact). Additional documentation shall include but is not limited to: a. Date and time of wound management treatments. b. Weekly progress towards healing and effectiveness of current intervention. c. Any treatment for pain, if present. d. Modifications of treatment or interventions. e. Notifications to physician and/or responsible part regarding wound or treatment changes. This was determined to be an Immediate Jeopardy (IJ) on 5/31/24 at 3:43 p.m. The Administrator was notified. The Administrator was provided with the Immediate Jeopardy template on 5/31/24 at 3:48 p.m. The following Plan of Removal submitted by the facility was accepted on 6/1/24 at 11:36 a.m. and included: 1. Immediate actions The Medical Director (Resident #1's Primary Care Physician) was notified by the Director of Nursing on 05/31/2024 of the Immediate Jeopardy. A full skin sweep was completed on all residents on 05/31/24 by the Wound Care Nurse and the Director of Nursing. There were no further negative findings with the full facility skin sweep. The Director of Nursing verified that Resident #1's wound care was performed and documented. Resident #1's RP and provider were notified by the Director of Nurses, of the negative findings. All residents were reviewed to ensure head-to-toe skin and wound assessments were completed appropriately, by the Director of Nurses and Wound Care Nurse. 2. Education (provided by the DON, the ADON or Designee) (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The VP of Clinical Services in-serviced the Director of Nursing and Wound Care Nurse on all of the below in-services on 05/31/2024. All nurses were in-serviced by the Director of Nursing on appropriately completing skin assessments and notifying the provider of all newly identified skin issues in a timely manner on 05/31/2024. Each nurse will be in-serviced prior to returning to shift. This will be completed by 06/01/2024 and nurses will not return to shift without the in-service. The Director of Nursing and the Wound Care Nurse were responsible for ensuring each nurse completed their skin assessments and wound treatments. The Director of Nurses and/or the Wound Care Nurse will monitor the omissions report for wound care, prior to leaving their shifts for the day. Wound care will be assigned to another nurse by the DON or designee, if the attending nurse was not able to complete wound care for their shift. In the electronic healthcare system, there was a reports selection to monitor if there were any omissions in the ETAR's and EMAR's. The Director of Nursing or designee can access the EMARs and ETARs through the software system as well. Schedules were auto created through the Electronic Medical Record system. Nursing staff were in-serviced by the Director of Nursing on 05/31/2024, to notify the Director of Nurses before the end of their shift if they were not able to complete their wound care treatments. This must be communicated in the electronic health reporting system so there was documentation of this being performed. The VPCO, the Administrator, the DON, the ADON, and the Wound Care Nurse monitor the system constantly throughout the entire 24-hour period. The VPCO, the Administrator, the DON, and the Wound Care Nurse will ensure any entries in the system were addressed and all wound care was completed or reassigned to another nurse if needed. The Director of Nursing in-serviced nursing staff on 05/31/24, to complete an audit of their EMARs and ETAR's with the oncoming nurse to ensure there were no omissions in the EMAR's and ETARs for their shift. Each nurse will sign off that they agree there were no omissions. The signature sheet will be reviewed by the Director of Nurses, daily for the next 90 days. The Wound Care Nurse and the DON were re-trained on how to pull the omissions report and directed to check it daily during am clinical meeting, to ensure no treatments were missed going forward, by the VP of Clinical Operations on 5/31/24. If omissions were noted on the report, the nurse responsible for the omission would be contacted immediately by the Director of Nurses or designee to complete documentation related to the omission. The director of Nursing was educated on this process by the VP of Clinical Operations on 05/31/24. All nurses were in-serviced by the Director of Nursing on Policy and Procedure for Pressure Injury Prevention and Skin and Wound Care Management on 05/31/24. This in-service will be completed by 06/01/2024 and nurses will not return to shift without the in-service. This in-service included appropriately completing skin assessments, information on pressure and injury prevention, treatment for non-pressure injuries, accurate documentation of treatments provided, and the importance of wound care management and following the treatment orders. 3. Medical Director - The Medical Director has been notified of the Immediate Jeopardy. 4. QAPI Committee Review - An interim QAPI committee meeting will be completed on 06/01/2024. On 6/1/24 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observations, interviews, and record reviews were conducted on 06/01/24 from 6:57 p.m. through 10:03 p.m. including the following: Record review of the Skin Sweep Audit Sheet dated 05/31/24 listed all residents' names and highlighted yellow indicated completed and verified skin assessments dated 05/31/24 were documented for all 84 residents. Record review of a QAPI committee signature sheet dated 05/31/24 indicated a meeting was held regarding treatment/services to prevent/heal pressure ulcers. Record review of Resident #1's five-page Treatment Administration Record (TAR) from 5/1/24 to 5/31/24 indicated that the DON and the Wound Nurse reviewed the TAR. Record review of in-services dated 05/31/24 indicated the DON, Wound Care Nurse, and nurses were trained on completing skin assessments and wound treatment, notifying the provider of all newly identified skin issues in a timely manner, pressure injury prevention and management, audit from shift to shift to verify EMAR and ETAR are complete with the off going and oncoming nurse with signature sheet, nurses to notify the DON if unable to complete treatments as ordered on their shift, all documentation on MAR and TAR should be completed prior to leaving shift, pulling omissions report daily, monitor the report, and address any omissions before the end of the day, pressure injury prevention, treatment for pressure and non-pressure injuries, importance of wound care management and following treatment orders, if Wound Care Nurse was unable to complete treatments or skin assessments, and the DON or designee would assign duties to another nurse and ensure duties were completed. During interviews with the DON and Wound Care Nurse, they said they completed a skin sweep on 05/31/24 and all residents had skin assessments completed. They said Resident #1's wound care was completed and documented as completed. They said they were in-serviced regarding completing skin assessments and notifying the provider of all newly identified skin issues in a timely manner. They said they were responsible for ensuring nurses completed skin assessments and wound care treatments. They said they were in-serviced on monitoring the omissions report for wound care in the electronic healthcare system. They said the Wound Care Nurse would complete all treatments and skin assessments and on the days the Wound Nurse was not available, treatments and skin assessments would be delegated to another nurse. They said an audit of the EMAR and ETAR would be completed with the off going and oncoming nurse to ensure there were no omissions for the shift and each nurse would sign off that they agree there were no omissions. The DON said nurses would use barrier creams during patient care on residents with wounds and CNAs would use barrier creams on all other incontinent residents. They said they were in-serviced on appropriately completing skin assessments, pressure injury prevention, treatment for pressure and non-pressure injuries, accurate documentation of treatments provided, and the importance of wound care management and following treatment orders. The Wound Care Nurse said on Thursdays, wound assessment profiles were scheduled on all Big Wounds (anything Wound doctor sees) and Wound Doctor visits/made rounds. She said 100 Hall skin checks were scheduled on Mondays, 200 hall skin checks were scheduled on Tuesday, 300 hall skin checks were scheduled on Wednesday, and 400 hall skin checks were scheduled on Friday. During interviews with the Administrator, DON, and Wound Care Nurse, they said nurses were in-serviced on completing skin assessments and notifying the provider of any new skin issues identified in a timely manner. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 6/1/24 at 9:55 p.m. LVN B was able to demonstrate using the facility's computer on the 100 Hall nurse cart how to complete an audit of their EMARs and ETARs. Observed and verified the staff signature sheets located in the narcotic notebook the oncoming nurse and the off going nurse at each shift change used to verify that there was nothing in red on the previous shift prior to taking the shift assignment. During an observation on 6/1/24 at 9:58 p.m., the DON and the Wound Care Nurse were able to demonstrate on facility computer how to pull the omissions report. During interviews with LVN B (DOH 04/30/24, worked 6:00 p.m. to 6:00 a.m. and 2:00 p.m. to 6:00 a.m.), LVN C (DOH - December 2023, worked 6:00 a.m. to 6:00 p.m. and 6:00 a.m. to 12:00 a.m.), and LVN D (DOH - April 2024, worked 6:00 p.m. to 6:00 a.m.), said they were in-serviced on completing skin assessments and notifying the provider of any new skin issues timely. They said the Wound Care Nurse was responsible for completing treatments and skin assessments and if the Wound Nurse was not available, treatments and skin assessments would be delegated to another nurse. They said they were in-serviced on notifying the DON and documenting in the electronic record if they were not able to complete an assigned skin assessment or treatment during their shift. They said they would notify the DON before the end of their shift if they were unable to complete a skin assessment or treatment. They said they were in-serviced on the importance of wound care and following treatment orders, pressure injury prevention, treatment for non-pressure injuries, accurate documenting of treatments provided, and completing skin assessments. They said the DON in-serviced on auditing the EMAR and ETAR with the off going and oncoming nurse to verify there were no omissions in the EMAR or ETAR during the shift. On 6/1/24 at 10:03 p.m. the Administrator was informed the IJ was removed; however, the facility remained out of compliance the facility remained out of compliance with a scope identified as pattern and a severity of no actual harm with a potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.