STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676365	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOW PARK REHABILITATION AND CARE CENTER	**300 CROWNE POINT BLVD WILLOW PARK, TX 76087**

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** 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 are complete, accurately documented and readily accessible for one (Resident #1) of 5 residents reviewed for clinical records. The facility failed to ensure the nursing staff accurately documented Resident #1's skin condition and treatments. This failure could place residents at risk for delays in treatment and worsening of skin conditions due to incomplete and in accurate clinical records. Findings included: Review of Resident #1's Admission Record dated 09/01/20 revealed the [AGE] year old male resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He discharged home on[DATE]. Review of Resident #1's Nursing Admission Evaluation dated 06/23/20 revealed the resident had surgical wounds to his left hip and upper right chest and bruising to his bilateral arms. He did not have any pressure ulcers. Review of Resident #1's Care Plan dated 06/23/20 revealed the resident had actual impairment to skin integrity of the chest related to a surgical wound and to the left hip related to a surgical wound, the interventions included to monitor/document location, size and treatment of [REDACTED]. Review of Resident #1's admission MDS dated [DATE] revealed the resident was moderately cognitively impaired with a BIMS score of 10 (a score of 8-12 indicated moderate cognitive impairment). His [DIAGNOSES REDACTED]. His weight was 194 pounds and he had no nutritional issues. He had no behaviors and no rejection of care. He was extensive assistance of two staff for transfers. He was frequently incontinent of bowel and bladder. He was at risk for pressure ulcers/injuries but did not have any unhealed pressure ulcers/injuries. He did have surgical wounds. He had no skin and ulcer/injury treatments. Review of Resident #1's Braden Scale for Predicting Pressure Sore Risk dated 07/14/20 revealed the resident was at moderate risk for pressure sores. Review of Resident #1's physician's orders [REDACTED]. Resident #1's Care Plan dated 07/16/20 revealed the resident had two non-stageable pressure ulcers to bilateral heels, right heel measured 4.5 x 4 cm and the left measured 3.5 x 3.5 cm. The interventions included follow the facility's policies/protocols for the prevention and treatment of [REDACTED].#1's Treatment Administration Record dated 07/01/20 - 07/31/20 revealed no documentation of any wound care treatments until 07/23/20. Review of Resident #1's Skilled Nurses Note dated 07/16/20 at 1:35 PM revealed the form had a section for Skin Conditions and the surgical wounds were documented but the pressure ulcers/injuries to his heels were not documented. The form also had a section for Services Provided, which included skin treatments and pressure ulcer treatment, but none were documented. The progress notes on the form did not document any skin issues. In an interview on 09/01/20 at 11:35 AM the Rehab Director said nursing was responsible for the resident's skin assessments and wound care. She said the therapy notes documented bandages to his lower extremities on 07/16/20 and 07/21/20. Review of Resident #1's Nursing Progress Notes dated 07/16/20 did not contain any documentation regarding his wounds. There was no nursing progress note for 07/17/20. Review of Resident #1's Nursing Progress Notes dated 07/18/20 did not contain any documentation regarding his wounds. Review of Resident #1's Skilled Nurses Note dated 07/18/20 at 12:47 PM revealed the form had a section for Skin Conditions but no skin issues were documented. The form also had a section for Services Provided, which included skin treatments and pressure ulcer treatment, but none were documented. The progress note on the form did not document any skin issues. There was no nursing progress note for 07/19/20. Review of Resident #1's Nursing Progress Note dated 07/20/20 did not contain any documentation regarding his wounds. Review of Resident #1's Skilled Nurses Note dated 07/20/20 at 2:11 PM revealed the form had a section for Skin Conditions and the surgical wounds were document but the pressure ulcers/injuries were not documented. The form also had a section for Services Provided, which included skin treatments and pressure ulcer treatment, but none were documented. The progress notes on the form did not document any skin issues. Review of Resident #1's Physician order [REDACTED]. Review of Resident #1's Skilled Nurses Note dated 07/22/20 at 12:51 PM revealed the form had a section for Skin Conditions and the surgical wounds were document but the pressure ulcers/injuries were not documented. The form also had a section for Services Provided, which included skin treatments and pressure ulcer treatment, but none were documented. The progress notes on the form did not document any skin issues. Review of Resident #1's Skin/Wound Note dated 07/23/20 at 3:55 PM, LVN A documented, daily dressing to bilateral heels completed; has very little exudate coming from the wounds now. Remain unstageable with very little change. Review of Resident #1's Skin/Wound Note dated 07/24/20 at 2:30 PM, LVN A documented, the resident had discharge planned for 07/25/20; treatment information for wound will be sent home with resident. Bilateral heel wounds, continue seeping clear fluid. Wound care completed today, no signs or symptoms of infection noted. Review of Resident #1's Skilled Nurses Note dated 07/25/20 at 9:42 AM revealed the form had a section for Skin Conditions and the surgical wounds were documented but the pressure ulcers/injuries were not documented. The form also had a section for Services Provided, which included skin treatments and pressure ulcer treatment, but none were documented. The progress notes on the form did not document any skin issues. Review of Resident #1's Nursing Progress note dated 7/25/2020 at 10:39 AM revealed the resident was taken to the front of building with his medications and suitcases. Discharge papers were given to his daughter and she signed them. Medications explained to daughter and sheet tells how to take them. There was no documentation regarding his wounds. In an interview on 09/01/20 at 2:05 PM RN B, who was Resident #1's charge nurse, said he did not remember anything about Resident #1's skin condition but the resident did have some [MEDICAL CONDITION] to his lower extremities. He said the resident did ambulate to the bathroom, at times, without assistance but he was encouraged to call for assistance. In an interview on 09/01/20 at 2:16 PM LVN A said she was the wound nurse for about two weeks and saw Resident #1. She said the previous wound nurse left the position to work the weekends. She said she did not know when Resident #1's wounds developed and only found two wound care notes in the electronic medical record. She said she did not know if there were more notes in the nursing progress notes. She said when she saw the wounds on the resident's heels there was small dark areas of eschar with very little drainage and no signs or symptoms of infection. In an interview on 09/01/20 at 3:26 PM the DON said Resident #1's wounds were found on 07/16/20 and wound care was started on 07/16/20 but LVN A was new to the wound care position and did not know how to enter the treatment order it the computer correctly for it to appear on the Treatment Administration record and therefore, the daily treatment was not documented. She said Resident #1 was receiving the daily wound care treatment, as ordered by the physician, but it was not documented. In telephone interview on 09/01/20 at 3:40 PM Resident #1's physician said the facility was having a difficult time with staffing in July 2020 because of a COVID-19 outbreak. He said Resident #1's pressure sores were unavoidable because the resident had [MEDICAL CONDITION] and vascular insufficiency to his lower extremities. He said he believes the nursing staff were doing the wound care daily, as ordered, but the facility had different nurses doing the wound care because of the outbreak. In an interview on 09/01/20 at 4:20 PM ADON C said she looked for other notes regarding Resident #1's wound care and skin assessments but could only find one handwritten note in the ADON office regarding a skin assessment on 07/16/20. She said she could not find any other skin assessments. She said there were no weekly skin

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676365	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOW PARK REHABILITATION AND CARE CENTER	**300 CROWNE POINT BLVD WILLOW PARK, TX 76087**

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	(continued... from page 1) assessments in the electronic medical record from 06/24/20 to 07/16/20 (2 weeks). She said the resident skin should have been assessed weekly from his admission. She said she did not know why the nursing staff failed to address the resident's pressure ulcers and treatment on the Skilled Nurses Notes from 07/16/20 - 07/25/20. Review of Resident #1's handwritten Weekly Skin assessment dated [DATE] completed by LVN A revealed the resident had two unstageable pressure ulcers (definition on the form: unstageable full thickness tissue loss in which the base of the ulcer is covered by eschar - tan, brown or black in the wound bed) on his left and right heels. The left heel had eschar and measured in length 3 x 5 cm and in width 3 x 5 cm. The right heel had eschar and measured in length 4 x 5 cm and in width 4 x 0 cm. The form documented the family was notified of the finding to the resident's bilateral heels. The resident was alert and oriented x 4. Treatment orders received by the physician and started immediately. The interventions included: pressure reducing device for his bed, off-loading of his heels, turning and re-positioning and nutrition and hydration intervention. In an interview on 09/01/20 at 5:15 PM the DON said the expectation was for the resident's skin condition to be assessed weekly by the floor nurse or the treatment nurse and documented. She said she thinks some of the assessments may have been done on paper because the facility was having issues with the electronic medical records system. In an interview on 09/01/20 at 5:21 PM LVN A said Resident #1's physician ordered treatment was being done daily and she started the treatment on 07/16/20 but she did not click for the order to be carried over to the Treatment Administration Record and the daily treatments were not documented on the Treatment Administration Record until 07/23/20 (from 07/16/20 - 07/23/20 was 6 days). She said the skin assessments were scheduled for either the charge nurses or the wound care nurse to complete weekly. She said she did not know why Resident #1's skin assessments were not completed weekly. Review of the facility's Charting and Documentation Policy dated July 2017 revealed all services provider to the resident or changes in the resident's medical condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record may be electronic, manual or a combination. Documentation of procedures and treatments will include care-specific details, including: date and time the procedure/treatment was provided, name and title of individual who provided the care, the assessment data and/or any unusual findings obtained during the procedure/treatment.