STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455959	A. BUILDING _____ B. WING _____	**09/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTWARD TRAILS NURSING AND REHABILITATION	**3001 WESTWARD DR NACOGDOCHES, TX 75964**

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 0580 **Level of harm** - Actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was consulted regarding a need to alter treatment and notify the resident's representative for 1 of 1 residents reviewed for notification. (Resident #1) The facility did not consult the physician for a treatment when Resident #1 sustained two skin tears; when the skin tears worsened to a Stage 2 pressure injury; and when the Stage 2 declined to an unstageable pressure injury. The facility did not notify the Resident #1's representative when her wound worsened from skin tears to an unstageable pressure injury. This failure could place residents at risk decreased quality of care, health decline and having their medical needs met by a physician. Findings included: Resident #1's physician's orders [REDACTED]. The most recent MDS dated [DATE] indicated Resident #1 was totally dependent and required on one person to physically assist with bed mobility, and personal hygiene. Resident #1 and was incontinent of bowel and bladder. The assessment indicated Resident #1 was at risk for pressure injuries, but no skin conditions were identified. A Braden Scale assessment dated [DATE] indicated Resident #1 was at moderate risk of pressure injury development. A care plan initiated 08/11/20 indicated Resident #1 developed skin tears to the right buttock. The following interventions were checked on the care plan: handle carefully during transfers/repositioning, treatment to skin tears per physician orders, and use draw sheets to reposition when in bed. The care plan did not address pressure injuries. A Wound Evaluation Flow Sheet dated 08/11/20 indicated Resident #1 had a skin tear to the right buttock that measured 1.7 cm (centimeters) x 4.7 cm with irregular margins. The Wound Evaluation Flow Sheet only noted one skin tear. A Weekly Non Pressure Injury QI (Quality Improvement) Log dated 08/13/20 indicated Resident #1 had two skin tears to the right buttock on 08/11/20. One measured 2.6 cm x 4.7 cm and the other measured 1.7 x 2.3 with irregular wound margins. The skin tears were to be cleaned with wound cleanser, patted dry, collagen applied, and covered with a dry dressing daily until healed. During an interview on 09/03/20 at 2:23 p.m., the Treatment Nurse clarified the wound to Resident #1's right buttock started as two skin tears. A physician telephone order written 08/11/20 indicated Resident #1 was to receive collagen for the skin tears to the right buttocks. The order was not signed by the physician. A Weekly Pressure Injury QI Log dated 08/20/20 indicated the skin tears to Resident #1's right buttock decreased in size but worsened to a Stage 2. The Stage 2 measured 0.6 cm x 1.5 cm. The wound edges were irregular with no odor or drainage. The treatment remained unchanged but two supplements (Vitamin C and Zinc) were added as new interventions for Resident #1. The August 2020 Medication Administration Records for Resident #1 did not include Vitamin C or Zinc. During an interview on 09/04/20 at 11:26 a.m., the Treatment Nurse stated, It slipped my mind to get an order for [REDACTED]. The Wound Evaluation Flow Sheet dated 08/27/20 indicated the wound had yellow exudate, irregular margins, and an odor. The description of the wound bed was left blank. The Weekly Pressure Injury QI Logs dated 08/20/20 and 08/27/20 noted Resident #1 was non-compliant with turning and repositioning. The nursing notes for Resident #1 dated 06/01/20 to 09/02/20 indicated no documentation of being noncompliant with repositioning and/or turning. The nursing notes further indicated there was no documentation addressing the wound or evidence the physician was consulted about the wound between 08/11/20 to 09/03/20. During an interview on 09/03/20 at 10:30 a.m., LVN A denied Resident #1 was noncompliant with turning and repositioning. A care plan updated 08/19/20 did not indicate Resident #1 was noncompliant with repositioning and/or turning nor did it address Resident #1's pressure injuries. During an observation and interview on 09/03/20 at 8:59 a.m., Resident #1 was lying in bed on her left side with a wedge in place. The DON unsecured Resident #1's brief and a pungent odor was noted to an unstageable wound to the resident's right buttock. The edges of the wound were irregular with a small amount of exudate. Brownish/black eschar was noted to wound. The wound did not have dressing on it and there was a small amount of serosanguinous drainage noted on Resident #1's brief. The DON said she thought Resident #1 had a bowel movement, but the resident's brief was free of feces/urine. The resident was not observed to be resistant with being turned at the time of the observation. During an interview on 09/03/20 at 9:16 a.m., the Treatment Nurse said she measured Resident #1's wound on yesterday and it measured 4 cm x 5.5 cm. During an interview on 09/03/20 at 2:23 p.m., the DON said the wound to Resident #1's right buttock started as two skin tears. The next week they merged into one and became a Stage 2. The next week the wound was unstageable. The August 2020 Treatment Administration Record for Resident #1 indicated the skin tears were treated with collagen daily from 08/11/20 until 08/26/20. During an interview on 09/04/20 at 11:26 a.m., the Treatment Nurse said initially the wound was a skin tear. When asked if she had received an order to treat the skin tear with collagen from the physician, she stated, No, I've just seen it work in the past. The Treatment Nurse said she had not notified Resident #1's responsible party the wound had worsened. She stated, the last notification was when it was a skin tear. A Pressure Injuries Policy revised on January 2019 noted, .It is the policy of this facility that a resident who enters the facility without an identified pressure injury will not develop a pressure injury unless the resident's clinical condition demonstrates that it was unavoidable .The physician should be notified, and a treatment order received for each pressure injury . A Pressure Injuries Policy revised on January 2019 noted, .Pressure Injury Staging .Stage 2 Partial-thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or ruptured serum-filled blister .Unstageable Full-thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed . The National Pressure Ulcer Advisory Panel guidelines dated 2016 noted, .Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin 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 not 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 (MASD) including incontinence associated [MEDICAL CONDITION] (IAD), intertriginous [MEDICAL CONDITION] (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions) .Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without [DIAGNOSES REDACTED] or fluctuance) on the heel or ischemic limb should not be softened or removed .
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement interventions based on the comprehensive assessment to prevent development and worsening of pressure injuries for 1 of 2 residents reviewed for pressure injuries. (Resident # 1) Resident #1 had two skin tears to the right buttock that worsened to an unstageable

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.

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) pressure injury. The facility did not obtain a physician's orders [REDACTED]. This failure could place residents with pressure injuries at risk for the development of new pressure injuries or worsening of existing pressure injuries. Findings included: Resident #1's physician's orders [REDACTED]. The most recent MDS dated [DATE] indicated Resident #1 was totally dependent and required on one person to physically assist with bed mobility, and personal hygiene. Resident #1 and was incontinent of bowel and bladder. The assessment indicated Resident #1 was at risk for pressure injuries, but no skin conditions were identified. During an observation and interview on 09/03/20 at 8:59 a.m., Resident #1 was lying in bed on her left side with a wedge in place. The DON unsecured Resident #1's brief and a pungent odor was observed from the unstageable wound to the resident's right buttock. The edges of the wound were irregular there was brownish/black eschar and a small amount of exudate (drainage) to wound. The wound was not covered with a dressing and was a small amount of serosanguinous drainage was on Resident #1's brief. When the pungent odor was first observed the DON said she thought Resident #1 had a bowel movement, but the resident's brief was free of feces and urine. The resident was not observed to be resistant with being turned at the time of the observation. A Braden Scale assessment dated [DATE] indicated Resident #1 was at moderate risk of pressure injury development. A care plan initiated 08/11/20 indicated Resident #1 developed skin tears to the right buttock. The following interventions were checked on the care plan: handle carefully during transfers/repositioning, treatment to skin tears per physician orders, and use draw sheets to reposition when in bed. The care plan did not address pressure injuries. 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Nurses' notes for Resident #1 dated 06/01/20 to 09/02/20 indicated no documentation of noncompliance with repositioning and/or turning. The nurses' notes further indicated there was no documentation addressing the wound or evidence the physician was consulted about the wound between 08/11/20 to 09/03/20. During an interview on 09/03/20 at 10:30 a.m., LVN A denied Resident #1 was noncompliant with turning and repositioning. A care plan updated 08/19/20 did not indicate Resident #1 was noncompliant with repositioning and/or turning and did not address Resident #1's pressure injuries. During an interview on 09/03/20 at 9:16 a.m., the Treatment Nurse said she measured Resident #1's wound on yesterday and it measured 4 cm x 5.5 cm. During an interview on 09/03/20 at 2:23 p.m., the DON said the wound to Resident #1's right buttock started as two skin tears. The next week they merged into one and became a Stage 2. The next week the wound was unstageable. 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