STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455494	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Wellness & Rehabilitation	7625 Glenview Dr North Richland Hills, TX 76180

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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 - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review the facility failed to ensure residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 3 residents (Resident #1) reviewed for treatment of pressure ulcers. The facility failed to follow their Wound Care management protocol when they failed to refer Resident #1 to the Wound care consultant at the time of her re-admission to the facility when she was admitted with a sacral pressure ulcer. Resident #1 was readmitted on [DATE] and facility did not refer the resident to the Wound Care consultant until 03/25/25. The noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 03/17/25 and ended on 03/25/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for worsening wounds, infection, and hospitalization . Findings included: Record review of Resident #1's Face sheet dated 04/07/25 revealed she was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses of unspecified displaced fracture of cervical vertebrae (neck region), fusion of spine-cervical region, osteoporosis (condition where bones become weak and brittle) with current pathological fractures (a bone break caused by underlying disease that weakens the bone structure) and severe protein-calorie malnutrition, Record review of Resident #1's 5-day MDS assessment dated [DATE] reflected the resident had a BIMS of 14 which indicated she was cognitively intact, required substantial to maximum assistance with ADLs, was always incontinent of bowel and urine, was at risk of developing pressure ulcers and had one stage III pressure (exposing the underlying fatty tissue, but not reaching muscle or bone) and one surgical wound. She had received Speech therapy, physical therapy, and occupation therapy with a start date of 03/18/25. Record Review of Resident #1's Physician order summary dated 04/07/25 reflected, Pressure relieving mattress and Pressure relieving chair cushion with a start date of 03/17/25 .Wound care for coccyx stage 2 pressure injury. Cleanse with wound cleanser. Apply Mepilex padded dressings every day and PRN .with a start date of 03/07/25 . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan with an initiation date of 03/17/25, reflected, [Resident #1] is at increased risk for impaired skin integrity and additional skin breakdown due to impaired ability to move and the resident being mostly incontinent of bowel and bladder. Resident with pressure injury to coccyx (the small bone at the bottom of the spine)upon admission .Goal .Resident's pressure injury will resolve or show improvement by review date .the resident will not have any additional skin breakdown through the next review period .Interventions .Educate resident/representative about the proper usage of pressure reducing devices .The resident has a low-air-loss mattress due to admitting with pressure injuries .Wound care to coccyx as ordered by the physician . Record review of Resident #1's skin assessments: 03/18/25- Pressure Injury to buttocks 03/21/25- Pressure injury to coccyx 2x3x.5 on admission 03/28/25- open wound to coccyx Record Review of Resident #1 Physician Telephone order dated 03/25/25 reflected, Wound Care Consult. Record review of Resident #1's Progress Note dated 03/27/25 at 11:22 am by ADON A, reflected, NP ordered Medi honey (supports the removal of necrotic tissue), calcium alginate (dressing used to absorb wound drainage) to cover with foam dressing. [Family member] aware of the order . Record Review of Resident #1's Wound care Physician's report dated 03/31/25, Location: Sacrum Measurement: 1.5 cm length 3.0 cm width Depth 0.50 cm Etiology: Pressure Stage/Severity: Stage 4 Date Wound Acquired: 03/17/25. Wound Status: Present on Admission %Slough (by product of the inflammatory phase of wound healing comparison of dead and living cells): 100% Treatment- daily wound cleanser, apply Santyl, Calcium alginate and cover with dry dressing. Record Review of Resident #1's Wound Care consult report dated 04/07/25, Location: Sacrum Measurement: 1.5 cm length 3.0 cm width Depth 0.50 cm (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Etiology: Pressure Stage/Severity: Stage 4 Date Wound Acquired: 03/17/25. Wound Status: Subsequent- Stable Undermining: From 5 o'clock to 7 o'clock 2.5 cm %Granulation (health new tissue) 50% %Slough: 50% Treatment: Treatment- daily wound cleanser, apply Santyl, Calcium alginate and cover with dry dressing. In an interview and observation with Resident #1 on 04/07/25 at 08:30 a.m. revealed resident in her room lying on an alternating pressure mattress. Resident was turned on her side with pillows supporting her arms and a pillow between her legs. Resident's family member was at bedside. Family member stated the Resident had been living at home when she suffered a fall and was taken to the hospital around the first of February. She stated she was transferred to this facility around the end of February. Family stated the resident was not progressing and getting weaker, so she requested an MRI to be completed since the resident was having decreased sensation in her arms. She stated the facility transferred her to the hospital for the MRI on 03/07/25 where it was determined she had C1 fracture. She stated the resident underwent cervical neck fusion of the C1 through C7 (neck vertebrae) and she had done remarkable through the surgery. She stated she knew she had a wound while at the hospital and requested the hospital order an alternating pressure mattress for her when she returned to the facility on [DATE]. She stated the pressure mattress the facility provided was not working properly and it took them 4 days to get another pressure mattress. She stated the wound care they were providing in the beginning was not effective and she requested the wound care physician be consulted. She stated she was told the Wound Care physician only came once a week to the facility. She stated she asked if they could call the physician and let her know the condition of the wound. She stated later that week the NP came by and ordered a new treatment for the wound. She stated the wound care physician came last week on 03/31/25 and is due to return today (04/07/25). She stated she just wanted to make sure they were doing everything they could for Resident #1 to aide in her healing. She stated she was going to discuss with the wound care physician about a wound vac to see if that would aide in the healing of the wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Wound Care Physician on 04/07/25 at 09:15 a.m. she stated she had received a referral on 03/27/25 for Resident #1. She stated she saw her on 03/31/25 which was her normal scheduled day at the facility. She stated she staged the wound at a stage 4 (involves full-thickness tissue loss where muscle, tendon or bone is exposed), but stated it was going to take time to be able to determine its true size until all of the slough had been removed. She stated she had debrided (removing non-viable tissue) the wound some on her first visit. She stated the facility had the resident on an alternating pressure mattress and were off loading and turning her. She stated she would visit with the Family member today about the possibility of a wound vac but stated it would depend on the progression of the wound. She stated the facility would usually obtain a consent for a wound care consult on any admission or any resident who acquired a wound, and she would evaluate them on her next onsite visit. She stated the facility would usually continue the hospital wound care orders if they came with orders or would have the primary physician give wound care orders until she evaluated the resident. She stated had they referred her when she admitted she would have seen her on 03/24/25, but instead saw her on 03/31/25. She stated she can't really say the delay caused any harm, since she was receiving wound care and did have interventions in place. An observation of the Wound Care Physician's evaluation of Resident #1 on 04/07/25 at 09:35 a.m. revealed the Physician measuring and assessing the wound. The Wound Care Physician spoke with the resident and the family member and explained the wound had made some progression with 50 % less slough than last week, but stated it was difficult to tell how deep the wound was until all the slough was removed. She told the Family member the wound was most likely going to get larger due to the removal of the devitalized tissue. The wound care physician told the Family member she would consider a wound vac in the future, but the wound was not at the point that it would benefit from a wound vac at this time. She stated she wanted to continue with the current wound care orders, turning side to side, continue with the alternating pressure mattress and limit her out of bed to an hour 3 times a day. ADON A proceeded with the prescribed wound care and covered the wound with a border gauze. In an interview with Medical Records clerk on 04/07/25 at 11:00 a.m. she stated she had received a request to order an alternating pressure mattress for Resident #1 on 03/25/25. She stated she ordered it that day and it was delivered the same day and was placed on the bed for the resident. She stated she was not aware of any problems with the previous air loss mattress, she was just told to order a new one. In in an interview with CNA C on 04/07/25 at 11:00 a.m. she stated she had been assigned to Resident #1 since her return to the facility. She stated they were turning her every 2 hours. She stated the resident had an alternating pressure mattress since her admission. She stated the wound on the resident's bottom had a small opening. She stated the nurses were putting a dressing over the wound. In an interview with the RA D on 04/07/25 at 11:05 a.m. she stated Resident #1 had an alternating pressure mattress on her bed as soon as she came into the facility. She stated the family member did not like the one the facility had and had brought in an egg crate mattress to put over the bed. She stated then she got a different alternating pressure mattress. She stated she had never seen the wound uncovered, stating it always had a dressing over it. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN E on 04/07/25 at 11:10 a.m. she stated she works the 6 a.m. to 2 p.m. shift Monday through Friday. She stated Resident #1 admitted with a wound to her sacral area. She stated they were providing wound care to the wound on the days the Treatment Nurse did not. She stated the Treatment nurse was the one who made the referrals for the Wound Care Consult. She stated any time a resident had a wound the Treatment Nurse would refer them to the Wound Care physician. She stated she had assumed the Treatment Nurse had referred Resident #1 to the wound care physician. She stated Resident #1 had an alternating pressure mattress, but stated it was not working properly, so they ordered another mattress. She stated the Treatment Nurse had resigned a few weeks ago. She stated when they were looking back to see if the referral had been made, she did not find a consent form for them to refer the resident, so she obtained the consent from the family and placed it in the Wound Care Physician's folder. She stated they had an Inservice a few weeks back and stated all the nurses would be responsible for wound care, obtaining the consents and treatment orders until a new Treatment Nurse could be put in place. In an interview with the DON on 04/07/25 at 11:30 a.m. she stated she had started for the facility around the first of March 2025. She stated the Treatment Nursed quit on 03/20/25 with no notice. She stated she had assumed all the weekly treatments, wound measurements and referrals were current and up to date. She stated she worked the floor on 03/22/25 and 03/23/25 and had done Resident #1's treatments. She stated when she saw the wound she would have staged it as unstageable due to the amount of slough. She stated the hospital had it staged as a Stage 2 but stated that was not where she would have staged it. She stated the family was very upset about the wound care treatment that was being provided and stated the Treatment Nurse had informed the family that the Wound Care Physician would be seeing her. She stated she offered to send the resident to the hospital for wound care management, but stated the family declined and wanted to wait to be seen in house. She stated after this they did a complete skin sweep of the building and an audit of the records and referrals and that was when they discovered the consent had not been obtained for the wound care consult. She stated they did obtain the consent, update the physician, and make the referral to the wound care physician. She stated the resident was provided an alternating pressure mattress upon the family members request, and when the family was not happy with the one, they provided, they ordered a replacement mattress the same day. She stated they had made an offer for ADON A to take the full-time position as ADON/Treatment nurse. She stated she had a background in wound care. She stated in addition she met with the staff and reviewed the process for all residents with wounds. She stated the admitting nurse is responsible for documenting the location and a description of the wound. She stated only the Wound Care Physician, the Treatment Nurse or ADON will stage the wounds. She stated the admitting nurse will obtain the signed consent for the Wound Care referral. She stated if the resident comes with treatment orders, they will review those orders with the physician upon admission. She stated herself and the ADONs will perform a chart audit after the admission to ensure all the orders had been obtained as well as any consents required or interventions. She stated the Treatment Nurse will provide weekly updates with the progress and measurements of all pressure and non-pressure wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with ADON B on 04/07/25 at 12:54 a.m. she stated the previous ADON/Treatment nurse was responsible for the Rehab Hall and for the wound care management. She stated the previous ADON/Treatment Nurse was still working when Resident #1 readmitted . She stated they were aware the resident was admitting with a wound, and she had told her to make sure she went and assessed the wound. She stated she knew the family had requested an alternating pressure mattress and she stated one was provided. She stated they were not aware there was a problem with the mattress until 03/25/25, and that was when they ordered a new mattress for her. She stated the protocol had always been to refer anyone admitted with a wound or even a surgical wound for the Wound Care physician to evaluate and treat if necessary. She stated she was surprised the previous Treatment nurse had not made the referral. She stated as soon as the lapse was discovered they obtained the necessary consent, and the Wound Care physician was notified. An attempt to contact the previous Treatment Nurse by phone was made on 04/07/25 at 01:13 p.m. Message was left, with no return call received prior to survey exit. In an interview with the NP on 04/07/25 at 01:02 p.m. she stated the staff had informed her at the time of Resident #1's admission that she had a sacral wound, and they wanted an air mattress for her. She stated the facility always referred any resident with a wound to the Wound Care physician, so she had assumed they would be obtaining any treatment orders needed from the Wound Care physician. She stated the Family member reached out to her on 03/27/25 and sent her a picture of the wound and was requesting a different treatment for the wound care. She stated she gave a new order for wound care and started the resident on Antibiotics as a precaution, until the Wound Care Physician could see her. She stated the wound did not appear to be infected. She stated the Wound care Physician saw the resident on 03/31/25. In an interview with the Administrator on 04/07/25 at 2:15 p.m. stated she the non-compliance was the result of the sudden departure of the Previous/Treatment nurse who had failed to complete her responsibilities. She stated the nursing staff had been re-educated on the process. She stated through the audits and skin sweeps it was determined no other oversight had occurred. She stated going forward chart audits will be conducted on all new admission to ensure any resident admitted with a wound received the necessary referrals, treatments and interventions required to promote wound healing and prevention for further decline. Record review of the facility's policy, Wound Management, dated June 2020, reflected, Purpose: To provide a system for the treatment and management of resident with wounds including pressure and non-pressure injury. A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure injuries from developing .An assessment of care needs for pressure injury and wound management will be made with emphasis on, but not limited to .Treatment . Mechanical offloading and pressure reducing devices .Evaluating and modifying interventions for a resident with an existing Pressure ulcer/Pressure injury .The Attending Physician will be notified to advise on appropriate treatment promptly . Record Review of Resident #1's consent for Wound Care Treatment reflected consent was provided by Resident #1's Family member on 03/25/25. Record Review of the Facility's Mandatory staff meeting dated 03/26/25 reflected the nursing staff would be responsible for all aspects of wound care until a Treatment Nurse could be hired. In addition, the staff were re-educated on the facility's wound care protocol. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON, ADON A and ADON B on 04/07/25 at 2:20 p.m. they stated they had been in serviced on the wound care protocol and knew they were responsible for ensuring the wound care consent and referral were made on any wound upon admission or any new wound acquired while in the facility going forward. The noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 03/17/25 and ended on 03/25/25. The facility had corrected the noncompliance before the survey began.