STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455876	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands Healthcare Center	4650 S Panther Creek Dr The Woodlands, TX 77381

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 (CR #1) of 3 residents reviewed for quality of care. - The facility failed to ensure treatment and care was provided to CR #1 consistent with professional standards of practice. CR #1's left stump was found with maggots and roaches on 06/07/25. The wound was also found with roaches in addition to the maggots per the findings. CR #1 was transported to the hospital where she later had an above the knee amputation. An Immediate Jeopardy (IJ) was identified on 06/13/25. The IJ template was provided to the facility on [DATE] at 10:51 a.m. While the IJ was removed on 06/15/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal (POR). This failure could place residents at risk of not receiving necessary medical care, infection, a decline in health, the need for hospitalization and/or death. The findings included: Record review of CR #1's admission Record, dated 06/11/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy (brain dysfunction caused by underlying condition that affects metabolism), cardiac arrest (sudden loss of heart function), peripheral vascular disease (disorder that restricts blood flow to the arms, legs, or other body parts), acquired absence of left leg below knee, and infection of amputation stump. Record review of CR #1's MDS Quarterly Assessment, dated 04/10/25, revealed a BIMS score of 15, indicating she was cognitively intact. Further review revealed resident required a helper to complete toileting, shower/bathe, and lower body dressing. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's care plan report, undated, revealed the resident had a left BKA stump infection, date initiated: 04/27/25, and interventions included to administer antibiotic and antipyretic as per MD orders. Resident was on IV medications for infection of left stump for 6 weeks r/t stump infection, date initiated and revision on 03/28/25. Resident was on antibiotic therapy r/t wound infection. Resident had potential/actual impairment to skin integrity to the left BKA r/t ulcer. Resident was at risk for impaired skin integrity related to non-compliance with treatment to left BKA. Interventions included resident returned from hospital and refused recommended treatment options while admitted , date initiated: 04/04/25, administer medications as ordered, conduct skin inspections / examinations weekly and as needed, encourage resident participation and compliance with plan of care, if resident refuses treatment, discuss with resident / family / IDT to determine why and try alternative methods / interventions to gain compliance, date initiated for these interventions was 06/08/25. Record review of CR #1's physician orders, undated, revealed the following orders: if resident leaves the building or goes outside-apply dressing to wound for protection as needed, every 2 hours as needed, start date: 06/07/2025 . Removed maggots gently on left leg stump, clean with wound cleanser, applied idone [sic], let dry and covered with dry dressing, one time only for stump infection for 1 day, start 06/07/2025 . ceftriaxone sodium injection solution reconstituted 1 GM, inject 1 gram intramuscularly one time a day for skin infection for 3 days, start 06/07/2025, .amoxicillin-pot clavulanate oral tablet 875-125 MG, give 1 tablet by mouth two times a day for wound infection for 1 month, start 06/07/2025 .Left BKA: Cleanse with NS/wound cleanser, pat dry. Apply iodine, leave open to air, one time a day for skin mgmt., start : 03/05/25 . weekly skin evaluation one time a day every Thu, start date 02/06/25 .doxycycline hyclate oral tablet 100 MG, give 1 tablet by mouth two times a day for wound infection for 1 month, start 04/28/25, end 05/28/25 . amoxicillin-pot clavulanate tablet 875-125 MG, give 1 tablet by mouth two times a day for wound infection for 1 month, start 04/28/25, end 05/28/25 . Record review of CR #1's progress notes, dated 06/07/25 at 13:36 (1:36 p.m.), Type: Change of Condition, Author: Nurse A, read in part .Maggots on stump left leg, started 06/07/2025, since started it has gotten: Stayed the same .Removed maggots, clean with wound cleanser, applied idone [sic] let dry and covered with dry dressing .Notifications: [family member] 06/07/2025 1:40 PM, Dr [name] 06/07/2025 1:40 PM . Record review of CR #1's progress notes, dated 06/07/25 at 14:32 (2:32 p.m.), Author: Nurse A, read in part . For [family member's] request res was sent to [hospital name], 911 was called @ 14:00 [2:00 p.m.], arrive @ 14:08 [2:08 p.m.], res was lying on bed, alert, oriented x3, res no complains of pain or discomfort, left stump was already clean and covered by Dr orders, VSNL, SPO2 98% 3L n/c, no distress or SOB . Record review of CR #1's hospital records, dated 06/07/25, read in part .Pt arrives EMS from [nursing facility name] with reports of possible wound infection. Pt had a BKA a couple of years ago. Pt had cardiac arrest in January and was in the hospital for 9 days then went to rehab. While in the hospital the physician stated she needs AKA and pt has refused. Pt has maggots and roaches in the wound according to EMS. Both insects were visualized . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/11/25 at 10:13 a.m., Treatment Nurse B said it was her understanding that Nurse A saw something concerning and grabbed Nurse C and sent the resident to the hospital. She said when the resident was moving around, the maggots were not visible, but when the resident was still and her leg was not moving, they got close and that was when they saw movement on the backside of the wound. She said they notified the physician and when talking with the family they decided to send her out to the hospital. She said she spoke to Nurse A over the telephone on Saturday, 06/07/25, around 4:00 p.m. or 5:00 p.m. and told her to keep her updated. She said the nurse from the hospital called and reported to Nurse A there were maggots in CR #1's stump. She said CR #1's wound treatment was done daily. She said she did not know if the treatment nurse had already performed wound care for the day. She said neither Treatment Nurse B nor Nurse B reported any wound care concerns to her for CR #1 for the month of June 2025. She said CR #1's wound was very hard, scabbed, and had eschar (a hardened, dry, black, or brown dead tissue that forms a scab-like covering over deep wounds). She said if a wound had maggots, it was a sign of infestation. She said CR #1 had been on long term antibiotics and believed it recently switched to by mouth. She said the eggs could be present in the wound from 0-24 hours but said she did not know what the development was until they transitioned into a fly. During a telephone interview on 06/11/25 at 10:53 a.m., Treatment Nurse C said she did not provide wound care to CR #1 on 06/07/25 nor had she seen her on this day. She said Nurse A told her there might be maggots in CR #1's wound. She said Nurse A and Nurse C said they were going to send CR #1 out to the hospital. She said they wrapped her leg and moved her roommate out of the room. She said the resident was very non-compliant with her dressing and was always tearing it off and would not keep it wrapped. She said the resident was a heavy smoker. She said the life cycle of a maggot was approximately 3-4 days from the time they lay eggs. She said the last time she provided wound care to CR #1 was on Tuesday morning, 06/03/25, and it looked fine. She said the wound was hard like tree bark. During an interview on 06/11/25 at 11:07 a.m., Nurse A said around 10 something in the morning on 06/07/25 CR #1 was outside in the smoking area when one of the staff came to her and told her the resident was outside and was not feeling well. She said she went outside, took her vitals and her BP and O2 were low. She said she took CR #1 back to her room and she and a CNA put her on her bed. She said she contacted the NP, did everything that was ordered, and called the family. She said she did not recall the time, but later when she was checking on CR #1, CR #1 asked her to cover her leg and when she went to cover her leg, she saw more than 5 but less than 10 maggots coming from her left stump. She said the resident did not feel any pain, was verbal, oriented, and alert. She said she went and told ADON B who told her to call the doctor. She said the doctor gave an order to clean area, apply iodine, and cover with dry dressing. She said before cleaning the area, she contacted CR #1's family member who said he would like for her to go to the hospital. She said she did not see any other insects/bugs in the wound. She said when CR #1 was in a resting position, the maggots would come out and when she moved the maggots would go back inside. She said she observed small holes, but the skin was hard. She said she did her rounds around 1:30 p.m. During an interview on 06/11/25 at 11:28 a.m., Treatment Nurse A said he has been working for the facility since October of last year (2024) and working as a Treatment Nurse since 06/02/25. He said he provided wound care to CR #1 on 06/06/25 and the wound was fine. He said he did not see any drainage or maggots. He said the wound was dark and hard. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 06/11/25 at 11:37 a.m., Nurse C said she was at the nurse's station on 06/07/25 (did not recall the time) when a resident came and said CR #1 was not feeling well. She said she assisted Nurse A take CR #1 back to her room. She said she did not remember what time but approximately 45 minutes later, Nurse A asked her for assistance with wrapping CR #1's leg. She said she saw a little bit of blood and about 5-10 maggots on the underside of CR #1's stump. During a telephone interview on 06/11/25 at 12:06 p.m., the Wound Care Doctor who said CR #1 had really bad peripheral vascular disease and had recommended further amputation, but CR #1 declined. He said she had dry gangrene, and they were waiting for it to progress to wet gangrene because she refused surgery. He said it would take a couple of days to see maggots. He said they could [NAME] underneath if there was no drainage but as they multiply, they could come out. He said CR #1's stump was all one big piece of necrotic, dead, dry tissue. During an interview on 06/11/25 at 1:40 p.m., CR #1, said they were not doing wound care at the facility. She said the Wound Care Doctor would go and see her. She said she did not know she had maggots. She said they had to do surgery. During an interview on 6/11/25 at 1:47 p.m., the Hospital Nurse who said he took care of CR #1 the day after she was admitted , 06/08/25, and saw maggots on the floor. He said her stump was necrotic, black, had gangrene, and maggots were coming out. During an interview on 06/11/25 at 2:05 p.m., the Hospital MD , who said it was unexpected to have a patient to come from a NF with maggots in a wound. He said it also depended on the compliance of the patient. He said it probably takes 3 or so days to develop maggots. He said going outside could cause exposure to other things. He said when they talked to CR #1 about surgery, she said yes and did not hesitate. He said CR #1 had an above knee amputation. During an interview on 06/12/25 at 7:28 a.m., CNA A said she worked 06/07/25 and was assigned to CR #1. She said she first saw CR #1 during her first round around 6:30 a.m.-7:00 a.m. She said she was providing incontinent care, CR #1 was turned towards the wall, lying on her right side, and as she was wiping her, she happened to look down and saw that her wound was leaking blood and saw something moving on the left side of her wound. She said she asked the resident if she was hurting, and CR #1 said yes, her leg was hurting and said CR #1 always said her leg hurt. She said she finished incontinence care and went and told Nurse A she saw something moving and CR #1 said she was hurting. She said Nurse A went to CR #1's room and looked at the wound and then left the room and went back to her cart which was right outside of the room. She said she saw CR #1 after breakfast, approximately around 9:30 a.m.-10:00 a.m., and the resident was in bed and had an IV. She said CR #1 was usually quiet, she would get up for smoke breaks, was not too fond of the food, and slept the majority of the day if she was not up smoking a cigarette. She said she saw her during lunch, and she was the same. CNA A said when she would check on CR #1, she would say she was okay, but she was out of it and would go back to sleep. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/12/25 at 8:12 a.m., the DON who said at first CR #1 would not allow a lot of dressing changes. She said there were times where they could not find her or times where she would be outside smoking and would tell them she was not going back inside for wound care. She said when the wound care doctor would come, they would ask him to see her first in case she refused and that way he could check back before he left. She said the hospital talked to her about having additional surgery back in April of 2025, but CR #1 declined. She said the resident also declined palliative care. She said Nurse A called her around 1:00 p.m. on 06/07/25, and said it was like she saw a worm and when CR #1 moved, it went back in, so she told her to lie still. She said she went and got Nurse C and she had CR #1 lie still and they started coming out. She said Nurse A called the doctor and the family. She said the brother wanted CR #1 to go to the hospital, so they called 911 and sent her out. She said the Physician gave an order to clean, betadine, cover, and contact family. She said her graph was already occluded and would require surgery. During a telephone interview on 06/12/25 at 9:23 a.m., the Physician who said CR #1 would refuse to get dressing changes. He said the nurse called him immediately (he did not recall the exact day and time). He said he gave an order to clean the wound, apply iodine, wrap, and to talk to the family. He said maggots are unexpected and it was not acceptable to see them in a wound, but maggots per se helps clean a wound. He said maggots were not preventable and if they were going to happen, they were going to happen. He said keeping it clean was the only way to prevent but it did not not provide 100% protection. He said there would always be some kind of contamination if a resident was going outside or to other places. He said he did not know the life cycle of a maggot, but it could not be long, maybe 24 to 48 hours. During a follow-up interview on 06/12/25 at 10:06 a.m., Nurse A said on the morning of 06/07/25, around 7:00 a.m., CNA A told her she saw something in CR #1's wound. She said the wound was open to air and that she moved the leg and looked around and did not see anything. She said they were in the process of changing her brief and clothing her so they could transfer her to her wheelchair. During a follow-up interview on 06/14/25 at 8:44 a.m., the Physician who said maggots reflected the dirtiness of the wound. He said he had been telling CR #1 to have the amputation for more than a year. He said he knew she liked to go outside, sit in her wheelchair, the flies could go and smell the wound, and could land on it. He said the wound was already necrotic for a long time. He said he repeatedly talked to her about getting surgery for the past year, he thinks, more or less, and she would refuse. He said the last time he talked to her about surgery was about 3 months ago, her family member was present in the room, she refused, just kept complaining about the pain, and was requesting pain medication. He said her family member verbalized that was the way she was and would probably be better off with hospice because she was not going to agree with any treatment and was suffering with a lot of pain from the wound. He said her wound was dead necrotic tissue and it was a rich medium for infection for the maggots to come in. He said any creatures could smell the dead tissue and go by smell. He said she may not have been refusing the wound care treatment, but she was refusing the surgery. Physician said one of the reasons you leave the wound open to air was to allow the oxygen to reach the wound. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 06/17/25 at 8:18 a.m., CR #1's family member said there had been refusals from CR #1 from the beginning of January of this year. He said when CR #1 should not be smoking, she would be smoking which probably led to the problem she had. He said she was outside in the heat with an uncovered wound. He said there would be times that he would be sitting outside with CR #1 and flies would land on her wound and he would have to shoo them away. He said he never mentioned it to the facility. He said he had never spoken to the wound care doctor directly. He said a long time ago, he thought about 6 months ago, when CR #1 first entered the facility, he talked to the doctor. He said the doctor did not say anything about her wound. He said he just talked about her status. He said CR #1 had just come off from having a devastating heart attack and the doctor mentioned about her going on hospice, but it would be her choice. He said CR #1 and he decided not to do hospice. He said hospice was always on the table, offered several times, but did not recall when the last time was that the facility brought up hospice again. He said something he did not understand was why the doctor did not send CR #1 to the hospital. He said Nurse A called him and told him there were maggots coming out of CR #1's leg and the doctor said to clean and cover, and that was the end of their conversation. He said he spoke to his significant other and said to her why was CR #1 not in the hospital. He said he called the facility back and spoke to Nurse A and told her to send CR #1 to the hospital. He said he was never contacted by the doctor. He said CR #1 has refused treatment from the doctor, hospital, wound care doctor, and everywhere she has gone. He said CR #1 was a person who was non-compliant and did not accept help from anyone. He said he saw her earlier that week, probably on Thursday, 06/05/25. He said he did not notice anything different with the wound. He said there was no smell coming from the wound. He said the wound was just dark, hard, and looked like a big scab over CR #1's knee. He said the only thing he questioned to himself was why the doctor did not say send CR #1 to the hospital when he heard the word maggots come out of Nurse A's mouth. He said he was baffled. Record review of the facility's Treatment Nurse Job Description, undated, read in part .The treatment nurse will provide quality of care to prevent and promote healing of alterations and skin integrity at each residence as determined by resident assistance and individual plans of care . The Administrator was notified on 06/13/25 at 10:51 a.m. that an IJ was identified due to the above failures and the IJ template was provided. The following Plan of Removal (POR) was accepted on 06/13/25 at 8:10 p.m.: June 13, 2025 [Nursing Facility Name] LETTER OF CREDIBLE ALLEGATION FOR REMOVAL OF IMMEDIATE JEOPARDY Attention Sir or Madam: On June 13, 2025, the Facility was notified by the surveyor that immediate jeopardy had been called and the Facility needed to submit a letter of removal. The Facility respectfully submits this Letter for a Plan of Removal pursuant to Federal and State regulatory requirements. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The alleged Immediate jeopardy allegations are as follows: Issue: F684 - Quality of Care The facility failed to ensure treatment and care was provided to CR#1 consistent with professional standards of practice. CR#1's left stump was found with maggots on 6/7/25. CR#1 was transported to the hospital where she later had an above the knee amputation. Actions for Resident Involved -Resident CR#1 was discharged to the hospital on 6/7/25. -On 6/7/25, Resident CR#1's room was inspected by Maintenance Director or designee for insects/pests and there were none identified. The room was deep cleaned on 6/8/25. -On 6/7/25, Resident CR#1's beddings and clothing were removed by charge nurse and sent to [NAME] for wash. -On 6/7/25, Maintenance Director or Designee was called by Administrator and serviced room [ROOM NUMBER] for pest control. Identify residents who could be affected: -On 6/7/25, All current residents with wounds were checked and visualized by the Director of Nursing and/or Designee to ensure that there are no signs of insects/pests and that wounds are treated and are covered with dressings as ordered. There were no other findings noted. -On 6/8/25, DON/Designee completed a review of wound care orders and care plan updates. Residents with wound orders with no wound dressings i.e., open to air and/or residents refusing wound care treatments/non-compliance will be referred to physician for review of orders, document and care plan will be updated. -On 6/7/25, ADONs completed room checks to identify presence of pests/insects and there were none noted. Action Taken/ System Change: -On 6/7/25 and 6/13/25, All Facility staff were re-educated by the Administrator or designee on: o Abuse and Neglect Prohibition o Observing and immediately reporting any observation of insects/pests in the facility. -On 6/7/25 and 6/13/25, 100% of licensed nurses were re-educated on the following: o Wound inspection for presence of pests/insects in wounds/impaired skin integrity (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 06/14/25-06/15/25, surveyor confirmed the facility implemented their plan or removal (POR) to sufficiently remove the IJ by the following: Record review of the Abuse & Neglect and Pest Control in-service training report, dated 06/07/25, reflected 146 staff members were reeducated on the facilities Abuse and Neglect Policy and Procedure, as well as observing for and immediately reporting the presence of pest in the facility with examples provided. Reeducation included immediately reporting observations to the Administrator and/or DON, as well as department supervisor. Record review of the Observation of Wounds and Orders in-service training report, dated 06/07/25, reflected 31 licensed nurses were educated on the etiology and appearance of maggots, as well as observing for and immediately reporting the presence of maggots in wounds / open skin conditions. The reeducation included obtaining orders for wounds to be covered with a dressing when residents leave the building, including wounds with orders to leave open to air. Record review of the Abuse & Neglect and Pest Control in-service training report, dated 06/13/25, reflected 130 staff members were reeducated on the facility's Abuse and Neglect Policy and Procedure, as well as observing for and immediately reporting the presence of pest in the facility with examples provided. Reeducation included immediately reporting observations to the Administrator and/or DON, as well as department supervisor. Record review of Observation of Wounds and Orders in-service training report, dated 06/13/25, reflected 31 licensed nurses, LVNs and RNs, were reeducated on observing for the presence of pests/insects in wounds and open skin conditions. The reeducation included immediately reporting any observation of pest/insects and/or abnormality in a wound to the MD and initiating a change in condition. Licensed nurses were also reeducated on following physician orders and informing the MD of any refusals and/or non-compliance related to wounds and wound care. Reeducation also included ensuring wound care orders included covering wounds and consulting the physician whenorders for wounds to be left open to air. Record review of CR #1's progress notes, entered by Nurse A, on 06/07/25, reflected that the beds were stripped, room was checked for any food or perishable products that would attract insects, all bedding and clothing was sent to laundry, and the room would be treated and deep cleaned. Record review revealed an undated typed statement by the Environmental Supervisor that read he deep cleaned CR #1's room on 06/07/25, after she discharged , and he did not see any signs of pests in the room at the time of cleaning or after cleaning the room. Record review of progress notes, dated 06/07/25, reflected the DON or designee checked and visualized all current residents with wounds and none were found to have signs of insects/pests and their wounds were treated and covered with dressing(s) as ordered. Record review of the care plan audit, dated 06/07/25, reflected 48 residents who had a wound identified. Record review of the wound care order audit, dated 06/07/25, reflected 48 residents whose orders were reviewed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455876	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands Healthcare Center	4650 S Panther Creek Dr The Woodlands, TX 77381

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interviews were conducted from 06/14/25 to 06/15/25 with staff from all shifts (6:00 a.m.to 6:00 p.m., 6:00 p. m. to 6:00 a.m., 6:00 a.m. to 2:00 p.m., 2:00 p.m. to 10:00 p.m., and 10:00 p.m. to 6:00 a.m.). Staff interviewed included the following: Administrator, DON, ADON B, Environmental Supervisor, Maintenance Assistant, Nurses B, D, E, F, G, and H, MA A, CNAs B, C, D, E, F, G, H, I, J, K, L, M, N, O, and P, and Nursing Assistant in Training. All staff interviewed verbalized an understanding of the facility's Abuse and Neglect Policy and Procedure, as well as observing for and immediately reporting the presence of pest in the facility to the Administrator and/or DON, and department supervisor. Licensed nurses verbalized an understanding on wound inspection for presence of pests/insects in wounds/impaired skin integrity, ensuring wounds are covered with wound dressings as ordered, wound treatments with no wound dressing orders, residents who refuse wound treatments/wound dressings and non-compliance with wound care. During an interview on 06/14/25 at 8:19 a.m., Environmental Supervisor said one of the maintenance guys (not sure who) called him and told him the room was ready for deep cleaning. He said he did not recall what time he was notified. He said he checked trash cans, observed the room, dust, broomed, mopped, and after sweeping and cleaning, used DC33, a disinfectant cleaner, on hand to surface areas throughout the room that were commonly touched by residents and staff, i.e. doorknobs, dresser handles, anything hand to surface. He said he wiped down the beds, handrails, sanitized/mopped down the floors. He said he did not find anything that he could recall during the deep cleaning process. He said he believed the deep cleaning occurred on 06/07/25. During an interview on 06/14/25 at 9:18 a.m., the Maintenance Assistant who said he received a call last Saturday, 06/07/25, from the Administrator around 3:00 p.m.-4:00 p.m. and he told him that CR #1's room had a complaint that they had seen some pests or something like that. He said he went to the facility around 6:00 p.m.-6:30 p.m. He said he checked the room from side to side and did not see anything. He said he used some disinfectant wipes, the linens had already been removed, and he wiped down the mattress. He said after that he requested a deep cleaning for the room through the department heads via text. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/14/25 at 10:51 a.m., the DON who said they put their eyes on all the residents with wounds on 06/07/25 and made sure all were checked. She said Treatment Nurse C, ADON A, ADON B, ADON C, and her helped. She said they looked at orders and sites on Saturday, 06/07/25, and on Sunday, 06/08/25, they made sure the care plans were updated and matched the orders and sites. She said CR #1 was the only one who was consistently refusing wound care. She said none of the residents had to be referred to physician for non-compliance of wound care. She said the medical director said if they have a resident that has an order for leave open to air that to PRN cover if they are going to go outside and/or leave the building for right now. She said as of today, all open wounds have an order to be covered. She said it is part of the in-service for new admissions, and/or if they return from a doctor's appointment with a new order to leave open to air they have to call and clarify with the physician to see if they can cover it, and if not then to document. She said the preferred treatment is for the wound to always be covered. She said on 06/07/25 at about 3:30 p.m. Nurse A and she moved out the other resident from the room, stripped the beds, she checked their drawers and bedside tables for any food or open items, then took all laundry and bedding to laundry and had them rewash everything. She said the Maintenance Assistance came later that evening, around 6:44 p.m., and treated the room. She said the ADONs and her started conducting in-service on 06/07/25 with licensed nursing staff on wound inspection for presence of pests/insects in wounds/impaired skin integrity, ensuring wounds are covered with wound dressings as ordered, wound treatments with no wound dressing orders, residents who refuse wound treatments/wound dressings and non-compliance with wound care. She said if they see any changes to the skin site they do a change in condition, or if a resident is being non-compliant and going outside with an exposed wound then it needed to be documented and notifications needed to be made appropriately and care plan updated by nursing. She said she was running the TAR every morning for missed documentation, refusals, and a full order listing report to ensure that it was a complete order, and a dressing was part of the order. She said they reviewed all new admission charts, and they would ensure that the orders had dressings in place or ask for clarification at that time. She said if they were identified as a refusal, she would ensure documentation was done and the wound would be reassessed at that time. She said it was part of the morning clinical meeting to review all residents a[TRUNCATED]