

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455917	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2025
NAME OF PROVIDER OR SUPPLIER Deer Creek of Wimberley		STREET ADDRESS, CITY, STATE, ZIP CODE 555 Ranch Rd 3237 Wimberley, TX 78676	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for two (Resident #1 and Resident #2) of five residents reviewed for quality of care.</p> <p>The facility failed to document wound care treatments for Resident #1's right calf (11 times) and Resident #2's left and right heels (4 times) according to physician orders in the months of May and June 2025.</p> <p>This failure could place residents at risk of not receiving appropriate care and treatment and/or a decline in health.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including personal history of traumatic brain injury, type II diabetes, and venous insufficiency (the flow of blood through the veins is impaired).</p> <p>Review of Resident #1's quarterly MDS assessment, dated 04/27/25 reflected a BIMS score of 15, indicating he was cognitively intact. Section M (Skin Conditions) reflected Resident #1 was at risk of developing pressure ulcers/injuries.</p> <p>Review of Resident #1's quarterly care plan, dated 04/09/25, reflected he had a post-surgical wound to his right calf with an intervention of treating it as ordered.</p> <p>Review of Resident #1's physician order dated 03/27/25 reflected, Wound care - post surgical wound of right calf - cleanse wound with w/c, pat dry, soften Hydrofera Blue with wound cleaner, and apply to wound bed, cover with ABD pad, and wrap with Kerlix every day [sic] shift for wound care start date 03/28/25.</p> <p>Review of Resident #1's TAR for May 2025 reflected the wound care to the post-surgical wound of the right calf was not documented as completed on 05/03/25, 05/04/25, 05/10/25, 05/11/25, 05/14/25, 05/17/25, 05/18/25, 05/24/25, and 05/31/25.</p> <p>Review of Resident #1's TAR for June 2025 reflected the wound care to the post-surgical wound of the right calf was not documented as completed on 06/07/25 and 06/08/25.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 06/11/25 at 11:19 AM revealed Resident #1 lying in bed as the WCN treated the wound on his right calf. The wound bed was pink/red, and the edges were clean. There was no drainage or foul odor noted.</p> <p>Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including type II diabetes, muscle weakness, chronic kidney disease, and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke.</p> <p>Review of Resident #2's quarterly MDS assessment, dated 05/29/25, reflected a BIMS of 13, indicating he was cognitively intact. Section M (Skin conditions) reflected he was at risk of developing pressure ulcers/injuries and had one or more unhealed pressure ulcers/injuries.</p> <p>Review of Resident #2's quarterly care plan, dated 02/07/25, reflected he had a DTI to his left and right heels with an intervention of providing treatment as ordered.</p> <p>Review of Resident #2's physician's order dated 05/20/25 reflected, Wound care - Stage 4 right heel - cleanse wound with w/c, pat dry, apply collagen sheet to wound bed, cover with ABD pad, wrap with Kerlix daily every day [sic] shift for wound care. Start date 05/21/25.</p> <p>Review of Resident #2's physician's order dated 05/20/25 reflected, Wound care - Stage 4 left heel - cleanse wound with w/c, pat dry, apply collagen sheet to wound bed, cover with ABD pad, wrap with Kerlix daily every day [sic] shift for wound care. Start date 05/21/25.</p> <p>Review of Resident #2's TAR for May 2025, reflected the wound care for both the right and left heels was not documented as completed on 06/25/25 and 05/31/25.</p> <p>Review of Resident #2's TAR for June 2025, reflected the wound care for both the right and left heels was not documented as completed on 06/01/25 and 06/07/25.</p> <p>An observation and interview on 06/11/25 at 4:08 PM, revealed Resident #2 sitting up in his bed. Resident #1 stated the staff provided frequent wound care and he believed his wounds were improving.</p> <p>During an interview on 06/11/25 at 1:52 PM, the ADM stated she expected wound care to be completed and documented accurately by the nurse. She stated the administrative team was responsible to monitor documentation.</p> <p>During an interview on 06/11/25 at 2:26 PM, LVN A stated treatments were documented in the medical record when the treatment was completed. He stated if a treatment was not completed, he marked it as not completed and entered the code number for the reason it was not completed. He stated if a treatment was not documented on the TAR, that meant the treatment was not done. He stated if documentation was not accurate, you may not have been able to assess the effectiveness of interventions, or the resident may not have received the intended care.</p> <p>During an interview on 06/11/25 at 2:40 PM, RN B stated the nurses were expected to complete the treatments on their assigned residents. She stated the treatments should have been documented in the medical record when it was completed. She stated a blank on the TAR indicated the treatment was not completed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/11/25 at 3:10 PM, the DON stated she expected the nurses followed the physicians' orders. She stated if the order was for a daily treatment, she expected the treatment to be completed daily. She stated she expected treatments to be documented when done so the nurse would not get distracted or forget to go back later to document. She stated it was her second day at the facility and she was not yet familiar with all the monitoring systems in place.</p> <p>During an interview on 06/11/25 at 4:16 PM, the ADM stated the facility did not have a policy specific to documentation.</p> <p>Review of the facility policy titled Wound Care dated Qtr. 3, 2024, reflected in part, Documentation. The following information may be recorded in the resident's medical record, if applicable: 1. The type of wound care given. 2. The date and time the wound care was given . 4. The name and title of the individual performing the wound care . 9.</p> <p>If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data .</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for one (Resident #2) of five residents reviewed for pressure injuries.</p> <p>The facility failed to conduct wound care treatments for Resident #2's left and right heels (4 times) according to physician orders in the months of May and June 2025.</p> <p>This failure could place residents at risk of not receiving appropriate care and treatment and/or a decline in health.</p> <p>Findings included:</p> <p>Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including type II diabetes, muscle weakness, chronic kidney disease, and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke.</p> <p>Review of Resident #2's quarterly MDS assessment, dated 05/29/25, reflected a BIMS of 13, indicating he was cognitively intact. Section M (Skin conditions) reflected he was at risk of developing pressure ulcers/injuries and had one or more unhealed pressure ulcers/injuries.</p> <p>Review of Resident #2's quarterly care plan, dated 02/07/25, reflected he had a DTI to his left and right heels with an intervention of providing treatment as ordered.</p> <p>Review of Resident #2's physician's order dated 05/20/25 reflected, Wound care - Stage 4 right heel - cleanse wound with w/c, pat dry, apply collagen sheet to wound bed, cover with ABD pad, wrap with Kerlix daily every day [sic] shift for wound care. Start date 05/21/25.</p> <p>Review of Resident #2's physician's order dated 05/20/25 reflected, Wound care - Stage 4 left heel - cleanse wound with w/c, pat dry, apply collagen sheet to wound bed, cover with ABD pad, wrap with Kerlix daily every day [sic] shift for wound care. Start date 05/21/25.</p> <p>Review of Resident #2's TAR for May 2025, reflected the wound care for both the right and left heels was not documented as completed on 06/25/25 and 05/31/25.</p> <p>Review of Resident #2's TAR for June 2025, reflected the wound care for both the right and left heels was not documented as completed on 06/01/25 and 06/07/25.</p> <p>An observation and interview on 06/11/25 at 4:08 PM, revealed Resident #2 sitting up in his bed. Resident #1 stated the staff provided frequent wound care and he believed his wounds were improving.</p> <p>During an interview on 06/11/25 at 1:52 PM, the ADM stated she expected wound care to be completed and documented accurately by the nurse. She stated the administrative team was responsible to monitor documentation.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/11/25 at 2:26 PM, LVN A stated treatments were documented in the medical record when the treatment was completed. He stated if a treatment was not completed, he marked it as not completed and entered the code number for the reason it was not completed. He stated if a treatment was not documented on the TAR, that meant the treatment was not done. He stated if documentation was not accurate, you may not have been able to assess the effectiveness of interventions, or the resident may not have received the intended care.</p> <p>During an interview on 06/11/25 at 2:40 PM, RN B stated the nurses were expected to complete the treatments on their assigned residents. She stated the treatments should have been documented in the medical record when it was completed. She stated a blank on the TAR indicated the treatment was not completed.</p> <p>During an interview on 06/11/25 at 3:10 PM, the DON stated she expected the nurses followed the physicians' orders. She stated if the order was for a daily treatment, she expected the treatment to be completed daily. She stated she expected treatments to be documented when done so the nurse would not get distracted or forget to go back later to document. She stated it was her second day at the facility and she was not yet familiar with all the monitoring systems in place.</p> <p>Review of the facility policy titled Wound Care dated Qtr. 3, 2024, reflected in part, Documentation. The following information may be recorded in the resident's medical record, if applicable: 1. The type of wound care given. 2. The date and time the wound care was given . 4. The name and title of the individual performing the wound care . 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data .</p>		