STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675002	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center/San Antonio West	636 Cupples Rd San Antonio, TX 78237

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 - Immediate jeopardy to resident health or safety 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** 48753 Based on observation, interview and record review the facility failed to immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications for one of six residents (Resident #5) reviewed had a change of condition. The facility failed to notify the wound care physician, primary care physician, and Resident #5's resident representative of changes observed with Resident #5's wound, which resulted in the wound becoming an unstageable pressure ulcer (a wound that is covered by slough(debris that appears tan, yellow, green or brown in color) and eschar (hard plaque that is tan, brown or black in color). An Immediate Jeopardy (IJ) situation was identified on 09/17/2024 at 4:57 p.m. While the IJ was removed on 09/19/2024 at 6:05 p.m., the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for worsening of existing wounds or development of new pressure ulcers. The findings were: Record review of Resident #5's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included diabetes mellitus (a chronic disease that affects how the body uses insulin and glucose), end stage renal disease (a condition where the kidney reaches advanced stage of loss of function) and hypertension (high blood pressure in the arteries that carry blood from the heart to the resident of the body). (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's quarterly MDS, dated [DATE], reflected Resident #5 had short-term and long-term memory problems and Resident #5's cognitive skills for daily decision making were moderately impaired. Section GG Functional Abilities and Goals reflected Resident #5 used a wheelchair for mobility and required partial to moderate assistance with rolling left and right in bed and transferring from bed to wheelchair. Section H Bladder and Bowel reflected Resident #5 was frequently incontinent of bowel and bladder. Section M Skin Conditions reflected Resident #5 was at risk for developing pressure ulcers and had moisture associated skin damage (MASD; incontinence-associated dermatitis, perspiration, drainage). Record review of Resident #5's care plan, initiated 05/22/2024 and revised 05/30/2024, reflected Resident #5 had a pressure ulcer or potential for pressure ulcer development related to needing assistance with repositioning, diabetes, end stage renal disease and dialysis, 3 days a week. The goal was Resident#5 would have intact skin, free of redness, blisters or discoloration by/through review date, 09/12/2024. The intervention was Resident #5 needs monitoring/reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested. Resident #5 had an additional care plan, initiated on 08/01/2024 and revised on 08/02/2024, stating Resident #5 had altered skin integrity, non-pressure related to MASD on sacrum (a triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis). The goal was for the affected area to heal without complications, target date 09/21/2024. Interventions included: a) evaluation for pain prior to cleansing or dressing changes b) monitor for signs and symptoms of infection such as swelling, redness, warm discharge, odor and notify physician of significant findings c) notify practitioner if symptoms worsen or do not resolve d) nutritional and hydration support e) provide thorough skin care after incontinent episodes and apply barrier cream f) skin assessment to the complete per living center policy g) treatments as ordered - cleanse area with wound cleanser or normal saline, pat dry, apply Medi honey, alginate, dry foam dressing as needed if soiled or removed at every day shift every Tuesday, Thursday and Saturday. Record review of Resident #5's progress note, written by LVN A on 07/28/2024, reflected resident has skin breakdown to sacrum, will have wound care evaluate, notify doctor, daughter, and DON, per [nurse name] with [physician name], she ordered cleanse with n/s pat dry apply hydrocolloid change q 72 hours, add vitamin c 500 mg bid x 30 days. MVI with Mineral 1 tab daily, zinc sulfate 220mg 1-tab daily x 14 days. Record review of Resident #5's progress note written by the Treatment Nurse, dated 08/01/2024, reflected the treatment nurse rounded with the wound care physician and the area is MASD to sacrum, new orders are to apply Medi honey, alginate, dry foam dressing T. TH. S, prn if soiled. Record review of Resident #5's weekly head to toe skin check, completed by the treatment nurse, dated 08/01/2024, reflected Resident #5 had a MASD - 3.0 x 1.4 x .2, pink, serous, moderate drainage on the sacrum. Wound documentation reflected Medi honey, alginate, dry foam dressing. Record review of Resident #5's August 2024 treatment administration record revealed an order for MASD on sacrum - cleanse area with wound cleanser or normal saline pat dry, apply Medi honey, alginate, dry foam dressing every day shift every Tue, Thu, Sat for skin breakdown to sacrum, start date 08/03/2024. Resident #5 also had an order MASD on sacrum - cleanse area with wound cleanser or normal saline pat dry, apply Medi honey, alginate, dry foam dressing as needed for if soiled or removed, start date 08/01/2024. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's weekly head to toe skin check, dated 08/12/2024 written by the treatment nurse, reflected Resident #5 had non pressure wound to sacrum- 1.5 x 0.4 x 0.1cm, moderate serous drainage, open areas with exposed dermis. Record review of Resident #5's initial wound evaluation and management summary, dated 08/12/2024 by the wound care physician, reflected Resident #5 was seen for a wound on her sacrum. The focused wound exam listed etiology as moisture associated skin damage. Duration was documented as less than 50 days. The objective was healing/maintaining healing. The wound size was documented as 1.5 x 0.4 x 0.1 cm and surface area was 0.60 cm. Exudate (fluid released by an organism through pours or a wound) was documented as moderate serous (clear or pale-yellow water fluid that is found in the body especially in the spaces between organs and membranes) and dermis (middle layer of skin) was documented as open areas with exposed dermis. Record review of Resident #5's progress note, by the treatment nurse, dated 08/12/2024, reflected Resident #5's wound care orders remained the same for non-pressure wound to sacrum. Record review of Resident #5's weekly wound review by the treatment nurse, dated 08/19/2024, reflected Resident #5 had a non-pressure wound on her sacrum measuring 2 x 1 x .2 cm. Resident #5 had 30% slough and 0% eschar and serous drainage. The treatment plan was Medi honey, alginate, dressing. The wound care physician was notified of the wound on 08/12/2024 and Resident #5's daughter was notified. Record review of Resident #5's wound care physician progress note, dated 08/19/2024, revealed signing off without visit- in house. Record review of Resident #5's wound care physician progress note, dated 08/26/2024, reflected Resident #5's weekly visit was rescheduled due to Resident #5 being gone from the facility at dialysis. Record review of Resident #5's weekly wound review completed by the treatment nurse, dated 08/28/2024, reflected Resident #5 had a non-pressure wound on the sacrum measuring 2 x 1 x .03 cm. Resident had 30% slough and 0% eschar with scant serous drainage. The treatment plan was Medi honey, alginate, dressing. The wound care physician was notified of the wound on 08/12/2024 and Resident #5's family notification was blank. Record review of Resident #5's September 2024 treatment administration record reflected an order for MASD on sacrum - cleanse area with wound cleanser or normal saline, pat dry, apply Medi honey, alginate, dry foam dressing every day shift every Tue, Thu, Sat for skin breakdown to sacrum, start date 08/03/2024. MASD on sacrum-cleanse area with wound cleanser or normal saline pat dry, apply Medi honey, alginate, dry foam dressing as needed for if soiled or removed, start date 08/01/2024. Record review of Resident #5's weekly wound review completed by the treatment nurse, dated 09/04/2024, reflected Resident #5 had a non-pressure wound to the sacrum measuring 2 x 2 x 0.2cm. The slough and eschar percentages were blank, and drainage was marked as scant. The physician and family notification sections were blank, and the treatment plan was blank. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's progress note, dated 09/04/2024, by the treatment nurse, reflected resident continues with non-pressure wound to sacrum. Area remains the same at this time. Resident continues to attend dialysis and have extended time sitting in wheelchair. Will continue to encourage and offload and reposition throughout shift. Record review of Resident #5's weekly wound review completed by treatment nurse, 09/09/2024 at 1:41 p.m. , revealed Resident #5 has MASD to the sacrum measuring 2 x 0.6 x .2 and had 20% slough and 10% eschar with no drainage. The physician notification was checked as completed but there was no name of physician or date and time of notification. The family notification section was blank. The treatment plan was Medi honey, alginate, board gauze. Record review of Resident #5's wound care physician progress note, 09/09/2024, reflected the patient's visit has been rescheduled. She is at dialysis. Record review of hospital photos reflected a sacrum wound, dated 09/09/2024 at 11:20 p.m. that revealed a wound bed covered in slough and black eschar necrotic tissue, and a left heel purple wound, dated 09/09/2024 at 11:30 p.m. Record review of Resident #5's hospital wound care note, by the hospital wound care RN, dated 09/11/2024 at 1:47 p.m., reflected a wound assessment located on the coccyx, classified as an unstageable pressure injury. The description of the wound was large, foul-smelling wound with dark, boggy necrotic tissue covering wound bed. Necrotic tissue extends down to the perirectal area. Wound measurement is 12.4cm x 8.0cm. A second wound located on the left heel was classified as a deep tissue injury. The wound was described as dark purple, but intact tissue overlying heel and measured 2.5 x 2.3cm. The hospital wound RN stated patient will likely need debridement to this wound but unsure if she is an ideal surgical candidate. Patient with leukocytosis, likely due to wound. Patient was not responsive during assessment and did not wake to movement. Patient being offloaded on specialty bed with bilateral heel protectors. Record review of Resident #5's hospital consult notes, dated 09/11/2024 at 2:19 p.m., reflected Resident #5 presented with leukocytosis and found to have unstageable sacral decubitus ulcer and a general surgery consult for possible debridement. The note also stated Resident #5 had an unstageable sacral decubitus ulcer with necrotic tissue and concern for infection. Under Medical Decision Making the consult note reflected will take her to the operating room tomorrow in the morning for debridement of the area with possible wound vac placement. Patient is a very poor surgical candidate for any other intervention. Will take cultures intraoperatively. Continue neurological workup. Consider hospice discussion. Record review of hospital physician progress note dated 09/11/2024 at 10:05 p.m., reflected Resident #5 had significant metabolic encephalopathy (brain disorder caused by a chemical imbalance in the blood that effects to brain) in the context of an acutely infected ulcer. The note also reflected the patient has a significant wound on her buttocks, which is black with foul odor, suggestive of necrosis or infection. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the hospital operative surgeon note, dated 09/12/2024 at 1:01 p.m., reflected Resident #5's surgical procedure performed was incision, drainage and debridement of sacral decubitus ulcer, sacral bone biopsy, substitute skin graft product placement and negative pressure wound VAC therapy (a device that removed pressure over the area of the wound that can help a wound heal and gently pulls fluid from the wound). Post Operative diagnosis stated, unstageable infected sacral ulcer, abscess, concern for osteomyelitis. Findings documented were 9 x 7 x 3cm unstageable infected sacral decubitus ulcer with associated abscess and significant necrotic tissue. Record review of Resident #5's physician progress note, dated 09/15/2024 at 11:41 a.m., reflected Resident #5's sacral decubitus ulcer wound culture collected on 09/12/2024 was positive for E coli, a type of bacteria that can cause diarrhea, vomiting and kidney failure. During an interview with Resident #5's family member on 09/14/2024 at 1:57 p.m., Resident #5's family member stated she was notified by hospital staff when Resident #5 arrived at the hospital and Resident #5 was unresponsive and had one wound on her heel and a bad one on her bottom. Resident #5's family member said she was never notified by the facility that Resident #5 had a wound on her heel or bottom. The family member stated she was told by the facility Resident #5 had a diaper rash. Resident #5's family member said she was told by the hospital the wound on her bottom was black, and the hospital was checking to see if the infection went to her bone. During an interview with Hospital RN Z on 09/14/2024 at 3:20 p.m., Hospital RN Z said Resident #5 admitted with a diagnosis of metabolic encephalopathy (alteration in consciousness) and sepsis. Hospital RN Z said Resident #5 had a DTI to her left heel and she had a very bad sacrum wound and was now on a wound vac. Hospital RN Z stated the hospital took pictures of the wounds upon admission. During an interview with the facility Treatment Nurse on 09/15/2024 at 12:54 p.m., the treatment nurse revealed she began doing treatments at the facility at the beginning of August 2024. She stated her role as the treatment nurse was to assess skin, round with the wound care physician, take orders, notify the doctors and family of changes with the wound and provide wound care daily. The treatment nurse stated wound treatments were documented on the resident TAR and she was notified of changes in the resident skin by the direct care staff and also received copies of the resident shower sheets. The treatment nurse stated she performed skin assessments weekly and the last time she completed a skin assessment for Resident #5 was on the morning of 09/09/2024 around 5am-6am prior to Resident #5 going to dialysis. The treatment nurse described Resident #5's wound on the morning of 09/09/2024 as pink with scant amount of drainage and close to her sacrum. She said Resident #5 had no eschar and the skin was pink and moist. The Treatment Nurse said she did not look at Resident #5's heels that morning and was not aware of Resident #5 having a wound on her left heel. The Treatment Nurse stated she did a treatment on Resident #5 on the morning of 09/09/2024 and said she did not know why it was not documented on Resident #5's TAR as being completed. The Treatment Nurse revealed the Wound Care Physician rounded at the facility weekly and should have seen Resident #5 weekly but stated the Wound Care Physician often rounded while Resident #5 was at dialysis. The Treatment Nurse stated she thought it had been a couple of weeks since the wound care physician had assessed Resident #5's wound. The Treatment Nurse described the wound as MASD and the wound was around 2.0 x1.0 x0.4cm. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the facility Treatment Nurse on 09/15/2024 at 2:30 p.m., the treatment nurse stated when the wound care physician missed observations of Resident #5 each week she, just told her it was the same each time and she said if it gets worse to send her a picture. The Treatment Nurse stated the wound assessments she completed on 08/12/2024 was the original date the wound care physician assessed the wound so the treatment nurse would write down that date on each of the assessments. The treatment nurse said she did not have any documentation to prove she made notifications each time the wound was assessed and noted to be changing. During an interview with the facility Wound Care Physician on 09/16/2024 at 11:39 a.m., the physician stated she began assessing residents at the facility at the beginning of August 2024 and the facility would request the consult and the resident would get added to her list of residents to assess each week. The Wound Care Physician stated she observed Resident #5 sacrum wound on 08/12/2024 and said the wound measured 1.5 x 0.4 x 0.1cm and looked like dermis and classified as MASD. We do not assign a stage to MASD and cannot really measure a depth less than .1. It was superficial and looked like irritation. The Wound Care Physician stated she was supposed to assess Resident #5 weekly but Resident #5 was always gone to dialysis when she would come by to make rounds. She stated she relied on the treatment nurse to guide her to tell her which patients needed to be seen, if they were not at the facility from her previous visit, then she tried to make accommodations to see the resident. The Wound Care Physician stated she received updates on resident progress if she did not see them, she communicated very closely with [treatment nurse name]. We also have an option to do a telemedicine visit, because I am new, I have not mastered that, but it is something we can do in the future. The Wound Care Physician said there was a discussion about changing Resident #5's dialysis treatment days because I go to multiple facilities and my schedule is not flexible. The Wound Care Physician stated the Treatment Nurse mentioned she noticed some changes on Resident #5's wound on 09/09/2024 but did not say what type of changes. The Wound Care Physician stated she was not notified of the slough and eschar tissue documented on the treatment nurse assessment on 09/09/2024 and said if she was notified of she would have known the wound needed a debridement. The Wound Care Physician said I would have expected to be notified immediately that there is necrotic tissue and slough, that is a big change. I was just notified by [treatment nurse name] that she wanted me to come by and look at the wound sometime that week and we were talking about me coming on 09/11/2024. She did not tell me the current status of the wound. The Wound Care Physician stated she would have changed the treatment order if she was notified about the slough and eschar development on the wound and stated my suspicion is there is tissue that needed to be removed. That is not optimal that it was not removed. Without seeing the wound, I can only say that I think that the non-viable tissue needed to be removed. The Wound Care Physician stated she would have expected to be notified about the change in the wound and she said the facility treatment nurse did not notify her of necrotic tissue The wound care physician was shown a photo of Resident #5's sacrum wound taken at the hospital on 09/09/2024 at 10 p.m. and said that is very different than what I have seen or been notified of. I had no idea it looked like that. Oh geez, that is bad. If I knew it looked like that, I would have come in on a Saturday. I am a surgeon by training, I can smell the wound, I know how it is supposed to look and not look. We do have patients that are more complicated. If I knew it looked even 10% of that I would have debrided it. The Wound Care Physician also stated The honey and alginate did not make it worse; it just would not have done anything to heal it. It needed further treatment. The Wound Care Physician was asked how long it could take a wound to get to that stage and she said It could not happen in 8 hours. People on dialysis and diabetic progress pretty quickly. It could have been a week or 3 weeks but would not develop like that. Yeah, given her diagnosis, I would say a week to 2 weeks. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the facility Treatment Nurse on 09/16/2024 at 1:00 PM, the Treatment Nurse stated Resident #5 did not have necrotic tissue on her sacrum when she assessed her. The Treatment Nurse was shown her assessment from 09/09/2024 that reflected the Treatment Nurse documented Resident #5 had 10% necrotic tissue and 20% slough and she said yes, there may have been some eschar in there, I told the wound care physician it had gotten larger on 09/09/2024. The Wound Care Physician knew there was slough, I don't know if I mentioned the eschar. When asked if she had any documentation to support her notification, she said no but knew she called her and told her the wound was bigger on 09/09/2024 and she should have told her about the eschar. The Treatment Nurse was asked if she notified the Wound Care Physician about Resident #5 wound changes and slough from her 09/04/2024 assessment and she said I text The Wound Care Physician all the time, we just haven't been able to get together. I guess we could have gotten together and did a video chat. No, I don't have anything documented that I notified her, just verbally and I know I should have documented it. The Treatment Nurse said it was important to notify the physician of changes so we can change something and go in a different direction. Just the size was concerning, and I know she sits up a lot, but we could have changed the order, frequency or done something different. The Treatment Nurse stated she should have also notified Resident #5's primary physician if the wound was changing and Resident #5 was not being assessed by the Wound Care Physician. During an interview with Resident #5's primary facility physician on 09/16/2024 at 2:12 p.m., the Physician stated he last observed Resident #5 approximately two weeks prior to 09/16/2024. The Physician stated he did not see the sacrum wound and a wound care physician followed Resident #5. The Physician stated the Wound Care Physician should be notified of changes in wounds so the treatment orders could have been changed to address the changes in the wound and said I would hope the wound care physician would know about it because it is their responsibility. The physician stated he was not notified of Resident #5's wound having slough or eschar and stated I would expect the wound care doctor to be notified of that. I would be notified if the patient needs other things like antibiotics. If there was no wound care doctor I would want to be notified. The Physician was asked if he was notified of any change in condition with the resident and he said lethargy and altered mental status was not new for Resident #5 and she was declining for the last few months. The Physician was asked what should have been done if the Wound Care Physician was not able to see Resident #5 weekly and he said That is a question for the facility, what do they do when a provider doesn't come? I don't see the patient wounds because the wound care nurse should be following orders from the wound care doctor. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the facility DON, on 09/16/2024 at 4:07 p.m., the DON said the facility had a treatment nurse Monday - Friday and charge nurses were responsible for wound care on the weekends if the treatment nurse was not there. The DON said the facility had a clinical meeting daily and the charge nurses went to the meeting and gave report on the residents and the facility had a weight and skin meeting weekly on Wednesdays. The DON stated wound care was validated and monitored for wound healing through communication between the DON, Treatment Nurse and Wound Care Physician, and the Treatment Nurse kept a log of wounds which was reviewed weekly by the Corporate Nurse. The DON stated the Treatment Nurse was responsible for notifying the Wound Care Physician of wound changes, documenting the notification in the medical record and following new orders. The DON stated her expectation was for the Treatment Nurse to identify any changes in a resident wound and report those changes immediately so an appropriate treatment was implemented. When asked what harm can happen to a resident if the physician is not notified of changes in their wounds, the DON stated if the intervention is not working and you are not getting the results that you need, a lot of factors can effect wound healing including nutrition or other comorbidities and the physician should be notified so the physician could make a clinical judgement on what to do. The DON said she knew Resident #5 had MASD on her sacrum but never observed the wound. The DON said she was not informed Resident #5's wound had changed or developed slough and eschar and said she would have expected to be notified of these changes immediately. During an interview with the Hospital Wound Care RN on 09/17/2024 at 10:13 a.m., the Hospital Wound Care RN stated she assessed Resident #5 on 09/11/2024 and observed an unstageable pressure ulcer with full eschar, necrotic tissue covering the wound and could not see the depth. The Hospital Wound Care RN said the sacrum wound had a foul odor and Resident #5's laboratory results reflected a high white blood cell count that indicated the wound needed an urgent surgical debridement the Hospital Wound Care RN stated she submitted a surgery consult request and Resident #5 was taken for surgery on 09/12/2024 and received a debridement, skin graft and bone biopsy. The Hospital Wound Care RN also revealed Resident #5 had a wound vac placed on the sacrum wound and an order to leave it on for one week. The Hospital Wound Care RN stated slough usually appeared on a stage 3 wound and if Resident #5 had 10% eschar documented prior to hospitalization , the wound would not have been classified as MASD and should have been classified as a pressure ulcer. The Hospital Wound Care RN also stated Resident #5's wound, in her opinion would take at least a week to develop on a patient who was never turned or repositioned and about 2- 3 weeks for a patient who was repositioned and had other comorbidities. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Wound Care Physician on 09/17/2024 at 11:32 a.m., with the DON, Treatment Nurse, Administrator and Corporate RN present, the Wound Care Physician was asked about her assessing Resident #5 on 08/12/2024 and not receiving any updates on Resident #5 until 09/09/2024 and the wound care physicians said, that is because there were no changes with the wound until 09/09/2024. The Wound Care Physician said when she spoke to the Treatment Nurse on 09/09/2024, the treatment nurse told her there were changes in the wound, but she did not remember exactly what the changes were because they discussed so many wound when she was rounding. The Wound Care Physician said whatever the change that occurred prompted her to change her schedule and make a plan to go see Resident #5 outside of her regular schedule, but the resident was sent to the hospital. The Wound Care Physician hung up the call at 11:40a.m. and the other members stayed in the room. The Treatment Nurse was asked where she documented the physician notification of the wound changes, and she said it was not documented. The treatment nurse said she did not call any other physicians, did not notify the DON and did not add any additional interventions to prevent the wound from worsening. The Treatment Nurse states she was responsible for notifications. The Treatment Nurse and DON stated they did not know what N/A meant and the DON stated it was a process she was working on This was determined to be an Immediate Jeopardy (IJ) on 09/17/2024 at 4:55 p.m. The Administrator and the DON were notified, The Administrator and the DON were provided with the IJ Template on 09/17/2024 at 4:57 p.m. The following Plan of Removal submitted by the facility was accepted on 09/18/2024 at 4:52 p.m.: [Facility Name and Address] PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY To Whom it May Concern, Summary of details which leads to outcomes. On September 14, 2024 an investigation was initiated at [Facility Name and Address]. At approximately 5:00 p.m. on September 17, 2024 a surveyor provided verbal notification that Texas Health and Human Services had determined the conditions at [the facility] constitute immediate jeopardy to resident health and safety. The Immediate Jeopardy findings were identified in the following areas: F580 - Notice of Changes Immediate Corrections Implemented for Removal of Immediate Jeopardy. On September 9, 2024 Resident #5 was transferred to the hospital after becoming unresponsive at dialysis. Action: Through review of hospital record, facility identified Resident #5 was at baseline upon being received to dialysis center and became unresponsive during treatment. Intake to emergency department reveals physician plan to address the following diagnosis: seizure-like activity, leukocytosis, ESRD on dialysis (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On September 17, 2024, at approximately 7:00am the following action was taken: Action: 100% skin sweep of 85 of 85 residents to identify and ensure no new skin pressure areas were observed. Any resident identified to have a skin pressure area had documentation updated in facility electronic medical record system. Responsible party and physicians were notified. Resident care plans were reviewed to ensure care plan was up to date. Start Date: 9/17/2024 Completion Date: 9/17/2024 Responsible: DON Action: All licensed nursing staff were provided education and in-servicing on requirement to notify responsible party and physician of new or worsening skin pressure conditions. Nursing staff were educated on what conditions constituted a change included but not limited to change in size, color, appearance and smell. Start Date: 9/17/2024 Completion Date: 9/17/2024 Responsible: DON Action: Facility implemented Stop and Watch notification process. All staff were educated on identification, notification and utilization of stop and watch process. The stop and watch process will utilize a predetermined questionnaire, accessible by all staff, to identify any potential change in condition to include but not limited to, cognition, skin condition, ADL assistance, etc. The questionnaire form will have a carbon copy attached to the original form being completed. Upon staff identification of potential change in cognition, skin condition, ADL assistance, etc., the form will be completed and given to the charge nurse. The charge nurse will review documentation on the Stop and Watch form and follow facility protocol to address any potential change. The carbon copy of the form will be provided to ADON/designee to ensure daily, Monday through Friday, timely follow up, documentation and notification has been completed. ADON/designee will bring copies to daily clinical meetings, Monday through Friday, and provide update to Director of Nursing. Start Date: 9/17/2024 Completion Date: 9/18/2024 Responsible: DON Action: Ad hoc QAPI meeting held with IDT team and MD to review Plan of removal/response to Immediate Jeopardy Citation on 9/17/2024 Start Date: 9/17/2024 Completion Date: 9/17/2024 Responsible: Administrator IDENTIFICATION OF OTHER AFFECTED: All residents experiencing a change in condition have the potential to be affected. Action: Facility conducted 100% skin sweep of 85 of 85 residents to identify and ensure no new skin pressure areas were observed. Any resident identified to have skin pressure area had documentation updated in facility electronic medical record system. Responsible party and physicians were notified. Resident care plans were reviewed to ensure care plan was up to date. Start Date: 9/17/2024 Completion Date: 9/17/2024 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Responsible: Director of nursing/designee SYSTEMIC CHANGES AND/OR MEASURES: Action: In-service and education was provided to facility nursing staff regarding the process for residents who have been identified as having new or worsening pressure skin conditions. In-service and education was provided to facility staff on utilization of stop and watch notific [TRUNCATED]

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview and record review the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one of six residents reviewed (Resident #5) for pressure ulcers. 1. The facility failed to ensure Resident #5 received services and treatment orders to prevent sacral and left heel pressure ulcers from developing. 2. The facility failed to notify the wound care physician or primary care physician of changes observed with Resident #5's wound, which resulted in the wound becoming an unstageable pressure ulcer (a wound that is covered by slough [debris that appears tan, yellow, green or brown in color] and eschar [hard plaque that is tan, brown or black in color]). An Immediate Jeopardy (IJ) situation was identified on 09/17/2024 at 4:57 p.m. While the IJ was removed on 09/19/2024 at 6:05 p.m., the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for worsening of existing wounds or development of new pressure ulcers. The findings were: Record review of Resident #5's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included diabetes mellitus (a chronic disease that affects how the body uses insulin and glucose), end stage renal disease (a condition where the kidney reaches advanced stage of loss of function) and hypertension (high blood pressure in the arteries that carry blood from the heart to the resident of the body). Record review of Resident #5's quarterly MDS, dated [DATE], reflected Resident #5 had short-term and long-term memory problems and Resident #5's cognitive skills for daily decision making were moderately impaired. Section GG Functional Abilities and Goals reflected Resident #5 used a wheelchair for mobility and required partial to moderate assistance with rolling left and right in bed and transferring from bed to wheelchair. Section H Bladder and Bowel reflected Resident #5 was frequently incontinent of bowel and bladder. Section M Skin Conditions reflected Resident #5 was at risk for developing pressure ulcers and had moisture associated skin damage (MASD; incontinence-associated dermatitis, perspiration, drainage). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's care plan, initiated 05/22/2024 and revised 05/30/2024, reflected Resident #5 had a pressure ulcer or potential for pressure ulcer development related to needing assistance with repositioning, diabetes, end stage renal disease and dialysis, 3 days a week. The goal was Resident#5 would have intact skin, free of redness, blisters or discoloration by/through review date, 09/12/2024. The intervention was Resident #5 needs monitoring/reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested. Resident #5 had an additional care plan, initiated on 08/01/2024 and revised on 08/02/2024, stating Resident #5 had altered skin integrity, non-pressure related to MASD on sacrum (a triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis). The goal was for the affected area to heal without complications, target date 09/21/2024. Interventions included: a) evaluation for pain prior to cleansing or dressing changes b) monitor for signs and symptoms of infection such as swelling, redness, warm discharge, odor and notify physician of significant findings c) notify practitioner if symptoms worsen or do not resolve d) nutritional and hydration support e) provide thorough skin care after incontinent episodes and apply barrier cream f) skin assessment to the complete per living center policy g) treatments as ordered - cleanse area with wound cleanser or normal saline, pat dry, apply Medi honey, alginate, dry foam dressing as needed if soiled or removed at every day shift every Tuesday, Thursday and Saturday. Record review of Resident #5's progress note, written by LVN A on 07/28/2024, reflected resident has skin breakdown to sacrum, will have wound care evaluate, notify doctor, daughter, and DON, per [nurse name] with [physician name], she ordered cleanse with n/s pat dry apply hydrocolloid change q 72 hours, add vitamin c 500 mg bid x 30 days. MVI with Mineral 1 tab daily, zinc sulfate 220mg 1-tab daily x 14 days. Record review of Resident #5's weekly head to toe skin check, dated 07/28/2024, by LVN A, reflected Resident #5 had skin breakdown quarter size on the sacrum. The assessment reflected a heel check with no skin issues noted. Record review of Resident #5's July 2024 treatment administration record reflected an order which stated, cleanse skin breakdown on sacrum with normal saline, pat dry, apply hydrocolloid, change q 72 hours for skin breakdown to sacrum, start date 07/28/2024. Record review of Resident #5's progress note written by the treatment nurse on 08/01/2024, reflected the treatment nurse rounded with the wound care physician and the area is MASD to sacrum, new orders are to apply Medi honey, alginate, dry foam dressing T. TH. S, prn if soiled. Record review of Resident #5's weekly head to toe skin check completed by the treatment nurse, 08/01/2024, reflected Resident #5 had a MASD - 3.0 x 1.4 x .2, pink, serous, moderate drainage on the sacrum. Wound documentation reflected Medi honey, alginate, dry foam dressing. The assessment reflected a heel check with no skin issues noted. Record review of Resident #5's August 2024 treatment administration record reflected an order for MASD on sacrum - cleanse area with wound cleanser or normal saline pat dry, apply Medi honey, alginate, dry foam dressing every day shift every Tue, Thu, Sat for skin breakdown to sacrum, start date 08/03/2024. Resident #5 also had an order which reflected MASD on sacrum - cleanse area with wound cleanser or normal saline pat dry, apply Medi honey, alginate, dry foam dressing as needed for if soiled or removed, start date 08/01/2024. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's weekly head to toe skin check, 08/08/2024 by the treatment nurse, reflected Resident #5 had MASD 1.5 x 0.4 x 0.1cm, pink, no slough, no odor, scant drainage to the sacrum. The assessment reflected a heel check with no skin issues noted. Record review of Resident #5's weekly head to toe skin check, 08/12/2024 by the treatment nurse, reflected Resident #5 had non pressure wound to sacrum- 1.5 x 0.4 x 0.1cm, moderate serous drainage, open areas with exposed dermis. The assessment reflected a heel check with no skin issues noted. Record review of Resident #5's initial wound evaluation and management summary, dated 08/12/2024 by the wound care physician, reflected Resident #5 was seen for a wound on her sacrum. The focused wound exam listed etiology as moisture associated skin damage. Duration was documented as less than 50 days. The objective was healing/maintaining healing. The wound size was documented as 1.5 x 0.4 x 0.1 cm and surface area was 0.60 cm. Exudate (fluid released by an organism through pours or a wound) was documented as moderate serous (clear or pale-yellow water fluid that is found in the body especially in the spaces between organs and membranes) and dermis (middle layer of skin) was documented as open areas with exposed dermis. Record review of Resident #5's progress note, by the treatment nurse, dated 08/12/2024, reflected Resident #5's wound care orders remained the same for non-pressure wound to sacrum. Record review of Resident #5's weekly wound review by the treatment nurse, dated 08/19/2024, reflected Resident #5 had a non-pressure wound on her sacrum measuring 2 x 1 x .2 cm. Resident #5 had 30% slough and 0% eschar and serous drainage. The treatment plan was Medi honey, alginate, dressing. The wound care physician was notified of the wound on 08/12/2024 and Resident #5's daughter was notified. Record review of Resident #5's wound care physician progress note, dated 08/19/2024, reflected signing off without visit - in house. Record review of Resident #5's wound care physician progress note, dated 08/26/2024, reflected Resident #5's weekly visit was rescheduled due to Resident #5 being gone from the facility at dialysis. Record review of Resident #5's weekly wound review completed by the treatment nurse, dated 08/28/2024, reflected Resident #5 had a non-pressure wound on the sacrum measuring 2 x 1 x .03 cm. Resident had 30% slough and 0% eschar with scant serous drainage. The treatment plan was Medi honey, alginate, dressing. The wound care physician was notified of the wound on 08/12/2024 and Resident #5's family notification was blank. Record review of Resident #5's September 2024 treatment administration record reflected an order for MASD on sacrum - cleanse area with wound cleanser or normal saline, pat dry, apply Medi honey, alginate, dry foam dressing every day shift every Tue, Thu, Sat for skin breakdown to sacrum, start date 08/03/2024. MASD on sacrum-cleanse area with wound cleanser or normal saline pat dry, apply Medi honey, alginate, dry foam dressing as needed for if soiled or removed, start date 08/01/2024. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's weekly wound review completed by the treatment nurse, dated 09/04/2024, reflected Resident #5 had a non-pressure wound to the sacrum measuring 2 x 2 x 0.2cm. The slough and eschar percentages were blank, and drainage was marked as scant. The physician and family notification sections were blank, and the treatment plan was blank. Record review of Resident #5's progress note, dated 09/04/2024, by the treatment nurse, reflected resident continues with non-pressure wound to sacrum. Area remains the same at this time. Resident continues to attend dialysis and have extended time sitting in wheelchair. Will continue to encourage and offload and reposition throughout shift. Record review of Resident #5's foot check assessment completed at the dialysis clinic, dated 09/06/2024, reflected Resident #5 presented with left heel dressing noted. Dressing clean, dry and intact. Record review of Resident #5's progress note, by LVN C, dated 09/09/2024 at 11:44 a.m., LVN C documented received a call from [name] RN from resident's dialysis center. As per [name] RN resident was transferred to [hospital name] ER for altered mental status as per nephrologist. [Name] RN notified residents daughter prior to transferring resident. Called ER but did not get an answer. Record review of Resident #5's wound care physician progress note, 09/09/2024, reflected the patient's visit has been rescheduled. She is at dialysis. Record review of Resident #5's weekly wound review completed by the treatment nurse, dated 09/09/2024 at 1:41 p.m., reflected Resident #5 has MASD to the sacrum measuring 2 x 0.6 x .2 and had 20% slough and 10% eschar with no drainage. The physician notification was checked as completed but there was no name of physician or date and time of notification. The family notification section was blank. The treatment plan was Medi honey, alginate, board gauze. Record review of Resident #5's dialysis report, dated 09/09/2024 at 11:13 a.m., reflected treatment early due to clotting with minimal blood loss. Post treatment patient hard to arouse and MD order to refer to [hospital name] ER per EMS: AMS. Record review of hospital photos reflected a sacrum wound, dated 09/09/2024 at 11:20 p.m. that revealed a wound bed covered in slough and black eschar necrotic tissue, and a left heel purple wound, dated 09/09/2024 at 11:30 p.m. Record review of Resident #5's hospital admission H&P, dated 09/09/2024 at 7:30 p.m., reflected Resident #5 was admitted due to AMS during dialysis and Resident #5 was dialyzed for 3 hours and went unconscious. Resident #5 was acting normal prior to the start of dialysis. When Resident #5 arrived at the hospital, Resident #5 was completely obtunded (a state of reduced alertness or consciousness) with inability to answer any questions with some deviated gaze as well as significant facial droop. The assessment/plan reflected: 1) seizure-like activity 2) leukocytosis (elevated white blood cell count indicating an infection, inflammation or injury) - treat this patient for possible episode of sepsis (chemicals released in the bloodstream to fight an infection trigger inflammation throughout the body that can damage multiple organs, leading them to fail, sometimes resulting in death) due to pronounced leukocytosis with neutrophilia (caused when a body produces too many neutrophils which are a type of white blood cells). No clear source at this point. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's hospital wound care note, by the hospital wound care RN, dated 09/11/2024 at 1:47 p.m., reflected a wound assessment located on the coccyx, classified as an unstageable pressure injury. The description of the wound was large, foul-smelling wound with dark, boggy necrotic tissue covering wound bed. Necrotic tissue extends down to the perirectal area. Wound measurement is 12.4cm x 8.0cm. A second wound located on the left heel was classified as a deep tissue injury. The wound was described as dark purple, but intact tissue overlying heel and measured 2.5 x 2.3cm. The hospital wound RN stated patient will likely need debridement to this wound but unsure if she is an ideal surgical candidate. Patient with leukocytosis, likely due to wound. Patient was not responsive during assessment and did not wake to movement. Patient being offloaded on specialty bed with bilateral heel protectors. Record review of Resident #5's hospital consult notes, dated 09/11/2024 at 2:19 p.m., reflected Resident #5 presented with leukocytosis and found to have unstageable sacral decubitus ulcer and a general surgery consult for possible debridement. The note also stated Resident #5 had an unstageable sacral decubitus ulcer with necrotic tissue and concern for infection. Under Medical Decision Making the consult note reflected will take her to the operating room tomorrow in the morning for debridement of the area with possible wound vac placement. Patient is a very poor surgical candidate for any other intervention. Will take cultures intraoperatively. Continue neurological workup. Consider hospice discussion. Record review of hospital physician progress note dated 09/11/2024 at 10:05 p.m., reflected Resident #5 had significant metabolic encephalopathy (brain disorder caused by a chemical imbalance in the blood that effects to brain) in the context of an acutely infected ulcer. The note also reflected the patient has a significant wound on her buttocks, which is black with foul odor, suggestive of necrosis or infection. Record review of the hospital operative surgeon note, dated 09/12/2024 at 1:01 p.m., reflected Resident #5's surgical procedure performed was incision, drainage and debridement of sacral decubitus ulcer, sacral bone biopsy, substitute skin graft product placement and negative pressure wound VAC therapy (a device that removed pressure over the area of the wound that can help a wound heal and gently pulls fluid from the wound). Post Operative diagnosis stated, unstageable infected sacral ulcer, abscess, concern for osteomyelitis. Findings documented were 9 x 7 x 3cm unstageable infected sacral decubitus ulcer with associated abscess and significant necrotic tissue. Record review of Resident #5's hospital MD progress note, dated 09/13/2024 at 10:57 a.m., reflected the resident received a decubitus ulcer debridement, substitute skin graft and wound vac placement on 09/12/2024. The disposition planning note stated continue wound care with negative pressure wound therapy. Wait at least 5 to 7 days for dressing change due to presence of skin graft substitute in the area. Very poor prognosis due to medical comorbidities and location of wound. Record review of Resident #5's physician progress note, dated 09/15/2024 at 11:41 a.m., reflected Resident #5's sacral decubitus ulcer wound culture collected on 09/12/2024 was positive for E coli, a type of bacteria that can cause diarrhea, vomiting and kidney failure. Record review of Resident #5 shower sheets provided by the DON for the month of August and September 2024 reflected one shower sheet marked refused on 09/07/2024, one shower sheet reflected mark on butt/red dated 08/12/2024. All other shower sheets were marked N/A. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation in Resident #5's room with hospital RN [NAME] 09/14/2024 at 3:25 p.m., RN A removed Resident #5 left heel dressing to reveal a quarter size purple DTI. Resident #5 did not arouse during the observation. During an interview with Resident #5's family member on 09/14/2024 at 1:57 p.m., Resident #5's family member stated she was notified by hospital staff when Resident #5 arrived at the hospital and Resident #5 was unresponsive and had one wound on her heel and a bad one on her bottom. Resident #5's family member said she was never notified by the facility that Resident #5 had a wound on her heel or bottom. The family member stated she was told by the facility Resident #5 had a diaper rash. Resident #5's family member said she was told by the hospital the wound on her bottom was black, and the hospital was checking to see if the infection went to her bone. During an interview with Hospital RN Z on 09/14/2024 at 3:20 p.m., Hospital RN Z said Resident #5 admitted with a diagnosis of metabolic encephalopathy (alteration in consciousness) and sepsis. Hospital RN Z said Resident #5 had a DTI to her left heel and she had a very bad sacrum wound and was now on a wound vac. Hospital RN Z stated the hospital took pictures of the wounds upon admission. During an interview with LVN A on 09/15/2024 at 10:56 a.m., LVN A stated she was the charge nurse for Resident #5 on the 2 p.m. -10 p.m. shift on 09/08/2024. LVN A stated she observed Resident #5's wound around 9 p.m. on 09/08/2024 when she provided wound care. LVN A stated she provided wound care to Resident #5, 2-3 times a day. LVN A stated treatments were documented on the resident treatment administration record. LVN A stated it was not documented on the TAR for 09/08/2024 and said she did not know why it was not documented. LVN A stated Resident #5 had PRN orders for wound care and said, well it was done, and I do it daily. LVN A said, on 09/08/2024 around 9pm, Resident #5's wound appeared red with greyish area and larger than quarter size and it was deep. LVN A said she would instruct staff to rotate Resident #5 when in the bed and said Resident #5 was not up and in her wheelchair long at all on her shifts but she did not work on Resident #5's dialysis days. During an interview with CNA A on 09/15/2024 at 11:21 a.m., CNA A said the last time she provided care for Resident #5 was approximately 2 weeks ago. CNA A stated Resident #5 had a quarter size red area on her bottom and said she was not aware of any other wounds. During an interview with CNA B on 09/15/2024 at 11:32 a.m., CNA B stated she had not worked in the last 2-3 weeks. CNA B stated when she observed Resident #5's wound about 3 weeks ago, it was small and I think it hurt her, maybe quarter size. She complained that it hurt every time we changed her. CNA B said she would reposition Resident #5 during the shift and said she thought Resident #5 was scheduled for baths three times a week but didn't know often she was getting them. During an interview with LVN C on 09/15/2024 at 12:28 p.m., LVN C stated she worked for a staffing agency and was the charge nurse on 6 a.m. - 2p.m. shift on 09/09/2024. LVN C said she did not assess Resident #5 prior to her leaving for dialysis on the morning of 09/09/2024. LVN C said she received a call from the dialysis clinic around noon and the nurse said Resident #5 was sent to [hospital name] ER because she had altered mental status after the dialysis procedure. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the facility Treatment Nurse on 09/15/2024 at 12:54 p.m., the treatment nurse revealed she began doing treatments at the facility at the beginning of August 2024. She stated her role as the treatment nurse was to assess skin, round with the wound care physician, take orders, notify the doctors and family of changes with the wound and provide wound care daily. The treatment nurse stated wound treatments were documented on the resident TAR and she was notified of changes in the resident skin by the direct care staff and also received copies of the resident shower sheets. The treatment nurse stated she performed skin assessments weekly and the last time she completed a skin assessment for Resident #5 was on the morning of 09/09/2024 around 5am-6am prior to Resident #5 going to dialysis. The treatment nurse described Resident #5's wound on the morning of 09/09/2024 as pink with scant amount of drainage and close to her sacrum. She said Resident #5 had no eschar and the skin was pink and moist. The Treatment Nurse said she did not look at Resident #5's heels that morning and was not aware of Resident #5 having a wound on her left heel. The Treatment Nurse stated she did a treatment on Resident #5 on the morning of 09/09/2024 and said she did not know why it was not documented on Resident #5's TAR as being completed. The Treatment Nurse revealed the Wound Care Physician rounded at the facility weekly and should have seen Resident #5 weekly but stated the Wound Care Physician often rounded while Resident #5 was at dialysis. The Treatment Nurse stated she thought it had been a couple of weeks since the wound care physician had assessed Resident #5's wound. The Treatment Nurse described the wound as MASD and the wound was around 2.0 x1.0 x0.4cm. During an interview with the facility Treatment Nurse on 09/15/2024 at 2:30 p.m., the treatment nurse stated when the wound care physician missed observations of Resident #5 each week she, just told her it was the same each time and she said if it gets worse to send her a picture. During an interview with the DON on 09/15/2024 at 2:50 p.m., the DON revealed the facility had not spoken to Resident #5's family since Resident #5 went to the hospital on 09/09/2024 and had not received any updates or medical records from the hospital since Resident #5's admission to the hospital on 09/09/2024. During an interview at Resident #5's dialysis clinic with the Clinical Manager and Social Worker on 09/16/2024 at 9:15 a.m., the Social Worker revealed Resident #5 was arriving at dialysis with an altered mental status for about a month but significantly improved once she was dialyzed. The Social Worker said Resident #5 received treatment at the clinic since 08/15/2023 and usually arrived at dialysis around 7 a.m. and left around 2 p.m. to return to the facility. The Clinical Manager said on 09/09/2024, Resident #5 became unresponsive to stimuli and very lethargic toward the end of her dialysis treatment, the nurse notified the physician, and the physician gave an order for Resident #5 to be sent to the ER. The Clinical Manager said Resident #5 had a foot check on 09/06/2024 and was observed to have a dressing to her left heel. The Clinical Manager stated it was not facility proctive to remove the dressing to look at the wound and Resident #5 arrived dressed to her treatments each week and clinic staff would not have observed a sacrum wound. The Clinical Manager stated Resident #5 arrived on 09/09/2024 around 7:30 a.m. and was picked up by EMS at 11:23 a.m. to be transported to the ER. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675002	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center/San Antonio West	636 Cupples Rd San Antonio, TX 78237

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the facility Wound Care Physician on 09/16/2024 at 11:39 a.m., the physician stated she began assessing residents at the facility at the beginning of August 2024 and the facility would request the consult and the resident would get added to her list of residents to assess each week. The Wound Care Physician stated she observed Resident #5 sacrum wound on 08/12/2024 and said the wound measured 1.5 x 0.4 x 0.1cm and looked like dermis and classified as MASD. We do not assign a stage to MASD and cannot really measure a depth less than .1. It was superficial and looked like irritation. The Wound Care Physician stated she was supposed to assess Resident #5 weekly but Resident #5 was always gone to dialysis when she would come by to make rounds. She stated she relied on the treatment nurse to guide her to tell her which patients needed to be seen, if they were not at the facility from her previous visit, then she tried to make accommodations to see the resident. The Wound Care Physician stated she received updates on resident progress if she did not see them she communicated very closely with [treatment nurse name]. We also have an option to do a telemedicine visit, because I am new, I have not mastered that, but it is something we can do in the future. The Wound Care Physician said there was a discussion about changing Resident #5's dialysis treatment days because I go to multiple facilities and my schedule is not flexible. The Wound Care Physician stated the Treatment Nurse mentioned she noticed some changes on Resident #5's wound on 09/09/2024 but did not say what type of changes. The Wound Care Physician stated she was not notified of the slough and eschar tissue documented on the treatment nurse assessment on 09/09/2024 and said if she was notified of she would have known the wound needed a debridement. The Wound Care Physician said I would have expected to be notified immediately that there is necrotic tissue and slough, that is a big change. I was just notified by [treatment nurse name] that she wanted me to come by and look at the wound sometime that week and we were talking about me coming on 09/11/2024. She did not tell me the current status of the wound. The Wound Care Physician stated she would have changed the treatment order if she was notified about the slough and eschar development on the wound and stated my suspicion is there is tissue that needed to be removed. That is not optimal that it was not removed. Without seeing the wound, I can only say that I think that the non-viable tissue needed to be removed. The Wound Care Physician stated she would have expected to be notified about the change in the wound and she said the facility treatment nurse did not notify her of necrotic tissue The wound care physician was shown a photo of Resident #5's sacrum wound taken at the hospital on 09/09/2024 at 10 p.m. and said that is very different than what I have seen or been notified of. I had no idea it looked like that. Oh geez, that is bad. If I knew it looked like that, I would have come in on a Saturday. I am a surgeon by training, I can smell the wound, I know how it is supposed to look and not look. We do have patients that are more complicated. If I knew it looked even 10% of that I would have debrided it. The Wound Care Physician also stated The honey and alginate did not make it worse; it just would not have done anything to heal it. It needed further treatment. The Wound Care Physician was asked how long it could take a wound to get to that stage and she said It could not happen in 8 hours. People on dialysis and diabetic progress pretty quickly. It could have been a week or 3 weeks but would not develop like that. Yeah, given her diagnosis, I would say a week to 2 weeks. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the facility Treatment Nurse on 09/16/2024 at 1:00 PM, the Treatment Nurse stated Resident #5 did not have necrotic tissue on her sacrum when the treatment nurse assessed her. The Treatment Nurse was shown her assessment from 09/09/2024 which reflected the Treatment Nurse had documented Resident #5 had 10% necrotic tissue and 20% slough and she said Yes, there may have been some eschar in there, I told the wound care physician it had gotten larger. The Wound Care Physician knew there was slough, I don't know if I mentioned the eschar. The Treatment Nurse stated she did not have any documentation to support her notification but knew she called The Wound Care Physician r and told her the wound was bigger and said she should have told her about the eschar. The Treatment Nurse was asked if she notified the wound care physician about Resident #5's wound changes and slough from her 09/04/2024 assessment and she said I text her all the time, we just haven't been able to get together. I guess we could have gotten together and did a video chat. No, I don't have anything documented that I notified her, just verbally and I know I should have documented it. The Treatment Nurse said it was important to notify the physician of changes so we can change something and go in a different direction. Just the size was concerning, and I know she sits up a lot, but we could have changed the order, frequency or done something different. The Treatment Nurse stated she should have notified Resident #5's primary physician if the wound was changing and Resident #5 was not being assessed by the Wound Care Physician. She stated I could have notified him too. The Treatment Nurse stated the sheets were completed by the direct care staff who provided the shower and then turned into the Charge Nurse and to the Treatment Nurse to review. The Treatment Nurse stated she assumed that N/A marked on the shower sheets meant Resident #5 did not get a shower. The Treatment Nurse was asked about Resident #5 having N/A on the majority of her shower sheets in August and September and the treatment nurse said we just implemented the sheets in August. If someone refuses, we should be documenting refusals on it so those must be on her dialysis days so they should have been changed and given to her before she leaves for dialysis or on the opposite days. During an interview with Resident #5's primary facility physician on 09/16/2024 at 2:12 p.m., the Physician stated he last observed Resident #5 approximately two weeks prior to 09/16/2024. The Physician stated he did not see the sacrum wound and a wound care physician followed Resident #5. The Physician stated the Wound Care Physician should be notified of changes in wounds so the treatment orders could have been changed to address the changes in the wound and said I would hope the wound care physician would know about it because it is their responsibility. The physician stated he was not notified of Resident #5's wound having slough or eschar and stated I would expect the wound care doctor to be notified of that. I would be notified if the patient needs other things like antibiotics. If there was no wound care doctor I would want to be notified. The Physician was asked if he was notified of any change in condition with the resident and he said lethargy and altered mental status was not new for Resident #5 and she was declining for the last few months. The Physician was asked what should have been done if the Wound Care Physician was not able to see Resident #5 weekly and he said That is a question for the facility, what do they do when a provider doesn't come? I don't see the patient wounds because the wound care nurse should be following orders from the wound care doctor. (continued on next page)

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