Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/30/2026
NAME OF PROVIDER OR SUPPLIER Balch Springs Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Shepherd LN Balch Springs, TX 75180	

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for one (Resident #1) of 14 residents, reviewed for care plans. The facility failed to address Resident #1's required off-loading of heels and repositioning every two hours, as these orders were not reflected in Resident #1's Comprehensive Care Plan. Resident #1 developed a Stage 4 Pressure Wound. On 03/25/2026 at 6:22 p.m. an Immediate Jeopardy (IJ) was identified. The IJ template was provided to the facility on [DATE] at 6:22 PM. While the IJ was removed on 03/27/26 at 2:40 PM, the facility remained out of compliance at a scope of Isolated and severity level of No Actual Harm with a potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place the residents at risk of not receiving the care and services to maintain their highest practicable physical, mental, and psychosocial well-being.Findings included: A record review of Resident #1's Face Sheet dated 03/24/2026 reflected a [AGE] year-old female with an initial admittance date of 12/30/2025 with diagnosis that included: Malnutrition, Anxiety, Asthma-Chronic obstructive Pulmonary Disease, Toxic Encephalopathy (Brain dysfunction caused by exposure to toxic chemicals), Alcohol Dependance, Muscle Wasting and Atrophy Lower Leg, Cognitive Communication Deficit, and Muscle Weakness. A record review of Resident #1's Quarterly MDS dated [DATE], revealed a [AGE] year-old female that initially admitted to the facility on [DATE]. Resident #1 had medically complex conditions that included active diagnosis of Malnutrition, Anxiety, Asthma-Chronic obstructive Pulmonary Disease, Toxic Encephalopathy (Brain dysfunction caused by exposure to toxic chemicals), Alcohol Dependance, Muscle Wasting and Atrophy Lower Leg, Cognitive Communication Deficit, and Muscle Weakness. A BIMS Score of 06 (Severe Cognitive Impairment). Resident #1 was always incontinent of bowel and bladder, was dependent (required the assistance of two or more helpers) for tub/shower transfer, and Resident #1 either refused or was unable to: sit to lying, lying to sitting, sit to stand, chair/bed to chair transfer, toilet transfer or walk. A record review of Resident #1's Care Plan Report dated 03/25/2026 reflected the following: Focus: Pressure Ulcer Risk: Resident has the potential for the development of a pressure ulcer. (Date Initiated 01/12/2026). Goal: The Resident will be free of preventable breakdown through next review date. (Date Initiated 01/12/2026, Revision on 03/18/2026, Target Date 06/19/2026). Interventions: Check Frequently for wetness and soiling, every two hours provide incontinence care as needed. (Date Initiated 01/12/2026). Bathe per schedule. (Date Initiated 01/12/2026). Weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new skin conditions to the physician. (Date Initiated 01/12/2026). The Care plan did not address off-loading of heels or repositioning the resident. Record Review of Resident #1's Braden Scale for Predicting Pressure Sore Risk dated 12/30/2025 at 8:26 p.m., and signed by RN ee rated Resident #1 as low risk with a score (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of 16 out of a possible 23 (Higher score indicates higher risk). Record review of Resident #1's EHR, dated 12/30/2025 through 03/30/2026 and accessed between 3/24/2026 and 03/30/2026, revealed there were no documented Skilled Observation Notes (what the facility claimed they used as skin assessments) from 01/01/2026 until 02/20/26. All Skilled Observation Notes after 02/26/2026 indicated the skin as warm, dry, skin intact, with no notable changes in skin condition. Record Review of a hospital document discovered in the facility EHR titled Wound Care Service, dated 12/22/25, and identifying Resident #1 as the recipient of services found that Resident #1 had orders under Prevention Plan: Heels - Offload using Heel Protector Boot or pillows lengthwise. Record review of a document titled Specialty Physician Initial Wound Evaluation & Management Summary, dated 02/17/2026 and signed by Wound Care Physician revealed that Resident #1 had been diagnosed with an unstageable DTI of the right heel, undetermined thickness that was measured at: 2.7 cm (length) x 3 cm (width) x unmeasurable cm (depth), with a total surface area of the wound measured at 8.10 cm squared, and an unstageable DTI of the left heel measuring 1.5 cm (length) x1 cm (width) not measurable depth cm, with a total surface area of the wound measured at 1.50 cm squared. Record review of a document titled Specialty Physician Wound Evaluation & Management Summary, dated 3/10/2026 and signed by Wound Care Physician reflected that Resident #1 had a diagnosis of unstageable DTI of the right heel, undetermined thickness that was measured at: 1. cm (length) x 3 cm (width) x .06 cm (depth), with a total surface area of the wound measured at 3.90 cm squared, and a Stage 4 Pressure Wound of the Left heel, full thickness measuring 1 cm (length) x1.3 cm (width) not measurable depth cm, with a total surface area of the wound measured at 1.30 cm squared. In an interview on 03/24/2026 at 12:00 p.m. with a family representative of Resident #1, he stated that [Resident #1] had had two little wounds on her that were healed before she had left the hospital [just prior to admitting to the facility], she [Resident #1] didn't have any wounds on her heels and now she has a pressure ulcer. He stated that he had visited Resident #1 many times and he had never seen her wearing any boots on her feet or that they had pillows under her legs until after they started putting bandages on her feet. In an interview on 03/24/2026 at 1:55 p.m. NP stated that Resident #1 had admitted with no Pressure Ulcers or DTI's. She stated that she had seen that Resident #1 had developed blisters on both of her heels on 02/09/2026 and that she had for offloading and heel [boots] risers and that she had been told Resident #1 had been compliant with them. She stated that Resident #1 might have developed a pressure ulcer on her heel if the staff had not been repositioning/offloading her heels, or the resident might have been taking of her heel protectors. She stated that she had been unaware that Resident #1 had developed a stage 4 pressure ulcer on her heel. In an interview on 03/24/2026 at 4:03 p.m. CNA ff revealed that she had worked often with Resident #1 and that she had done peri-care for Resident #1. She stated that Resident #1 never had a pressure ulcer on her bottom. She denied any knowledge of Resident #1 having any injuries to her feet. In an interview on 03/25/26 at 10:18 a.m. DON related that VOHRA (third party wound treatment consultant) gets referred too when wounds reach stage 2. She stated that Repositioning is not reflected on the TAR/MAR. She stated that there was no indication of any injuries to [Resident #1's] heels at the time of admission [to the facility]. She stated that the facility had not received heel riser boots yet for Resident #1. In an interview on 03/25/2026 at 10:20 a.m. ADON stated that the NP had ordered the wrong type of boot for Resident #1, so she only had the cone protectors. She stated that she had discovered the blisters on Resident #1's feet on 02/09/2026 as part of regular care, and had informed NP about it and new orders had been written. She stated that she might be able to provide the order slip for the boot protectors, but she did not provide the document/proof before exit from the facility on 03/30/2026. During an interview on 03/26/2026 at 2:42 PM DON stated that after reviewing Resident #1's care plan she was unable to find interventions for offloading heels or repositioning Resident #1. Record review of the facility's Comprehensive Care Plans Policy, dated 2/10/2021 and revised 9/4/2024 reflected that: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	needs is developed and implemented for each resident.Policy Interpretation and ImplementationI. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.1. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.2. The IDT includes:a. The Attending Physician;b. A registered nurse who has responsibility for the resident;c. A nurse aide who has responsibility for the resident;d. A member of the food and nutrition services staff;e. The resident and the resident's legal representative (to the extent practicable); andf. Other appropriate staff or professionals as determined by the resident's needs or as requested by the resident.3. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to:a. Participate in the planning process;b. Identify individuals or roles to be included;c. Request meetings;d. Request revisions to the plan of care;e. Participate in establishing the expected goals and outcomes of care;f. Participate in determining the type, amount, frequency and duration of care;g. Receive the services and/or items included in the plan of care; andh. See the care plan and sign it after significant changes are made.4. The resident will be informed of his or her right to participate in his or her treatment.5. An explanation will be included in a resident's medical record if the participation of the resident and his/her resident representative for developing the resident's care plan is determined to not be practicable.6. The care planning process will:a. Facilitate resident and/or representative involvement;b. Include an assessment of the resident's strengths and needs; andc. Incorporate the resident's personal and cultural preferences in developing the goals of care.7. The comprehensive, person-centered care plan will:a. Include measurable objectives and timeframes;b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;d. Describe any specialized services to be provided as a result of PASARR recommendations;e. Include the resident's stated goals upon admission and desired outcomes;f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire;g. Incorporate identified problem areas;continues on next page h. Incorporate risk factors associated with identified problems;i. Build on the resident's strengths;j. Reflect the resident's expressed wishes regarding care and treatment goals;k. Reflect treatment goals, timetables and objectives in measurable outcomes;l. Identify the professional services that are responsible for each element of care;m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels;n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; [NAME]. Reflect currently recognized standards of practice for problem areas and conditions.8. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan.9. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.a. No single discipline can manage an approach in isolation.b. The resident's physician (or primary healthcare provider) is integral to this process.10. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers.b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident.11. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment.12. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.13. The Interdisciplinary Team must review and update the care plan:a. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents 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 1 (Resident #1) of 14 residents reviewed for pressure ulcers. The facility failed to address Resident #1 required off-loading of heels and repositioning every two hours. Resident #1 developed a Stage 4 Pressure Wound. On 03/25/2026 at 6:22 p.m. an Immediate Jeopardy (IJ) was identified. The IJ template was provided to the facility on [DATE] at 6:22 PM. While the IJ was removed on 03/27/26 at 2:40 PM, the facility remained out of compliance at a scope of Isolated and severity level of No Actual Harm with a potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place the residents at risk of not receiving the care and services to maintain their highest practicable physical, mental, and psychosocial well-being.Findings included: Record review of Resident #1's Face Sheet, dated 03/24/2026, reflected a [AGE] year-old female, admitted [DATE], diagnosis included Malnutrition, Anxiety, Asthma-Chronic obstructive Pulmonary Disease, Toxic Encephalopathy (brain dysfunction caused by exposure to toxic chemicals), Alcohol Dependance, Muscle Wasting and Atrophy Lower Leg, Cognitive Communication Deficit, and Muscle Weakness. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 06 indicating severe cognitive impairment. Resident #1 was always incontinent of bowel and bladder, was dependent (required the assistance of two or more helpers) for tub/shower transfer, and Resident #1 either refused or was unable to: sit to lying, lying to sitting, sit to stand, chair/bed to chair transfer, toilet transfer or walk. Resident #1 had a pressure ulcer injury, a scar over bony prominence, or a non-removable dressing/device. Formal assessment instrument/tool and had been clinically assessed. Resident #1 was indicated at being at risk for pressure ulcer/injuries and had unhealed Pressure Ulcers/Injuries. Record review of Resident #1's Care Plan Report, dated 03/25/2026, reflected the following: Focus: Pressure Ulcer Risk: Resident has the potential for the development of a pressure ulcer. (Date initiated 01/12/2026). Goal: The Resident will be free of preventable breakdown through next review date. (Date initiated 01/12/2026, revised on 03/18/2026, target date 06/19/2026). Interventions: Check frequently for wetness and soiling, every two hours provide incontinent care as needed. (Date initiated 01/12/2026). Bathe per schedule. (Date initiated 01/12/2026). Weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new skin conditions to the physician. (Date initiated 01/12/2026). Nutritional Status: Resident [#1] is on Mechanical soft, no added salt, with thin liquids. (Date initiated 12/30/2025). Record review of Resident#1's Order Summary Report dated 03/27/2026 revealed that Resident #1 did not have any orders to offload bilateral heels with pillows or heel protectors/boots while in bed every shift until 02/09/2026. No orders for an air pressure mattress were found. Record review of Resident #1's Braden Scale for Predicting Pressure Sore Risk assessment, dated 12/30/2026 and signed by RN ee rated Resident #1 as low risk with a score of 16 out of a possible 23 (higher score indicates higher risk). No other Braden Scale for Predicting Pressure Sore Risk assessment were found. Record review of Resident #1's EHR, dated 12/30/2025 through 03/30/2026 and accessed between 3/24/2026 and 03/30/2026, revealed there were no documented Skilled Observation Notes (what the facility claimed they used as skin assessments) from 01/01/2026 until 02/20/26. All Skilled Observation Notes after 02/26/2026 indicated the skin as warm, dry, skin intact, with no notable changes in skin condition. Record review of Resident #1's hospital document (from the hospital she was admitted to prior to being admitted to the facility) titled Wound Care Service, dated 12/22/25 at 4:29 p.m., indicated Resident #1 had orders that outlined Prevention Plan: Heels - Offload using Heel Protector Boot or pillows lengthwise. Record review of Resident #1's progress note, dated 12/30/25 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	at 8:26 p.m. and written by RN ee, revealed. No s/sx of acute distress noted at this time. Skin warm and dry; redness noted to buttocks and peri-area (an area of skin located between the sexual organ and the anus), abrasion noted to left inner thigh, and open area to buttocks. Record review of Resident #1's progress note dated 02/09/26 at 7:00 a.m. and written by RN ee wrote. blisters noted to bilat heels, HCP notified, spoke with [NAME] (NP) per routine visit. New orders received to apply skin prep to bilat[eral] heels blisters daily; offload bilat heels with heel protectors while in bed. Record review of Resident #1's Specialty Physician Initial Wound Evaluation & Management Summary, dated 02/17/2026 and signed by the Wound Care Physician revealed Resident #1 was diagnosed with an unstageable DTI of the right heel, undetermined thickness that measured 2.7 cm (length) x 3 cm (width) x unmeasurable cm (depth), with a total surface area of the wound measured at 8.10 cm squared, and an unstageable DTI of the left heel measuring 1.5 cm (length) x1 cm (width) not measurable depth cm, with a total surface area of the wound measured at 1.50 cm squared. It did not state in the document if the wounds had been avoidable or not. Record review of Resident #1's Specialty Physician Wound Evaluation & Management Summary, dated 3/10/2026 and signed by the Wound Care Physician reflected Resident #1 had a diagnosis of unstageable DTI of the right heel, undetermined thickness that was measured 1 cm (length) x 3 cm (width) x .06 cm (depth), with a total surface area of the wound measured at 3.90 cm squared, and a Stage 4 Pressure Wound of the Left heel, full thickness measuring 1 cm (length) x1.3 cm (width) not measurable depth cm, with a total surface area of the wound measured at 1.30 cm squared. Record review of Resident #1's MAR/TAR, accessed 03/27/2026 and dated 02/01/2026 to 02/28/2026, revealed Resident #1's orders to Offload bilat [both heels] with pillows or heel protectors/boots while in bed every shift with a start date of 02/09/2026. The MAR/TAR indicated Resident #1 did not have her heels offloaded during the 6:00 -a.m. to 2:00 p.m. shift on 2/10/26, 2/11/26, 2/12/26, 2/13/26 and 2/24/26. Further record review revealed Resident #1 no documentation her heels were offloaded during the 2:00 p.m. to 10:00 p.m. shift on 2/24/26 and 2/25/26. Record review further indicated Resident #1 had physician orders, initiated on 12/31/2025 reflected, Perform head to toe skin assessment. Document any changes in skin integrity in the medical record in the morning every Mon, Wed, Fri, Sun for wound prevention/early identification. Notify the physician of any changes in skin integrity. There was no evidence a head to toe skin assessment was performed on Wednesday 2/4/26, Monday 2/9/26, Wednesday 2/11/26, or Friday 2/13/26. Physician orders initiated on 02/10/2026, reflected, Apply Skin Prep to bilat [both] heels blisters every day shift, start date of 02/10/2026, D/C 03/17/2026. Record review revealed no evidence documented Resident #1 had Skin Prep applied to both heels on 2/10/26, 2/11/26, 2/12/26, 2/13/26 or 2/24/26. During an interview on 03/24/2026 at 12:00 p.m. Resident #1's family representative stated [Resident #1] had two little wounds on her backside that healed before she left the hospital and admitted to the facility. Resident #1's family representative stated Resident #1 didn't have any wounds on her heels when she discharged from the hospital and now Resident #1 had developed a pressure ulcer. During an interview on 03/24/2026 at 1:55 p.m., the NP stated Resident #1 admitted without pressure ulcers or DTIs. She stated she saw Resident #1 after Resident #1 had developed blisters on both of her heels on 02/09/2026 and that she had ordered for offloading [of the heels], and heel [boots] risers and had been told Resident #1 had been compliant with the heel protectors. She stated Resident #1 might have developed a pressure ulcer on her heel if the staff had not been repositioning/offloading her heels, or the resident might have been taking off her heel protectors. She stated that she had been unaware that Resident #1 had developed a stage 4 pressure ulcer on her heel. During an interview on 03/24/2026 at 4:03 p.m. CNA ff revealed she worked often with Resident #1 and that she had done peri-care 9cleaning of the area between the sexual organ and the anus) for Resident #1. She stated that Resident #1 never had a pressure ulcer on her bottom. She denied any knowledge of Resident #1 having any injuries to her feet. During an interview on 03/24/26 at 4:44 p.m. CNA U revealed she worked often with Resident #1 and that she had alerted the nurse about Resident #1's blisters on her heels. She stated that Resident #1 had had a (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Balch Springs Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Shepherd LN Balch Springs, TX 75180	

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	scab on her bottom that had healed over quickly and that she would put the heel protectors on Resident #1's feet but that the nurses would take them (heel protectors) off and sometimes Resident #1 did not want to wear them. She stated that (after the blisters had burst) that she would often find that Resident #1's bandages had not been changed over the weekends and that she had informed the nurses about the bandages not being changed on the weekends. During an interview on 03/25/26 at 10:18 a.m. DON related that VOHRA (third party wound treatment consultant) gets referred too when wounds reach stage 2. She stated that Repositioning is not reflected on the TAR/MAR. She stated that there was no indication of any injuries to [Resident #1's] heels at the time of admission [to the facility]. She stated that the facility had not received heel riser boots yet for Resident #1. She stated that Resident #1 had come from the hospital with the cone shaped heel protectors, but that they had ordered heel boots [after the discovery of the heel blisters 02/09/26] but the facility had not received them yet. During an interview on 03/25/2026 at 10:20 a.m. ADON stated that the NP had ordered the wrong type of boot for Resident #1, so she only had the cone protectors. She stated that she had discovered the blisters on Resident #1's feet on 02/09/2026 as part of regular care, and had informed NP about it and new orders had been written [to offload heels apply treatment to the affected areas] . She stated that she might be able to provide the order slip for the boot protectors, but she did not provide the document/proof before exit from the facility on 03/30/2026. During an interview and observation on 03/25/2026 at 11:40 a.m. at the hospital where Resident #1 was currently admitted Resident #1 was observed having her bandages changed. Resident #1 was able to indicate that it was painful to turn but was unable to answer any questions. During an interview on 03/25/2026 at 11:50 a.m. DON stated that (in reference to Skilled Observation Notes) that it should have been reflected that the skin [for Resident #1] was not intact after acquisition of the pressure ulcers on the Skilled Assessments and that the section of the skilled assessment under skin was what the facility used for skin assessments. During an interview on 03/25/2026 at 12:30 p.m. Wound Care Physician stated that she had been seeing Resident #1 for her bilateral heel wounds since they developed [2/17/25]. She stated she had seen Resident #1 weekly and stated that Sometimes she [Resident #1] wouldn't be wearing the heel protectors. Wound Care Physician further related that Resident #1's wound development was related to immobility and general decline, she stated that being bedbound increases the risk of pressure so getting out of the bed would have been helpful. During an interview on 03/25/2026 at 4:40 p.m., ADON stated that skin assessments were not available in the EHR for surveyors to view. Residents' skin assessments documentation was requested, and she stated she and the administrator were working on getting them. During an interview on 03/25/2026 at 5:12 p.m., ADON stated that resident skin assessments were not documented but they were only signed off on the MAR/TAR when ordered. She stated only if there was a change in skin-integrity was there anything documented and it would be in a nursing progress note. During an interview on 03/26/2026 at 2:42 PM DON stated that after reviewing Resident #1's care plan she was unable to find interventions for offloading heels or repositioning Resident #1. Record review of the facility's Skin Integrity Management policy, revised October 10, 2020, reflected: Review the discharge records, transfer sheets or other data regarding the patients history of, or risk factors for skin alterations and pressure ulcer development.Reposition residents at risk for pressure sore or with pressure sores at least every two (2) hours, if unable to turn themselves.Use pillows or foam wedges to keep bony prominences from direct contact .The presence of a pressure-reducing device/specialty bed does not negate the need to turn/reposition the resident at least every two (2) hours in order to prevent pulmonary and renal complications as well as pressure sores .If eschar or necrotic tissue is present, debridement may be indicated. Physicians do surgical debridement only. Facility Name: [NAME] Springs Healthcare and RehabDate of IJ Notification: 03/25/2026 Date/Time IJ Identified by Surveyor: 03/25/2026 at 6:22 PM Plan of Removal - F686Tag: F686 - Treatment/Services to Prevent and Heal Pressure UlcersThe facility has failed to prevent new pressure ulcers and treating existing pressure ulcers.How the facility will identify other residents (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	having the potential to be affected and take corrective actionThe DON/ADON conducted an audit of all current residents to determine what resident at risk for pressure injuries, including residents with limited mobility, dependence on staff for repositioning, malnutrition, existing wounds, or recent decline. We use this criterion to determine who is at risk for pressure injuries. After screening all 69 residents, based on the audit, 51 residents were identified to have the potential to be affected. Systemic Changes Made All identified at-risk residents received- completed by DON/MDS: Start date 3/25/26- updated skin assessments on the 69 residents, will be kept in the medical record under document tab- completion date 3/27/26verification of pressure-relieving devices- out of the 51 identified residents (physician order as required, Care planned and device in place)review of treatment orders- verified all at risk residents have treatment orders for all identified skin issues, any without treatment orders MD will be notified to receive orders.review of nutrition status- verified all at risk residents were reviewed to determine that nutritional status has been assessed, MD orders as needed, care plan update, and RD review.care plan review- all at risk residents were reviewed to ensure care plan addresses all concerns regarding skin- including identify wounds, treatment, pressure relieving devices, repositioning, nutrition, etc.Skin assessment findings lists are attached. The facility revised/reinforced its skin integrity and pressure injury prevention process to include: timely risk identification on admission and with condition change using the 24-hour report at nurse's station, DON/MDS will review every admission/condition change within 24/48 hours to ensure all conditions are identified and addressedweekly skin assessments completed by charge nurse and the ADON will audit after completion.physician notification- Charge nurse will notify within 2 hours of identifying skin issues-DON will audit physician notification daily through progress notes. wound consultant follow-up, ADON to round with Wound Physician weekly, ADON implement orders or new treatments within 2 hours.care plan revision- charge nurse/ADON/MDS will revise care plan immediately following the care plan change required- DON will audit care plan changes. heel offloading for applicable residents (see attached heel offloading list)- charge nurse/CNAs are in charge of offloading heels [NAME] are in bed- ADON/DON to validate daily but utilizing a monitoring sheet - DON is developing the list of residents that are requiring heel offloading, the list will be available when the systematic changes are complete by 3/26/26Systemic Changes were started on 3/25/26 at 9:30pm.Date of Completion: 3/26/26Education with Post Test for staffDON/ADON will re-educate licensed nurses and CNA staff on: pressure injury risk recognition, repositioning/offloading techniques, reporting skin changes immediately, documentation of skin checks on skin observation sheets, All nursing staff will be educated and staff not attending will not work until education has been completed. Administrator will be responsible for tracking attendance and completion of posttests.Education started on 3/25/26 at 9:30pm.Date of Completion: 3/26/26Monitoring to Ensure Ongoing ComplianceThe DON, ADON will audit: residents with current pressure injuries, residents at risk for skin breakdown, repositioning documentation, weekly skin assessments, wound treatment compliance, and care plan updates. DON/ADON will complete wound care and skin audits: Once daily (7 days per week) x 2 weeks 3 times each weekly x 2 weeks Once a weekly x 4 weeks Any negative findings will be corrected immediately, including staff counseling/re-education, resident reassessment, physician notification, and care plan revision as indicated. Audit findings and trends will be reported to the QAPI Committee for ongoing review and additional action if needed. Medical Director was notified of IJ, plan of removal was discussed and approved 3-25-26 9:15pmMonitoring was started on 3/27/26 Date of Completion: 3/27/26 On 03/27/2026 the investigator began monitoring if the facility implemented their plan of removal sufficiently to remove the IJ by the following: Audits for residents with pressure injuries, residents with skin breakdown, weekly skin assessments, wound treatment compliance, and care plan updates were reviewed. No new pressure injuries were found, two residents were found, Resident #12 with a slightly increased area of rash, and Resident #14 with a bruise under the 4th digit of her right foot. The Point of Contact System that CNA's use to document repositioning and off-loading heels was observed to be updated, with those (continued on next page)

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