STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675078	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodway Nursing & Rehab	2808 Stoneybrook Drive Houston, TX 77063

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders for 1 (CR#1) of 45esidents reviewed for advanced directives. CR #1 was found unresponsive on [DATE]. LVN A failed to perform CPR on resident or contact Hospice A for further instruction. CR#1 was pronounced deceased on [DATE] at 6:20 p.m. The noncompliance was identified as Past Non-Compliance. The IJ began on [DATE] and ended on [DATE]. The facility corrected the noncompliance before the survey began. The failure could place residents at risk of experiencing a diminished quality of life and death. The findings included:Record review of CR#1's facesheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His admitting diagnoses were dementia, cerebral infraction (stroke), and COPD (Chronic Obstructive Pulmonary Disease). Advance directives stated that he was a FULL CODE- CPR (when care team will initiate CPR and all resuscitation efforts if a patient's heart or breathing stops). Record review of CR#1's MDS assessment dated [DATE] did not document his code status. Record review of CR#1's care plan initiated [DATE] revealed no documentation that he was FULL CODE- CPR. Record review of CR#1's Orders started [DATE] revealed that he was admitted under Hospice A and they were to be notified of any change in condition. CR#1 was a FULL CODE- CPR with an ordered start date on [DATE]. Record review of CR#1's weights and vitals on [DATE] revealed no documentation on his BP, temperature, pulse, and respirations. At 3:57 p.m., CR#1's oxygen saturation was documented at 99% via nasal canula by LVN A. Record review of CR#1's BIMS score completed [DATE] revealed a score of 99, staff assessed. Record review of CR#1's Progress note dated [DATE] at 8:04 a.m. documented that his BIMS test could not be completed and CR#1 seemed to recall after 5 minutes. CR#1 made decisions regarding tasks of daily life and was moderately impaired. Record review of CR#1's progress note documented on [DATE] at 6:20 p.m. by LVN A revealed that at 5:25 p.m., CR#1 was noted unresponsive with eyes closed and unable to obtain vitals. Upon assessments, body was warm to touch with absence of respiration and no detectable airway movement. Findings were reported to the MD and DON. Documentation did not note that CPR was administered. In an interview on [DATE] at 11:50 a.m., CNA B stated that on [DATE], she noticed CR#1 unresponsive in B bed around 5 p.m. while she passed out dinner trays. She stated that his skin looked yellow and he did not respond when she touched his hand and called out to him. She informed LVN A, who checked his pulse and pulled the covers back. CR#1 was not breathing. In an interview on [DATE] at 1:06 p.m. with LVN A, she stated that she had noticed increased weakness from CR#1 throughout her shift on [DATE] and she was notified by CNA B that CR#1 was unresponsive. LVN A immediately entered the room and took his pulse and BP, but forgot to document it and could not recall the reading. She explained that she did not administer CPR to CR#1 because in the code status binder at the nurse's station, CR#1's code status stated he was a DNR. After she found CR#1 unresponsive, LVN A stated she contacted the NP and the DON about his expiration. LVN A was unfamiliar of anything related to Resident #1 and stated that she could not recall telling the DON Resident #1's name instead of CR#1. LVN A explained (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that she was PRN and the last time she worked at the facility was in [DATE]. In an interview on [DATE] at 10:18 a.m. with the DON, she stated that she was first notified that a resident had passed on [DATE] around 5:45 p.m. LVN A informed her that Resident #1 had passed and she needed additional information on who to contact since Resident #1 was in the process of obtaining guardianship. On the morning of [DATE], the DON inquired about Resident #1's passing during the morning meeting and she was informed that CR#1 was the expired client and not Resident #1, who was still alive and well inside the facility. DON stated that LVN A was PRN and she requested her to come to the facility for additional information. DON asked LVN A if she initiated CPR twice. LVN A paused and stated she did not initiate CPR and that she had been a nurse for several years and could not say what happened. DON stated that if a resident was found unresponsive, the pulse and heart rate should be checked, someone should check the code status, and if Full Code, perform CPR but 911 should be contacted first. In an interview on [DATE] at 12:35 a.m., Hospice A Rep stated that CR#1 had always been a full code with their hospice company and he signed the documentation to be full code himself. She stated that the facility never notified them that CR#1 had expired and they found out about his expiration because the facility needed funeral home information because CR#1 was sent to a funeral home . Hospice A Rep explained that even if a patient was on hospice, they should still receive CPR if they were coded to do so. A call attempt was made to CR#1's NP on [DATE] at 2:59 p.m. Voicemail was left requesting call back Record review of the facility's policy titled Cardiopulmonary Resuscitation- CPR revised [DATE] stated that it is the facility's policy to adhere to resident rights to formulate advance directives and CPR will be performed if the resident does not show obvious sign of clinical death (rigor mortis, decomposition, decapitation). On [DATE] at 3:52 p.m., the facility's Administrator, DON, and Regional Nurse were notified of the past noncompliance IT. A plan of removal was not requested. An IT template was provided to the Administrator on [DATE] at 3:52 p.m. Verification of PNCRecord review of CR#1's code status completed [DATE] confirmed him as Full Code, and a root cause analysis was initiated by the ADM, DON, and MD. The staff involved were removed from direct resident care pending investigation, and the physician and responsible party were notified. LVN A was terminated on [DATE]. Record review of a facility audit date [DATE] by the DON confirmed that the status orders were current and accurately reflected in the EMR, care plans, face sheets, and code status identification tools. Record review of the facility's discharge and significant change reports completed [DATE] reviewed the previous 30 days of resident events involving significant change or death to ensure CPR had been initiated appropriately when indicated. No issues were indicated due to know changes in condition in the last 30 days. Record review of the facility's code binder updated [DATE] revealed 42 residents who were full code were identified and facesheets and care plans were reviewed for accuracy. Three residents were identified as DNR and all documentation was accurate. Records review of in-service education dated [DATE] revealed100% of licensed nurses, CNAs, and agency staff were in-serviced on CPR policy, code status verification, emergency response procedures, AED use (a portable, life-saving medical device used to treat sudden cardiac arrest by analyzing the heart's rhythm and delivering an electric shock to restore normal function), and CPR competency validation. Documentation confirmed current BLS certification for licensed nurses and implementation of mock code drills on all shifts. The facility implemented monitoring which included weekly mock code drills for four weeks, then monthly for three months, and weekly audits of resident code status documentation, with results reviewed through QAPI oversight. The DON, Staff Development Coordinator, and Administrator were identified as responsible for ongoing monitoring and compliance. In an interview on [DATE] at 10:36 a.m., the DON stated staff received post-incident in-service which included review of the facility protocol for responding to unresponsive residents, verification of resident code status, and use of the AED machine. The DON stated staff were also educated on abuse and neglect reporting procedures. The ADM was identified as the facility's abuse coordinator and stated staff were instructed to report suspected abuse immediately to the ADM, or to the DON or ADON if the ADM was unavailable. She stated the CPR (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	training included review of the steps staff should take when a resident is found unresponsive, including calling for help, verifying responsiveness and pulse, activating 911, and initiating CPR if the resident was Full Code. The DON stated staff received hands-on CPR training with return demonstration, and both licensed nurses and CNAs participated in the training. She stated that during an emergency response, staff would call EMS, obtain the crash cart, apply AED pads, and continue CPR until EMS arrived, while another staff member documented the timeline of events.The DON also stated that following an emergency event, staff were expected to complete documentation, notify the physician and resident's family, and complete required follow-up reporting. The facility completed an audit of residents who experienced a change in condition, and a 30-day review did not identify additional adverse events. The facility planned to implement mock code drills on all shifts for nursing staff and CNAs to reinforce emergency response procedures. In an interview on [DATE] at 12:14 p.m., CNA F stated she had been employed at the facility since [DATE] and worked the 6:00 a.m. - 2:00 p.m. shift. CNA F stated that if she found a resident unresponsive, she would call for help, check if the resident was breathing and had a pulse, and begin CPR with chest compressions and rescue breaths while another staff member contacted 911. She stated staff would also notify the charge nurse and other available staff to assist. CAN F stated resident code status could be located in the Kardex (tool used to locate summarized patient care) in PCC or in the resident information binder. CNA F stated she maintained current CPR certification and identified the ADM, as the abuse coordinator, stating abuse or neglect would be reported immediately. In an interview on [DATE] at 12:21 p.m., CNA C stated she had been employed at the facility for seven months and worked the 6:00 a.m. - 2:00 p.m. shift. CNA C stated that if a resident was found unresponsive, she would call for help, assess responsiveness, and notify the nurse immediately. She stated CPR could be initiated by staff while another employee called 911. CNA C stated she had received CPR training and understood the procedures, including observing the resident's chest for breathing an identified the ADM as the abuse coordinator and stated abuse should be reported immediately.In an interview on [DATE] at 11:23 a.m., CNA E stated she had been employed at the facility since [DATE]. CNA E stated that if a resident was found unresponsive, she would call for the nurse, clear the area, and request assistance, including having someone call 911 and obtain the AED, which she stated was located near the front nurses' station. CNA E stated resident code status could be located on the resident door, in the MAR, or in the computer system. CNA E stated she felt confident in the CPR training provided and identified the ADM as the abuse coordinator. In an interview on [DATE] at 11:41 a.m., LVN D stated she had been employed at the facility for approximately one month and worked the 6:00 a.m. - 6:00 p.m. shift. LVN D stated that if a resident was found unresponsive, she would assess the resident for responsiveness and pulse, call for help, initiate CPR, and instruct another staff member to call 911 and obtain the crash cart and AED. LVN D stated CPR would continue until emergency services arrived, and staff would document the event and times accordingly. LVN D identified the ADM, as the abuse coordinator and stated abuse would be reported immediately. In an interview on [DATE] at 11:47 a.m., CNA M stated he had been employed at the facility for nine years and worked the 6:00 a.m. - 2:00 p.m. shift. CNA M stated that if a resident was found unresponsive, staff would call for help, assess the resident, initiate CPR, and have another staff member contact 911. CNA M identified the ADM, as the abuse coordinator and stated abuse would be reported immediately. In an interview on [DATE] at 11:51 a.m., CNA G stated she had been employed at the facility since [DATE] and worked the 2:00 p.m. - 10:00 p.m. shift. CNA G stated that if a resident was found unresponsive, she would remain with the resident, call for help, and assist nursing staff as needed, including calling 911 or obtaining emergency supplies. CNA G stated her CPR certification had recently expired but she was scheduled to complete a CPR course the following week and stated she felt comfortable performing CPR. CNA G identified ADM as the abuse coordinator and stated abuse or neglect would be reported immediately. In an interview on [DATE] at 11:56 a.m., CNA D stated she had been employed at the facility for six months and worked the 6:00 a.m. - 2:00 p.m. shift. CNA D stated that if a resident was (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	found unresponsive, staff would ensure the environment was safe, call for help, assess the resident, and notify the nurse. CNA D stated the nurse would then direct staff to obtain the crash cart or call 911 as needed. CNA D stated resident code status could be verified in the resident care binder or through nursing staff. CNA D identified the ADM, as the abuse coordinator and stated abuse would be reported immediately following the chain of command. The noncompliance was identified as Past Non-Compliance. The IJ began on [DATE] and ended on [DATE]. The facility corrected the noncompliance before the survey began.

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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 that residents with pressure ulcers receive necessary treatments and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 (Resident #1) of 5 residents reviewed for wound prevention. The facility failed to provide Resident #1 wound care every day shift as ordered on 2/23/26, 2/24/26, and 2/25/26 for his 6 documented wounds. Pressure wound on Resident #1's left hip developed a strong odor with moderate serosanguinous fluid. Wound Care Doctor (WCD) diagnosed the wound as infected on 2/27/26. An IJ was identified on 03/01/256. The IJ template was provided to the facility on [DATE] at 3:30 p.m. While the IJ was removed on 03/02/26, the facility remained out of compliance at a scope of pattern and a severity level of not actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to monitor the implementation of the plan of removal. These failures could place residents at risk for infection, pain, hospitalization, and death. Findings included:Record review of Resident #1's facesheet revealed a seventy-five-year-old man who was admitted to the facility on [DATE]. His admitting diagnoses were severe protein-calorie malnutrition, metabolic encephalopathy (acute brain dysfunction caused by systemic illness), peripheral vascular disease, and the presence of pressure ulcers with unspecified stages for the sacral region and right heel, and osteomyelitis of the right ankle and foot upon admission. Record review of Resident #1's MDS assessment dated [DATE] revealed that he was admitted with a pressure injury and treatments included nonsurgical dressings, ointments/medications, and application of dressings. Record review of his baseline care plan completed 12/31/25 by the DON documented that Resident #1 had a sacral PU and bilateral heels were red and boggy with skin excoriations. Record review of Resident #1's Care Plan revised 2/11/26 documented that the facility was to keep the MD informed of the resident's wound progress, inform the MD of signs and symptoms of infection, and perform treatments per order. Care plan identified a wound to the coccyx/sacral region and a wound to the right heel. Record review of Resident #1's Orders, start date 2/11/26 reflected that each wound was to be treated every day shift with normal saline, pat dry, and apply Santyl/calcium alginate/border foam dressing the wound on the left hip, right hip, left posterior shoulder, coccyx, and left medial lateral foot every day shift. DTPI to the 5th toe was ordered to be treated with betadine and iota every day shift. Record overview of Resident #1's progress notes documented the following:*On 02/06/26 at 9:38 a.m., RN B documented that Resident #1 was sent out to the hospital by request of his family to have his suprapubic catheter replaced.*On 02/10/26 at 7:00 p.m., LVN B documented that Resident #1 was readmitted to the facility alert and oriented x3 (person, place, time) with noted forgetfulness and intermittent confusion. A wound was found on his right ischium (hip) and treatment orders were in place for daily care and wound care orders were confirmed with the on-call MD upon return.*On 02/11/26 at 1:26 p.m., the WCN assessed Resident #1's skin and identified the following:Unstageable pressure ulcer to right hip with 100% eschar, small serosanguinous exudate, no odor, no s/s of infection with surrounding skin dry and intact. It was noted that resident had a stage 2 pressure ulcer to right hip before transfer to hospital and wound changed to unstageable upon return with increase in size.Unstageable pressure ulcer to left hip with 100% eschar, moderate serosanguinous exudate, no odor, no s/s of infection with surrounding skin dry and intact.Resident has a stage 4 pressure ulcer to left posterior shoulder with 50% granulation tissue, 50% slough, small serosanguinous exudate, no odor, no s/s of infection with surrounding skin dry and intact.There is a stage 3 pressure ulcer to coccyx with 60% slough, 40% granulation tissue, small serosanguinous exudate, no odor, no s/s of infection with surrounding skin dry and intact.There is an unstageable pressure ulcer to left medial lateral foot with 100% slough, rolled edges, small serosanguinous exudate, no odor, no s/s of infection with surrounding skin dry and intact.Resident has a DTPI to left foot lateral 5th toe with no exudate, no odor, no s/s of infection (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	with surrounding skin dry and intact.The WCN wrote that the MD was at the facility and had new orders for Santyl/calcium alginate/dry dressing to right and left hip, left posterior shoulder, coccyx, and left medial lateral foot and paint with betadine and lota to left lateral foot, 5th toe. Resident verbalized no c/o pain or discomfort before, during, or after treatment. Resident turned and repositioned in bed with call light in reach. Resident on hospice services. No other issues noted. *On 02/11/26 at 1:31 p.m., DON noted that Resident #1 had a consistent decline in condition and weight loss and was under the care of Hospice A and they were to continue their plan of care.*On 02/17/26 at 6:46 p.m., RN A wrote that she reached out to Hospice A to clarify coverage and authorization status due to a change in hospice admission. Hospice team stated that Resident #1's previous RP had not been reachable and was needed to sign his hospice paperwork for readmission.*On 02/22/26 at 6:33 p.m., RN A documented that she provided wound care to Resident #1.*On 02/23/26 at 10:15 a.m., RN A wrote that she was still waiting for feedback from management about Resident #1's hospice status. Record review of Resident #1's TAR reflected that wound care was documented completed on 2/22/26 by RN A. All wound care documentation was left blank for 2/23/26, 2/24/26, and 2/25/26. Record review of Resident #1's change in condition assessments did not provide any documentation of a change in condition on 02/26/26 Record review of the facility's Wound Tracking report updated 02/18/26 documented that the wound on his left hip was unstageable and measured 8.4 x.5.9 cm and had moderate serosanguineous drainage and eschar tissue. In an observation on 2/27/26 at 1:22 p.m., Resident #1 was in bed at the lowest position and the room was engulfed with a pungent smell of feces. He mouthed that he was ok and was informed that an aide would come in shortly to preform peri care. He could not communicate to answer any further questions. In an interview on 02/27/26 at 1:23 p.m., CNA C was asked to provide peri care for Resident #1 and she stated that she just checked his brief and he was clean. She explained that room smelled the way it did because of his wounds. In an interview on 02/27/26 at 1:28 p.m., RN A stated that she last dressed Resident #1's wound on 02/23/26 and there was no odor. On 02/26/26, she accompanied LVN D during wound care for Resident #1 and noticed that the bandages on his wounds had her initials on it from the last time she did wound care. She stated the wound on his left hip smelled really bad because it had not been dressed in 2-3 days. In an interview on 02/27/26 at 1:31 p.m., LVN D stated that her first time seeing Resident #1 was on 02/26/26 when she provided wound care. She stated the odor from the wound on his left hip was very bad, so bad that the RT across the hall had to spray inside her office. The wound on his left hip had a lot of serosanguineous drainage and the drainage seeped outside of bandage. She could not remember the date on the bandage. In an interview on 02/27/26 at 1:42 p.m., the DON stated that the WCN was on leave from the facility due to a family emergency and she had assigned floor nurses to provide wound care for the 5 residents with wounds. She explained that the WCD was scheduled to come every Tuesday at 1 p.m. but he could not come that Tuesday and he had rescheduled today (Friday 02/27/26). She initially told him that she was not available to round with him and wanted to reschedule, but she reached back out to the WCD and asked him to come in and check the wounds. In an observation and interview on 02/27/26 at 3:43 p.m., the WCD arrived to the facility and stated that Resident #1 was not on his list to provide wound care because he did not have documented consent, but he would provide a courtesy look, measurement, and treatment update. During wound care, the WCD stated the following:*the wound on his right hip was very dark and measured 11.5x8.5 cm, with 90% eschar and 10% granulation tissue on the edges. WCD stated the wound had a mild odor and moderate drainage and updated treatment orders to include Santyl.*the wound on his left hip, he stated that the wound looked infected, was very smelly, and his purlin and serosanguinous drainage looked gnarly. He described the wound as unstageable with an undetermined depth and measured 13 x 8.5 cm. When he pushed the wound, a yellow tinged drainage identified as purlin oozed out and the WCD stated that that worried him because it indicated the wound was deep. Treatment orders were updated to include Daikon's wash, which he described as bleach.*The wound to the left shoulder measured 2.3x3.5 cm with a dept of .1;*the coccyx wound was described as (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	sacral coccyx and measured 3x 1 cm;*left lateral foot had an undetermined depth and measured 8x 2 cm; and*the left 5th toe had a wound in between the toes and measured 2x 1.5 cm with an undetermined depth.The WCD stated that Resident #1 was sticks and stones and his pressure ulcers were unavoidable because he did not have the nutrition. The WCD stated that if Resident #1 would have received wound care on 02/23/26, 02/24/26, 02/25/26 it could have helped prevent the decline of the left hip because some wound care was better than no wound care but because of his comorbidities, lack of nourishment, and thin frame, he could not say that an infection was unavoidable. In an interview on 02/27/26 at 2:49 p.m., CNA D stated that when she assisted LVN E with wound care on 02/26/26, the bandage on Resident #1 had a date from a few days prior to 02/26/26. She thought the bandaged was labeled 02/23/26 but she was not sure but she did know that the wound smelled bad and it leaked blood. CNA D stated that she knew the bandages had not been changed in 2-3 days because she discussed it with RN A and LVN D during Resident #1's wound care. In an interview on 02/27/26 at 4:33 p.m., the DON stated that Resident #1 arrived back to the facility on [DATE] and was taken off hospice because the hospital usually removed patients from Hospice to provide care. Hospice could not put Resident #1 back on hospice because Resident #1's RP could not be reached to sign the consent forms. DON stated that there was an open APS case with Resident #1's RP and the facility was told not to contact his RP anymore regarding his care. The facility was currently in the process of getting guardianship for Resident #1 and the facility was trying to get his paperwork expedited. Due to the WCN's emergency leave on 02/23/26, wound care was assigned to RN A. On 02/24/26, LVN E was called in PRN to complete wound care and LVN D was assigned wound care on 02/25/26. In an interview on 02/27/26 at 5:05 p.m., LVN E stated she was PRN and worked on 02/24/26 to perform wound care for the Residents. LVN E stated that she performed wound care for Resident #1 but did not document it in the TAR because she could not find his name. She stated that not documenting was a mistake she made and she planned to ask the DON for assistance but she did not answer the phone when she called her and she did not ask any other nurses on shift for assistance. After she stated that she could not locate Resident #1's profile and orders inside the facility's TAR, she was asked how she knew what his treatment orders were. There was a 30 second pause and LVN E stated that she cleaned the wound with calcium alginate. LVN E also stated that when she performed wound care, Resident #1's roommate was not in the room. Record review of LVN E employee time punches on 02/24/26 revealed that LVN E worked from 2:15pm to 6:15 pm. In an interview on 02/27/26 at 5:37 p.m., the DON stated that she received orders from Resident #1's PCP to start him on Clindamycin 450 mg to take 3 times a day for 14 days to treat a wound infection. The WCD had picked up Resident #1 and he would be seen weekly. The DON oversaw wound care completion and delegated wound care to the floor nurses and could not speak to why the nurses did not perform wound care for Resident #1 as she had instructed and all documentation should be recorded in the TAR and progress notes. In an interview on 02/27/26 at 5:43 p.m. with RN A, she stated that she performed wound care to Resident #1 on 02/23/26 but she could not explain why it was not documented and no staff were able to corroborate wound care completion for Resident #1 on 2/23/26. In an interview on 02/28/26 at 11:14 a.m. with Hospice B DON, she stated that Resident #1's wounds were unavoidable due to his comorbidities and his poor nutrition. His wounds escalated quickly, where the left hip went from a stage 2 PU to an unstageable wound. She stated that although his wounds may not get better, it did not mean that they had to be infected. She stated having an unavoidable wound is one thing, but having wounds that are not being treated is neglect. Infections are avoidable. A call attempt was made to Resident #1's PCP on 03/01/26 at 10:45 a.m. and 12:14 p.m. No answer. Voicemail was left requesting call back. A follow-up attempt was made on 03/02/26 at 4:19 p.m. with no answer. In an interview on 03/01/26 at 12:15 p.m., the DON stated that wound cultures had not been captured for Resident #1's wound at that time. She stated that she would inform staff to capture them immediately. Record review of the facility's policy Wound Treatment Management revised 5/15/25 documented that wound treatments will be provided in (continued on next page)

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	675078	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodway Nursing & Rehab	2808 Stoneybrook Drive Houston, TX 77063

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. The Administrator, DON, and ADON were notified of the IJ on 03/01/26 at 3:30 p.m. and given the IJ template due to the above failures and a POR was requested. On 03/02/256 at 11:36 a.m., the POR was accepted. It was documented as follows:Tag: F686 - Treatment/Services to Prevent/Heal Pressure UlcersDate of IJ Identification: 3/1/26Date IJ Removed: _03/02/26_____1. Immediate Corrective Actions for Resident #1 Resident #1 was immediately assessed by the Wound Care Doctor on 02/27/26 and diagnosed with an infected unstageable pressure ulcer to the left hip. Physician orders obtained for Clindamycin 450 mg three times daily for 14 days. Wound care resumed immediately per physician order (daily day shift treatment). Wound cultures ordered 03/01/26 and obtained. DON initiated direct oversight of wound care completion and documentation.2. Identification of Other Residents at Risk Facility census reviewed; all residents with wounds identified. 100% audit completed of all wound treatment orders and TAR documentation. Head-to-toe skin assessments completed for all current residents, 03/01/26. Any identified documentation gaps were immediately corrected, 03/01/26 and treatments provided.3. Systemic Changes to Prevent Recurrence All licensed nurses re-educated on wound care policy, including treatment frequency, dressing type, and documentation requirements. Education included expectations for notifying the physician of any changes in wound condition. Daily wound care assignment sheet implemented to ensure accountability. DON or designee to perform daily spot checks of wound treatments4. Monitoring Plan Daily audit of all wound treatments for 14 days. Weekly audits thereafter for 30 days. Audit results to be reviewed in QAPI meeting. Staff failing to follow wound care procedures will receive immediate counseling and retraining5. Date of ComplianceThe Immediate Jeopardy will be considered removed when the facility has verified that the following is completed by 3/2/2026: All residents are receiving wound care as ordered. All licensed nurses have completed re-education. Monitoring systems are in place and functioning to ensure ongoing compliance. Monitoring/Verification of Plan of removalThe POR was reviewed as followed. The facility created a binder and numbered each tab in the binder with the completed documentation necessary to fulfill the plan. Record review of the facility's comprehensive resident TAR dated 02/23/26- 03/01/26 revealed that no adverse effects were noted from other residents with wounds. Skin assessments for 42 residents dated 03/01/26 were reviewed and no adverse effects were noted. All skin was intact and no new open areas were identified on skin shower sheets. Weekly wound care tracking log dated 03/01/26 was provided and reviewed. No adverse progression or infections documented out of Resident #1. An interview was conducted on 03/02/26 at 12:54 p.m. with the DON. She stated that on 03/01/26 the DCO completed an audit of all wound treatment orders and the TAR. The DON reported that no negative findings related to wound presence were identified during the audit; however, omissions in TAR documentation were identified, staff were in-serviced, and the physician/primary care providers were notified. The DON stated that 43 resident skin assessments were completed, which identified minor scratches or redness but no pressure injuries, and physicians were notified with orders obtained as indicated. The DON stated that an in-service regarding the facility's wound care policy was conducted on 03/01/26, which included review of daily medication audit reports, physician notification procedures, monitoring for significant changes in condition, care plan updates, daily rounding, and ensuring dressings are dated, initialed, and consistent with treatment orders. The DON also stated that CNAs were educated to monitor resident skin during bathing and personal care, report any new skin issues, foul odors, missing or soiled dressings, pain complaints, or other changes in condition immediately to nursing staff, and to complete skin/shower documentation sheets when changes were identified. Licensed nursing staff were educated regarding assessment responsibilities, documentation, physician notification, ensuring treatments are completed according to orders, and addressing significant changes in condition promptly. The DON further stated staff were reminded that failure to follow physician orders for wound care could constitute neglect. Interviews were conducted on 03/02/26 between 1:15 p.m. and (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3:06 p.m. with CNAs B, C, H, I, J, K, L, M, Q, and R who worked the 6:00 a.m.- 2:00 p.m. and 2:00 p.m. - 10:00 p.m. shift. The CNAs stated that the in-service covered monitoring residents' skin and reporting any abnormalities to nursing staff. Staff reported that if they observed bruising, skin tears, wounds, blisters, redness, drainage, foul odors, bleeding, or leaking dressings, they would immediately report the findings to the nurse and complete a skin/shower documentation sheet. Staff also stated that during showers, incontinent care, dressing changes, or resident transfers, they monitored the skin for abnormalities. The CNAs stated that they were instructed to report missing, soiled, or incorrectly dated dressings, as well as dressings that appeared leaking, bleeding, or producing odor, to nursing staff for further assessment. CNA's also stated that dressings should be dated and initialed, and staff were expected to notify the nurse if the dressing appeared outdated or inconsistent with treatment orders. At 1:15 p.m., CNA H stated that during the in-service, aides were instructed that the facility operated under a see something, say something expectation, which meant that if staff observed any change in a resident's condition they should immediately notify the charge nurse, ADON, or DON if the nurse was unavailable. Interviews were conducted on 3/2/26 between 2:36 p.m. and 2:46 p.m. with licensed nursing staff who worked the 6:00 a.m. - 6:00 p.m. shift, including RN A, RN B, LVN D, and LVN E. During the interviews, licensed nursing staff stated that the in-service covered procedures for identifying, reporting, and treating resident wounds and skin conditions. Licensed nursing staff stated that if a new wound or skin issue was identified, the nurse assessed the resident, notified the physician and the WCN, and initiated wound care until physician orders were received so the wound would not remain untreated. Nursing staff stated that CNAs were expected to report any new wounds, redness, skin breakdown, drainage, odor, or changes in existing wounds immediately to nursing staff, and to document findings on the skin observation or shower sheet so the nurse could assess the resident. Licensed nursing staff also stated that if a dressing was missing, uncovered, soiled, or incorrectly dated, staff notified nursing immediately. Nursing staff stated that when the WCN was not present in the facility, the assigned nurse completed wound care treatments and documented the treatment in the TAR, including dating and initialing the dressing and documenting the treatment provided. Nursing staff also stated that new skin conditions or worsening wounds were reported to the physician and a skin assessment was completed, with treatment orders implemented and documented accordingly. Licensed nursing staff stated that the in-service also addressed that failure to report, document, or treat wounds in accordance with physician orders could be considered neglect. Telephone interviews were conducted on 03/02/26 between 9:21 p.m. and 9:37 p.m. with LVN B and LVN F who worked the 6:00 p.m. - 6:00 a.m. shift. The LVNs stated that the in-service included education regarding proper wound care practices, neglect prevention, and ensuring dressings are dated, timed, and initialed according to physician orders. Licensed nurses reported that if skin issues were reported by aides, they would assess the resident, initiate treatment such as applying a dressing if indicated, notify the physician and wound care nurse, and obtain treatment order LVN B and LVN F stated they would document wound findings in the resident assessment and progress notes and ensure treatments were documented in the TAR. Nurses also stated that CNAs documented skin issues on shower or skin observation sheets, which were reviewed by nursing staff. CNAs were expected to notify nursing staff immediately when drainage, odor, or removed dressings were observed. Telephone interviews were conducted on 03/02/26 between 9:45 p.m. and 10:07 p.m. with CNA N and CNA O who worked the night shift from10:00 p.m.-6:00 a.m. CNAs reported that during the in-service they were instructed to document any skin abnormalities, including bruising, scratches, wounds, or other unusual skin findings, on a skin observation or shower sheet and notify nursing staff immediately. Staff further stated they monitor dressings for drainage, odor, or soiling, and report if a dressing appears missing, dirty, or incorrectly dated. During the interview conducted on 03/05/26 at 11:01 a.m., the DON and Administrator stated that Resident #1 was sent to the hospital on [DATE] for further evaluation and treatment. An interview was conducted on 03/05/26 at 11:07 a.m. with LVN H, who stated she worked PRN on the 6:00 p.m.-6:00 a.m. shift as needed. LVN H stated that during the (continued on next page)

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