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	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodway Nursing & Rehab	2808 Stoney Brook Dr 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 0655 Level of Harm - Actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a base-line person-centered care plan for each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 9 residents (CR #1) reviewed for base-line care plans. The facility failed to provide CR #1 with a base-line personal-centered care that addressed, monitored, and managed the development of wounds to CR #1's posterior area. This failure places residents at risk for appropriate care, treatment, monitoring, and timely assessment for the development of infections, resulting in hospitalization, a decline in health, or death. Findings included: Record review of CR #1's face sheet dated 06/03/2026, revealed that he was a [AGE] year-old male who originally admitted on [DATE] and discharged on 06/02/2026 with diagnoses including injury of head, displaced comminuted fracture (several breaks where the bone shatters into three or more pieces and the fragments are pushed out of their normal alignment) of shaft (break along the long, straight section of a major long bone) of left tibia (shinbone), traumatic subarachnoid hemorrhage (bleeding into the fluid-filled space between the brain and the protective tissue covering) with loss of consciousness, multiple fractures of pelvis with unstable disruption of pelvic ring (two or breaks in pelvis with loss of ability to support weight), fracture of part of neck or left femur (longest, heaviest, and strongest bone in the human body), fracture (bone break) of facial bones, major depressive disorder (persistent sadness, emptiness, and loss of interest), and bipolar disorder (MI that causes mood, energy, and activity level). Record review of CR #1's Hospital Records, reflected on 03/24/2026, an active pressure injury to coccyx medial. On 05/04/2026, wound, DTPI, deep purple, maroon: red, no closure, no odor, and cleaned. On 05/05/2026, no symptoms of infection. On 05/08/2026, new dressing interventions. On 05/11/2026, wound dressing status: area clean, dry and intact. Record review of CR #1's Baseline Care Plan dated 05/15/2026, reflected, CR #1 was dependent on staff for all his ADL's, lethargic level of consciousness, impaired cognition, and incapacitated, with skin integrity documented as an external fixator to pelvis (an emergency and temporary medical device used to stabilize severe, unstable pelvic fractures), and no documentation of any posterior wounds. Record review of CR #1's MD A order dated 05/16/2026 at 01:11 a.m., reflected, perform head to toe assessment of all areas of skin every day shift every 7-days. Record review of CR #1's Skin and Nutrition IDT Review dated 05/20/2026 at 06:43 a.m., reflected revealed, CR #1 was a new admit on 05/16/2026, with a score and risk category left blank and recorded as N/A. Wound Summary category indicated no active wounds upon admission and recorded as N/A. Record review of CR #1's Skin and Nutrition IDT Review dated 05/26/2026 at 02:43 p.m., reflected weekly review noting no wound summary/selection of wound locations. Record review of CR #1's IDT Care Conference dated 06/01/2026, reflected nurse's summary and evaluation/goals: free from infections. Record review of CR #1's Hospital Discharge Transfer Form dated 06/02/2026 at 08:30 a.m., reflected CR #1 had no skin/wound care/pressure ulcers/injures. Other wounds: surgical wound to abdomen. Dependent for all ADLs. Record review of CR #1's Discharge MDS dated [DATE], reflected CR #1 had no BIM score indicated the resident was unable to answer the assessment questions. Record review of CR #1's (continued on next page)

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

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F 0655 Level of Harm - Actual harm Residents Affected - Few	Hospital Records dated 06/02/2026, reflected it was unclear if the NF had evaluated or treated the resident's deteriorating skin and emerging skin breakdown. Record review of CR #1's Care Plan date initiated on 06/03/2026, reflected (non-pressure) incision site to anterior with unstable disruption of the pelvic ring. CR #1 at risk for infection, delayed wound healing, pain, and impaired mobility with Interventions: Assess, monitor, clean and report abnormalities to physicians. CR #1 had current skin concerns and was at risk for further skin breakdown, infection and pressure ulcer formation (specific skin concerns not documented) initiated on 06/03/2026, with no risk interventions. No documentation of an air mattress. Record review of CR #1's hospital dated 06/04/2026, reflected, CR #1 presented to the acute care hospital with a Stage IV sacral decubitus ulcer. Observation on 06/03/2026 06:01 p.m., CR #1, appeared groomed and clean with no odors. CR #1 verbally identified pain to his buttock while at the facility at a 4 out of 5. CR #1 observed using only one word responses to questions, and requests. During an interview on 06/03/2026 at 12:20 p.m., with FM B and FM C, FM B stated that the NF completely neglected CR #1's provided wound care and infection prevention care to CR #1 had pressure ulcers and skin injuries to his back. FM C stated FM A had provided photographs detailing the condition of CR #1s wounds upon readmission to the hospital on [DATE]. She stated that CR #1 had pressure ulcers on his buttocks and back with no bandages and active bleeding and an odor. She stated it appeared CR #1 had no wound care management while admitted at the NF. During an interview on 06/03/2026 at 02:29 p.m., the WCN stated that she performed CR #1's first weekly head-to-toe assessed on 05/20/2026. She stated his skin looked real good at that time. She stated due to his severe risk, his cognitive inability to articulate basic toileting needs, and his status as a heavy wetter with extra-large bowel movements, the NF standards required staff to turn and reposition him every 2-hours and provide incontinent care every 1 - 2 hours. She stated based on her physical assessment of CR #1, his Braden Score rated at a 9 (a severe, maximum clinical risk for developing pressure wounds). She stated she completed CR #1's 05/26/2026, weekly head-to-toe assessed finding no changes to his skin and no posterior wounds. She stated she had performed his 06/01/2026, weekly head-to-toe assessed finding no skin changes or posterior wounds. She stated CR #1 had an external pelvic hardware and did not hinder her or staff's ability to repositing, provide incontinent care and wound care. She stated after observing photographic evidence of CR #1's skin status upon admission to the ER on [DATE], she identified CR #1's left-side sacral with maceration and redness, which she stated was a direct result of being wet too long, with slough, and necrosis (dead tissue) on the right side of the sacrum, and skin breakdown on his shoulder blade. She stated advanced, necrotic tissue damage was caused directly by a resident laying in one spot for too long over bony prominences. She stated that sloughs occur after being exposed to feces and urine. She stated that the wounds pictured appeared to be a failure of systemic monitoring. She stated the NF failure to document required skin assessments and daily treatments to CR #1's exterior surgical wounds on 5/25/2026 and 05/26/2026 when she was off-shift. During an interview on 06/03/2026 at 03:05 p.m., FM B stated that on 05/23/2026, he and Family C visited CR #1 at the NF and found CR #1's room smelled like an [NAME], staff were hateful, and the bedbound resident was left in these hot, unpowered room conditions for an entire week without the ability to move or contact staff, until they filed a formal complaint with the SW, and the NF finally moved CR #1 on 05/26/2026, to another room. During an interview on 06/03/2026 at 3:10 p.m., FM C stated on 06/02/2026, she was present when CR #1 arrival at the ER for a scheduled surgery, and observed his incontinent brief soaking wet, like he had been that way a while, forcing her to immediately alert the ER staff. She stated that when the ER staff shifted and turned CR #1, she observed horrible buttock and back wounds with active bleeding. She stated the NF had placed no padding or dressing on those wounds, leaving his open, bleeding sores directly sitting in his urine saturated brief. She stated on 05/23/2026, during a visit to CR #1, her and Family B found the CR #1's room had no electricity and no functioning air conditioning (A/C) despite the resident being really hot natured. She stated that the room smelled like an [NAME], staff were hateful, when their concerns were expressed about CR #1 a bedbound resident left in these (continued on next page)

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F 0655 Level of Harm - Actual harm Residents Affected - Few	hot, unpowered room. She stated on 05/26/2026, CR #1 was moved to another room. During an interview on 06/03/2026 at 06:30 p.m., On-Call Hospital MD A stated it was clinically impossible during a brief 2-hour transport ride from the NF, for pressure ulcer/wounds to deteriorate or reach the severe condition observed on CR #1's upon admission to the hospital on [DATE]. During an interview on 06/04/2026 at 09:03 a.m., LVN B stated she was responsible for CR #1's admission head-to-toe skin and wound assessment immediately upon CR #1's 05/16/2026 admission. She stated she received and reviewed CR #1's hospital discharge summary and had not solely relied on that record when completing assessment and incorporated her visual assessment of both CR #1's front, back and head-to-toe observation as contributing findings to add to the assessment. She stated CR #1 had no wounds or skin integrity issues up admission. During an interview on 06/04/2026 at 10:22 a.m., MD B stated according to his MD notes he had not reflected the residents' needs for ADL and could not recall CR #1's ADL condition. He evaluated the CR #1 on 05/21/2026, and performed a thorough initial physical evaluation, discovered CR #1 had a superficial sacral wound. He stated on 05/28/2026, during a following examined found CR #1's sacrum wound remained the same, superficial, and no breakdown or anything serious of a stage 2, 3, or 4. He stated during rounding on both 05/12/2026 and 05/28/2026, he emphasized his verbal orders to the NF nurses, CR #1 was a dependent resident who required repositioning every 2 hours, wounds to receive daily cleaning, dressings, and attention to prevent infection and worsening. He stated he had been his expectation that those verbal orders were charted immediately so that subsequent shifts knew the exact care plan. He stated that had the NF been properly monitoring CR #1 as requested, severe wound degradation should never have occurred. He stated that no facility staff had ever contacted him to report CR #1's skin had worsened. During an interview on 06/04/2026 at 11:31 a.m., LVN Q stated she had not rounded with MD B, the WCD on 05/21/2026 and 05/28/2026 when CR #1 was assessed. She stated there were no orders and was not aware of sacrum or posterior wounds of CR #1. She stated that CR #1 required mandatory 2-hour turning schedules due to him having a rotator/metal external fixator on his pelvic area. She stated she had reviewed CR #1's clinicals dated 05/06/2026, and found that he had a weekly skin assessment, and his 05/20/2026, SBAR and found no tracking of skin deterioration or mention of a sacral wound. She stated as CR #1's nurse she monitored his pelvic area external fixator pins and no CNAs reported to her he had skin issues. She stated that she was responsible for performing weekend wound care but had not provided CR #1 any wound care on any weekends for CR #1. She stated had she witnessed skin trauma on CR #1, facility protocol required her to generate an change of condition SBAR report, update the skin assessment/progress notes, notify the FM, MD A, and the DON of which would have trigger the need for CR #1's care plan to be updated and include his skin changes and required interventions. During an interview on 06/04/2026 at 12:07 p.m., the WCN stated that she had not rounded with CR #1's MD B. During an interview on 06/04/2026 at 12:21 p.m., the DON stated CNAs were required to inspect resident's skin during daily incontinence care and weekly showers, document findings on shower sheets, and report findings to the nurses immediately. She stated once reported, the nurse was assess, notify the MD for new orders, FM, reported to the DON, the generation of a change of condition SBAR report, update a skin and pain assessment/progress note, which would trigger the need for the resident's care plan to be updated and include the changes and required interventions. She stated CR #1 admitted to the facility with only two clean surgical sites from fixator hardware, required total assist: staff to assist with absolutely everything, including eating/feeding, incontinence care, and all movement. She stated due to an extensive MVA, he suffered multiple fractures and had an external pelvic fixator. She stated that the external fixator did not interfere with skin assessments or showers/bed baths. She stated if CR 1's MDS reflected he needed maximum assistance from staff for showers/baths, CR #1 was allowed to shower. She stated CR #1 would scream out in pain with any involuntary arm movement. She stated his cognitive status was alert but varied. She stated she had no knowledge; CR #1 had any skin changes over time. She stated that MD B found a wound, a progress note and order should have been in the system. The DON (continued on next page)

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F 0655 Level of Harm - Actual harm Residents Affected - Few	stated that even for a DTPI, expectations are clear: it must be noted on the skin assessment, monitored closely, verbal orders must be entered into the system, tracked on the TAR and both the FM and MD B must be notified. During an interview on 06/04/2026 at 03:49 p.m., LVN B stated she had not rounded with MD B or received orders for CR #1 and a sacrum wound. She stated she performed CR #1's initial physical admissions assessment, a head-to-toe skin assessment, and had not observed a sacrum or back skin integrity issues. She stated that had CR #1 had any skin changes, CNAs A, B, C, D, E, F were responsible for CR #1's daily repositioning, identifying the development of foul smells, pressure wounds, and need for ADL care and reporting to her any changes in his skin condition. Had she received a change of condition report, she would have evaluated the resident, reported the changes to the MD, notified the DON and FA, completed an SBAR change of condition report, which would have triggered the need to update the resident's care plan and add interventions. During an interview on 06/04/2026 at 04:04 p.m., CNA C stated she was responsible for proving CR #1 with basic ADLs and reporting changes of condition to the nurse immediately. She stated CR #1 had a sacral wound already present when she began working with him. She stated the area had no drainage, redness, and bandage covering, and she was not aware if the area had worsened, and had she known, would have reported that immediately to his nurse. During an interview on 06/04/2026 at 04:19 p.m., CNA E stated she provided CR #1 with his ADL care: incontinence care and had she observed any redness or changes to CR #1's sacrum she would have reported to the changes to the nurse immediately. During an interview on 06/05/2026 at 11:23 a.m., CNA D stated he had visual knowledge of a 2 inches scratch with light redness to CR #1's sacrum when providing incontinent care assistance with CNA C. He stated he reported the scratch to a floor nurse, whom he could not recall on 05/26/2026 on the 2:00 p.m. to 10:00 p.m., shift, his first day working with the resident, and after his return from vacation. He stated all the nurses were already aware of CR #1's scratch and severe pain. He stated that was the reason he had not reported it to the nurse. He stated had they not been aware, he would have reported the scratch and any other skin issues to the nurse immediately. During an interview on 06/05/2026 at 12:06 p.m., CNA G stated she provided direct care to CR #1 and had direct visualization of a wound that was not that big, just small with no color and no drainage to CR #1's sacrum during incontinent care. She stated that the floor nurses knew about CR #1's wound and could not verify the name of the specific nurses who knew. She stated had the nurse's not known, she would have reported it to the nurses immediately. During an During an interview onthe ADM on 06/06/2026 at 1:55 p.m., he stated that the facility's expectation upon a resident's admission were that a full head-to-toe assessments and care directives were completed to ensure skin integrity, and that any changes in skin condition must be immediately identified and reported. He stated that the NF enforces a zero-tolerance policy regarding ANE, and that all staff had responsibility to maintain vigilance, immediately document, and protect residents. He stated the failure to properly develop, capture, and execute proper assessments and care planning protocols could affect all residents who reside at the facility. Record review of NF policy titled, Notification of Changes dated 5/16/2025, reflected, Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Definition:. Clinical Complications: Examples - Development of stage 2 pressure injury.

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 1 of 4 residents (CR #1) reviewed for ADLs. The facility failed to ensure CR #1, a resident with wounds, was provided with personal grooming, showers, and bed baths on the 2:00 p.m. to 10:00 p.m. shift. These failures could place residents at risk for skin breakdown, offensive odors, or infections, resulting in a decline in health, hospitalization, or dealth. Findings included: Record review of CR #1's face sheet dated 06/03/2026, revealed a [AGE] year-old male who originally admitted on [DATE] and discharged on 06/02/2026 with diagnoses including traumatic subarachnoid hemorrhage (bleeding into the fluid-filled space between the brain and the protective tissue covering) with loss of consciousness, injury of head, displaced comminuted fracture (several breaks where the bone shatters into three or more pieces and the fragments are pushed out of their normal alignment) of shaft (break along the long, straight section of a major long bone) to left tibia (shinbone), fracture of part of neck or left femur(longest, heaviest, and strongest bone in the human body), multiple fractures of pelvis with unstable disruption of pelvic ring (two or breaks in pelvis with loss of ability to support weight), fracture (bone break) of facial bones, bipolar disorder, (MI that causes mood, energy, and activity level), and major depressive disorder (persistent sadness, emptiness, and loss of interest). Record review of CR #1's Baseline Care Plan dated 05/15/2026, reflected, CR #1 was dependent on staff for all ADL's: eating, oral hygiene, toileting, shower/baths, upper/lower/footwear dressing, personal hygiene, left/right rolling mobility, shower/tub transfers, and always incontinent for bowel and bladder. Skin integrity documented as an external fixator to pelvis (an emergency and temporary medical device used to stabilize severe, unstable pelvic fractures). CR #1 was a lethargic level of consciousness, impaired cognition, and documented as incapacitated. Record review of CR#1's Pain assessment dated [DATE] at 5:43 a.m., revealed CR #1 was unable to answer pain Frequency, pain interference with therapy activities. Record review of CR #1's Discharge MDS assessment dated [DATE] reflected CR #1 had no BIMS score, which indicated the resident was unable to answer the assessment questions. Record review of CR #1's Hospital Records date 06/02/2026, reflected, CR #1 was admitted [DATE], with severe clinical concerns stemming from care received at the NF over the preceding two weeks. The documentation reflected a significant lack of routine bathing, the development of new pressure ulcers, and active skin breakdown, irritation, with potential infection surrounding the resident's surgical hardware sites. The records reflected a post-surgical wound infection, identifying concern for infection at the surgical sites secondary to delayed hardware removal. Removal of hardware was originally planned at 8 weeks, later changed to 12 weeks, but had not occurred due to transfer between facilities and difficulty returning to the original surgical team. Record review of CR #1's Care Plan date initiated on 06/03/2026, reflected multiple fractures of the pelvis with unstable disruption of the pelvic ring (fractured bone segments and stabilizing ligaments to separate) fixation sites following a MVA, placing CR #1 at risk for infection, delayed wound healing, and impaired mobility. Non-Pressure (surgical): Clean non-pressure incision site to anterior pelvic ring fixator. Interventions included: Assess, monitor, clean and report abnormalities to physicians. CR #1 had current skin concerns and was at risk for further skin breakdown, infection and pressure ulcer formation (specific skin concerns not documented) initiated on 06/03/2026, with no risk interventions and documentation of an air mattress. Record review of CR #1's Hospital Records dated 06/04/2026, reflected, CR #1 had a stage IV sacral decubitus ulcer (a severe, full-thickness wound extending through the skin and fat into muscle, tendons, or bone). During an observation on 06/03/2026 at 06:01 p.m., CR #1 appeared groomed and bathed sitting in the hospital bed. CR #1 verbally identified his rate of pain to his buttock while at the NF at a 4 out of 5 (with 5 being the worst pain). FM B was observed actively rubbing CR (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	#1's right hand to provide comfort. CR #1 expressed a desire for fluid, and FM B was observed to be administering a drink to CR #1. During an interview on 06/03/2026 at 12:20 p.m., FM A stated that the NF completely neglected CR #1's grooming and hygiene. She stated on 06/03/2026, EMS transported CR #1 from the NF to a hospital for a planned surgery to remove CR #1's fixator pins. She stated at the hospital, hospital staff had to spend 2 to 3 hours using specialized soaps and lotions to get the resident clean in preparation for surgery because CR #1 was filthy like he had not had a bath the entire time he was at the NF. She stated CR #1 never refused showers or bed baths at the hospital and was fully cooperative with all hygiene care. She stated the lack of bathing CR # 1 directly affected the development and worsening of his wounds. She stated that CR #1 was able to communicate clearly when and where he was hurting. She stated she presented photographic evidence showing of his wound. She stated that she called the NF on 06/02/2026, reporting these concerns, speaking to both the ADM and DON who both brushed off her concerns and told her RN A had looked CR #1 over before EMS transported the resident out of the facility, and he looked fine. During an interview on 06/03/2026 at 01:37 p.m., DON stated CR #1 admitted to the NF following a MVA (struck while riding a bicycle) resulting in multiple fractures. She stated CR #1 had a pelvic fracture with external fixation hardware (a hallo shaped rod, fixated to the outside of the lower abdomen/pelvis area). She stated CR #1 discharged the morning of 06/02/2026, for a prescheduled surgery to remove the fixator hardware. She stated CR #1's assigned CNAs were CNA A and CNA B and were responsible for giving CR #1 his baths on the 2:00 p.m. to 10:00 p.m. shift M/W/F. She stated on 06/01/2026, in preparation for transport for CR #1's scheduled surgery, CNA B and RN A provided CR #1 a bath. She stated she spoke to FM A on 06/02/2026, and no complaints were made about CR #1 hair being dirty and falling out or made a formal complaint. She stated that CR #1's family subsequently decided to relocate him closer to home 2-hours away. During an interview on 06/03/2026 at 01:57 p.m., CNA B stated that CR #1 was a totally dependent resident, required two-person assistance for feeding, turning, repositing, and incontinent care. He stated CR #1 laid flat on his back consistently and he had observed slight redness to CR #1's backs due to the pelvic hardware screwed into CR #1's waist keeping him in that position. He stated that CR #1 could not say he needed his brief changed. He stated on 06/01/2026, he found CR #1 soaked through the brief with urine and bed linen was soaked. He stated the volume of urine was so heavy they had to change CR #1's gown and wipe down the actual bed frame/mattress before replacing the linen. He stated during CR #1's incontinent care, he had not observed open redness or wounds on CR #1's buttock, back, or shoulders, and had he would have reported to the nurse immediately. During an interview on 06/03/2026 at 02:29 p.m., the WCN stated that CR #1 was assessed upon admission with a Braden Score of 9, indicating a severe, maximum clinical risk for developing pressure injuries. She stated due to his severe risk, the cognitive inability to articulate basic toileting needs, and his status as a heavy wetter with extra-large bowel movements, the NF standards required staff to turn and reposition him every 2-hours and provide incontinent care every 1 - 2 hours. She stated CR #1 had an external pelvic hardware and did not hinder staff's ability to reposition and turn him. She stated after observing photographic evidence provided by FM A of CR #1's skin status upon admission to the ER on [DATE], she identified left-side sacral maceration (softening and breakdown of skin caused by prolonged exposure to excessive moisture) and redness, which she stated was a direct result of being wet too long, with slough, maceration, and necrosis (dead tissue) on the right side of the sacrum, and skin breakdown on his shoulder blade. She stated advanced, necrotic tissue damage was caused directly by a resident laying in one spot for too long over bony prominences and being left exposed to feces and urine, noting that slough takes hours to form. She stated that the wounds pictured appeared to be a failure of systemic monitoring, and failure to document required skin assessments and daily treatments from 5/25/2026 and 05/26/2026 when she was off-shift, concluding that if it is not here, it was not done. During an interview on 06/03/2026 at 03:05 p.m., FM B stated that on 05/23/2026, he and Family C visited CR #1 at the NF and found CR #1's room smelled like an [NAME], staff were (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	hateful, and the bedbound resident was left in these hot, unpowered room conditions for an entire week without the ability to move or contact staff, until they voiced their concerns with the SW, and the NF finally moved CR #1 on 05/26/2026, to another room. During an interview on 06/03/2026 at 3:10 p.m., FM C stated on 06/02/2026, CR #1 arrival at the ER for a scheduled surgery, his incontinent brief was soaking wet and it appeared like he had been there for a while, forcing her to immediately alert the ER staff. She stated that when the ER staff shifted and turned CR #1, she observed horrible buttock and back wounds with active bleeding. She stated when CR #1 arrived at the hospital, she seen that the NF had placed no padding or dressing on those wounds, leaving his open, bleeding sores directly sitting in his urine saturated brief. She stated on 05/23/2026, during a visit to CR #1, her and FM B found the CR #1's room had no electricity and no functioning air conditioning (A/C) despite the resident being really hot natured. She stated that the room smelled like an [NAME], staff were hateful, when their concerns were expressed about CR #1 a bedbound resident left in the hot room, unpowered room. She stated on 05/26/2026, CR #1 was moved to another room. During an interview on 06/03/2026 at 06:01 p.m., FM B stated on 06/02/2026, CR #1 arrived at the ER with an overwhelming, foul body odor. He stated that he rubbed CR #1's leg and the smell remained on his hands even after washing. He stated CR #1 had not had a bathe in some time, having crusted, dry, flaking skin had heavily accumulated inside the resident's foot-drop boots and across his feet. He stated that the ER staff had to fully clean and wash CR #1 upon admission due to the accumulation of filth. He stated he observed CR #1's completely soaked brief, urine soaked, and prominent, dried brown stains visible on the bedding, indicating to him the linens had not been changed for an extended period. He stated CR #1 had dried food crumbs and debris on his back that he wiped off CR #1 with his hand. He stated that CR #1 experienced severe pain and cried out whenever his leg was moved. During an interview on 06/03/2026 at 06:01 p.m., FM C stated when CR #1 arrived at the ER, his odor was so severe that she was unable to touch/massage his leg as she usually did. During an interview on 06/03/2026 at 06:01 p.m., Hospital RN stated she was CR #1 RN during his 03/07/2026 to 05/15/2026 hospital stay. She stated that when CR #1 discharged to the NF, his legs were straight, was cooperative with all care, could communicate his needs, and did not resist hygiene changes or wound care. She stated on 06/02/2026, CR #1 had a strong smell, unwashed hair, and filthy skin that immediately revealed he had not been groomed or bathed for an extended period. She stated she had to scrub the callus of CR #1's feet and had to tag team with another RN to get CR #1 clean. She stated his legs had contracted back up and he yelled in pain when attempting to move his legs straight. During an interview on 06/04/2026 at 10:22 a.m., MD B stated according to his MD notes, he evaluated CR #1 on 05/21/2026, and CR #1 could not reliably provide his own medical history, a complex background of a recent admission, external orthopedic fixator, and a bipolar diagnosis. MD B stated his notes had not reflected the residents' needs for ADL and could not recall CR #1's ADL condition. He stated that if the NF had been properly monitoring and providing CR #1 with adequate showers/bed baths, the severe wound degradation should have never happened. During an interview on 06/04/2026 at 11:31 a.m., LVN Q stated CR #1 required a two-person physical assist for incontinent care, and repositioning, and consistently requested water. She stated she had not rounded with CR #1's MD B or his WCD on 05/21/2026 and 05/28/2026. She stated there were no orders and she was not aware of CR #1's need for mandatory 2-hour turning schedules. She stated she had reviewed CR #1's clinicals, his 05/06/2026 Weekly Skin Assessment, and his 05/20/2026, SBAR and found no tracking on skin deterioration or mention of a sacral wound. She stated she was not aware of CR #1's condition on 06/02/2026, discharged to the ER. She stated as CR #1's nurse she monitored his pelvic area external fixator pins. She stated that she was responsible for performing weekend wound care but had not provided CR #1 any wound care when she worked the weekends. She stated that if she had witnessed skin trauma, facility protocol required her to generate an SBAR, update the skin assessment/progress notes, notify the FM, MD A, and the DON. During an interview on 06/04/2026 at 12:07 p.m., the WCN stated that she had not rounded with CR #1's MD B. During an (continued on next page)

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	675078	A. Building B. Wing	06/05/2026

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

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F 0677 Level of Harm - Actual harm Residents Affected - Few	interview on 06/04/2026 at 12:21 p.m., the DON stated CNAs must visually inspect the skin during daily incontinence care and weekly showers, document findings on shower sheets, and report them to the nurses. She stated CR #1 admitted to the facility with two clean surgical sites, required total assist: staff to assist with absolutely everything, including eating/feeding, incontinence care, and all movement. She stated due to an extensive MVA, he suffered multiple fractures and had an external pelvic fixator. She stated that the external fixator did not interfere with skin assessments or showers/bed baths. She stated if CR #1's MDS reflected he required maximum assistance from staff for showers/baths. She stated CR #1 would scream out in pain with any involuntary arm movement. She stated his cognitive status was alert but varied. She stated she had no knowledge; CR #1 had any skin changes over time. She stated had MD B found a wound, a progress note and that order should have been in the system. The DON stated that even for a DTPI, expectations were clear: it must be noted on the skin assessment, monitored closely, verbal orders must be entered into the system, tracked on the TAR and both the FM and MD B must be notified. During an interview on 06/04/2026 at 03:49 p.m., LVN B stated CR #1 was completely dependent for care and had a rotator/metal external fixator on his pelvic area. She stated she had not rounded with MD B. She stated she performed CR #1's initial physical admissions assessment, a head-to-toe skin assessment. She stated CR #1 had no sacrum or back skin integrity issues. She stated that CNAs A, B, C, D, E, F were responsible for CR #1's daily repositioning, identifying the development of foul smells, pressure wounds, and need for ADL care. During an interview on 06/04/2026 at 04:04 p.m. CNA C stated she was responsible for proving CR #1 with basic ADLs, including feeding, providing water, and incontinent care. She stated she had not provided CR #1 with a bath or a shower during all her shifts and never noticed a body odor, or dirty skin. She stated incontinent care always required a two-person physical assistance protocol. She stated that when she began working with CR #1, she was told to be very careful and that staff devised a plan on how to physically hold and lift the resident to avoid interrupting the integrity of a sacrum wound. She stated she had frequently found CR #1 would shift and completely move out of position and she had to locate another staff to assist with his repositing. She stated CR #1's sacral wound was already present when she began working with him. She stated the area had no drainage, redness, or bandages covering, and was not aware if the area had worsened. She stated that CNA A and CNA D were the staff who provided the most direct line care to CR #1. During an interview on 06/04/2026 at 04:19 p.m., CNA E stated she provided CR #1 with his ADL care: incontinence care, who required two-person protocol. She stated she had not provided CR #1 with a bath or a shower during any of her shifts. She stated she had observed redness to CR 1's sacrum but denied seeing any open wounds. She stated had she seen a wound; she would have reported it to his nurse immediately. During an interview on 06/05/2026 at 11:23 a.m., CNA D stated due to the severe staffing shortage on every shift, he was forced to cover three of the four halls at the NF, managing to complete baths for only one or two residents total per shift. He stated as CR #1 required two-personal assist for bed bath or showers, there was never enough time to complete bathing for CR #1 and had never known CR #1 to receive a shower or bath on any of the shifts he worked. He stated that managing multiple halls required a massive amount of physical strength and severely restricted his ability to complete basic care tasks, and He can't do it, he is not a machine. He stated that he had visual knowledge of a 2-inchs scratch with light redness to CR #1's sacrum when providing incontinent care assistance with CNA C. He stated he reported the scratch to a floor nurse, whom he could not recall on 05/26/2026 on the 2:00 p.m. to 10:00 p.m., shift, his first day working with the resident. During an interview on 06/05/2026 at 12:05 p.m., CNA F stated she only worked in the secure memory care unit and had not provided CR #1 with ADL care or a shower or bed bath. During an interview on 06/05/2026 at 12:06 p.m., CNA G stated she provided direct care to CR #1 who had an external pelvic hardware that made him turning difficult and painful for him. She stated to maneuver CR #1 to prevent active physical harm, 3-staff were required to repositing him. She stated she had not provided him with a shower or bed bath on any shift while CR #1 was admitted to the facility. She (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	stated she had direct visualization of a wound that was not that big, just small with no color and no drainage to CR #1's sacrum during incontinent care. She stated that the floor nurses knew about CR #1's wound and could not verify or name the specific nurses who knew. During an interview on 06/05/2026 at 02:58 p.m., Maintenance Director stated when he was informed the FA had concerns with CR #1's outlets and A/C, CR #1 was moved into another room. During an interview on 06/06/2026 at 01:55 p.m., ADM stated it had been his expectations that residents were to receive showers 3-times a week and those showers were to be completed according to residents' needs and preferences. He stated it was all staff responsible for identifying and reporting, and the nursing staff were to complete assessments and interventions. He stated it was all the staff's responsibility, the DON/designee ensures compliance, and the ADM ensures systems and regulatory requirements are met. Record review of the CNAs staff scheduled and actual staff who worked with CR #1 reflected, CNA A, CNA B CNA C, CNA D, CNA F, and CNA G. Record review of NF's in-service training report dated 05/15/2026, topic tiled. Residents Rights, ANE, Caution when Reporting and Providing Personal Care conducted by DON. Record review of NF's in-service training report dated 05/15/2026, topic tiled. ANE Reporting, Bathes/Showers and Providing Personal Care conducted by DON. Record review of NF's in-service training report dated 06/03/2026, topic tiled, Rounding and ANE conducted by DON. Record review of NF policy titled, Perineal Care dated 05/12/2025, reflected, Policy: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Always note any skin changes such as rash, red or pink areas or any discolorations to skin. Report to nurse when applicable .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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 a resident with pressure ulcers receives necessary treatments and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 9 residents (CR #1) reviewed.The facility failed to ensure CR #1, received orders, monitoring, and interventions to an existing wound and development of new wounds resulting in the lack of wound care management and hospitalization. These failures could place residents at risk of developing, reopening and worsening of pressure ulcers Findings included: Record review of CR #1's face sheet dated 06/03/2026, revealed that he was a [AGE] year-old male originally admitted on [DATE] and discharged on 06/02/2026 with diagnoses included traumatic subarachnoid hemorrhage (bleeding into the fluid-filled space between the brain and the protective tissue covering) with loss of consciousness, injury of head, displaced comminuted fracture of shaft (break along the long, straight section of a major long bone), of left tibia (shinbone), multiple fractures of pelvis with unstable disruption of pelvic ring (two or breaks in pelvis with loss of ability to support weight), fracture (bone break) of facial bones, major depressive disorder (persistent sadness, emptiness, and loss of interest), and bipolar disorder (MI that causes mood, energy, and activity level). Record review of CR #1's Hospital Records, reflected on 03/24/2026, CR #1 had an active pressure injury to his coccyx medial. On 05/04/2026, the wound was stated as a deep purple, maroon: red coloration, no closure, no odor, and clean. On 05/05/2026, no symptoms of infection. On 05/08/2026, new dressing interventions. On 05/11/2026, wound dressing status: area clean, dry and intact. Record review of CR #1's Baseline Care Plan dated 05/15/2026, reflected, CR #1 had skin integrity documentation related to an external fixator to pelvis (an emergency and temporary medical device used to stabilize severe, unstable pelvic fractures), and no documentation of any posterior wounds. CR #1 was dependent on staff for all his ADL's, lethargic level of consciousness, impaired cognition, and incapacitation. Record review of CR #1's MD A order dated 05/16/2026 at 01:11 a.m., reflected, perform head-to-toe assessment of all areas of skin every day shift every 7-days. Record review of CR #1's Skin and Nutrition IDT Assessment (used to proactively identify, prevent and manage pressure ulcers) dated 05/20/26 at 6:43 a.m., revealed, CR #1 was a new admit, with a Braden (assessment tool to determine the risk of developing pressure ulcers) score of 9. CR #1's score and risk category was left blank and recorded as N/A, and Wound Summary category indicated N/A for no active wounds upon admission. Record review of CR #1's Care plan had not reflected CR #1 had an active pressure wound or an air mattress with no wound interventions. Record review of CR #1's Skin and Nutrition IDT Review dated 05/26/2026 at 02:43 p.m., reflected weekly review noting no wound summary/selection of wound locations. Record review of CR #1's IDT Care Conference dated 06/01/2026, reflected nurse's summary and evaluation/goals: free from infections. Record review of CR #1's Hospital Discharge Transfer Form dated 06/02/2026 at 08:30 a.m., reflected CR #1 had no skin/wound care/pressure ulcers/injures. Other wounds: surgical wound to abdomen. Dependent for all ADLs. Record review of CR #1's Discharge MDS dated [DATE] reflected CR #1 had no BIM score which indicated CR #1 was unable to answer the assessment questions. Record review of CR #1's Care Plan date initiated on 06/03/2026, reflected CR #1 had current skin concerns and was at risk for further skin breakdown, infection and pressure ulcer formation (specific skin concerns not documented) initiated on 06/03/2026, with no risk interventions. No documentation of an air mattress. Record review of CR #1's Hospital Records dated 06/04/2026, reflected CR #1 was assessed upon admission to the hospital as having a Stage IV sacral decubitus ulcer (full-thickness tissue loss with exposed fascia, muscle, tendon, or bone). Observation on 06/03/2026 at 06:01 p.m., CR #1, sat in the hospital bed and appeared groomed and bathed. He verbally identified pain to his buttock while at the facility at a 4 out of 5. CR #1 observed using only one word responses to questions, and requests. During an (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	interview on 06/03/2026 at 12:20 p.m., FM A stated that the NF completely neglected and directly affected the development and worsening of CR #1's wounds. She stated CR #1 admitted to the NF on 05/16/2026, with hospital discharge instructions for his surgical wound care. She stated there were no wound care instructions of an active pressure sore to his buttocks. She stated on 06/02/2026, CR #1 was discharged from the NF and readmitted to the hospital for a scheduled surgery. She stated when CR #1 arrived at the hospital, he had unmanaged, actively bleeding wounds on his buttocks and back, severe hygiene neglect, unkempt hair and acute pain to the wounds. She stated the Hospital RN who received CR #1, was literally in tears at how bad CR #1's appearance, foul smell, and wound mismanagement. She stated on that same day, she immediately addressed her concerns with the ADM and DON about their failure in executing wound care. She stated the staff, brushing off her concerns as if they had no care and concerns for CR #1's condition. She stated she had provided photographs detailing the condition of CR #1's pressure ulcers on his back and buttocks. During an interview on 06/03/2026 at 02:29 p.m., the WCN stated she performed CR #1's first weekly head-to-toe skin assessment on 05/20/2026 and found his skin looked real good at that time. She stated that due to the resident's severe risk factors, cognitive inability to verbalize toileting needs, and status as a heavy wetter with extra-large bowel movements, facility standards required staff to turn and reposition him every 2 hours and provide intensive incontinence care every 1 to 2 hours. She stated her initial assessment yielded a Braden Score of 9, signifying a severe, maximum clinical risk for developing pressure wounds. She stated she completed subsequent weekly assessments on 05/26/2026 and 06/01/2026, documenting no posterior wounds, though she noted she could not enter the 06/01/2026 assessment into the clinical record due to facility computer issues. She explicitly stated that the resident's external pelvic hardware did not hinder staff's ability to properly reposition and turn him. She stated after review of CR #1's photographic evidence documenting CR #1's skin status upon his readmission to the hospital on [DATE], she identified extensive left-sided sacral maceration (the softening and breakdown of skin caused by prolonged exposure to excessive moisture) and redness, which was the direct result of the resident being wet too long, identified slough (buildup of pale yellow, stringy, or soggy dead tissue on the wound bed), maceration, and necrosis (dead tissue) on the right side of the sacrum, alongside active skin breakdown on his shoulder blade. She stated that the advanced, necrotic tissue damage was caused directly by a resident laying in one spot for too long over bony prominences and being left exposed to feces and urine, noting that slough takes hours to form. During an interview on 06/03/2026 at 3:10 p.m., FM C stated on 06/02/2026, CR #1 arrival at the ER for a scheduled surgery, his incontinent brief was soaking wet, and it appeared like he had been there for a while, forcing her to immediately alert the ER staff. She stated that when the ER staff shifted and turned CR #1, she observed horrible buttock and back wounds with active bleeding. She stated the NF had placed no padding or dressing on those wounds, leaving his open, bleeding sores directly sitting in his urine saturated brief. During an interview on 06/03/2026 at 06:01 p.m., FM B stated on 06/02/2026, CR #1 originally discharged from the hospital to the NF with only one pressure ulcer that was clean and covered. He stated on readmission to the hospital on [DATE], CR #1's diaper was soaked, with active bedding and wet and old brown stained sheets. He stated CR #1 smelled so bad that FM C could not provide CR #1 with her usual therapeutic leg massages. He stated he apologized for his visibly emotional state of weeping during the interview, while recounting what he observed, and the need to wash his hands several times to get the foul smell off his hands after touching CR #1's legs. He stated the Hospital RN had to spend hours deep-cleaning CR #1's crusted feet and neglected skin. During an interview on 06/03/2026 at 06:21 p.m., Hospital RN stated she was CR #1's Hospital RN during his 03/07/2026 to 05/15/2026 hospital stay. She stated CR #1's had a documented sacrum wound that had not actually broken the skin, and was not bad. She stated she was present when FM C had taken the photographic evidence of CR #1's skin status upon admission to the ER on [DATE]. She stated that CR #1 had left-side sacral maceration and redness, from being in a wet too long. She stated the left-side had (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	slough, maceration, and the right side had necrosis, and the shoulder blade had skin breakdown. She stated advanced, necrotic tissue damage was caused directly by a resident laying in one spot for too long over bony prominences and being left exposed to feces and urine,. She stated slough developed over days and weeks of skin trauma and lack of care. During an interview on 06/03/2026 at 06:30 p.m., On-Call Hospital MD A stated CR #1's advanced skin breakdown, left-side sacral maceration, right-side sacral necrosis (dead tissue), and shoulder blade breakdown to a prolonged, systemic lack of preventative care within the NF, and clinically impossible during a brief 2-hour transport from the NF to the hospital for such skin breakdown. During an interview on 06/04/2026 at 09:03 a.m., LVN B stated on 05/16/2026, she performed CR #1's initial admissions comprehensive, head-to-toe skin and wound assessment. She stated she received and reviewed CR #1's hospital discharge summary finding no notes or orders for pressure wounds and completed the comprehensive assessment and used her visual assessment of a front, back and head-to-toe observation of CR #1 to complete her findings. She stated CR #1 had no wounds or skin integrity issues upon admission. During an interview on 06/04/2026 at 10:22 a.m., MD stated he evaluated CR #1 on 05/21/2026, and CR #1 could not reliably provide his own medical history, a complex background of a recent admission, external orthopedic fixator, and a bipolar diagnosis. MD B stated he took the initiative to conduct a thorough initial physical evaluation, where he discovered a superficial sacral wound. He stated he had not recalled any admission orders for the sacral wound. He stated he provided verbal orders to the rounding nurse to prevent infection and worsening of the wound, CR #1, a dependent residents must be repositioned every 2 hours, and wound must receive daily cleaning, dressing, and attention, and educate the resident on avoiding scratching and touching the area to avoid opening and infecting the area. He stated it was the responsibility of the rounding nurse to add his verbal orders into CR #1's clinicals and his expectation, the orders were followed. He stated on 05/28/2026, he re-examined CR #1 and found the sacrum wound remained the same, superficial breakdown, and nothing serious of a stage 2, 3, or 4 at that time. He stated when he rounded at the NF a nurse always accompanied him. He stated and emphasized the rounding nurse was to chart his verbal orders immediately so that subsequent shifts knew the exact care plan. He stated that if the NF had been properly monitoring CR #1 as requested, the severe wound degradation should have never happened. He stated that no facility staff ever contacted him to report the worsening or development of any wounds to CR #1. During an interview on 06/04/2026 at 11:31 a.m., LVN A stated she was responsible for monitoring CR #1's pelvic area external fixator with pins and was unaware of sacrum pressure sore or postural wounds. She stated the standard protocol when obtaining verbal order from a physician must be formally entered into the resident's clinicals to trigger an immediate, comprehensive skin care assessment. She stated she was completely unaware of any sacral wound orders upon CR #1's admission or from MD B, and stating she received no new orders regarding the sacrum. She stated she reviewed CR #1's clinicals and found zero tracking of any skin deterioration. During an interview on 06/04/2026 at 12:07 p.m., WCN stated that she had not received orders from MD B for monitoring of a wound CR #1's sacrum. During an interview on 06/04/2026 at 12:21 p.m., DON stated CR #1 was a total-assist resident admitted with complex injuries, including an external fixator. She stated she was not aware CR #1 had a DTPI and had no sacrum wound care order upon admission. She stated CNAs must visually inspect resident's skin during daily incontinence care and weekly showers and report changes to the skin immediately to the nurses. She stated had a wound been identified, nurses were required to immediately notify the physician and obtain a specific order for new and pre-existing wounds, with consistent monitoring. She stated failures in this protocol, combined with a lack of admission wound care orders, created severe risks of further breakdown, infection, and sepsis. During an interview on 06/04/2026 at 03:49 p.m., LVN B stated she had not rounded with MD B. She stated she performed CR #1's initial physical admissions assessment, and head-to-toe skin assessment. She stated CR #1 had no sacrum or back skin integrity issues and had he, per policy, she would have notified the physician immediately and obtained wound care orders, documented and identified the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	wound on a skin, pain, and change of condition report. She stated that CNAs A, B, C, D, E, F were responsible for CR #1's daily repositioning, and incontinent care and would have been the front line staff in identifying the development of foul smells, and pressure wounds. She stated she had not been made aware of any reports that CR #1 had skin integrity issues. During an interview on 06/04/2026 at 04:04 p.m., CNA C stated she was responsible for proving CR #1 with basic ADLs, including incontinent care and repositioning. She stated CR #1 had a sacral wound already present when he admitted with no drainage, redness, or bandages. She stated she was not aware of the wound worsening. She stated that CNA A and CNA D were the staff who provided the most direct care to CR #1. She stated that when she began working with CR #1, she was told to be very careful and that staff devised a plan on how to physically hold and lift the resident to avoid interrupting the integrity of a sacrum wound. She stated she had not reported the wound, because he admitted with the wound and the nurses were aware of the wound. During an interview on 06/04/2026 at 04:19 p.m., CNA E stated she provided CR #1 with incontinence care and had observed redness to CR #1's sacrum and reported the redness to a floor nurse of whom she could not recall. She stated she denied seeing any wounds. She stated had she seen an open wound or development of a wound; she would have reported it to the resident's nurse immediately. She stated she had not provided CR #1 with a shower or bed bath. During an interview on 06/05/2026 at 11:23 a.m., CNA D stated that he had visual knowledge of a 2 inches scratch with light redness to CR #1's sacrum observed during incontinent care assistance with CNA C. He stated he reported the scratch to a floor nurse, whom he could not recall on 05/26/2026 on the 2:00 p.m. to 10:00 p.m., shift, his first day working with the resident returning from vacation. He stated all the nurses were already aware of the scratch to the residents' back and stated CR #1 had severe pain in that area but had never worsened. He stated she had not provided CR #1 with a shower or bed bath. During an interview on 06/05/2026 at 12:06 p.m., CNA G stated she provided direct care to CR #1 who had an external pelvic hardware that made him turning difficult and painful for him. She stated to maneuver CR #1 to prevent active physical harm, 3-staff were required to repositing him. She stated she had not provided him with a shower or bed bath. She stated she had direct visualization of a wound that was not that big, just small with no color and no drainage to CR #1's sacrum area during incontinent care. She stated the wound was present when CR #1 admitted . She stated that the floor nurses knew about CR #1's wound and could not verify or name the specific nurses who knew. During an interview on 06/06/2026 at 1:55 p.m. ADM stated that the facility's expectation upon a resident's admission were that a full head-to-toe assessments and care directives were completed to ensure skin integrity, and that any changes in skin condition must be immediately identified and reported. He stated staff were expected to identify and report all changes in condition, skin integrity and these changes should be reported to physician, DON, ADM, and resident's responsible party immediately. He stated that the NF enforces a zero-tolerance policy regarding ANE, and that all staff had responsibility to maintain vigilance, immediately document, and protect residents. He stated the failure to properly develop, capture, and execute proper assessments and care planning protocols could affect all residents who reside at the facility. He stated the alleged deficient practice could affect all residents who resided at the facility. Record review of photos received from FM A of CR #1s dated 06/02/2026, and times reflected,11:58 a.m., right and left buttock/sacrum with slough, maceration and redness12:02 p.m., right and left buttock/sacrum wound, left shoulder blade, and from blood on white linen.12:02 p.m., left over bony prominences (shoulder blade) with skin breakdown, tissue damage, and redness12:02 p.m., right and left buttock/sacrum wound with slough, maceration, and redness12:03 p.m., under right shoulder blade with skin breakdown, tissue damage, and redness04:59 p.m., right plantar surface (and ball of foot) and heel yellowed with dry crust (2 of 2 pictures)04:59 p.m., left plantar surface (ball of foot) yellowed with dry crustRecord review of NF policy titled, Wound Treatment Management dated 05/15/2025, reflected, Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. (continued on next page)

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	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodway Nursing & Rehab	2808 Stoney Brook Dr 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 - Actual harm Residents Affected - Few	Treatment selection will consider wound etiology, condition, resident preferences, and risk factors. In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse .

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record reviews and interviews, the facility failed to ensure resident environment remained as free of accident hazards as was possible for 1 of 4 shower rooms (A Hall shower room) reviewed for accidents.^^ The facility failed to ensure the A Hall shower room was locked and sharps in the shower room were secured and not accessible to residents on 06/02/2026 and on 06/03/2026. This failure could place residents at risk of entering the shower room that and could harm themselves due to the presence of unsecured sharp items. During observations on 06/02/2026 at 10:02 a.m., and on 06/03/2026 at 3:10 p.m., the A Hall shower room door was ajar and accessible to residents. No residents or staff were in the hallway or inside the shower room at that time. Further observation on both days revealed staff stored 14 unopened disposable razors on an unsecured shelf inside the shower room. The razors were scattered and not inside a box or a container. The shower room did not contain a locked box or cabinet. In an interview on 06.03.3026 at 9:47 a.m., the Maintenance Director stated he was unaware the shower room door was broken. He stated staff did not report that to him verbally or wrote it on the Maintenance book. He stated he did Maintenance rounds every morning on all the facility halls for any visible problems which needed repairs. He stated he did not look at locked doors to determine if they worked as part of his rounds, but expected staff to let him know verbally or in the maintenance log book when those locks were broken. He stated residents could slip and hurt themselves if they entered the shower room unsupervised. In an interview on 06.03.2026 at 3:15 p.m., RN Q stated the A Hall shower room door did not lock because the keypad did not work. She said the keypad worked in the past and had a code to use in order to access the shower room but did not have a code anymore which caused the door to be unsecured. She stated she was unaware who opened the door and left it open. RN Q stated she was unaware if staff reported the broken keypad to maintenance. She stated if the shower room door was unsecured, residents could get in the room and slip on a wet floor or hurt themselves if they decided to use the stored razors unsupervised. She stated she checked the shower room at the beginning of her shift, and it was closed but not locked. In an interview on 06.03.2026 at 3:23 p.m., CNA Q stated he was aware of the shower room door keypad problem and reported it only to the Maintenance Director verbally a while ago who said he would fix it. CNA Q stated he did not follow up on the matter after that. CNA Q stated staff could log maintenance issues in the maintenance book but he did not do that this time. He stated if residents entered the opened shower room, they could cut themselves. He stated he rounded at the beginning of his shift and the shower room door was closed but not locked. In an interview on 06.03.3026 at 3:35 p.m., the DON stated she was unaware the shower room door lock did not work. She stated she did round the whole facility every day and did not notice if the door was open or closed. She stated residents could slip or cut themselves if they accessed the shower room unsupervised. The DON stated she expected staff to report the broken shower room door to maintenance and to log it in the maintenance book and let her know as well. In an interview on 06.03.3026 at 3:53 p.m., the Administrator stated he was unaware the shower room door lock did not work. He stated residents could slip or cut themselves if they accessed the shower room unsupervised. The Administrator stated he expected staff to report the broken shower room door to maintenance and to log it in the maintenance book. Record review of the Maintenance Log, dated between 07/22/2025 through 05/27/2026, showed staff did not report the broken shower room door lock to the Maintenance Director. Record review of the facility's Safe-and-Homelike-Environment-Policy, dated 06/15/2026, revealed, .Staff should .e. Report any furniture in disrepair to Maintenance promptly. f. Report any unresolved environmental concerns to the Administrator.

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	675078	A. Building B. Wing	06/05/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals), to meet the needs of each resident 1 of 1 medical supply reviewed for medication storage and labeling. The facility failed to ensure the medication cart was free from expired medical supplies on 06/05/2026. This failure could place residents at risk of using items that were less effective or risky due to a change in their chemical composition and could cause infections due to compromised sterile equipment.Findings included: During an observation of C hall's medication cart and interview on 06/05/2026 at 9:36 a.m., revealed staff stored unopened expired Selan zinc oxide barrier cream (a medical and skincare topical ointment designed to form a protective layer on the skin, shielding it from moisture, irritants, and friction) count 17, all expired on 12/2025. In an interview on 06/05/2026 at 9:40 a.m., LVN Q stated she checked the medication cart for expired medications and supplies every day and before each use but overlooked the barrier cream. She stated if staff used expired barrier cream it could harm residents' skin. She stated she should have noticed the expired barrier cream and discarded them. In an interview on 06/05/2026 at 10:08 a.m., the Regional Nurse stated using expired barrier cream could cause the cream to not work as indicated. She stated she expected nurses to check the medication cart for expired medications and supplies every day and before each use. The DON was not available for an interview. Record reviews of the facility's Perineal Care policy dated 05/02/2025, revealed .Policy explanation and compliance guidelines.14. Apply skin protectant as needed. The policy did not mention checking the item's expiration date.