STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675346	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Oaks Nursing and Rehabilitation Center	5301 University Ave Lubbock, TX 79413

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop a comprehensive care plan for each resident, consistent with the resident's rights, that includes measurable short-term and long-term objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #1) of 7 residents reviewed for comprehensive care plans. The facility failed to revise Resident #1's care plan, a resident with an active Stage IV pressure ulcer, to reflect the use of a pressure-relieving mattress that was ordered by the physician on 11/8/25. This failure could place residents at risk for unclear staff guidance, inconsistent implementation of care, inadequate monitoring, delayed wound healing, and potential worsening or development of additional pressure injuries.Findings included:Record review of Resident #1's face sheet, dated 1/05/26, revealed a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses to include central cord syndrome at unspecified level of cervical spinal cord (incomplete spinal cord injury) and quadriplegia (person with paralysis affecting all limbs and torso). Record review of Resident #1's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 03, which indicated the resident's cognition was severely impaired. Section I Active Diagnoses revealed Resident #1 had the following diagnosis:Quadriplegia Section M Skin Conditions revealed Resident #1 was at risk of developing pressure ulcers (M0150) and he had no unhealed pressure ulcers(M0210). Resident #1's skin and ulcer injury treatments included a pressure reducing device for bed (M1200). Section V did reflect item 16 (Pressure Ulcer) as a triggered CAA and should be care planned. Record review of Resident #1's physician order, dated 1/5/26, revealed the following:Resident #1 had an order for a pressure reducing mattress to bed ordered 11/17/25 with a start date of 11/18/25.Resident #1 had a Pressure Ulcer, unstageable; Coccyx (Small triangular bone at the base of the spinal column) [cleanse with wound cleanser/ normal saline, pat dry, apply triad to wound bed, apply collagen, cover with superabsorbent dressing. Change daily and prn.] [Order dated 12/24/25 and Start date 12/25/25]Record review of Resident #1's admission assessment (Observation detail report), undated, revealed that Resident #1 had a pressure ulcer injury.Record review of Resident #1's wound risk assessment dated [DATE] revealed that Resident #1 had a pressure ulcer located on his coccyx. Record review of Resident #1's wound care clinic notes, dated 12/24/26, revealed the wound was present upon admission and was previously deteriorating but was currently stable.Record review of Resident #1's weight from PCC (electronic medical record software system) checked on 01/05/26 revealed that Resident #1 weighed 168 lbs as of 10/28/25. Record review of Resident #1's care plan, last revised 1/5/26 revealed the following:Resident #1 had a focus of wound management. Resident #1's goal for the focus area was his pressure ulcer would show signs of improvement and would be free from signs and symptoms of infection. Resident #1's interventions included the following: administer antibiotic therapy as prescribed, notify provider if there are no (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signs of improvement on current wound regimen and provide wound care per treatment order. Resident #1 had a focus that addressed him being resistive to care in regards to allow staff to reposition him due to his anxiety. Resident #1's goal for the focus area was Resident would cooperate with care. Resident #1's interventions included the following: educate Resident #1 and family of the possible outcome of not complying with treatment or care and to praise when the behavior was appropriate. Resident #1's care plan did not include the air-flow mattress, clear guidance for staff regarding implementation, monitoring, and expectations for pressure injury management.Record review of Resident #1's progress notes, dated 11/05/25-1/05/26, did not reveal any progress notes related to the pressure relieving air mattress, but did reveal the following regarding the pressure ulcer:LVN M documented on 10/16/25 at 4:18 PM the following: Resident #1 admitted to the facility for long term care. No skin integrity documentation was noted in the progress note.LVN N documented on 10/17/25 at 5:13 PM the following: Resident #1 complained of chest pain and shortness of breath.There was no progress note for the date Resident #1 returned. LVN N documented on 10/25/25 at 1:04 AM the following: Resident #1 transported back to the facility from the hospital on [DATE] at 6:45 PM with a stage 2 to coccyx.LVN O documented on 11/17/25 at 5:09 PM the following: Resident #1 noted with a decline in pressure injury to coccyx. Now presents as unstageable. Staff continues to educate and encourage him to allow them to turn and reposition him. Resident frequently chooses to lay on his back and refuses to offload pressure.LVN O documented on 11/20/25 at 1:51 PM the following: Resident #1 refused wound care after 2 attempts the NP was notified.LVN F documented on 11/20/25 at 8:00 PM the following: Resident #1 transported to the hospital for shortness of breath.There was no date for the day Resident #1 returned. The DON documented on 11/28/25 at 1:39 PM the following: Resident #1 order for his wound was Coccyx- Cleanse with NS, pat dry with 4x4 gauze, apply Calcium Alginate, cover with Super absorbent Silicone dressing, secure with Silicone tape. Change qod and prn and every day related to pressure ulcer of sacral region. The DON documented on 11/28/25 at 9:09 PM the following: Skin issue: Location: Coccyx. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. Wound is greater than 3 months. Signs and symptoms of infection: Nonhealing. Painful: Yes. Wound pain (Frequency): At dressing. Pain description: Aching. Pain description: Cramping. Pain description: Sharp. Wound pain interventions: Change in position. Wound pain interventions: Distraction techniques. Wound pain interventions: Relaxation techniques. Wound pain interventions: dressing change. Relief from interventions: Yes. LVN P documented on 12/03/25 at 10:34 AM the following: Resident #1 complained that he felt like he was crawling out of his skin Resident #1's vitals were checked all within normal limits. Resident #1 requested to go the hospital. Resident went to the hospital by his own request. No progress note to indicate Resident #1's return. LVN P documented on 12/06/25 at 4:40 AM the following: Resident #1 was admitted the hospital due to elevated troponin (protein found in the heart) levels.LVN F documented on 12/09/25 at 9:16 AM the following: Resident #1 arrived back to the facility. Head to toe assessment conducted. Resident #1 placed and the bed, positioned. Resident #1 continues to have open area to the coccyx. Resident #1 had a new order for Doxycycline 100 mg once a day for 7 days related to a UTI and infection in his wound. LVN F documented that the staff will continue to monitor Resident #1 for progress for worsening or improvement in his overall condition. LVN F documented on 12/10/25 at 3:42 AM the following: Resident #1 Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. Wound is greater than 3 months. Staged by: In-house nursing. ADON A documented on 12/10/25 at 9:55 AM the following: Resident #1 has an order for Mafenide Acetate External (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cream 85 MG/GM Apply to coccyx topically in the morning related to pressure ulcer of sacral region. The Dietician documented on 12/12/25 at 92:27 PM the following: Skin: coccyx, PU stage 2, improving since 11/28/25.LVN F documented on 12/15/25 at 11:37 PM the following: Resident #1 Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. Wound is greater than 3 months. Staged by: In-house nursing.LVN F documented on 12/17/25 at 12:05 AM the following: Resident #1 Resident is Completely Immobile: does not make even slight changes in body or extremity position without assistance.LVN F documented on 12/18/25 at 12:09 PM the following: Resident #1 Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. Wound is greater than 3 months. Staged by: In-house nursing.The DON documented on 12/24/25 at 12:33 PM the following: Skin issue has been evaluated. Location: Coccyx. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure ulcer / injury. Unstageable ulcer due to other: Debridement occurred Wound was present on admission. Wound is greater than 3 months. Staged by: Health care provider. Length (cm): 8 Width (cm): 7.5 Depth (cm): 3 Exudate amount: Moderate. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Edema: No swelling or edema. Dressing appearance: Intact.ADON A documented on 12/30/25 at 4:14 PM the following: Resident #1 had a Change In Condition/s reported: Skin wound or ulcer Change in skin color or condition.LVN F documented on 12/30/25 at 11:02 AM the following: Resident on Clindamycin day 1 of 12 for coccyx wound infection. No adverse reactions noted at this time. Will continue to monitor for any changes or worsening in condition. Plan of care ongoing.The DON documented on 12/31/25 at 1:23 PM the following: Location: Coccyx. Laterality / Orientation: Medial. Issue type: Pressure ulcer /injury. Pressure ulcer staging: Unstageable pressure ulcer / injury. Wound was present on admission. Wound is greater than 3 months. Staged by: Health care provider. Length (cm): 10.1 Width (cm): 11.2 Depth (cm): 4 Epithelial: 10%. Exudate amount: Moderate. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Odor after cleansing: Faint. Other: none. Edema: No swelling or edema. Dressing appearance: Intact. Additional care: Pressure reducing device for bed. Additional care: Turning / repositioning program. Additional care: Mattress with pump. Additional care: Pressure reducing device for chair.LVN F documented on 12/31/25 at 8:45 PM the following: Resident #1 on Clindamycin day 2 of 12 for coccyx wound infection. No adverse reactions noted at this time. Will continue to monitor for any changes or worsening in condition. Plan of care ongoing. Location: Coccyx. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Unstageable pressure ulcer / injury. Wound was present on admission. Wound is greater than 3 months. Staged by: Health care provider.LVN F documented on 1/01/26 at 11:38 AM the following: Resident #1 on Clindamycin day 2 of 12 for coccyx wound infection. No adverse reactions noted at this time. Will continue to monitor for any changes or worsening in condition. Plan of care ongoing.LVN F documented on 1/03/26 at 9:36 PM the following: Resident #1 on Clindamycin day 2 of 12 for coccyx wound infection. No adverse reactions noted at this time. Will continue to monitor for any changes or worsening in condition. Plan of care ongoing.LVN F documented on 1/04/26 at 8:35 PM the following: Resident #1 on Clindamycin day 2 of 12 for coccyx wound infection. No adverse reactions noted at this time. Will continue to monitor for any changes or worsening in condition. Plan of care ongoing.An observation was made on 1/5/26 at 11:45 AM of Resident #1 lying in bed on a low-pressure airflow mattress. The large dial on the left side indicated it was set at 320. The normal pressure light was illuminated, and the static button was turned on.An observation was made on 1/6/26 at 11:26 AM of coccyx wound during wound care for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 with LVN L. Assisting LVN L to turn and reposition Resident #1 was the DON. Large coccyx wound observed with a small-moderate amount of slough (sluff or to shed something off) on the wound bed. Wound had slight odor, and drainage was noted to abd pad when dressing was removed. Resident tolerated wound care wo s/s of distress. During an interview on 1/5/26 at 11:45 AM, Resident #1 stated he had been having issues with his bed since he was admitted to the facility in October 2025. He stated that when he informed staff (names unknown), they appeared not to know what to do. He stated he never observed anyone checking his bed. He stated facility staff finally changed his bed after he and Family Representative E continued to complain about the bed. He did not specify the date. He stated he was afraid his wound could worsen if he was not on the correct bed. He stated he did not want to return to the hospital. He stated he was admitted to the facility with his wound. He stated staff did not appear to know what they were doing, and he was unsure whether they had been trained regarding his specific needs. He did not specify which needs that he felt staff were not trained on. During a confidential interview, they reported concerns regarding Resident #1's bed had been reported multiple times to facility staff (specific staff names unknown), including certified nurse aides and nurses. They stated they reported concerns that the bed was not properly inflated to the Social Worker and the DON. They stated they did not have exact dates for when concerns were reported. They stated the Social Worker informed them it was a nursing clinical issue and that she could not assist. They stated the bed was not properly inflated on multiple occasions. They stated they pressed on the mattress and were able to push it down to the bed frame. They stated they spoke with an agency nurse (name unknown) who did not have knowledge about the bed to provide assistance, but they expected the nurse to notify the appropriate person. They stated they did not know whether the issue was ever reported to facility management. They stated they were told the facility was changing ownership and that purchases could not be made. They stated they had concerns regarding whether staff knew how to manage Resident #1's bed due to the length of time it took for the bed to be replaced. They stated when they requested assistance, nurses and aides did not know how to fix the bed. They stated they did not know whether any lights were illuminated on the mattress control panel. They stated no facility staff could provide information about the low-pressure airflow mattress. They stated Resident #1 received a new bed in December 2025, and it had functioned properly since replacement.During an interview on 1/5/26 at 2:41 PM, CNA C stated nursing staff checked the low-pressure air mattresses. She stated she did not know what to look for regarding low-pressure air mattresses because certified nurse aides did not handle them.During an interview on 1/5/26 at 3:18 PM, CNA D stated all staff could check the mattress. She stated if an issue was reported, it was to be reported to the nurse in charge. She stated she did not know much about the low-pressure air mattress and had not received instruction regarding low-pressure air mattresses at the facility. She stated she did not know the mechanics of low-pressure air mattresses.During an interview on 1/5/26 at 3:18 PM, CMA S stated she recalled that Resident #1 was admitted to the facility with a pressure ulcer.During an interview on 1/5/26 at 3:48 PM, LVN Q stated she was an agency nurse. She stated she completed wound care for Resident #1 on this date. LVN Q stated Resident #1 was sometimes cooperative with wound care and repositioning.During an interview on 1/5/26 at 4:05 PM, the SW stated she did not have information regarding Resident #1's low-pressure air mattress. She stated Family Representative E had not expressed concerns about the mattress to her.During an interview on 1/5/26 at 7:20 PM, LVN F stated Resident #1's bed was replaced due to concerns that it was not inflating properly in the middle. She stated Resident #1 complained that he felt as though he was sitting on the rail. She stated she visually checked the bed to ensure it was inflated when she completed wound care. She stated Resident #1's wound care was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	done daily and as needed if he soiled his brief and it affected the wound dressing. She stated she was unaware whether other staff checked the bed when providing care. She stated the bed was replaced within one week of the concern being brought to facility staff's attention. She stated she did not complete wound care on the date of the interview with the HHSC investigator and was unaware of the condition of the bed at the time of the interview. She stated wound care was completed on the day shift majority of the time. She stated no one had reported issues with Resident #1's bed. She did not disclose details regarding how often staff should be checking the mattress or which setting the mattress should have been set. She did state Resident #1's wound was stable but it started to look worse after it had been debrided by the wound care provider. She did not have an exact date of when the procedure was completed but stated the wound remained smaller and the same size until debridement. She did not disclose who was responsible for checking the bed but stated anytime she was in the room she checked the bed by physically touching the mattress. During an interview on 1/5/26 at 7:47 PM, CNA G stated the Maintenance Supervisor was responsible for checking low-pressure airflow mattresses. She stated the ADM would also check them if needed. She stated she had not received instruction regarding low-pressure airflow mattresses and that staff were not provided individualized instruction regarding those mattresses.During an interview on 1/5/26 at 8:08 PM, CNA H stated Resident #1 had experienced issues with his bed at one time. She stated she did not know about the lights or indicators on the bed because staff had not been trained on the mechanics of the bed. She stated that on one occasion, on an unknown date, while changing Resident #1, she placed pillows under him and felt as though she could feel the bed frame. She stated she reported the concern to LVN F and assumed it was addressed, which was why she did not follow up. She stated she had not received individualized training regarding Resident #1's bed or what to monitor.During an interview on 1/5/26 at 8:27 PM, CNA I stated she had heard Resident #1 had problems with his bed but had not personally noticed any issues. She stated she did not check beds and assumed nurses checked them, but she was unsure. She stated staff had not received additional instruction regarding Resident #1's low-pressure mattress.The HHSC investigator attempted to contact MD J on 1/6/26 at 8:53 AM to discuss Resident #1's wound and the low-pressure air bed. He did not answer, and a message was left.The HHSC investigator attempted to contact NP K on 1/6/26 at 9:17 AM to discuss Resident #1's wound and the low-pressure air bed. He did not answer, and a message was left.During an interview on 1/6/26 at 9:36 AM, the DON stated Resident #1 was admitted to the facility from another facility with a wound to the coccyx. The DON stated Resident #1 was at the facility for 1-2 days before he was transferred to the hospital. The DON stated Resident #1 returned from the hospital with worsened wounds. The DON stated Resident #1 returned to the hospital at least 1 or 2 more times after his initial admission. The DON stated Resident #1 had received wound care services since admission and had received wound care supervision from NP R on a weekly basis. The DON stated Resident #1 was non-compliant with repositioning. The DON stated Resident #1 had been on an air mattress due to his coccyx wound since admission. The DON stated that on 12/16/25, Resident #1's wound culture revealed an infection, and he was currently taking antibiotics to address the infection.During an interview on 1/6/26 at 10:15 AM via telephone, the Vendor's Operations Manager stated low-pressure airflow beds could operate with the low-pressure light illuminated; however, the static light should not be illuminated. He stated if the static light was on, it indicated the bed had no movement and would attempt to inflate further. He stated the bed was designed to operate with the center of the mattress slightly softer and that the head of the bed should not remain in a constant upright or 90-degree position. He stated the bed was functioning at full capacity when it was plugged in and turned on. He stated the head of the bed was at the correct angle, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used to ensure staff were doing what they needed to do to keep residents safe. He stated, for example, if a resident had behaviors, the resident would have interventions to assist in keeping the resident safe. He stated they would want a general outcome to be positive and to correlate with the interventions. He stated the use of the low-pressure air mattress should have been care planned. He stated he was unaware that the use of a low-pressure air mattress for Resident #1 had not been care planned and did not have a reason why it was not care planned. He stated the potential negative outcome for not care planning the use of the low-pressure air mattress was that if the mattress was low, the resident could acquire pressure ulcers or wounds in the facility, which could be dangerous. He stated he was unsure of the facility's system for monitoring and ensuring care plans included all required information and were revised accordingly. He stated that, based on his experience, the MDS Coordinator would have been responsible for ensuring interventions such as the use of a low-pressure air mattress were care planned. He stated in his past experience the MDS Coordinator was usually particular about residents' care plans. He stated he had been trained on the facility's policy and expectations regarding care plans. He stated the facility was in the process of changing EMR systems. He stated he expected care plans to read almost like a biography and that the information in the care plan should be accurate to keep residents safe. He stated all wounds were not the same and all low-pressure airflow mattresses were not the same. He stated processes and troubleshooting could differ depending on the bed. He stated everyone in Administration was responsible for ensuring all interventions were entered into resident care plans. He stated the MDS Coordinator would be the key essential person responsible for resident care plans. He stated he had not been specifically trained on low-pressure airflow mattresses at the facility but had general knowledge that the low-pressure light should not be illuminated and that the head of the mattress should remain above 30 degrees.During an interview on 1/6/26 at 12:39 PM, ADON A stated she had not been trained and had not received information regarding the specifics of low-pressure airflow mattresses. She stated she had not received training on ensuring the air mattresses were functioning properly. She stated a care plan was a plan that established care for each resident. She stated it included goals for the resident and interventions to address any problems the resident may have. She stated low-pressure airflow mattresses were implemented to help offload pressure and assist residents with pressure sores. She stated the potential negative outcome of staff not having information regarding low-pressure airflow mattresses was that staff may not know how the bed functioned. She stated low-pressure airflow mattresses were used to treat and prevent pressure ulcers. She stated she had not been in her role very long (since November 2025) and could not state whether the low-pressure airflow mattress should have been care planned for Resident #1. She stated she had not been trained on care plans due to being pulled to the floor because of short staffing. She stated she was unsure whether residents had the same type of air mattress and assumed differences in mattresses would affect what staff needed to know. She stated she did not have an answer regarding how staff were trained on the differences and expectations related to low-pressure airflow mattresses. She stated Resident #1 admitted with a pressure ulcer. She stated she was unsure whether the low-pressure airflow mattress was implemented upon admission or afterward. She stated she was unaware that Resident #1's low-pressure airflow mattress had not been care planned and did not have a reason why it was not care planned. She stated she was unfamiliar with the facility's system for monitoring resident care plans. She stated she had started training but was pulled to the floor shortly thereafter. She stated she believed the MDS Coordinator would have been responsible for resident care plans.During an interview on 1/6/26 at 12:56 PM, the DON stated that regarding the low-pressure airflow bed, the expectation was that the dial should be set to the resident's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675346	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Oaks Nursing and Rehabilitation Center	5301 University Ave Lubbock, TX 79413

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight. She stated the static light should never be illuminated unless indicated by a physician's order or at the resident's request. She stated if the static light was illuminated and would not turn off, it indicated the bed needed maintenance. She stated nursing staff had been trained on the expectations for low-pressure airflow mattresses. She stated her training documentation would only include nurses' signatures because they were responsible for checking the function of the low-pressure airflow bed. She stated she would provide a copy of the training; however, the training was not provided prior to investigator exit. She stated she did not have a specific policy for low-pressure airflow mattresses. She stated all wounds and treatments were not the same and should be treated differently and individualized. She stated Resident #1 admitted to the facility with a pressure ulcer and the low-pressure airflow bed intervention was implemented upon admission. She stated she was unaware that Resident #1's care plan did not include the low-pressure airflow mattress intervention. She stated the potential negative outcome for not care planning the intervention was that it could result in an increase in infection or worsening wounds. She stated the purpose of the low-pressure airflow mattress was to prevent pressure ulcers. She stated the system to monitor resident care plans was that care plans were reviewed quarterly, upon admission, and whenever there was a change in condition. She stated overall she and the MDS Coordinator were responsible for ensuring all applicable interventions were included. She stated the care plan should have reflected the implementation of the low-pressure airflow bed at admission. She stated the charge nurse at admission would also have been responsible. She stated the reason the low-pressure airflow bed may not have been care planned was because the facility was transitioning companies.During an interview on 1/6/26 at 1:25 PM, the ADM stated he was unaware of the logistics related to the low-pressure airflow bed, but staff were aware of the logistics and expectations. He stated he could not state in detail what the care plan should include because it had been some time since he received in-depth training on care plans. He stated the care plan was what staff, specifically direct care staff, used to guide how residents were cared for. He stated interventions such as the use of a low-pressure airflow mattress were expected to be care planned. He stated residents did not all have the same type of mattress and that mattress selection was based on acuity. He stated all resident pressure ulcers and wounds were treated differently based on physician's orders. He stated Resident #1 admitted with a pressure ulcer. He stated without reviewing the EMR, he could not confirm whether the low-pressure airflow mattress was implemented upon admission or