STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675399	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Navasota Nursing & Rehabilitation	1405 E Washington Navasota, TX 77868

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure residents received care and services consistent with professional standards of practice to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable for 1 (Resident #1) of 3 residents reviewed for pressure ulcers. The facility failed to:A. Ensure Resident #1 had appropriate interventions in place to prevent unstageable pressure ulcers under her C- Collar neck brace.B. Perform thorough skin assessments under Resident #1's C-collar to ensure pressure ulcers were not developing.C. Ensure Resident #1's C-collar was applied properly and maintained, as it was noted to be taped in place to prevent removal, with fecal matter smeared on tape.These failures resulted in an Immediate Jeopardy (IJ) situation on 09/17/2025. The IJ template was provided to the facility on [DATE] at 1:01PM. While the IJ was removed on 09/18/2025, the facility remained out of compliance at a scope of isolated and a severity level potential for more harm than minimal harm that is not Immediate Jeopardy, due to staff needing more time to monitor the plan of removal for effectiveness.These failures could place residents at risk of physical harm. Record review of Resident #1 face sheet, dated 09/16/2025 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Dementia, dissection of vertebral artery (small tear in artery wall), nondisplaced posterior arch fracture of first cervical vertebra(hairline break in back part of top neck), and non-displaced fracture of seventh cervical vertebra(small break in seventh bone).Record Review of Resident #1's Significant Change MDS assessment, dated 09/11/2025, reflected she was assessed with a BIMS score of 00, indicating severe cognitive impairment. Further review reflected she was assessed as not having any pressure ulcers.Record Review of Resident #1's initial skin assessment, dated 09/04/2025, reflected she was assessed as having no pressure ulcers. Record Review of Resident #1's comprehensive care plan reflected a focus area, dated 09/12/2025, Resident #1 has cervical fractures related to falling from her wheelchair-neck brace in place per MD orders. Review of interventions included neck brace as orders and skin assessment per facility protocol and prn. The care plan did not include interventions for brace removal.Record Review of Resident #1's physician orders reflected an order dated 09/05/2025, C-Collar on at all times except for showers. Further review reflected an order for Philadelphia collar, dated 09/05/2025, for showers (soft collar). Further review of Resident #1's physician orders reflected no order for removal of the collar to perform skin checks.Record Review of Resident #1's hospital record, dated 09/15/2025, reflected, Patient diagnosis pressure ulcer unstageable.Skin.bruising under c-collar, inspection findings include pressure ulcer, wound behind left ear and on chin under c-collar. Inspection findings include swelling to the anterior neck. Notes . c-collar taped to patient with fecal matter smeared on tape.During an interview on 09/16/2025 at 2:54 pm, the ER RN stated the ER did a head-to-to-toe assessment, and the ER was concerned about: ER removed the Aspen Collar which was missing all padding from the plastic collar, no padding at all noted and the collar was wrapped with 2-inch silk tape all the way around, rolled around the brace to adhere it to the neck. ER RN stated the tape was not on the skin, but the neck brace was wrapped so tightly around the neck that they had to use bandage scissors to remove the 10 -12 wrapped circles of tape around the brace and around her neck. ER RN stated, I understand she was probably pulling it off, but the tape was excessive and if it was an emergency they would not be able to get it off of the resident's neck. The ER RN stated in the ER they cut it off with bandage scissors and it took about 5 minutes to get off. The silk tape was soiled with food and fecal matter. The ER RN stated when they finally got it loose, there was bloody tissue where a skin adhesion to the collar had occurred. It was difficult to get the collar off the skin. The skin had a very strong smell the ER RN described as rotting flesh, putrid, or a bacteria smell. The smell was so strong the ER cultured the wounds on the left ear area of the neck, and chin for bacteria. The ER RN described the wounds as ulcers from the c-collar. In an interview on 09/16/2025, at 3:39 PM, the RP stated on 9/11/2025, she visited the facility to pick up Resident #1's cell phone for repair. The RP stated the facility had her sign a form acknowledging Resident #1 may fall and sustain injury due to her behaviors. The RP stated that during that visit, her loved one was wearing a brace that was covered with cotton gauze which had a foul odor and appeared dirty. She further stated that each time she visited, she requested that the facility clean Resident #1's room. She also reported observing fecal matter on the resident's bedsheets and fingers. Review of Resident #1's weekly skin assessment dated [DATE] performed by LVN C reflected no identified pressure