

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/08/2026
NAME OF PROVIDER OR SUPPLIER Reunion Plaza Senior Care and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Hampton Rd Texarkana, TX 75503	
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 - Minimal harm or potential for 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 observations, interviews and record review the facility failed to ensure residents with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 4 residents (Resident #1) reviewed for pressure injury. The facility failed to ensure Resident #1 was turned/repositioned at a minimum of every two hours on 6/08/26. The facility failed to ensure Resident #1 had boot style heel protectors on both feet at all times per the physician orders on 6/08/26. The facility failed to provide cushioning/positioning devices between Resident #1's bony prominences (areas of bones that lie close to the skin's surface, with minimal protective cushioning of fat/muscle, including knees, ankles, feet, and heels) of her lower extremities (legs/knees/feet) on 6/08/26. These failures could place residents at risk for deterioration of wounds. Findings included: Record review of Resident #1's face sheet dated 6/08/26 indicated she was [AGE] years old and admitted to the facility on [DATE] initially and re-admitted [DATE]. Resident #1 had diagnoses which included Multiple Sclerosis (MS) (causes breakdown of the protective covering of nerves [transmits electrical and chemical signals throughout the body] which interrupts communication between the brain and the rest of the body and could cause numbness, weakness, trouble walking, vision changes, unable to walk on their own or move at all), polyneuropathy (simultaneous malfunction or damage of multiple peripheral [outside the brain and spinal cord] nerves throughout the body resulting in numbness, tingling, weakness and burning pain, frequently starting in the feet and hands), Heart disease, and history of Myocardial Infarction (heart attack-occurs when blood flow to part of the heart is blocked or severely reduced resulting in heart muscle damage). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was usually understood and usually understood others. The MDS indicated Resident #1 had a BIMS score of 6 which indicated she had severe cognitive impairment. The MDS indicated Resident #1 had fluctuating inattention and disorganized thinking. The MDS did not indicate Resident #1 refused care. The MDS indicated Resident #1 had functional limitation in range of motion to both lower extremities (hip, knee, ankle and foot). The MDS indicated Resident #1 required substantial/maximal assistance to roll left and right, dressing upper body and was dependent on staff for most other ADLs. The MDS indicated Resident #1 was always incontinent of bladder and frequently incontinent of bowel. The MDS indicated Resident #1 was at risk for pressure ulcers/injuries but did not have any unhealed pressure ulcers/injuries at the time of the assessment. The MDS indicated Resident #1 was on hospice services. Record review of Resident #1's care plan printed 6/08/26 indicated she had a problem area of skin breakdown with the following interventions: Assist resident to turn and reposition frequently. Keep skin clean and moisturized. Inspect skin complete body head to toe every week and document results. Pressure reducing/relieving mattress. Administer skin/wound treatments as ordered. Record review of Resident #1's Active Order Report printed 6/08/26 revealed the following orders: Cleanse area to buttocks with soap and water, pat dry, apply barrier cream PRN with brief changes. Boot-style heel protector device to wear on both feet at all times with a start date of 5/06/26. Cleanse buttock with normal or wound cleaner, pat dry, apply calcium alginate, cover with (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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Resident #1 would not or could not answer questions. Resident #1 nodded yes, indicating it was okay to observe her feet, and she was able to raise the covers. Resident #1's legs were pulled up, and her knees were out to her right side at approximately hip level, and her feet were pulled under her buttocks. Resident #1's knees were laid on top of each other allowing skin-to-skin contact. Resident #1's feet were laid on top of each other allowing skin to skin-to-skin contact. Resident #1's heels were pulled up to her buttocks, and her left heel was touching her lower right buttock. Resident #1 was noted to have multiple reddened areas to both feet and there was a dark covering over her left heel and her right heel appeared to be missing a layer of skin. There were no positioning devices or pillows between Resident #1's knees, ankles, or feet. Resident #1 had a large wound dressing in place to her sacral area. Resident #1's protective heel boots were noted to be placed on top of a dresser by the wall across the room.During an observation on 6/08/26 at 2:53 PM, Resident #1 continued to be lying in bed on her right side. Resident #1 nodded yes, indicating it was okay to observe her feet, and she was able to raise the covers. Resident #1's legs continued to be pulled up, and her knees were out to her right side at approximately hip level, and her feet were pulled under her buttocks. Resident #1's knees continued to be laid on top of each other allowing skin-to-skin contact. Resident #1's feet continued to be laid on top of each other allowing skin to skin-to-skin contact. Resident #1's heels continued to be pulled up to her buttocks, and her left heel was touching her lower right buttock. Resident #1 continued to have multiple reddened areas to both feet and there was a dark covering over her left heel, and her right heel appeared to be missing a layer of skin. There continued to be no positioning devices or pillows in place between Resident #1's knees, ankles, or feet. Resident #1 continued to have a large wound dressing in place to her sacral area. Resident #1's protective heel boots continued to be placed on top of a dresser by the wall across the room.During a phone interview on 6/08/26 at 3:16 PM, Resident #1's family member said the wound on Resident #1's bottom was getting better. Resident #1 said the facility got her up into a chair 6/07/26 and that was the first time Resident #1 had been out of bed in a while. Resident #1's family member said around the week of 5/18/26, she saw there was a pressure sore on the side of Resident #1's left heel. She said the skin was closed but it appeared to be a deep tissue pressure wound (serious type of pressure sore caused by prolonged pressure damages the soft tissue beneath the intact skin) and it had a scab. Resident #1's family member said Resident #1's right heel area was red and mushy/soft. Resident #1's family member said an order was obtained for heel protector boots to both of Resident #1's feet at that time.During an observation on 6/08/26 at 4:08 PM, Resident #1 continued to be lying in bed on her right side. Resident #1 nodded yes, indicating it was okay to (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observe her feet, and she was able to raise the covers. Resident #1's legs continued to be pulled up, and her knees were out to her right side at approximately hip level, and her feet were pulled under her buttocks. Resident #1's knees continued to be laid on top of each other allowing skin-to-skin contact. Resident #1's feet continued to be laid on top of each other allowing skin-to-skin contact. Resident #1's heels continued to be pulled up to her buttocks, and her left heel was touching her lower right buttock. Resident #1 continued to have multiple reddened areas to both feet and there was a dark covering over her left heel, and her right heel appeared to be missing a layer of skin. There continued to be no positioning devices or pillows in place between Resident #1's knees, ankles, or feet. Resident #1 continued to have a large wound dressing in place to her sacral area. Resident #1's protective heel boots continued to be placed on top of a dresser by the wall across the room. During an observation and interview on 6/08/26 at 4:40 PM, Resident #1's family member was at her bedside. Resident #1 continued to be lying in bed on her right side. Resident #1's family member raised Resident #1's covers. Resident #1's legs continued to be pulled up, and her knees were out to her right side at approximately hip level, and her feet were pulled under her buttocks. Resident #1's knees continued to be laid on top of each other allowing skin-to-skin contact. Resident #1's family member lifted Resident #1's top knee and there was a reddened area approximately the size of a quarter to both inner knees. Resident #1's feet continued to be laid on top of each other allowing skin-to-skin contact. Resident #1's heels continued to be pulled up to her buttocks, and her left heel was touching her lower right buttock. Resident #1's family member lifted each foot for better visualization of areas. Resident #1 had a reddened area to the outside of the right great toe approximately the size of a dime. Resident #1 had a reddened area approximately the size of a quarter to the right ball area of the foot just below the great toe with the top layer of skin missing in the approximate size of a nickel with a small dark purple area toward the bottom of the area, it appeared to be dry and without drainage. Resident #1 had a reddened area to the inside middle part of her right foot with an approximate dime size dark purple area with intact skin. Resident #1's right heel had an area covering the base of the heel, that appeared to be missing a layer of skin and had a small dark purple area in the center, it appeared to be dry and without drainage. Resident #1 had a reddened area approximately the size of a nickel on the outside middle area of her right foot. Resident #1 had redness to the back of her left heel with an area approximately the size of a quarter with a dark purple/black covering in the center. Resident #1 had an intact area approximately the size of a dime to the inside of her left lower ankle with redness and a dark purple/black area in the center. There continued to be no positioning devices or pillows in place between Resident #1's knees, ankles, or feet. Resident #1 continued to have a large wound dressing in place to her sacral area. Resident #1's protective heel boots continued to be placed on top of a dresser by the wall across the room. Resident #1's family member said she was a nurse and she knew Resident #1 was on hospice and could be nearing the end of her life. Resident #1's family member said the wounds on her bottom and feet could be Kennedy ulcers (rapidly developing skin wound that can appear during a person's final weeks/hours of life. Resident #1's family member said she knew Resident #1 would refuse to turn/reposition at times and would kick her heel protector boots off at times, but the staff should be turning/repositioning her at least every two hours and trying to cushion between Resident #1's legs/feet and documenting if their efforts failed. During an observation and interview on 6/08/26 at 5:08 PM, Resident #1's family member was at her bedside. Resident #1's family member raised the covers and Resident #1 continued to be lying in bed on her right side. Resident #1's legs continued to be pulled up, and her knees were out to her right side at approximately hip level, but her feet were not pulled as close to her buttocks as previous observations. Resident #1 had her heel protector boots on both feet. Resident #1's family member said the ADON had come in and put Resident #1's heel protector boots on not long ago. Resident #1's knees continued to be laid on top of each other allowing skin-to-skin contact and there were no positioning devices/pillows between Resident #1's knees. During an interview on 6/08/26 at 11:30 AM, RN A said she was the Treatment Nurse. RN A said the floor nurses did the weekly skin (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessments on all the residents. RN A said the nurses would let her know when they found new skin issues or if there was a problem with current skin issues. RN A said the wound specialist did not see residents on hospice, unless hospice agreed to it. RN A said if the nurses found a skin issue, they would notify her, but the nurse normally called the provider to get orders and either the nurse or herself would enter the order into the software. RN A said if the resident was on hospice, they had to contact the hospice provider for orders and normally the hospice nurse would come by and assess the wound and give them orders for the wound care. During an interview on 6/08/26 at 12:40 PM, RN B said she worked for Resident #1's hospice service and she had been seeing Resident #1 for some time. RN B said Resident #1 was not able to turn herself at all now. RN B said Resident #1 went from not being contracted in her legs to being completely contracted within about two weeks and Resident #1 would holler out if you tried to straighten her legs. RN B said part of her becoming contracted could be related to her disease process with her MS. RN B said Resident #1 started getting dark spots on her heels, so they started pressure-relieving boots. RN B said Resident #1 would draw her feet up under her. RN B said often when she visited Resident #1, there would not be any pillows between her legs, and her pressure-relieving boots were not on. RN B said the facility let her know that the area on Resident #1's bottom had opened on 5/26/26 and orders were obtained to treat the wound on her bottom. RN B said they encouraged the facility to get the residents up out of bed, turning and repositioning, and using positioning devices/pillows to relieve pressure to areas and help prevent pressure injuries. During an interview on 6/08/26 at 2:58 PM, CNA C said she had worked at the facility for about a month. CNA C said she repositioned and turned residents every two hours and checked them for incontinence during her rounds. CNA C said she had just came in on her shift at 2:00 PM and was just fixing to start her rounds. CNA C said she was assigned to 100 hall (Resident #1's hall). CNA C said to help prevent pressure ulcers, she made sure the residents were clean and dry, kept barrier cream on them, and turned/repositioned residents who were not able to turn themselves, every two hours. CNA C said she may put a pillow between the resident's legs if needed for positioning. CNA C said if she saw a new skin issue, skin tear, skin breakdown, or a pressure sore on a resident, she would tell the nurse or the treatment nurse, so they could address it. During an interview on 6/08/26 at 4:10 PM, LVN D said she had worked at the facility since February 2026. LVN D said she normally worked on 100 hall on the 6 AM to 6 PM shift. LVN D said she rounded on the residents multiple times during the day. LVN D said she did a medication pass every 2 to 2 1/2 hours and peeked in on residents throughout the day. LVN D said she had not seen a problem with residents not being turned/repositioned. LVN D said the residents who could not turn themselves, she double checked to make sure they were being turned routinely. LVN D said she would make sure the heel protector boots were on the resident, if they had an order for them, put something like pillows or folded blankets between those joints such as knees and ankles to keep them from being on top of each other, make sure they are being turned and kept dry, to prevent pressure injuries. LVN D said Resident #1 had her heel protector boots on this morning (6/08/26) when she made her first rounds around 6 AM. LVN D said she did not notice Resident #1 had not had her boots on the rest of her shift. LVN D said to be honest, I did not thoroughly check and had just peaked in on her. LVN D said she had not looked at Resident #1's feet today (6/08/26) because she did not have Resident #1's skin assessment due. LVN D said she thought Resident #1's skin assessments were due on Thursdays. LVN D said Resident #1 was one that if you placed a blanket between her knees/ankles, she could pull it out. LVN D said she would not think Resident #1 could have taken her heel protector boots off. LVN D said Resident #1 liked to lay facing the door and not away from the door was what she had noticed. LVN D said sometimes when they tried to roll Resident #1, she would get frustrated and say no, no that she wanted to stay in a position. LVN D said with no padding in the bony areas, such as knees, ankles, and feet, it could cause skin breakdown, infections, and pressure ulcers. LVN D said it could cause the resident pain and overall decline in the resident's status. LVN D said she was off a couple days and when she came back, she noticed Resident #1 had started pulling her legs up. LVN D (continued on next page)		

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