STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675823	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Normandy Terrace Nursing & Rehabilitation Center	841 Rice Rd San Antonio, TX 78220

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide necessary services to maintain good grooming, personal hygiene for residents who were unable to carry out activities of daily living for 3 of 6 Residents (Residents #1, #2, and #3) reviewed for quality of life. 1. The facility failed to ensure Resident #1 received scheduled showers on 04/22/2026, 04/27/2026, 05/1/2026, 05/4/2026, 05/6/2026, 05/8/2026, and 05/13/2026. 2. The facility failed to ensure Resident #2 received scheduled showers on 04/25/2026, 04/28/2026, 05/9/2026, and 05/12/2026. 3. The facility failed to ensure Resident #3 received scheduled showers on 04/22/2026, 04/27/2026, 05/8/2026, 05/13/2026, and 5/15/2026. These failures could affect any resident and contribute to feelings of poor self-esteem and hopelessness.The findings included: 1. Record review of Resident #1's admission record, dated 05/18/2026, revealed a [AGE] year-old male readmitted to the facility on [DATE], with an original admission date of 06/03/2022, with diagnoses which include: unspecified dementia, unspecified severity, with other behavioral disturbance (cognitive decline accompanied by behavioral disturbances such as sleep issues), vascular dementia, unspecified severity, with other behavioral disturbance (cognitive decline accompanied by behavioral disturbances such as agitation, depression or anxiety) and hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (often resulting from a stroke leading to one-sided paralysis or weakness). Record review of Resident #1's MDS assessment, dated 07/08/2025, revealed a BIMS score of 3 out of 15, which indicated severe cognitive impairment. Further review revealed the resident needed substantial/maximal assistance to shower/bathe self and was independent for tub/shower transfers. Record review of Resident #1's care plan, last revised on 02/20/2026, revealed a focus area for the following: The resident has a ADL self-care performance deficit r/t confusion, dementia, hemiplegia, impaired balance, ambulates without assistance device, revised on 04/25/2025, with interventions including, Bathing/Showering: the resident requires moderate by 1 staff with showering 3 times weekly and as necessary, revised on 04/09/2024. Record review of Resident #1's task record revealed the residents scheduled bathing days as Tuesdays, Thursdays, and Saturdays. Review of the task record set for a 30-day look back period reflected the following dates as marked as not applicable; 04/22/2026, 04/27/2026, 05/1/2026, 05/4/2026, 05/6/2026, 05/8/2026, and 05/13/2026. During an observation and interview on 05/18/2026 at 11:50 a.m., Resident #1 was sitting in bed and appeared clean. Resident #1 stated the staff did not shower him but instead he showered himself. Resident #1 could not recall the last time they had showered him. Resident #1 stated they did like to shower. 2. Record review of Resident #2's admission record, dated 05/18/2026, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included: multiple sclerosis, unspecified (neurological disorder where the immune system attacks apart of the nerve cells), hemiplegia and hemiparesis following cerebral infraction affecting left non-dominant side (often resulting from a stroke leading to one-sided paralysis or weakness), and muscle weakness. Record review of Resident #2's MDS, dated [DATE], revealed a BIMS score of 15 out of 15, which indicated the resident's cognition was intact for daily decision-making skills, and did not have an indication of the assistance level Resident #2 required for shower/bathing nor tub/shower transfers. Record (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #2's care plan, last revised on 01/14/2026, revealed a focus area for the following: The resident has a ADL self-care performance deficit, initiated on 11/18/2025, with interventions including, bathing: requires staff x2 for assistance, initiated on 11/18/2025. Record review of Resident #2's task record revealed no indication of the resident's shower schedule. Review of the task record set for a 30-day look back period reflected the following dates as marked as not applicable; 04/25/2026, 04/28/2026, 05/9/2026, and 05/12/2026. During an observation and interview on 05/18/2026 at 10:43 a.m. Resident #2 was in his wheelchair and appeared disheveled. Resident #2 stated he thought his shower days were Monday, Wednesday, and Friday. Resident #2 stated he was lucky if he got one shower a week and thought the last shower he got was last Thursday, 05/14/2026. Resident #2 stated he never refused a shower and if he did not get one it was because of the facility being short staffed. Resident #2 stated he would ask for showers and not get one. 3. Record review of Resident #3's admission record, dated 05/18/2026, revealed a [AGE] year-old female readmitted to the facility on [DATE], with an original admission date of 10/14/2021, with diagnoses which included: restless legs syndrome (neurological disorder that causes an irresistible urge to move legs), muscle wasting and atrophy, not elsewhere classified, multiple sites (refers to loss of muscle mass and strength at an unspecified site), and muscle weakness. Record review of Resident #3's MDS, dated [DATE], revealed a BIMS score of 12 out of 15, which indicated the resident's cognition was intact for daily decision-making skills, and did not have an indication of the assistance level Resident #3 required for shower/bathing nor tub/shower transfers. Record review of Resident #3's care plan, last revised on 10/06/2025, revealed a focus area for the following: The resident has a ADL self-care performance deficit r/t impaired balance, pain in lower extremity, revised on 03/26/2024, with interventions including, bathing/showering: resident prefers to bath independently, revised on 11/24/2025. Record review of Resident #3's task record revealed the residents scheduled bathing days as Monday, Wednesday, and Friday. Review of the task record set for a 30-day look back period reflected the following dates as marked as not applicable; 04/22/2026, 04/27/2026, 05/8/2026, 05/13/2026, and 5/15/2026. During an observation and interview on 05/18/2026 at 10:11 a.m. Resident #3 was sitting in her wheelchair in the hallway and appeared clean. Resident #3 stated she was supposed to get showers on Monday's, Wednesday's, and Friday's and received a shower on 05/15/2026 but before then it had been about two weeks since the last shower. Resident #3 stated staff told her they did not have any help when Resident #3 did not receive showers. Resident #3 stated they did not feel safe showering alone and that was why they waited for staff to be available. During an interview on 05/19/2026 at 12:42 p.m., CNA A stated residents should be receiving three showers a week based off their bathing schedule. CNA A stated residents were not receiving their showers due to short staffing. CNA A stated resident shower days were based off of the hall they were in and if their room number was even or odd. CNA A stated residents had complained about not receiving showers and when it was brought up to management the CNAs would provide them with a shower then. CNA A stated if not applicable had been marked on a resident's shower sheet they were not sure why other than the CNA did not get to the resident's shower that day. CNA A stated Resident #3 had not raised any concerns regarding showers to staff, the resident had not refused showers in the past, and the CNA provided the resident with showers. CNA A further stated Resident #1 needed assistance with showers, did not refuse showers, and was provided with showers. CNA A stated if a resident did not get their weekly showers, it could cause skin infections. During an interview on 05/19/2026 at 2:02 p.m., LVN B stated residents should be receiving three showers a week. LVN B stated residents were not receiving three showers a week due to staffing. LVN B stated it had been brought up to management, and they were told the nurses needed to step in and help. LVN B stated they were told the facility was trying to hire people. LVN B stated if a resident had a complaint regarding not getting showered, they would do it. LVN B stated the CNAs were supposed to use the shower sheets to document, but some CNAs had told them when a resident did not get showered, but some CNAs did not. LVN B stated Resident #2 received showers but did not (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	know why they were not being documented. LVN B stated if a resident did not get their weekly showers, it could cause skin breakdown and/or personal humiliation. During an interview on 05/19/2026 at 5:09 p.m., the DON stated residents should be receiving a minimum of three showers weekly, either on Monday, Wednesday, Friday or Tuesday, Thursday, and Saturday. The DON stated they had been actively working to hire more staff. The DON stated they were unsure of why CNAs were marking not applicable on shower sheets due to the shower sheets having other options to mark instead such as resident refused or resident not available. The DON stated she had been aware of the complaints made by residents regarding not receiving showers. The DON stated if a resident did not receive their showers it could lead to UTIs, fungal rashes, and all different skin issues or infections. Record review of the facility's policy titled, Bath, Tub/Shower, with no revision date noted, revealed the following: Bathing by tub bath or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation, and relaxation.The frequency and type of bathing depends on resident preference, skin condition, tolerance and energy level.Although a daily bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed . The resident will experience improved comfort and cleanliness by bathing.The resident will maintain intact skin integrity.The resident will be free from soil, odor, dryness, and pruritus following bathing.The resident will receive assistance with bathing according to their resident centered plan of care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice for 1 of 6 residents (Resident #4) reviewed for quality of care. The facility failed to ensure Resident #4 received wound care on 04/01/2026, 04/03/2026, 04/05/2026, 04/06/2026, 04/07/2026, 04/08/2026, 04/09/2026, 04/10/2026, 04/11/2026, 04/12/2026, 04/13/2026, 04/15/2026, 04/16/2026, 04/20/2026, 04/20/2026, 04/24/2026, 04/30/2026, 05/06/2026, 05/08/2026, 05/09/2026, 05/10/2026, 05/13/2026, 05/04/2026, and 05/18/2026. These failures could affect residents who receive wound care treatments by placing them at risk for receiving inadequate treatments resulting in the worsening of the wounds.The findings include: Record review of Resident #4's face sheet, dated 05/20/2026, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included: type 2 diabetes mellitus with hyperglycemia (insulin resistance and high blood sugar levels) and pressure ulcer of right heel, stage 4 (full-thickness wound that exposes muscle, tendon, or bone). Record review of Resident #4's MDS, dated [DATE], revealed a BIMS score of 14 out of 15, which indicated the resident's cognition was intact for daily decision-making skills. The MDS indicated Resident #4 had 1 stage 4 pressure ulcer in Section M-Skin conditions under M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. Record review of Resident #4's weekly ulcer assessment dated [DATE] revealed a stage 4 ulcer to the right heel, present upon admission, with dimensions of length 2.5cm by width 2.5cm by depth 0.2cm, with no odor or drainage, and with current wound treatment as clean with NS, pat dry, apply calcium alginate, cover with border gauze and secure with gauze bandage roll. Apply boots and off load, air mattress. Record review of Resident #4's wound care physicians' initial wound evaluation and management summary, dated 03/25/2026, revealed a stage 4 pressure wound of the right heel, full thickness with dimensions length 2.5 cm width 2.5 cm and depth 0.2 cm and no signs of infection. Record review of Resident #4's wound care physicians' wound evaluation and management summary, dated 04/24/2026, revealed a stage 4 pressure wound of the right heel, partial thickness, with dimensions length 2.5 cm width 2.5 cm and depth 0.1c m and no signs of infection. The evaluation stated the wound had improved evidenced by decreased depth and decreased necrotic tissue. Record review of Resident #4's wound care physicians' wound evaluation and management summary, dated 05/20/2026, revealed the stage 4 pressure wound of the right heel, full thickness was changed to a diabetic wound of the right heel, full thickness, with dimensions length 1.0 cm width 2.0 cm and depth 0.1 cm and no signs of infection. The evaluation stated the wound had improved evidenced by decreased surface area. Record review of Resident #4's care plan, last revised on 04/23/2026, revealed a focus area for the following: The resident has a pressure ulcer to right heel, with a revised date of 04/16/2026, with interventions including, follow facility protocols for treatment of injury, and, treatment as ordered, with a revised date of 04/16/2026. Record review of Resident #4's order summary, dated 05/19/2026, reflected the following: - Wound care: stage 4 ulcer: clean with NS, pat dry, apply calcium alginate and apply dry dressing. PRN, one time a day for pressure injury, with an order date 03/23/2026 with no end date.- May have pressure relieving mattress, every day shift, with an order date 03/23/2026 with no end date.- Zinc Oral Tablet (Zinc) give 220 mg by mouth one time a day for wound healing related to pressure ulcer of right heel, stage 4, with an order date of 03/23/2026 with no end date.- Vitamin C oral tablet 500 mg (ascorbic acid) give 1 tablet by mouth in the morning for wound healing related to pressure ulcer of right heel stage 4, with an order date of 03/23/2026 with no end date.- Protein Oral Liquid (protein), give 30 ml by mouth three time a day for wound healing related to pressure ulcer of right heel, stage 4, with an order date of 03/24/2026 with no end date. Record review of Resident #4's April WAR indicated no documentation of wound care for the following dates: 04/01/2026, 04/03/2026, 04/05/2026, 04/06/2026, 04/07/2026, 04/08/2026, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/09/2026, 04/10/2026, 04/11/2026, 04/12/2026, 04/13/2026, 04/15/2026, 04/16/2026, 04/20/2026, 04/20/2026, 04/24/2026, and 04/30/2026. Record review of Resident #4's May WAR indicated no documentation of wound care for the following dates: 05/06/2026, 05/08/2026, 05/09/2026, 05/10/2026, 05/13/2026, 05/04/2026, 05/18/2026. During an interview on 05/18/2026 at 3:48 p.m., the DON stated they currently did not have a treatment nurse and the nurses assigned to the floor were responsible for providing the residents with wound care treatment. The DON stated the nurses knew they were responsible for providing wound care to the residents who required it. The DON stated the ADON was responsible for overlooking wound care while their facility did not have a wound care nurse. During an interview on 05/19/2026 at 2:02 p.m., LVN B stated the floor nurses were responsible for wound care. LVN B stated they were supposed to be checking the resident's administration record everyday to know who required wound care. LVN B stated they were supposed to be documenting wound care on the residents' WAR or TAR. LVN B stated no one had been ensuring the wound care was completed. During an interview on 05/19/2026 at 4:08 p.m., ADON D stated she would round with the wound care practitioner when they were at the facility. ADON D stated the nurses on the floor were responsible for providing wound care to residents. ADON D stated nurses knew which residents required wound care because she told them to check orders every time they came in, especially because they facility did not have a wound care nurse. ADON D stated no one was checking to make sure wound care was provided to residents. ADON D stated if residents were not provided with wound care as ordered their wounds could get worse and the residents could have an overall decline. ADON D stated no wounds had gotten worse to their knowledge. During an interview on 05/19/2026 at 4:55 p.m., Wound Care Physician E stated the facility regularly communicates with them regarding wound care and they were made aware of issues, if any, that would arise. Wound Care Physician E stated she gave orders to the facility regarding treatment and participated in care planning. Wound Care Physician E stated they were not aware of any issues with any wounds at the facility. During an interview on 05/19/2026 at 5:09 p.m., the DON stated it appeared that Resident #4 did not receive wound care for the right heel based off of Resident #4's WAR. The DON stated Resident #4's wound had not gotten worse. The DON stated if wound care was not provided as ordered it could possibly lead to the wound getting worse or hospitalization. During an interview on 05/20/2026 at 11:02 a.m., LVN B stated they were familiar with Resident #4 and were a regular nurse on Resident #4's hall. LVN C stated she knew he had a wound but thought it had been resolved. LVN C stated she could not recall providing wound care treatment to Resident #4's right heel. During an interview on 05/20/2026 at 11:10 a.m., LVN C stated they were familiar with Resident #4 and were a regular floor nurse on Resident #4's hall. LVN C stated the floor nurses were responsible for the residents' wound care and LVN C personally provided wound care for the residents who required wound care treatment. LVN C stated they checked residents' WARs and TARs anytime they were working and that was how they knew who required wound care. LVN C stated they had provided wound care to Resident #4's right heel the morning of 05/20/2026 and the resident's right heel did not look infected. LVN C stated they were not aware of if any other nurses had been providing wound care to Resident #4. LVN C stated they documented when they provided wound care to Resident #4 in the resident's WAR or TAR. LVN C stated the risk of not providing wound care could be the wound getting worse or infection. During an interview and observation on 05/20/2026 at 11:38 a.m., Resident #4 had a what appeared to be a clean white bandage over their right heel with a date of 05/21/2026. Resident #4 stated they received wound care treatment but not daily. Resident #4 stated their wound sometimes hurt but it appeared to be healing. Resident #4 stated he was not sure how often the wound care was supposed to be completed. During an interview on 05/20/2026 at 11:59 a.m., ADON D stated they were aware of Resident #4's right heel pressure wound. ADON D stated they were not aware of Resident #4's lack of wound care treatment. ADON D stated ADON E had informed them on 05/15/2026 that the wound to Resident #4's right heel had been resolved. During an interview on 05/20/2026 at 12:51 p.m., Wound Care Physician E stated they were familiar with Resident #4's right (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	heel wound. Wound Care Physician E stated the wound had decreased in size since Resident #4 arrived at the facility and that they had no concerns with the wound deteriorating. Wound Care Physician E stated they had received a picture from facility staff on 05/15/2026 which showed Resident #4's wound dimensions as length 1.5 cm by width 2.3 cm. Wound Care Physician E stated if wound care was not provided as ordered then the wound could deteriorate. During an interview on 05/20/2026 at 3:55 p.m., ADON G stated they took a picture of Resident #4's right heel wound on 04/24/2026 and that was the last time ADON G saw Resident #4's wound. ADON G stated Resident #4's right heel wound appeared yellowish, not open and no pink area on 04/24/2026. ADON G stated if wound care was not provided as ordered the wound could further break down. During an interview on 05/20/2026 at 4:38 p.m., LVN C stated if they did not document in Resident #4's WAR or TAR regarding the resident's wound care to the right heel it could have been due to either not getting around to documenting the care, or that they did not get to the wound care and would report that to the nurses coming in for the next shift. During an interview and observation on 05/20/2026 at 5:00 p.m., Wound Care Physician F performed a wound care observation and assessment on Resident #4's right heel wound. Wound Care Physician F stated the wound was open and not necrosed, and the wound measured at length 1.0 cm, width 2.0 cm, and width 0.1 cm. Wound Care Physician F stated Resident #4's wound looked really healthy and would be changing the pressure wound to a diabetic wound instead. Wound Care Physician F stated the wound had improved by 68% since the last time Resident #4 had been seen by the wound care company. Record review of the LVN B and LVN C's Nurse Proficiency audit, with no date, revealed both had been checked off as satisfactory for treatment procedures. Record review of the facility's policy titled, Pressure Injury: Prevention, Assessment and Treatment, revision date 05/25/2025, revealed: 7. Nursing Care plan. 2. Under Nursing intervention physician ordered treatments.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 2 of 6 residents (Residents #4 and #5) reviewed for accuracy of records: 1. Nursing staff failed to document accurate weekly skin assessments and weekly ulcer assessments for Resident #4 from March to May 2026 when it was documented the resident had no skin breakdown when the resident had a wound to the right heel. 2. Nursing staff failed to document weekly skin assessments for Resident #5 for May 2026. These failures could affect residents whose records were maintained by the facility and could place the residents at risk of errors in care and treatment.The findings include: 1. Record review of Resident #4's face sheet, dated 05/20/2026, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included: type 2 diabetes mellitus with hyperglycemia (insulin resistance and high blood sugar levels) and pressure ulcer of right heel, stage 4 (full-thickness wound that exposes muscle, tendon, or bone). Record review of Resident #4's MDS, dated [DATE], revealed a BIMS score of 14 out of 15, which indicated the resident's cognition was intact for daily decision-making skills. The MDS indicated Resident #4 had 1 stage 4 pressure ulcer in Section M-Skin conditions under M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. Record review of Resident #4's care plan, last revised on 04/23/2026, revealed a focus area for the following: The resident has a pressure ulcer to right heel, with a revised date of 04/16/2026, with interventions including, follow facility protocols for treatment of injury, and treatment as ordered, with a revised date of 04/16/2026. Record review of Resident #4's weekly ulcer assessment record was as follows:-Weekly ulcer assessment on 03/23/2026 documented a stage 4 right heel pressure wound with measurements length 2.5cm width 2.5cm and depth 0.2cm.-Weekly ulcer assessment on 03/31/2026 documented a stage 4 right heel pressure wound with measurements length 2.5cm width 2.5cm and depth 0.2cm.- Weekly ulcer assessment on 04/07/2026 documented a stage 4 right heel pressure wound with measurements length 1.6cm width 2.0cm and depth 0.2cm.-Weekly ulcer assessment on 04/14/2026 documented a stage 4 right heel pressure wound with measurements length 1.0cm width 2.0cm and depth 0.2cm.- Weekly ulcer assessment on 04/21/2026 documented a stage 4 right heel pressure wound with measurements length 0.5cm width 2.0cm and depth 0.2cm.- Weekly ulcer assessment on 04/28/2026 documented a stage 4 right heel pressure wound with measurements length 0.5cm width 2.0cm and depth 0.2cm.- Weekly ulcer assessment on 05/05/2026 documented a stage 4 right heel pressure wound with measurements length 0.2cm width 0.2cm and depth 0.1cm.- Weekly ulcer assessment on 05/12/2026 documented the stage 4 right heel pressure wound as closed and intact- Weekly ulcer assessment on 05/19/2026 documented a stage 4 right heel pressure wound with measurements length 1.5cm width 2.3cm and depth 0.1cm. Record Review of Resident #4's weekly skin assessments record was as follows:-Weekly skin assessment on 03/30/2026 documented no skin tears, bruises or ulcers.-Weekly skin assessment on 03/31/2026 documented no skin tears, bruises or ulcers.- Weekly skin assessment on 04/08/2026 documented a pressure ulcer.- Weekly skin assessment on 04/16/2026 documented no skin tears, bruises or ulcers.- Weekly skin assessment on 05/19/2026 documented a pressure ulcer. 2. Record review of Resident #5's face sheet, dated 05/20/2026, revealed a [AGE] year-old male readmitted to the facility on [DATE], with an original admission date of 11/06/2025, with diagnoses which included: pneumonitis due to inhalation of food and vomit (foreign substances enter lungs leading to inflammation and respiratory distress), muscle weakness, unspecified lack of coordination (signs of poor motor control), unspecified intellectual disabilities (developmental disorders characterized by significant limitations in intellectual and adaptive functioning). Record review of Resident #5's MDS, dated [DATE], revealed a BIMS score of 99 out of 15, which indicated (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's cognition was severely impaired. Record review of Resident #5' s care plan, last revised on 05/05/2026, revealed a focus area for the following: The resident has potential for pressure ulcer development: impaired mobility, bowel and bladder incontinence, with a revised date of 01/07/2026, with interventions including, follow facility protocols/policies for the prevention/treatment of skin breakdown, with a revised date of 11/16/2025. Record review of Resident #5's weekly skin assessment record was as follows:- Weekly skin assessment on 05/06/2026 documented no skin tears, bruises, or ulcers.- Weekly skin assessment on 05/19/2026 documented a pressure ulcer. During an interview on 05/18/2026 at 3:48 p.m., the DON stated the facility did not have a treatment nurse therefore the floor nurses were responsible for weekly skin and ulcer assessments. The DON stated ADON D was responsible for ensuring weekly skin and ulcer assessments were completed when they did not have a treatment nurse. During an interview of 05/19/2026 at 2:02 p.m., LVN B stated the floor nurses were responsible for completing weekly skin assessments. LVN B stated she had not gotten to a number of skin assessments the week of 05/18/2026. LVN B stated she tried to ensure they got done. LVN B stated the risk of not completing weekly skin or ulcer assessments could be skin breakdown. During an interview on 05/19/2026 at 4:08 p.m., ADON D stated the floor nurses were responsible for completing residents' weekly skin and ulcer assessments, and the nurses were to check residents electronic record regarding if a skin assessment was due. ADON D stated they were not checking to see if skin assessments or ulcer assessments were being completed. ADON D stated the risk of not completing weekly skin assessments or ulcer assessments could be moisture associated skin damage could worsen into a pressure wound. ADON D stated to her knowledge no wounds have gotten worse. During an interview on 05/19/2026 at 5:09 p.m., the DON stated residents should be getting a weekly skin assessment. The DON stated each nurses' station had a schedule of skin assessments due for their residents. The DON stated weekly skin and ulcer assessments should be accurate and complete. The DON stated if weekly skin and ulcer assessments were not completed there could be a risk of not knowing if a wound were to develop on a resident. During an interview on 05/20/2026 at 11:10 a.m., LVN C stated the nurses were responsible for weekly skin assessments. LVN C stated they received reminders in the facility's EMR system for residents with skin assessments due. LVN C stated the risk of not completing weekly skin assessments could be a wound getting worse. During an interview on 05/20/2026 at 3:27 p.m., ADON D stated they were told by the DON to catch up on Resident #4's skin and ulcer assessments. ADON D stated that for some of Resident #4's ulcer assessments she did not have the wounds measurements so she would put the same measurements as the previous assessment because no one was measuring the wound. ADON D stated she had a couple of measurements from the previous treatment nurse and sometimes she received measurements from ADON G. ADON D stated she could not provide dates of when she received previous measurements of Resident #4's wound and what dates she had not received measurements for the wound. During an interview on 05/20/2026 at 3:55 p.m., ADON G stated the nurses on the floor measure the residents' wounds and give them to ADONG G who then gives them to ADON D. ADON G stated the nurses take measurements of the residents' wounds when ADON D asks for them. ADON G stated she could not provide the previous dates and measurements taken for Resident #4. ADON G stated ADON D is the one who completes weekly ulcer assessments. ADON G stated the risk of not completing weekly skin or ulcer assessments could be further breakdown. Record Review of the facility's policy titled, Pressure Injury: Prevention, Assessment and Treatment, revision date 05/25/2025, revealed: Assessment: 1. All residents should have a skin assessment on a weekly basis completed in [the facility's EMR system]. 2. If a resident has any type of ulcer (pressure injury, arterial, venous, diabetic) an ulcer assessment should be completed at least weekly. Record review of the facility's policy titled, Documentation, with no date, revealed: Goal 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 2. The facility will ensure that information is comprehensive and timely and properly signed.