STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675834	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Galleria	2929 Post Oak Blvd Houston, TX 77056

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47531 Based on interview and record review the facility failed immediately consult with the resident's physician when there is a significant change in the resident's physical status for 1 (Resident #1) of 5 residents reviewed physician notification. Facility staff identified sacral wound on Resident #1 on 2/16/2024 and facility staff failed to perform and document a wound assessment, notify the physician, and obtain wound care orders until 4 days later 2/20/2024. An IJ was identified on 4/1/2024. The IJ template was provided to the facility on [DATE] at 4:14pm. The Immediate jeopardy was removed on 4/4/2024 due to the facilities implemented actions that corrected the non-compliance. This failure could affect residents with impaired skin integrity and residents at risk for impaired skin integrity of developing life threatening infections, hospitalization , and worsening pressure ulcers. Findings included: Record Review of Resident #1's Face Sheet undated revealed an [AGE] year old female who was admitted to facility on 2/8/2024 with diagnoses of Other fracture of left femur (Bone that runs from hip to knee), subsequent encounter for closed fracture with routine healing (Unopen fracture), Encounter for other orthopedic after care (At facility for rehabilitation), Extended Spectrum Beta Lactamase (ESBL) resistance (Antibiotic resistant urinary infection), Urinary Tract Infection where urine is excreted), Morbid Severe Obesity due to excess calories, Type 2 Diabetes Mellites with Hyperglycemia (High blood sugar). Record Review of Resident #1's MDS dated [DATE] revealed Resident #1 had a BIMS score of 9 indicating the resident was moderately cognately impaired, Resident #1 required extensive assistance with ADLs. Section I revealed fractures and other multiple traumas, urinary tract infection last 30 days, Swallowing Disorder . Risk of pressure injuries .yes, Unhealed pressure ulcers/Injuries yes .Unhealed pressure ulcers/injuries Yes .stage 1 .0 .Stage 2 .0, Stage 3 .0. Stage 4 .0 (No pressure injuries at admission) Unstageable deep tissue injury .1 .MASD (Moisture Associated Skin Damage). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's Care Plan dated 2/9/2024 read in part .Resident #1 has potential/actual impairment to skin integrity . Interventions: Assist with turning and reposition as needed. Reduce friction and shearing with use of lift or transfer sheets 2/8/2024 .Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc to MD. 2/8/2024 . Record Review of Resident #1's Comprehensive Nursing notes dated 2/16/2024, 2/18/2024 and 2/19/2024 read no new or worsening skin conditions. Record review of Resident #1's orders dated 2/20/2024 read . Cleanse sacrococcygeal ulcer (Area above and center of buttocks) with NSS (normal saline), Pad Dry, apply calcium alginate (Fabric) and med honey (medication for healing) and cover with sacral dressing (area at top and center of buttocks) qd (daily). Record Review of Resident #1's BD Weekly Wound Data Collection Flow Sheet dated 2/20/2024 revealed wound 6.5x14.0 depth, unstageable. Record Review of Resident #1's Change of Condition dated 2/20/2024 read in part . Skin status evaluation . pressure ulcer injury .Sacrum .unstageable pressure wound. 3/2/2024 Family Member #1 removed Resident #1 from the skilled nursing facility and took her to the hospital due to the pressure wound on her sacrum. Record Review of Resident #1's hospital records dated 3/2/2024 to 3/11/2024 revealed Resident #1 was admitted to the hospital with diagnoses of Infected decubitus ulcer (Infection at buttocks), unspecified ulcer stage. 8.0 x 10.0 x Unstageable due to 80% adherent necrotic tissue. Resident underwent Incision and drainage of sacral wound on 3/5/2024, intraoperative cultures grew Protease mirabilis (Bacteria in Urine infections), ESBL E. coli MDR (Harder to treat with antibiotics) and Enterococcus faecalis Pan sensitive (Bacteria found in the intestine). Resident #1 was discharged with orders for IV Meropenem (Intravenous antibiotic) every 8 hours for 21 days. Interview 3/13/2023 at 10:30am the Assistant Director Clinical Services said if a nurse found a wound and the skin was broken the expectations were to clean it, put a dry dressing on it and contact the Nurse Practitioner or Doctor for the findings and get and order for wound care. If that was not done the wound could have possibly deteriorated even more. She said they wanted staff to put in nursing interventions and needed them to offload from the wound. She said looking back they saw there was no notification to the physician and no orders for wound care for 2 days. She said they did rounds with the wound care physician so when the wound was found, they put interventions in place, making sure the wound care physician was notified, made sure the proper treatments were in place and notified the family. Interview 3/13/2024 at 10:44am with Family Member #1 he said he had to take his Resident #1 out of the nursing facility himself as the facility transportation would not take him to the hospital of his choice and he wanted Resident #1 to go to a particular hospital for her wound. He said he had to initiate the transfer as the facility said Resident # 1 did not need to go to the hospital. He said Resident #1 was in the hospital for nine days for her infected bedsore and she had been discharged the previous day to another nursing facility. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 3/13/2024 at 1:20pm with LVN A she said she worked on 2/18/2023 in the evening. She said the weekend supervisor told her Resident #1 had a wound on her sacrum. She said she thought the weekend supervisor was going to manage everything. She said she did not necessarily say she was going to manage everything, she said she thought they were going to handle the wound together. She said she guessed it was her fault the physician was not called about the wound even the CNAs were telling her they were reporting it to previous nurses the day before on 2/17/2024. They said there were bandages on the wound already and there were bandages in the room. She said the CNAs that told her they were from the weekend shifts. They said the bandage fit on the specific part for the sacrum. She said the CNAs had been putting the bandage on the wound and said they had been reporting it to previous nurses. She said the weekend supervisor looked at the wound. She said she thought the supervisor was going to call the doctor. She said she had not worked at the facility in 2 or 3 weeks. She said she talked to the DON and ADON about the wound and they asked how it looked at the time, they wanted to know if it looked black at that time. She said the wound was large. She said no one had previously reported a wound to the sacrum. No one had reported a wound on Saturday. She said she had been a nurse for one year, worked at the facility for one month, and was in-serviced on wound care in February 2024. Interview on 3/13/2024 at 2:00pm, CNA K said she remembered Resident #1. She said she came back from 5 days off and had her as a patient and when she was changing her, she saw she had redness and told her nurse. She said from then on, they started turning Resident #1 every 2 hours to get her off her bottom. She said this was on Wednesday February 21, 2024. She said when she saw the wound it was very large, very tender, obvious it had been there for a few days. She said the skin was broken. She said it was very vibrant colored, so she reported it to LVN B. She said she had been a CNAs for 10 months and worked at the facility for 5 months. She said prior to this happening she was in-serviced on wounds at a retirement home and was reminded at this facility. She said the facility had done an in-service . She said they had shown them how to add notes so they could have said they told the nurse about wounds and so the residents could have gotten treatment. Interview on 3/13/2024 at 2:50pm CNA L said she worked on Sunday 2/18/2024. She said she had only worked with Resident #1 a handful of times, and she was dead weight. She said when she got to Resident #1, she noticed a wound with no covering on her back side (2/16/2024). She said another CNA said she noticed it the day before on 2/17/2024, but she did not remember who it was. She said this had to have happened about a month ago if not more. She said the skin was broken off at the back and butt crack and she told the nurse but could not remember who on the morning shift. She said the wound looked pretty bad and looked like it would have stung. She said it was medium to large. She said they should have known about the wound if the CNA noticed it before her. She said it was a Sunday. She said she did not really know some of the nurses. She said she had worked at facility 7 months and been a CNA for 3 years. She said she was last in-serviced on skincare the prior weekend, and before that 3 months ago. Interview on 3/13/2024 at 3:55pm CNA M she said she was not at the facility at first but when she came back on 2/16/2024, she saw Resident #1 had a wound to her buttocks. She said she told the nurse it needed to be cleaned and it had an odor. She said the wound was open, large and had an odor. She said the skin was off the wound. She said she told the nurse LVN C about the wound, but she did not do anything about it because after that she got a call from the DON asking about the wound and when it started. An interview with LVN C could not be conducted as she was in the hospital. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's Braden Scale for predicting pressure ulcer risk dated 2/15/2024 read Resident #1 had slightly limited sensory perception, was bedfast, occasionally moist, made frequent though slight changes in body or extremity position independently, friction or shear was a potential problem, and the total score was above 16. (Mild risk for pressure ulcers). Interview on 3/14/2024 at 2:55pm with the Assistant Director Clinical Services she said they did investigations with the staff to figure the gaps on Resident #1's wound. She said she looked herself and the skin initially was intact. She said even the week prior the evening nurse showed on the 14th it was intact. She said it was Resident #1's positioning, nutrition, and incontinence, and it was a combination that caused the wound. She said she knew they were putting zinc on the wound. She said on Sunday 2/20/2024, the CNA had identified and informed the off going nurse on the 3 to 11shift of the wound and she looked at it and told RN S. She said LVN A told RN S Resident #1 had skin breakdown and could she look at it look at it let her know. She said RN S said she would help LVN A if she needed it. The Assistant Director Clinical Services stated according to the RN S she told the nurse to get the information and call the doctor. LVN A said she would call the doctor and get the order. The Assistant Director Clinical Services stated It was he said she said situation. She said she had not heard anything about February 16th and when she did her weekly assessment on the 14th it was ok and there was no breakdown on the sacral area. She said the reason the resident had a sacral wound was because she had not been repositioned. She said when residents get sacral wounds, they can become infected. Interview on 3/14/2024 at 2:55pm with the ADON she said she did not know a CNA had reported skin breakdown to LVN C on 2/16/2024. She said on 2/18/2024 LVN A and RN S told her it was the others responsibility to call the physician. She said LVN C told her RN S would call the physician for orders and RN S said LVN A would call the physician for orders. She said RN S should have called the physician for orders for wound care as she was the person who reported to the oncoming staff. On 3/13/2024 at 11:05am outreached RN S who had been terminated by the facility for not contacting the physician for wound care orders, and she refused the interview. Interview on 3/15/2024 at 8:30am with the ADON she said the failure with Resident #1's wound was a combination of timely identification of the wound and not getting timely treatment in place. She said Resident #1 was being treated for ESBL (Antibiotic Resistant bacteria) and E. coli (Intestinal bacteria) in urine. She said Resident #1 had a slight decrease in mobility and it was their job to have repositioned her, to have been timely in reporting the wound, and she said the reason Resident #1 developed the wound was because she was not repositioned enough. She said she had been a part of the QAPI (Quality Assurance and Performance Improvement) subcommittee, with KPI (report to look at metrics and pressure ulcers) were worked on this year, she said this issue was disheartening, she said they had identified wounds and they had multiple sessions with the nurses. She said she thought the failure was communication regarding Resident #1. She said they educated the staff so when they saw something to report it. She said staff were to report skin breakdown instead of someone assuming it had already been reported. She said Resident #1 did not really want to be turned and Resident #1 could have gotten the wound by not being turned, she said Resident #1 needed assistance with turning. She said what should have happened was as soon as anything was different with Resident #1's skin, they should have reported to the charge nurse starting at the stage 1. She said staff should have notified charge nurse, notified wound care physician, and gotten orders for wound care. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 3/15/2024 at 6:46am CNA N said she worked the night shift last night. She said she had worked at the facility for [AGE] years and been a CNA for 20 plus years. She said she worked on the first floor. She said she saw Resident #1's wound. She said she saw her wound, but she was not assigned to her, but she did see it, she said she assisted with turning. She said when Resident #1 needed changing she would assist with changing her. She said Resident #1 would call and let us know when she was ready to be changed. She said Resident #1 was with it and she was coherent. She said she saw the bedsore and saw the wound as medium sized, she said they would have patches on it, they would clean it and put patches on it. She said she told the nurse about the wound, and they had so many since then she did not know the name of the nurse, she reported it to. She said she did not know if the ADON knew about the wound. She said she was sure she did, she said you can tell nurses about a wound but after that you do not know what happens. She said if a resident was not turned, they could have gotten a bedsore and it could have gotten larger. She said it could have gotten infected. She said she did not know how Resident #1 got the bedsore but had been shocked to hear about it and said she saw it when it was smaller. Interview on 3/15/2024 7:31am with LVN D she said she had worked at the facility for about 5 weeks. She said she had been a nurse for 2 years. She said she saw the wound on Resident #1's sacrum. She said the wound was unstageable when she saw it. She said it was red around the perimeter and black on the inside. She said she did not believe the CNA reported the wound. She said she believed there was a dressing on the wound on Friday 2/16/2024. She said she did not know it had not been reported to the physician as they each had a list of comprehensive nursing notes to write, and she had not documented on her. She said the CNA told her there was a wound and it was not dirty. She said she did not call the physician. She said they do skin checks on the 7 to 3 and 3 to 11 shifts so they would have called and received an order as she worked nights. She said she found a wound on Resident #1's inner thigh the following week and called the wound care physician and received an order for that. She said if a resident had a bedsore, they could get an infection and have pain. She said she did not know how long Resident #1's sacral wound had been there. Interview on 3/15/2024 at 7:33am with CNA O she said she had worked at the facility since October 2023, she said she would have been a CNA for a year in May 2024. She said she had seen the wound on Resident #1's sacrum and reported it to the nurse. She said she reported it to LVN D because the bandage was soiled, and she took it off so that LVN D could replace it. She said LVN D came in and replaced the bandage. She said she saw the wound after Valentines Day . She said she did not work on weekends, so it was on Thursday 2/15/2024, or Friday 2/16/2024. She said it was not the week of 2/23/24. She said if a resident was not turned, they could have gotten a bedsore, the bedsore could have gotten worse, and the resident could have gotten an infection. Record Review of facilities policy titled, Skin Observation and Wound Prevention Protocol dated 10/2022 read in part . Charge nurses should observe the condition of the resident's skin on admission and on a routine basis. Record Review of facilities policy titled, Change of Condition for Skilled Nursing Communities dated 8/2023 read in part .An associate should communicate information about a residents status change to appropriate licensed personnel upon observation .or observing a difference in the residents usual physical .the licensed nurse should .notify the HCP (Healthcare provider) of observations and relevant change of condition information .Implement treatment interventions, received orders and document HCP recommendations as indicated . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record Review of Facility In-Service dated 2/2/2024, 2/3/2024 and 2/7/2024 .Topic .Annual Charge Nurse Check-off Training read in part . Importance of pressure wound prevention .Doctors, On-call, Telehealth. Record Review of Facility In-Service dated 2/20/2024 .Topic . Offloading/Repositioning read in part . Repositioning patients throughout shift to offload bony prominences .offload areas at risk for breakdown . Record Review of Facility In-Service dated 2/21/2024 .Topic .Infection Control read in part . Signs and Symptoms of wound infection: Swelling, Redness, Slight odor, increased pain at wound site . Record Review of Facility In-Service dated 3/13/2024 .Topic .Reporting New or Progression of Wound read in part .CNA to report New or Worsening wounds too Charge nurse immediately .Document Change in Skin Condition in PCC using Stop-N-Watch Tool .Charge Nurse to report New or Worsening wounds to Physician/NP to receive wound care orders immediately .Charge Nurse should place call to DCS (Director Clinical Services) or ADCS (Associate Director Clinical Services) to inform of New or Worsening wound identified. An IJ was identified on 4/1/2024 and the facility administrator was notified at 7:00pm. The IJ template was provided to the facility on [DATE] at 4:14pm. On 4/3/2024 at 4:40pm the following Plan of Removal was accepted. Plan of Removal Brookdale Galleria - April 2, 2024 F580 Notifications of Changes Immediate Action: On 2/19/2024, an impromptu Quality Assurance Performance Improvement (QAPI) Meeting was completed with the Healthcare Administrator (HCA), Director of Clinical Services, Assistant Director of Clinical Services (ADCS), and Medical Director via the phone related to the Skin Management Process related to Resident # 1 skin documentation. The additional actions included re-education to Certified Nursing Assistance (C.N.As) and Licensed Nurses on repositioning and abuse neglect reporting. Re-education for Licensed Nurses on skin assessments, Skin observation protocol (which includes notification of healthcare provider), repositioning, and wound prevention. These Inservices were completed on 2/20 by the ADCS. On 2/20/2024, the ADCS and Attending Physician assessed the wound to Resident #1's sacrum and new orders received by the attending physician for medical honey and calcium alginate, supplements, and a low air loss mattress. On 2/22/2024 the Third Party Wound Doctor assessed the wound, orders were updated to include Santyl. The Third Party Wound Doctor discussed the skin management plan of care with the resident # 1 representative at bedside. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 2/22/24, the ADCS performed wound rounds on current residents with wounds. No new pressure concerns were noted. On 3/2/24, Resident # 1 discharged from the community. On 3/13/24, an Impromptu QAPI Meeting held with the HCA, ADCS, Regional Director of Clinical Services (RDCS), and the Medical Director via the phone related to the Skin Management Process. The additional actions included the ADCS or designee to extend the audits of 5 residents dressing to be completed weekly for 90 days, review residents that would benefit from a Low Air Loss Mattress, complete skin checks on current residents, and re-education to C.N.A's and Licensed Nurses to notify the DCS or ADCS on new pressure ulcers. The regional support nurse conducted an audit on 3/14 no additional findings relating to physician notification were noted. On 3/13-3/14/24, the ADCS and designee completed skin checks on current residents. No new pressure concerns were noted. On 3/14/24, a Registered Nurse (RN) performed a remote Skin Documentation Audit. The audit included the following items. The audit was documented on an audit form. o Weekly Skin Integrity Review form to verify every resident had either the weekly skin form or the section completed in the Nursing Admission Data Collection form, if newly admitted . o That every resident had a weekly skin integrity review activated schedule to be completed weekly in PCC. Form scheduled as needed in PCC. o Weekly Wound Data Collection form if completed, the date, and information in the form. o Third Party Wound Care MD notes in PCC Miscellaneous tab with notes on wounds (location, etc.) o Third Party Wound Care MD orders from their notes on wounds from bullet above. o Physician orders written in PCC for wounds or anything related to skin. o Care Plans related to wounds. Plan for Compliance: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	From 3/13/- 3/16/2024, the DCS or designee re-educated all Licensed Nurses on change of condition documentation which includes notifying physician and representative, skin documentation, obtaining orders for any wounds, reviewing and addressing clinical alerts on skin concerns from C.N.A's, notifying provider as indicated, professional standards of wound care, that the C.N.A can't apply a treatment, Braden Scale which includes preventative measures. Licensed nurses not available between 3/13/2024 to 3/16/2024 received re-education by the DCS or designee before their next scheduled shift and this will include new hires hired after 3/16/2024. Competency validated with a post test. From 4/1 -4/3 the DCS or designee re-educated nurse on physician notification of new skin issues, change of condition documentation, aides performing dressing changes, skin observation and wound prevention protocol. Licensed nurses not available between 4/1 to 4/3 will receive re-education by the DCS or designee before their next shift, this will include new hires hired after 4/3. Competency validated with a post test. Starting 3/14/24, the Licensed Nurses will initiate the wound data collection sheets on any new pressure ulcers. The RAI or designee will update resident care plans as needed as new pressure concerns arise. The Licensed Nurse will review the clinical alerts in the dashboard periodically through the shift to verify that any new skin concerns communicated by the C.N.A are addressed. The ADCS or designee overseeing will complete the weekly wound data collections for residents with new pressure ulcers until pressure ulcer is resolved or the resident is discharged . Order listing report, progress notes, weekly skin and wound documentation is reviewed during daily standup for any new or worsening pressure ulcers. From 3/13- 3/16/24, the ADCS or designee re-educated all C.N.A.s on communication of changes in skin integrity with the licensed nurse and DCS or ADCS, documentation of any new skin concerns in the electronic medical record every shift including the stop and watch, what to do if dressing falls off the resident's wound, moisture barriers, and turning and repositioning. The C.N.A may complete a Stop and Watch Alert that there is a Change in skin color or condition as indicated. These alerts display on the licensed nurse clinical alert dashboard in the electronic medical record. The C.N.A will also communicate verbally to the licensed nurse what they documented in the electronic medical record related to new skin concerns. The C.N.A. will contact the DCS, ADCS, or the Healthcare Administrator to report new skin issue for additional follow up. C.N.As not available between 3/13- 3/16/23 received re-education by the DCS or designee before their next scheduled shift and this will include new hires hired after 3/16/24. Competency validated with a post test. From 4/1 to 4/3 C.N.A. were re-educated on C.N.A. not performing dressing changes and are allowed to apply barrier cream, reporting changes in skins and wound prevention. Aides not available between 4/1 to 4/3 will receive re-education by the DCS or designee before their next shift, this will include new hires hired after 4/3. Competency validated with a post test. For 90 days, the DCS or designee will review clinical alerts in stand-up meeting five days a week, to determine if there is documentation of new skin concerns noted by a C.N.A. and verify that appropriate follow up and documentation was completed by a licensed nurse as indicated. The licensed nurses will review clinical alerts including the stop and watch periodically through their shifts daily, to assist with identification of new skin concerns documented by the C.N.A's. For 90 days, the ADCS or designee will audit the weekly skin integrity review for 5 residents a week to verify completion, validate accuracy with a head-to-toe skin check, confirm that appropriate skin care orders are in place as applicable, and notification of the Healthcare was completed as applicable if skin concerns identified. These audits will be documented on an audit form. (continued on next page)

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	For 90 days, the ADCS or designee will audit 5 residents' wound care orders a week to verify treatments were completed per physician orders. These audits will be documented on an audit form and reported in the next morning stand up meeting. For 90 days, the DCS or designee will review the audits monthly at the QAPI meeting. Compliance date: 4/3/2024 An IJ was identified on 4/1/2024 and the facility was notified at 7:00pm. The IJ template was provided to the facility on [DATE] at 4:14pm. The Immediate jeopardy was removed on 4/4/2024 due to the facilities implemented actions that corrected the non-compliance. The surveyor monitoring was from 4/1/2024 to 4/4/2024. Immediate Jeapordy monitoring included: Record review on 3/13/2024 revealed a QAPI sign in sheets for 2/19/2024, 3/13/2024, 3/15/24, 3/20/2024, 3/27/2024 with sign in sheets in IJ book by Administrator, Infection preventionist/ADON, Medical Director (3/15/2024). Record review on 3/13/2024 of nurse's notes dated 2/20/2024 revealed the physician was notified immediately on 2/20/2024 at 1:51pm and orders implemented for wound care and wound care physician consulted. Record review on 3/13/2024 revealed staff in-services 2/20/2024 for Abuse and Neglect, the facility provided a copy of policy, Offloading and Repositioning, Skin observation and repositioning, 2/21/24 In-service included Hand Hygiene, Incontinent Care Cleansing, Signs and Symptoms of wound infection, Cleansing of Shared equipment, Handouts: Charge nurse responsibilities, Nursing Forms, Shift Report, Patient appointments and facility provided policy on infection control. Inservice 3/1/2024 Charge nurse responsibilities, 3/13/2024 Reporting new or progression of wound, 3/21/2024 Wound care paperwork, 3/25/2024 Infection Control. Facility provided policy. 3/25/24 Order Confirmation from Physician/NP. Record review on 3/13/2024 revealed wound care physician visit on 2/22/2024 Record review on 3/13/2024 of physician orders dated 2/23/2024 15:00 were updated to include Santyl Ointment as part of the residents wound care regimen. Record review on 3/13/2024 revealed staff were in-service 3/13/2024 Reporting New or Progression of Wound: CNAs t report new or worsening wounds to charge nurse immediately, Charge nurse to report new or worsening wounds to Physician/NP to receive wound care orders immediately, Charge nurse should place call to Director of Clinical Services or Assistant Director of Clinical Services to inform of New or worsening wound identified. Record review on 3/13/2024 revealed skin assessments performed on 2/21/2024 to 2/23/2024 and 3/13/2024. Record review 4/3/2024 revealed Woundcare Orders and Treatment audit for March 2024 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review on 4/3/2024 revealed staff were in-serviced 4/2/2024 and 4/3/2024 for Physician notification for new skin issue, change of condition documentation, and CNAs and dressing changes. In-service included CNAs should never apply Zinc oxide to patients' body, change a wound dressing and if the dressing comes off during a shower or bath the CAN needed to notify the nurse to put a new dressing on the wound. The in-service was followed by a post test for CNA's. Record review on 4/3/2024 revealed staff were in-serviced 4/2/2024 for Skin observation/Wound prevention; facility provided policy. Record review on 4/3/2024 revealed audits on 4/2/2024 for residents admitted within the last 30 days for new pressure ulcers and notification to healthcare provider. Audit consisted of reviewing the weekly skin integrity forms, admission assessment and weekly wound data forms. Wound physician progress notes as indicated. No additional findings. Record review on 4/3/2024 revealed weekly skin integrity reviews for February 2024 and March 2024 revealed no new or worsening wounds. Observation of wound care on 4/3/2024 11:45am on Resident #6. Resident #6 noted to be on a low air loss mattress. Nurse washed hands, donned gloves, removed dressing, removed gloves, applied hand sanitizer . donned gloves, wiped wound from inside to outside with gauze impregnated with wound cleanser, removed gloves, hand sanitizer, donned gloves, patted are around wound for adhesion, removed gloves, hand sanitizer, applied calcium alginate and bordered dressing. Dated. Noted wound was healthy and healing, It appeared sacral wound had been larger at one time but now wound small, healthy red with granulation tissue. In an interview on 4/2/2024 at 12:47pm LVN E said she had been in-serviced a few times on wounds and wound care, she said she had been in-service the previous night on reporting new wounds to the physician, letting the unit manager and ADON know, calling the physician for orders and letting them know about changes in condition and weekly skin data. Interview on 4/2/2024 at 12:53pm CNA P said she was not supposed to change dressings on a resident, she said she was supposed to report missing or damaged dressings to the charge nurse or DON and document in the system who she told. Se said she would have reported skin breakdown to the charge nurse or DON, she said she had been in-service today, last week on wounds, change of condition, not to use zinc oxide and moisture barrier. Interview on 4/2/2024 1:00pm CNA Q said he had been in-service on wounds and wound care that morning. He said reporting wounds, new skin issues, not to change dressings, role as a CNAs, and when he saw redness or wounds to report and document in the system. He said he would have reported to the nurse and ADON. Interview on 4/2/2024 at 1:05pm CNA R said she had been in-service that day on what to do and what not to do with wounds and who to report them to. She said not to have changed dressings and not to apply Zinc Oxide. She said they were in serviced on reporting wounds to the nurse or DON and documenting in PCC system. Interview on 4/2/2024 at 1:30pm LVN F said he had been i [TRUNCATED]

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47531 Based on interview and record review the facility failed to ensure that a resident reviewed for pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for 1 (Resident #1) of 5 residents. 1. Facility staff identified sacral wound on Resident #1 on 2/16/2024 and facility staff failed to perform and document a wound assessment, notify the physician, and obtain wound care orders until 4 days later on 2/20/2024. Wound Care Physician assessed Resident #1 on 2/22/2024 and diagnosed Resident #1 with an unstageable (Due to Necroses) Sacrum Full Thickness pressure wound with a surface area of 129.72 cm. 2. Facility staff were performing dressing changes without a physician's order. An IJ was identified on 4/1/2024. The IJ template was provided to the facility on [DATE] at 4:14pm. The Immediate jeopardy was determined to have been removed 4/4/2024 due to the facilities implemented actions that corrected the non-compliance. This failure could affect residents with impaired skin integrity and residents at risk for impaired skin integrity of developing life threatening infections, hospitalization , and worsening pressure ulcers. Findings included: Record Review of Resident #1's Face Sheet undated revealed an [AGE] year old female who was admitted on [DATE] with diagnoses of Other fracture of left femur (Bone that runs from hip to knee), subsequent encounter for closed fracture with routine healing (Unopen fracture), Encounter for other orthopedic after care (At facility for rehabilitation), Extended Spectrum Beta Lactamase (ESBL) resistance (Antibiotic resistant urinary infection), Urinary Tract Infection where urine is excreted), Morbid Severe Obesity due to excess calories, Type 2 Diabetes Mellites with Hyperglycemia (High blood sugar). Record Review of Resident #1's MDS dated [DATE] revealed Resident #1 had a BIMS score of 9 indicating the resident was moderately cognately impaired, Resident #1 required extensive assistance with ADLs. Section I revealed fractures and other multiple trauma, urinary tract infection last 30 days, Swallowing Disorder, Risk of pressure injuries .yes, Unhealed pressure ulcers/Injuries yes .Unhealed pressure ulcers/injuries Yes .stage 1 .0 .Stage 2 .0, Stage 3 .0. Stage 4 .0 Unstageable deep tissue injury .1 .MASD (Moisture Associated Skin Damage). Record review of Resident #1's Care Plan dated 2/9/2024 read in part . Goal The resident will have no worsening of skin alteration . INTERVENTIONS: Monitor/document/report to MD changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size and stage. Record Review of Resident #1's Comprehensive Nursing notes dated 2/16/2024, 2/18/2024 and 2/19/2024 read no new or worsening skin conditions. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's orders dated 2/20/2024 read . Cleanse sacrococcygeal ulcer (Area above and center of buttocks) with NSS (normal saline), Pad Dry, apply calcium alginate (Fabric) and med honey (medication for healing) and cover with sacral dressing (area at top and center of buttocks) qd (daily). Record review of Resident #1's orders for Februrary 2023 and March 2023 revealed Resident #1 was not placed on antibiotics before she went to the hospital. Record Review of Resident #1's Change of Condition dated 2/20/2024 read in part . Skin status evaluation . pressure ulcer injury .Sacrum .unstageable pressure wound. Record review of Resident #1's orders dated 2/21/2024 read .Pressure Redistribution Mattress-Low air loss. Record review of Resident #1's wound care notes dated 2/22/2024 read in part . Unstageable (due to necroses) sacrum full thickness .Etiology .pressure .Duration >6 days wound size 14.1x9.2x0.1cm . Surface area 129.72 .Thick adherent devitalized necrotic tissue 90%. 3/2/2024 Family Member #1 removed Resident #1 from the skilled nursing facility and took her to the hospital due to the pressure wound on her sacrum. Record Review of Resident #1's hospital records dated 3/2/2024 to 3/11/2024 revealed Resident #1 was admitted to the hospital with diagnoses of Infected decubitus ulcer (Infection at buttocks), unspecified ulcer stage. 8.0 x 10.0 x Unstageable due to 80% adherent necrotic tissue. Resident underwent Incision and drainage of sacral wound on 3/5/2024, intraoperative cultures grew Protease mirabilis (Bacteria in Urine infections), ESBL E. coli MDR (Harder to treat with antibiotics) and Enterococcus faecalis Pan sensitive (Bacteria found in the intestine). Resident #1 was discharged with orders for IV Meropenem (Intravenous antibiotic) every 8 hours for 21 days. Interview 3/13/2023 10:30am with the Assistant Director Clinical Services said if a nurse found a wound and the skin was broken the expectations were to clean it, put a dry dressing on it and contact the Nurse Practitioner or Doctor for the findings and get and order for wound care. If that was not done the wound could have possibly deteriorated even more. She said they wanted staff to put in nursing interventions and needed them to offload from the wound. She said looking back they saw there was no notification to the physician and no orders for wound care for 2 days. She said they did rounds with the wound care physician so when the wound was found, they put interventions in place, making sure the wound care physician was notified, made sure the proper treatments were in place and notified the family. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 3/13/2024 at 1:20pm with LVN A she said she worked on 2/18/2023 in the evening. She said the weekend supervisor told her Resident #1 had a wound on her sacrum. She said she thought the weekend supervisor was going to manage everything. She said she did not necessarily say she was going to manage everything, she said she thought they were going to handle the wound together. She said she guessed it was her fault the physician was not called about the wound even the CNAs were telling her they were reporting it to previous nurses the day before on 2/17/2024. They said there were bandages on the wound already and there were bandages in the room. She said the CNAs that told her they were from the weekend shifts. They said the bandage fit on the specific part for the sacrum. She said the CNAs had been putting the bandage on the wound and said they had been reporting it to previous nurses. She said the weekend supervisor looked at the wound. She said she thought the supervisor was going to call the doctor. She said she had not worked at the facility in 2 or 3 weeks. She said she talked to the DON and ADON about the wound and they asked how it looked at the time, they wanted to know if it looked black at that time. She said the wound was large. She said no one had previously reported a wound to the sacrum. No one had reported a wound on Saturday. She said she had been a nurse for one year, worked at the facility for one month, and was in-serviced on wound care in February. Interview on 3/13/2024 at 2:00pm, CNA K said she remembered Resident #1. She said she came back from 5 days off and had her as a patient and when she was changing her, she saw she had redness and told her nurse. She said she could not remember the day when she first saw the redness on Resident #1. She said from then on, they started turning Resident #1 every 2 hours to get her off her bottom. She said this was on Wednesday February 21, 2024. She said when she saw the wound it was very large, very tender, obvious it had been there for a few days. She said the skin was broken. She said it was very vibrant colored, so she reported it to LVN B. She said she had been a CNAs for 10 months and worked at the facility for 5 months. She said prior to this happening she was in-serviced on wounds at a retirement home and was reminded at this facility. She said the facility had done an in-service. She said they had shown them how to add notes so they could have said they told the nurse about wounds and so the residents could have gotten treatment. Interview on 3/13/2024 at 2:50pm CNA L said she worked on Sunday 2/18/2024. She said she had only worked with Resident #1 a handful of times, and she was dead weight. She said when she got to Resident #1, she noticed a wound with no covering on her back side. She said another CNAs said she noticed it the day before on 2/17/2024, but she did not remember who it was. She said this had to have happened about a month ago if not more. She said the skin was broken off at the back and butt crack and she told the nurse but could not remember who on the morning shift. She said the wound looked pretty bad and looked like it would have stung. She said it was medium to large. She said they should have known about the wound if the CNA noticed it before her. She said it was a Sunday. She said she did not really know some of the nurses. She said she had worked at facility 7 months and been a CNA for 3 years. She said she was last in-serviced on skincare the prior weekend, and before that 3 months ago. Interview on 3/13/2024 at 3:55pm CNA M she said she wasn't at the facility at first but when she came back on February 16, 2024, she saw Resident #1 had a wound to her buttocks. She said she told the nurse it needed to be cleaned and it had an odor. She said the wound was open, large and had an odor. She said the skin was off the wound. She said she told the nurse LVN C about the wound, but she did not do anything about it because after that she got a call from the DON asking about the wound and when it started. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's Braden Scale for predicting pressure ulcer risk on 3/14/2023 read Resident #1 had slightly limited sensory perception, was bedfast, occasionally moist, made frequent though slight changes in body or extremity position independently, friction or shear was a potential problem, and the total score was above 16. (Mild risk for pressure ulcers). Interview on 3/14/2024 at 2:55pm with the Assistant Director Clinical Services she said they did investigations with the staff to figure the gaps on Resident #1's wound. She said she looked herself and the skin initially was intact. She said even the week prior the evening nurse showed on the 14th it was intact. She said it was Resident #1's positioning, nutrition, and incontinence, and it was a combination that caused the wound. She said she knew they were putting zinc on the wound. She said on Sunday February 20, 2024, the CNA had identified and informed the off going nurse 3 to 11 and she looked at it and told RN S. She said LVN A told RN S Resident #1 had skin breakdown and could she look at it look at it let her know. She said RN S said she would help LVN A if she needed it. According to the RN S she told the nurse to get the information and call the doctor. LVN A said she would call the doctor and get the order. It was he said she said. She said she had not heard anything about February 16th and when she did her weekly assessment on the 14th it was ok and there was no breakdown on the sacral area. She said the reason the resident had a sacral wound was because she had not been repositioned. She said when residents get sacral wounds, they can become infected. Unable to get an interview with RN S as she was terminated for not contacting the physician regarding the wound and obtaining orders for wound care. Interview on 3/14/2024 at 2:55pm with the ADON she said she did not know a CNA had reported skin breakdown to LVN C on 2/16/2024. She said on 2/18/2024 LVN A and RN S told her it was the others responsibility to call the physician. She said LVN C told her RN S would call the physician for orders and RN S said LVN A would call the physician for orders. She said RN S should have called the physician for orders for wound care as she was the person who reported to the oncoming staff. Interview on 3/15/2024 at 8:30am with the ADON she said the failure with Resident #1's wound was a combination of timely identification of the wound and not getting timely treatment in place. She said Resident #1 was being treated for ESBL (Antibiotic Resistant bacteria) and E. coli (Intestinal bacteria) in urine. She said Resident #1 had a slight decrease in mobility and it was their job to have repositioned her, to have been timely in reporting the wound, and she said the reason Resident #1 developed the wound was because she was not repositioned enough. She said she had been a part of the QAPI (Quality Assurance and Performance Improvement) subcommittee, with KPI (report to look at metrics and pressure ulcers) were worked on this year, she said this issue was disheartening, she said they had identified wounds and they had multiple sessions with the nurses. She said she thought the failure was communication regarding Resident #1. She said they educated the staff so when they saw something to report it. She said staff were to report skin breakdown instead of someone assuming it had already been reported. She said Resident #1 did not really want to be turned and Resident #1 could have gotten the wound by not being turned, she said Resident #1 needed assistance with turning. She said what should have happened was as soon as anything was different with Resident #1's skin, they should have reported to the charge nurse starting at the stage 1. She said staff should have notified charge nurse, notified wound care physician, and gotten orders for wound care. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 3/15/2024 at 6:46am CNA N said she worked the night shift last night. She said she had worked at the facility for [AGE] years and been a CNA for 20 plus years. She said she worked on the first floor. She said she saw Resident #1's wound. She said she saw her wound, but she was not assigned to her, but she did see it, she said she assisted with turning. She said when Resident #1 needed changing she would assist with changing her. She said Resident #1 would call and let us know when she was ready to be changed. She said Resident #1 was with it and she was coherent. She said she saw the bedsore and saw the wound as medium sized, she said they would have patches on it, they would clean it and put patches on it. She said she told the nurse about the wound, and they had so many since then she did not know the name of the nurse, she reported it to. She said she did not know if the ADON knew about the wound. She said she was sure she did, she said you can tell nurses about a wound but after that you do not know what happens. She said if a resident was not turned, they could have gotten a bedsore and it could have gotten larger. She said it could have gotten infected. She said she did not know how Resident #1 got the bedsore but had been shocked to hear about it and said she saw it when it was smaller. Interview on 3/15/2024 7:31am with LVN D she said she had worked at the facility for about 5 weeks. She said she had been a nurse for 2 years. She said she saw the wound on Resident #1's sacrum. She said the wound was unstageable when she saw it. She said it was red around the perimeter and black on the inside. She said she did not believe the CNA reported the wound. She said it was Friday February 16, 2024. She said she believed there was a dressing on the wound on Friday February 16, 2024. She said she did not know it had not been reported to the physician as they each had a list of comprehensive nursing notes to write, and she had not documented on her. She said the CNA told her there was a wound and it was not dirty. She said she did not call the physician. She said they do skin checks on the 7 to 3 and 3 to 11 shifts so they would have called and received an order as she worked nights. She said she found a wound on Resident #1's inner thigh the following week and called the wound care physician and received an order for that. She said if a resident had a bedsore, they could get an infection and have pain. She said she did not know how long Resident #1's sacral wound had been there. Interview on 3/15/2024 at 7:33am with CNA O she said she had worked at the facility since October 2023, she said she would have been a CNA for a year in May 2024. She said she had seen the wound on Resident #1's sacrum and reported it to the nurse. She said she reported it to LVN D because the bandage was soiled, and she took it off so that LVN D could replace it. She said LVN D came in and replaced the bandage. She said she saw the wound after Valentines Day February 14, 2024, on Thursday or Friday. She said she did not work on weekends, so it was on Thursday February 15, 2024, or Friday February 16, 2024. She said it was not the week of February 23, 2024. She said if a resident was not turned, they could have gotten a bedsore, the bedsore could have gotten worse, and the resident could have gotten an infection. Record Review of facilities policy titled, Skin Observation and Wound Prevention Protocol dated 10/2022 read in part . Charge nurses should observe the condition of the resident's skin on admission and on a routine basis. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record Review of facilities policy titled, Change of Condition for Skilled Nursing Communities dated 8/2023 read in part .An associate should communicate information about a residents status change to appropriate licensed personnel upon observation .or observing a difference in the residents usual physical .the licensed nurse should .notify the HCP (Healthcare provider) of observations and relevant change of condition information .Implement treatment interventions, received orders and document HCP recommendations as indicated . Record Review of Facility In-Service dated 2/2/2024, 2/3/2024 and 2/7/2024 .Topic .Annual Charge Nurse Check-off Training read in part . Importance of pressure wound prevention .Doctors, On-call, Telehealth. Record Review of Facility In-Service dated 2/20/2024 .Topic . Offloading/Repositioning read in part . Repositioning patients throughout shift to offload bony prominences .offload areas at risk for breakdown . Record Review of Facility In-Service dated 2/21/2024 .Topic .Infection Control read in part . Signs and Symptoms of wound infection: Swelling, Redness, Slight odor, increased pain at wound site . Record Review of Facility In-Service dated 3/13/2024 .Topic .Reporting New or Progression of Wound read in part .CNA to report New or Worsening wounds too Charge nurse immediately .Document Change in Skin Condition in PCC using Stop-N-Watch Tool .Charge Nurse to report New or Worsening wounds to Physician/NP to receive wound care orders immediately .Charge Nurse should place call to DCS (Director Clinical Services) or ADCS (Associate Director Clinical Services) to inform of New or Worsening wound identified. An IJ was identified on 4/1/2024 and the facility administrator was notified at 7:00pm. The IJ template was provided to the facility on [DATE] at 4:14pm. On 4/3/2024 at 4:40pm the following Plan of Removal was accepted. On 2/19/2024, an impromptu Quality Assurance Performance Improvement (QAPI) Meeting was completed with the Healthcare Administrator (HCA), Director of Clinical Services, Assistant Director of Clinical Services (ADCS), and Medical Director via the phone related to the Skin Management Process related to Resident # 1 skin documentation. The additional actions included re-education to Certified Nursing Assistance (C.N.As) and Licensed Nurses on repositioning and abuse neglect reporting. Re-education for Licensed Nurses on skin assessments, Skin observation protocol (which includes notification of healthcare provider), repositioning, and wound prevention. These Inservice's were completed on 2/20 by the ADCS. On 2/20/2024, the ADCS and Attending Physician assessed the wound to Resident #1's sacrum and new orders received by the attending physician for medical honey and calcium alginate, supplements, and a low air loss mattress. On 2/22/2024 the Third Party Wound Doctor assessed the sacral wound; orders were updated to include Santyl. On 2/22/24, the ADCS performed wound rounds on current residents with wounds. No new pressure concerns were noted. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 3/2/24, Resident # 1 discharged from the community. On 3/13/24, an Impromptu QAPI Meeting held with the HCA, ADCS, Regional Director of Clinical Services (RDCS), and the Medical Director via the phone related to the Skin Management Process. The additional actions included the ADCS or designee to extend the audits of 5 residents dressing to be completed weekly for 90 days, review residents that would benefit from a Low Air Loss Mattress, complete skin checks on current residents, and re-education to C.N.A's and Licensed Nurses to notify the DCS or ADCS on new pressure ulcers. On 3/13-3/14/24, the ADCS and/or designee completed skin checks on current residents. No new pressure concerns were noted. On 3/14/24, a Registered Nurse (RN) performed a remote Skin Documentation Audit. The audit included the following items. The audit was documented on an audit form. o Weekly Skin Integrity Review form to ensure every resident had either the weekly skin form or the section completed in the Nursing Admission Data Collection form, if newly admitted . o That every resident had a weekly skin integrity review activated schedule to be completed weekly in PCC. Form scheduled as needed in PCC. o Weekly Wound Data Collection form if completed, the date, and information in the form. o Third Party Wound Care MD notes in PCC Miscellaneous tab with notes on wounds (location, etc.) o Third Party Wound Care MD orders from their notes on wounds from bullet above. o Physician orders written in PCC for wounds, or anything related to skin. o Care Plans related to wounds. Plan for Compliance From 3/13/- 3/16/2024, the DCS or designee re-educated all Licensed Nurses on change of condition documentation which includes notifying physician and representative, skin documentation, obtaining orders for any wounds, reviewing and addressing clinical alerts on skin concerns from C.N.A's, notifying provider as indicated, professional standards of wound care, that the C.N.A can't apply a treatment, Braden Scale which includes preventative measures. Licensed nurses not available between 3/13/2024 to 3/16/2024 received re-education by the DCS or designee before their next scheduled shift and this will include new hires hired after 3/16/2024. Competency validated with a post test. From 4/1 -4/3 the DCS or designee re-educated nurse on physician notification of new skin issues, change of condition documentation, aides performing dressing changes, skin observation and wound prevention protocol. Licensed nurses not available between 4/1 to 4/3 will receive re-education by the DCS or designee before their next shift, this will include new hires hired after 4/3. Competency validated with a post test. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675834	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Galleria	2929 Post Oak Blvd Houston, TX 77056

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Starting 3/14/24, the Licensed Nurses will initiate the wound data collection sheets on any new pressure ulcers. The RAI or designee will update resident care plans as needed as new pressure concerns arise. The Licensed Nurse will review the clinical alerts in the dashboard periodically through the shift to verify that any new skin concerns communicated by the C.N.A are addressed. The ADCS or designee overseeing will complete the weekly wound data collections for residents with new pressure ulcers until pressure ulcer is resolved or the resident is discharged . Order listing report, progress notes, weekly skin and wound documentation is reviewed during daily standup for any new or worsening pressure ulcers. From 3/13- 3/16/24, the ADCS or designee re-educated all C.N.A.s on communication of changes in skin integrity with the licensed nurse and DCS or ADCS, documentation of any new skin concerns in the electronic medical record every shift including the stop and watch, what to do if dressing falls off the resident's wound, moisture barriers, and turning and repositioning. The C.N.A may complete a Stop and Watch Alert that there is a Change in skin color or condition as indicated. These alerts display on the licensed nurse clinical alert dashboard in the electronic medical record. The C.N.A will also communicate verbally to the licensed nurse what they documented in the electronic medical record related to new skin concerns. The C.N.A. will contact the DCS, ADCS, or the Healthcare Administrator to report new skin issue for additional follow up. C.N.A s not available between 3/13- 3/16/23 received re-education by the DCS or designee before their next scheduled shift and this will include new hires hired after 3/16/24. Competency validated with a post test. From 4/1 to 4/3 C.N.A. were re-educated on C.N.A. not performing dressing changes and are allowed to apply barrier cream, reporting changes in skins and wound prevention. Aides not available between 4/1 to 4/3 will receive re-education by the DCS or designee before their next shift, this will include new hires hired after 4/3. Competency validated with a post test. For 90 days, the DCS or designee will review clinical alerts in stand-up meeting five days a week, to determine if there is documentation of new skin concerns noted by a C.N.A. and verify that appropriate follow up and documentation was completed by a licensed nurse as indicated. The licensed nurses will review clinical alerts including the stop and watch periodically through their shifts daily, to assist with identification of new skin concerns documented by the C.N.A's. For 90 days, the ADCS or designee will audit the weekly skin integrity review for 5 residents a week to verify completion, validate accuracy with a head-to-toe skin check, confirm that appropriate skin care orders are in place as applicable, and notification of the Healthcare was completed as applicable if skin concerns identified. These audits will be documented on an audit form. For 90 days, the ADCS or designee will audit 5 residents' wound care orders a week to verify treatments were completed per physician orders. These audits will be documented on an audit form and reported in the next morning stand up meeting. For 90 days, the DCS or designee will review the audits monthly at the QAPI meeting. Compliance date: 4/3/2024 The surveyor monitoring was from 4/1/2024 to 4/4/2024. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review on 3/13/2024 revealed a QAPI sign in sheets for 2/19/2024, 3/13/2024, 3/15/24, 3/20/2024, 3/27/2024 with sign in sheets in IJ book by Administrator, Infection preventionist/ADON, Medical Director (3/15/2024). Record review on 3/13/2024 of nurse's notes dated 2/20/2024 revealed the physician was notified immediately on 2/20/2024 at 1:51pm and orders implemented for wound care and wound care physician consulted. Record review on 3/13/2024 revealed staff in-services 2/20/2024 for Abuse and Neglect, the facility provided a copy of policy, Offloading and Repositioning, Skin observation and repositioning, 2/21/24 In-service included Hand Hygiene, Incontinent Care Cleansing, Signs and Symptoms of wound infection, Cleansing of Shared equipment, Handouts: Charge nurse responsibilities, Nursing Forms, Shift Report, Patient appointments and facility provided policy on infection control. Inservice 3/1/2024 Charge nurse responsibilities, 3/13/2024 Reporting new or progression of wound, 3/21/2024 Wound care paperwork, 3/25/2024 Infection Control. Facility provided policy. 3/25/24 Order Confirmation from Physician/NP. Record review on 3/13/2024 revealed wound care physician visit on 2/22/2024 Record review on 3/13/2024 of physician orders dated 2/23/2024 15:00 were updated to include Santyl Ointment as part of the residents wound care regimen. Record review on 3/13/2024 revealed staff were in-service 3/13/2024 Reporting New or Progression of Wound: CNAs t report new or worsening wounds to charge nurse immediately, Charge nurse to report new or worsening wounds to Physician/NP to receive wound care orders immediately, Charge nurse should place call to Director of Clinical Services or Assistant Director of Clinical Services to inform of New or worsening wound identified. Record review on 3/13/2024 revealed skin assessments performed on 2/21/2024 to 2/23/2024 and 3/13/2024. Record review 4/3/2024 revealed Woundcare Orders and Treatment audit to for March 2024 Record review on 4/3/2024 revealed staff were in-serviced 4/2/2024 and 4/3/2024 for Physician notification for new skin issue, change of condition documentation, and CNAs and dressing changes. In-service included CNAs should never apply Zinc oxide to patients' body, change a wound dressing and if the dressing comes off during a shower or bath the CAN needed to notify the nurse to put a new dressing on the wound. The in-service was followed by a post test for CNA's. Record review on 4/3/2024 revealed staff were in-serviced 4/2/2024 for Skin observation/Wound prevention; facility provided policy. Record review on 4/3/2024 revealed audits on 4/2/2024 for residents admitted within the last 30 days for new pressure ulcers and notification to healthcare provider. Audit consisted of reviewing the weekly skin integrity forms, admission assessment and weekly wound data forms. Wound physician progress notes as indicated. No additional findings. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review on 4/3/2024 revealed weekly skin integrity reviews for February 2024 and March 2024 revealed no new or worsening wounds. Observation of wound care on 4/3/2024 11:45am on Resident #6. Resident #6 noted to be on a low air loss mattress. Nurse washed hands, donned gloves, removed dressing, removed gloves, applied hand sanitizer . donned gloves, wiped wound from inside to outside with gauze impregnated with wound cleanser, removed gloves, hand sanitizer, donned gloves, patted are around wound for adhesion, removed gloves, hand sanitizer, applied calcium alginate and bordered dressing. Dated. Noted wound was healthy and healing, It appeared sacral wound had been larger at one time but now wound small, healthy red with granulation tissue. In an interview on 4/2/2024 at 12:47pm LVN E said she had been in-serviced a few times on wounds and wound care, she said she had been in-service the previous night on reporting new wounds to the physician, letting the unit manager and ADON know, calling the physician for orders and letting them know about changes in condition and weekly skin data. Interview on 4/2/2024 at 12:53pm CNA P said she was not supposed to change dressings on a resident, she said she was supposed to report missing or damaged dressings to the charge nurse or DON and document in the system who she told. Se said she would have reported skin breakdown to the charge nurse or DON, she said she had been in-service today, last week on wounds, change of condition, not to use zinc oxide and moisture barrier. Interview on 4/2/2024 1:00pm CNA Q said he had been in-service on wounds and wound care that morning. He said reporting wounds, new skin issues, not to change dressings, role as a CNAs, and when he saw redness or wounds to report and document in the system. He said he would have reported to the nurse and ADON. Interview on 4/2/2024 at 1:05pm CNA R said she had been in-service that day on what to do and what not to do with wounds and who to report them to. She said not to have changed dressings and not to apply Zinc Oxide. She said they were in serviced on reporting wounds to the nurse or DON and documenting in PCC system. Interview on 4/2/2024 at 1:30pm LVN F said he had been in-service on 4/1/2024 on wound care, who to notify, progress notes, handwashing, and infection control. He said he would have initially let the primary physician and the wound physician know about the wound. He said when a resident had a wound to let the doctor know and get orders and follow them, he said he would have let the DON and unit manager know. In an interview on 4/2/2024 at 1:50pm CNA S said he had been in-service on wounds and wound care. He said CNAs were not to change dressings and not to use ZINC. He said they were supposed to report wounds to the nurse, the ADON and document in PCC. Interview on 4/2/2024 at 2:00pm RN T [TRUNCATED]