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	12/17/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41469 Based on interview, and record review, the facility failed to ensure 1 of 6 residents (Resident #1) reviewed for wound care received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent new ulcers from developing, in that: - The facility failed to identify a healed area to Resident #1's sacrum which included a scab and pink skin when Resident #1 admitted to the facility on [DATE]. Appropriate interventions were not implemented for Resident #1 and the area developed into a pressure ulcer within approximately 12 days of admission and eventually developed into a Stage IV pressure ulcer. - CNA B stated she did not reposition the resident frequently enough while working with Resident #1 upon her first few days admission. This failure placed residents with low skin integrity at risk for skin breakdown or failure of wounds to heal. Findings included: Resident #1 Record review of Resident #1's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses of fracture of head and neck of left femur, and Alzheimer's disease. Record review of Resident #1's admission MDS , dated 08/15/2024 reflected no BIMS score as resident was assessed to be never/rarely understood. Resident #1's MDS also reflected her need for touching assistance/supervision for eating and substantial/maximal assistance for bed mobility. The resident was also assessed to be at risk of pressure injuries and was noted to have a surgical wound. Record review of Resident #1's care plan, dated 11/18/2024, reflected resident, .has a Stage IV pressure ulcer to sacrum w/ potential for pressure ulcer development [related to] impaired mobility ., with interventions including dietary supplementation, low air loss mattress, assisting with turning and repositioning as needed (starting 08/08/2024), and monitoring effectiveness of wound treatment. (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's hospital discharge summary, dated 08/08/2024, reflected the resident had a pressure injury to right buttocks starting 08/04/2024 and an incision wound to left hip starting on 08/05/2024. Record review of Resident #1's progress notes, dated 08/08/2024 at 6:39PM revealed LVN C wrote an admission note documenting , .Resident non-verbal and unable to participate in medical history . Needs assistance with eating and drinking . Resident observed with surgical site to left hip . There were no other skin concerns disclosed in her notes. Record review of Resident #1's TAR, dated August 2024, reflected the resident was ordered remedy clinical silicone barrier cream twice a day for preventative treatment with each incontinence episode starting 08/13/2024. The TAR also reflected resident was later ordered clinical zinc paste every shift for skin care preventative with each incontinence episode starting 08/15/2024. Record review of Resident #1's TAR, dated August 2024, reflected the resident was ordered : - wound care to left inner buttock starting on 08/18/2024 and ending on 08/19/2024. - wound care to sacrum starting on 08/20/2024 and ending 09/14/2024. Record review of Resident #1's wound doctor's assessment, dated 08/16/2024, revealed the resident had: - a non-pressure wound on sacrum full thickness, measuring 1.3 X 4.1 X 0.1cm = 5.33cm squared surface area with a duration of greater than three days, and etiology being trauma/injury from a transfer. The resident was recommended zinc ointment once daily, cleansing wound at time of dressing change, and off-loading wound. Record review of Resident #1's wound doctor's assessment, dated 08/22/2024, revealed the resident had: - a non-pressure wound on sacrum full thickness, measuring 2.2 X 4.1 X 0.1cm = 9.02cm squared surface area. Resident was ordered a dressing treatment plan and was recommended to have wound cleansed at time of dressing change, off-load wound, turn side to side in bed ever 1-2 hours, a low air loss mattress and vitamin C supplementation. Observations of Resident #1 on 11/21/2024 at 8:25AM, revealed the resident was in bed being fed by a CNA. Resident #1 was lying on a low air loss mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In a phone interview with LVN C on 11/22/2024 at 2:44PM, she stated all nurses do their own wound care because there is no dedicated wound case nurse. She stated Resident #1's skin was not open on admission, but appeared to only have what looked like a healed, pink-colored scab on her buttocks that was not open. She stated she could not recall documenting the pink skin but after some time of being there she was told it had reopened. She stated in the beginning of Resident #1's stay, the resident had a regular mattress and she was not asked for help by her aides to reposition the resident but the aides repositioned the resident themselves. She stated immobility and poor nutrition can both contribute to skin breakdown and turning every two hours could help prevent further skin breakdown. She stated that she believed there was not a risk in not reporting scabs found on the resident because the skin was technically open. She stated she was not told by any nursing aides that Resident #1's skin was opening. In a phone interview with CNA D on 11/25/2024 at 9:08AM, she stated when Resident #1 first came to the facility, her bottom was clear. She said she eventually noticed skin breakdown on the resident's bottom and notified her nurse. She stated initially the resident, who unable to turn herself, did not have an air mattress and she did not help reposition her outside of the times she provided the resident with incontinent care because the resident was getting in her wheelchair and going to therapy. She stated she started repositioning her more often using pillows and wedges only after the skin breakdown started. She stated the resident likely developed the skin breakdown because she was not being turned as much. She also stated she knew that residents with bed immobility were supposed to be repositioned every two hours once they came in, but she did not know where to reference what care, such as repositioning, should be provided to certain residents. She stated she felt that she could only discover the level of care residents needed only after interacting with the residents because she is not told that information upfront by the nurses. In an interview with the DON on 12/03/2024 at 9:42AM, she stated LVN C should have noted the pink scab she found on Resident #1 upon admission considering that finding could indicate vulnerability of the patient's skin. This could have possibly led to more preventative measures being put in place at an earlier time for Resident #1 to help prevent further skin breakdown. In a phone interview with the DON on 11/25/2024 at 7:40PM, she stated for Resident #1, they had interventions in place from the start to prevent skin breakdown, including application of barrier cream by nurse aides and zinc ointment by nurses after incontinent care. She stated the goal was to use frequent incontinent care, barrier ointment and repositioning as interventions to maintain skin integrity and the air mattress was introduced later as an additional intervention due to the ineffectiveness of the initial interventions. She stated nurse aides have been inserviced and audited on their knowledge to refer to the Kardex for resident ADLs such as frequent repositioning which is also listed in the care plan. She stated she believed aides are providing changing in a timely manner to their residents but did not believe repositioning was being done every two hours exactly. She believed Resident #1's issues with hydration, nutrition and immobility following fracture likely contributed towards her skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview phone interview with the Wound Physician on 11/26/2024 at 1:36PM, she stated the history came out that Resident #1 did have a pre-existing wound before and it was communicated in hospital's documentation. She stated they saw documentation on hospital documents saying that she had a wound before. She stated she is not sure if the nurse who initially did the skin assessment captured it. She stated she did not what to say whether Resident #1's sacral wound was avoidable or unavoidable because of the resident's issues with nutrition and overall she has had good progress so far. She stated since the wound was identified and treated, the resident has done well. She said a couple of weeks there was a stall related to the nutrition intervention, while talking with the family about placing a G-tube, but the resident had improved her nutrition status overtime. In terms of all the components being optimized she would say they optimized everything. She stated if there was a wound present before in the same location, there would always be a risk of the wound reopening, but the resident was already on an air mattress during her first evaluation of her. She stated she typically recommended air mattresses for residents with a Stage III or higher, and they look at immobility as a factor. She said if the staff were changing the position every 2 hours, there would be no reason for an air mattress. If the resident is declining and cannot reposition themselves, that is when they need the air mattress. Record review of the facility's policy and procedure on, dated March 2009, reflected, Charge nurse should: 1> Complete physical observation, documenting findings within the admission data collection form. If a wound is present on admission the Charge Nurse should initiate and describe the wound on the Weekly Wound Data Collection Sheet . 4. Initiate treatment intervention. 5. Initiate plan of care . Update plan of care with each intervention. The Certified Nursing Assistant (CNA) should: a. Complete documentation of new skin concerns as identified in Point of Care and notify the nurse as indicated . c. Provide skin care during routine care. D. Apply moisturizing creams, barrier products per the plan of care and scope of practice .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44591 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 1 of 1 resident (Resident #1) reviewed for infection. -The facility failed to ensure RN B performed hand hygiene during wound care for Resident #1. This failure could lead to the spread of infection to residents. Finding included: Record review of the admission sheet (undated) for Resident #1 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Fracture of left femur, history of falling, presence of left artificial hip joint, hypertension (a condition in which the force of the blood against the artery walls is too high). Record review of Resident #1's Entry MDS, dated [DATE], revealed there was no section for BIMS score, functional status, urinary incontinence, and bowel incontinence . Record review of Resident #1's care plan, initiated 08/08/2024 revealed the following: Care Plan Description: Potential for and actual impairment to skin integrity related to impaired mobility, blister to upper right buttock and pressure injury to left buttock. Date Initiated: 11/18/24. Care Plan Goal: The resident will have no worsening of skin alteration through review date. Intervention; Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to MD. Record review of Resident #1's physician order dated 11/22/24 revealed an order to cleanse sacrum with normal saline, pat dry with gauze, use alginate rope to pack wound, collagen powder and cover with Opti-foam dressing. Observation on 11/22/24 at 08:38 am, revealed RN B provided Resident #1 with wound care. RN B was assisted by Unit Manager LVN P. RN B gathered the supplies at the treatment cart in the hallway before bringing them into Resident #1's room. Supplies included 1 bottle normal saline, 4 packages of 4x4 gauze, 1 package Maxorb II alginate, 1 package Opti-foam, 1 tongue depressor and three cups. Closed curtain for privacy and assisted resident on to her left side. LVN P held the resident on her left side, unfastened the resident's brief. RN B removed the resident's brief and dated sacral area wound dressing and placed in the garbage can at bedside. Continued observation revealed an open area of approximately 2-3 centimeters in diameter. RN B applied/cleaned with damp 4x4's the skin around wound, applied other 4x4's and applied/cleaned inside the wound, the applied/dried inner and outer wound area. Without washing/sanitizing hands or changing gloves, she placed collagen powder around and into the wound, then handled and applied alginate rope into wound with tongue depressor, placed Opti-foam over wound without washing/sanitizing hands or changing gloves. RN B completed wound care with the same soiled gloves on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/22/2024 at 11:07 am, RN B stated washing/sanitizing hands was important to protect resident from infection. RN B reported she should have washed/sanitized her hands, placed clean gloves on after removing dirty dressing and prior to providing wound care with new wound dressing. RN B stated she doesn't know why she didn't remember to wash/sanitize her hands after removing dirty dressing/brief and before providing wound care treatment. Reports wound care training and infection training were performed with in the last month. In an interview on 11/22/2024 at 11:36 am, LVN P, she stated washing/sanitizing hands was important to protect resident from infection. LVN P reported RN B should have washed/sanitized her hands after removing dirty brief and sacral dressing prior to providing wound care with new dressing. Reports wound care training and infection training was performed with in the last month. In an interview on 11/22/2024 at 11:50 am, the DON stated it is important to wash/sanitize hands, place gloves on, obtain supplies, clean tabletop, provide protective barrier. Wash/sanitize hands, place on gloves, remove old dressing, wash/sanitize hands place gloves on, clean wound, wash/sanitize hands, place gloves on, provide treatment to wound, cover with dressing. The DON reported washing/sanitizing hands is important to protect resident from infection, she reported RN B should have washed/sanitized her hands prior to providing wound care with new wound dressing and thinks RN B may have been nervous while being observed. The DON reports wound care training and infection training was performed with in the last month. The DON said the expectation was to maintain infection control throughout the process. She said staff received in-service on infection control once or twice a month. She said nurses was provided training and competency check offs annually and as needed if noted concerns. The DON said she did do another competency check off and in-service with RN B. Record review of facility's Infection Prevention and Control Program dated (Revised July 2018) read in part: . Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Record review of facility's Wound Care Competency revised 02/2020 for RN B performed on 11/22/2024 read in part: . 5. Pull glove over dressing and discard into appropriate receptacle. Perform hand hygiene. 6. Put on gloves. 11. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with wound cleanser or normal saline. 12. Perform hand hygiene. 13. Apply treatments as indicated. Record review of facility's Procedure: Wound Care . 5. Pull glove over dressing and discard into appropriate receptacle. Perform hand hygiene. 6. Put on gloves. 11. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with wound cleanser or normal saline. 12. Perform hand hygiene. 13. Apply treatments as indicated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's Handwashing/Hand Hygiene policy dated (October 2015 Last revised 01/2021) read in part: .Policy Overview: This community considers hand hygiene the primary means to prevent the spread of infections. Policy Detail: B. All associates shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other associates, residents, and visitors. C. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for associates use to encourage compliance with hand hygiene policies. G. CDC recommends using Alcohol Based Hand Sanitizer with 60-95% alcohol in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water during routine resident care. 7. Before handling clean or soiled dressings, gauze pads, etc.; 8. Before moving from a contaminated body site to a clean body site during resident care;10. After contact with blood or bodily fluids;11. After handling used dressings, contaminated equipment, etc.