STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675877	A. Building B. Wing	01/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Health Care Center	301 W Randol Mill Rd Arlington, TX 76011

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 - Few	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** Based on observation, interview, and record review, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for one (Resident #1) of four residents reviewed for physician notification. The facility failed to notify Resident #1's physician when there was a significant change in her wound status on 12/22/25. The resident was sent out on pass with her family on 12/25/25. The RP took her to the hospital the same night and was told the resident had sepsis due to an infection of the wound. The resident did not recover and passed away on 01/03/26. On 01/08/26 at 5:10PM, an Immediate Jeopardy (IJ) was identified, and the Administrator was notified. While the Administrator was notified that the IJ was removed on 01/10/26 at 12:15PM, the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of deterioration of their wound if the physician is not notified of changes in wound status.Findings included: Record review of Resident #1's Quarterly MDS Assessment, dated 11/26/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMs score was 9. Her cognitive skills for daily decision-making was moderately impaired. Her diagnoses included cancer, heart failure, and sepsis. The resident was at risk for pressure ulcers. The resident did not have a pressure ulcer. Record review of Resident #1's Care Plans reflected:12/09/25 Resident was at risk for skin alterations. Unstageable to the buttock.Facility interventions included:Monitor site for signs/symptoms of infection, monitor for effectiveness of treatment, notify the physician as needed, and perform weekly skin assessments. Record review of Resident #1 Physician Order Summary Report for December 2025 reflected:12/18/25: Cleanse coccyx with wound cleanser or normal saline, pat dry, apply collagen, cover with dry dressing one time a day for wound care. Record review of Resident #1 Treatment Administration Record for December 2025 reflected that the wound treatment was not completed on 12/19/25. LVN C treated the wound on 12/20/25-12/21/25. The WCN treated the wound 12/22/25 - 12/25/25. Record review of Resident #1's progress notes reflected:Effective Date: 12/18/25 1:30 PM Skin Check .Skin Issues Note: reopen wound to sacrum, open areas to left and right buttocks. Skin issue education: Treatment of skin issue. Skin issue education: Turn every 2 hours. - LVN A Effective Date: 12/22/25 3:24 PM Type: Skin/Wound Note: Note Text: Sacral pressure injury assessed and treated per order. Wound cleansed and dressing changed. Peri wound skin protected. Patient repositioned and tolerated well. - WCN Date of Service: 12/24/2025 Visit Type: Skin and Wound Note: .Information necessary for today's visit was obtained from the patient, nursing staff, per patient's medical record. Reason for visit: first evaluation of existing wound patient by new wound care team. 12/24/2025: Received new consult to assess resident for (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 - Few	sacrum pressure ulcer. WOUND ASSESSMENT:Wound: 1Location: CoccyxPrimary Etiology: Pressure Ulcer/InjuryStage/Severity: Unstageable (Pressure ulcer that cannot be staged due to the large amount of dead tissue on the ulcer)Wound Status: First Evaluation of existing wound by new ProviderOdor Post Cleansing: Malodorous (bad smell)Size: 4.5 cm x 4.5 cm x 3.5 cm. Calculated area is 20.25 sq cm.Wound Base: . 40% granulation (indicates percentage of wound that is healing), 40% slough (the percentage of dead tissue in the wound), 20% eschar (percentage of dead tissue in the wound that is black in color)Exposed Tissues: Dermis, SubcutaneousWound Edges: AttachedPeri-wound (area around the wound): Ecchymosis (type of bruise), Fragile, Non-blanchable (indicates structural problems in the tissue), maroon discolorationExudate (drainage): Moderate amount of Serosanguineous (watery, pink, drainage). PROCEDURES:A sharp debridement (procedure to cut away dead tissue) was not performed today due to this is the first evaluation of the patient and further plan for debridement will be reviewed as part of the care plan. An autolytic (assists in healing of wound) dressing is in place. WOUND TREATMENT:Wound # 1 Coccyx Pressure Ulcer/InjuryTreatment Recommendations:1. Cleanse with 0.125% Dakins solution (antiseptic solution for wounds).2. apply Iodoform packing strip (antiseptic dressing strips) to base of the wound.3. secure with superabsorbent (dressing).4. change Every other day, and PRN. - Wound Care Nurse Practitioner Effective Date: 12/25/25 9:12 AM Type: Nurse's Note Note Text: Resident stable RP here pick up the resident and left for Christmas cerebrations, left with portable Oxygen machine and the charge. - LVN A Review of Resident #1's Hospital Records reflected:12/25/25 6:24 PM Emergency Department Physician Note: .Skin: Wound check: unstageable decubitus noted to coccyx with foul odor and necrotic tissue. - Emergency Department PhysicianThe remaining hospital records were requested by the State Surveyor and were not received. An observation of Resident #1's wound picture, dated 12/25/25, on 01/08/26 at 11:10 AM revealed the resident had a large, open, dark, unstageable pressure ulcer to her coccyx. The wound had necrotic tissue and was packed loosely with a dressing, possibly iodoform. The wound was a dark brown color. Unable to determine depth and size. The ulcer looked to be about the size of an orange. The tissue around the wound was a deep red color. The resident also had a Stage II pressure ulcer on her right, lower buttock that was open, red, and approximately the size of a quarter. An interview was conducted with the Responsible Party for Resident #1 on 01/08/26 at 11:15 AM. The Responsible Party said they took Resident #1 home for a holiday dinner on 12/25/25. The Responsible Party said the facility told her the resident had a hot spot on her bottom and were treating it. The facility did not tell her the severity of the wound. The Responsible Party said on the night of 12/25/25 they saw the wound and immediately took the resident to the hospital. The Responsible Party said the resident had sepsis possibly due to the wound and ultimately passed away. An interview on 01/08/26 at 10:45 AM with the WCN for Resident #1 revealed she started employment at the facility on 12/15/25. She said she was notified on 12/18/25 that Resident #1 had a wound, unknown location. The WCN said the Wound Care Nurse Practitioner saw the wound on 12/24/25. She said she notified the Responsible Party for Resident #1 about the wound on 12/24/25. An interview on 01/08/26 at 1:00 PM with the DON regarding Resident #1 revealed she never looked at the wound for Resident #1. An interview on 01/08/26 at 1:05 PM with LVN A and CNA B for Resident #1 revealed CNA B saw Resident #1's open wound on 12/18/25. He said he notified LVN A about the wound. LVN A said she did not measure the wound, but it was about the size of a dime. LVN A said she notified the WCN about the wound. LVN A said an order was obtained from the WCN and LVN A said she did not treat the wound because the WCN was at the facility. CNA B said following 12/18/25, the wound always had a dressing on it and he never visualized the wound after 12/18/25. LVN A said she never visualized the wound after 12/18/25. LVN A and CNA B said on 12/25/25 the wound had a dressing on it and they both assisted (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 into the car of the Responsible Party. An interview on 01/08/26 at 1:35 PM with the Wound Care Nurse Practitioner for Resident #1 revealed she said she ordered Dakin's solution to clean the wound and iodoform to pack the wound. She said she requested a wound culture but was told the facility did not have wound culture supplies, by unknown staff. She said she did not find out about the wound until she arrived to the facility on [DATE]. She said she was given a list of residents to see, and Resident #1 was on the list. The Wound Care Nurse Practitioner said the resident had an unstageable pressure ulcer on her coccyx. She said the facility should have notified her or the facility physician before the wound worsened. She said when she saw the resident she was not septic and did not need to go to the hospital. An interview on 01/08/26 at 2:05 PM with the Facility Physician revealed he did not assess Resident #1's wound from 12/18/25 - 12/25/25. He said he did not know what the wound looked like. He said he was only notified about the wound on 12/18/25. He said staff should have notified him when the wound had a change in condition or they suspected an infection. He said he did not know if the facility should have sent her to the hospital for the wound. An interview on 01/08/26 at 2:20 PM with CNA C revealed he was the CNA that would bathe Resident #1. He said he noticed a change in the resident's wound on 12/21/25. He said it looked a little more open and he notified the nurse, unknown name. He said he did not know how to describe the size of it. He said every time he saw the wound; it had cream on it. An interview on 01/08/26 at 3:09 PM with the WCN and DON revealed they both looked at the Treatment Administration Record for Resident #1. The WCN said her initials were not on the Treatment Administration Record and she did not know who completed the treatments for the resident on 12/23/25 and 12/25/25. The WCN said she only saw the resident's wound on 12/22/25 and on 12/24/25. She said on 12/22/25 the wound on the coccyx was about the size of a tangerine and was curved in. She said she did not measure it, and it did not have drainage or odor. The WCN said she contacted the Wound Care Nurse Practitioner by phone on 12/22/25 but did not document it. She said she did not notify the Facility Physician about the wound because the resident was going to be seen by the Wound Care Nurse Practitioner. The WCN said when she saw the wound on 12/24/25, it looked the same as it did on 12/22/25. The DON said she did not recognize the initials on Resident #1 Treatment Administration Record for 12/22/25-12/25/25 even though it was the same initials each day. The DON said she was over the Wound Care Program and that the Facility Physician was notified on 12/18/25 about the wound. An interview on 01/08/26 at 4:05 PM revealed LVN D performed wound care for Resident #1 on 12/20/25-12/21/25. He said the treatment was to apply calcium alginate (treatment that keeps the wound bed moist for healing) and a dry dressing. He said when he saw the wound it was about the size of a quarter and was not very deep. He said the wound did not have drainage. An interview on 01/08/26 at 5:10 PM with the Corporate Nurse revealed the initials on the Treatment Administration Record for Resident #1 (12/22/25-12/25/25) belonged to the WCN. Record review of the facility policy, Change in a Resident's Condition or Status, revised April 2025, reflected:. Policy Interpretation and Implementation1. The nurse will notify the resident's attending physician or physician on call when there has been a(an):a. accident or incident involving the resident;b. discovery of injuries of an unknown source;c. adverse reaction to medication;d. significant change in the resident's physical/emotional/mental condition;e. need to alter the resident's medical treatment significantly;f. refusal of treatment or medications three (3) or more consecutive times);g. need to transfer the resident to a hospital/treatment center;h. discharge without proper medical authority; and/[NAME]. specific instruction to notify the physician of changes in the resident's condition.2. A significant change of condition is a major decline or improvement in the resident's status that:a. will not normally resolve itself without intervention by staff or by implementing standard disease-related (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	clinical interventions (is not self-limiting). This was determined to be an IJ on 01/08/26 at 4:50 PM. The Administrator and the DON were notified. The Administrator was provided the IJ template on 01/08/26 at 4:55 PM. The following Plan of Removal was submitted by the facility and was accepted on 01/09/26 at 11:36 AM and reflected the following:The facility failed to consult with the resident's physician a significant change in the resident's physical, mental, or psychosocial status for Resident #1.Action: All residents with wounds assessed on 01/08/26, current condition of the wound communicated with the residents' physician and the wound care nurse practitioner. Person(s) Responsible: Director of Nursing, Treatment Nurse, Assistant Director of Nursing, and/or DesigneeDate: 01/08/26Action: Regional Nurse Consultant will provide education to the Director of Nursing, Treatment Nurse, Assistant Director of Nursing over the Change in Condition policy as it relates to physician notification and documenting all characteristics of wounds, including the measurements.Change in condition to include:a. accident or incident involving the resident; b. discovery of injuries of an unknown source; c. adverse reaction to medication; d. significant change in the resident's physical/emotional/mental condition (to include changes in skin) e. need to alter the resident's medical treatment significantly; f. refusal of treatment or medications three (3) or more consecutive times); g. need to transfer the resident to a hospital/treatment center; h. discharge without proper medical authority; and/or i. specific instruction to notify the physician of changes in the resident's condition.Person(s) Responsible: Regional Nurse ConsultantDate: 01/08/26Action: Education provided to all nurses on the Change in Condition policy as it relates to physician notification. Change in condition to include:a. accident or incident involving the resident; b. discovery of injuries of an unknown source; c. adverse reaction to medication; d. significant change in the resident's physical/emotional/mental condition (to include changes in skin) e. need to alter the resident's medical treatment significantly; f. refusal of treatment or medications three (3) or more consecutive times); g. need to transfer the resident to a hospital/treatment center; h. discharge without proper medical authority; and/or i. specific instruction to notify the physician of changes in the resident's condition.All nurses will be educated prior to working their next shift. Person(s) Responsible: Director of Nursing, Treatment Nurse, Assistant Director of Nursing, and/or DesigneeDate: 01/08/26Action: Education provided to all nurses, including the treatment nurse, as it relates to documenting all characteristics of wounds, including the measurements. All nurses will be educated prior to working their next shift. Person(s) Responsible: Director of Nursing and/or DesigneeDate: 01/08/26Action: A test to ensure competency completed with nurses as it relates to physician notification and changes in skin. All nurses will be educated prior to working their next shift. Person(s) Responsible: Director of Nursing, Treatment Nurse, Assistant Director of Nursing, and/or DesigneeDate: 01/08/26Action: The Treatment Nurse is designated to complete wound care Monday-Friday, Assistant Director of Nursing, Director of Nursing, or a Designated Nurse will complete wound care in the event that the Treatment Nurse is unable to complete/on leave. Saturday and Sunday wound care will be completed by weekend supervisor or assigned charge nurse. Person(s) Responsible: Director of Nursing for scheduling/designating wound care. Treatment Nurse. Weekend Supervisor. And/or DesigneeDate: 01/08/26Action: Director of Nursing and/or designee will observe 3 wounds a week, x4 weeks, to ensure documentation and proper notification is charted. Any discrepancies or concerns noted will be immediately discussed with the resident's physician and wound care practitioner and will result in reeducation for the nurse. Director of Nursing and/or designee will review the wound care nurse practitioner's notes weekly, x4 weeks to ensure no additional concerns are noted by the Nurse Practitioner. Person(s) Responsible: Director of Nursing and/or DesigneeDate: 01/08/26Action: A QAPI meeting was performed with the Medical Director to review (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the IJ template, root cause the deficient practice, and discuss the facility's plan to remove the immediacy. Person(s) Responsible: Director of NursingDate: 01/08/26 Monitoring the facility's Plan of Removal included the following: Observations of Resident #2 and #3's wound care was not completed. The residents wound care had been completed prior to plan of removal acceptance. Record review of Resident #2 and #3's wound care on 01/09/26 did not reflect worsening of their wounds. Record review of Staff In-services was completed on 01/09/26. Interviews were conducted on 01/09/26 from 1:45 PM to 01/10/26 at 12:25 PM with staff from various shifts. The staff included LVN A, ADON, LVN E, LVN F, LVN G, LVN H, LVN D, LVN I, and RN J.All staff were able to identify:Changes in conditions including wound changes had to be reported to the Physician. The staff were able to identify what wound changes could look like as well as the signs/symptoms of a wound infection. An interview on 01/09/26 at 2:15 PM with the WCN revealed she understood that changes in wound conditions and signs and symptoms of an infection had to be reported to the physician immediately. An interview on 01/10/26 at 12:00 PM with the DON revealed her role in the facility plan of removal included: Make sure the staff were notifying the physician for changes in resident condition. An interview on 01/10/26 at 12:25 PM with the Administrator revealed her role in the facility plan of removal included: ensuring the Plan of Removal was overseen and completed. She said the facility would have weekly clinical meetings and she would review documentation and speak to the physician regarding changes in condition. On 01/08/26 at 5:10PM, an Immediate Jeopardy (IJ) was identified, and the Administrator was notified. While the Administrator was notified that the IJ was removed on 01/10/26 at 12:15PM, the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the MDS Assessment accurately reflected the resident's status for (Residents #3) of four residents reviewed for MDS Assessments. The facility failed to ensure Resident #3's MDS Assessment was correct. This failure could place residents at risk of not receiving care for issues not addressed in the MDS assessment.Findings included: Record review of Resident #3's admission MDS Assessment, dated 12/23/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 15. His cognitive skills for daily decision-making were intact. His diagnoses included heart failure, wound infection, paraplegia, malnutrition, and chronic bone infection. The resident had a Stage III pressure ulcer. The MDS did not show that Resident #3 had any other wounds. Record review of Resident #3's Care Plans, not dated, reflected:Resident had an actual impairment to skin integrity related to a non-pressure chronic ulcer to right leg. Facility interventions included:Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to the Physician. Treat per physician orders. Record Review of the Facility Wound Care Report dated 12/31/25 reflected:Resident #3 had an atypical lesion on his right leg and one on his left leg. The resident had a Stage III pressure ulcer on his coccyx. He admitted with the wounds on 12/16/25. An interview was attempted with the MDS Coordinator on 01/09/26 at 4:00 PM and 01/10/26 at 10:35 AM. The MDS Coordinator did not return the phone calls. An interview on 01/09/26 at 4:25 PM with the DON revealed she did not sign the MDS Assessment for Resident #3. The Corporate Nurse signed the MDS. The DON said she did not know who was responsible for ensuring MDS Assessments were correct but did say they were important to ensure the resident received the right interventions for care. An interview on 01/10/26 at 10:36 AM with the Corporate Nurse revealed she signed the MDS Assessment for Resident #3 on 12/29/25. She said she signed the MDS Assessment to show it was completed. She said the MDS Coordinator filled out the MDS. Record review of the facility policy, Resident Assessments, dated 2001, reflected: 3. A comprehensive assessment includes:completion of the Minimum Data Set.5. The interdisciplinary team uses the MDS form currently mandated by federal and state regulations to conduct the resident assessment.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for two (Residents #1 and #3) of four residents reviewed for care plans. The facility failed to follow Resident #1's care plan. The resident's wound site was not monitored for signs/symptoms of infection, the effectiveness of treatment, and the physician was not notified for wound changes. The resident was sent out on pass with her family on 12/25/25. The RP took her to the hospital the same night and was told the resident had sepsis due to an infection of the wound. The resident did not recover and passed away on 01/03/26. On 01/09/26 at 3:00PM, an Immediate Jeopardy (IJ) was identified, and the Administrator was notified. While the Administrator was notified that the IJ was removed on 01/10/26 at 12:15PM, the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. 2. The facility failed to ensure Resident #3 had a care plan in place for his pressure ulcer on the coccyx and chronic ulcer of the left leg. This failure could place residents at risk of deterioration of their wound if the care plan was not initiated and followed.Findings included: Record review of Resident #1's Quarterly MDS Assessment, dated 11/26/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMs score was 9. Her cognitive skills for daily decision-making was moderately impaired. Her diagnoses included cancer, heart failure, and sepsis. The resident was at risk for pressure ulcers. The resident did not have pressure ulcers. Record review of Resident #1's Care Plans, not dated, reflected:12/09/25 Resident was at risk for skin alterations. Unstageable to the buttock.Facility interventions included:Monitor site for signs/symptoms of infection, monitor for effectiveness of treatment, notify the physician as needed, and perform weekly skin assessments. Record review of Resident #1 Physician Order Summary Report for December 2025 reflected:12/18/25: Cleanse coccyx with wound cleanser or normal saline, pat dry, apply collagen, cover with dry dressing one time a day for wound care. Record review of Resident #1 Treatment Administration Record for December 2025 reflected that the wound treatment was not completed on 12/19/25. LVN C treated the wound on 12/20/25-12/21/25. The WCN treated the wound 12/22/25 - 12/25/25. Record review of Resident #1's progress notes reflected:Effective Date: 12/18/25 1:30 PM Skin Check .Skin Issues Note: reopen wound to sacrum, open areas to left and right buttocks. Skin issue education: Treatment of skin issue. Skin issue education: Turn every 2 hours. - LVN A Effective Date: 12/22/25 3:24 PM Type: [Weekly] Skin/Wound Note: Note Text: Sacral pressure injury assessed and treated per order. Wound cleansed and dressing changed. Peri wound skin protected. Patient repositioned and tolerated well. - WCN Date of Service: 12/24/2025 Visit Type: [Weekly] Skin and Wound Note: .Information necessary for today's visit was obtained from the patient, nursing staff, per patient's medical record. Reason for visit: first evaluation of existing wound patient by new wound care team. 12/24/2025: Received new consult to assess resident for sacrum pressure ulcer. WOUND ASSESSMENT:Wound: 1Location: CoccyxPrimary Etiology: Pressure Ulcer/InjuryStage/Severity: Unstageable (Pressure ulcer that cannot be staged due to the large amount of dead tissue on the ulcer)Wound Status: First Evaluation of existing wound by new ProviderOdor Post Cleansing: Malodorous (bad smell)Size: 4.5 cm x 4.5 cm x 3.5 cm. Calculated area is 20.25 sq cm.Wound Base: . 40% granulation (indicates percentage of wound that is healing), 40% slough (the percentage of dead tissue in the wound), 20% eschar (percentage (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	of dead tissue in the wound that is black in color)Exposed Tissues: Dermis, SubcutaneousWound Edges: AttachedPeri-wound (area around the wound): Ecchymosis (type of bruise), Fragile, Non-blanchable (indicates structural problems in the tissue), maroon discolorationExudate (drainage): Moderate amount of Serosanguineous (watery, pink, drainage). PROCEDURES:A sharp debridement (procedure to cut away dead tissue) was not performed today due to this is the first evaluation of the patient and further plan for debridement will be reviewed as part of the care plan. An autolytic (assists in healing of wound) dressing is in place. WOUND TREATMENT:Wound # 1 Coccyx Pressure Ulcer/InjuryTreatment Recommendations:1. Cleanse with 0.125% Dakins solution (antiseptic solution for wounds).2. apply Iodoform packing strip (antiseptic dressing strips) to base of the wound.3. secure with superabsorbent (dressing).4. change Every other day, and PRN. - Wound Care Nurse Practitioner Effective Date: 12/25/25 9:12 AM Type: Nurse's Note Note Text: Resident stable RP here pick up the resident and left for Christmas cerebrations, left with portable Oxygen machine and the charge. - LVN A Review of Resident #1's Hospital Records reflected:12/25/25 6:24 PM Emergency Department Physician Note: .Skin: Wound check: unstageable decubitus noted to coccyx with foul odor and necrotic tissue. - Emergency Department Physician An observation of Resident #1's wound picture, provided by Resident #1's Responsible Party and dated 12/25/25, on 01/08/25 at 11:10 AM revealed the resident had a large, open, dark, unstageable pressure ulcer to her coccyx. The wound had necrotic tissue and was packed loosely with a dressing, possibly iodoform. The wound was a dark brown color. Unable to determine depth and size. The ulcer looked to be about the size of an orange. The tissue around the wound was a deep red color. The resident also had a Stage II pressure ulcer on her right, lower buttock that was open, red, and approximately the size of a quarter. An interview was conducted with the Responsible Party for Resident #1 on 01/08/26 at 11:15 AM. The Responsible Party said they took Resident #1 home for a holiday dinner on 12/25/25. The Responsible Party said the facility told her the resident had a hot spot on her bottom and were treating it. The facility did not tell her the severity of the wound. The Responsible Party said on the night of 12/25/25 they saw the wound and immediately took the resident to the hospital. The Responsible Party said the resident had sepsis possibly due to the wound and ultimately passed away. An interview on 01/08/26 at 10:45 AM with the WCN for Resident #1 revealed she started employment at the facility on 12/15/25. She said she was notified on 12/18/25 that Resident #1 had a wound. The WCN said the Wound Care Nurse Practitioner saw the wound on 12/24/25. She said she notified the Responsible Party for Resident #1 about the wound on 12/24/25. An interview on 01/08/26 at 1:00 PM with the DON regarding Resident #1 revealed she never looked at the wound for Resident #1. An interview on 01/08/26 at 1:05 PM with LVN A and CNA B for Resident #1 revealed CNA B saw Resident #1's open wound on 12/18/25. He said he notified LVN A about the wound. LVN A said she did not measure the wound, but it was about the size of a dime. LVN A said she notified the WCN about the wound. LVN A said an order was obtained from the WCN and LVN A said she did not treat the wound because the WCN was at the facility. CNA B said following 12/18/25, the wound always had a dressing on it and he never visualized the wound after 12/18/25. LVN A said she never visualized the wound after 12/18/25. LVN A and CNA B said on 12/25/25 the wound had a dressing on it and they both assisted Resident #1 into the car of the Responsible Party. An interview on 01/08/26 at 1:35 PM with the Wound Care Nurse Practitioner for Resident #1 1 revealed she saw the wound on 12/24/25 but did not take a picture of it. She said she ordered Dakin's solution to clean the wound and iodoform to pack the wound. She said she requested a wound culture but was told the facility did not have wound culture supplies. She said she did not find out about the wound until she arrived to the facility on [DATE]. She said she was given a list of residents to see, and Resident #1 was on the list. The Wound Care Nurse (continued on next page)

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	675877	A. Building B. Wing	01/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Practitioner said the resident had an unstageable pressure ulcer on her coccyx. She said the facility should have notified her or the facility physician before the wound worsened. She said when she saw the resident she was not septic and did not need to go to the hospital. An interview on 01/08/26 at 2:05 PM with the Facility Physician revealed he did not assess Resident #1's wound from 12/18/25 - 12/25/25. He said he did not know what the wound looked like. He said he was only notified about the wound on 12/18/25. He said staff should have notified him when the wound had a change in condition or they suspected an infection. He said he did not know if the facility should have sent her to the hospital for the wound. An interview on 01/08/26 at 2:20 PM with CNA C revealed he was the CNA that would bathe Resident #1. He said he noticed a change in the resident's wound on 12/21/25. He said it looked a little more open and he notified the nurse. He said he did not know how to describe the size of it. He said every time he saw the wound; it had cream on it. Record review of Resident #3's admission MDS Assessment, dated 12/23/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 15. Her cognitive skills for daily decision-making were intact. His diagnoses included heart failure, wound infection, paraplegia, malnutrition, and chronic bone infection. The resident had a Stage III pressure ulcer. The MDS did not show that Resident #3 had any other wounds. Record review of Resident #3's Care Plans, not dated, reflected:Resident had an actual impairment to skin integrity related to a non-pressure chronic ulcer to right leg. Facility interventions included:Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to the Physician. Treat per physician orders.There was not a care plan for the chronic ulcer on the left leg and the pressure ulcer on the sacrum. Record Review of Resident #3's January 2026, Order Summary Report reflected: 12/17/25 Clean left lower leg area with NS (normal saline), pat dry cover with Xerofoam (dressing), Iodoplex (dressing) in hypergrandulated (area of wound) area and apply abdominal pad dressing, wrap with kerlix and ACE wrap, dry gauze dressing in between toes every Monday, Wednesday, and Friday for wound treatment. 12/17/25 Clean right lower leg with NS, pat dry cover with Xerofoam, iodoplex hypergrandulated area and abdominal pad dressing, pad, wrap with kerlix and ACE wrap, dry gauze dressing in between toes every Monday, Wednesday, and Friday. 12/25/25 Cleanse [coccyx] wound with wound cleanser; pat dry. Apply Collagen (treatment) and Triad paste (treatment) cover with bordered dressing for daily wound care. Review of the Facility's Wound Report, dated 01/07/26 reflected Resident #3 was not listed on it. An interview on 01/09/26 at 8:00 AM with the WCN revealed she said she had already provided wound care for Resident #3. She said Resident #3 had wounds and that included a pressure ulcer. An interview on 01/09/26 at 8:30 AM with the DON revealed she did not know why Resident #3 was not listed on the Wound Care Report. She said Resident #3 had a pressure ulcer and two leg wounds. The State Surveyor requested an accurate copy of the facility Wound Care Report. An interview on 01/09/26 at 11:10 AM with the WCN revealed she did not know why the care plan for Resident #1 was not followed. She said she did not know why Resident #3 did not have a care plan for the wound on his sacrum and left leg. She said she was responsible for ensuring wound care plans were written and she used the care plans to educate staff about the resident's wounds. An interview on 01/09/26 at 11:10 AM with the DON revealed an in-service on completing care plans was given on 12/30/25. She said if treatments were not administered and care plans were not implemented and followed then the resident was at risk of infection and deterioration of the wound. She said the WCN was responsible for wound care plans for residents with wounds. Record review of the facility policy, Care Plans, Comprehensive Person-Centered, dated 2001, reflected: Policy StatementA comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	functional needs is developed and implemented for each resident.7. The comprehensive, person-centered care plan:a. includes measurable objectives and time frames;b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including:(1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;(2) any specialized services to be provided as a result of PASARR recommendations; and(3) which professional services are responsible for each element of care;c. includes the resident's stated goals upon admission and desired outcomes;d. builds on the resident's strengths; ande. reflects currently recognized standards of practice for problem areas and conditions.8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are:a. provided by qualified persons;b. culturally competent; andc. trauma-informed. This was determined to be an IJ on 01/09/26 at 2:55 PM. The Administrator and the DON were notified. The Administrator was provided the IJ template on 01/09/26 at 2:59 PM. The following Plan of Removal was submitted by the facility and was accepted on 01/09/26 at 5:06 PM and reflected the following:The facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs for 2 of 4 residents reviewed for care plans.Action: Resident #1 no longer resides at the facility. Resident #3's care plan was updated to reflect the current state of their wound and interventions per the interdisciplinary team's discussion. Person(s) Responsible: MDS CoordinatorDate: 01/09/26Action: All residents with wounds were reviewed to ensure the care plans are reflecting the residents' current wound status. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, MDSC, and/or Designee Date: 01/09/26Action: Regional Nurse Consultant will educate Director of Nursing, Assistant Director of Nursing, Treatment Nurse, and MDSC Nurse over the care plan policy with emphasis on care planning wounds to include- Wound, location of the wound, type of wound, stage of wound and to follow physician orders and to ensure the care plans are developed and implemented as comprehensive person-centered, consistent with the resident rights, and include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs.Person(s) Responsible: Regional Nurse Consultant Date: 01/09/26Action: All licensed nurses will be educated over the care plan policy with emphasis on care planning wounds to include- Wound, location of the wound, type of wound, stage of wound and to follow physician orders, and to ensure the care plans are developed and implemented as comprehensive person-centered, consistent with the resident rights, and include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs.All nurses will be educated prior to working their next shift. Person(s) Responsible: Director of Nursing and/or Designee Date: 01/09/26Action: The Treatment Nurse and/or Designee will complete and update the care plans with any changes for wounds. The Director of Nursing or Designee will review the wound care plans as needed and at minimum weekly to ensure they are present, accurate, and being followed. Person(s) Responsible: Treatment Nurse, Director of Nursing, and/or Designee Date: 01/09/26Action: Once weekly, in Quality of Care meeting, the Director of Nursing, Assistant Director of Nursing, Treatment Nurse, and/or Designee will review residents with wounds, weekly wound report from wound care nurse practitioner, facility wound report, wound care orders, and wound care plans to ensure accurate information is present and documented. Person(s) Responsible: Director of Nursing, Treatment Nurse, and/or Designee Action: Ad hoc QAPI performed with Medical Director to inform them of the Immediate Jeopardy and the facility's plan to remove the immediacy. Person(s) Responsible: AdministratorDate: 01/09/26 Monitoring the facility's Plan of Removal included (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the following:Observations of Resident #2 and #3's wound care was not completed. The residents wound care had been completed prior to plan of removal acceptance. Record review of Resident #2 and #3's wound care on 01/09/26 did not reflect worsening of their wounds. Record review of Staff In-services was completed on 01/09/26. Interviews were conducted on 01/09/26 from 1:45 PM to 01/10/26 at 12:25 PM with staff from various shifts. The staff included LVN H, LVN D, LVN I, and RN J.All staff were able to identify that the RN was responsible for initiating care plans. Any nurse could update a care plan. The care plan was important because it showed staff how to care for the resident. An interview on 01/10/26 at 11:50 AM with the WCN revealed a care plan had to be created by an RN. She said she was responsible for updating the care plans for residents with wounds. She said the care plan was important because it shoed updates on the wound and interventions to care for the wound. She said she and the DON were responsible for ensuring the Wound Care Report was accurate. An interview on 01/10/26 at 12:00 PM with the DON revealed her role in the facility plan of removal was to ensure each care plan was initiated and that the WCN would update care plans for residents with wounds. The DON said she would be monitoring the care plans and that the interventions were put in place. An interview on 01/10/26 at 12:25 PM with the Administrator revealed her role in the facility plan of removal included: ensuring the Plan of Removal was overseen and completed. She said the facility would have weekly clinical meetings and she would review documentation and speak to the physician regarding changes in condition. On 01/09/26 at 3:00PM, an Immediate Jeopardy (IJ) was identified, and the Administrator was notified. While the Administrator was notified that the IJ was removed on 01/10/26 at 12:15PM, the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for two (Residents #1 and #2) of four residents reviewed for pressure ulcers. The facility failed to ensure Resident #1 received the physician ordered treatment for her pressure ulcer. Staff did not consult with the facility physician or wound care nurse practitioner when the wound started deteriorating. The ulcer worsened and the resident required hospitalization on 12/25/25. On 01/08/26 at 5:10PM, an Immediate Jeopardy (IJ) was identified, and the Administrator was notified. While the Administrator was notified that the IJ was removed on 01/10/26 at 12:15PM, the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. 2. The facility to ensure the WCN treated Resident #2's pressure ulcer according to facility policy. This failure could place residents at risk of deterioration of their wound if they were not treated according to physician orders and facility policy.Findings included: Record review of Resident #1's Quarterly MDS Assessment, dated 11/26/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMs score was 9. Her cognitive skills for daily decision-making was moderately impaired. Her diagnoses included cancer, heart failure, and sepsis. The resident was at risk for pressure ulcers. The resident did not have a pressure ulcer. Record review of Resident #1's Care Plans, not dated, reflected:12/09/25 Resident was at risk for skin alterations. Unstageable to the buttock.Facility interventions included:Monitor site for signs/symptoms of infection, monitor for effectiveness of treatment, notify the physician as needed, and perform weekly skin assessments. Record review of Resident #1 Physician Order Summary Report for December 2025 reflected:12/18/25: Cleanse coccyx with wound cleanser or normal saline, pat dry, apply collagen, cover with dry dressing one time a day for wound care. Record review of Resident #1 Treatment Administration Record for December 2025 reflected that the wound treatment was not completed on 12/19/25. LVN C treated the wound on 12/20/25-12/21/25. The WCN initials were listed for 12/22/25 - 12/25/25. Record review of Resident #1's progress notes and skin checks reflected:Effective Date: 12/18/25 1:30 PM Skin Check .Skin Issues Note: reopen wound to sacrum, open areas to left and right buttocks. Skin issue education: Treatment of skin issue. Skin issue education: Turn every 2 hours. - LVN A Effective Date: 12/22/25 3:24 PM Type: [Weekly] Skin/Wound Note: Note Text: Sacral pressure injury assessed and treated per order. Wound cleansed and dressing changed. Peri wound skin protected. Patient repositioned and tolerated well. - WCN Date of Service: 12/24/2025 Visit Type: [Weekly] Skin and Wound Note: .Information necessary for today's visit was obtained from the patient, nursing staff, per patient's medical record. Reason for visit: first evaluation of existing wound patient by new wound care team. 12/24/2025: Received new consult to assess resident for sacrum pressure ulcer. WOUND ASSESSMENT:Wound: 1Location: CoccyxPrimary Etiology: Pressure Ulcer/InjuryStage/Severity: Unstageable (Pressure ulcer that cannot be staged due to the large amount of dead tissue on the ulcer)Wound Status: First Evaluation of existing wound by new ProviderOdor Post Cleansing: Malodorous (bad smell)Size: 4.5 cm x 4.5 cm x 3.5 cm. Calculated area is 20.25 sq cm.Wound Base: . 40% granulation (indicates percentage of wound that is healing), 40% slough (the percentage of dead tissue in the wound), 20% eschar (percentage of dead tissue in the wound that is black in color)Exposed Tissues: Dermis, SubcutaneousWound Edges: AttachedPeri-wound (area around the wound): Ecchymosis (type of bruise), Fragile, Non-blanchable (indicates structural problems in the tissue), maroon discolorationExudate (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(drainage): Moderate amount of Serosanguineous (watery, pink, drainage). PROCEDURES:A sharp debridement (procedure to cut away dead tissue) was not performed today due to this is the first evaluation of the patient and further plan for debridement will be reviewed as part of the care plan. An autolytic (assists in healing of wound) dressing is in place. WOUND TREATMENT:Wound # 1 Coccyx Pressure Ulcer/InjuryTreatment Recommendations:1. Cleanse with 0.125% Dakins solution (antiseptic solution for wounds).2. apply Iodoform packing strip (antiseptic dressing strips) to base of the wound.3. secure with superabsorbent (dressing).4. change Every other day, and PRN. - Wound Care Nurse Practitioner Effective Date: 12/25/25 9:12 AM Type: Nurse's Note Note Text: Resident stable RP here pick up the resident and left for Christmas cerebrations, left with portable Oxygen machine and the charge. - LVN A Review of Resident #1's Hospital Records reflected:12/25/25 6:24 PM Emergency Department Physician Note: .Skin: Wound check: unstageable decubitus noted to coccyx with foul odor and necrotic tissue. - Emergency Department Physician An observation of Resident #1's wound picture, provided by Resident #1's Responsible Party and dated 12/25/25, on 01/08/25 at 11:10 AM revealed the resident had a large, open, dark, unstageable pressure ulcer to her coccyx. The wound had necrotic tissue and was packed loosely with a dressing, possibly iodoform. The wound was a dark brown color. Unable to determine depth and size. The ulcer looked to be about the size of an orange. The tissue around the wound was a deep red color. The resident also had a Stage II pressure ulcer on her right, lower buttock that was open, red, and approximately the size of a quarter. An interview was conducted with the Responsible Party for Resident #1 on 01/08/26 at 11:15 AM. The Responsible Party said they took Resident #1 home for a holiday dinner on 12/25/25. The Responsible Party said the facility told her the resident had a hot spot on her bottom and were treating it. The facility did not tell her the severity of the wound. The Responsible Party said on the night of 12/25/25 they saw the wound and immediately took the resident to the hospital. The Responsible Party said the resident had sepsis possibly due to the wound and ultimately passed away. An interview on 01/08/26 at 10:45 AM with the WCN for Resident #1 revealed she started employment at the facility on 12/15/25. She said she was notified on 12/18/25 that Resident #1 had a wound. The WCN said the Wound Care Nurse Practitioner saw the wound on 12/24/25. She said she notified the Responsible Party for Resident #1 about the wound on 12/24/25. An interview on 01/08/26 at 1:00 PM with the DON regarding Resident #1 revealed she never looked at the wound for Resident #1. An interview on 01/08/26 at 1:05 PM with LVN A and CNA B for Resident #1 revealed CNA B saw Resident #1's open wound on 12/18/25. He said he notified LVN A about the wound. LVN A said she did not measure the wound, but it was about the size of a dime. LVN A said she notified the WCN about the wound. LVN A said an order was obtained from the WCN and LVN A said she did not treat the wound because the WCN was at the facility. CNA B said following 12/18/25, the wound always had a dressing on it and he never visualized the wound after 12/18/25. LVN A said she never visualized the wound after 12/18/25. LVN A and CNA B said on 12/25/25 the wound had a dressing on it and they both assisted Resident #1 into the car of the Responsible Party. An interview on 01/08/26 at 1:35 PM with the Wound Care Nurse Practitioner for Resident #1 1 revealed she saw the wound on 12/24/25 but did not take a picture of it. She said she ordered Dakin's solution to clean the wound and iodoform to pack the wound. She said she requested a wound culture but was told the facility did not have wound culture supplies. She said she did not find out about the wound until she arrived to the facility on [DATE]. She said she was given a list of residents to see, and Resident #1 was on the list. The Wound Care Nurse Practitioner said the resident had an unstageable pressure ulcer on her coccyx. She said the facility should have notified her or the facility physician before the wound worsened. She said when she saw the resident she was not septic and did not need to go to the hospital. An (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	interview on 01/08/26 at 2:05 PM with the Facility Physician revealed he did not assess Resident #1's wound from 12/18/25 - 12/25/25. He said he did not know what the wound looked like. He said he was only notified about the wound on 12/18/25. He said staff should have notified him when the wound had a change in condition or they suspected an infection. He said he did not know if the facility should have sent her to the hospital for the wound. An interview on 01/08/26 at 2:20 PM with CNA C revealed he was the CNA that would bathe Resident #1. He said he noticed a change in the resident's wound on 12/21/25. He said it looked a little more open and he notified the nurse. He said he did not know how to describe the size of it. He said every time he saw the wound; it had cream on it. An interview on 01/08/26 at 3:09 PM with the WCN and DON revealed they both looked at the Treatment Administration Record for Resident #1. The WCN said her initials were not on the Treatment Administration Record and she did not know who completed the treatments for the resident on 12/23/25 and 12/25/25. The WCN said she only saw the resident's wound on 12/22/25 and on 12/24/25. She said on 12/22/25 the wound on the coccyx was about the size of a tangerine and was curved in, but she did not actually measure the wound or document the size of it. She said it did not have drainage or odor. The WCN said she contacted the Wound Care Nurse Practitioner by phone on 12/22/25 but did not document it. She said she did not notify the Facility Physician about the wound. The WCN said when she saw the wound on 12/24/25, it looked the same as it did on 12/22/25. The DON said she did not recognize the initials on Resident #1 Treatment Administration Record for 12/22/25-12/25/25 even though it was the same initials each day. The DON said she was over the Wound Care Program and that the Facility Physician was notified on 12/18/25 about the wound. An interview on 01/08/26 at 4:05 PM revealed LVN D performed wound care for Resident #1 on 12/20/25-12/21/25. He said the treatment was to apply calcium alginate (treatment that keeps the wound bed moist for healing) and a dry dressing. He said the wound was about the size of a quarter and was not very deep. He said the wound did not have drainage. An interview on 01/08/26 at 5:10 PM with the Corporate Nurse revealed the initials on the Treatment Administration Record for Resident #1 (12/22/25-12/25/25) belonged to the WCN. Record review of Resident #2's Quarterly MDS Assessment, dated 10/29/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMs score was 7. Her cognitive skills for daily decision-making were severely impaired. Her diagnosis included diabetes. The resident had a Stage III pressure ulcer on her sacrum. Record review of Resident #2's Care Plans reflected:10/15/25 Resident had a pressure ulcer wound due to prolonged pressure and limited mobility, which requires wound care and repositioning to support healing and prevent infection. Facility interventions included:Assess and document wound appearance (size, depth, exudate, tissue type, odor) during dressing changes. Record review if Resident #2's Order Summary Report, January 2026, reflected: 12/25/25 Cleanse with wound cleanser, pat dry, apply medical grade honey, apply bordered dressing until healed one time a day for wound care. day for wound care An observation on 01/09/26 at 10:25 am of wound care for Resident #2 revealed the WCN and the DON were in the room together. The resident was positioned on her right side. The DON raised the left buttock to keep it from touching the pressure ulcer. The open ulcer was red, shallow, and had slough in it. The WCN sprayed wound cleanser, picked up gauze sponges and cleaned the wound cleanser off the skin around the wound. She did not clean the wound cleanser off the ulcer. The WCN measured the wound to be 1.5 cm long. The WCN stepped away from the bed to change her gloves. The DON let go of the resident's left buttock and it fell on the ulcer. The WCN put on new gloves and the DON picked up the left buttock. The WCN nurse measured the width of the wound to be 1.0 cm. The WCN performed hand hygiene but did not re-clean the wound. The WCN put the treatment for the wound on a long Q-tip and started to apply it to the wound bed. The WCN was asked if she was going to clean the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675877	A. Building B. Wing	01/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Health Care Center	301 W Randol Mill Rd Arlington, TX 76011

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	wound. The WCN stopped and put the treatment on the table. The WCN sprayed the wound with wound cleanser but did not clean the wound cleanser out of the ulcer itself, just the intact skin around the wound. The WCN was asked if she was going to clean the wound cleanser off the wound. The WCN picked up a gauze and cleaned the wound cleanser of the wound and then cleaned the wound cleanser off the skin around the wound. The WCN applied the treatment to the wound after cleaning it and applied a bandage. An interview on 01/09/26 at 11:00 AM with the DON revealed she said it was important to clean the ulcer and the skin around the wound and to reclean the wound if the resident's buttock touched the wound. An interview on 01/09/26 at 11:10 AM with the WCN said it was important to cleanse the wound cleaner off the ulcer and the skin around the ulcer. She said it was important to reclean the ulcer if the resident's buttocks re-touched the wound because she did not want to transfer bacteria into the ulcer itself. Record review of the facility policy, Wound Care, revised October 2025, reflected: .PurposeThe purpose of this procedure is to provide guidelines for the care of wounds to promote healing.Preparation1. Verify that there is a physician's order for this procedure.2. Review the resident's care plan to assess for any special needs of the resident.8. Pour liquid solutions directly on gauze sponges on their papers.9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound.10. Wear gloves when physically touching the wound or holding a moist surface over the wound.11. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or normal saline solution.12. Apply treatments as indicated.13. Dress wound. This was determined to be an IJ on 01/08/26 at 4:50 PM. The Administrator and the DON were notified. The Administrator was provided the IJ template on 01/08/26 at 4:55 PM. The following Plan of Removal was submitted by the facility and was accepted on 01/09/26 at 11:36 AM and reflected the following:The facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (Resident #1) of 4 residents reviewed for pressure ulcers.Action: All residents with wounds assessed on 01/08/26, current condition of the wound communicated with the residents' physician and the wound care nurse practitioner to ensure proper treatments to treat and heal residents' wounds are in place. Person(s) Responsible: Director of Nursing, Treatment Nurse, Assistant Director of Nursing, and/or DesigneeDate: 01/08/26Action: Regional Nurse Consultant will provide education to the Director of Nursing, Treatment Nurse, Assistant Director of Nursing over the Change in Condition policy as it relates to physician notification, following orders that promote healing and prevention of pressure ulcers, and documenting all characteristics of wounds, including the measurements.Person(s) Responsible: Regional Nurse ConsultantDate: 01/08/26Action: Education provided to all nurses on the Change in Condition policy as it relates to physician notification. All nurses will be educated prior to working their next shift. Person(s) Responsible: Director of Nursing, Treatment Nurse, Assistant Director of Nursing, and/or DesigneeDate: 01/08/26Action: Education provided to all nurses, including the treatment nurse, as it relates to documenting all characteristics of wounds, including the measurements, and following physician orders as it relates to healing and preventing pressure ulcers. All nurses will be educated prior to working their next shift. Person(s) Responsible: Director of Nursing and/or DesigneeDate: 01/08/26Action: A test to ensure competency completed with nurses as it relates to physician notification, following orders that promote healing and prevention of pressure ulcers, and changes in skin.All nurses will be educated prior to working their next shift. Person(s) Responsible: Director of Nursing, Treatment Nurse, Assistant Director of Nursing, and/or DesigneeDate: 01/08/26Action: The Treatment Nurse is designated to complete wound care Monday-Friday, Assistant Director of Nursing, Director of Nursing, or a (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Designated Nurse will complete wound care in the event that the Treatment Nurse is unable to complete/on leave. Saturday and Sunday wound care will be completed by weekend supervisor or assigned charge nurse. Person(s) Responsible: Director of Nursing for scheduling/designating wound care. Treatment Nurse. Weekend Supervisor. And/or DesigneeDate: 01/08/26Action: Director of Nursing and/or designee will observe 3 wounds a week, x4 weeks, to ensure documentation and proper notification is charted. Any discrepancies or concerns noted will be immediately discussed with the resident's physician and wound care practitioner and will result in reeducation for the nurse. Director of Nursing and/or designee will review the wound care nurse practitioner's notes weekly, x4 weeks to ensure no additional concerns are noted by the NP. Person(s) Responsible: Director of Nursing and/or DesigneeDate: 01/08/26Action: Ad hoc QAPI performed with the Medical Director to review the IJ template, root cause the deficient practice and discuss the facility's plan to remove the immediacy. Person(s) Responsible: Director of NursingDate: 01/08/26 Monitoring the facility's Plan of Removal included the following: Monitoring the facility's Plan of Removal included the following: Observations of Resident #2 and #3's wound care was not completed. The residents wound care had been completed prior to plan of removal acceptance. Record review of Resident #2 and #3's wound care on 01/09/26 did not reflect worsening of their wounds. Record review of Staff In-services was completed on 01/09/26. Interviews were conducted on 01/09/26 from 1:45 PM to 01/10/26 at 12:25 PM with staff from various shifts. The staff included LVN A, ADON, LVN E, LVN F, LVN G, LVN H, LVN D, LVN I, and RN J.All staff were able to identify:The required documentation for pressure ulcers included type of wound, color of wound, odor, wound size, drainage, and wound location. They understood the WCN/designee was required to treat the wounds Monday - Friday, and the charge nurse/house supervisor/designee would provide wound treatments on the weekend. The staff were able to verbalize the necessity to provide wound care as ordered. An interview on 01/09/26 at 2:15 PM with the WCN revealed she understood the process to treat wounds and the requirements for documentation. She said she knew the importance of completing wound care per physician orders. An interview on 01/10/26 at 12:00 PM with the DON revealed her role in the facility plan of removal included: to ensure the wounds were treated per policy and physician orders. She said she would also be monitoring a sample of wounds herself. An interview on 01/10/26 at 12:25 PM with the Administrator revealed her role in the facility plan of removal was to ensure the Plan of Removal was overseen and completed. On 01/08/26 at 5:10PM, an Immediate Jeopardy (IJ) was identified, and the Administrator was notified. While the Administrator was notified that the IJ was removed on 01/10/26 at 12:15PM, the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.