STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675901	A. Building B. Wing	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Health and Rehabilitation Center	1106 Golfview Richmond, TX 77469

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 - 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** 32677 Based on observation, interview, and record review the facility failed to ensure residents who entered the facility without pressure ulcers did not develop pressure ulcers and a resident having pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development of skin breakdown or pressure ulcers for 1 (CR #1) of 6 residents reviewed for pressure ulcers. -The facility failed to prevent the development of CR #1's Stage IV facility acquired sacrum pressure wound and left heel deep tissue injury resulting in debridement and hospitalization . Resident was diagnosed with sepsis due to MRSA, Sacral osteomyelitis and sacral pressure ulcer. -The facility failed to timely intervene when CR#1's Stage IV Pressure ulcer continued to get worse and did not send him to the local hospital and only suggested hospice. -The facility failed to ensure a wound care specialist physician was notified that CR#1's facility acquired Stage 4 pressure Ulcer was continuing to worsen and the wound care specialist physician did not evaluate and or modify wound treatment during the 12 days to promote healing and prevent the pressure ulcer from worsening. An Immediate Jeopardy (IJ) was identified on 01/28/24. While the IJ was removed on 01/30/24 at 2:02 p.m., the facility remained out of compliance at a severity level of actual harm that is not an Immediate Jeopardy and a scope of pattern as the facility continued to monitor the implementation and effectiveness of their plan of removal. These failures placed residents at risk of developing new pressure wounds, worsening of existing wounds, decline in quality of care, infection and experiencing pain. Findings include: CR #1 (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's face sheet dated 1/10/24 revealed a [AGE] year-old male who admitted to the Nursing Facility on 10/21/2023 with the diagnoses of encephalopathy (damage or disease that affects the brain), epidural hemorrhage with loss of consciousness (bleeding between the inside of the skull and the outer covering of the brain), hyperlipidemia (high cholesterol), hypertension (high blood pressure), paroxysmal atrial fibrillation (irregular heart beat), gastro-esophageal reflux disease (acid reflux), low back pain, muscle weakness, obstructive and reflux uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow), dysphagia (difficulty swallowing), unsteadiness on feet, abnormality of gait, repeated falls, cognitive communication deficit, and need for assistance with personal care. Record review of CR#1's Quarterly MDS dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. Section on Functional Abilities and goals revealed nothing was answered, no pressure injuries were noted, weight loss was answered no indicating no or unknown if loss of 5% or more in the last month or loss of 10% or more in last 6 months and no weight gain. Skin Conditions revealed CR#1 was indicated for pressure injuries and shows 1 stage 4 pressure ulcer (Stage 4 pressure ulcers are the most serious. These sores extend below the subcutaneous fat into your deep tissues, including muscle, tendons, and ligaments. In more severe cases, they can extend as far down as the cartilage or bone), and there was 1 unstageable (Unstageable pressure injuries are widely understood to be full-thickness pressure injuries in which the base is obscured by slough and/or eschar. Correct identification of these pressure injuries can be challenging among health care professionals and, although treatments vary, debridement is key) - slough and/or eschar (Eschar, pronounced es-CAR, is dead tissue that sheds or falls off from the skin. It's commonly seen with pressure ulcer wounds (bedsores). Eschar is typically tan, brown, or black, and may be crusty). Record review of CR# 1's Comprehensive Care plan undated revealed the following care areas: * an Actual pressure ulcer development r/t impaired mobility. Location #1 Sacral Stage 4 dated initiated 10/23/23 and revised on 11/10/23. A goal was for the resident to have intact skin, free of redness, blisters or discoloration by/through review date. The interventions were for an air mattress applied to bed dated initiated 11/10/23, call light in reach date initiated 10/23/23, encourage fluid intake and assist to keep skin hydrated dated 10/23/23, float heels as resident allows dated 10/23/23 and revised 11/10/23, Follow MD treatment as ordered date initiated 11/10/23, needs assistance to turn/reposition 10/23/23, notify nurse immediately of any new areas of skin breakdown: Redness, blisters, bruises, discoloration noted during bath or daily care date initiated 10/23/23, and weekly head to toe skin assessment date initiated 10/23/23. Requires assistance/potential to restore function to maximum self -sufficiency for mobility characterized by the following functions: positioning, locomotion/ambulation r/t: Impaired coordination date initiated 10/23/23. *ADL Self Care performance deficit r/t impaired cognition and functional decline following lumbar laminectomy and epidural hematoma s/p surgical evacuation date initiated 10/21/23. A goal was to safely perform ADLs at highest level of independence through the review date. The interventions included to explain all procedures/tasks before starting (10/23/23) .toilet use (toilet transfer, toilet hygiene): Requires staff participation to use toilet. Monitor for incontinent episodes and provide care. (date 10/23/23). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Has unplanned/unexpected weight loss r/t poor food intake date initiated 11/13/23. Goal: weight will return to baseline range by review date and will consume two of three meals/day through the review date. The interventions were to give supplements as ordered, Alert nurse/dietician if not consuming on a routine basis, If weight decline persists, contact physician and dietician immediately, Monitor and evaluate any weight loss, Determine percentage loss and follow facility protocol for weight loss, Monitor and record food intake at each meal, Offer and encourage snacks/fluids between meals, Remeron as appetite stimulant. *Has surgical incision to lumbar s/p laminectomy (surgery that creates space by removing bone spurs and tissues associated with arthritis of the spine). Date initiated 10/21/23. A goal was the surgical incision will show signs of healing and remain free from infection by/through review date. The interventions were to administer treatments as ordered and monitor for effectiveness and Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/sx of infection, wound size and stage. Record review of CR#1's Medication Administration Record/Treatment Administration Record dated December 2023 revealed: -Wound care Left Heel: Cleanse with wound cleanser, pat dry, apply skin prep 3 x week every day shift every Mon, Wed, Fri for purplish blister left heel order date 11/28/23 was completed as ordered. -Wound care to stage 4 (sacral) pressure injury- cleanse with Dakin's solution, pat dry, apply sterile gauze and cover with dry dressing daily and prn when soiled or dislodged. every day shift -order date- 12/14/2023 was completed as ordered. -Wound care to stage 4 (sacral) pressure injury- cleanse with ns solution, pat dry, apply Santyl, apply calcium alginate, cover with dry dressing daily and prn when soiled or dislodged every day shift -order date-11/23/2023 was -d/c date-12/14/2023 was completed as ordered. -Low air loss mattress for skin maintenance- check function every shift order date 11/7/23 revealed it was not completed on 12/1/23 evening shift and 12/25/23 evening shift. Preventive Care-apply skin prep to bilateral heels every shift order date 11/7/23 revealed it was not completed on 12/1/23 evening shift, and 12/25/23 evening shift. Record review of Local Hospital Records for CR #1 dated 10/19/23 revealed review of systems, skin symptoms: no jaundice, no rash. There was no pressure injury noted. Record review of CR#1's licensed Nurse Initial Admission Record completed by LVN A dated 10/21/23 revealed supportive devices were bed cradle, no alternating air mattress, no pressure re-distributing overlay mattress, no infections, and skin integrity revealed vertebrae (upper-mid) surgical incision with no skin issues noted. Record review of CR#1's LN Braden Scale for Predicting Pressure Sore Risk dated 10/21/23 indicated the following: *category: Moderate risk with score being 13.0. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Sensory perception: very limited: responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness or has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body. *Moisture: rarely moist: skin is usually dry; linen only requires changing at routine intervals. *Activity: Degree of physical activity: bedfast: confined to bed. *Mobility: Ability to change and control body position: Very limited: makes occasional slight changes in body or extremely position but unable to make frequent or significant changes independently. *Nutrition: Usual food intake pattern: Probably inadequate: Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake include includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding. *Friction & Shear: Potential problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintain relatively good position in chair or bed most of the time but occasionally slides down. Record review of CR#1's IDT- Care Plan Review signed on 10/27/23 revealed an initial review where CR#1's family member did attend, and the resident did not require special treatments, procedures or devices. CR#1 was alert oriented x3 scoring 10 in BIMS. Record review did not reveal any issues with pressure ulcers. Record review of CR#1's Mini Nutritional assessment dated [DATE] at 4:47 p.m. revealed a score of 12 (meaning normal nutritional status) .weight 209 lbs. on 10/21/23, no decrease in food intake, weight loss during the last 3 months: .no psychological stress, mild dementia, BMI 23 or greater . Record review of CR#1's IDT- Care Plan Review signed on 12/20/23 revealed CR#1's family requested to discuss CR#1's care, and nothing was discussed regarding pressure ulcer. Record review of CR#1's IDT Care on 10/27/23 and 12/20/23 Plan Reviews did not reveal any notice about the Stage 4 Sacral Pressure Wound and the progression of the wound. Record review of CR#1's Weight and vitals dated 1/9/24 revealed the following weights: *10/21/23 - 209.8 lbs. , *11/6/23 - 191.2 lbs., and *12/7/23 -182.8 lbs. Record review of CR #1's Physician Care Orders dated 1/10/24 revealed the following orders: *11/2/23-Unstageable: Sacral Pressure Injury- cleanse with normal saline solution, pat dry and apply calcium alginate, cover with dry dressing daily and PRN when soiled or displaced every day shift, discontinued date unknown. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*11/2/23 -Unstageable: Sacral Pressure Injury- cleanse with normal saline solution, pat dry and apply calcium alginate, cover with dry dressing daily and PRN when soiled or displaced every 8 hours as needed, discontinued date unknown. *11/7/23-Low Air loss mattress for skin: Maintenance-check function every shift. *11/7/23-Preventive Care-apply skin prep to bilateral heels every shift. *11/8/23 -Mirtazapine Oral tablet 15 mg give 1 tablet by mouth one time a day for appetite stimulant discontinued date unknown *11/9/23 -Wound care to stage 4 Sacral pressure injury-cleanse with normal saline solution, pat dry and apply calcium alginate, cover with dry dressing daily and PRN when soiled or displaced every day shift . *11/12/23-Left Heel: Apply skin prep leave open to air daily. Every shift for purplish blister left heel . *11/15/23-Mirtazapine Oral tablet 30 mg give 1 tablet by mouth one time a day for appetite stimulant. *11/28/23-Wound care Left Heel: Cleanse with wound cleanser, pat dry, apply skin prep 3 x week every day shift every Monday, Wednesday, Friday for purplish blister left heel . *12/14/23-Wound care to stage 4 Sacral pressure injury-cleanse with Darkin's solution, pat dry, apply sterile gauze and cover with dry dressing daily and PRN when soiled or dislodged, Every 8 hours as needed. *12/27/23-Send resident to local hospital per family request for wound evaluation. One time only for evaluation until 12/27/23. Record review of CR#1's Wound Care notes dated 11/1/23 by Wound Care Doctor A revealed the following: location: sacrum. Physical Exam Details: Integumentary (hair, skin): Skin and subcutaneous tissue without rashes or lesions. Wound orders- Wound #1 Sacral: Cleanse wound with normal saline, wound dressing-apply alginate, cover wound with dry absorptive dressing, change dressing daily. Pressure relief/Offloading: air mattress, reposition per facility protocol, off-load wound. Additional orders: Plan of care discussed with facility staff, plan of care discussed with patient, follow up next week. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Wound measurements: 5x5 cm, depth 0, area 25%. Wound encounter Initial exam, Unstageable pressure injury obscured full thickness skin and tissue loss, moderate sero-sanguineous (contains or relates to both blood and the part of blood -serum), normal for skin. Record review of CR#1's Wound Care Doctor notes dated 11/8/23 by Wound Care Doctor A indicated the following: *sacrum, *nutrition: poor appetite, getting multivitamins, *musculoskeletal: immobile, *Support surfaces: group 2 mattress. *Integumentary: dry wrinkled skin on lower extremities .Wound 1 Sacral Pressure ulcer .measurements 8.5 cm length x 10 cm width x depth 0 and area 85. *Wound description: Wound progress deteriorating, stage 4 pressure injury with moderate sero-sanguineous exudate, surrounding skin is normal for skin and moist yellow slough was 76 to 100% and there was exposed ligament and adipose necrosis. *Debridement details: post debridement measurements 8.5 cm length x 10 cm width x1.5 cm area, percent debrided 100, total area debrided 85 sq cm and volume was 127.5. Record review of CR#1's LN Skin Pressure Ulcer Weekly written by Clinical Resource dated 11/9/23 revealed: Pressure Ulcer Review Site 1, onset date 10/28/23, sacrum with 76-100% slough, Stage 4, size 8. 5x10cm, depth 0, tunneling 0, undermining 0, exudate amount was serosanguinous, exudate amount was moderate, no odor, wound bed was slough, wound edges were macerated, and the surrounding tissues was normal for skin. Documented interventions and the residents response to the interventions included: cleanse with normal saline (NS), pat dry, apply calcium alginate, cover with dry dressing. Surgical debridement completed; resident tolerated well. CR #1 was not stated to experience pain. Comments included: Wound rounds completed with wound MD location #1: sacral etiology: Pressure stage 4 ([NAME]) Measurement: 8.5 cm x 10cm x 0 Risk factors: poor appetite, immobile, non-compliant with turning and repositioning and offloading. Laminectomy history. Interventions: 1. Air mattress, 2. Float heel as resident allows, 3. Therapy services, 4. Pain management, 5. RD to follow. Education provided: Wound MD educated resident on risk and benefit of noncompliance with off-loading. MD and Responsible Party notified of wound progression. Record review of CR#1's LN- Skin Pressure Ulcer Weekly dated 11/14/23 signed by LVN B and re-signed by Clinical Resource on 12/5/23 revealed: Pressure Ulcer Review site 1 follow up onset date 10/28/23, Sacrum 76-100% eschar, stage 4, size 6x8 cm, depth 4, tunneling 0, undermining 0, serosanguinous-moderate, no odor, wound bed was black/brown (eschar), wound edges macerated, surrounding tissue was normal for skin, surgical debridement. Cleanse with normal saline, pat dry, apply Santyl, apply calcium alginate, cover with dry dressing . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's Wound Care Doctor notes revealed CR#1 did not see a Wound Care Doctor from 11/9/23 to 11/20/23 (12 days) with a Stage 4 Sacral Pressure Wound because he was asked not to return to the facility and there was no other Wound Care Doctor Record review of CR#1's LN- Skin Pressure Ulcer Weekly dated 11/21/23 and signed on 11/22/23 by LPN A revealed follow up onset 10/28/23, sacrum 100% adherent devitalized necrotic tissue, stage 4, size 8x9 cm, exudate type: serous (Serous drainage is a clear to yellow fluid that leaks out of a wound. It's slightly thicker than water .Too much serous fluid is a sign of an infection), amount scant, no odor, wound bed black/brown (eschar), wound edges defined, surrounding tissue normal for skin. Document interventions and the residents response to the interventions: cleanse with NS, pat dry, Santyl and calcium alginate and dover with gauze island with dry dressing for 30 days. Wound rounds completed with wound MD, location #1: sacrum etiology: Pressure stage 4 ([NAME]) Measurement: 8 cm x 9 cmx not measurable cm. Description: serous drainage, wound bed 100% eschar, no odor. Wound progression: deteriorated. Treatment: cleanse with normal saline, apply Santyl, apply calcium alginate and cover with dry dressing everyday . Record review of CR#1's Wound Care Doctor notes dated 11/21/23 by wound Care Doctor B revealed the following: CR#1 present with a wound on his sacrum and a rash *Review of Systems: Appetite- Fair, Supplements- Multivitamins, protein, Vitamin C . *Bed- group 2 . *Wound Exam (Site 1): Stage 4 pressure wound sacrum full thickness *wound size (LxWxD): 8x9x no measurable cm. Depth is unmeasurable due to presence of nonviable tissue and necrosis (Necrotic wounds are areas of tissue loss that occur following the death of their component cells. Once an area of tissue becomes devitalized, dead tissue build-up commences which might inhibit the rate at which wound repair occurs) *Surface area: 72.00 cm2 x exudate moderate serous (Serous drainage is a clear to yellow fluid that leaks out of a wound. It's slightly thicker than water .Too much serous fluid is a sign of an infection) and thick adherent devitalized necrotic tissue-100%. *Dressing Treatment Plan: Alginate calcium apply once daily for 30 days; Santyl apply once daily for 30 days. Secondary dressing(s): gauze island w/ bdr apply once daily 30 days. *Plan of Care reviewed and addressed: recommendations: off-load; reposition per facility protocol; turn side to side in bed every 1-2 hours if able. Site 1: Surgical excisional debridement procedure: remove necrotic tissue and establish the margins of viable tissue. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Consent for procedure: treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained were explained on 11/21/23 to the patient who indicated agreement to proceed with the procedures. Procedure note: The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise 14.4 cm2 of devitalized tissue and necrotic muscle level tissue were removed at a depth of 0.5 cm and healthy bleeding tissue was observed. As a result of this procedure, the non-viable tissue in the wound bed decreased from 100% to 80%. Hemostasis was achieved and a clean dressing was applied. *Post-operative recommendations and updates to the plan of care are documented in the Assessment and plan section below. *Post-debridement assessment of this previously unstageable necrotic wound has revealed the underlying deep tissue (pressure ulcer described as purple or maroon localized area of discolored intact skin or blood filled blister due to damange of underlying soft tissue from pressure and/or shear) at the muscle/fascia level, which had been obscured by necrosis prior to this point. This Wound has now revealed itself to be a Stage 4 pressure injury. This is not a wound deterioration. *Other diagnosis: Irritant dermatitis from body fluid: location buttock for at least 1 day, *history: bilateral buttocks, *treatment: zinc oxide-based barrier cream as directed. *Coordination of Care: Data and history pertinent to this patient's care were obtained via CR#1, nursing staff, nursing facility records. CR#1's plan of care was discussed with CR#1, nursing staff member. The clinical documentation for this consultation was made available to the referring physician. This documentation has also been made available for access to the appropriate personnel and placement in the medical record. Record review of CR#1's LN-Skin Pressure Ulcer Weekly dated 11/28/23 and signed by LPN A revealed: Follow up, not present on admission, onset date 10/28/23, Sacrum, stage 4, size 8x9 cm, moderate serous exudate, no odor, wound bed black/brown (eschar), wound edges: macerated, surrounding tissue normal for skin, cleanse with normal saline, pat dry, apply Santyl and calcium alginate and cover with dry dressing daily. Pressure ulcer review Site 2, onset date unknown, left heel unstageable deep tissue injury (DTI), size 3x4cm, document interventions and the residents response to the interventions: skin prep to area and leave open to air . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's Wound Care Doctor notes dated 11/28/23 by wound Care Doctor B revealed CR#1 has wounds on his sacrum and left heel .Focused Wound Exam (Site 1) Stage 4 Pressure Wound Sacrum full thickness. Wound size (LxWxD): 8 x 9 x not measurable, Depth is unmeasurable due to presence of nonviable tissue and necrosis. Surface area: 72.00 cm2, exudate: moderate serous, thick adherent devitalized necrotic tissue: 100%, wound progress: not at goal. Site 1: Surgical excisional debridement procedure: Indication for procedure: Remove necrotic tissue and establish the margins of viable tissue. Consent for procedure: Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 11/21/23 .Focused Wound Exam (Site 2): Unstageable DTI of the left heel partial thickness .Wound size (L x W x D): 3 x 4 x not measurable cm2, surface area: 12.00 cm2, exudate: none. Coordination of Care: . Data and history pertinent to this patient's care were obtained via CR#1, nursing staff, nursing facility records. CR#1's plan of care was discussed with CR#1, nursing staff member. The clinical documentation for this consultation was made available to the referring physician Record review of CR#1's Wound Care Doctor notes dated 12/5/23 by wound Care Doctor B revealed CR#1 has wounds on his sacrum and left heel .Wound size (L x W x D): 9.5 x 9 x not measurable cm. Surface area: 85.50 cm2, moderate serous, thick adherent devitalized necrotic tissue: 70%, granulation tissue: 30%, wound progress: improved evidenced by increased granulation, decreased necrotic tissue. Focused wound exam (site 2): unstageable DTI of the left heel partial thickness. Wound size: (L x W x D): 3x4x not measurable cm, surface area: 12.00 cm2, exudate: none, Wound progress: at goal. Dressing treatment plan: skin prep apply three times per week for 23 days .recommendations: float heels in bed; off-load wound. Summarized Wound Care Assessment and Individualized Treatment Plan . Procedure today: Surgical excisional debridement was performed today on this wound . Record review of CR#1's LN-Skin Pressure Ulcer Weekly dated 12/5/23 and signed by LPN A revealed: Follow-up, not present on admission, onset date unknown, sacrum, full thickness stage 4, size 9.5x 9 cm, depth 0, moderate serous, no odor. Pressure Ulcer Review Site 2, follow up, not present on admission, onset date unknown, left heel unstageable DTI (slough/eschar), 3 x 4 cm, depth 0, skin prep to area and leave open to air . Record review of CR#1's LN-Skin Pressure Ulcer Weekly dated 12/14/23 signed by LPN A, follow-up . sacrum stage 4, 11x11 cm, moderate serous, Pressure Ulcer Review Site 2 Left heel, unstageable DTI with intact skin, skin prep 3 times a week. Additional documentation/comments: Wound rounds with Wound Dr. for location #1: sacrum etiology: Pressure stage 4 ([NAME]) procedure: surgical excisional debridement, measurement 11cmx 11cm x 0cm. Description: moderate serous drainage, wound bed 60% necrotic tissue, 40% granulation tissue. Odor present. Wound progression: improved evident by increased granulation, decreased necrotic tissue. Treatment: clean with Darkin's solution, apply sterile gauze and cover with dry dressing every day. Location #2: left heel etiology: Pressure unstageable DTI with intact skin, measurement: 3 cm x 4 cm x 0 cm. Treatment: Record review of CR#1's LN-Skin Pressure Ulcer Weekly dated 12/19/23 signed by LPN A revealed: Follow up sacrum full thickness, stage 4 size 11 x 12 cm, surgical excisional debridement performed. Cleanse with Darkin's solution, pack with sterile gauze and cover with dry dressing daily. Pressure Ulcer Site 3: Follow up, onset date unknown for Left heel unstageable DTI with intact skin- Resolved. (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	Record review of CR#1's Wound Care Doctor notes dated 12/14/23 by wound Care Doctor B revealed CR#1 has wounds on his sacrum and left heel. Wound size (LxWxD): 11x11x not measurable cm. Surface area: 121.00 cm2, exudate: moderate serous, thick adherent devitalized necrotic tissue: 60%, granulation tissue: 40%, Wound progress: improved evidenced by increased granulation, decreased necrotic tissue .Procedure today: Surgical excisional debridement was performed today on this wound .Dressing Treatment Plan: Skin prep three times per week. Record review of CR#1's Wound Care Doctor notes dated 12/19/23 by wound Care Doctor B revealed CR#1 has wounds on his sacrum, left heel and a rash .Skin: Back- wound present, left lower extremity- dermatitis, right lower extremity-dermatitis. Wound size (L x W x D): 11x12x not measurable cm. Depth is unmeasurable due to presence of nonviable tissue and necrosis. Surface area: 132.00 cm2, exudate: moderate serous, thick adherent devitalized necrotic tissue- 50%, granulation tissue: 50%, Wound progress: improved evidenced by increased granulation, decreased necrotic tissue. Dressing Treatment plan: Gauze sponge sterile apply once daily for 25 days; sodium hypochlorite solution (Dakin's) apply once a day for 25 days. Secondary dressing: gauze island with bdr apply once daily for 25 days Site 1: Surgical excisional debridement procedure: remove necrotic tissue and establish the margins of viable tissue. Consent for procedure: Treatment options-risks-benefits and the possible need to subsequent additional procedure on this wound were explained on 11/21/23 to the patient who indicated agreement to proceed with the procedure(s). Focused Wound Exam (Site 2): Unstageable DTI of the left heel (Resolved on 12/19/23). Record review of CR#1's Daily Skilled notes from 12/21/23-12/25/23 written by RN A had the same entry for all skilled notes: Cognition: alert, oriented x2 .Integumentary: Overall skin description is skin warm and dry to touch. There are No active symptoms effecting the Integumentary system observed. No active skin condition(s) or treatments observed. other skilled treatments: bed mobility: self-performance- total dependence, bed mobility: support provided-two+ persons physical assist, transfer: self-performance total dependence transfer: support provided- two+ persons physical assist, eating: self-performance total dependence- eating: support provided -two+ persons physical assist, toilet use: self-performance total dependence- toilet use: support provided one person physical assist, additional documentation: no education/teaching provided Record review of CR#1's Progress notes dated 12/27/23 at 12:10 p.m. written by ADON B revealed, Social worker came to this ADON stating that resident [CR#1] family had sent an email in regards of wanting resident [CR#1] to be sent to ER at [Local Hospital] for wound evaluation, and to see if an order can be given to send resident [CR#1]. This ADON notified NP Doctor and she gave a verbal order to send resident to ER per family request .and transportation is set for today, pick-up between 2-3pm, this ADON also informed CR#1's family member that family will be paying for transport . Record review of CR#1's Daily Skilled Note dated 12/27/23 at 4:48 p.m. written by LVN C revealed, Vitals dated 12/26/23: blood pressure 115/70, temperature 97.3, no pain .Cognition: alert x2 .Integumentary: Overall skin description is: skin warm and dry to touch. There are No active symptoms effecting the Integumentary system observed. No active skin condition(s) or treatments observed. Record review of CR#1's Hospital Radiology report by MD dated 12/27/23 at 9:17 p.m. revealed: There is a large sacral decubitus ulcer noted that appears to extend down to the level of the bone with lucency of the tip of the coccyx though diffuse overall osteopenia making osteomyelitis difficult to exclude . IMPRESSION: 1. Possible sacrococcygeal osteomyelitis (infection in the bone), MRI would best evaluate. Please (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675901	A. Building B. Wing	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Health and Rehabilitation Center	1106 Golfview Richmond, TX 77469

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	correlate. 2. Moderate fecal retention suggesting constipation and possible impaction, please correlate . Record review of CR#1's Hospital Wound Care Documentation dated 12/27/23 at 9:50 p.m. by hospital RN revealed: Wound, pressure injury, bony prominence, sacrum, pressure injury present on admit, Stage 4, Length 14, width 15, depth 3, wound treatment performed on 12/27/23 at 10:50 p.m. by RN, tunneling under skin, moderate exudate, wound exudate was purulent, Strong odor, necrotic tissue-eschar, surrounding tissue boggy-ecchymotic (discoloration of the skin due to the rupture of the blood vessels below the surface), wound status is deteriorating, gauze, damp to dry. Record review of CR#1's Hospital note dated 12/27/23 at 10:08 p.m. revealed, As related to the inpatient hospital stay starting on 12/27/2023 10:08 PM. Provider response text: sepsis due to Sacral osteomyelitis, present on admission Risk Factors: HP 12/27: 78 M with Sacral osteomyelitis, Sacral pressure ulcer, Transaminitis S/S: ED Assessment 12/27: stage 4 wound, 15cm wide x 14cm long x 3cm deep, infected wound tunneling under the skin, with eschar pockets and fowl smelling HP 12/27: Blood pressure on the low side, large decubitus ulcer on the sacrum, CT showed possible sacrococcygeal osteomyelitis Vital sign 12/27: Blood pressure 89/69_82/61, Heart rate 95-106, Lab 12/28: Sedimentation rate (level of protein in blood) 120, C Reactive Protein 82.1, Procalcitonin 0.11, WBC 11.5 Record review of CR#1 Hospital Drug Therapy Management Order Details Dated 12/27/2023 11:05 p.m. signed by MD revealed: Indication for Vancomycin : Bone and joint infection Vancomycin Anticipated Duration : 7 day. Record review of CR#1's Hospital Miscellaneous Progress note dated 12/29/23 at 5:15 p.m. revealed:: ED assessment 12/27: cleaned with saline, packed with wet to dry dressing. HP 12/27: started on cefepime/vancomycin .IV fluids, id/ortho consult in the morning Clinic Nurse 12/28 (gen sx): bedside debridement will be done with wound care nursing, possible colostomy. -- Sepsis due to Sacral osteomyelitis, present on admission, -- Sepsis due to Sacral pressure ulcer, present on admission, -- Sepsis due to Gram positive bacteremia, present on admission ED Assessment 12/27: stage 4 wound, infected wound tunneling under the skin, with eschar pockets and fowl smelling. HP 12/27: Blood pressure on the low side, large decubitus ulcer on the sacrum, CT showed possible sacrococcygeal osteomyelitis Lab 12/27-29: Chloride 113_120_117 (amount of chloride in the blood), CO2 22_22 (the presence of the gas carbon dioxide. Record review of Hospital Progress note dated 12/29/23 at 12:27 p.m. by MD revealed: Discussed with Wound Care. Agree with wound vac would be a good option for. This will all slough [TRUNCATED]