STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676147	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stallings Court Nursing and Rehabilitation	4616 NE Stallings Dr Nacogdoches, TX 75965

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection and new pressure ulcers from developing for 1 of 3 (Resident #1) residents reviewed for pressure injuries.1.The facility did not ensure Resident #1's interventions were in place with heel protectors and keep heels floating while in bed on 5/27/2026.2.The facility failed to ensure Resident #1 did not develop a pressure-related deep tissue injury on 4/23/2026. These failures could place residents at risk for new development or worsening of existing pressure injuries, pain, and a decreased quality of life.Findings include:Record review of Resident #1's admission Record, dated 5/27/2026, indicated an [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia (affects memory, thinking, and social abilities that can interfere with a person's daily life), hypertension (high blood pressure), acute embolism and thrombosis of deep veins of her right lower extremity (blood clot in the right leg).Record review of Resident #1's active physician orders, dated 5/27/2026, indicated an order for wound care, dated 5/13/2026, which indicated: an unstageable pressure wound to the right heel with wound care to be provided one time a day to promote wound healing. Wound care orders were to clean the area with normal saline/wound cleanser, pat dry with 4x4 gauzes, apply leptospermum honey (used to aid in wound healing) and cover with gauze island border dressing.Record review of Resident #1's care plan, dated 4/23/2026, indicated she had a pressure injury unstageable DTI to her right heel. Interventions included pressure relieving devices: heel protectors.Record review of Resident #1's admission MDS Assessment, dated 4/21/2026, indicated she had severe impairment in thinking with a BIMS score of 3. Resident #1 was at risk of developing pressure ulcers/injuries but did not have any unhealed pressure ulcers/injuries.Record review of Resident #1's Braden scale for predicting pressure sore risk, dated 4/16/2026, indicated a low risk with a score of 19.Record review of Resident #1's admission skin assessment, dated 4/16/2026, by LVN B, indicated the resident did not have any pressure injuries or wounds. Her skin was intact.Record review of Resident #1's weekly skin assessment, dated 4/23/2026, by the Treatment Nurse, indicated she had redness to her left heel that was blanchable (skin can turn white or pale when pressure is applied and then returns to its normal color when pressure is removed). New open area was indicated to her right heel with a suspected deep tissue injury that measured 2 cm x 2 cm. The RP and physician were notified. There were not any pressure reducing devices in place.Record review of Resident #1's weekly skin assessment, dated 4/29/2026, by the Treatment Nurse, indicated she had redness to her left heel that was blanchable. Her right heel with a deep tissue injury that measured 1.4 cm x 1 cm. The RP and physician were notified. Pressure reducing devices in place included heel protectors.Record review of Resident #1's wound physician notes, dated 4/29/2026, revealed the resident had an unstageable DTI of the right heel that measured 1.4 cm x 1 cm, no drainage, with the skin being intact with purple/maroon discoloration. Orders for skin prep to be applied once daily. Recommendations to float heels in bed.Record review of a clinical unavoidable pressure injury for Resident #1, dated 4/29/2026, by the wound care physician, indicted she had interventions in place prior to the development or (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 - Minimal harm or potential for actual harm Residents Affected - Few	worsening of a pressure injury.Record review of a facility wound report, dated 5/21/2026, indicated Resident #1 had an in-house wound to her right heel that was a deep tissue injury that was identified on 4/23/2026.Record review of Resident #1's wound physician notes, dated 5/27/2026, revealed the resident had an unstageable wound of the right heel that measured 1.5 cm x 1.8 cm x 0.1 cm. Wound progress had improved as evidenced by decreased surface area. The wound was undergoing autolytic debridement. The goal of treatment was healing as evidenced by a 2.7% decrease in surface area within the wound bed in comparison to the previous wound care visit.During an observation and interview on 5/27/2026 at 12:55 PM, revealed Resident #1 was in bed awake and alert to person only with confusion noted. Her RP was present in the room and said the resident had dementia and would not be able to answer questions appropriately. The RP said the resident had a wound on her right heel that had been there since 4/23/2026. The resident was lying on her back with a pillow under her knees. She was wearing one heel protector on her right foot, and both heels were touching the mattress.During an interview on 5/27/2206 at 1:15 PM, CNA A said she was assigned to care for Resident #1 that day. She said the facility told her to put heel protectors on both feet on Resident #1 and to keep her heels floating. She said the RP requested the staff to place a pillow under her knees while in bed as it helped to lift her heels up off the mattress. She said Resident #1 only had one of the heel protectors in place on her right foot because the other heel protector had gotten dirty from a bowel movement about 2 weeks ago and she threw it away. She said she had been using the one heel protector on her right heel. She said the heel protectors were used to prevent pressure sores and Resident #1 had a wound to her right heel. She said the facility was aware Resident #1 only had one heel protector and said they were ordering more.During an observation and interview on 5/27/2026 at 1:29 PM, the Treatment Nurse said she was responsible for completing the skin assessments in the facility for the residents. She said Resident #1 admitted to the facility without any wounds but developed a DTI to her right heel after admission. She said they had wound treatment orders in place, and the wound physician saw the resident weekly. She said Resident #1 did not like to be repositioned and liked to lie on her back, but they had heel protectors in place for her. She observed Resident #1 in bed moving around with the covers pulled back. She said the resident was supposed to have two heel protectors on but only had one on her right heel and her heels should not be on the mattress. She said the heel protectors came in a set of two. She said if a resident did not wear heel protectors as ordered then they could develop more wounds. She said she would get another heel protector for the resident.During an observation on 5/28/2026 at 9:10 am, the Treatment Nurse was in the room of Resident #1 to provide wound care. She gathered wound care supplies in the hallway and placed them on wax paper, donned (put on) a gown and entered the room. She washed her hands in the bathroom and donned gloves. Resident #1 was in bed awake with her feet on top of the linens. She had heel protectors on both feet, and her heels were floated on a pillow. She was wearing nonskid socks. The Treatment Nurse removed the heel protector from her right foot and along with Resident #1's sock. The Treatment Nurse removed her gloves and placed them in the trash; sanitized her hands; and applied clean gloves. A dressing was noted to Resident #1's right heel dated 5/27 and she removed the dressing and placed it in the trash. An open wound was noted to Resident #1's right heel with a small amount of bleeding noted. The Treatment Nurse sanitized her hands and put on clean gloves and cleaned the wound with wound cleanser and 4x4 gauze and patted the area dry with gauze. She removed her gloves and placed them in the trash and sanitized her hands. She applied medihoney to the wound bed and placed a dressing on her right heel that was dated 5/28/26 along with her initials. She removed her gloves and placed them in the trash. She washed her hands and applied gloves; placed the sock back on Resident #1's right foot along with the heel protector. The linens were pulled back over resident in bed, and a pillow was placed under her feet to float her heels. She gathered the trash and lowered Resident #1's bed; doffed (took off) her gown and placed it in the trash; sanitized her hands and exited the room.During an interview on 5/28/2026 at 9:42 AM, LVN B said she was the nurse who completed the admission for Resident #1. She Resident #1 admitted to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility on [DATE] and had some bruises from a fall she had prior to her admission and a skin cancer lesion that was on her forehead. She said she did not have any open wounds or pressure ulcer injuries on admission. She said the facility had a Treatment Nurse that did weekly skin assessments on the residents in the facility. She said Resident #1 had a wound to her right heel with an order for heel protectors after she was admitted . She said the heel protectors were to relieve pressure on their heels, and the heels should be floated with a pillow positioned on the shins so the heels would not touch the bed.During an interview on 5/28/2026 at 1:34 PM, the ADON said Resident #1 had a DTI to her heel and had the heel protectors in place with wound care daily. She said the Treatment nurse performed wound care and the facility had a wound physician that visited weekly. She said the heel protectors should be on while a resident was in bed, and all staff were responsible for ensuring they were in place. She said they had a stock supply of foam heel protectors in the facility. She said the purpose of the heel protectors was to prevent wounds. She said they tried to float the heels with a pillow under the ankles, so the heel did not touch the bed. She said she was not aware Resident #1 only had one heel protector.During an interview on 5/28/2026 at 1:50 PM, the DON said she received a phone call from the Treatment nurse one day and was informed Resident #1 had a DTI to her heel and she questioned the Treatment Nurse when the last skin assessment was conducted and was told Resident #1 did not have any wounds observed between that week and that was when the heel protectors were put in place for Resident #1 when the wound was identified. She said the heel protectors should be on a resident while they were in bed and should have both heel protectors on. She said her feet should be positioned offloaded and not touching the mattress. She said she was made aware yesterday (5/27/2026) that Resident #1 only had one heel protector on and her heels were not floating. She said Resident #1's heels should be floated with a pillow so the heels should not touch the mattress. She said the heel protectors were to prevent the skin from touching the mattress and relieve pressure. She said on admission Resident #1 did not have any wounds on her feet and acquired the wound in house. She said the facility had a wound physician who visited weekly and was seeing Resident #1.During an interview on 5/28/2026 at 2:39 PM, the Administrator said she had been at the facility since March 2026. She said she was made aware in a morning meeting by the Treatment nurse that Resident #1 had developed a wound to her heel that was not present on admission to the facility. She said the Treatment nurse put heel protector orders in place for Resident #1 to ensure the wound did not get any worse. She said the heel protectors were for both feet. She said the staff would place a pillow under her legs to keep the heels from touching the mattress. She said she was not aware the resident was not wearing heel protectors. She said the purpose of the heel protectors was to help prevent pressure wounds. She said she planned to reeducate the staff to communicate, and it was not acceptable to not have things in place. She said all staff were responsible for ensuring residents had heel protectors if ordered and should be worn when in bed. She said the risk would be that they could develop more wounds if they did not wear them.Record review of the facility's policy titled Prevention of Pressure Ulcers, revised March 2005, indicated .The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors. 5. Risk factor-immobility c. when in bed, every attempt should be made to float heels' (keep heels off of the bed) by placing a pillow from knee to ankle or with other devices as recommended by therapist and prescribed by the physician.