

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Kingwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23775 Kingwood Place Kingwood, TX 77339	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure 4 (CR#2, CR#3 R#1 and R#2) of 9 resident reviewed was free from abuse and neglect</p> <p>The facility failed to prevent neglect and failed to provide the required structures and processes in order to meet the needs of CR#2 when interventions were not implemented: WCD orders for changing bandages, turning, and repositioning, and getting CR#2 in the chair twice daily. As a result, CR#2 did not receive proper treatment to prevent wound deterioration and infection, which resulted in hospitalization with severe sepsis and required surgical wound debridement.</p> <p>An Immediate Jeopardy (IJ) was identified on 5.28.2025. The IJ template was provided to the facility on 5.28.2025 at 1:15p.m. While the IJ was removed on 6.1.25 at 6:25p.m., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>The facility failed to protect CR#3 from abuse from staff after his allegation of verbal and physical abuse and allowed the abuser to provide care before transferring CR#3 to another hall. CR #3 verbalized fear of the alleged abuse perpetrator (LVN B), and LVN B continued to work with CR#3 after the allegation.</p> <p>An Immediate Jeopardy (IJ) was identified on 5.30.2025. The IJ template was provided to the facility on 5.30.2025 at 1:27p.m. While the IJ was removed on 6.1.25 at 6:25p.m., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures placed residents at risk for physical harm and mental anguish and neglect.</p> <p>Findings included:</p> <p>Record review of CR#2's face sheet revealed a [AGE] year-old female, initially admitted to the facility on [DATE], readmitted [DATE] and discharged [DATE] with a diagnosis of COPD, Osteomyelitis of vertebra (rare bone infection that inflames and infects spinal disc), sacral and sacrococcygeal region (butt area).</p> <p>(continued on next page)</p>		

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of CR#2's Annual MDS assessment dated 3.13.25 revealed a BIMS score of 15 (cognitively intact). Section GG (Functional Abilities) revealed, CR#2 is impaired on both sides (lower extremity-hip, knee, ankle, foot), uses a wheelchair. CR#2 need substantial/maximal assistance with oral, toilet, and personal hygiene, shower/bathe, upper and lower body dressing and putting on/taking off footwear; requires partial/moderate assistance to roll left and right; has an Indwelling catheter (carries the urine out of the body) and Ostomy (collects waste); paraplegic (inability to move the lower parts of the body). Section M (Skin Conditions) revealed CR#2 is at risk and has stage 3 and 4 pressure ulcers.</p> <p>Record review of CR#2's orders dated 1.2.2025 revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ascorbic Acid Tablet 500 MG one time a day for wound healing related to unspecified skin changes, Order date 1/3/2025-05/22/2025; Colostomy to LLQ (bottom left area of abdomen) every day shift, every 3-days Change colostomy bag and wafer (piece of pouch that sticks to the body) every 3 days-Order date 1/2/2025-05/22/2025; Type of wound: Pressure (injury to skin and underlying tissue) and MASD (Moisture-Associated Skin Damage) caused by prolonged exposure to moisture. Location of wound: right and left buttocks, and left post upper thigh, irrigate or cleanse wound bed with normal saline, nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): Collagen and Cal Alginate cover (Wound dressing) with dry dressing secure dressing with tape as needed Order date 3/26/2025-5/22/2025; Type of wound: Pressure stage 3. Location of wound: Right Gluteus (buttock) irrigate or cleanse with normal saline, Nexodyn solution (wound care solution containing hypochlorous acid) or wound cleanser, pat dry and apply or pack collagen & Cal alginate cover-Order date 3/28/25-5/22/2025; Type of wound: Pressure stage 4. Location of wound: left buttock irrigates or cleanse wound bed with Normal saline, Nexodyn solution (wound care solution containing hypochlorous acid) or wound cleanser, pat dry and apply or pack collagen & Cal alginate cover-Order date 5/5/25-5/22/2025; Type of wound: PRESSURE Location of wound: LEFT PHONE GLUTEUS Irrigate or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): COLLAGEN AND CAL ALGINATE Cover with: ABD (abdomen) PAD AND DRY DRESSING Secure dressing with: TAPE; Type of wound: PRESSURE Location of wound: LEFT GLUTEUS Irrigate or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): COLLAGEN AND CAL ALGINATE Cover with: ABO PAD AND DRY DRESSING Secure dressing with: TAPE-Order date 2/27/2025- 5/22/2025; Type of wound: PRESSURE Location of wound: LEFT UPPER POSTERIOR THIGH irrigate or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): COLLAGEN AND CAL ALGINATE Cover with: ABD PAD AND DRY DRESSING Secure dressing with: TAPE PAIN CODE Order date 2/27/2025-05/22/2025; WEEKLY SKIN ASSESSMENT. COMPLETE HEAD TO TOE SKIN ASSESSMENT AND DOCUMENT FINDINGS ON WEEKLY SKIN OBSERVATION TOOL UDA every day shift every Tue -Order Date- 01/02/2025- 05/22/2025; COLOSTOMY TO LLQ every shift COLOSTOMY CARE QSHIFT AND PRN USE STOMA PASTE AND/OR POWEDER AROUND THE OSTOMY -Order Date 01/02/2025-05/22/2025; Enhanced Barrier Precautions (EBP) every shift with high contact care activities. -Order Date- 04/22/2025-05/22/2025; OBSERVE AND MONITOR MIDLINE ABD SURGICAL INCISION FOR PROPER HEALING, NO INFECTION AND APPROXIMATION EVERYDAY, EVERY SHIFT every day and night shift -Order Date 01/14/2025-05/22/2025; Santyl External Ointment 250 UNIT/GM (Collagenase)Apply to RIGHT HEEL topically related to PRESSURE ULCER OF RIGHT HEEL, STAGE 4 -Order Date 03/27/2025-05/22/2025, Type of wound: [NAME] Location of wound: LEFT GLUTEUS Irrigate or cleanse wound bed with Normal saline, Nexodyn solution o wound cleanser, pat dry and apply or pack (if applicable): COLLAGEN ANDCALALG Cover with:(6X6) SUPRAABSORBENT SILICONE BORDERED DRSG. Secure dressing with: MEDIFIX TAPE-Order Date 01/16/2025- 5/22/2025; Type of wound: PRESSURE DTI Location of wound: RIGHT HEEL (CORRECTION TO LOCATION) Irrigate or cleanse wound bed with Nonnal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): SANTYL AND CAL ALGINATE Cover with: DRY DRESSING Secure dressing with: TAPE Order Date 03/21/2025-5/22/2025; Type of wound: PRESSURE STAGE 4 - Location of wound: LEFT POSTERIOR THIGH_ Irrigate or cleanse wound bed with Normak saline, Nexodyn solution o wound cleanser, pat dry and apply or pack (if applicable): COLLAGEN ANDCALALG Cover with: DRY DRESSING Secure dressing with: TAPE AS NEEDED -Order Date 04/17/2025-05/22/2025.</p> <p>Record review of CR#2's care plan dated 3.27.2025 revealed the following:</p> <p>Focus: [CR#2] Requires Wound Care Management</p> <p>Goal: [CR#2] Wound will be free of signs or symptoms of infection. Target Date: 6.19.2025</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interventions: Evaluate ulcer characteristics, measure ulcer on at regular intervals, monitor ulcer for signs of infection, monitor ulcer for signs of progression or declination, notify provider if no signs of improvement on current wound regimen, Provide Wound Care per Treatment Order</p> <p>Focus: [CR#2] requires assistance to perform functional abilities in Self Care and mobility (AEB), unsafe or poor quality in functional range of motion (Specify- to upper or lower, right or left, etc. r/t Medically complex conditions transfer with mechanical lift)</p> <p>Goal: [CR#2] will have improvement in functional abilities in the following areas by end of their skilled stay. Target date 6.19.2025.</p> <p>Interventions: Provide the following self-care assistance: (Specify in A-H below-Partial, Substantial/Maximal</p> <p>A.</p> <p>Eating: Independent</p> <p>B.</p> <p>Oral hygiene: Independent</p> <p>C.</p> <p>Toilet Hygiene: Substantial/Maximal</p> <p>E. Shower/Bathe self: Partial/Moderate</p> <p>F. Upper body Dressing: Independent</p> <p>G. Lower body Dressing: Substantial/Maximal</p> <p>H. Putting on/taking off footwear: Substantial/Maximal</p> <p>I. Personal Hygiene: Independent</p> <p>Focus:[CR#2] has Specify: Suprapubic Catheter present and is at risk for UTI and complications due to catheter use R/T Neurogenic bladder.</p> <p>Goal:[CR#2] will be/remain free from catheter-related complications through review date. Target Date: 6.19.2025.</p> <p>Interventions: Check tubing for kinks throughout each shift, encourage fluid intake, monitor for leg strap placement and change as needed, monitor for s/sx of discomfort on urination and frequency, monitor urinary output amount, color, odor and sediments, etc. report abnormal to MD.</p> <p>Focus: [CR#2] has potential fluid deficit r/t Dx of Septicemia (blood infection)</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Goal: [CR#2] will be free of symptoms of dehydration and maintain moist mucous, membranes, good skin turgor. Target Date: 6.19.25</p> <p>Interventions: Monitor and document intake and output as per facility policy;</p> <p>Monitor/document/report PRN any s/sx monitor/document/report PRN any s/sx of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increase pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes, obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated.</p> <p>Focus: [CR#2] has stage 4 pressure injury to left buttock, left posterior upper thigh and stage 3 PI to right buttock.</p> <p>Goal: [CR#2] Pressure injury will be free from signs and symptoms of infections. Target Date: 6.19.25; will remain free of pressure injury through the next review date. Target date: 6.19.25; will show granulation and reduction in size through review date. 6/19/25</p> <p>Interventions: Add additional supplements as needed, administer treatment to decubitus ulcers(s) as ordered. If no wound improvement notify MD/NP to obtain new orders (1.16.2025: Collagen and cal alginate daily; 3.17.2025: Collagen and cal alginate with dry drsg daily); assist resident with Turning & repositioning during rounds and as needed; monitor and report MD and RP and s/s of infection.</p> <p>Weekly skin assessment, notify M.D. for Ulcers that are deteriorating, as needed. 1.16.25 Left gluteus 12x10x0.4cm and left upper posterior thigh 9x9.8x0 cm; 3.17.2025 Left buttock - 10x10x0.4cm and left upper posterior thigh 9x10x0.3cm and right buttock 8.8x8x0.2;</p> <p>Focus: [CR#2] has a pressure DTI pressure injury to bilateral heels d/t</p> <p>Goal: [CR#2] will have no complication from wound. Target date: 6.19.2025.</p> <p>Interventions: Assist with turn/repositioning during rounds and as needed</p> <p>Focus: [CR#2] is on antibiotics for osteomyelitis and is at risk for adverse reactions.</p> <p>Goal: [CR#2] Infection will be resolved or resolving at the end of antibiotic therapy and resident will not have any adverse reactions to antibiotic therapy. Target date.6.19.2025</p> <p>Interventions: Assess effectiveness of interventions and adjust plan as indicated.</p> <p>Focus: [CR#2] has a colostomy</p> <p>Goal: [CR#2] will have adequate emptying of bowels daily and evidence any signs of symptoms of obstruction or constipation until next review. Target date: 6.19.2025.</p> <p>Interventions: Monitor bowel put daily, nursing staff will change colostomy bag as needed, provide stoma care daily as instructed and prn. Report any abnormalities to MD and RP.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Focus: [CR#2] has the history of osteomyelitis a vertebrae sacrococcygeal region and is at risk for recurrent infection to bones.</p> <p>Goal: [CR#2] will not experience signs and symptoms of osteomyelitis unaddressed during review. Target date 6.19.2025</p> <p>Interventions: encourage resident to report abnormal pain to bones, labs as ordered, medications as ordered, monitor for s/s of infection as needed and report abnormalities, therapy to screen and eval as needed.</p> <p>Focus: [CR#2] as paraplegia. At risk for complications related to conditions.</p> <p>Goal: [CR#2] will have no complications related to condition through the next review date. Target date 6.19.2025.</p> <p>Interventions: Encourage to maintain physical activity within limits, monitor 4 autonomic dysreflexia (overreaction of the nervous system) symptoms such as hypertension (high blood pressure), diaphoresis (excessive sweating), dizziness, anxiety, increase spasticity (stiff muscles), flushing of the skin, bradycardia (low heart rate), cool pale skin, visual disturbances,</p> <p>Focus: [CR#2] has diagnosis of Paraplegia and is at risk for contracture and skin breakdown.</p> <p>Goal: [CR#2] will not develop contractures until the next review. Target date: 6.19.2025, Resident will not develop skin breakdown until the next review. Target Date: 6.19.2025.</p> <p>Interventions: Report any skin breakdown to MD, Staff to provide all ADL care, weekly skin assessment.</p> <p>Focus: [CR#2] has frequent UTI's and is at risk for increased temperature, dehydration, and pain/discomfort.</p> <p>Goal: [CR#2] frequency of UTI's will that decrease, and resident will not have c/o (complaint of) pain discomfort, temp. will remain with in baseline limits until the next review. Target date: 6/19/2025.</p> <p>Interventions: give meds per order -monitor labs-report abnormals to M.D, monitor for increased temp, dehydration, pain discomfort, etc-report to M.D., Monitor to assure proper peri care (washing anal and genital area) is done, monitor urine for sediment, color, odor, amount, etc-report abnormals to MD.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In a telephone interview on 5.22.2025 at 3:40pm with FM B, he stated CR#2 is currently in the hospital. He stated CR#2 was not turned properly and her wounds became worst, which resulted in a colostomy bag. He stated nursing staff, including DON and Administrator, refused to communicate with him although he sent several emails to the DON regarding this issue. FM B stated the staff not answering phones half of the time and he would see them (employees) on their personal phones, then when they notice him looking at them then they would jump up and begin working. FM B stated CR#2 was somewhere on the 200 Hall. FM B stated because of CR#2 not being changed he would call the DON who would address this issue with staff, but nothing ever was corrected. FM B stated CR#2 can talk and let you know what's going on. He stated she is paraplegic. FM B stated CR#2 has been at the facility since 2015. He stated CR#2 was not seen daily by a wound care nurse because they either quit or get fired, then other nurses who are not good at doing wounds would try. FM B stated CR#2 treatment at this facility was horrible. FM B stated one issue is the staff would not change CR#2's urine bag and it backed up causing multiple UTI's.</p> <p>In an interview on 5/23/25 at 3:42 with ADON A - stated CR#2 was here for 10 years. She stated CR#2 has a chronic suprapubic catheter and she goes monthly to have her suprapubic catheter changed. She stated CR#2's wound stays moist, and she was being treated. ADON A stated when CR#2 went to the hospital; the sacrum womb got worse and became a stage 4. She stated CR#2 had to have a colostomy bag. ADON A stated CR#2 was being turned every 2 hours. ADON A stated CR#2 can reposition herself by grabbing hold of the bar. ADON A stated a previous wound care nurse took care CR#2. She stated the WCD makes rounds in the facility and sees residents, including CR#2, every week on Thursday.</p> <p>In an interview on 5/23/25 at 3:57pm with WCN - She stated she was in training and only completed CR#2's wound care a couple of times. She stated CR#2's sacrum wounds were stage 4. She stated she doesn't know what the instructions to staff from WCD as she was rounding with another wound care nurse and was to only observe and not take notes. She stated the wound care nurse who was rounding with her was more senior and responsible for taking notes. WCN stated the last time wound care on CR#2 was around 5/15/2025 with WCD and a previous weekend wound care nurse. She stated CR#2 had some serious wounds that were always draining. She stated there were 3 wounds, the sacrum (buttocks), one on the left thigh and one on the right heel. WCN stated a few days after CR#2 was seen by WCD she transferred to the hospital.</p> <p>In an interview on 5.24.25 at 7:30PM with HNM - She stated CR#2 arrived at the hospital emergency room on 5/18/2025 at 8:37pm. The admitting diagnosis was: Severe Sepsis; however, she stated according to doctors' notes, CR#2's chief complaint was her sacral (buttock) wound. HNM stated CR#2 is currently in surgery for wound debridement. The HNM stated upon CR#2's arrival to emergency room, CR#2 vitals were:</p> <p>B/P: 108/88</p> <p>Temp: 97.9</p> <p>Pulse: 88</p> <p>Respirations: 18</p> <p>WBC: 11.37</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an Interview with CNA D on 5/26/2025 at 10:30am -She stated she has worked at the facility for 3 years. She stated she has worked with CR#2. CNA D stated she turned CR#2 every two hours. CNA D stated CR#2 was cognizant enough to inform nursing staff what she needs and wants and is direct in her words. CNA D stated she has not witnessed CR#2 refusing care. CNA D stated CR#2 complained often about the 2-10 shift CNA's not bathing or turning her. CNA D stated her bath/shower was scheduled on the 2-10 shift. CNA D stated she would give CR#2 her baths if she had time on her shift. CNA D stated she has observed CR#2 requesting a nurse to flush her catheter. CNA D stated CR#2 does not like poop to get on her or her bandages and she demands to get changed immediately. CNA D stated CR#2 would only refuse to get out of bed when she is in a lot of pain. CNA D stated she would inform the wound care nurse or charge nurse when resident has issues or refused care. CNA D stated R#2 did not get her bandaged changed on 5/25/2025 and she noticed the 5/24/2025 date when she went into his room with the WCN.</p> <p>In an interview with WCN on 5/26/25 at 10:47am who stated she has recently been task to provide wound care. She stated she is a nurse that does wounds. WCN stated she completed CR#2's wound care a couple of times. She stated CR#2's sacrum wound was stage 4. She stated she doesn't know what previous instruction was given to former wound care nursing staff from wound care doctor because she only was observing. WCN stated the last time wound care was provided on CR#2 was around 5/15/2025 with WCD and weekend wound care nurse, LVN F. WCN stated CR#2 had some serious wounds that were always draining. She stated there were 3 wounds that she observed, one on the sacrum (buttocks), one on the left thigh and one on the right heel. She stated when it was time for her (WCN) to do wound care on CR#2 she transferred to the local hospital. In reference to R#1 and R#2, the WCN stated the date on R#1's bandage 5/24/2025, and R#2's bandage was dated 5/24/2025. WCN stated the bandages should be changed daily. She stated her last working day was 5/24/25. WCN stated in her absence, the charge nurses should have replaced the bandages. WCN stated either the weekend wound care nurse or charge nurses should have provided wound care to residents and replaced the bandages and dated them as well. WCN stated not changing wound care bandages, not replacing bandages that have fallen off and not following doctors' orders for wound care could place resident at risk for infection .</p> <p>In a Telephone Interview with WCD on 5/26/2025 at 12:42pm - he stated CR#2 appeared to be OK the last time he saw her on 5.15.25. He stated that the residents' wounds are chronic but not progressing. The WCD stated this was an issue, which is why he ordered Dakins Solutions. The WCD stated he observed CR#2's wound bandages to be saturated when he comes to visit and had some concerns with the wounds and not progressing well. He stated that CR#2's bandages on her wounds would be soiled. He stated one reason for the wound bandages would be if the catheter was not in properly or if the bandages were not being changed as ordered. The WCD stated he has not smelled any urine when he came to see CR#2. He stated CR#2 had a colostomy bag and a Foley catheter. The WCD stated that a saturated dressing could increase infection and could lead to systemic also known as sepsis if not changed properly. He stated he noticed that CR#2 does not get out of bed as she should. The WCD stated if wound dressings are not on the wound, it also increases the likelihood of bioburden infection (presence of microorganisms in wound that impedes healing and lead to infection) that could also lead to sepsis. WCD stated CR#2 should get up out of the bed several times during the day for at least 60 minutes to two hours and then placed back in bed . He stated when CR#2 refuses to get out of bed, facility staff should be a little more diligent with residents to encourage her to do so. The WCD stated that he has known resident for many years and the one thing that she does not do is lie!</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Kingwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23775 Kingwood Place Kingwood, TX 77339	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In a telephone interview with CNA G 5/26/2025 at 2:45pm, she stated she was very familiar with CR#2 because she worked 6am-2pm shift was responsible for her care. She stated CR#2 moods would change when she was in pain. She stated CR#2's wounds were always open and draining, which made her bandages soiled. CNA G stated CR#2 would get up in the chair sometimes after receiving a bed bath; however, she would refuse when she was tired and hurting. CNA G stated she put resident up in chair when she would ask. She stated CR#2 was a two person assist and needed to be lifted with the help of a Mechanical lift. CNA G stated whenever she would see CR#2's colostomy bag leaking it was changed as needed. CNA G stated if CR#2's bandage had a little poop on it she wanted it changed immediately. CNA G stated in her opinion, a little poop on the bandage did not mean the bandage should be changed. CNA G stated because CR#2's bandage had a small amount of poop on it, it didn't need changing and this would upset CR#2.</p> <p>In a telephone interview with LVN F on 5/26/2025 at 3:40pm -She stated she worked the 6a-6p and worked the 200 hall and first half of 600 hall. She stated the treatment nurse is responsible for wound care; however, if treatment nurse isn't available then the floor/charge nurse is responsible. She stated she did not turn R#2 and didn't see the sacrum wound because the treatment nurse was making rounds. LVN F stated she did not look at R#2's neck area. She stated the treatment nurse was in the building looking at all residents with wounds. LVN F stated when a resident's wound care dressing comes off, the treatment nurse is responsible; however, if the treatment nurse isn't available, then the charge/floor nurse would be responsible if they become aware. LVN F stated it is important for dressing to be changed as ordered to eliminate infections and to ensure the wound to heals. If the dressing is not redressed it can get contaminated and could get infected.</p> <p>In a telephone interview with LVN G on 5/26/2025 at 3:58pm She stated she worked yesterday as the wound care nurse. She stated she cannot remember the resident wounds that were changed. She stated does not remember changing R#2's bandages and she stated she did not change R#1's bandages. LVN G stated each time she went to R#1's room, she was not in the room. She stated she went by the room [ROOM NUMBER]-5 times, and she noted that she had provided wound care because she was going to return to R#1's room, but she forgot. LVN G stated it is important to change wound bandages, so they don't create infections. If the dressing on the wound comes off the resident's wound, it should be cleansed and replaced immediately. If the wound is not cleansed and bandage did not get replace, the wound could get infected. LVN G stated she checked off in the MAR which appears she provided care because she intended to go back to R#1's room. She stated as a nurse, I absolutely should NOT have done that. She stated R#1 could have gotten an infection and been sick from it.</p> <p>In an interview with DON on 5/26/2025 at 6:00pm she stated she would oversee wound</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Care by ensuring unit managers who, were initially doing wound care, have access to the VOHRA notes for nurses to upload weekly notes. This is what will occur until the facility has a wound care nurse. The DON stated she is ultimately responsible for wound care; however, she delegates this responsibility to her nurse managers. She stated in the event the managers are unable to do it then they are responsible to find a floor nurse to do the wounds in their own particular areas. The DON stated if wound care bandages are not changed, the wound can deteriorate and get worse by possible infection. The DON stated it important for wound dressing to be changed as ordered for proper healing of wound and prevent infection. The DON stated if a resident's dressing comes off the CNA has to notify the charge nurse so a dressing can be reapplied. If the dressing comes off and the nurse observes it then they would go to the Emar (Electronic Medication Administration Record), read the treatment notes and re-do dressing themselves. If the wound is not redressed there is a risk for infection and further declined of the wound.</p> <p>In an interview with Administrator on 5/26/202 at 6:15pm -She stated that in the past the facility had a regular wound care nurse and if the wound care nurse had become ill or unable to continue the job as the wound care nurse there were back up people trained to do wound care. She stated the facility was allowed to call a staffing agency for wound care nurses. Administrator stated there is a unit manager assigned to do wounds or delegate a licensed nurse to that position . She stated it use to be the DON. She stated they have assigned a nurse to be the wound care nurse, LVN G. She stated she is in training but does wounds currently. LVN G is making that transition from the position as the unit nurse to the wound care nurse. She stated the wound care nurse's position is still open and posted in case LVN G changes her mind. However, the DON is ultimately responsible for wound care. Administrator stated if there isn't a nurse in the building who is able to do wounds the DON is qualified to do wound care. She stated the ADON B is the unit manager, and she is also qualified to do wound care. Administrator stated that if wound care bandages are not changed per doctors' orders it could be a possibility for the wound not to heal as expedient as it needs to be. She stated if a resident's dressing comes off the charge nurse should be informed so that it can be replaced. She stated if a CNA observes the dressing has come off of a resident's wound, they should inform charge nurse immediately because if the wound is not redressed, it could place resident at risk for it getting bigger or worse. Administrator stated her expectation out of nursing staff is to do their jobs, report any issues, treat residents kindly, ensure their changed and turned as ordered and fed. She states she expect the DON to be the leader in carrying out clinical expectation of caring for residents in this facility.</p> <p>Record review of the Abuse, Neglect and Exploitation policy dated 1/2023 written by Corporate RN revealed, the definition of abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations.</p> <p>III. Prevention of abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves:</p> <p>B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of individual needs and behavioral symptoms</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors.</p> <p>IV Identification of Abuse, Neglect and Exploitation</p> <p>B. Possible indicators of abuse include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Resident, staff or family report of abuse 8. Failure to provide care needs such as comfort, safety, feeding, bathi[TRUNCATED] 		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interviews and record review the facility failed to implement the facility's abuse policy ensuring 1 (CR#3) of 9 residents was free from abuse reviewed for developing/implementing abuse policies.</p> <p>The facility failed to implement their abuse policy when CR #3 made an allegation of physical and verbal abuse. The allegation was not reported to the abuse coordinator or investigated and the alleged abuser had access to CR#3 after an allegation of abuse was made.</p> <p>An Immediate Jeopardy (IJ) was identified on 5.30.2025. The IJ template was provided to the Administrator and DON on 5.30.2025 at 1:27p.m. While the IJ was removed on 6.1.25 at 6:25 p.m., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures placed residents at risk for physical harm and mental anguish.</p> <p>Findings included:</p> <p>Record Review of Abuse, Neglect and Exploitation policy dated/implemented 01/2023 and Reviewed/Revised 01/2025 by Corporate RN stated, All reports of resident abuse (including injuries or unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</p> <p>1. The facility will develop and implement written policies and procedures that:</p> <p>a.</p> <p>Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property;</p> <p>b. Establish policies and procedures to investigate any such allegations; and</p> <p>c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention and my colon and</p> <p>d. Establish coordination with the QAPI program</p> <p>III. Prevention of abuse, Neglect, and Exploitation</p> <p>The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/ or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual regional care needs and behavioral symptoms.</p> <p>Record Review of CR#3's undated face sheet revealed a 51-year male initially admitted to the facility on [DATE], re-entry 5/16/2025 and discharged [DATE] with diagnosis of Parkinson Disease.</p> <p>Record review of CR#3's Orders dated 5/16/2025 revealed Gabapentin Oral Capsule 300mg 1 capsule by mouth in the evening related to Neuralgia and Neuritis. Order dated 5/16/2025-D/C 5/22/2025; Insulin Glargine (long-acting insulin used to treat diabetes) subcutaneous solution 100. Inject 20 unit subcutaneously (injection in the fatty tissue) in the morning related to Type 2 Diabetes Mellitus with other Diabetic Kidney Complication. Order date 5/16/2025 5:31pm - 5/22/2025 8:18am; Lantus SoloStar (Disposable prefilled) Subcutaneous solution Pen Injector 100 UNIT/ML inject 20 unit subcutaneously in the morning for DM related to type 2 diabetes mellitus with other diabetic kidney complication. Order date 5/2/2025-D/C (discontinued) 5/15/2025.</p> <p>Record review of CR#3's MDS dated [DATE] revealed CR#3 has a BIMS of 13 (indicates cognition is intact). CR#3 requires staff assistance with self-care, indoor mobility, upper extremity; he requires substantial/maximal assistance with eating, shower/bath and CR#3 requires partial/moderate assistance with toileting hygiene, upper and lower body dressing, putting on/taking off footwear, toilet transfer, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand and chair/bed-to-chair transfer; CR#3 is occasionally incontinent</p> <p>Record review of the I-Phone recordings on CR#3's phone revealed the following information:</p> <p>CR#3 stated he had a recording on his I-Phone, which had a date and time stamp, of him informing the DON on 10.4.2025 and Administrator 10.11.2025 of his abusive encounter with LVN B.</p> <p>The telephone recording on 10/4/2024 revealed a conversation between the DON and CR#3. It was regarding the treatment CR#3 received from LVN B. The DON is heard asking CR#3 what happened, and CR#3 stated that he was uncomfortable with LVN B providing his care because she jabbed a needle in his arm. CR#3 told DON that his arm hurt like hell. The CR#3 could be heard telling the DON that LVN B did not take his blood sugar before administering his insulin as ordered, even though it appeared that she did in the system. According to the recording, CR#3 expressed his fearfulness of LVN B and did not want DON to personally address the issue with LVN B for fear of retaliation. The DON could be heard stating that she will be in-serviced with other staff so it doesn't appear that LVN B would know where the complaint came from. She stated her in-service would let all staff know that the facility is the resident's home. CR#3 again informed the DON he feared for his life and didn't want anyone to know. The DON assured him she would not mention his name. The DON did tell him she would change his room and that she does not intend to move LVN B from the floor. You could hear CR#3 crying while telling DON.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The telephone recording on 10/11/2024 revealed a conversation between administrator and CR#3. During the recording, CR#3 could be heard telling the administrator he spoke with the administrator concerning issues with LVN B at this time the administrator corrected him and identified the DON by her first name and told him she was the administrator. During the recording you could hear CR#3 tell administrator he was scared and didn't know who to trust. CR#3 told the administrator he asked the DON not to say anything, but later LVN B came in his room explaining her position with the aide at which time he told her to get out of his room. CR#3 stated he was scared that LVN B may have brothers who would come to the facility and informed administrator he knew that LVN B had daughters who also worked in the facility. During the recording, CR#3 could be heard telling the administrator LVN B hit him at which time administrator appeared to gasp and she could be heard saying, Oh No. During the conversation, CR#3 was heard telling administrator that LVN B came to his room and cursed him out and the administrator told him that she has had a previous conversation with LVN B about her Potty mouth. Administrator could be heard telling LVN B when he discussed his views and the jab with the insulin needle to his arm BON should have notified her immediately.</p> <p>In an interview 5.20.25 at 11:25am with CR#3 who was in seated on his bed, appropriately dressed and just finished speaking with occupational therapist. CR#3 stated he has Parkinson disease and shakes really bad. He stated he has been treated horrible by the facility. CR#3 stated he was in 400 hall and was assaulted by LVN B in October 2024. He stated LVN B doesn't like him and was mean to him. He stated one day he was in his room crying when an aide came to him and asked if she could pray with him. LVN B stated while the two were praying the LVN B came in his room and began using foul (Cursing) language toward the aide and told her to get out of his room. He stated the employee was later terminated. Afterwards LVN B had to administer him his insulin shot. CR#3 stated LVN B jabbed him in the arm with the needle causing a lot of pain. CR#3 stated when LVN B gave him his pills she hit him in the face purposely. He stated he spoke with the DON initially then the Administrator who is the abuse coordinator. CR#3 stated next thing he knew; he was transferred to 200 hall believes this is retaliatory.</p> <p>In an interview on 5.20.25 at 12:23 pm with DON regarding CR#3. The DON stated CR#3 is upset because he received a discharge notice (4/25/2025) due to non-payment. She stated the resident was moved from hallway 400 to 200 because he was transitioning from skilled nursing to LTC. She stated she remembers the resident complaining that his arm hurt after the LVN B gave him a shot. She stated she assessed his arm he did not have any marks or bruises from the jab. The DON stated she did not complete a head-to-toe assessment, nor did she notify the abuse coordinator, nor did she call in the report. She stated the administrator is the abuse coordinator. She stated he told her LVN B was aggressive, and he did not want any dealings with her. She stated she couldn't remember the exact date this conversation occurred. The DON stated it was decided that CR#3 would have a room change; however, until there was a room on another hallway, LVN B was told to take a witness (another employee) in CR#3's room with her when she provided care CR#3. The DON told investigator that she stated she and administrator went to speak with resident today who became upset and had to be transported to local hospital.</p> <p>In an interview on 5.20.25 at 2:45pm with PTA -She stated CR#3 was receiving therapy and on the 400 Hall where most skilled residents are located. She stated during one visit, she noticed CR#3 was on the 200 hall and she asked him why he was transferred. She stated CR#3 told her he was mistreated by his nurse and transferred on another hallway. She stated CR#3 did not get into specifics; however told her he reported this information to DON and Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 5/29/2025 at 1:25pm with the Administrator -she stated she has been at the facility for 12 years and the abuse coordinator for as long as she has been here. She stated the resident never told her LVN B had jabbed or stabbed him in the arm. She stated if CR#3 had said he received a Jab or Stab from LVN B or any staff member, she would have expected CR#3 to come to her immediately. Administrator stated when CR#3 didn't feel safe with LVN B, the DON should have informed her immediately. The administrator stated if a resident stated they have been mistreated, abuse, or feel unsafe they should come and tell her since she is the abuse coordinator. She stated LVN B is scheduled to work on the skill hall (400 Hallway) 99% of the time. She stated LVN B should not have been providing care after CR#3 left her floor because CR#3 didn't feel comfortable with her . Administrator stated CR#3 would not have felt comfortable being administered medication from LVN B. Administrator stated she and the DON went to CR#3's room on 5/20/25 to speak with him regarding his issues with LVN B. Administrator said she told resident that she heard there were some issues. She stated the DON told CR#3 he didn't tell her LVN B stabbed or jabbed him with the insulin needle. She stated CR#3 called DON a liar and appeared to lunge toward her aggressively and raising his voice. She stated CR#3 told her and the DON that they were giving him heart problems. She stated with CR#3's behavior she feared for the DON and the two left and called the ambulance because he complained of heart issues.</p> <p>Administrator stated she did not file a report with the state and should have.</p> <p>An Immediate Jeopardy (IJ) was identified on 5.30.2025. The IJ template was provided to the Administrator and DON on 5.30.2025 at 1:27p.m. While the IJ was removed on 6.1.25 at 6:25 p.m., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>The following Plan of Removal submitted by the facility was accepted on 5.31.2025 at 8:55am.</p> <p>PLAN OF REMOVAL (F-607)</p> <p>Name of facility:</p> <p>Date: 05/30/2025</p> <p>F 607 - The facility will implement a written policy that prohibits abuse of residents.</p> <p>Problem: The facility failed to follow the facility's abuse policy by not reporting the allegation of physical abuse to HHSC and investigating allegations reported to the Administrator and DON</p> <p>Immediate action:</p> <p>7.</p> <p>CR#3 resident no longer resides in the facility.</p> <p>8.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>LVN B was removed from the schedule and placed on administrative suspension pending investigation. Completed 05/30/25</p> <p>9.</p> <p>PTA is no longer working for the facility. Rehab staff received an inservice on abuse, neglect and exploitation and incident and accidents facility policy and procedures. The QA corporate nurse inservice the rehab staff. Completion date 05/30/25</p> <p>10.</p> <p>The facility administrator immediately completed a self-report incident to HHSC d/t allegation of physical abuse on 05/30/2025.</p> <p>11.</p> <p>On 05/30/25 The facility nursing management staff immediately initiated skin assessment focusing on any new skin concerns or discoloration, no issues noted. Completed 05/30/25</p> <p>12.</p> <p>5/30/25 The QA corporate nurse provided the inservice on resident rights following facility policy and procedures to all staff present, the DON sent the inservice to all other staff no present. Completed 5/30/25</p> <p>13.</p> <p>Resident interviews were conducted with residents who were able to participate and answer questions, no issues were identified. All alert residents were interviewed. A skin assessment audit was completed in all 89 residents residing in the facility and no issues were identified. Completion date 05/30/2025</p> <p>14.</p> <p>5/30/25 The QA Corporate nurse initiated and in-serviced on the corporate Compliance hotline to report any unresolved issues by the facility administration. The QA corporate nurse provided the inservice. Completion date 05/30/25</p> <p>Interventions:</p> <p>15.</p> <p>The Administrator received 1:1 inservice on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the Vice-President of Operations. The DON received 1:1 education on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the corporate nurse. Completion date 05/30/25</p> <p>16.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Kingwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23775 Kingwood Place Kingwood, TX 77339	
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)		
<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The [NAME] President of Operation conducted and in-service with the facility Administrator: Review of Abuse and Neglect and Exploitation Policy. The in-service included the company expectation to immediately initiate an investigation with any allegation of abuse and neglect including any signs and symptoms of sexual abuse. Completed 05/30/25</p> <p>17.</p> <p>On 5/30/25 the corporate nurse/Designee initiated an in-service to all facility staff on Abuse and Neglect Facility Expectations based on policy. This included an explanation of the definition of Abuse, Neglect and exploitation. Completion 05/30/25</p> <p>18.</p> <p>On 5/30/25 the corporate nurse/Designee initiated an in-service with the facility staff on all six types of elder abuse. Completion 05/30/25</p> <p>19.</p> <p>On 05/30/25 the corporate nurse/Designee initiated and in-service with the facility staff on Resident Rights to include Correspondence to possible/suspected abuse occurrences, interventions, what to do, reporting. Completion 05/30/25</p> <p>20.</p> <p>On 5/30/25 the corporate nurse/Designee initiated an in-service with facility staff on: Who is the facility abuse prevention coordinator, notifications of suspected abuse and neglect to be reported to the administrator immediately. Completion 5/30/25</p> <p>Any staff member who is not present or in service on 05/30/25 will not be allowed to assume their duties until in-serviced. Ongoing In-service will be completed by corporate nurse/Designee, until all staff complete the in-services.</p> <p>1.</p> <p>On 05/30/25 the corporate nurse/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the corporate nurse/designee if any staff is unable to answer appropriately the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Completion 05/30/25.</p> <p>2.</p> <p>An impromptu QAPI meeting was conducted with the facility's Medical Director on 05/30/25 to notify of the potential for non-compliance and the action plan implemented for approval. Completed 05/30/25.</p> <p>Monitoring of the facility's Plan of Removal included the following:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record Review of documentation CR#3 resident no longer resides in the facility.</p> <p>Record Review LVN B was removed from the schedule and placed on administrative suspension pending investigation. Completed 05/30/25.</p> <p>Record Review PTA is no longer working for the facility. Rehab staff received an inservice on abuse, neglect and exploitation and incident and accidents facility policy and procedures. The QA corporate nurse inservice the rehab staff. Completion date 05/30/25</p> <p>Record Review of The facility administrator immediately completed a self-report incident to HHSC d/t allegation of physical abuse on 05/30/2025.</p> <p>Record Review of 05/30/25 The facility nursing management staff immediately initiated skin assessment focusing on any new skin concerns or discoloration, no issues noted. Completed 05/30/25.</p> <p>Record Review of 5/30/25 The QA corporate nurse provided the inservice on resident rights following facility policy and procedures to all staff present, the DON sent the inservice to all other staff not present. Completed 5/30/25.</p> <p>Record Review of Resident interviews were conducted with residents who were able to participate and answer questions, no issues were identified. All alert residents were interviewed. A skin assessment audit was completed in all 89 residents residing in the facility and no issues were identified. Completion date 05/30/2025</p> <p>Record Review of 5/30/25 The QA Corporate nurse initiated and in-serviced on the corporate Compliance hotline to report any unresolved issues by the facility administration. The QA corporate nurse provided the inservice. Completion date 05/30/25</p> <p>Interventions:</p> <p>Record Review of The Administrator received 1:1 inservice on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the Vice-President of Operations. The DON received 1:1 education on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the corporate nurse. Completion date 05/30/25</p> <p>Record Review of The [NAME] President of Operation conducted and in-service with the facility Administrator: Review of Abuse and Neglect and Exploitation Policy. The in-service included the company expectation to immediately initiate an investigation with any allegation of abuse and neglect including any signs and symptoms of sexual abuse. Completed 05/30/25</p> <p>Record Review of the 5/30/25 the corporate nurse/Designee initiated an in-service to all facility staff on Abuse and Neglect Facility Expectations based on policy. This included an explanation of the definition of Abuse, Neglect and exploitation. Completion 05/30/25</p> <p>Record Review of the 5/30/25 the corporate nurse/Designee initiated an in-service with the facility staff on all six types of elder abuse. Completion 05/30/25</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record Review of the 05/30/25 the corporate nurse/Designee initiated and in-service with the facility staff on Resident Rights to include Correspondence to possible/suspected abuse occurrences, interventions, what to do, reporting. Completion 05/30/25</p> <p>Record Review of the 5/30/25 the corporate nurse/Designee initiated an in-service with facility staff on: Who is the facility abuse prevention coordinator, notifications of suspected abuse and neglect to be reported to the administrator immediately. Completion 5/30/25</p> <p>Any staff member who is not present or in service on 05/30/25 will not be allowed to assume their duties until in-serviced. Ongoing In-service will be completed by corporate nurse/Designee, until all staff complete the in-services.</p> <p>Record Review of 05/30/25 the corporate nurse/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the corporate nurse/designee if any staff is unable to answer appropriately the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Completion 05/30/25.</p> <p>Record Review of the impromptu QAPI meeting was conducted with the facility's Medical Director on 05/30/25 to notify of the potential for non-compliance and the action plan implemented for approval. Completed 05/30/25</p> <p>Interviews with the following staff from 5.31.2025 at 12:36 AM to 6.1.2025 6:25pm who worked all shifts and all days of the week revealed they had been in-serviced on Reporting Abuse and Neglect, Kardex, Stop and Watch, reporting and documenting when residents refuse care, turning and repositioning, change of condition and reporting, and documentation: RN, LVN B, LVN D, LVN E, LVN H, LVN I, LVN J, MA C, MDS, CNA E, CNA D, CNA J, CNA H, CNA I, CNA M, CNA U, CNA V, WCN, DON, and the Administrator. Each staff was asked if they understood all aspects of their training and they responded in the affirmative. Each staff understood their particular roles in the Abuse Neglect and reporting, documentation, stop and watch, change of condition and where to document this information.</p> <p>The Administrator was informed that the Immediate Jeopardy was removed on 6/1/2025 at 6:25 p.m. The facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to immediately investigate, report and protect 1 (CR#3) of 9 residents reviewed for abuse and neglect.</p> <p>The facility failed to immediately investigate, report, and protect CR#3 when he reported being stabbed in the arm with an insulin needle and scratched on the nose by LVN B.</p> <p>They facility failed to prevent further potential abuse when the facility failed to remove CR#3 from LVN B care after the report of abuse.</p> <p>An Immediate Jeopardy (IJ) was identified on 5.30.2025. The IJ template was provided to the Administrator and DON on 5.30.2025 at 1:27p.m. While the IJ was removed on 6.1.25 p.m., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures placed residents at risk for physical harm and mental anguish.</p> <p>Findings included:</p> <p>Record Review of CR#3's undated face sheet revealed a 51-year male initially admitted to the facility on [DATE], re-entry 5/16/2025 and discharged [DATE] with diagnosis of Parkinson Disease.</p> <p>Record review of CR#3's Orders dated 5/16/2025 revealed Gabapentin Oral Capsule 300mg 1 capsule by mouth in the evening related to Neuralgia and Neuritis. Order dated 5/16/2025-D/C 5/22/2025; Insulin Glargine (long-acting insulin used to treat diabetes) subcutaneous solution 100. Inject 20 unit subcutaneously (injection in the fatty tissue) in the morning related to Type 2 Diabetes Mellitus with other Diabetic Kidney Complication. Order date 5/16/2025 5:31pm - 5/22/2025 8:18am; Lantus SoloStar (Disposable prefilled) Subcutaneous solution Pen Injector 100 UNIT/ML inject 20 unit subcutaneously in the morning for DM related to type 2 diabetes mellitus with other diabetic kidney complication. Order date 5/2/2025-D/C (discontinued) 5/15/2025.</p> <p>Record review of CR#3's MDS dated [DATE] revealed CR#3 has a BIMS of 13 (indicates cognition is intact). CR#3 requires staff assistance with self-care, indoor mobility, upper extremity; he requires substantial/maximal assistance with eating, shower/bath and CR#3 requires partial/moderate assistance with toileting hygiene, upper and lower body dressing, putting on/taking off footwear, toilet transfer, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand and chair/bed-to-chair transfer; CR#3 is occasionally incontinent.</p> <p>Record review of the I-Phone recordings on CR#3's phone revealed the following information:</p> <p>CR#3 stated he had a recording on his I-Phone, which had a date and time stamp, of him informing the DON on 10.4.2025 and Administrator 10.11.2025 of his abusive encounter with LVN B.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The telephone recording on 10/4/2024 revealed a conversation between the DON and CR#3. It was regarding the treatment CR#3 received from LVN B. The DON is heard asking CR#3 what happened, and CR#3 stated that he was uncomfortable with LVN B providing his care because she jabbed a needle in his arm. CR#3 told DON that his arm hurt like hell. The CR#3 could be heard telling the DON that LVN B did not take his blood sugar before administering his insulin as ordered, even though it appeared that she did in the system. According to the recording, CR#3 expressed his fearfulness of LVN B and did not want DON to personally address the issue with LVN B for fear of retaliation. The DON could be heard stating that she will be in-serviced with other staff so it doesn't appear that LVN B would know where the complaint came from. She stated her in-service would let all staff know that the facility is the resident's home. CR#3 again informed the DON he feared for his life and didn't want anyone to know. The DON assured him she would not mention his name. The DON did tell him she would change his room and that she does not intend to move LVN B from the floor. You could hear CR#3 crying while telling DON.</p> <p>The telephone recording on 10/11/2024 revealed a conversation between administrator and CR#3. During the recording, CR#3 could be heard telling the administrator he spoke with the administrator concerning issues with LVN B at this time the administrator corrected him and identified the DON by her first name and told him she was the administrator. During the recording you could hear CR#3 tell administrator he was scared and didn't know who to trust. CR#3 told the administrator he asked the DON not to say anything, but later LVN B came in his room explaining her position with the aide at which time he told her to get out of his room. CR#3 stated he was scared that LVN B may have brothers who would come to the facility and informed administrator he knew that LVN B had daughters who also worked in the facility. During the recording, CR#3 could be heard telling the administrator LVN B hit him at which time administrator appeared to gasp and she could be heard saying, Oh No. During the conversation, CR#3 was heard telling administrator that LVN B came to his room and cursed him out and the administrator told him that she has had a previous conversation with LVN B about her Potty mouth. Administrator could be heard telling LVN B when he discussed his views and the jab with the insulin needle to his arm BON should have notified her immediately.</p> <p>In an interview 5.20.25 at 11:25am with CR#3 who was seated on his bed, appropriately dressed and just finished speaking with occupation therapist. CR#3 stated he has Parkinson disease and shakes really bad. He stated he has been treated horrible by the facility. CR#3 stated he was in 400 hall and was assaulted by LVN B in October 2024. He stated LVN B doesn't like him and was mean to him. He stated one day he was in his room crying when an aide came to him and asked if she could pray with him. LVN B stated while the two were praying the LVN B came in his room and began using foul (Cursing) language toward the aide and told her to get out of his room. He stated the employee was later terminated. Afterwards LVN B had to administer him his insulin shot. CR#3 stated LVN B jabbed him in the arm with the needle causing a lot of pain. CR#3 stated when LVN B gave him his pills she hit him in the face purposely. He stated he spoke with the DON initially then the Administrator who is the abuse coordinator. CR#3 stated next thing he knew; he was transferred to 200 hall believes this is retaliatory.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview on 5.20.25 at 12:23 pm with the DON regarding CR#3. The DON stated CR#3 is upset because he received a discharge notice due to non-payment. She stated the resident was moved from hallway 400 to 200 because he was transitioning from skilled nursing to LTC. She stated she remembers the resident complaining that his arm hurt after the LVN B gave him a shot. She stated she assessed his arm he did not have any marks or bruises from the jab. DON stated she did not complete a head-to-toe assessment, nor did she notify the abuse coordinator, nor did she call in the report. She stated the administrator is the abuse coordinator. She stated he told her LVN B was aggressive, and he did not want any dealings with her. She stated she couldn't remember the exact date this conversation occurred. The DON stated it was decided that CR#3 would have a room change; however, until there was a room on another hallway, LVN B was told to take a witness (another employee) in CR#3's room with her when she provided care CR#3. The DON told investigator that she stated she and administrator went to speak with resident today who became upset and had to be transported to local hospital.</p> <p>Interview on 5/29/2025 at 1:25pm with the Administrator -she stated she has been at the facility for 12 years and the abuse coordinator for as long as she has been here. She stated the resident never told her LVN B had jabbed or stabbed him in the arm. She stated if CR#3 had said he received a Jab or Stab from LVN B or any staff member, she would have expected CR#3 to come to her immediately. Administrator stated when CR#3 didn't feel safe with LVN B, the DON should have informed her immediately. The administrator stated if a resident stated they have been mistreated, abuse, or feel unsafe they should come and tell her since she is the abuse coordinator. She stated LVN B is scheduled to work on the skill hall (400 Hallway) 99% of the time. She stated LVN B should not have been providing care after CR#3 left her hall. She stated LVN B should not have been providing care after CR#3 left her floor because CR#3 didn't feel comfortable with her . Administrator stated CR#3 would not have felt comfortable being administered medication from LVN B. Administrator stated she and the DON went to CR#3's room on 5/20/25 to speak with him regarding his issues with LVN B. Administrator said she told resident that she heard there were some issues. She stated the DON told CR#3 he didn't tell her LVN B stabbed or jabbed him with the insulin needle. She stated CR#3 called DON a liar and appeared to lunge toward her aggressively and raising his voice. She stated CR#3 told her and the DON that they were giving him heart problems. She stated with CR#3's behavior she feared for the DON and the two left and called the ambulance because he complained of heart issues.</p> <p>Administrator stated she did not file a report with the state and should have.</p> <p>Record Review of Abuse, Neglect and Exploitation policy dated/implemented 01/2023 and Reviewed/Revised 01/2025 by Corporate RN stated, All reports of resident abuse (including injuries or unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</p> <p>An Immediate Jeopardy (IJ) was identified on 5.30.2025. The IJ template was provided to the Administrator and DON on 5.30.2025 at 1:27p.m. While the IJ was removed on 6.1.25 p.m., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>The following Plan of Removal submitted by the facility was accepted on 5.31.2025 at 1:16pm.</p> <p>PLAN OF REMOVAL</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Name of facility:</p> <p>Date: 05/30/25</p> <p>F 610 -. Investigate/Prevent/Correct Alleged Violations</p> <p>Problem: The facility failed to immediately investigate, report, and protect the resident when CR#3 reported being stabbed in the arm with an insulin needle and scratched on the nose by LVN B.</p> <p>Immediate action:</p> <p>1.</p> <p>On 05/29/25 The facility administrator completed a self-report incident to HHSC d/t allegation of physical abuse on resident CR#3. Staff and residents' interviews will be completed, and incident investigation will be sent to HHSC by end of day 05/31/25</p> <p>2</p> <p>LVN B was in serviced on abuse, neglect and exploitation and placed on administrative suspension pending investigation on 5/30/25 and employment was terminated on 05/31/25 Completion date 05/31/25</p> <p>3.</p> <p>CR#3 resident is no longer a resident in the facility. The Administrator received 1:1 inservice on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the Vice-President of Operations. The DON received 1:1 education on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the corporate nurse. Completion date 05/30/25</p> <p>4.</p> <p>Resident interviews were conducted with residents who were able to participate and answer questions, no issues were identified. All alert residents were interviewed. A skin assessment audit was completed in all 89 residents residing in the facility and no issues were identified. Completion date 05/30/2025</p> <p>5.</p> <p>The Facility Corporate nurse reviewed Abuse, neglect and Exploitation policy and procedure no changes were made. Completion 05/30/2025</p> <p>6.</p> <p>PTA is no longer working for the facility. Rehab staff received an inservice on abuse, neglect and exploitation and incident and accidents facility policy and procedures. The QA corporate nurse inservice the rehab staff. Completion date 05/30/25</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>7.</p> <p>5/30/25 The QA corporate nurse provided the inservice on resident rights following facility policy and procedures to all staff present, the DON sent the inservice to all other staff no present. Completed 5/30/25</p> <p>8.</p> <p>5/30/25 The QA Corporate nurse initiated and in-serviced on the corporate Compliance hotline to report any unresolved issues by the facility administration. The QA corporate nurse provided the inservice. Completion date 05/30/25</p> <p>Interventions</p> <p>9.</p> <p>The Administrator received 1:1 inservice on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the Vice-President of Operations. The DON received 1:1 education on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the corporate nurse. Completion date 05/30/25</p> <p>10.</p> <p>The [NAME] President of Operation conducted and in-service with the facility Administrator: Review of Abuse and Neglect and Exploitation Policy. The in-service included the company expectation to immediately initiate an investigation with any allegation of abuse and neglect including a review of policy section III. Prevention of Abuse, Neglect and Exploitation. And section VI. Investigation of Allege Abuse, Neglect and Exploitation and Section VII. Protection of Resident. Completed 05/30/25</p> <p>11.</p> <p>On 5/30/25 The Corporate nurse/designee immediately initiated and in-service with all facility staff regarding Abuse and Neglect focusing on reporting any suspicious of abuse allegations immediately to the Administrator who is the abuse coordinator, including a review of policy section III. Prevention of Abuse, Neglect and Exploitation. And section VI. Investigation of Allege Abuse, Neglect and Exploitation and Section VII. Protection of Resident. Staff will not provide direct resident care until the training has been completed. Completed 5/30/25</p> <p>12.</p> <p>The [NAME] President of Operation conducted and in-service with the facility Administrator: The in-service included a review of policy section III. Prevention of Abuse, Neglect and Exploitation. And section VI. Investigation of Allege Abuse, Neglect and Exploitation and Section VII. Protection of Resident. Completed 5/30/25</p> <p>13.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The corporate nurse conducted an in-service with the DON: The in-service included a review of policy section III. Prevention of Abuse, Neglect and Exploitation. And section VI. Investigation of Alleged Abuse, Neglect and Exploitation and Section VII. Protection of Resident. Completed 5/30/25</p> <p>14.</p> <p>On 5/30/25 Resident council meeting was held with no abuse allegations concerns.</p> <p>15.</p> <p>On 5/30/25 the Administrator reviewed the grievances from the last month, all grievances were addressed and up to date with no abuse concerns were identified. Completion 5/30/25.</p> <p>16.</p> <p>On 5/30/25 the corporate nurse/Designee initiated an in-service with the facility staff on all six types of elder abuse. Completion 05/30/25</p> <p>17.</p> <p>On 05/30/25 the corporate nurse/Designee initiated and in-service with the facility staff on Resident Rights to include Correspondence to possible/suspected abuse occurrences, interventions, what to do, reporting. Completion 05/30/25</p> <p>18.</p> <p>On 5/30/25 the corporate nurse/Designee initiated an in-service with facility staff on: Who is the facility abuse prevention coordinator, notifications of suspected abuse and neglect to be reported to the administrator immediately. Completion 5/30/25</p> <p>Any staff member who is not present or in service on 05/30/25 will not be allowed to assume their duties until in-serviced. Ongoing In-service will be completed by corporate nurse/Designee, until all staff complete the in-services.</p> <p>Monitoring</p> <p>1.</p> <p>On 05/30/25 the corporate nurse/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the corporate nurse/designee if any staff is unable to answer appropriately the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Completion 05/30/25.</p> <p>2.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Kingwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23775 Kingwood Place Kingwood, TX 77339	
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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An impromptu QAPI meeting was conducted with the facility's Medical Director on 05/30/25 to notify of the potential for non-compliance and the action plan implemented for approval. Completed 05/30/25.</p> <p>Monitoring of the facility's Plan of Removal included the following:</p> <p>Record Review of the 05/29/25 The facility administrator completed a self-report incident to HHSC d/t allegation of physical abuse on resident CR#3. Staff and residents' interviews will be completed, and incident investigation will be sent to HHSC by end of day 05/31/25</p> <p>Record Review of the LVN B was in-serviced on abuse, neglect and exploitation and placed on administrative suspension pending investigation on 5/30/25 and employment was terminated on 05/31/25 Completion date 05/31/25</p> <p>Record Review of the documentation CR#3 resident is no longer a resident in the facility. The Administrator received 1:1 inservice on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the Vice-President of Operations. The DON received 1:1 education on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the corporate nurse. Completion date 05/30/25</p> <p>Record Review of the Resident interviews were conducted with residents who were able to participate and answer questions, no issues were identified. All alert residents were interviewed. A skin assessment audit was completed in all 89 residents residing in the facility and no issues were identified. Completion date 05/30/2025</p> <p>Record Review of the The Facility Corporate nurse reviewed Abuse, neglect and Exploitation policy and procedure no changes were made. Completion 05/30/2025</p> <p>Record Review of the PTA is no longer working for the facility. Rehab staff received an inservice on abuse, neglect and exploitation and incident and accidents facility policy and procedures. The QA corporate nurse inservice the rehab staff. Completion date 05/30/25</p> <p>Record Review of the 5/30/25 The QA corporate nurse provided the inservice on resident rights following facility policy and procedures to all staff present, the DON sent the inservice to all other staff no present. Completed 5/30/25</p> <p>Record Review of the 5/30/25 The QA Corporate nurse initiated and in-serviced on the corporate Compliance hotline to report any unresolved issues by the facility administration. The QA corporate nurse provided the inservice. Completion date 05/30/25</p> <p>Interventions</p> <p>Record Review of the The Administrator received 1:1 inservice on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the Vice-President of Operations. The DON received 1:1 education on abuse, neglect and exploitation policy and procedures along with the company expectation to adhere to it by the corporate nurse. Completion date 05/30/25</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record Review of the [NAME] President of Operation conducted and in-service with the facility Administrator: Review of Abuse and Neglect and Exploitation Policy. The in-service included the company expectation to immediately initiate an investigation with any allegation of abuse and neglect including a review of policy section III. Prevention of Abuse, Neglect and Exploitation. And section VI. Investigation of Allege Abuse, Neglect and Exploitation and Section VII. Protection of Resident. Completed 05/30/25</p> <p>Record Review of the 5/30/25 The Corporate nurse/designee immediately initiated and in-service with all facility staff regarding Abuse and Neglect focusing on reporting any suspicious of abuse allegations immediately to the Administrator who is the abuse coordinator, including a review of policy section III. Prevention of Abuse, Neglect and Exploitation. And section VI. Investigation of Allege Abuse, Neglect and Exploitation and Section VII. Protection of Resident. Staff will not provide direct resident care until the training has been completed. Completed 5/30/25</p> <p>Record Review of the [NAME] President of Operation conducted and in-service with the facility Administrator: The in-service included a review of policy section III. Prevention of Abuse, Neglect and Exploitation. And section VI. Investigation of Allege Abuse, Neglect and Exploitation and Section VII. Protection of Resident. Completed 5/30/25</p> <p>Record Review of the corporate nurse conducted an in-service with the DON: The in-service included a review of policy section III. Prevention of Abuse, Neglect and Exploitation. And section VI. Investigation of Allege Abuse, Neglect and Exploitation and Section VII. Protection of Resident. Completed 5/30/25</p> <p>Record Review of the 5/30/25 Resident council meeting was held with no abuse allegations concerns.</p> <p>Record Review of the 5/30/25 the Administrator reviewed the grievances from the last month, all grievances were addressed and up to date with no abuse concerns were identified. Completion 5/30/25.</p> <p>Record Review of the 5/30/25 the corporate nurse/Designee initiated an in-service with the facility staff on all six types of elder abuse. Completion 05/30/25</p> <p>Record Review of the 05/30/25 the corporate nurse/Designee initiated and in-service with the facility staff on Resident Rights to include Correspondence to possible/suspected abuse occurrences, interventions, what to do, reporting. Completion 05/30/25</p> <p>Record Review of the 5/30/25 the corporate nurse/Designee initiated an in-service with facility staff on: Who is the facility abuse prevention coordinator, notifications of suspected abuse and neglect to be reported to the administrator immediately. Completion 5/30/25</p> <p>Record Review of the documentation that says Any staff member who is not present or in service on 05/30/25 will not be allowed to assume their duties until in-serviced. Ongoing In-service will be completed by corporate nurse/Designee, until all staff complete the in-services.</p> <p>Monitoring</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record Review of the 05/30/25 the corporate nurse/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the corporate nurse/designee if any staff is unable to answer appropriately the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Completion 05/30/25.</p> <p>Record Review of the impromptu QAPI meeting was conducted with the facility's Medical Director on 05/30/25 to notify of the potential for non-compliance and the action plan implemented for approval. Completed 05/30/25.</p> <p>Interviews with the following staff from 5.31.2025 at 12:36 AM to 6.1.2025 6:25pm who worked all shifts and all days of the week revealed they had been in-serviced on Reporting Abuse and Neglect, Kardex, Stop and Watch, reporting and documenting when residents refuse care, turning and repositioning, change of condition and reporting, and documentation: RN, LVN B, LVN D, LVN E, LVN H, LVN I, LVN J, MA C, MDS, CNA E, CNA D, CNA J, CNA H, CNA I, CNA M, CNA U, CNA V, WCN, DON, and the Administrator. Each staff was asked if they understood all aspects of their training and they responded in the affirmative. Each staff understood their particular roles in the Abuse Neglect and reporting, documentation, stop and watch, change of condition and where to document this information.</p> <p>The Administrator was informed that the Immediate Jeopardy was removed on 6/1/2025 at 6:25 p.m. The facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual 's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 3 (CR2, R#1, R#2) of 9 residents reviewed for Treatment/Services to Prevent/Heal Pressure Ulcers in that:</p> <p>The facility failed to ensure CR #2's wound interventions were implemented: WCD orders for changing bandages, turning, and repositioning, and getting CR#2 in the chair twice daily. As a result, CR#2 did not receive proper treatment to prevent deterioration and infection, which resulted in hospitalization with severe sepsis and surgical wound debridement.</p> <p>Facility failed to provide wound care daily as ordered for ordered for R#1 and R#2 when the residents did not receive wound care for 5/25/2025.</p> <p>An Immediate Jeopardy (IJ) was identified on 5.28.2025. The IJ template was provided to the Administrator and DON on 5.28.2025 at 1:15p.m. While the IJ was removed on 6.1.25 at 6:25pm, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures placed residents at risk of physical harm.</p> <p>Findings included:</p> <p>Record review of CR#2's face sheet revealed a [AGE] year-old female, initially admitted to the facility on [DATE], readmitted [DATE] and discharged [DATE] with a diagnosis of Osteomyelitis of vertebra, sacral and sacrococcygeal region.</p> <p>Record review of CR#2's Annual MDS assessment dated 3.13.25 revealed a BIMS score of 15 (cognitively intact). Section GG (Functional Abilities) revealed, CR#2 is impaired on both sides (lower extremity-hip, knee, ankle, foot), uses a wheelchair. CR#2 need substantial/maximal assistance with oral, toilet, and personal hygiene, shower/bathe, upper and lower body dressing and putting on/taking off footwear; requires partial/moderate assistance to roll left and right; has an Indwelling catheter (carries the urine out of the body) and Ostomy (collects waste); paraplegic (inability to move the lower parts of the body). Section M (Skin Conditions) revealed CR#2 is at risk and has stage 3 and 4 pressure ulcers.</p> <p>Record review of CR#2's orders dated 1.2.2025 revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ascorbic Acid Tablet 500 MG one time a day for wound healing related to unspecified skin changes, Order date 1/3/2025-05/22/2025; Colostomy to LLQ (bottom left area of abdomen) every day shift, every 3-days Change colostomy bag and wafer (piece of pouch that sticks to the body) every 3 days-Order date 1/2/2025-05/22/2025; Type of wound: Pressure (injury to skin and underlying tissue) and MASD (Moisture-Associated Skin Damage) caused by prolonged exposure to moisture. Location of wound: right and left buttocks, and left post upper thigh, irrigate or cleanse wound bed with normal saline, nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): Collagen and Cal Alginate cover (Wound dressing) with dry dressing secure dressing with tape as needed Order date 3/26/2025-5/22/2025; Type of wound: Pressure stage 3. Location of wound: Right Gluteus (buttock) irrigate or cleanse with normal saline, Nexodyn solution (wound care solution containing hypochlorous acid) or wound cleanser, pat dry and apply or pack collagen & Cal alginate cover-Order date 3/28/25-5/22/2025; Type of wound: Pressure stage 4. Location of wound: left buttock irrigates or cleanse wound bed with Normal saline, Nexodyn solution (wound care solution containing hypochlorous acid) or wound cleanser, pat dry and apply or pack collagen & Cal alginate cover-Order date 5/5/25-5/22/2025; Type of wound: PRESSURE Location of wound: LEFT PHONE GLUTEUS Irrigate or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): COLLAGEN AND CAL ALGINATE Cover with: ABD (abdomen) PAD AND DRY DRESSING Secure dressing with: TAPE; Type of wound: PRESSURE Location of wound: LEFT GLUTEUS Irrigate or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): COLLAGEN AND CAL ALGINATE Cover with: ABO PAD AND DRY DRESSING Secure dressing with: TAPE-Order date 2/27/2025- 5/22/2025; Type of wound: PRESSURE Location of wound: LEFT UPPER POSTERIOR THIGH irrigate or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): COLLAGEN AND CAL ALGINATE Cover with: ABD PAD AND DRY DRESSING Secure dressing with: TAPE PAIN CODE Order date 2/27/2025-05/22/2025; WEEKLY SKIN ASSESSMENT. COMPLETE HEAD TO TOE SKIN ASSESSMENT AND DOCUMENT FINDINGS ON WEEKLY SKIN OBSERVATION TOOL UDA every day shift every Tue -Order Date- 01/02/2025- 05/22/2025; COLOSTOMY TO LLQ every shift COLOSTOMY CARE QSHIFT AND PRN USE STOMA PASTE AND/OR POWEDER AROUND THE OSTOMY -Order Date 01/02/2025-05/22/2025; Enhanced Barrier Precautions (EBP) every shift with high contact care activities. -Order Date- 04/22/2025-05/22/2025; OBSERVE AND MONITOR MIDLINE ABD SURGICAL INCISION FOR PROPER HEALING, NO INFECTION AND APPROXIMATION EVERYDAY, EVERY SHIFT every day and night shift -Order Date 01/14/2025-05/22/2025; Santyl External Ointment 250 UNIT/GM (Collagenase)Apply to RIGHT HEEL topically related to PRESSURE ULCER OF RIGHT HEEL, STAGE 4 -Order Date 03/27/2025-05/22/2025, Type of wound: [NAME] Location of wound: LEFT GLUTEUS Irrigate or cleanse wound bed with Normal saline, Nexodyn solution o wound cleanser, pat dry and apply or pack (if applicable): COLLAGEN ANDCALALG Cover with:(6X6) SUPRAABSORBENT SILICONE BORDERED DRSG. Secure dressing with: MEDIFIX TAPE-Order Date 01/16/2025- 5/22/2025; Type of wound: PRESSURE DTI Location of wound: RIGHT HEEL (CORRECTION TO LOCATION) Irrigate or cleanse wound bed with Nonnal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): SANTYL AND CAL ALGINATE Cover with: DRY DRESSING Secure dressing with: TAPE Order Date 03/21/2025-5/22/2025; Type of wound: PRESSURE STAGE 4 - Location of wound: LEFT POSTERIOR THIGH_ Irrigate or cleanse wound bed with Normak saline, Nexodyn solution o wound cleanser, pat dry and apply or pack (if applicable): COLLAGEN ANDCALALG Cover with: DRY DRESSING Secure dressing with: TAPE AS NEEDED -Order Date 04/17/2025-05/22/2025.</p> <p>Record review of CR#2's care plan dated 3.27.2025 revealed the following:</p> <p>Focus: [CR#2] Requires Wound Care Management</p> <p>Goal: [CR#2] Wound will be free of signs or symptoms of infection. Target Date: 6.19.2025</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interventions: Evaluate ulcer characteristics, measure ulcer on at regular intervals, monitor ulcer for signs of infection, monitor ulcer for signs of progression or declination, notify provider if no signs of improvement on current wound regimen, Provide Wound Care per Treatment Order</p> <p>Focus: [CR#2] requires assistance to perform functional abilities in Self Care and mobility (AEB), unsafe or poor quality in functional range of motion (Specify- to upper or lower, right or left, etc. r/t Medically complex conditions transfer with Hoyer lift)</p> <p>Goal: [CR#2] will have improvement in functional abilities in the following areas by end of their skilled stay. Target date 6.19.2025.</p> <p>Interventions: Provide the following self-care assistance: (Specify in A-H below-Partial, Substantial/Maximal</p> <p>A.</p> <p>Eating: Independent</p> <p>B.</p> <p>Oral hygiene: Independent</p> <p>C.</p> <p>Toilet Hygiene: Substantial/Maximal</p> <p>E. Shower/Bathe self: Partial/Moderate</p> <p>F. Upper body Dressing: Independent</p> <p>G. Lower body Dressing: Substantial/Maximal</p> <p>H. Putting on/taking off footwear: Substantial/Maximal</p> <p>I. Personal Hygiene: Independent</p> <p>Focus: [CR#2] has Specify: Suprapubic Catheter present and is at risk for UTI and complications due to catheter use R/T Neurogenic bladder.</p> <p>Goal: [CR#2] will be/remain free from catheter-related complications through review date. Target Date: 6.19.2025.</p> <p>Interventions: Check tubing for kinks throughout each shift, encourage fluid intake, monitor for leg strap placement and change as needed, monitor for s/sx of discomfort on urination and frequency, monitor urinary output amount, color, odor and sediments, etc. report abnormal to MD.</p> <p>Focus: [CR#2] has potential fluid deficit r/t Dx of Septicemia</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Goal: [CR#2] will be free of symptoms of dehydration and maintain moist mucous, membranes, good skin turgor. Target Date: 6.19.25</p> <p>Interventions: Monitor and document intake and output as per facility policy;</p> <p>Monitor/document/report PRN any s/sx monitor/document/report PRN any s/sx of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increase pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes, obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated</p> <p>Focus: [CR#2] has stage 4 pressure injury to left buttock, left posterior upper thigh and stage 3 PI to right buttock.</p> <p>Goal: [CR#2] Pressure injury will be free from signs and symptoms of infections. Target Date: 6.19.25; will remain free of pressure injury through the next review date. Target date: 6.19.25; will show granulation and reduction in size through review date. 6/19/25</p> <p>Interventions: Add additional supplements as needed, administer treatment to decubitus ulcers(s) as ordered. If no wound improvement notify MD/NP to obtain new orders (1.16.2025: Collagen and cal alginate daily; 3.17.2025: Collagen and cal alginate with dry drsg (dressing) daily); assist resident with Turning & repositioning during rounds and as needed; monitor and report MD and RP and s/s of infection.</p> <p>Weekly skin assessment, notify M.D. for Ulcers that are deteriorating, as needed. 1.16.25 Left gluteus 12x10x0.4cm and left upper posterior thigh 9x9.8x0 cm; 3.17.2025 Left buttock - 10x10x0.4cm and left upper posterior thigh 9x10x0.3cm and right buttock 8.8x8x0.2;</p> <p>Focus: [CR#2] has a pressure DTI pressure injury to bilateral heels d/t</p> <p>Goal: [CR#2] will have no complication from wound. Target date: 6.19.2025.</p> <p>Interventions: Assist with turn/repositioning during rounds and as needed</p> <p>Focus: [CR#2] is on antibiotics for osteomyelitis and is at risk for adverse reactions.</p> <p>Goal: [CR#2] Infection will be resolved or resolving at the end of antibiotic therapy and resident will not have any adverse reactions to antibiotic therapy. Target date.6.19.2025</p> <p>Interventions: Assess effectiveness of interventions and adjust plan as indicated.</p> <p>Focus: [CR#2] has a colostomy</p> <p>Goal: [CR#2] will have adequate emptying of bowels daily and evidence any signs of symptoms of obstruction or constipation until next review. Target date: 6.19.2025.</p> <p>Interventions: Monitor bowel put daily, nursing staff will change colostomy bag as needed, provide stoma care daily as instructed and prn. Report any abnormalities to MD and RP.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Focus: [CR#2] has the history of osteomyelitis a vertebrae sacrococcygeal region and is at risk for recurrent infection to bones.</p> <p>Goal: [CR#2] will not experience signs and symptoms of osteomyelitis unaddressed during review. Target date 6.19.2025</p> <p>Interventions: encourage resident to report abnormal pain to bones, labs as ordered, medications as ordered, monitor for s/s of infection as needed and report abnormalities, therapy to screen and eval as needed.</p> <p>Focus: [CR#2] as paraplegia. At risk for complications related to conditions.</p> <p>Goal: [CR#2] will have no complications related to condition through the next review date. Target date 6.19.2025.</p> <p>Interventions: Encourage to maintain physical activity within limits, monitor 4 autonomic dysreflexia (overreaction of the nervous system) symptoms such as hypertension (high blood pressure), diaphoresis (excessive sweating), dizziness, anxiety, increase spasticity (stiff muscles), flushing of the skin, bradycardia (low heart rate), cool pale skin, visual disturbances,</p> <p>Focus: [CR#2] has diagnosis of Paraplegia and is at risk for contracture and skin breakdown.</p> <p>Goal: [CR#2] will not develop contractures until the next review. Target date: 6.19.2025, Resident will not develop skin breakdown until the next review. Target Date: 6.19.2025.</p> <p>Interventions: Report any skin breakdown to MD, Staff to provide all ADL care, weekly skin assessment.</p> <p>Focus: [CR#2] has frequent UTI's and is at risk for increased temperature, dehydration, and pain/discomfort.</p> <p>Goal: [CR#2] frequency of UTI's will that decrease, and resident will not have c/o (care of) pain discomfort, temp. will remain with in baseline limits until the next review. Target date: 6/19/2025.</p> <p>Interventions: give meds per order -monitor labs-report abnormal to M.D, monitor for increased temp, dehydration, pain discomfort, etc-report to M.D., Monitor to assure proper peri care (washing anal and genital area) is done, monitor urine for sediment, color, odor, amount, etc-report abnormal to MD.</p> <p>VOHRA_5/8/2025_ Stage 4 Pressure Wound of the Left Buttock wound size: 9.8x10.4x0.0.4_Dressing Treatment Plan:</p> <p>Primary Dressing(s):</p> <p>Alginate calcium apply twice daily for 30 days; Santyl apply once daily for 16 days</p> <p>Secondary Dressing(s)</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Kingwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23775 Kingwood Place Kingwood, TX 77339	

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Gauze island w/ bdr apply twice daily for 30 days</p> <p>Peri Wound Treatment</p> <p>House barrier cream apply twice daily for 30 days</p> <p>VOHRA_5/8/2025_Stage 4 Pressure Wound of the Left Posterior Thigh wound size: 9x7.5.0.3_Dressing Treatment Plan:</p> <p>Primary Dressing(s):</p> <p>Collagen sheet apply twice daily for 30 days; Alginate calcium apply twice daily for 30 days</p> <p>Secondary Dressing(s)</p> <p>Gauze island w/ bdr apply twice daily for 30 days</p> <p>Peri Wound Treatment</p> <p>House barrier cream apply twice daily for 30 days</p> <p>VOHRA_5/8/2025_Stage 4 Pressure Wound of the right heel wound size: 4.4x7x0.3</p> <p>VOHRA_5/8/2025_Stage 3 Pressure Wound of the right buttock_Resolved.</p> <p>VOHRA_5/15/2025_Stage 4 Pressure Wound of the Left Buttock wound size: 12.3x10.4x0.0.4_Dressing Treatment Plan:</p> <p>Primary Dressing(s):</p> <p>Alginate calcium apply twice daily for 23 days; Sodium hypochlorite solution (dakins) apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days: 0.25% soaked gauze in wound bed.</p> <p>Secondary Dressing(s)</p> <p>Gauze island w/ bdr apply twice daily for 23 days</p> <p>Peri Wound Treatment</p> <p>House barrier cream apply twice daily for 23 days</p> <p>VOHRA_5/15/2025_Stage 4 Pressure Wound of the Left Posterior Thigh wound size: 9x8.5.0.3_Dressing Treatment Plan:</p> <p>Primary Dressing(s):</p> <p>Alginate calcium apply once daily for 23 days; Leptospermum honey apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Secondary Dressing(s)</p> <p>Gauze island w/ bdr apply twice daily for 23 days</p> <p>Peri Wound Treatment</p> <p>House barrier cream apply twice daily for 23 days</p> <p>VOHRA_5/15/2025_Stage 4 Pressure Wound of the right heel wound size: 4.4x5.2x0.3</p> <p>DRESSING TREATMENT PLAN</p> <p>Primary Dressing(s)</p> <p>Alginate calcium apply once daily for 30 days; Collagen sheet apply once daily and as needed: if saturated, soiled, or dislodged. For 23 days</p> <p>Secondary Dressing(s)</p> <p>Gauze island w/ bdr apply once daily for 23 days</p> <p>Record Review of skin observation tool dated 5/13/25 at 5:19pm revealed CR#2's sacrum wound with no other comments.</p> <p>In a Telephone interview with FM B on 5.22.2025 at 3:40pm, FM B stated CR#2 is currently in the local hospital. FM B stated CR#2 was not turned properly and her wounds became worst, which resulted in a colostomy bag. He stated staff refused to communicate with him although he sent several emails to the DON regarding this issue. FM B stated the staff do not answer phones half of the time and when he would visit the facility, he would see employee on their personal phones not caring for residents. FM B stated when employees noticed him looking at them then they would begin working. FM B stated CR#2's room was so on the 200 Hall most times. FM B stated as a results of the lack of care CR#2 received, he continued calling and emailing the DON who would always tell him the issue would be addressed. FM B stated he received the same response, which is frustrating. He stated he called in to the state about this issue and it was not addressed. FM B stated CR#2 can speak and understand. She is paraplegic. FM B stated CR#2 has been at the facility since 2015. FM B stated CR#2 was not being seen daily by the wound care nurse either because the wound care nurses quit or got fired; and then other floor nurses who are not good at doing wounds would try. FM B stated CR#2 was not being turned as required by aides. He stated he has addressed this multiple times. FM B stated CR#1's treatment at this facility was just horrible. Another issue FM B stated he spoke with DON and Administrator about was staff would not change CR#2's urine bag and it backed up causing multiple UTI's.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview with ADON A on 5/23/25 at 3:42pm -she stated CR#2 has resided in the facility for 10 years and has a chronic suprapubic catheter. She stated CR#2 goes monthly to have her suprapubic catheter changed. She stated the wounds are not being resolved because CR#2 stays moist in those areas, however, CR#2 was being treated. ADON A stated when CR#2 went to hospital the sacrum womb got worse (stage 4) while she was there, not at the facility. ADON A stated CR#2 had to have a colostomy bag. ADON A stated CR#2 was being turned every 2 hours. ADON A stated CR#2 can reposition herself by grabbing hold of the bar. She stated the previous wound care nurse took care resident before her employment was terminated. ADON A stated the WCD makes rounds every week on Thursday.</p> <p>In an interview with WCN on 5/23/25 at 3:57pm who stated she has recently been task to provide wound care. She stated she is a nurse that does wounds. WCN stated she completed CR#2's wound care a couple of times. She stated CR#2's sacrum wound was stage 4. She stated she doesn't know what previous instruction was given to former wound care nursing staff from wound care doctor because she only was observing. WCN stated the last time wound care was provided on CR#2 was around 5/15/2025 with WCD and weekend wound care nurse, LVN F. WCN stated CR#2 had some serious wounds that were always draining. She stated there were 3 wounds that she observed, one on the sacrum (buttocks), one on the left thigh and one on the right heel. She stated when it was time for her (WCN) to do wound care on CR#2 she transferred to the local hospital.</p> <p>In an Interview on 5.24.25 at 7:30am with HNM- She stated CR#2 arrived at the hospital emergency room on 5/18/2025 at 8:37pm. The admitting diagnosis was: Severe Sepsis; however, she stated according to doctors' notes, CR#2's chief complaint was her sacral (buttock) wound. HNM stated CR#2 is currently in surgery for wound debridement. The HNM stated upon CR#2's arrival to emergency room, CR#2 vitals were:</p> <p>B/P: 108/88</p> <p>Temp: 97.9</p> <p>Pulse: 88</p> <p>Respirations: 18</p> <p>WBC: 11.37</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an Interview with CR#2 on 5/24/2025 at 12:35pm - she stated that her wound was very bad, which is the reason why she had to have the surgery for debridement at the hospital this morning. CR#2 stated that she was supposed to be changed twice a day and turned every 2 hours. However, she was only changed one time per day on the 1st shift and never on the 2nd shift. CR#2 stated she complained multiple times to all the staff, including DON and administrator and nothing was resolved. She stated FM B called and spoke with the DON, and he has spoken with the nurses on her shift, and nothing has never really been done to address or resolve her sacrum wounds. CR#2 stated in fact, the wounds worsened over time. She stated sometimes her butt hurts so bad she didn't know what to do other than cry and endure the pain. CR#2 stated she came to the hospital on 5.18.25 due to low blood pressure; However, she was informed she had severe sepsis. CR#2 stated that the WCD put in his note that she was to be turned several times each shift and her bandages should be changed twice, one time on 1st shift and once on 2nd shift. CR#2 stated she was only changed one time and that was after lunch prior to 2nd shift. CR#2 stated she was supposed to have been changed then put in her chair. CR#2 stated she has not been put in the chair for the last two weeks. CR#2 stated her bandages were always soaking wet and her wounds were always draining. CR#2 stated last week, she could not remember the exact date day or shift, an agency nurse came in and removed her bandages, washed, and cleaned her wounds. CR#2 stated a little later that same day and shift, an agency CNA came in to give her wash up, and when she rolled her over, she noticed that there were no bandages on her wounds and that her wounds were open because the agency nurse never redressed her bandages after cleaning her wounds. CR#2 stated that she has never been turned every two hours on the shift. She stated a lot of times she would have to call her children who would call the facility and demand a nurse, or someone come to her room and turn her. CR#2 stated that she has never refused wound care and never will because she knows just how important that is to her. She stated that she's trying to get better and hopefully one day she can go home. CR#2 stated she has been left to lie in her own poop for hours without being changed. She stated she's had to call her children who have had to call the facility to have a nurse go to her room and change her. CR#2 stated that first shift is a little short of staff, but second shift has been short of staff for quite some time and in order to have the call light answered it would be at least an hour or two. CR#2 stated in January 2025, she had a colonoscopy bag. She stated she had a colonoscopy, and it found a mass on her, but it was not cancer. She stated the colonoscopy bag was a result of wounds and that her wounds are so bad, and the care is so bad at the facility, the doctors at the hospital did not want to take a chance and continue letting her sit in her poop with open wounds. CR#2 stated staff barely changed her urine bags and they would stay full which resulted in her getting multiple UTI's.</p> <p>On 05/26/25 at 10:06AM Observation of Wound Care for R#1 in room [ROOM NUMBER] A-bed by WCN and LVN B. R#1 was resting in bed to her left side on an air mattress and was not inter-viewable. R#1's right hip dressing date on old dressing read 05/24/25 with moderate amount of dark brown, black color drainage on old dressing. WCN said the last time she worked at the facility doing dressing changes was on 05/24/25. R#1's wound bed was approximately the size of a silver dollar coin with inside tissue appearing pink reddish in color.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an Interview with CNA D 5/26/2025 at 10:30am she stated she has worked at the facility for 3 years and has worked with CR#2. She was nice and stated that she turned CR#2 every two hours. CNA D stated CR#2 is extremely verbal and will tell staff what she needs because she is direct in her words. CNA D stated she has not witnessed CR#2 refusing care. She stated CR#2 complained often about 2-10 shift not bathing her. She stated CR#2 was currently 2-10 bath. CNA D stated she would give CR#2 her baths if she had time on her shift. CNA D Stated resident has asked nurses to flush he catheter. CNA D stated CR#2 does not like poop to get on her and demands to get changed immediately. CNA D stated CR#2 would only refuse to get out of bed during the times she is in a lot of pain. CNA D stated she will inform the WCN or charge nurse when CR#2 has issues or refuse care. She stated R#2 did not get his bandaged changed on 5/25/2025 and she noticed the 5/24/2025 when she went into the room with the WCN.</p> <p>In an interview with WCN on 5/26/25 at 10:47am who stated she has recently been task to provide wound care. She stated she is a nurse that does wounds. WCN stated she completed CR#2's wound care a couple of times. She stated CR#2's sacrum wound was stage 4. She stated she doesn't know what previous instruction was given to former wound care nursing staff from wound care doctor because she only was observing. WCN stated the last time wound care was provided on CR#2 was around 5/15/2025 with WCD and weekend wound care nurse, LVN F. WCN stated CR#2 had some serious wounds that were always draining. She stated there were 3 wounds that she observed, one on the sacrum (buttocks), one on the left thigh and one on the right heel. She stated when it was time for her (WCN) to do wound care on CR#2 she transferred to the local hospital. In reference to R#1 and R#2, the WCN stated the date on R#1's bandage 5/24/2025, and R#2's bandage was dated 5/24/2025. WCN stated the bandages should be changed daily. She stated her last working day was 5/24/25. WCN stated in her absence, the charge nurses should have replaced the bandages. WCN stated either the weekend wound care nurse or charge nurses should have provided wound care to residents and replaced the bandages and dated them as well. WCN stated not changing wound care bandages, not replacing bandages that have fallen off and not following doctors' orders for wound care could place resident at risk for infection.</p> <p>In a Telephone Interview with WCD on 5/26/2025 at 12:42pm - he stated CR#2 appeared to be OK the last time he seen her on 5.15.25. He stated that the residents' wounds are chronic but not progressing. WCD stated this was an issue, which is why he ordered Dakins Solutions. WCD stated he observes CR#2's wound bandages to be saturated when he comes to visit and had some concerns with the wounds and not progressing well. He stated that CR#2's bandages on her wounds would be soil. He stated one reason for the wound bandages would be if the catheter was not in properly or if the bandages were not being changed as ordered. The WCD stated he has not smelled any urine when he came to see CR#2. He stated CR#2 had a colostomy bag and a Foley catheter. WCD stated that a saturated dressing could increase infection and could lead to systemic also known as sepsis if not changed properly. He stated he noticed that CR#2 does not get out of bed as she should. WCD stated if wound dressings are not on the wound, it also increases the likelihood of bioburden infection that could also lead to sepsis. WCD stated CR#2 should get up out of the bed several times during the day for at least 60 minutes to two hours and then place back in bed. He stated when CR#2 refuses to get out of bed, facility staff should be a little more diligent with residents to encourage her to do so. WCD stated that he has known resident for many years and the one thing that she does not do is lie!</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In a telephone interview with CNA G 5/26/2025 at 2:45pm, she stated she was very familiar with CR#2 because she worked 6am-2pm shift was responsible for her care. She stated CR#2 moods would change when she was in pain. She stated CR#2's wounds were always open and draining, which made her bandages soiled. CNA G stated CR#2 would get up in the chair sometimes after receiving a bed bath; however, she would refuse when she was tired and hurting. CNA G stated she put resident up in chair when she would ask. She stated CR#2 was a two person assist and needed to be lifted with the help of a Mechanical lift. CNA G stated whenever she would see CR#2's colostomy bag leaking it was changed as needed. CNA G stated if CR#2's bandage had a little poop on it she wanted it changed immediately. CNA G stated in her opinion, a little poop on the bandage did not mean the bandage should be changed. CNA G stated because CR#2's bandage had a small amount of poop on it, it didn't need changing and this would upset CR#2.</p> <p>In a telephone interview with LVN F on 5/26/2025 at 3:40pm -She stated she worked the 6a-6p and worked the 200 hall and first half of 600 hall. She stated the treatment nurse is responsible for wound care; however, if treatment nurse isn't available then the floor/charge nurse is responsible. She stated she did not turn R#2 and didn't see the sacrum wound. LVN F stated she did not look at R#2's neck area. She stated the treatment nurse was in the building looking at all residents with wounds. LVN F stated when resident dressing comes off the treatment nurse is responsible, but the charge/floor nurse would be responsible if they become aware. LVN F stated it is important for dressing to be changed as ordered to eliminate infections and to ensure the wound to heals. If the dressing is not redressed it can get contaminated and could get infected.</p> <p>Record Review of R#1's undated face sheet was the [AGE] year-old female admitted to the facility on [DATE] with the diagnosis of Alzheimer's disease.</p> <p>Record Review of R#1's MDS dated [DATE] revealed no BIMS score, severely impaired, unable to respond, impaired on the lower extremities (both sides), uses a wheelchair. R#1 required substantial/maximal assistance in the areas of eating, oral & toileting hygiene, shower/bath, upper & lower body dressing, putting on and taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sit on side of bed, sit to stand, and chair/bed to chair transfer. R#1 is totally dependent on staff for Tub/Shower transfer. Section H (Urinary Toileting Program) R#1 is always in continent in the areas of urinary and bowel continence. Section M (Skin Conditions) revealed R#1 is at risk of developing pressure ulcers/injuries and has one or more unhealed pressures ulcers/injuries. R#1 has a stage 4 pressure ulcer and requires pressure ulcer/injury care and application of nonsurgical dressings.</p> <p>Record Review of R#1's May 2025 orders revealed Type of wound: abrasion located right lower media irrigate or cleanse wound bed with normal saline, nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): collagen cover with dry dressing. Order date 5/6/2025 5:32pm; Type of wound: open area Location of wound: Coccyx irrigate or cleanse wound bed with normal saline, nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): collagen Cover with dressing daily. Order Date-5/6/2025 at 5:35pm D/C-5/26/2025 at 1:11pm; Type of Wound: Pressure Sore Location of wound: Left Buttock. Irrigate or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanse, pat dry and apply or pack (if applicable): Collagen. Cover with: Dry Dressing secure dressing with Tape. Order date-4/20/2025 at 5:23pm; Type of wound: Pressure Stage 4. Location of wound: Right hip irrigate or cleanse wound Fobed with Normal saline, Nexodyn solution or wound cleaner, pat dry and apply or pack (if applicable): 1/4 Iodoform packing strip and cal alginate. Cover with: Dry dressing. Secure dressing with: Tape. Order Date: 4/10/2025 at 11:11am.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on, interviews and record review the facility failed to ensure resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 9 residents (CR #1) reviewed for accidents and supervision, in that:</p> <p>The facility failed to ensure CR#1 was transferred properly per therapy assessments and instruction, by CNA B. CR#1, a bedbound resident, who was totally dependent on staff for care sustained an unexplained head injury and hip fracture in her room alone.</p> <p>The facility failed to ensure precautionary interventions in place for CR#1, who was a known fall risk.</p> <p>An Immediate Jeopardy (IJ) was identified on 5.22.2025. The IJ template was provided to the Administrator on 5.22.2025 at 1:07 p.m. While the IJ was removed on 5.25.25 at 3:38 p.m., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>These failures could place residents at an increased risk of decline, and diminished quality of life.</p> <p>Findings included:</p> <p>Record review of CR#1's face sheet revealed a [AGE] year-old female, admitted to the facility on [DATE]; on 3/16/2020 and discharged 5.14.2025 with a diagnosis of COPD, rheumatoid arthritis, contracture, right hand, congestive heart failure and dementia.</p> <p>Record review of CR#1's MDS dated [DATE] revealed, CR #1 has impaired communication AEB (as evidenced by) difficulty understanding others, CR #1 has substantial/maximal dependency on staff to meet all of her ADL needs. CR #1 is an extensive total assist times 1-2 staff for transfer, toileting and bathing, and limited assist times one with eating. Is at risk for falls and injury related to contusions, disorientation, incontinence, and poor safety awareness. CR#1 has a BIMS score of 5 (severe cognitive impairment) Co. Section GG (Functional Abilities) indicated CR#1 has an impairment on both sides, upper (shoulder, elbow, wrist, and hand) and lower extremities (hip, knee, ankle, and foot). CR#1 is totally dependent on staff of all her personal hygiene needs. CR#1's needs substantial/maximal (Helper does more than half the effort) assistance with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, the ability to roll left and right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer and CR#1's required partial/moderate assistance in the areas of eating, oral hygiene, and upper body dressing. Section O (special treatments, procedures, and programs) indicated CR#1 required oxygen therapy.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of CR#1's Orders revealed: Monitor pain level every shift; tramadol (Pain medication) HCl (Hydrochloride)-Give 1 tablet by mouth every 8 hours related to chronic pain syndrome (order date: 12/12/2024 at 1148-D/C date 5/19/2025); Acetaminophen (used for moderate pain) tab 325 MG give 1 tablet orally every 6 hours as needed for pain related to Chronic pain syndrome do not exceed more than 3 gm in 24 hours (Order date:11/8/2024 at 11:07am-D/C 5/19/2025 at 8:44am)</p> <p>Record Review of CR#1's care plan dated 5.21.2025, revealed the following:</p> <p>Focus: [CR#1] has impaired cognition function and impaired thought processes AEB (Short Term memory deficit, Impaired ability to make daily decisions, BIMS=5 related to dementia).</p> <p>Goal:[CR#1] needs will be met, and dignity will be maintained through the next review,</p> <p>Target Date: 8/5/2025</p> <p>Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness; ask yes/no questions to determine resident needs; Cue, reorient and supervise as needed; Don't argue or correct me if I get confused to reality; Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status; redirect gently when needed for meals, room, daily activities; Use task segmentation to support short term memory deficits. Break tasks into one step at a time.</p> <p>Focus: [CR#1] has impaired communication AEB difficulty understanding others, difficulty finding words related to Dementia and Dysphagia</p> <p>Goal: [CR#1] will maintain current level of communication function through the review date. Target date: 8/5/2025.</p> <p>Interventions: Allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact, turn off TV/radio to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/ cues, use alternative communication tools as needed; Anticipate and meet needs; Ensure/provide a safe environment: call light in reach, adequate local air light, bed in lowest position and wheels locked, avoid isolation; monitor/document/report PRN any changes in: Ability to communicate, potential contributing factors for communication problems, potential for improvement; OT/PT/Nurse to evaluate resident dexterity/ability to use communication board, writing, use computer or use or sign language as alternate communication to speech; refer to speech therapy for evaluation and treatment as ordered; Validate resident's message by repeating aloud.</p> <p>Focus: [CR#1] requires assistance to perform functional abilities in self-care and mobility AEB, unsafe or poor quality and functional range of motion to upper or lower, right or left, etc. r/t medically complex conditions</p> <p>Goal: [CR#1] will have improvement in functional abilities in the following areas by end of the skilled stay. Target Date: 8/5/2025</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interventions: Provide the following Self Care assistance: (SPECIFY in A-H below- Independent, Setup/Cleanup, Supervision/Touching, Partial/Moderate, Substantial/Maximal, Dependent)</p> <p>A. Eating: Partial/Mod; B. Oral Hygiene: Partial/Mod; C. Toilet Hygiene: Substantial/Max;</p> <p>E. Shower/Bathe self: Substantial/Max; F. Upper Body Dressing: Partial/Mod;</p> <p>G. Lower Body Dressing: Substantial/Max; H. Putting on/taking off footwear: Substantial/Max;</p> <p>I. Personal Hygiene: Dependent;</p> <p>Provide the following Mobility assistance: (Specify in A-H below-Independent, Setup/Cleanup, Supervision/Touching, Partial/Moderate, Substantial/Maximal, Dependent)</p> <p>A. Roll left to right: Substantial/Max; B. Sit to lying: Substantial/Max; C. Lying to sitting on the side of the bed and with no back support: Substantial/Max.</p> <p>B.Sit to Lying: Substantial/Max</p> <p>C. Lying to sitting on the side of the bed and with no back support: Substantial/Max</p> <p>D. Sit to Stand: Not Applicable</p> <p>E. Chair/Bed-to-chair transfer: Substantial/Max</p> <p>F. Toilet Transfer: Substantial/Max</p> <p>FF. Tub/Shower Transfer: Substantial/Max</p> <p>I. Walk 10 feet: Not Attempted</p> <p>Focus: [CR#1] has an ADL self-care performance deficit r/t Dementia, COPD (damaged lungs) Disease processes</p> <p>Goal: [CR#1] will improve current level of function through the review date. Target Date: 8/5/2025</p> <p>Interventions: Provide the following assistance with ADL's in Self Performance and Staff Support:</p> <p>A. Bed Mobility:</p> <p>B. Transfer: Extensive - Total assist x1-2 staff</p> <p>H. Eating: Limited assist x1 staff</p> <p>I. Toileting; Extensive-Total assist x1 staff</p> <p>K. Bathing: Extensive assist x1 staff</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Focus: [CR#1] is at risk for falls and is at risk for increased falls and injury r/t confusion, disorientation, incontinence, poor safety awareness.</p> <p>Goal: [CR#1] dignity will be maintained. Incident of falls will be reduced, and no occurrence of injury will occur through next review. Target date: 8/5/2025.</p> <p>Interventions: Administer pain medications per MD order for any pain discomfort; anticipate needs, provide prompt assistance with ADL's and other special needs, assess for psych services; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; coordinate with appropriate staff to ensure a safe environment with floors free of clutter, adequate glare free light, call light accessible, bed in lowest position, handrails on walls, and personal items within reach; ensure that resident is wearing appropriate footwear or nonskid socks when ambulating or when up in wheelchair for mobility; evaluate for and supply adaptive equipment or devices as needed. Reevaluate as needed for continued appropriateness and to ensure the least restrictive device is used; Fall risk assessments per facility protocol; head to toe assessment post fall; monitor and report to MD and family for any injury from a fall, increased confusion and disorientation; participate in falling star program per facility protocol; proper position and body alignment when up in wheelchair; rehab screen/evaluate and treat as indicated for therapeutic exercises and safety measures; vital signs as needed, Neuro checks as needed.</p> <p>Focus: [CR#1] has had an actual fall with (Specify: No Injury-Injury, pain, hematoma, bruise, skin tear---major injury such as fracture, subdural hematoma, etc.) Confusion, poor balance, unsteady gait. Actual Falls: 5.14.2025 Hematoma, Pain Forehead abrasion</p> <p>Goal: [CR#1] Will have no further fall during the next 14 days. Target Date: 8/5/2025</p> <p>Interventions: 2 persons assist for transfers post fall; administer pain medications prn per MD order for any pain or discomfort, anticipate needs, provide prompt assistance with ADL's and other special need, call MD and RP for any changes in condition, Continue interventions on the at-risk plan, encourage resident to ask and wait for assistance from staff, for no apparent acute injury, determine and address causative factors of the fall, head to toe assessment, ice pack applied, monitor and report to MD and RP for any injury from fall, monitor/document-report PRN x 72h to MD for s/sx: Pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation; Rehab consult for strength and mobility.</p> <p>Record review of facility video recorder, revealed the DON, LVN A and other unknown nursing staff standing outside CR#1's door. It appears to have time lapse.</p> <p>Record review of nursing notes dated 5.14.2025 revealed the following occurrences:</p> <p>At 3:45pm authored by LVN A notes CR#1's signs and symptoms of hematoma to left side of forehead that started on 5/15/2025. The note further stated that since the start of the injury, CR#1 condition has stayed the same. LVN stated the condition is worse upon touch. LVN A noted that CR#1's condition, symptom, or sign has not occurred before. Vitals were monitored. Both NP and FM notified 5/15/2025 at 3:45pm.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>At 5:13pm authored by DON indicated CR#1 was picked up by non-emergency transportation to transfer to hospital. FM called and made aware.</p> <p>At 6:11pm authored by LVN A stated she was in the hallway and was alerted by CR#1 crying out loud in distress. LVN A stated she walked into CR#1's room to assess. LVN A stated CR#1 expressed she was in pain on the left side of her body. LVN A stated she observed a hematoma the size of a walnut on the left side of CR#1 forehead with an abrasion. LVN A stated she immediately reported to the DON and NP, applied an icepack to the hemotoma and retrieved vitals. Bp (blood pressure) 135/74, Hr (heart rate) 94, O2 (oxygen) sat 95% on continuous O2, RR (respiratory rate) 20. CR#1 was already administered a scheduled Tramadol for pain. The LVN stated she called NEMS (non-emergency medical service), FM was called by DON.</p> <p>Record review of CR#1's pain level revealed the following:</p> <p>5.14.2025 at 7:55am Level 0</p> <p>5.14.2025 at 4:46pm Level 0</p> <p>5.14.2025 at 5:39pm Level 10</p> <p>5.14.2025 at 5:43pm Level 10</p> <p>Review of CR#1's therapy records dated 5.14.2025 revealed the following:</p> <p>CR#1's Speech Therapy Treatment encounter notes indicated CR#1 is not to feed herself due to increased risk of choking and/or aspirations. CR#1 is on a puree diet with thin liquids.</p> <p>CR#1's Physical Therapy Treatment Encounter Notes indicated CR#1 bed mobility was not applicable because CR#1 was unable to sit up, roll from side to side nor was she able to sit on the bed. Transfers were not applicable as CR#1 required an Assistive Device During Transfers (Hoyer Lift).</p> <p>CR#1's Occupational Therapy Treatment Encounter notes indicated CR#1 was not tested on sitting balance or standing balance because she was unable to do either according to the DOR.</p> <p>Record Review of the Provider Investigative Report dated 5.14.2025 at 5:56pm revealed the following:</p> <p>Revealed on 5/14/25 at 3:45pm Neuro Checks started.</p> <p>LVN A statement stated she responded to CR#1 room after hearing yelling and crying out. She completed an assessment and noted a hematoma with abrasion.</p> <p>MA A statement said she seen CR#1 during lunch and CR#1 did not have knot on the side of her head; however, after lunch she did.</p> <p>MA B statement stated she did care for CR#1 before lunch. She administered CR#1 morning meds. After lunch she had knot on the head.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an interview with LVN A on 5.20.25 at 4:20pm she stated she was administering meds on the floor. She stated almost at 3:00pm CNA A was giving resident a bed bath. She stated CR#1 had 3:00pm scheduled meds. She stated when she went into the room, CR#1 was laying on her left side. She stated during CR#1's bed bath she checked on CR#1 because she had a sacrum wound. LVN A stated she assisted CNA A pull resident up on the bed after the bed bath. LVN A stated before she left the room, she administered the scheduled medication, tramadol then assisted CNA A pulled CR#1 up to the head of the bed with the bed pad, then she left out of the room. She stated she went to the cart to make a notation of administering the medication on the MAR's system. At approximately 5-10 minutes later, LVN A said she heard CR#1 scream and say, God something wrong. She stated CR#1 continued praying and saying, something is wrong. LVN A stated CR#1 was alone in her room. She stated CR#1 had on her nasal cannula, a green bonnet, and her gown. LVN A stated CNA A had moved on to the next resident, so she was in the room alone with CR#1. She stated she moved the bonnet and observed the hematoma. LVN A stated she went to notify DON and returned to CR#1's room and completed a head-to-toe assessment. She stated she has never seen CR#1 turn or roll on her own. She stated CR#1 did not have the hematoma when she administered the tramadol medication for her 3:00pm scheduled meds.</p> <p>Arrived at local hospital 5.20.25 at 6:30pm - Interviewed with ICUN who stated CR#1 arrived on 5.14.2025 and the admitting diagnosis was terminal illness and left femur fracture. She stated hospital records noted swelling on the left side of the CR#1's head. She stated CR#1 was discharged today to rehab facility.</p> <p>In a telephone interview with CNA A 5.20.25 at 7:03pm. She stated on 5.14.2025, she worked at 2:00PM because she works the second shift 2:00 PM to 10:00 PM. She stated she had given CR#1 a bath, which was a little bit after 3:00PM because there was another resident she had to bath prior to CR#1. She stated when she was almost done giving CR#1 her bed bath LVN A walked into the room and administered medication to CR#1. CNA A stated that she asked LVN A to help her pull CR#1 up to the head of the bed as CR#1 is a two person assist. CNA A stated during the bed bath, she cleaned CR#1's eyes and did not see any bumps and bruises in her facial area. CNA A stated CR#1 was not moaning while she was giving her a bed bath. CNA A stated she finished the bed bath and dressed the resident and left. CNA A stated she returned to CR#1's room and LVN A told her that CR#1 had a knot on her head. CNA A stated she was not in the room when LVN A observed the knot on the residence head. CNA A stated she observed the knot was on the left side of CR#1 head. CNA A stated that resident did not hit her head or anything while she was giving her a bed bath, CR#1 did not fall while giving her a bed bath, and she did not accidentally hit the resident while giving her a bed bath. CNA A stated there's no possibility that CR#1 bumped her head while she was caring for her. CNA A stated that if she had seen an unusual mark or a bruise on CR#1 she would have reported it to her supervisor or the nurse manager as soon as possible. CNA A stated CR#1 uses a specialized wheelchair and is a 2 person assist. CNA A stated CR#1 is bottom heavy. CNA A stated she did CR#1's bed bath alone. She stated she used a hospital gown on 5.14.2025 because she wasn't going dining room for dinner. CNA A stated her last day of training for abuse and neglect was last year.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In a telephone interview on 5.21.2025 at 7:30am with FM she stated she received a call on 5.14.2025 between 3:00pm - 3:45pm by a CNA C whom she knows from working with CR#1 for the last 8 years. She stated CNA C informed her that while caring for another resident who reside in the room next to CR#1 when she heard CR#1 screaming. FM stated CAN C told she immediately went into CR#1's room to check on her and found CR#1 lying on her back in the middle of the bed with a knot on her head that was bleeding. FM stated CNA C informed her that she observed CNA A and CNA B standing in the hallway across from CR#1's room and could not understand why they did not go into the room to check on CR#1. FM stated CNA C stated the DON was standing at the nurses' station speaking with LVN A when CAN C approached DON and told her what she had observed. FM stated this was around 3:55pm when she received a call from the DON. During this call, FM stated she could hear CR#1 screaming in the background and DON told her that she and LVN was in CR#1's room. FM stated DON stated she was calling the ambulance. FM stated after 20 minutes had gone by without a call back from the DON she called the DON back and was told CR#1 wasn't being transported through emergency transportation, but the facility called a non-emergency transportation to pick her up. FM stated after CR#1 was admitted into the hospital she received a call from the asking how CR#1 was doing. FM stated she told the DON CR#1 has a broken hip too. FM stated the DON asked if the hip was a new injury and she responded in the affirmative. FM stated the DON sounded surprised that CR#1 had a new injury. FM stated she was told by the hospital medical staff that CR#1 needed surgery; however, due to CR#1's age ([AGE] years old), the hospital stated they would not be able to do surgery because CR#1 is not strong enough to survive it. FM stated she saw CR#1 Mother's Day (5.11.2025) and the Monday (5.12.2025) afterward and there was no issues, bumps or bruises. FM stated CR#1's bed has never been in a low position. FM stated on a prior occasion the facility had taken resident to the hospital for a knee injury. FM stated it was a small fracture. She stated DON told her CR#1 was fragile and any little bump could happen because her age, bones being brittle, bump in wheelchair could also be an issue. FM says CR#1 has been transferred to a local hospice care facility.</p> <p>In a Telephone Interview with CNA C on 5.21.2025 at 9:10am. CNA C stated she found CR#1 just after 3:00pm. CNA C stated on 5.14.2025 she was called in to the facility by the administrator to work the front desk. CNA C stated she previously worked for the facility full-time, but now she only works PRN. CNA C stated she is familiar with CR#1 as she has worked with her for nearly 8 years. CNA C stated on 5.14.2025 a little after 3:00pm she transported a resident to his room. She stated she then went to check on another resident who is in the room next to CR#1. CNA C stated she heard screaming in the room next to the resident's room she was in and immediately went into CR#1's room. CNA C stated CNA A & CNA B were standing in hallway and could hear her also; however, both just stood there and did not move. CNA C stated CR#1 was laying on her back and she could visually see CR#1 with the knot on the left side of her head and it was bleeding. CNA C stated she immediately went to the end of the hall by nurses' station and told the DON CR#1 was screaming and bleeding. CNA C stated the DON told LVN A to go to CR#1's room and told LVN A to call CR#1's FM. CNA C stated resident laid there for about an hour and a half. CNA C stated she came to check on CR#1 and observed a bag of ice (look like in a Ziploc bag), without being covered in a cloth, on resident's forehead. CNA C stated CR#1 was visually cold, shaking and screaming, please help me I'm cold and hurt. CNA C stated this is when she returned to the front desk and called her daughter back and told the daughter her mom was cold, shaking and had not been picked up by the ambulance yet.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Kingwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23775 Kingwood Place Kingwood, TX 77339	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In an Interview with NP on 5.21.25 at 9:30am the NP stated there was a concern regarding CR#1's injury when she was informed. NP stated she was notified of CR#1's injury and instructed the facility to send CR#1 out to hospital. NP stated non-emergency transport was okay. NP stated she completed her own investigation when she was in facility. NP stated she spoke with the CNA A who was providing care to CR#1. She stated the CNA A told her she didn't know how CR#1 got the bump on her head. NP stated CNA A told her, while giving resident her bath, she used a roll sheet (pad) to roll her on her side, then held onto her left hip and washed her backside with the right hand. She stated CNA A told her she did not see any bump or bruises. NP stated CR#1 has osteoporosis and is very frail. NP stated she doesn't believe CR#1 was abused or neglected. She stated that she does believe that when the CNA A rolled CR#1 on her side, the CR#1 may have hit her head on either the wheelchair that was on the side of the bed or the bedside table or tray table. NP stated if CR#1 had fallen, she would have sustained, based on her frail and brittle condition, multiple injuries, and multiple fractures. NP stated CR#1 sustained a fractured hip located between ball joint and hip. NP stated she believes CNA A didn't see CR#1 hit her head while giving care. NP stated CR#1's pain was delayed, which is why she screamed afterwards. NP stated she checked hospital records and there were no signs of brain bleed. NP stated the bump on CR#1's head didn't come out of nowhere. NP stated her synopsis is CR#1 could have hit her head on wheelchair or tray that was at her bedside. NP stated the CNA A told her she held CR#1's hip with her left hand. NP stated this could have caused the hip was fractured between ball joint and hip. NP continued stating CR#1 could fracture easily because she was brittle. NP stated she does not suspect abuse. NP stated CR#1's comorbidities due to brittle bones could very well have been cause during the care she was receiving from CNA A. Can't say she fell. She was told one can gave bath.</p> <p>In an Interview with DON on 5.21.2025 at 11:14am she stated the hematoma could have occurred when CR#1 was turned over during her bed bath. DON stated CNA A said the bedside table and wheelchair was by CR#1's bed. DON stated CNA A told her CR#1's injuries were unintentional, and she believes CNA A. According to the camera, the screaming began after bed bath. DON stated she believes it happened during an earlier timeframe it took time for the swelling. Stated she will look to see if there. As far as fracture goes, the nurse completed a head-to-toe assessment. She Stated CNA A used padding to turn resident (resident is dead weight). Stated can have her hand on left hip to bathing her backside. Stated resident never complained. She stated she will send me the ADL policy. When asked why resident went .out 911 she stated she felt that resident was stabled, assessments were completed along with neuro-checks.</p> <p>In an interview with Administrator on 5.21.2025 at 11:50am. She stated 5/14/2025 she was informed about CR#1. She stated a head-to-toe assessment was complete and Neuros started. The administrator stated she was informed CR#1 had a knot on her forehead area. An investigation was initiated and called in to the state. She stated she was informed later about CR#1's hip fracture. She stated the facility did everything they were supposed to do in this situation including filing a police report. She stated at this time she believes her staff followed protocol.</p> <p>Record Review of Facility's Provision of Quality-of-Care Policy dated 2/2023 revealed the following:</p> <p>1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Kingwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23775 Kingwood Place Kingwood, TX 77339	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>2. A comprehensive care plan will be developed for each resident in accordance with procedures for development of the care plan.</p> <p>3. Responsibilities for interventions on the care plan will be clearly identified.</p> <p>An Immediate Jeopardy (IJ) was identified on 5.22.2025. The IJ template was provided to the Administrator on 5.22.2025 at 1:07 p.m. While the IJ was removed on 5.25.25 at 3:38 p.m., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>The following Plan of Removal submitted by the facility was accepted on 5/23/2025 at 6:46 p.m.</p> <p>PLAN OF REMOVAL</p> <p>Name of facility:</p> <p>Date:5/23/25</p> <p>F689- Accidents/supervision</p> <p>Problem:</p> <p>-The facility failed to ensure the resident environment remained free of accident hazards as is possible in that residents receive adequate supervision and assistance when being transferred.</p> <p>-The facility failed to ensure adequate supervision for CR#1, a bedbound resident, who is totally dependent on staff for care resulting in CR#1's sustained hematoma to head and fractured hip.</p> <p>-The facility failed to ensure CR#1 was transferred properly by using a gait belt.</p> <p>CR#1 was transferred to the hospital for further evaluation and treatment 5/14/25.</p> <p>C.N.A #1 is no longer employed by our facility d/t failure to immediately report</p>		