STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676161	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Healthcare and Rehabilitation Center	6850 Rufe Snow Dr Fort Worth, TX 76148

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44405

Based on observations, interviews, and records review the facility failed to develop and implement comprehensive person-centered care plans that include measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs, and describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #1) of 3 resident's care plans reviewed.

1. The facility failed to develop a comprehensive care plan to address the risk of/actual altered skin integrity for Resident #1. Admission paperwork (to the SNF) dated 11/08/24, revealed Resident #1 had altered skin integrity.

2. The facility failed to develop a comprehensive care plan for PAD for Resident #1. Admission paperwork (to the SNF) dated 11/08/24, revealed Resident #1 had a history of PAD.

These failures could negatively impact the resident's quality of life, as well as the quality of care and services received if care planning is not complete or is inadequate.

Findings included:

A record review of Resident #1's modified Admission MDS assessment, dated 11/15/24, revealed a 78-years-old female, admitted to the facility on [DATE]. Resident #1 had an initial diagnosis of metabolic encephalopathy (an alteration in consciousness caused by diffuse or global brain dysfunction). Other admission diagnoses included AKF (a sudden episode of kidney damage or kidney failure); E. coli (infection commonly found in the lower intestine); and T2DM (a chronic condition characterized by insulin resistance and high blood sugar levels). A BIMS score of 10 suggested Resident #1 had a moderate cognitive decline. Resident #1's functional status required one-person substantial/maximal assistance with ADLs and transfers. Resident #1 was always incontinent of bowel and bladder. Section M - Skin conditions of the modified Admission MDS assessment revealed Resident #1 did not have any unhealed PU/PI, venous/arterial ulcers, or other ulcers, wounds, and skin problems. Resident #1 was at risk for developing pressure ulcers/injuries. The modified Admission MDS assessment indicated pressure reducing devices for chair and bed and applications of ointments/medications other than to feet were active skin and ulcer/injury treatments in place.

Record review of Resident #1's Discharge MDS assessment dated [DATE] indicated Resident #1 did not have one or more unhealed pressure ulcers/injuries.

(continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676161	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER: Green Valley Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 6850 Rufe Snow Dr Fort Worth, TX 76148	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's comprehensive care plan [Date initiated: 11/11/24; Review Date: 12/02/24] did not reflect a Focus problem for impaired skin integrity, risk of developing a pressure injury, or goals and interventions in accordance with the resident's choices, including, to the extent possible, attempting to improve or stabilize the skin integrity/tissue breakdown and to provide treatments. Resident #1's care plan goals revealed Resident #1 would remain free from skin breakdown due to incontinence and brief use related to functional bladder incontinence [Date initiated: 12/10/24] and would be free from skin tears and maintain intact skin related to the potential for impairment of skin integrity - bruise to right elbow r/t fragile skin [Date initiated: 12/06/24] through the review date (03/02/25). Interventions for the potential impairment of skin integrity included weekly skin checks, notify MD/NP/PA/RP of impairments of skin integrity, and to follow facility protocol for treatment of skin impairment. A record review of Resident #1's transfer admission orders dated 11/08/24 sent by the discharging facility (acute care hospital [admission: 11/04/24 - 11/08/24]) revealed: - Resume Calamine Topical. Apply to affected area three (3) times daily to buttocks. - Resume mineral oil-hydrophil ointment. Commonly known as: Aquaphor (used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations [such as diaper rash]) to buttocks for itching. - MD physical examination dated 11/08/24 at 11:34 AM revealed wound (11/05/24) - rash midline coccyx (3 days) A record review of Resident #1's Order Summary Report, printed 01/04/25, reflected: - Order Date 11/08/24: Pressure redistribution cushion to wheelchair - Order Date 11/08/24: Pressure redistribution mattress to bed - Order Date 11/08/24: Resident to have weekly skin check. - Order Date 11/08/24: Calamine External Lotion. Apply to buttocks topical three times a day for skin repair. - Order Date 11/18/24: Med Pass (nutritional shake to supplement calories and protein) 90 cc two times a day. - Order Date 12/05/24: Monitor bruise to right elbow every shift until resolved for skin assessment. There was no evidence of orders to apply pressure relieving devices to Resident #1 heels. Record review of Resident #1's progress notes reflected: Effective Date: 11/08/24 at 11:10 PM Type: Gen Nurses Notes - narrative (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Author: LVN A Note Text: [Resident #1] admitted to the facility under [APMD] from [acute care hospital] . presents redness on the sacrum area. Effective Date: 11/12/24 10:15 AM Type: Skin and Wound Note Author: WNP H [Third party wound care service provider] HPI: Information necessary for today's visit was obtained from the patient, nursing staff, per patient's medical record. Reason for visit: new admission to the facility, skin/wound assessment. PHYSICAL EXAMINATION: fecal incontinence, urinary incontinence; generalized weakness; bilateral lower extremity skin without evidence of acute ischemic (insufficient blood flow to a part of the body) changes, diminished pedal pulses ([of the foot] Diminished pedal pulses are a sign of peripheral vascular disease [PAD] that mean that the blood vessels are narrowed or blocked, and the blood flow is reduced or absent); no history of a pressure ulcer. SKIN: warm and dry, intact, no open wound, bruising BUE. Lower Extremity Exam: edema: No edema (swelling caused by excess fluid trapped in the body's tissues). Texture: intact, dry. Perfusion (referring to the delivery of blood to a capillary bed in tissue): diminished pedal pulses, RLE warm, LLE warm. Sensation: BLE intact to light touch Associated Findings: clean and dry, generalized dryness. WOUND ASSESSMENT: The patient was noted to have intact skin upon assessment today. The patient has moderate/high risk for skin breakdown. NEW RECOMMENDATIONS: The patient was noted to have intact skin upon assessment today. Patient is at moderate risk for pressure ulcer formation related to decreased mobility, incontinence of urine and stool. The patient is incontinent of urine and stool and is at an increased risk of skin breakdown. Effective Date: 11/21/24 7:18 PM Type: Skin and Wound Note (Facility Skin Sweep - Comprehensive skin assessment) Author: WNP H [Third party wound care service provider] (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HPI: Information necessary for today's visit was obtained from the patient, nursing staff, per patient's medical record. Reason for visit: The resident is being evaluated today for a comprehensive skin assessment. 11.22. 24: [Resident #1] being seen for skin assessment. noted to have intact skin on assessment today. noted to have generalized xerosis (a condition of rough, dry, scaling, itchy, red, and sometimes cracking skin). SKIN: warm and dry, Dry, flaky, intact, no open wound. RECOMMENDATIONS: Apply moisturizer to resident's skin routinely. Do not massage over bony prominences. The patient was noted to have dry skin generalized to entire body. Recommend use of emollient daily. Maintain adequate oral hydration as indicated if not contraindicated. Continue with turning and repositioning schedule per protocol for pressure prevention. Position patient side to side as tolerated. Recommend resident out of bed as tolerated for limited intervals of time, alternating activity to minimize pressure. The resident is incontinent of bowel and bladder. Use appropriate moisture barrier creams per formulary to provide thorough skin care with each incontinent episode. Use formulary briefs when indicated to manage moisture and assess often. Ensure proper fitting briefs, socks, stockings, and other clothing to prevent pressure. Ensure resident has proper fitting footwear to prevent/minimize unwanted pressure and friction. A review of Resident #1's hospital medical records (Admission: 12/29/24; discharged to Hospice: 01/07/25 at 7:52 PM) revealed Resident #1 arrived at the ED 12/29/24 at 10:40 PM and admitted inpatient 12/30/24 at 1:54 AM. The first ED provider notes dated 12/29/24 at 11:03 PM identified Resident #1's legs were slightly mottled (patchy discoloration), abrasion-like spots on toes of right foot, no distal (position that is farther from the center of the body or the point of attachment) pulses. The Admission H & P summary entered by the provider on 12/30/24 at 3:53 AM reflected altered skin integrity to Resident #1's buttocks - excoriation (mechanical removal or rubbing of the skin's surface layer, resulting in superficial wounds or scratches) vs abrasion (process of rubbing away the surface of something); skin dry and flaky; heels were boggy (deep tissue injuries may be recognized as areas on the heel that are dark purple or reddish-purple in color, boggy or firm and warmer or cooler to touch than surrounding tissue). On 01/01/25 at 10:00 AM, the wound consultant identified the altered skin integrity to Resident #1's sacral area as an unstageable deep pressure injury. Wounds identified: Rash midline coccyx; Abrasion right toes; and Pressure injury sacrum (01/01/25) found to have ischemic eschar (a thick, dry, and dark crust that forms over a wound due to a reduced blood flow to a part of the body) of the gluteal area. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/04/25 at 3:43 PM, WCN B said that she was the weekend wound care nurse. WCN B said that the facility policy and procedures for PU/PI prevention included turning and repositioning every two hours, pressure reduction devices, a low air loss mattress based on the wound stage, and barrier cream. WCN B said that the ADON(s) and WCN(s) were responsible for ordering pressure relieving devices and to ensure devices were in place. WCN B said that she coordinated with all direct care staff and conducted daily rounds to ensure care was provided and low air loss mattresses were functioning properly. WCN B said that she performed the admission head to toe skin assessment on Resident #1 in November 2024. WCN B said that she did not observe any wounds and that Resident #1 did not have any skin issues. WCN B stated in her own words that wounds were open areas that required treatment(s). WCN B said that the residents' assigned nurses were responsible for weekly skin assessments. WCN B said that Resident #1 was not followed for wound care or required treatments by the wound care nurse on the weekends. WCN B said that interventions such as turning and repositioning every two hours, off-loading pressure areas, and weekly skin assessments were in place to prevent skin breakdown for all residents. WCN B said care plan interventions were determined by the WMD/WNP, DON, ADON, Weekday WCN, and collaboration with direct care staff. WCN B emphasized that she was the weekend wound care nurse, and the Monday through Friday wound care nurse [WCN C] would be the first contact about care plans. WCN B said that the weekday wound care nurse would likely be aware of or notified about any skin changes to Resident #1. WCN B said that the DON and MDS nurse was responsible for the development and updating resident care plans. During an interview and record review on 01/05/25 at 2:20 PM, the DON stated residents were assessed on admission for altered skin integrity and to identify PU/PI. The DON stated that it was a collaborative effort with the clinical care team, included the ADON, DON, MDS nurse to implement and update care plans. The DON said that the interdisciplinary team reviewed the 24-hour report and reviewed care plans to ensure the care plan was consistent with the resident's disease process, risks, needs, preferences, and behaviors. The DON said that she was unaware that the facility failed to develop a comprehensive person-centered, measurable, and time-based care plan to address risk for skin breakdown or PAD skin issues including problems, goals, and interventions. The DON indicated that care plans should be person-centered, developed, and implemented to meet the preferences and goals of the resident. During a phone interview on 01/05/25 at 3:37 PM, LVN A stated he was the admitting nurse for Resident #1. LVN A said that he noted and documented redness to Resident #1's buttocks. LVN A described the redness as spread out and not directed in one place on Resident #1's buttocks and there no open areas. LVN A could not recall assessment of Resident #1's lower extremities. LVN A denied the responsibility or role of developing and updating care plans. LVN A stated that the ADON, DON, or WCN were responsible for individual care plans but was not sure. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/06/25 at 2:19 PM, the ADON said that she inspected Resident #1's skin alongside the wound care nurse (WCN C) following Resident #1's admission to the facility. The ADON said that Resident #1 presented with redness to the buttocks. The ADON described the redness in her own words as MASD (moisture-associated skin damage), a widely spread red, irregular shaped raised reddened dots. The ADON said barrier cream was applied to Resident #1's bottom after incontinent care. The ADON said that the area was healed before Resident #1 transferred to another hall within the facility. The ADON denied she provided direct care or conducted a skin assessment to ensure the area was healed. The ADON said that it was possible for an incontinent resident to be at an increased risk for pressure injuries who were exposed to moisture from urine or feces. The ADON stated that the MDS nurse was responsible for preparing and updating care plans. The ADON said that she participated in care plan meetings but did not create or make changes to care plans. The ADON stated care plans guided staff about resident care needs and what interventions to provide. The ADON said that the risk to Resident #1 was the failure to provide appropriate interventions to prevent deep tissue injuries or worsening of a disease process. During an interview on 01/06/2025 4:16 PM, LVN E said that he was assigned to Resident #1 a couple of times while she resided on his assigned Hall. LVN E recalled completing a weekly skin assessment on Resident #1 that reflected Resident #1 had a wound or skin issues that were not new. LVN E stated that Resident #1 had redness on her rear end and that he did not see any opened areas or anything. LVN E said that he did not catch the bruise to Resident #1's elbow or discoloration to lower extremities. LVN E said that he communicated with the CNAs to generously apply barrier cream to prevent skin breakdown. LVN E described the discoloration on Resident #1's buttocks as a range of light to a dark redness. LVN E said that he did not inform the treatment nurse about the redness. LVN E denied the responsibility or role of developing and updating care plans. LVN E could not state the responsible individual for care plans. During an interview and record review on 01/27/25 at 9:51 AM, WCN C said that she was the wound care nurse scheduled during the weekdays, Monday - Friday. WCN C said that there was a wound care nurse scheduled on the weekends (WCN B). WCN C said that she was responsible for conducting the head-to-toe skin assessment upon resident admission and provide scheduled wound care, and round with the wound care physician. WCN C stated that the MDS nurse was responsible for preparing and updating care plans. WCN C said that she verbalized feedback during care plan meetings but was not solely responsible for developing or updating care plans. WCN C stated the risks of not developing or timely updates of the comprehensive care plan about skin issues included the failure of the implementation of nurse interventions to monitor skin issues, notify the physician, consult the wound care physician, and document temperature, color, and palpable/diminished pulses of Resident #1's lower extremities. The WCN C said that she did not assess or follow residents for skin issues after admission if she was not aware of any changes in skin condition. Record review of the facility's Care Plans, Comprehensive Person-Centered policy, revised March 2022 reflected, . care plan includes but is not limited to initial goals of the resident; a summary of the resident's medications and dietary instructions; any services and treatments to be administered by the facility; and consistent with the resident's rights and will incorporate resident-centered goals and wishes about their care, activities, and lifestyle to include measurable short-term and long-term objectives and time frames. The resident's goals for admission and desired outcomes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on observations, interviews, and records review, the facility failed to identify and provide needed care and services that were resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs, for 1 (Resident #1) of 3 residents reviewed for quality of care. 1. The facility failed to perform at least two weekly skin assessments for Resident #1 from the admitted [DATE]. The first weekly skin assessment was completed on 11/27/24 that reflected No skin issues or wounds. On 11/12/24, WNP H identified and documented bilateral lower extremities skin without evidence of acute ischemic changes (ranges from symptomless to necrosis [the death of most or all the cells in an organ or tissue due to disease, injury, or failure of the blood supply] and limb loss) and diminished pedal pulses. On 12/29/24 after 10:00 PM, Resident #1 was transferred to the ED for a non-wound injury. On 12/29/24 at 11:03 PM the ED provider identified Resident #1's legs were slightly mottled (patchy discoloration), abrasions on all toes of right foot, no distal (position that is farther from the center of the body or the point of attachment) pulses. Hospitalist visit information dated 01/03/25 revealed absent pulses of both lower extremities. The hospital summary dated 01/07/25 revealed Resident #1 had gangrenous skin of the toes. 2. The facility failed to identify and monitor for signs/symptoms of PAD. The facility failed to identify, monitor, treat, and document Resident #1's history of peripheral artery disease ([PAD] (a common condition in which narrowed arteries reduce blood flow to the arms or legs). On 12/29/24 at 11:03 PM, the ED provider discovered and documented Resident #1's legs were slightly mottled and abrasion to dorsal aspects of all right toes during history and physical (H&P) exam. These failures placed residents with untreated arterial ulcers at an unnecessary risk of serious diseases or complications, including infection, tissue necrosis, and, in extreme cases, amputation. Findings included: A record review of Resident #1's modified Admission MDS assessment, dated 11/15/24, revealed a 78-years-old female, admitted to the facility on [DATE]. Resident #1 had an initial diagnosis of metabolic encephalopathy (an alteration in consciousness caused by diffuse or global brain dysfunction). Other admission diagnoses included AKF (a sudden episode of kidney damage or kidney failure); E. coli (infection commonly found in the lower intestine); and T2DM (a chronic condition characterized by insulin resistance and high blood sugar levels). A BIMS score of 10 suggested Resident #1 had a moderate cognitive decline. Resident #1's functional status required one-person substantial/maximal assistance with ADLs and transfers. Resident #1 was always incontinent of bowel and bladder. Section M - Skin conditions of the modified Admission MDS assessment revealed Resident #1 did not have any unhealed PU/PI, venous/arterial ulcers, or other ulcers, wounds, and skin problems. Resident #1 was at risk for developing pressure ulcers/injuries. The modified Admission MDS assessment indicated pressure reducing devices for chair and bed and applications of ointments/medications other than to feet were active skin and ulcer/injury treatments in place. Record review of Resident #1's Discharge MDS assessment dated [DATE] indicated Resident #1 did not have any unhealed PU/PI, venous/arterial ulcers, or other ulcers, wounds, and skin problems. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's comprehensive care plan [Date initiated: 11/11/24; Review Date: 12/02/24] did not reflect a Focus problem for impaired skin integrity, risk of developing a pressure injury, PAD management, or goals and interventions in accordance with the resident's choices, including, to the extent possible, attempting to improve or stabilize the skin integrity/tissue breakdown and to provide treatments. Resident #1's care plan goals revealed Resident #1 would remain free from skin breakdown due to incontinence and brief use related to functional bladder incontinence [Date initiated: 12/10/24] and would be free from skin tears and maintain intact skin related to the potential for impairment of skin integrity - bruise to right elbow r/t fragile skin [Date initiated: 12/06/24] through the review date (03/02/25). Interventions for the potential impairment of skin integrity included weekly skin checks, notify MD/NP/PA/RP of impairments of skin integrity, and to follow facility protocol for treatment of skin impairment. A record review of Resident #1's clinical records from the previous SNF (02/26/20 - 11/04/24) revealed [Resident #1] had a history of PAD (12/21/20 arterial duplex scan identified PAD, moderate to severe arterial occlusion [partial or complete blockage of blood flow through an artery] in peripheral arterial disease to lower extremities). The U.S. Department of Health and Human Services [HHS], outlined overlapping symptoms in the legs and feet of PAD included diminished or an absent pulse in the foot or ankle, leg or foot that feels cool or cold to the touch compared to the other leg, discoloration, and slow healing or non-healing sores (ulcers) on toes, feet, or legs. Limited arterial flow to the extremities can develop purple legs and feet. A patchy appearance of the skin reflects purple and irregular colors. (Reference: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES [HHS], National Institutes of Health, & National Heart, Lung, and Blood Institute. (n.d.). Facts about Peripheral Arterial Disease (P.A.D.). https://www.nhlbi.nih.gov/sites/default/files/publications/06-5837_0.pdf) A record review of Resident #1's transfer admission orders dated 11/08/24 sent by the discharging facility (acute care hospital [admission: 11/04/24 - 11/08/24]) revealed: - Apply Sequential Compression Device - Continuous, Routine. If refuse mechanical VTE (a condition that occurs when a blood clot forms in a vein) prophylaxis (preventative treatment), contact provider to consider chemical prophylaxis if clinically appropriate and document provider response. A record review of Resident #1's Order Summary Report, printed 01/04/25, reflected: - Order Date 11/08/24: Pressure redistribution cushion to wheelchair - Order Date 11/08/24: Pressure redistribution mattress to bed - Order Date 11/08/24: Resident to have weekly skin check. - Order Date 11/08/24: Calamine External Lotion. Apply t buttocks topical three times a day for skin repair. - Order Date 11/18/24: Med Pass (nutritional shake to supplement calories and protein) 90 cc two times a day. A record review of Resident #1's TARs for November and December 2024 did not reveal preventative treatment orders for Resident #1's history of PAD/PVD. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Effective Date: 11/12/24 10:15 AM Type: Skin and Wound Note Author: WNP H [Third party wound care service provider] HPI: Information necessary for today's visit was obtained from the patient, nursing staff, per patient's medical record. Reason for visit: new admission to the facility, skin/wound assessment. PHYSICAL EXAMINATION: Bilateral lower extremity skin without evidence of acute ischemic (insufficient blood flow to a part of the body) changes, diminished pedal pulses ([of the foot] Diminished pedal pulses are a sign of peripheral vascular disease [PAD] that mean that the blood vessels are narrowed or blocked, and the blood flow is reduced or absent). SKIN: warm and dry, intact, no open wound, bruising BUE. Lower Extremity Exam: edema: No edema (swelling caused by excess fluid trapped in the body's tissues). Texture: intact, dry. Perfusion (referring to the delivery of blood to a capillary bed in tissue): diminished pedal pulses, RLE warm, LLE warm. Sensation: BLE intact to light touch Associated Findings: clean and dry, generalized dryness. WOUND ASSESSMENT: The patient was noted to have intact skin upon assessment today. The patient has moderate/high risk for skin breakdown. Effective Date: 11/21/24 7:18 PM Type: Skin and Wound Note (Facility Skin Sweep - Comprehensive skin assessment) Author: WNP H [Third party wound care service provider] HPI: Information necessary for today's visit was obtained from the patient, nursing staff, per patient's medical record. Reason for visit: The resident is being evaluated today for a comprehensive skin assessment. 11.22. 24: [Resident #1] being seen for skin assessment. noted to have intact skin on assessment today. noted to have generalized xerosis (a condition of rough, dry, scaling, itchy, red, and sometimes cracking skin). SKIN: warm and dry, Dry, flaky, intact, no open wound. Effective Date: 11/27/24 1:31 PM Type: Wound Effective Date: 12/13/24 9:17 PM Type: Wound Author: LVN E Note Text: Weekly Skin Check Summary: Resident is in facility and available for scheduled skin check. Resident allowed clinician to complete today's skin check. Resident currently has skin or wound issues. Skin or wound issues present are not new. If new skin or wound issues were found during today's skin check, they will be listed below. Otherwise, nothing will be notated below. [Left Blank] Turning and repositioning outcome: Resident allowed clinician to reposition them for pressure redistribution and comfort. Resident also left clean and dry. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Green Valley Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6850 Rufe Snow Dr Fort Worth, TX 76148	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Effective Date: 12/20/24 5:09 PM Type: Wound Author: LVN E Note Text: Weekly Skin Check Summary: Resident is in facility and available for scheduled skin check. Resident allowed clinician to complete today's skin check. Resident does not have any skin or wound issues. If new skin or wound issues were found during today's skin check, they will be listed below. Otherwise, nothing will be notated below. [Left Blank]. Turning and repositioning outcome: Resident allowed clinician to reposition them for pressure redistribution and comfort. Resident also left clean and dry. Effective Date: 12/27/24 8:22 AM Type: Wound Author: ADON LATE ENTRY Note Text: Weekly Skin Check Summary: Resident is in facility and available for scheduled skin check. Resident allowed clinician to complete today's skin check. Resident does not have any skin or wound issues. If new skin or wound issues were found during today's skin check, they will be listed below. Otherwise, nothing will be notated below. [Left Blank]. Turning and repositioning outcome: Resident allowed clinician to reposition them for pressure redistribution and comfort. Resident also left clean and dry. A review of Resident #1's hospital medical records (Admission: 12/29/24; discharged to Hospice: 01/07/25 at 7:52 PM) revealed the first ED provider notes dated 12/29/24 at 11:03 PM identified Resident #1's legs were slightly mottled (patchy discoloration), abrasions on all toes of right foot, no distal (position that is farther from the center of the body or the point of attachment) pulses. Hospitalist visit information dated 01/03/25 revealed absent pulses of both lower extremities. The hospital summary dated 01/07/25 revealed Resident #1 had gangrenous skin of the toes. During an interview on 01/04/25 at 1:38 PM, LVN F indicated he worked weekend doubles, 6A - 2P and 2P - 10P, Saturday and Sunday. LVN F said that weekly head-to-toe skin assessments were primarily performed throughout the week. LVN F said that he rarely did weekly head-to-toe skin assessments but occasionally performed a head-to-toe skin assessment if he was assigned a new admission or as needed if a resident sustained a fall/injury. LVN F said that although the treatment nurse provided wound care during his shift on the weekends, he was still responsible for implementing care to prevent skin breakdown and assessing a resident if it was reported to him about a new or worsening skin issue during a shower or incontinent care. LVN F said that he was familiar with Resident #1. LVN F said that Resident #1 was dependent with transfers, wheelchair bound, pleasant, needed blood sugars checked, and require verbal cues for meals. LVN F said that he was last assigned to Resident #1 on 12/29/24 and performed an assessment after an assisted fall to the floor. LVN F said that skin assessments for injuries were part of the assessment, but he was unaware of any wound or skin issues. LVN F denied he performed a thorough head-to-toe skin assessment on Resident #1 on or before 12/29/24, but the CNAs did not report any skin issues. LVN F said if there were any new wounds or skin issues, he would document findings in the chart and notify the treatment nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/04/25 at 3:43 PM, WCN B said that she was the weekend wound care nurse. WCN B said that she performed the admission head to toe skin assessment on Resident #1 in November 2024. WCN B said that she did not observe any wounds and that Resident #1 did not have any skin issues. WCN B stated in her own words that wounds were open areas that required treatment(s). WCN B said that the residents' assigned nurses were responsible for weekly skin assessments. WCN B said that Resident #1 was not followed for wound care or required treatments by the wound care nurse on the weekends. WCN B said that interventions such as turning and repositioning every two hours, off-loading pressure areas, and weekly skin assessments were in place to prevent skin breakdown for all residents. WCN B said care plan interventions were determined by the WMD/WNP, DON, ADON, Weekday WCN, and collaboration with direct care staff. WCN B emphasized that she was the weekend wound care nurse, and the Monday through Friday wound care nurse [WCN C] would be the first contact about skin issues if discovered during a weekly head to toe skin assessment or on a shower day. WCN B said that the weekday wound care nurse would likely be aware of or notified about any skin changes to Resident #1. WCN B said the CNAs were expected to inspect the residents' skin when assisting with showers, bed baths, incontinent care and notify the nurse about any changes to the skin such as redness, abrasions, skin tear, scratches, or any open area. The assigned nurse must notify the treatment nurse. The treatment nurse would notify the doctor to discuss plan of care or treatment options. The floor nurses would contact the doctor if the treatment nurse was not present. WCN B said that the DON and MDS nurse was responsible for the development and updating resident care plans. Observation of Resident #1 at the hospital on 01/05/25 at 9:37 AM revealed Resident #1 resting quietly in bed in an optimal resting position and pressure areas offloaded. The hospital nurse and patient care attendant repositioned Resident #1 to allow the Investigator to visually inspect Resident #1's lower extremities. A blue/purple discoloration to the left lower extremity, dark spots on the top of the right toes, red streaks and maroon irregular marks to the right hip were noted during visual observation. During an interview on 01/05/25 at 9:45 AM, the hospital nurse said that Resident #1 admitted to the unit with impaired skin integrity. The hospital nurse reviewed Resident #1's chart and stated that the impaired skin areas were noted during assessment in the ED on 12/29/24. During an interview and record review on 01/05/25 at 2:20 PM, the DON stated residents were assessed on admission for altered skin integrity and to identify PU/PI. The DON said that every resident's skin was assessed weekly and documented under the 'evaluations' section and on the TAR in the chart. The DON stated additional documentation was not required unless there were new skin issues. The DON said that she did not provide direct care to or assess Resident #1's skin but knew that Resident #1 did not present with any wounds or skin issues on the buttocks, legs, or heels. The DON reviewed the weekly skin assessments with the investigator and said that LVN E referenced the bruised elbow on his weekly head to toe skin assessment dated [DATE]. The DON said that it was not necessary to document the location of the same skin issue. The DON said that the treatment nurse (WCN C) completed pressure ulcer evaluations for residents weekly along with the wound care provider. The DON could not explain how Resident #1's impaired skin to the buttocks, sacrum, lower extremities were not identified. The DON indicated the resident had transferred from the facility on 12/29/24 and it was likely the skin issues occurred at the hospital. The DON said that the hospital follow-up clinical paperwork received on 01/02/25 only identified red marks to Resident #1's right hip. The DON said that the paperwork did not say anything else about skin issues. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 01/05/25 at 3:37 PM, LVN A stated he was the admitting nurse for Resident #1. LVN A said that he noted and documented redness to Resident #1's buttocks. LVN A described the redness as spread out and not directed in one place on Resident #1's buttocks and there no open areas. LVN A could not recall assessment of Resident #1's lower extremities. LVN A said that the treatment nurse followed up to conduct head to toe skin assessments on new admissions. LVN A said the primary nurse assigned to a resident was responsible for completing the weekly head to toe skin assessment. LVN A said when the weekly head to toe skin assessment was scheduled, it would show up on the TAR. LVN A said that there were no treatment orders in place or head to toe assessments scheduled whenever he was assigned to Resident #1. An email communication with WNP H on 01/05/24 at 4:35 PM indicated Resident #1's skin was intact on initial evaluation. There was a barrier cream ordered to apply to Resident #1's buttocks to protect from skin breakdown. WNP H indicated that she performed a skin sweep on 11/22/24 of all residents in the facility. A skin sweep was a comprehensive skin assessment to identify any changes in present wounds or development of any new skin or wound issues. WNP H indicated notes were entered in the electronic health record even if the resident presented with intact skin on assessment. WNP H was not notified by the facility of any skin issues with Resident #1 after the skin sweep. During an interview on 01/06/25 at 2:19 PM, the ADON said that she inspected Resident #1's skin alongside the wound care nurse (WCN C) following Resident #1's admission to the facility. The ADON said that Resident #1 presented with redness to the buttocks and no other skin issues. The ADON said that the nurses completed a weekly head-to-toe assessment of the resident skin and documented their findings even if the resident did not have any skin breakdown. The ADON also stated the CNAs observed for any skin issues while bathing and dressing residents and should notify the nurse. The ADON said that she conducted the weekly head to toe skin assessment prior to Resident #1 transferred to the hospital (12/29/24). The ADON said that Resident #1's skin was intact, there were no wounds or skin issues, and Resident #1's bottom was pearly white. The ADON said that she did not observe Resident #1's feet or toes when she conducted the head-to-toe skin assessment because Resident #1 was in bed. The ADON said that she did not recall seeing the red marks on Resident #1's right hip or right toe abrasions. During an interview on 01/06/2025 4:16 PM, LVN E said that he was assigned to Resident #1 a couple of times while she resided on his assigned Hall. LVN E recalled completing a weekly skin assessment on Resident #1 that reflected Resident #1 had a wound or skin issues that were not new. LVN E stated that Resident #1 had redness on her rear end and that he did not see any opened areas or anything. LVN E said that he communicated with the CNAs to generously apply barrier cream to prevent skin breakdown. LVN E described the discoloration on Resident #1's buttocks as a range of light to a dark redness. LVN E said that he did not inform the treatment nurse about the redness. LVN E said that he did not catch the bruise to Resident #1's elbow or discoloration to lower extremities. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 01/27/25 at 8:29 AM, the APMD indicated Resident #1 was admitted to the SNF for rehabilitation level care that fostered recovery and the process of the resident return to the community. The APMD stated Resident #1's comorbidities or chronic disease processes, such as peripheral artery disease (PAD), were not treated during a short-term skilled/rehabilitative stay and would be followed by the resident's PCP upon return to the community. The APMD stated if a resident transferred to long term care internally, the facility would meet the medical and non-medical needs of residents with a chronic illness or disability who cannot care for themselves for long periods. The APMD indicated she was not informed and was unaware that Resident #1 had skin issues during inpatient stay at SNF. The APMD stated residents with skin issues identified on admission to the SNF would be followed by the wound care team that included the facility wound care nurse(s) and a third party wound physician as needed. The APMD stated any skin changes discovered during Resident #1's stay associated with peripheral artery disease, included discoloration, dryness, and shiny or smooth texture of the extremities, would be reported to the wound care team for consultation and recommended treatment. The APMD said that she had access to the hospital records and her review did not find documentation about sores on Resident #1's toes or other documentation of skin concerns associated with PAD. The APMD was redirected to the ED Hospitalist documentation in the hospital records that revealed documentation on 12/29/24 of impaired skin integrity to Resident #1's lower extremities and toe abrasions. The APMD acknowledged the E.D. provider notes on 12/29/24 and 12/30/24 reflected Resident #1 had impaired skin integrity. During a follow up phone interview on 01/27/25 at 9:07 AM, WNP H stated she was not notified of any skin issues by the facility wound care nurse or staff after her [WNP H] skin sweep conducted on 11/12/24. WNP H stated she was not notified on or about 12/05/24 when documentation reflected Resident #1 had a skin issue/wound that was not new. WNP H indicated discolorations of lower extremities could indicate arterial or vascular concerns and the wound care provider must be notified for treatment options and further recommendations. WNP H indicated a vascular physician would be consulted to address arterial or vascular concerns of the extremities. During an interview and record review on 01/27/25 at 9:51 AM, WCN C said that she was the wound care nurse scheduled during the weekdays, Monday - Friday. WCN C said that there was a wound care nurse scheduled on the weekends (WCN B). WCN C said that she was responsible for conducting the head-to-toe skin assessment upon resident admission and provide scheduled wound care, and round with the wound care physician. WCN C said that the resident's assigned charge nurse was responsible for completing the weekly head-to-toe skin assessment and must notify the wound care nurses and DON of any discovered skin changes or issues. WCN C said that she was not scheduled to work when Resident #1 admitted to the facility and did not conduct the admission head-to-toe skin assessment. WCN C said that she was not informed about any skin issues during Resident #1's stay at the facility or about history of peripheral arterial disease (PAD). WCN C stated a resident with a history of PAD were at a high risk of developing foot sores and ulcers. WCN C said that the nurses should assess for any discoloration of the lower extremities or diminished pulses in the lower extremities during weekly skin assessments and must notify the attending physician, consult the wound care physician, and document the temperature, color, and palpable/diminished pulses of extremities. The WCN C said that she did not assess or follow residents for skin issues after admission if she was not aware of any changes in skin condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/27/25 at 2:00 PM, the hospital physician, MD K, stated he evaluated and documented Resident #1's skin issues and verified Resident #1 presented to and admitted to the hospital on 12/29/24 with abrasions to right toes. MD K said that the abrasions to the right toes were related to Resident #1's history of Peripheral Arterial Disease that eventually led to gangrene (identified on 01/07/25). Policies and procedures related to skin management were requested on 01/04/25 at 12:23 PM and skin assessment policies and related in-services were requested on 01/05/25 at 1:36 PM. The skin management and skin assessment policies and related in-services were not received by exit from facility on 12/06/25. The NFA was not able to speak to the process of skin assessments and management. The NFA stated steps taken to review written P&P that guide the nursing facility with staff and ensured staff understood. The NFA stated facility surveillance was conducted throughout the day to monitor resident care and correct as needed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on observations, interviews, and records review, the facility failed to ensure a resident did not develop pressure ulcers/injuries (PU/PIs) unless clinically unavoidable and that the facility provided care and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new pressure ulcers/injuries from developing for 1 (Resident #1) of 3 residents reviewed for pressure ulcers/injuries. 1. The facility failed to perform at least two weekly skin assessments for Resident #1 from the admitted [DATE]. On 11/09/24, the admitting nurse [LVN A] observed redness to Resident #1's buttocks. A record review of Resident #1's admission orders dated 11/08/24 sent by the discharging facility revealed wound (11/05/24) - rash midline coccyx (3 days). The first weekly skin assessment was completed on 11/27/24 and thereafter reflected No skin issues or wounds, except on 12/13/24 when the weekly skin assessment indicated Resident #1 currently had skin or wound issues that were present and not new. The following weekly skin assessments indicated Resident #1 had no skin or wound issues. 2. The facility failed to identify early signs of a pressure injury (localized damage to the skin and/or underlying soft tissue usually over a bony prominence. A pressure injury will present as intact skin. The appearance will vary depending on the stage and implement interventions to prevent a deep tissue pressure injury of the sacral (at the bottom of the spine) region. Resident #1 transferred to the hospital on 12/29/24 after 10:00 PM. The hospital ED provider discovered impaired skin integrity of the bilateral (right and left sides) buttocks and coccyx (the tailbone) area upon a brief visible inspection. On 01/01/25, Resident #1 was diagnosed with a Pressure injury of deep tissue of sacral region (DTI pressure injuries look like a deep bruise) and was found to have ischemic eschar (black necrotic tissue with a lack of blood flow and oxygen) of the gluteal (muscle group that make up the buttocks) area after a wound consultation. These failures placed residents with pressure wounds at an unnecessary risk of complications such as pain, acquiring new wounds, worsening of existing wounds, and infection. Findings included: A record review of Resident #1's modified Admission MDS assessment, dated 11/15/24, revealed a 78-years-old female, admitted to the facility on [DATE]. Resident #1 had an initial diagnosis of metabolic encephalopathy (an alteration in consciousness caused by diffuse or global brain dysfunction). Other admission diagnoses included AKF (a sudden episode of kidney damage or kidney failure); E. coli (infection commonly found in the lower intestine); and T2DM (a chronic condition characterized by insulin resistance and high blood sugar levels). A BIMS score of 10 suggested Resident #1 had a moderate cognitive decline. Resident #1's functional status required one-person substantial/maximal assistance with ADLs and transfers. Resident #1 was always incontinent of bowel and bladder. Section M - Skin conditions of the modified Admission MDS assessment revealed Resident #1 did not have any unhealed PU/PI, venous/arterial ulcers, or other ulcers, wounds, and skin problems. Resident #1 was at risk for developing pressure ulcers/injuries. The modified Admission MDS assessment indicated pressure reducing devices for chair and bed and applications of ointments/medications other than to feet were active skin and ulcer/injury treatments in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Discharge MDS assessment dated [DATE] indicated Resident #1 did not have one or more unhealed pressure ulcers/injuries. Record review of Resident #1's comprehensive care plan [Date initiated: 11/11/24; Review Date: 12/02/24] did not reflect a Focus problem for impaired skin integrity, risk of developing a pressure injury, or goals and interventions in accordance with the resident's choices, including, to the extent possible, attempting to improve or stabilize the skin integrity/tissue breakdown and to provide treatments. Resident #1's care plan goals revealed Resident #1 would remain free from skin breakdown due to incontinence and brief use related to functional bladder incontinence [Date initiated: 12/10/24] and would be free from skin tears and maintain intact skin related to the potential for impairment of skin integrity - bruise to right elbow r/t fragile skin [Date initiated: 12/06/24] through the review date (03/02/25). Interventions for the potential impairment of skin integrity included weekly skin checks, notify MD/NP/PA/RP of impairments of skin integrity, and to follow facility protocol for treatment of skin impairment. A record review of Resident #1's transfer admission orders dated 11/08/24 sent by the discharging facility (acute care hospital [admission: 11/04/24 - 11/08/24]) revealed: - Resume Calamine Topical. Apply to affected area three (3) times daily to buttocks. - Resume mineral oil-hydrophil ointment. Commonly known as: Aquaphor (used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations [such as diaper rash]) to buttocks for itching. - MD physical examination dated 11/08/24 at 11:34 AM revealed wound (11/05/24) - rash midline coccyx (3 days) A record review of Resident #1's Order Summary Report, printed 01/04/25, reflected: - Order Date 11/08/24: Pressure redistribution cushion to wheelchair - Order Date 11/08/24: Pressure redistribution mattress to bed - Order Date 11/08/24: Resident to have weekly skin check. - Order Date 11/08/24: Calamine External Lotion. Apply to buttocks topical three times a day for skin repair. - Order Date 11/18/24: Med Pass (nutritional shake to supplement calories and protein) 90 cc two times a day. - Order Date 12/05/24: Monitor bruise to right elbow every shift until resolved for skin assessment. There was no evidence of orders to apply pressure relieving devices to Resident #1 heels. A record review of Resident #1's TARs for November and December 2024 revealed application of Calamine lotion for skin repair of Resident #1's buttocks. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's progress notes reflected: Effective Date: 11/08/24 at 11:10 PM Type: Gen Nurses Notes - narrative Author: LVN A Note Text: [Resident #1] admitted to the facility under [APMD] from [acute care hospital] . presents redness on the sacrum area. Effective Date: 11/10/24 at 4:38 PM Type: SOAP Note Author: MD J Visit Type: Telemedicine Session. Details: Subjective: Virtual rounding. Objective: Was asked to evaluate [Resident #1] by the medical staff. Assessment: Clinically stable per staff with no complaints. Plan: Continue current treatment plan. Effective Date: 11/12/24 10:15 AM Type: Skin and Wound Note Author: WNP H [Third party wound care service provider] HPI: Information necessary for today's visit was obtained from the patient, nursing staff, per patient's medical record. Reason for visit: new admission to the facility, skin/wound assessment. PHYSICAL EXAMINATION: fecal incontinence, urinary incontinence; generalized weakness; bilateral lower extremity skin without evidence of acute ischemic (insufficient blood flow to a part of the body) changes, diminished pedal pulses ([of the foot] Diminished pedal pulses are a sign of peripheral vascular disease [PAD] that mean that the blood vessels are narrowed or blocked, and the blood flow is reduced or absent); no history of a pressure ulcer. SKIN: warm and dry, intact, no open wound, bruising BUE. Lower Extremity Exam: edema: No edema (swelling caused by excess fluid trapped in the body's tissues). Texture: intact, dry. Perfusion (referring to the delivery of blood to a capillary bed in tissue): diminished pedal pulses, RLE warm, LLE warm. Sensation: BLE intact to light touch Associated Findings: clean and dry, generalized dryness. WOUND ASSESSMENT: The patient was noted to have intact skin upon assessment today. The patient has moderate/high risk for skin breakdown. NEW RECOMMENDATIONS: The patient was noted to have intact skin upon assessment today. Patient is at moderate risk for pressure ulcer formation related to decreased mobility, incontinence of urine and stool. The patient is incontinent of urine and stool and is at an increased risk of skin breakdown. Effective Date: 11/21/24 7:18 PM Type: Skin and Wound Note (Facility Skin Sweep - Comprehensive skin assessment) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Author: WNP H [Third party wound care service provider] HPI: Information necessary for today's visit was obtained from the patient, nursing staff, per patient's medical record. Reason for visit: The resident is being evaluated today for a comprehensive skin assessment. 11.22. 24: [Resident #1] being seen for skin assessment. noted to have intact skin on assessment today. noted to have generalized xerosis (a condition of rough, dry, scaling, itchy, red, and sometimes cracking skin). SKIN: warm and dry, Dry, flaky, intact, no open wound. RECOMMENDATIONS: Apply moisturizer to resident's skin routinely. Do not massage over bony prominences. The patient was noted to have dry skin generalized to entire body. Recommend use of emollient daily. Maintain adequate oral hydration as indicated if not contraindicated. Continue with turning and repositioning schedule per protocol for pressure prevention. Position patient side to side as tolerated. Recommend resident out of bed as tolerated for limited intervals of time, alternating activity to minimize pressure. The resident is incontinent of bowel and bladder. Use appropriate moisture barrier creams per formulary to provide thorough skin care with each incontinent episode. Use formulary briefs when indicated to manage moisture and assess often. Ensure proper fitting briefs, socks, stockings, and other clothing to prevent pressure. Ensure resident has proper fitting footwear to prevent/minimize unwanted pressure and friction. Effective Date: 11/27/24 1:31 PM Type: Wound Author: LVN D Note Text: Weekly Skin Check Summary: Resident is in facility and available for scheduled skin check. Resident allowed clinician to complete today's skin check. Resident does not have any skin or wound issues. If new skin or wound issues were found during today's skin check, they will be listed below. Otherwise, nothing will be notated below. [Left Blank]. Turning and repositioning outcome: Resident allowed clinician to reposition them for pressure redistribution and comfort. Resident also left clean and dry. Effective Date: 12/05/24 2:33 PM Type: Gen Nurses Notes - narrative Author: LVN D Note Text: Bruise noted to [Resident #1] right elbow. Bruise red/purple in appearance. Resident #1 stated she hit elbow against rail. Denies pain to area. Effective Date: 12/05/24 2:35 PM Type: Wound Author: LVN D (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Green Valley Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 6850 Rufe Snow Dr Fort Worth, TX 76148	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note Text: Weekly Skin Check Summary: Resident is in facility and available for scheduled skin check. Resident allowed clinician to complete today's skin check. Resident currently has skin or wound issues. Skin or wound issues present are new. Right elbow - purple/red in appearance. Turning and repositioning outcome: Resident allowed clinician to reposition them for pressure redistribution and comfort. Resident also left clean and dry. Effective Date: 12/13/24 9:17 PM Type: Wound Author: LVN E Note Text: Weekly Skin Check Summary: Resident is in facility and available for scheduled skin check. Resident allowed clinician to complete today's skin check. Resident currently has skin or wound issues. Skin or wound issues present are not new. If new skin or wound issues were found during today's skin check, they will be listed below. Otherwise, nothing will be notated below. [Left Blank] Turning and repositioning outcome: Resident allowed clinician to reposition them for pressure redistribution and comfort. Resident also left clean and dry. Effective Date: 12/20/24 5:09 PM Type: Wound Author: LVN E Note Text: Weekly Skin Check Summary: Resident is in facility and available for scheduled skin check. Resident allowed clinician to complete today's skin check. Resident does not have any skin or wound issues. If new skin or wound issues were found during today's skin check, they will be listed below. Otherwise, nothing will be notated below. [Left Blank]. Turning and repositioning outcome: Resident allowed clinician to reposition them for pressure redistribution and comfort. Resident also left clean and dry. Effective Date: 12/27/24 8:22 AM Type: Wound Author: ADON LATE ENTRY Note Text: Weekly Skin Check Summary: Resident is in facility and available for scheduled skin check. Resident allowed clinician to complete today's skin check. Resident does not have any skin or wound issues. If new skin or wound issues were found during today's skin check, they will be listed below. Otherwise, nothing will be notated below. [Left Blank]. Turning and repositioning outcome: Resident allowed clinician to reposition them for pressure redistribution and comfort. Resident also left clean and dry. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #1's hospital medical records (Admission: 12/29/24; discharged to Hospice: 01/07/25 at 7:52 PM) revealed Resident #1 arrived at the ED 12/29/24 at 10:40 PM and admitted inpatient 12/30/24 at 1:54 AM. The first ED provider notes dated 12/29/24 at 11:03 PM identified Resident #1's legs were slightly mottled (patchy discoloration), abrasion-like spots on toes of right foot, no distal (position that is farther from the center of the body or the point of attachment) pulses. The Admission H & P summary entered by the provider on 12/30/24 at 3:53 AM reflected altered skin integrity to Resident #1's buttocks - excoriation (mechanical removal or rubbing of the skin's surface layer, resulting in superficial wounds or scratches) vs abrasion (process of rubbing away the surface of something); skin dry and flaky; heels were boggy (deep tissue injuries may be recognized as areas on the heel that are dark purple or reddish-purple in color, boggy or firm and warmer or cooler to touch than surrounding tissue). On 01/01/25 at 10:00 AM, the wound consultant identified the altered skin integrity to Resident #1's sacral area as an unstageable deep pressure injury. Wounds identified: Rash midline coccyx; Abrasion right toes; and Pressure injury sacrum (01/01/25) found to have ischemic eschar (a thick, dry, and dark crust that forms over a wound due to a reduced blood flow to a part of the body) of the gluteal area. During an interview on 01/04/25 at 1:38 PM, LVN F indicated he worked weekend doubles, 6A - 2P and 2P - 10P, Saturday and Sunday. LVN F said that weekly head-to-toe skin assessments were primarily performed throughout the week. LVN F said that he rarely did weekly head-to-toe skin assessments but occasionally performed a head-to-toe skin assessment if he was assigned a new admission or as needed if a resident sustained a fall/injury. LVN F said that although the treatment nurse provided wound care during his shift on the weekends, he was still responsible for implementing care to prevent skin breakdown and assessing a resident if it was reported to him about a new or worsening skin issue during a shower or incontinent care. LVN F said that he was familiar with Resident #1. LVN F said that Resident #1 was dependent with transfers, wheelchair bound, pleasant, needed blood sugars checked, and require verbal cues for meals. LVN F said that Resident #1 did not like to get out of bed, but the family member wanted Resident #1 to get up from bed. LVN F said that he was last assigned to Resident #1 on 12/29/24 and performed an assessment after an assisted fall to the floor. LVN F said that skin assessments for injuries were part of the assessment, but he was unaware of any wound or skin issues. LVN F denied he performed a thorough head-to-toe skin assessment on Resident #1 on or before 12/29/24, but the CNAs did not report any skin issues. LVN F said if there were any new wounds or skin issues, he would document findings in the chart and notify the treatment nurse. During an interview on 01/04/25 at 3:15 PM, CNA G said that she was familiar with Resident #1 and her care needs. CNA G said that Resident #1 required 1-person physical assistance with ADLs, required 1- to 2-person assistance with transfers, was wheelchair bound, and sometimes ate in the dining room. CNA G said that she assisted with direct care to Resident #1 for a short time when Resident #1 was assigned to her hall. CNA G said that Resident #1 moved back and forth between two halls (CNA I was the regular staff on the opposite hall of CNA G). CNA G said that she did not recall an open wound to Resident #1's bottom or any redness. CNA G said that she applied barrier cream to Resident #1's buttocks after changing the brief to protect skin when soiled and prevent breakdown of skin. CNA G said that she tried to check on residents every two hours or more frequently if a resident required incontinent care often. CNA G said that she would report to the nurse immediately after provided care to the resident and ensured was safe if discovered a skin tear, redness, a rash, or if a dressing was soiled or came off. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/04/25 at 3:43 PM, WCN B said that she was the weekend wound care nurse. WCN B said that the facility policy and procedures for PU/PI prevention included turning and repositioning every two hours, pressure reduction devices, a low air loss mattress based on the wound stage, and barrier cream. WCN B said that the ADON(s) and WCN(s) were responsible for ordering pressure relieving devices and to ensure devices were in place. WCN B said that she coordinated with all direct care staff and conducted daily rounds to ensure care was provided and low air loss mattresses were functioning properly. WCN B said that she performed the admission head to toe skin assessment on Resident #1 in November 2024. WCN B said that she did not observe any wounds and that Resident #1 did not have any skin issues. WCN B stated in her own words that wounds were open areas that required treatment(s). WCN B said that the residents' assigned nurses were responsible for weekly skin assessments. WCN B said that Resident #1 was not followed for wound care or required treatments by the wound care nurse on the weekends. WCN B said that interventions such as turning and repositioning every two hours, off-loading pressure areas, and weekly skin assessments were in place to prevent skin breakdown for all residents. WCN B said care plan interventions were determined by the WMD/WNP, DON, ADON, Weekday WCN, and collaboration with direct care staff. WCN B emphasized that she was the weekend wound care nurse, and the Monday through Friday wound care nurse [WCN C] would be the first contact about skin issues if discovered during a weekly head to toe skin assessment or on a shower day. WCN B said that the weekday wound care nurse would likely be aware of or notified about any skin changes to Resident #1. WCN B said the CNAs were expected to inspect the residents' skin when assisting with showers, bed baths, incontinent care and notify the nurse about any changes to the skin such as redness, abrasions, skin tear, scratches, or any open area. The assigned nurse must notify the treatment nurse. The treatment nurse would notify the doctor to discuss plan of care or treatment options. The floor nurses would contact the doctor if the treatment nurse was not present. WCN B said that the DON and MDS nurse was responsible for the development and updating resident care plans. Observation of Resident #1 at the hospital on 01/05/25 at 9:37 AM revealed Resident #1 resting quietly in bed in an optimal resting position and pressure areas offloaded. The hospital nurse and patient care attendant repositioned Resident #1 to allow the Investigator to visually inspect Resident #1's backside. Resident #1's buttocks revealed intact skin with an irregularly shaped localized area of deep red, maroon, purple discoloration. Some chafing, skin peeling, and shearing was noted to the buttocks and groin area upon visual inspection. The sacral area revealed dry, brown, or black, raised areas at the upper border of the impaired skin area. The surrounding skin appeared blue/purple to red color. A blue/purple discoloration to the left lower extremity, dark spots on the top of the right toes, red streaks and maroon irregular marks to the right hip was also noted during visual observation. During an interview on 01/05/25 at 9:45 AM, the hospital nurse said that Resident #1 admitted to the unit with impaired skin integrity. The hospital nurse reviewed Resident #1's chart and stated that the impaired skin areas were noted during assessment in the E.D. on 12/29/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 01/05/25 at 2:20 PM, the DON stated residents were assessed on admission for altered skin integrity and to identify PU/PI. The DON said that every resident's skin was assessed weekly and documented under the 'evaluations' section and on the TAR in the chart. The DON stated additional documentation was not required unless there were new skin issues. The DON said that she did not provide direct care to or assess Resident #1's skin but knew that Resident #1 did not present with any wounds or skin issues on the buttocks. The DON reviewed the weekly skin assessments with the investigator and said that LVN E referenced the bruised elbow on his weekly head to toe skin assessment dated [DATE]. The DON said that it was not necessary to document the location of the same skin issue. The DON said that the treatment nurse (WCN C) completed pressure ulcer evaluations for residents weekly along with the wound care provider. The DON could not explain how Resident #1's impaired skin to the buttocks, sacrum, lower extremities were not identified. The DON indicated the resident had transferred from the facility on 12/29/24 and it was likely the skin issues occurred at the hospital. The DON said that the hospital follow-up clinical paperwork received on 01/02/25 only identified red marks to Resident #1's right hip. The DON said that the paperwork did not say anything else about skin issues. During a phone interview on 01/05/25 at 3:37 PM, LVN A stated he was the admitting nurse for Resident #1. LVN A said that he noted and documented redness to Resident #1's buttocks. LVN A described the redness as spread out and not directed in one place on Resident #1's buttocks and there no open areas. LVN A could not recall assessment of Resident #1's lower extremities. LVN A said that the treatment nurse followed up to conduct head to toe skin assessments on new admissions. LVN A said the primary nurse assigned to a resident was responsible for completing the weekly head to toe skin assessment. LVN A said when the weekly head to toe skin assessment was scheduled, it would show up on the TAR. LVN A said that there were no treatment orders in place or head to toe assessments scheduled whenever he was assigned to Resident #1. An email communication with WNP H, a 3rd party wound consultant, on 01/05/24 at 4:35 PM indicated Resident #1's skin was intact on initial evaluation. There was a barrier cream ordered to apply to Resident #1's buttocks to protect from skin breakdown. WNP H indicated that she performed a skin sweep on 11/22/24 of all residents in the facility. A skin sweep was a comprehensive skin assessment to identify any changes in present wounds or development of any new skin or wound issues. WNP H indicated notes were entered in the electronic health record even if the resident presented with intact skin on assessment. WNP H was not notified by the facility of any skin issues with Resident #1 after the skin sweep. Redness to the resident's skin that was often moist with urine and soiled could quickly evolve to impaired skin issues (pressure injuries - unstageable, stage 3 or stage 4) that appeared as a darker red and remain intact and should be reported to the wound care nurse and/or wound care physician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/06/25 at 2:19 PM, the ADON said that she inspected Resident #1's skin alongside the wound care nurse (WCN C) following Resident #1's admission to the facility. The ADON said that Resident #1 presented with redness to the buttocks. The ADON described the redness in her own words as MASD (moisture-associated skin damage), a widely spread red, irregular shaped raised reddened dots. The ADON said barrier cream was applied to Resident #1's bottom after incontinent care. The ADON said that the area was healed before Resident #1 transferred to another hall within the facility. The ADON denied she provided direct care or conducted a skin assessment to ensure the area was healed. The ADON said that it was possible for an incontinent resident to be at an increased risk for pressure injuries who were exposed to moisture from urine or feces. The ADON said that the nurses were to complete a weekly head-to-toe assessment of the resident skin weekly and document their findings even if the resident did not have any skin breakdown. The ADON also stated the CNAs observed for any skin issues while bathing and dressing residents and should notify the nurse. The ADON said that she conducted the weekly head to toe skin assessment prior to Resident #1 transferred to the hospital (12/29/24). The ADON said that Resident #1's skin was intact, there were no wounds or skin issues, and Resident #1's bottom was pearly white. The ADON said that she did not observe Resident #1's feet or toes when she conducted the head-to-toe skin assessment because Resident #1 was in bed. The ADON said that she did not recall seeing the red marks on Resident #1's right hip. During an interview on 01/06/2025 4:16 PM, LVN E said that he was assigned to Resident #1 a couple of times while she resided on his assigned Hall. LVN E recalled completing a weekly skin assessment on Resident #1 that reflected Resident #1 had a wound or skin issues that were not new. LVN E stated that Resident #1 had redness on her rear end and that he did not see any opened areas or anything. LVN E said that he did not catch the bruise to Resident #1's elbow or discoloration to lower extremities. LVN E said that he communicated with the CNAs to generously apply barrier cream to prevent skin breakdown. LVN E described the discoloration on Resident #1's buttocks as a range of light to a dark redness. LVN E said that he did not inform the treatment nurse about the redness. During an interview and record review on 01/27/25 at 8:29 AM, the APMD stated residents with skin issues identified on admission to the SNF would be followed by the wound care team that included the facility wound care nurse(s) and a third party wound physician as needed. The APMD indicated she was not informed and was unaware that Resident #1 had skin issues during inpatient stay at SNF. The APMD said that she spoke with the SNF leadership and had access to the hospital documentation that did not reference a deep tissue injury of the sacrum until 01/03/25. The APMD was redirected to the E.D. Hospitalist documentation in the hospital records revealed documentation on 12/29/24 and 12/30/24 of impaired skin integrity to Resident #1's buttocks, heel(s), and toe abrasions. The APMD acknowledged the E.D. provider notes on 12/29/24 and 12/30/24 reflected impaired skin integrity. During a follow up phone interview on 01/27/25 at 9:07 AM, WNP H stated she was not notified of any skin issues by the facility wound care nurse or staff after her [WNP H] skin sweep conducted on 11/12/24. WNP H stated any redness that was not relieved by repositioning or improved with barrier cream should be assessed by the wound care nurse and the PCP or Wound Care Provider must be notified. WNP H explained blanchable redness referred to a rash or skin condition that turned white when pressure was applied and returned to its original color. WNP H said that blanching redness was less serious than non-blanchable redness that would suggest damage of underlying soft tissue and the likelihood of the onset of a Stage 1 pressure injury. WNP H stated she was not notified on or about 12/05/24 when LVN E documented Resident #1 had a skin issue/wound that was not new. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 01/27/25 at 9:51 AM, WCN C said that she was the wound care nurse scheduled during the weekdays, Monday - Friday. WCN C said that there was a wound care nurse scheduled on the weekends (WCN B). WCN C said that she was responsible for conducting the head-to-toe skin assessment upon resident admission and provide scheduled wound care, and round with the wound care physician. WCN C said that the resident's assigned charge nurse was responsible for completing the weekly head-to-toe skin assessment and must notify the wound care nurses and DON of any discovered skin changes or issues. WCN C said that she was not scheduled to work when Resident #1 admitted to the facility and did not conduct the admission head-to-toe skin assessment. WCN C said that she was not notified about any redness to Resident #1's sacrum noted at admission or about the skin issue reflected on a weekly skin assessment dated [DATE] by LVN E. WCN C said that she was not informed about any skin issues during Resident #1's stay at the facility. WCN C stated any discoloration of the lower extremities or diminished pulses in the lower extremities should have been monitored by the nurses, physician notified, wound care physician consulted, and documentation should reflect the temperature, color, and palpable/diminished pulses of Resident #1's lower extremities. The WCN C said that she did not assess or follow residents for skin issues after admission if she was not aware of any changes in skin condition. During an interview on 01/27/25 at 2:00 PM, the hospital physician, MD K, stated he evaluated and documented Resident #1's skin issues and verified Resident #1 presented to and admitted to the hospital on 12/29/24 with dark red, bruise-like discoloration on buttocks and across sacrum and abrasions to right toes. MD K said during his wound consultation on 01/01/25 the localized discoloration to the buttocks revealed a deep tissue injury with ischemic tissue (due to poor blood flow to the area and would be noticeable after a couple days) across the sacrum. Review of the facility's Prevention of Pressure Ulcers/Injuries policy and procedure provided by the facility, revised 07/2017 indicated: The purpose is to provide information regarding identification of pressure ulcer/injury risk factors and interventions. Risk Assessment: Assess the resident on admission for existing pressure ulcer/injury risk factors weekly x 4 and quarterly. Conduct a comprehensive skin assessment upon admission. Use a screening tool. Inspect the skin daily. Reference: Advantage Wound Care.Org. (2020). What is a Deep Tissue Ulcer (DTI)? https://www.advantagewoundcare.org/detail/what-is-a-deep-tissue-ulcer-dti