

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER The Rehabilitation & Wellness Centre of Dallas LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	

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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</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** 44405</p> <p>Based on observations, interviews, and record reviews, 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 4 residents reviewed for pressure ulcers/injuries.</p> <p>1. The facility failed to monitor early signs of a pressure injury (PI) to promote the prevention of pressure ulcer (PU) development to Resident #1's right medial foot and great toe. On 02/07/25, the hospice health aide reported a large blood blister on the right foot and a bruise to Resident #1's right medial foot and great toe to LVN D. LVN D reflected the blood blister on the Weekly Skin assessment dated [DATE]. Skin barrier cream was applied to the site(s) daily. On 03/02/25, the hospice RN assessed the site and ordered skin prep for application to the dried blister on Resident #1's right medial foot and great toe every shift (3 times a day [6A - 2P, 2P - 10P, and 10P - 6A]). On 03/18/25, the WMD was consulted to assess, evaluate, and treat Resident #1 for an unstageable (due to necrosis) pressure ulcer at the right medial foot and great toe.</p> <p>2. The facility failed to monitor early signs of a pressure injury. On 02/26/25, the hospice health aide reported a purple pressure area on Resident #1's left hip to LVN E. LVN E reflected an intact reddened area to Resident #1's left hip on the Weekly Skin assessment dated [DATE]. The facility failed to perform a weekly skin assessment for Resident #1 on 03/06/25. On 03/09/25, LVN A completed a weekly skin assessment that indicated Resident #1 had an abrasion described as Eschar noted to left hip and abrasion/wound reopened right below the necrotic area . after Resident #1's RP called LVN A and ADON I to the room to look at a wound discovered on Resident #1's left hip. On 03/18/25, the WMD was consulted to assess, evaluate, and treat Resident #1 for an unstageable (due to necrosis) pressure ulcer to the left hip.</p> <p>An IJ was identified on 05/09/25. The IJ template was provided to the facility on [DATE] at 2:00 PM. While the IJ was removed on 05/09/25, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.</p> <p>These failures could place residents admitted without wounds, to develop wounds, and placed at an increased and unnecessary risk of complications such as pain, acquiring new wounds, worsening of existing wounds, and infection.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER The Rehabilitation & Wellness Centre of Dallas LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Findings included:</p> <p>A record review of Resident #1's Admission MDS assessment, dated 11/18/24, revealed a [AGE] year-old female. On 11/11/24, Resident #1 admitted to the facility on hospice services. Resident #1 had a BIMS Summary Score of 10, that suggested Resident #1 had a moderate cognitive decline. Resident #1 had diagnoses that were primary risk factors for pressure injury development that included CHF; COPD; Impaired mobility and decreased functional ability, leg contracture; Parkinson's; and Dementia. Resident #1 had an impairment to the lower extremity on both sides. Resident #1 required substantial/maximal assistance with eating, oral hygiene, rolling from lying on back to left and right side, and return to lying on back on the bed. Resident #1 was dependent with all other ADLs. Resident #1 did not have any wounds on admission to the SNF. Resident #1 discharged to the hospital on 03/29/25.</p> <p>Record review of an Unavoidable Pressure Ulcer Assessment Form dated 01/15/25, completed on Resident #1, was signed by the WCN and WMD during a QAPI meeting.</p> <p>Record review of Resident #1's Discharge MDS assessment, dated 03/29/25, revealed Resident #1 had unhealed pressure ulcers/injuries, one (1) Stage 3 pressure ulcer, two (2) Stage 4 pressure ulcers, and one (1) unstageable pressure ulcer due to coverage of bound bed by slough and/or eschar.</p> <p>Record review of Resident #1's comprehensive care plan was developed on 02/16/25. The last care conference was 03/17/25. The comprehensive care plan reflected:</p> <p>[Resident #1] had contractures and was at risk for skin break down, increased pain from affected areas and injury [Problem Start Date: 11/11/24; Edited: 02/16/25]. Care plan goals indicated Contractures will not increase, skin break down will not occur, increased pain will be relieved within one hour of intervention and no injuries will occur over next 90 days [Edited: 02/16/25; Target date: 5/11/25]. Interventions included Assist with repositioning often using positioning devices to maintain proper body alignment, provide for comfort measures as needed and Provide pressure relieving devices on bed and chair [Approach Start date: 11/11/24; Edited: 02/16/25].</p> <p>[Resident #1] was at risk for pressure ulcers r/t incontinence status/Dementia [Problem Start Date: 11/11/24; Edited: 02/16/25]. Care plan goals indicated Resident's skin will remain intact [Edited: 02/16/25; Target date: 5/12/25]. Interventions included Avoid shearing (a combination of downward pressure and friction) resident's skin during position, transferring, and turning; Conduct a systematic skin inspection weekly. Pay particular attention to the bony prominences; Keep bony prominences from direct contact with one another; and Report any signs of skin breakdown (sore, tender, red, or broken areas). [Approach Start date: 11/11/24; Edited: 02/16/25].</p> <p>[Resident #1] had a pressure ulcer to sacrum (a large, triangular bone at the base of the spine). [Problem Start Date: 03/10/25; Created: 03/31/25]. Care plan goals indicated will heal without complications [Created: 03/31/25; Target date: 03/10/26]. Interventions included Apply dressings per MD order; Assess resident for pain related to pressure ulcer or its treatment. Prevent or treat pain by medicating per order; Assess the pressure ulcer for stage, size (length, width, and depth), presence/absence of granulation tissue and epithelization, and condition of surrounding skin ____ (frequency); Keep clean and dry as possible. Minimize skin exposure to moisture; Supplements: per MD; Turn and reposition every 2 hours; Use heel protectors to relieve pressure on the heels; and Use moisture barrier product to perineal area [Approach Start Date: 03/10/25; Created: 03/31/25].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER The Rehabilitation & Wellness Centre of Dallas LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>[Resident #1] had a pressure ulcer to right medial foot. [Problem Start Date: 03/10/25; Created: 03/31/25]. Care plan goals indicated ulcer will heal without complications [Created: 03/31/25; Target date: 03/10/26]. Interventions included Use heel protectors to relieve pressure on the heels; Apply dressings per MD order; Assess the pressure ulcer for stage, size (length, width, and depth), presence/absence of granulation tissue and epithelization, and condition of surrounding skin ____ (frequency); Keep clean and dry as possible. Minimize skin exposure to moisture; Supplements: per MD; and Turn and reposition every 2 hours if allowed [Approach Start Date: 03/10/25; Created: 03/31/25].</p> <p>[Resident #1] had a pressure ulcer to left hip. [Problem Start Date: 03/10/25; Created: 03/31/25]. Care plan goals indicated [Resident #1] will have intact skin, free of redness, blisters, or discoloration by/through review date. Will show signs of healing and remain free from infection by/through review date [Created: 03/31/25; Target date: 03/10/26]. Interventions included Administer protein supplements as ordered; Administer treatments as ordered and monitor for effectiveness; Assess/record/monitor wound healing at least weekly. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report declines to the MD; Inform family/caregivers/MD of any new area of skin breakdown; Monitor nutritional status. Serve diet as ordered, monitor intake and record; Requires a cushion to wheelchair or Geri chair when sitting up; Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care; Requires the use of an air mattress; and Wound care MD consult PRN [Approach Start Date: 03/10/25; Created: 03/31/25].</p> <p>[Resident #1] had a pressure ulcer to the right, medial first toe. [Problem Start Date: 03/10/25; Created: 03/31/25]. Care plan goals indicated [Resident #1] will have intact skin, free of redness, blisters, or discoloration by/through review date. Will show signs of healing and remain free from infection by/through review date [Created: 03/31/25; Target date: 03/10/26]. Interventions included Administer protein supplements as ordered; Administer treatments as ordered and monitor for effectiveness; Assess/record/monitor wound healing at least weekly. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report declines to the MD; Inform family/caregivers/MD of any new area of skin breakdown; Monitor nutritional status. Serve diet as ordered, monitor intake and record; Requires a cushion to wheelchair or Geri chair when sitting up; Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care; Requires the use of an air mattress; and Wound care MD consult PRN [Approach Start Date: 03/10/25; Created: 03/31/25].</p> <p>[Resident #1] was at risk of pressure ulcer/injury due to friction and shear [Date initiated: 04/01/25]. Care plan goals indicated will have intact skin, free of redness, blisters or discoloration through the next review date [Initiated: 04/01/25; Target date 5/11/25]. Interventions reflected Minimum of 2 people plus draw sheet to lift [Resident #1] while in bed. [Date initiated: 04/01/25].</p> <p>[Resident #1] had a pressure ulcer/injury. [Date initiated: 04/01/25]. Care plan goals indicated [Resident #1] will show no signs or symptoms of skin breakdown due to refusal to wear heel protectors through the next review date [Initiated: 04/01/25]. Interventions/tasks reflected Monitor and report re-emergence of skin breakdown secondary to resisting care and Reiterate the purpose and advantages of treatment.</p> <p>A record review of Resident #1's Order Summary Report reflected:</p> <p>- Start Date 11/11/24: May have pressure relieving mattress.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER The Rehabilitation & Wellness Centre of Dallas LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<ul style="list-style-type: none"> - Start Date 12/24/24: Weekly Skin Assessment to be done on Thursday during 6-2 shift. - Start Date 02/04/25: May have heel protectors to BLE. - Start Date 02/10/25: Wound consult for area to right foot. - Start Date 02/26/25: Bacitracin zinc (OTC) ointment; 500 unit/gram; thin layer; topical. Apply to reddened area on left thigh every shift for Rash and other nonspecific skin eruption. - Start Date 03/02/25: Apply skin prep to right foot every shift. - Start Date 03/02/25: Apply skin prep to right great toe every shift. - Start Date 03/09/25: Clean open area to left hip with normal saline or wound cleanser, pat dry, apply collagen and dry dressing. [D/C 03/10/25] - Start Date 03/09/25: Wound consult. - Start Date 03/10/25: wound treatment Special Instructions: Clean area to left hip with normal saline or wound cleanser, dry, apply calcium alginate and dry dressing 3xweek and PRN. - Start Date 03/10/25: wound treatment Special Instructions: Clean area to sacrum with normal saline or wound cleanser dry, apply calcium alginate and dry dressing 3x week and PRN. [D/C03/19/25] - Start Date 03/19/25: Clean area to right medial first toe with normal saline or wound cleanser, dry, apply ansept and dry dressing 3 times a week and PRN. - Start Date 03/19/25: Clean area to right medial foot with normal saline or wound cleanser, dry, apply ansept and dry dressing 3 times a week and PRN. - Start Date 03/19/25: Clean area to sacrum with normal saline or wound cleanser, dry, apply ansept dry dressing 3 times a week and PRN. <p>A record review of Resident #1's March 2025 MAR reflected RN B signed off that a weekly skin assessment was performed on Thursday, 03/06/25. Treatment orders for skin prep to right foot and great toe entered on 03/02/25. Treatment orders for the right foot, left hip, and sacrum were entered to begin on 03/10/25. Treatment orders were initialed that indicated care was provided as scheduled.</p> <p>Record review of Resident #1's completed Weekly Skin Assessments reflected:</p> <p>Date: Thursday, 02/07/25. Completed by LVN D. A large blood blister noted on the right side of the right big toe. Bruise noted on top of the right big toe.</p> <p>Date: Thursday, 02/13/25. Completed by LVN D. The blood blister on the right side of the toe is dry and purple. Bruise on top of right toe still visible.</p> <p>Date: Thursday, 02/20/25. Completed by LVN C. Treatment orders in place. No new skin integrity issues.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER The Rehabilitation & Wellness Centre of Dallas LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Date: Thursday, 02/27/25. Completed by LVN E. Redness to left hip, wound care nurse notified, and Zinc has been applied. No further issues noted.</p> <p>Date: Thursday, 03/06/25. No Weekly Skin Assessment Form completed.</p> <p>Date: Thursday, 03/09/25 at 1:29 PM. Completed by LVN A. Eschar noted to left hip and abrasion/wound reopened right below the necrotic area.</p> <p>Date: Thursday, 03/09/25 at 10:39 PM. Completed by ADON I. [Resident #1] with open area to left hip, continues with wounds to blister noted on the right side of foot, the right big toe and on top of right great toe. Sacrum area with multiple skin pigmentation with dark color around areas.</p> <p>Date: Thursday, 03/13/25 at 8:38 AM. Completed by RN B identified wounds described as a Stage 2 sacrum, Stage 2 left hip, and Unstageable right lateral foot.</p> <p>Record review of Resident #1's hospice health aide visits notes revealed the following:</p> <p>On 02/07/25 at 09:28 AM the hospice health aide documented LVN D was notified about Resident #1's right foot that developed a deep tissue pressure area on the ball of the foot.</p> <p>On 02/26/25 at 03:33 PM the hospice health aide documented notification to nurse and directions received - [Resident #1] has a purple pressure area developed on left hip, staff applied skin protection, Resident #1 was repositioned.</p> <p>02/28/25 at 02:57 PM the hospice health aide documented notification to nurse and directions received - [Resident #1] left hip has an open wound, staff nurse stated that she will apply Zinc to the area.</p> <p>Record review of Resident #1's progress notes reflected the following:</p> <p>LATE ENTRY on 02/13/25 at 11:15 AM (effective date 02/07/25 at 11:14 AM): LVN D wrote, A large blood blister noted on the right side of the right big toe. Bruise noted on top of the right big toe. Surrounding skin is dry, warm, and intact. Treatment nurse notified. The affected area was shown to [FM] in person. Will continue to monitor.</p> <p>On 02/10/25 at 7:57 PM, LVN C wrote, . Skin prep applied to discoloration on (Resident #1) right foot. Free from signs or symptoms of infection. Skin is unbroken and free of bleeding or drainage .</p> <p>On 02/26/25 at 2:05 PM, LVN E wrote, . Skin prep applied to discoloration on (Resident #1) right foot. Free from signs or symptoms of infection. Skin is unbroken and free of bleeding or drainage .</p> <p>On 03/02/25 at 2:00 PM, RN H wrote, . writer overheard Resident #1's RP talking on the phone with an angry tone. It appeared he was talking with the DON. The writer went into (Resident #1) room with ADON I to find out what the problem was. The RP was concerned that the blister to Resident #1 right foot had turned black . ADON I and supervisor went with the RP and assessed (Resident #1) blister, educated the RP that the blister was healing as expected. A recommendation was mad to have hospice come by and assess the blister and offer suggestions for further treatment if any .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER The Rehabilitation & Wellness Centre of Dallas LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #1's hospice RN visit note dated 03/02/25 at 6:00 PM revealed Dry blister to Right foot. No signs/symptoms of infection or pain. Patient comfortable during visit.</p> <p>Continued record review of Resident #1's progress notes reflected the following:</p> <p>On 03/03/25 at 6:09 PM, the WCN wrote, . Resident #1 continues to have a discoloration and swelling to feet area treated with skin prep and podus boots (applied to prevent and manage heel pressure and reduce pressure on the area). Area continues to be closed so no new treatment is warranted at this time. RP notified and reminded that Resident #1 was on hospice and other consults are not performed when this was the case.</p> <p>On 03/03/25 at 8:41 PM, LVN C wrote, . Skin prep applied to discoloration on (Resident #1) right foot. Free from signs or symptoms of infection. Skin is unbroken and free of bleeding or drainage .</p> <p>On 03/04/25 at 3:36 AM, RN H wrote, . Discoloration on right foot intact. No signs of infection noted .</p> <p>On 03/04/25 at 11:52 AM, RN B wrote, Resident #1 has a new order for skin prep to right great toe, skin prep applied, the area is clean, dry, skin intact.</p> <p>On 03/09/25 at 1:29 PM, LVN A wrote, RP called this nurse and ADON I to resident's room. RP states that the wound reopened. Upon assessing, abrasion/wound noted to left hip. minimal blood noted. Eschar noted to left hip and right below, skin reopened. cleansed area with NS, pat dry. applied collagen and dry dressing. skin assessment completed and wound care nurse made aware to eval and treat.</p> <p>On 03/09/25 at 10:47 PM, ADON I wrote, Upon head-to-toe skin assessment, resident noted with open area to left hip, dressing in place. Continues with blister to right side of foot, the right big toe and area on top of right great toe. Sacrum has multiple skin pigmentation areas, surrounded with dark color surrounding those areas, but skin is intact. No bruising noted to sacrum area. Skin intact underneath bilateral breast and abdomen areas. Resident with brown aging spot all over back area. Resident continues to be turned and repositioned every 2 hours. Podus boots in place.</p> <p>On 03/10/25 at 2:03 PM, RN B wrote, Upon incontinent care CNA (unidentified) reported opened area to sacrum with minimal bleeding no s/s of infection noted to the area, treatment nurse notified, treatment nurse notified, [RP] notified, treatment orders received, resident continues turning and repositioning every 2 hours, treatment nurse will be notified.</p> <p>On 03/10/25 at 2:33 PM, ADON I wrote, Treatment notified of new areas. Will wait for any orders.</p> <p>On 03/10/25 at 7:23 PM, the WCN wrote, Nurse rounded today and wound to left hip, sacrum, and right foot were assessed. Assessment performed by treatment nurse and new orders provided by MD. New orders noted in residents EHR, please refer to resident orders. Wound assessment updated. RP notified of new orders.</p> <p>On 03/11/25 at 1:45 PM, RN B wrote, Resident continues repositioning every 2 hours . wound care completed on open area to sacrum and open area to left hip .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER The Rehabilitation & Wellness Centre of Dallas LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of hospice physician visit and plan of care meeting notes, dated 03/17/25, revealed Resident #1 had a Stage II ulcer to the left lateral gluteal region. Eschar noted to medial aspect of right foot. During the plan of care meeting with the RP and facility staff, the hospice physician documented that the RP wished to maintain (Resident #1) comfort and dignity and wishes to forego aggressive interventions. Plan to continue with wound offloading and local wound care, facility wound care physician evaluation pending. Per the RP, understood that the patient would continue to have progressive wounds as it related to poor nutritional status, advanced disease, and multiple comorbidities.</p> <p>Record review of Resident #1's WMD visit reports dated 03/18/25 reflected the following:</p> <p>Date: Tuesday, 03/18/25</p> <p>[Resident #1] presented with wounds on the right medial foot; left hip; sacrum; and right medial first toe.</p> <p>Left hip - unstageable (due to necrosis). Duration: greater than 5 days. Wound size (LxWxD): 4.1 x 1.5 x Not measurable cm. Depth was unmeasurable due to presence of nonviable tissue and necrosis. Surgical excisional debridement procedure performed.</p> <p>Right Medial First Toe - unstageable (due to necrosis). Duration: greater than 5 days.: Wound size (LxWxD): 2.4 x 1.5 x Not measurable cm. Depth was unmeasurable due to presence of nonviable tissue and necrosis.</p> <p>Right Medial Foot - Stage 4 Pressure Wound. Duration: greater than 5 days.: Wound size (LxWxD): 2.9 x 3.1 x Not measurable cm. Depth was unmeasurable due to presence of nonviable tissue and necrosis. Surgical excisional debridement procedure performed.</p> <p>Sacrum - Stage 3 Pressure Wound. Duration: greater than 5 days.: Wound size (LxWxD): 1.5 x 1.2 x 0.2 cm. Surgical excisional debridement procedure performed.</p> <p>Continued record review of Resident #1's WMD subsequent visit reports dated 03/24/25 and 03/31/25, revealed Resident #1 wounds were at goal or improved. On 03/24/25, the WMD performed surgical excisional debridement to the right medial foot and left hip.</p> <p>During a telephone interview on 04/06/25 at 12:05 PM, Resident #1's RP said that he noticed a reddened sore on Resident #1's right foot during a visit on 02/02/25. The RP said that he spoke with ADON I who replied that the sore was due to poor circulation. The RP said that during a visit on 03/02/25 he looked at the sore on Resident #1's right foot and it had turned purple with black areas. The RP said that ADON I said that the area on the foot would get worse before it got better. The RP said that he was not informed about Resident #1's left hip. On Sunday, 03/09/25, the RP said that Resident #1 complained of pain at the left hip. The RP said that he pulled back the brief to check, which was stuck to an undressed sore. The RP said that the sore seemed to have scabbed over at that point. The RP said that he called for the nurse and ADON I to come to the room and asked about the sore. The RP said that ADON I cleaned the wound and applied a dressing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER The Rehabilitation & Wellness Centre of Dallas LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview and records review on 04/07/25 at 12:51 PM, RN B indicated that she was a new hire as of 03/03/25 and worked 6A - 2P shifts. RN B said that weekly skin assessments should be 7 days from the date of admission and the MAR would trigger the day the skin assessment was due and that was how she knew it needed to be completed. RN B said that she worked Thursday, 03/06/25, completed a skin assessment but did not know that she was supposed to complete a Weekly Skin Assessment form. RN B said that she performed the scheduled skin assessment on 03/13/25 and documented findings on the skin assessment form. RN B said that she documented the altered skin areas as the WCN described to the sacrum (Stage 2), left hip (Stage 2), and right foot (unstageable).</p> <p>During an interview on 04/07/25 at 2:43 PM, the WCN said that she performed wound care to residents with Stage 2 or larger wounds and performed rounds with the WMD every Tuesday. The WCN said that the charge nurses performed treatments to altered skin integrity like a rash, skin tear, or areas that required topical skin treatments. The WCN said that she or the WMD did not follow Resident #1 for wound care. The WCN said that she reviewed a weekly report that would reflect if a weekly skin assessment was not completed. The WCN said that she did not read the weekly skin assessment and expected the nurse to inform of any skin breakdown or changes observed during weekly skin assessments. The WCN said that the CNAs inspected the residents' skin for redness, bruising, or break in skin when assisting with showers, bed baths, and incontinent care. The WCN said that the CNAs should report any skin issues to the charge nurse. The WCN said that Resident #1 likely developed the pressure injury to the right foot because the heel protectors provided by hospice did not protect the whole foot. The WCN said that Resident #1 legs were contracted, and the feet pressed against each other. The WCN said that staff off-loaded pressure areas by turning and repositioning, with pillows, and position wedges. The WCN said that she became involved with Resident #1's skin management on or about 03/03/25, as reflected in Resident #1's progress notes, when she first learned about Resident #1's right foot in the morning meeting. The WCN said that she assessed and evaluated Resident #1's right foot that had discoloration and swelling. The WCN said that a purple or maroon discoloration could indicate a deep tissue pressure injury and could also present with a closed or ruptured blister. The WCN said the skin was not open. The WCN said that an immediate nursing intervention would be to prevent further damage and promote healing. The WCN said that staff were treating the area with skin prep and podus boots were applied to Resident #1's feet. The WCN reviewed the chart and said that she assessed and evaluated the discovered wound to Resident #1's left hip and notified the MD to obtain orders for treatment and a WMD consult on Monday, 03/10/25.</p> <p>During a telephone interview on 04/07/25 at 3:11 PM, the WMD said that he obtained permission from the RP before he performed surgical debridement to the wounds. The WMD said that the wounds overall condition was deteriorated to a degree but showed some progression with debridement and treatment. The WMD said that the wounds did not show any signs of infection. The WMD indicated that Resident #1 was a high risk for pressure ulcer development due to multiple disease processes, poor nutrition, and contractures.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER The Rehabilitation & Wellness Centre of Dallas LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 04/07/25 at 4:25 PM with ADON I said that once wounds were discovered, treatments were initiated on WMD rounds. An in-service was conducted related to turning and repositioning. ADON I said that Resident #1 received wound care every Monday, Wednesday, Friday, and PRN to right foot, left hip, and sacrum. ADON I did not recall when she first learned about wounds to Resident #1's hip and sacrum. ADON I said if she correctly recalled, the RP brought up concerns about the wound condition after RP removed dressing to Resident #1's left hip. The RP's said that the wound appeared to get worst and had a smell. ADON I said that she reassured the RP that the WCN was treating. ADON I denied the hip wound had an odor. ADON I did not recall the wound condition when she cleaned and covered with a dressing.</p> <p>During an interview on 04/18/25 at 3:34 PM, the DON said his expectation of skin management and pressure ulcer/injury prevention included weekly skin assessments to be completed every 7 days; CNAs to visualize the resident's skin on shower days and notify the charge nurse of any bruises, redness, sores, or any type of break in skin; off-loading and repositioning of residents as needed. The nurse must complete a weekly skin assessment form and initial the MAR that the skin assessment was completed. The DON said if a skin assessment was not document for one week, a resident's skin should still be checked during incontinent care, showers, and during random skin sweeps. The DON said that the discoloration to Resident #1's right foot/toe and left hip should have been monitored by the charge nurse for any changes or the need to notify the WCN. The DON said that ADON I ran weekly reports to determine if weekly skin assessments were completed.</p> <p>The National Pressure Ulcer Advisory Panel ([NPUAP], 2016) revised the definition and stages of pressure injury. Review of the new definition of suspected DTI is: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Further description is also given: Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. (Reference: Edsberg LE, Black JM, [NAME] M, [NAME] L, [NAME] L, Sieggreen M. Revised National Pressure Ulcer Advisory Panel Pressure Injury Staging System: Revised Pressure Injury Staging System. J Wound Ostomy Continence Nurs. 2016; 43(6):585-597. doi:10.1097/WON.0000000000000281 https://pmc.ncbi.nlm.nih.gov/articles/PMC5098472/)</p> <p>The Centers for Medicare & Medicaid Services ([CMS], 2024), defined pressure ulcer/injury characteristics as:</p> <ul style="list-style-type: none"> - Stage 1 Pressure Injury: Non-blanchable erythema of intact skin <p>Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI.</p> <ul style="list-style-type: none"> - Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon, or purple discoloration <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER The Rehabilitation & Wellness Centre of Dallas LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	
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 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Do not use DTP1 to describe vascular, traumatic, neuropathic, or dermatologic conditions. (Reference: Centers for Medicare & Medicaid [CMS], State Operations Manual, Appendix PP. (Rev. 225; Issued: 08-08-24). F686 Skin Integrity, p. 298. https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf</p> <p>Review of the facility's Skin Integrity Monitoring System policy and procedure, effective date 12/2018 indicated:</p> <p>Policy:</p> <p>It is the policy of this home that: 1) A system will be in place to assure that all residents will be assessed and monitored for any type of skin breakdown; 2) A system will be in place to assure that all residents will be assessed and preventative measures will be in place to prevent the development of pressure injuries; and 3) A system will be in place to assure any type of skin conditions that do not constitute pressure injuries, will be monitored closely for any type of complications.</p> <p>Procedures included:</p> <p>Assessment and Monitoring</p> <p>1) Braden Scale will be completed within 24 hours of admission / readmission and every week times 4 weeks for new admits/readmits; then quarterly and with any significant change in condition in software.</p> <p>2) Residents will be screened daily through direct care provided and any deficits identified will be reported.</p> <p>3) All residents will be assessed weekly using the Weekly Skin Assessment form for any type of skin integrity complications; this will include pressure injury and non-pressure related complications.</p> <p>4) When a pressure injury or non-pressure skin deficit is identified, treatment orders are obtained from physician.</p> <p>5) When a skin deficit is identified, dietary is to be notified .</p> <p>6) When a skin deficit is identified, the Interdisciplinary Care Plan and the CNA Kardex (document that helps nursing staff organize and access key resident information for care/care planning) are to be updated to communicate [NAME] [TRUNCATED]</p>		