STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676230	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperfield Healthcare and Rehabilitation	7107 Queenston Blvd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, interview and record review the facility failed to ensure residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (CR #1) of 5 residents reviewed for treatment of pressure ulcers. - The facility failed to notify the MD and receive orders for CR #1's sacral pressure ulcer from 1/24/25-1/27/25. There was no documentation of size until 1/27/25. The noncompliance was identified as PNC. The noncompliance began on 1/24/25 and ended on 2/24/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for worsening wounds, infection, and hospitalization . Findings included: Record review of CR #1's undated face sheet revealed she was a [AGE] year-old female admitted on [DATE] with diagnoses of acute respiratory failure (not enough oxygen in the body), severe protein-calorie malnutrition, COPD (lung diseases that cause ongoing breathing problems), stage III (exposing the underlying fatty tissue, but not reaching muscle or bone) pressure ulcer of the sacral region (bony area at the base of the spine), failure to thrive, dementia (decline in mental function), muscle wasting and atrophy, and difficulty in walking. Record review of CR #1's medical record revealed an Admission MDS assessment was not completed due to the resident being in the facility for 8 days. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676230	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperfield Healthcare and Rehabilitation	7107 Queenston Blvd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of CR #1's Care Plan dated 1/26/25, revealed the resident had an ADL self-care performance deficit r/t disease process and required the assistance of staff with all ADL's. She also had the potential for further pressure ulcer development r/t decreased mobility, incontinence, and being admitted with a decubitus ulcer (area of skin damage that develops when pressure is applied to the same spot for an extended period). Interventions included daily body checks, notifying the MD of any new areas of skin breakdown, out of bed unless contraindicated, pressure relieving mattress, and head to toe skin assessment. CR #1 also had a focus that revealed she had a stage III (full-thickness skin loss where subcutaneous fat is visible, but bone, tendon, or muscle is not exposed) pressure injury r/t disease process, h/o ulcers, immobility, incontinence, and failure to thrive. Interventions included administering treatments as ordered, assess/record/monitor wound healing, encourage to turn and reposition, inform family/MD of new skin breakdown, low air loss mattress, Vit C to promote wound healing, monitor dressing to ensure it is intact and adhering, report any loose dressing to Wound Care Nurse, and weekly head to toe skin assessment. Record review of CR #1's undated, Admission Nursing Report received from the hospital revealed the resident had an open Stage III to the sacrum. Record review of CR #1's previous hospital's After Visit Summary from 1/24/25 at 5:00pm revealed, Location: sacral wound- Cleane with Vashe sol. [type of wound cleanser] Apply Replicare dressing [type of wound dressing] to wound and change every 3 days Turning Regimen- Turn every 1-2 hours; Use wedges; No diapers to be use Sacrum/coccyx [last bone at the bottom (base) of your spine]- Protection sacral foam. Lift and assess EVERY shift. Change every 5 days *Discontinue if changed 2 or more times within 24 hours due to moisture issues Heels- Offload using 2 pillows. No socks or heel foam to be use. Record review of CR #1's Transfer Report from the previous hospital dated 1/24/25, revealed the resident had a Stage III sacral wound. Record review of CR #1's Progress Note dated 1/24/25 at 6:25pm by LVN O, revealed the resident presented with an open sacral wound. Record review of CR #1's Initial Admission Record dated 1/24/25 at 6:30pm by LVN O, revealed she came from an acute care hospital, and the Physician was notified of the admission. The resident was alert, could follow simple commands, and could make her needs known. LVN O documented the resident was always incontinent of bowel and bladder. She also documented the resident had a sacral wound present. Record review of CR #1's Braden Scale for Predicting Pressure Sores dated 1/24/25 by LVN O, revealed the resident was high risk. Record review of CR #1's Daily Skilled Note dated 1/25/25 at 7:46pm by LVN P, revealed the resident had MASD to her coccyx. Record review of CR #1's Progress Note dated 1/26/25 from PA V revealed the resident had a sacral wound stage 2 (partial-thickness skin loss, appearing as a shallow, open sore) on arrival. Record review of CR #1's Progress Note dated 1/26/25 at 11:06am, revealed NP V saw the resident and requested the Wound Care MD to see the resident and it was noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676230	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperfield Healthcare and Rehabilitation	7107 Queenston Blvd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of CR #1's January 2025 Physician Orders revealed no orders for Wound Care. Record review of CR #1's Progress Note dated 1/26/25 at 12:43pm by RN S, revealed the resident had 2 open areas on her sacrum. He cleaned the areas with NS, applied skin prep to the edges, and covered them with a dry protective dressing. Record review of CR #1's Skin Evaluation dated 1/27/25 at 8:40am by Wound Care Nurse G, revealed the resident had a sacrum pressure ulcer site 1 that was 0.5cm x 0.5cm x 0.1cm that was a stage II. She also had a sacrum pressure ulcer site 2 that was 2cm x 1.5cm x 0.1cm and was a stage III. Record review of CR #1's Physician Orders revealed the following orders from MD W: - Sacrum: Cleanse with Normal Saline, pat dry, apply collagen, cover with duoderm, change Q M-W-F. Ordered on 1/27/25 at 9:57am. - Sacrum: Cleanse with Normal Saline, pat dry, apply calcium alginate, cover with border dressing Q Day. Ordered on 1/27/25 at 11:56am. - Low air loss mattress to bed, monitor for proper function Q shift. Ordered on 1/27/25 at 2:23pm. Record review of CR #1's Wound Care Note dated 1/27/25 at 11:57am by MD W, revealed the resident had a stage III pressure ulcer to her sacrum that was 2cm x 1cm x 0.1cm. Record review of CR #1's Weekly Skin Pressure Ulcer dated 1/27/25 at 3:19pm by Wound Care Nurse G, revealed the resident had a sacrum stage III pressure ulcer that was present on admission, that was 2cm x 1cm x 0.1cm. The wound had moderate amount of serous exudate (clear drainage), no odor, and granulation tissue (healing tissue) present. Record review of CR #1's Daily Skilled Note dated 1/27/25 at 7:01pm by LVN M, revealed the resident had a skin injury/ulcer to her buttock and she was compliant with treatment and interventions were in place. Record review of CR #1's Change in Condition dated 2/3/25 at 11:27am, revealed she had shortness of breath and decreased level of consciousness and was being transferred to the hospital. Record review of CR #1's hospital records dated 2/3/25 at 11:36pm, revealed she had an acute on chronic sacral ulcer and wound care was consulted. Record review of CR #1's hospital discharge summary dated 2/24/25 at 2:20pm, revealed she had a stage 3 decubitus ulcer on admission, surgery was consulted, and a bedside debridement was performed. CR #1 was discharged home on hospice. In a telephone interview with CR #1's family member on 2/23/25 at 12:58pm, she said the resident was only at the facility for 8 days and when she first admitted to the facility on [DATE] she only had 2 small spots on her sacrum, but by the time she went to the hospital it had developed into a bigger stage III pressure ulcer with osteomyelitis (bone infection). CR #1's family member also said she would go to the facility and find CR #1's wound uncovered even though the resident was incontinent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676230	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperfield Healthcare and Rehabilitation	7107 Queenston Blvd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Wound Care Nurse G on 2/23/25 at 1:41pm, she said she assessed CR #1 on Monday (1/27/25) and the wound had some slough (dead skin). She said there were no orders in the system for the resident. She said she measured the wound and called the Wound MD to get orders and then followed them. She said her process for skin assessments was to find out who admitted to the facility from Friday evening, Saturday, and Sunday and then she would perform a skin assessment on them. She said if the new admissions had a wound, she would dress it and call the Wound MD. She said wounds should always be covered and nursing staff should be able to put the dressing back on. In an interview with RN S on 2/23/25 at 3:36pm, he said he came in on 1/26/25 and the family came to him and told him the wound care had not been done since the resident had been at the facility. He said Wound Care Nurse R was there, but she had gotten into an argument with CR #1's family so she did not go back in and do any treatment on the resident. He said he did a head-to-toe assessment and saw there were dressings still on her heals from the hospital, but they were just for protection, so he removed them. RN S said he cleaned the sacrum and covered it with a protective dressing. He said he called the on-call service but could never reach a doctor. He said the family member told him what wound care they were doing before the resident went to the hospital, and he told that to Wound Care Nurse R. He also informed Wound Nurse R to call MD W and inform her of the wounds. RN S said Wound Care Nurse R did not tell the MD W and never assessed the resident. He said Wound Care Nurse R did not assess the resident because she never went back into the room after the altercation with the family member. He also heard from other staff that no orders were ever put in until the Wound Care Nurse came in on Monday. In an interview with the DON on 2/23/25 at 3:48pm she said CR #1 admitted on [DATE] and LVN O said she had a wound but did not tell the MD. Wound Care Nurse R, also the Weekend Supervisor, came in Saturday morning (1/25/25) and applied barrier cream to the resident's bottom but left the wound undressed. The DON said Wound Care Nurse R did an assessment on Saturday (1/25/25), but the DON accidentally deleted it. The DON said on Sunday (1/26/25), the family member was upset because nothing had been done about CR #1's wound. She said Wound Care Nurse R got an attitude with the family member and said she was not going to do something and upset the family member. The DON said RN S performed a complete head to toe assessment, cleaned the wound and dressed it. Then on Monday (1/27/25) Wound Care Nurse G did the assessment, notified all parties, and received treatment orders. The DON said Wound Care Nurse R was not skilled at wounds but never said she needed help with anything. She terminated Wound Care Nurse R for customer service and documentation issues related to CR #1. She said she also did a 1-1 with LVN O and RN S. The DON said she also started a QIT and performed a bunch of check offs on Skin Assessments. In a telephone interview with LVN P on 2/29/25 at 4:17pm, she said the NP notified the Wound Care Nurse about the wound care consult and then the Wound Care Nurse would put the order in, that was why NP V did not put orders in. She said the protocol for open wounds on admission was for the admitting nurse to notify the MD about the wound when the nurse called to get admission orders. She said if the nurse could not reach the MD, then the nurse was supposed to clean the wound with NS, pay dry, and cover with a dry dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676230	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperfield Healthcare and Rehabilitation	7107 Queenston Blvd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a telephone interview with LVN O on 2/24/25 at 8:53am she said she had only been at the facility for a couple months. She said she was told by the DON that the protocol for admitting residents with wounds was that she would document them and then the Wounds Care Nurse would see the resident within 24hr to assess and enter orders. She said she was never told to inform the MD at admission about it because the Wound Care Nurse was supposed to handle it. LVN O said when she spoke to the MD about the admission, she went over the meds and labs, but not the wound. She said she did not cover the wound or take off the heel protectors. In a telephone interview with Wound Care Nurse R on 3/5/25 at 10:22am, she said she was never trained on wound care and only shadowed the previous Wound Care Nurse for 2 days before starting. She said she saw CR #1's sacrum and there were 2 little spots that she documented on 1/25/25, but the DON accidentally deleted her note. She said she only took care of the existing wounds with orders and assessed new wounds the nurses would tell her about. She said she did not know to look for new admissions or to call the Wound Care MD for orders. She said the family member was 'over the top' and was mad because the resident had not been turned and the wound was not addressed, on Saturday (1/25/25). Wound Care Nurse R said she tried to take the heel protectors off and turn the resident to put a dressing on her sacrum, but the resident screamed out in pain, so she left the heel protectors on and was unable to dress the sacrum. She said she would have covered the sacrum, but she could not turn the resident due to pain. She said since the family member was mad at her and did not want her to go back in the room, she did not see the resident on Sunday (1/26/25) and the nurse went in to take care of the resident instead. She said she was terminated because it looked bad and the DON did not really want to terminate her, but she had to. Record review of the facility's policy and procedure on Skin and Wound Monitoring and Management (Revised 12/2023) read in part: .A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. The purpose of this policy is that the facility provides care and services to: .Promote the healing of pressure injuries that are present .Resident Assessment: The nurse responsible for assessing and evaluating the resident's condition on admission and readmission is expected to take the following actions: Complete Initial Admission Record and Braden Scale to identify risk and to identify any alterations in skin integrity noted at that time .Skin and wound assessment on admission and readmission: A licensed nurse must assess/evaluate a resident's skin on admission. All areas of breakdown, excoriation, or discoloration, or other unusual findings, will be documented on the initial Admission Record. A licensed nurse will assess/evaluate each pressure injury and/or non-pressure injury that exists on the resident .Measuring the skin injury, Staging the skin injury (when the cause is pressure), Describing the nature of the injury (e.g., pressure, stasis, surgical incision), Describing the location of the skin alteration, Describing the characteristics of the skin alteration. Ongoing Skin and Wound Assessments: A licensed nurse will assess/evaluate a resident's skin at least weekly. Areas of breakdown, excoriation, or discoloration, or other unusual findings (either initially identified at the time of admission or as new findings) must be documented in the nursing notes or on the appropriate weekly assessment form .A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident .Once an area of alteration in skin integrity has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's Order. Treatments per physician order, should be documented in the resident's clinical record at the time they are administered .Communication of Changes: Any changes in the condition of the resident's skin as identified daily, weekly, monthly, or otherwise, must be communicated to: .The resident's physician . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676230	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperfield Healthcare and Rehabilitation	7107 Queenston Blvd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed a Quality Team Tracking Form was initiated on 2/3/25. The problem areas were skin assessments not being completed in a timely manner, and wound orders not being obtained in a timely manner. The compliance goal was the skin system would be monitored weekly and PRN, and interventions and implementation would be re-evaluated before March 2025. Team members who were part of the goals were the Medical Director, Wound Care Nurse G, ADON, DON, and the ADM. Record review of the Quality Team Tracking Form revealed the following problems: - Detailed skin assessments not completed within 24hrs of admission. - Wound orders not obtained and implemented in a timely manner. - Failure to thrive/poor intake related to malnutrition. - Lack of communication regarding the dressing removal/changes between the nurse and CNA. - Lack of nutrition. Record review of the Quality Team Tracking Formed revealed the following interventions: - On 2/3/25 re-education was provided about how the Charge Nurse would assess upon admission, and the Wound Nurse/designee would assess within 24hr of admission. - On 2/3/25 re-education was provided about how detailed skin assessments would be done within 24hrs of admission by the Wound Nurse/designee. - On 2/3/25 re-education was given about obtaining wound orders if a wound was present upon admission. Revised 2/24/25. - On 2/3/25 re-education was given about the Wound Nurse/designee completing the Care Plan within 24hr of admission and updating the skin Care Plans as needed when a change occurs. A verbal update was also given to the MDS and ADONs to assist with the Care Plans. - On 2/4/25 skin competency skill check offs were initiated with the nurses, Med Aides, and CNAs. - From 2/3/25-2/4/25 Braden Scales were performed on all residents and the residents who were high risk had their interventions reviewed to ensure they were in place and implemented. - From 2/3/25-2/4/25 the facility performed a facility wide skin sweep with no concerns. - On 2/4/25 orders for supplements were obtained and carried out. This would be re- evaluated weekly in the IDT skin/nutrition meeting. - On 2/3/25 re-education was provided to nurses and CNAs on communication about dressings to wounds being removed/missing and soiled. - On 2/3/25 re-education was provided to the nursing department about signs/symptoms of wound infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676230	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperfield Healthcare and Rehabilitation	7107 Queenston Blvd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 2/3/25 re-education was provided regarding the importance of supplements for wound healing. - On 2/3/25 re-education was provided to the nurses about completing skin assessments when the resident leaves/returns to the facility (like for appointments, out on pass, ER visit, etc.). - On 2/3/25 re-education was provided on turning and repositioning and incontinence care frequency. - On 2/3/25 skin/wound tests were initiated. - On 2/24/25 education was given about standing orders for skin tears, MASD, wounds, and redness. Record review of in-services revealed the following was done across all shifts and included all staff: - Incontinent Care performed on 2/3/25 with 53 staff member signatures. - Routine and PRN Wound Dressings preformed on 2/3/25 with 56 staff signatures. - Turning and Repositioning performed on 2/3/25 with 56 signatures. - No Facility Acquired Pressure Injuries performed on 2/3/25 with 44 staff signatures. - Initial Skin Assessments/Treatment Orders and Standing Orders for New Admissions for nurses performed on 2/24/25 with 12 staff signatures. - MASD for nurses performed on 2/24/25 with 28 staff signatures. - ADL's (Resident Showers) performed on 3/5/25 with 20 staff signatures. Record review revealed a staff development/in-service from the DON with LVN O on 2/3/25 regarding skin and wound assessment on admission and re-admission. Record review revealed a counseling/disciplinary notice from 2/4/25 for RN S about ensuring proper orders are received from the PCP/NP and immediately transcribing medications/treatments to ensure they were on the MAR/TAR. Record review revealed a counseling/disciplinary action notice from 2/4/25 for Wound Care Nurse R that revealed she was terminated on her last day of work, which was 1/26/25. Wound Care Nurse R was terminated due to failing to complete a head-to-toe assessment and failing to cover the wound. In an interview with LVN C on 2/23/25 at 2:10pm, she said if a wound was not covered, to look for orders and follow them and if there were not any orders to call the MD. She said skin assessments were done every day, but they had a schedule, so it depended on the room numbers, and some were done in the morning, and some were done at night. In an interview with CNA A on 2/23/25 at 2:20pm, she said they rounded every 2hrs and PRN. She said if a dressing was not on a wound, she would notify the nurse, or if she saw a new skin issue, she would tell the nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676230	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperfield Healthcare and Rehabilitation	7107 Queenston Blvd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA B on 2/23/25 at 2:28pm, he said he rounded every 2-3hrs and PRN. He said if he saw a wound on a resident, he would do a stop and watch (particular form to fill out) and if the dressing was missing, he would tell the nurse. In an interview with the DON on 2/23/25 at 5:00pm, she said the process now was that the resident got admitted and the nurse performed a head-to-toe assessment and documented the wounds on the admission record. She said if the resident was getting wound care at the hospital, the nurse would ask during report if the resident would continue those orders or get new orders. If the hospital said to get new orders, then the nurse needed to reach out to MD W and see if she wanted to continue the hospital orders or give new ones. The DON said if staff could not reach MD W, then they would call the regular MD, and if they could not reach them then they would call her. If the staff were unable to reach any MD, there were now standing orders to clean the wound with NS, pat dry, and cover with a dry dressing until someone sees the wound and orders treatment. In an interview with Wound Care Nurse P on 3/6/25 at 9:23am, she said the process for new admissions was that she checked all the new admissions that came in Friday night and through the weekend until Monday. She then would perform a full head-to-toe assessment on the new admissions and takes off any bandages, and treated any skin concerns as she went. She said if there were any orders from the hospital, she would use those until she spoke to MD W. She said she also performed the weekly skin assessment, the Braden Scale on admission and then every 4wks, and the pressure risk assessment. She said she did the assessments in less then 24hr from when the resident was admitted if they admitted M-F. She said if the resident had any skin concerns, she would talk about it to MD W and if there were any open wounds MD W was always consulted. She said there are standing orders now in place for wounds, MASD, pink skin, etc, so the nurse would know what to do until the Wound Care Nurse could see them. In an observation of Wound Care Nurse P on 3/6/25 at 9:30am, she was observed providing wound care to a resident's sacrum pressure ulcer. She followed all the infection control techniques by sanitizing the table, putting down a barrier, and washing her hands after each contact with an item. She appropriately turned and prepared the resident and sanitized her hands and re-gloved after removing the dirty dressing. She continued to sanitize and re-glove between each new wound care procedure performed. The resident's sacrum ulcer never touched the contaminated brief and remained clean the whole time. Wound Care Nurse P finished and sanitized her hands and changed gloves and assisted the resident into a comfortable position with a wedge under her right side for offloading. In an interview with NP T on 3/6/25 at 11:48am, he said the process for wounds was the admitting nurse would call him and tell him about any wounds while they were doing the admission. He then would consult MD W and he would order some kind of wound care until MD W could see the resident. He said if it was the weekend, the on-call would do the same. In an interview with MD W on 3/6/24 2:27pm, she said clinically, CR #1's wound appeared non-infected, and non-necrotic so it did not appear to have worsened, but she couldn't say for sure. However, it did not have any slough or infection noted and she did not have to debride it which is what she would need to do if it had worsened. She said in theory, if a wound isn't covered or treated for 3 days, yes it could get worse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676230	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperfield Healthcare and Rehabilitation	7107 Queenston Blvd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Med Aide E on 3/6/25 at 3:40pm, he said if there were any wounds on a resident, he would fill out the stop and watch form and notify the nurse. He said they also filled out shower sheets and documented on them if they saw any skin concerns and notified the nurse of any skin concerns. If he were to see any new wounds or a wound missing a dressing, he would notify the nurse. In an interview with RN F on 3/6/25 at 3:45pm, he said they had in-services on repositioning, skills check offs, checking the POC, skin assessments, shower sheets, and wound dressings. He said repositioning was for prevention of wounds and healing. The POC was where someone could see how the resident transferred. He also said skin assessments needed to always be done so wounds could be observed. In an interview with CNA D on 3/6/25 at 3:48pm, she said she had in-services on informing the nurse about any wounds, filling out shower sheets with any skin concerns. She said she notified the nurse if a wound was not dressed. She said they did skills check off also. In an interview with Med Aide G on 3/6/25 at 3:51pm, she said if she were to see any wounds or skin concerns, she would notify the nurse or Wound Nurse. She said she turned the residents every 2hrs. She said she filled out the shower sheets with any skin concerns and notified the nurse and she notified the nurse when the resident refused a shower also. In an interview with CNA H on 3/6/25 at 3:45pm, he said he gave daily showers and had to fill out the shower sheets with any skin concerns. He said he alerted the nurse about any wounds or missing dressings. He also said he turned and checked on the residents every 2hrs. In an interview with the DON on 3/6/25 at 5:50pm, she said the ADONs and herself checked behind all of the nurses to ensure the admissions and skin assessments were completed. The Administrator was informed of the past noncompliance on 3/6/25 at 4:10pm.