STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676236	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Champions Healthcare at Willowbrook	13500 Breton Ridge Houston, TX 77070

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45604 [NAME], Kymyaka Based on record review and interview the facility staff failed to ensure residents with pressure ulcers received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 6 residents (CR#1) reviewed for wound care. -The facility failed to obtain wound care orders for CR#1's sacral wound upon admission from 06/11/2024-06/17/2024, and failed to document that the orders were implemented once obtained from 06/17/2024-06/20/2024. This failure could place residents at risk of not receiving adequate care in a timely manner, deterioration of skin, and decreased quality of life. Findings included: Record review of CR#1's Face Sheet dated 6/21/2024 revealed, an [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of fracture of upper end of left humerus (upper arm fracture). CR#1 discharged to a local hospital on 06/20/2024, after a fall. Record review of CR#1's Admission MDS assessment dated [DATE] revealed in section C a BIMS score of 11 indicating she was moderately impaired cognitively. She was assessed to have unhealed pressure Ulcers/Injuries in Section M. Record review of a progress note completed by LVN A and dated 06/11/2024 revealed that resident (CR#1) admitted with an open area on right buttock. Record review of CR#1's discharge medical records dated 06/11/2024 from a local hospital revealed no discharge diagnosis or orders for wound care. Record review of the Initial Admission Record initiated on 06/11/2024 by LVN A revealed that CR#1 admitted with an open area to the right buttock in the section for skin integrity, and CR#1 admitted with no infection in the section for infection. Further review revealed that the document was updated by ADON B on 06/17/2024 that read in part, Resident (CR#1) admitted with open area stage 3 right buttocks area. Treatment initiated as ordered. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR#1's undated Care Plan revealed: Focus: Has pressure ulcer to Right buttocks r/t Disease process. stage 3. Revision on: 06/17/2024 Goal: Pressure ulcer will show signs of healing and remain free from infection by/through review date. Target Date: 09/12/2024 Intervention: Administer treatments as ordered and monitor for effectiveness. Record review of physician orders read in part, right buttocks: open area cleansed with normal saline, pat dry apply CA alginate (Calcium alginate), cover with dry dressing daily, starting on 06/17/2024 and entered by ADON B on 06/17/2024. Record review of undated TAR for CR#1 revealed no documentation from 06/17/2024-06/20/2024 to indicate that wound care orders were completed. Record review of skin assessment with effective date 6/18/2024 for CR#1 read in part, left buttock pressure length 3.0, width 2.5, and depth 0.2. Additional comments: Noted a wound with red granular tissue(a type of new connective tissue that forms in a wound during the healing process), middle of wound bed noted with tan tissue, edges flat, dry no drainage noted, tender to touch, noted multiple old bruises from hospital needle sticks to right wrist/forearm area. Skin barrier applied after each brief change and BID. Record review of progress note dated 06/20/2024 by Physician C revealed CR#1 was assessed to have pressure ulcer to the left buttock with onset date 06/11/2024 with Length: (cm) 3 Width: (cm): 2 and depth (cm) 0.2. 100% reticular dermis(the thick, bottom layer of the dermis, which is the inner layer of the skin) with bleeding, very superficial wound. There were no new orders provided. There was no documentation for concern with infection. Record review of CR#1's medical records dated 06/20/2024 from a local hospital revealed that CR#1 arrived via emergency services on 06/20/2024 with a chief complaint of fall, sepsis screening 0, and wound assessment revealed stage 3 pressure injury to left buttocks and sacrum that was dry, clean, and intact with slough (a soft, yellow, white, stringy, or thick substance that can appear on a wound's surface). In a phone interview on 06/21/2024 at 10:36am with RP, she said that CR#1 rolled out of bed and fell on the butt where her pressure ulcer was located on 06/20/2024, and she had not been told that there was a concern for infection. She said that she was at the bedside when the resident fell , and she requested that CR#1 be transferred to the hospital. She said that facility staff told her that CR#1 admitted with a pressure ulcer, but she did not believe it to be true. In an effort on 06/21/2024 at 12:24pm to interview CR#1, at a local hospital she was unavailable. In an interview on 06/21/2024 at 12:24pm with a RN at a local hospital, she said that CR#1 was having a round of testing, and it was unknow what time she would return to the room. She said that CR#1 arrived on 06/20/2024 by EMS from the facility after a fall on the buttock, and CR#1 had pressure ulcer on the sacrum. She said that there was no notation that infection was a concern. She said that CR#1 had a pressure ulcer to the sacrum at discharge from last hospital stay. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 08/13/2024 at 3:02 p.m. with LVN A, who started at the facility in July of 2023. She said that the duty of the admitting nurse is to complete a head to toe skin assessment at the time of admission. She said that if a pressure ulcer is identified during the skin assessment the wound should be documented, contact is made with the physician to continue hospital discharge orders to treat the wound if provided, or obtain orders to treat the wound if there are no hospital discharge orders provided. She said that if the wound care nurse was in the building at the time of admission, the wound care nurse would complete a second assessment and implement the wound care orders. She said that clinical nurses from the corporate office review new admissions to make sure they are done correctly on the next working day. She said that she was the admitting nurse for CR#1 who admitted to the facility with a sacral wound from the hospital, and she could not remember if she had discharge orders to treat the wound. She said that she communicated the presence of the wound to the ADON who was also the wound care nurse at the time. She said that the ADON was to complete a second skin assessment, obtain treatment orders from the physician, and implement the treatment orders. She said that the ADON did not complete the second assessment, obtain orders, or implement orders. She was unsure how long CR#1 went without orders to treat the wound. She said that the risk to the resident was wound infection. In an interview on 08/13/2024 at 4:13pm with ADON E, she said that she started in July of 2019 as a floor nurse and promoted to ADON in November of 2023. She said that ADON B transferred to the facility in April of 2024 as an ADON and wound care nurse. She said that ADON B was responsible for all wound care until the current DON started. She said that the admitting nurse should complete a skin assessment, ensure that orders are obtained at admission for any skin issues identified, and implement the orders. She said that ADON B should complete a second skin assessment the next business day to ensure the accuracy of the admission skin assessment, and correct errors immediately. She said that an audit of all new admissions should be completed on the next business day during the morning meeting with IDT members present to ensure the admission was completed with accuracy, and with any errors corrected immediately. She said the IDT consists of ED, DON, ADONs, Social Worker, and MDS Nurse. She said that she reviewed the EMR for CR#1 who admitted on [DATE]. She said that LVN A did not obtain orders to treat a wound identified at admission. She said that ADON B did not complete the second skin assessment until 06/17/2024. She said that she did not work on 06/12/2024, the IDT should have audited the admission, and it would have revealed that CR#1 did not have orders to treat the wound. She said without orders, there was a delay in treatment, and the delay could have caused the wound to deteriorate. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/13/2024 at 4:51 p.m. with ADON B, she said that she started at the facility in 2019, and she became an ADON in November of 2023. She said that the facility did not have a wound care nurse until August of 2024, and prior to the position being filled the floor nurses completed wound care, and she was the oversight. She said that she completed weekly skin assessments and rounded with wound care doctor weekly. She said that the admitting nurse should complete a head to toe skin assessment at the time of admission, ensure the resident has treatment orders at the time of admission, and implement the orders. She said that she was to complete a second skin assessment on the next business day to ensure the accuracy of the admitting nurse's skin assessment, ensure that orders were in place to treat any skin issues, and that the orders had been implemented. She said that an audit of all new admission is to be completed on the next business day during the morning meeting with IDT members present to ensure the admission was completed with accuracy, and with any errors corrected immediately. She said the IDT consists of ED, DON, ADONs, Social Worker, and MDS Nurse. She said that the audit is to prevent a delay in treatment. She said that CR#1 admitted on [DATE] with a pressure ulcer, and the admitting nurse(LVN A) did not ensure that orders were in place to treat the wound. She said that she worked on 06/12/2024, she did not complete a skin assessment on the next business day, she did not know why, and it was an oversight. She said that she completed the assessment on 06/17/2024, and she saw that the admitting nurse did not get treatment orders. She said that she contacted the physician to get orders to treat, she implemented the orders that same day, and each day until discharge. She said that she reviewed the TAR from 06/17/24-06/20/2024 and there was no documentation that CR#1 received wound care. She said that if something is not documented it did not happen. She said that the IDT members did not meet to review the admission of CR#1, and she did not know why. She said that if she had completed the assessment and the audit was completed on 06/12/2024 by IDT members the error should have been caught and corrected. She said that there was a delay in treatment, and the risk could have been wound deterioration. She said that CR#1 did not have an infection and she was assessed by Physician C on 06/20/24 with no concern for the wound. In an interview on 08/14/2024 at 11:16 a.m. with Physician D, he said that he was the primary physician for CR#1 and the facility's medical director. He said that he could not remember CR#1, but if a resident admitted with wounds, he should have received the information when contacted to reconcile medications at the time of the admission. He said that he would have provided a temporary order to treat the wounds on 06/11/2024 with a wound consult. He said that orders should have been in place at the time of admission on 06/11/2024, and if orders were not obtained until 06/17/2024 he would have a concern that treatment was delayed, and the delay could cause the wound to worsen. He said that once an order is obtained it should be documented, and if there was no documentation of wound care from 06/17/2024-06/20/2024 he would be concerned. He said that there is a standard that if something is not documented it did not happen. In an interview on 08/14/2024 at 11:37 a.m. with Physician C, he said that he is the wound care doctor for the facility. He said that the facility should have orders in place for wound care at the time a resident was admitted if they were to admit with the wound. He said that he would complete an initial evaluation on his next rounding day after the admission. He said that if a resident admitted on [DATE] with no orders in place until 06/17/2024 it would cause him to have a concern for delayed treatment. He said that all treatment should be documented, and there is standard that if something is not documented it did not happen. He said that he assessed CR#1 on 06/20/2024 he did not have a concern for the wound or concern for infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/14/2024 at 1:59p.m. with the Interim DON, she said that she is employed by the corporate office as a Clinical Resource, and she was assigned as the DON from 05/28/2024-06/10/2024. She said that while she was at the facility ADON B completed all wound care, weekly skin assessments, and rounded with the wound care doctor. She said that ADON F would assist ADON B with the wound care. She said that the admitting nurse should complete a skin assessment, and ensure treatment orders were in place at the time of admission if a resident admitted with wounds. She said that ADON B should complete a second skin assessment within 24 hours to ensure the accuracy of the admission skin assessment. She said that the IDT members should meet the next business day after the admission to ensure the accuracy of all new admissions with any errors corrected immediately to prevent a delay in treatment. She said that if a resident did not have treatment orders for a wound until 06/17/2024 after a 06/11/2024 admission, she would be concerned. She said it would be a delay in treatment that could cause the wound to worsen. She said that all treatments should be documented on the TAR and if it is not documented it did not happen. In an interview on 08/14/2024 at 2:46pm with the DON, she said that she started at the facility on 07/01/2024. She said that when she took the position, the floor nurses were completing wound care with ADON B as the oversight. She said that the admitting nurse should complete a skin assessment at the time of admission, ensure there are orders to treat any identified skin issue at the time of admission, and implement the orders. She said that the wound care nurse should complete a second skin assessment within 24 hours of admission to ensure the accuracy of the initial skin assessment and that orders have been put in place and implemented. She said that an audit of all new admissions should be completed by the next business day after admission to ensure the accuracy of the admission with errors corrected immediately. She said that the audit is completed at the clinical meeting with the ED, DON, ADONs, and MDS nurse. She said that from her review CR#1 admitted with a wound, LVN A did not obtain orders to treat at the time of admission, ADON B did not complete a skin assessment within 24 hours, and the clinical morning meeting did not audit the new admission. She said that delay in treatments could cause a risk of a wound to worsen. She said that CR#1 was assessed on 06/20/2024 and the wound appeared to be getting better and was superficial, even though it was not on the TAR. She said that all treatments should be documented on the TAR, and if treatments are not documented it did not happen. Interview on 08/14/2024 at 3:35pm. the ED said that audits should be completed of a new admission the next working day after admission at the morning meeting with all the department heads present to ensure admission was completed accurately, ensure orders are in place, and to prevent delays in treatment. She said that any error found during the audit would be corrected immediately. She said that the DON has clinical oversight for the audit, and she is the oversight for the DON. She said that CR#1 admitted on [DATE], and she could not remember if there was an audit of the admission on 6/12/24, but the audit should have caught that orders were not in place for wound care. She said that the orders should have been in place from 06/11/2024. She said that a risk to a resident if their treatment is delayed is the wound could worsen. She said that CR#1 did not have harm because the doctor described the wound as superficial on 06/20/2024. She said that all treatments should be documented on the TAR and if it is not documented it did not happen. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy, Skin and Wound Monitoring and Management dated December 2023 read in part, It is the policy of this facility that: 2. A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing . Procedure i. 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. j. Treatments per physician order, should be documented in the resident's clinical record at the time they are administered .9.Quality Assessment and Assurance a. The Quality Assurance Committee should, among other things, evaluate strategies to reduce the development and progression of pressure ulcers as well as monitoring the incidence and prevalence of skin breakdown in the facility .