

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Remington Transitional Care of Richardson		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 E Lookout Dr Richardson, TX 75082	
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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to ensure residents who entered the facility received care and treatment consistent with professional standards of practice to prevent pressure ulcers and a resident with pressure ulcers receives necessary treatment and service to promote healing and/or prevent further development of skin breakdown or pressure ulcers, for one (Resident #282) of four residents reviewed for prevention and maintenance of pressure ulcers.</p> <p>The facility failed to ensure Resident #282, who was identified as entered the facility with a pressure sore to the sacrum and was at risk of developing additional pressure ulcers, received necessary treatment and services thru use of a low air mattresses, which was chosen as prophylaxis by the Wound Care physician to prevent the development of or worsening of pressure ulcers.</p> <p>This failure could place residents at risk of developing pressure ulcers or worsening of existing pressure ulcers.</p> <p>The findings included:</p> <p>Record review of Resident #282's 5-day MDS assessment dated [DATE], revealed a [AGE] year-old female who admitted to the facility on [DATE] and discharged from the facility on 05/10/2024. Resident #282 had diagnoses which included: hypertension (high blood pressure), non-Alzheimer's dementia (confusion), and pressure areas (skin condition). Resident #282 was a BIMs score of 3 reflecting she was severely cognitively impaired, and unable to make decisions for herself and required one staff for assistance with activities of daily living. Further review of Resident #282's reflected she was incontinent of bowel and bladder, was dependent of for transfers, and bathing. Resident #282 had one unstageable pressure ulcer upon admission, receiving pressure ulcer care.</p> <p>Review of Resident #282's comprehensive plan of care dated 04/5/2024 with revisions dated 05/24/2024 reflected no noted goals or approaches for her behaviors related to her offloading her heels. Further review reflected, Problem: Resident #282 has pressure ulcers . left heel and right heel, that developed on 05/10/24, and unstable to sacrum (from admission) : goal: resident's pressure ulcer will show signs of healing and remain free of infection Intervention: Administer treatments as ordered . Focus: interventions: . pressure redistribution mattress as ordered by physician when in bed Further review reflected Problem: the resident is at risk for impaired skin integrity .goal the resident will understand the risks associated with my choice to not adhere to prevent skin breakdown and maintain skin integrity .</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #282's May 2024 Physician Orders indicated . a group two pressure reduction mattress (low air loss rotating mattress) ordered 04/05/2024.</p> <p>Record review of Resident #282's May 2024 weight log indicated Resident #282 was 93 pounds.</p> <p>Record Review of Resident #282's Initial Wound Evaluations and Management Summary dated 05/10/2024 by Wound Care physician reflected two wounds: the left heel Length 3.0, Width 3.0 cm, Depth-not measurable and right heel Wound Size=Length 3.0, Width 1.0 cm., Depth- not measurable both with duration less than one day. The evaluation also reflected wound detail friction blister from rubbing heels on sheet.</p> <p>Record review of Resident #282's Skin-Acute Care Plan dated 04/05/2024 and revised 05/10/2024 documented Pressure Ulcer: unstageable lower sacrum .present on admission ., decreased mobility, incontinence, friction/shear . off-load wound, float heels and legs . group-2 Mattress (low air loss mattress) Approach: Pressure relief device: Air Mattress; Reposition every two hours; Treatment as ordered .</p> <p>In an interview on 06/10/2025 at 2:00 p.m. with Wound Care physician revealed she had provided care to Resident #282 during her stay at the facility. The Wound Care physician stated Resident #282 entered the facility with wounds on her sacrum and had developed pressure areas on her right and left heel while at the facility. The Wound Care physician stated she had met with the family and had instructed them on how a different type of mattress would be better than the mattress brought from the hospital, but the family felt the hospital's mattress was better. The Wound Care physician stated the resident was mobile in the bed and she would remove the pillows the staff was using to offload her feet and legs; the resident would throw them on the floor. The Wound Care physician stated this had opened the possibility for Resident #282 to develop wounds on her feet, since she would rub and lay her feet on the hard surface of the Group one mattress. Group two mattress would have allowed her feet to have alternating air pressure. The Group one mattress does not allow that. The Wound Care physician stated Resident #282 was here for a month, the mattress should have been changed during that time. The Wound Care physician stated, There would have been no guarantee the low air loss mattress would have helped, but how would we have known if we did not try.</p> <p>In an interview on 06/11/2024 at 02:33 p.m. RN E stated she was taking care of Resident #282 while she was here. RN E recalled going into Resident 282's room and she would be on a mattress overlay that was from the hospital. RN E stated not a mattress that the Wound Care physician would recommend, as it does not offer pressure protection. RN E stated the mattress is just a blow up that is placed over the mattress and then covered by a sheet. The Wound Care physician always recommends that the residents with high risk to develop skin issues should be on low air loss rotation mattress, allowing the body to have increased and decreased pressure at different time on each area of the body. RN E stated she did inquire as to why Resident #282 was not on a low-air loss mattress and was told the family had refused and wanted to use the mattress provided by the hospital. RN E stated that the resident was mobile in the bed and could remove the pillows that were placed under her heels and legs. The resident would remove the pillows and throw them on the floor consistently. RN E stated Resident #282 did develop wounds on the heels of her feet because she would remove the pillows and her feet would just sit on that hard blow-up mattress.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the DON on 06/12/2025 at 2:00 p.m. revealed she was aware Resident #282 had a pressure ulcer upon admission and had developed pressure areas on each heel. Resident #282 used an air overlay mattress, from the hospital. The DON stated Resident #282's mattress had no adjustable air setting, it was just blown up and laid over the top of the mattress on the bed. The DON stated the purpose of the low air loss mattress was to prevent and treat pressure injuries, this is what the Wound Care physician had ordered, but the family did not want to use it. The staff tried to keep her feet offloaded with pillows, but the resident would remove them and throw them on the floor from the time that she admitted on [DATE] until she discharged on 05/10/24. Resident #282 never was on the ordered mattress (requested by the family) during her stay. The DON stated Resident did develop the pressure ulcers on both of her feet on 05/10/24.</p> <p>Review of the undated Medline Supra CXC Low Air Loss and Alternating Pressure Mattress Manufacturer Recommendations documented .Use for prevention and stage 1 through 4 pressure ulcers; pump alarms to indicate low pressure, Adjustable to patients' weight for customized therapy, 300 lb weight capacity . Directions for Use: .Pressure adjust knob controls the air pressure output. When turning clockwise the output pressure will increase. [NAME] versa for decreasing air pressure. Please consult your physician for a suitable setting .</p> <p>Record review of the facility policy titled Skin Management and Pressure Ulcer Prevention, dated 10/11/22, revealed the following [in part]:</p> <p>This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, other altered skin integrity, and to provide treatment and services to heal pressure ulcer/injury and/or altered skin integrity, prevent infection and the development of additional pressure ulcers/injuries. It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury prevention and skin management.</p> <p>1.</p> <p>The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.</p> <p>2.</p> <p>Assessment of Pressure Injury Risk</p> <p>a.</p> <p>Licensed nurses will conduct a pressure injury risk assessment, using the Braden Scale on all residents upon admission/re-admission, weekly x four weeks, then quarterly or whenever the resident's condition changes significantly.</p> <p>b.</p> <p>The tool will be used in conjunction with other risk factors not captured by the risk assessment tool. Examples of risk factors include, but are not limited to:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e.</p> <p>Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #29) of four resident's observed for infection control in that:</p> <p>LVN A failed to clean the scissors prior to or after usage during Resident #29's treatments. Placing the unclean scissors back on the treatment cart.</p> <p>This failure could place residents at risk for spread of infection through cross-contamination.</p> <p>Findings included:</p> <p>Review of Resident #29's 5-day MDS assessment, dated 05/26/2025, reflected he was a [AGE] year-old male admitted to the facility on [DATE], with the following diagnoses: diabetes, diabetic wound of the right heel, post-surgical wound of the right, and heart failure. Resident #29 BIMs score of 15 indicated the resident had intact cognition.</p> <p>Review of the Resident #29's plan of care dated 05/21/2025 with updates reflected goals and approaches to include wound care to a surgical wound right planter foot and a diabetic wound to the right heel.</p> <p>Review of the consolidated physician orders dated May 2025 reflected: order dated 05/23/2025 cleanse diabetic wound right foot apply alginate calcium with silver once daily, cover with abdominal pad for the next thirty days, and cleanse the post-surgical wound of right planter foot daily and apply an abdominal pad and wrap with gauze roll daily for the next thirty days.</p> <p>Observation on 06/10/2025 at 1:00 p.m. revealed LVN A went to the treatment cart and started preparing to perform wound care for Resident #29's diabetic wound on the right foot and the post-surgical wound of the right planter foot. LVN A did use hand gel and washed her hands prior to collecting supplies. The LVN took the calcium alginate/silver from the package, took scissors out of the drawer, without cleaning the scissors cutting off the top of the package. The LVN put the scissors with the supplies without cleaning them. LVN A gathered her supplies and entered Resident #29's room. LVN A washed her hands, put on her gloves, and gown used the scissors to remove the gauze on the post-surgical wound. LVN A cleaned the wounds with normal saline and then applied the silver nitrate to the wound on the diabetic wound. LVN A did not clean the scissors prior to using to cut the clean gauze placed on the post-surgical wound on the right planter foot. LVN A placed the scissors on the overbed table, removed her gloves, washed her hands, then took the scissors out of the room placing them on top of the treatment cart, and then placed the scissors back in the drawer of the treatment cart without cleaning them.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/10/2025 at 1:20 p.m., LVN A stated she was to prepare before completing the treatment with gathering her supplies, placing them on a clean area in the room, wash her hands, and placed on her gown and her gloves. LVN A stated she did not think of cleaning the scissors prior to using them because they were on the treatment cart and she thought the scissors were already cleaned, she said she did not clean them afterwards because she was nervous about completing the treatments correctly. She stated the risk would be spread of infection.</p> <p>In an interview on 06/12/2025 at 12:25 p.m., the DON (also infection control coordinator) stated the expectation was for the staff to clean all equipment used prior to using on residents and after using on residents. That included all direct care equipment, which included scissors. The DON stated she would have to complete more infection control in-services for equipment cleaning in between residents, she had just completed an in-service on infection control recently with all direct care staff. The DON stated the risk in not cleaning the scissors would be cross contamination. If performing treatments, the nurse was to provide a clean surface to place wound care supplies on, and equipment should always be sanitized before and after usage.</p> <p>Review of the in-services given in the past three months reflected an in-service dated May 10th, 2025, for infection control and cleaning of equipment. LVN A had attended the meeting.</p> <p>Review of the facility's policy Infection Prevention and Control Program dated May 2023, reflected, The facility has established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the . of soiled contaminated equipment . development and transmission of communicable diseases and infections . 10. Equipment protocol. a. all reusable items and equipment requiring special cleaning, disinfection . shall be cleaned in accordance with our current procedures governing the cleaning.</p>		