| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676258 | A. Building<br>B. Wing | 01/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mememorial City Nursing and Rehabilitation Center | 1341 Blalock<br>Houston, TX 77055 |

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) |
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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure based on the comprehensive assessment of a resident, residents received care, consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable; and a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one (CR#1) of five residents reviewed for pressure ulcers .<br><br>The facility failed to ensure CR #1 did not acquire an unstageable pressure ulcer to her bilateral buttock.<br><br>This failure could place residents at risk for developing pressure wounds, Cellulitis (skin infection), Sepsis (infection of the blood) and severe pain.<br><br>Findings included:<br><br>Record review of CR#1's face sheet dated 01/11/2025, reflected a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE]. CR #1 had a diagnosis which included Alzheimer's disease (a neurological disorder that causes irreversible changes in memory, thinking, and behavior, leading to a gradual decline in cognitive abilities and daily functioning).<br><br>Review of CR#1's annual MDS, dated [DATE], reflected CR#1's was assessed to require ADL assistance for movement in bed. CR#1 was at risk for pressure ulcers.<br><br>Record review of CR#1"s, undated, comprehensive care plan reflected a focus area initiated on 06/20/2022 and revised on 10/09/2024, CR#1 has Potential/Actual Skin Issue related to weakness. Goal: CR #1 skin will remain intact without signs of breakdown. Interventions: turn and reposition frequently to decrease pressure; skin checks weekly per facility protocol, document findings.<br><br>The comprehensive care plan did not address minimizing risks of pressure ulcer/injury prior to CR#1's discharge to the hospital on [DATE].<br><br>Record review of clinical record reveled that skin assessments were completed by WCN weekly and there was no documented finding of skin breakdown prior to 01/08/2025. There was no found documentation of turning and repositioning CR #1 to decrease pressure.<br><br>(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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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Record review of progress notes reflected CR #1 had a change in condition, diagnosed with pneumonia and was being monitored by the NP and physician.<br><br>Record review of Physician's Order for CR#1 reflected no wound care orders.<br><br>Record review of the skin assessment for CR#1, dated 01/08/2025, read in part, 3 x 2.5ins shear wound to sacrum, 6 x 4.5ins shear wound to right buttock and 5 x 3.5ins shear wound to left buttock with scant serous drainage. Record review of skin assessment in the 30-day look period of 12/01/2025 - 01/01/2025 reflected no pressure injury or skin breakdown to CR #1 sacrum.<br><br>Record review of the hospital skin assessment dated [DATE], reflected CR #1 was admitted to hospital from the facility on 01/08/2025 with an unstageable pressure wound to her bilateral buttock. There was no evidence the wound was contributing to the sepsis and the resident was receiving treatment for pneumonia and UTI.<br><br>Observation on 01/13/2025 at 6:25 p.m. revealed CR # 1 was seen at the hospital, lying in bed on a low airflow mattress and repositioning wedges. CR #1 was lethargic at the time of observation. Observation of the sacrum revealed an open wound with dark purple skin discoloration with moderate drainage. The State Surveyor was unable to interview CR # 1 due to orientation status of CR #1.<br><br>In an interview on 01/13/2025 at 4:00 p.m. the DON stated the facility policy required everyone who provided direct care for the residents were responsible for ensuring the prevention of acquired pressure wounds at the facility. The DON stated that the policy required pressure wound risk to be identified and addressed in the resident's comprehensive care plan. The DON stated the facility nurses and CNA were responsible for repositioning residents and timely incontinent care was provided for residents requiring assistance. The DON stated the WCN was responsible for completing skin assessments on all facility residents. The DON stated the facility's policy required skin observations to be completed by the CNA when residents' showers were provided. The DON stated if skin breakdown was identified the primary nurse should be notified. She stated the primary nurse was responsible for notifying the physician and responsible party. The DON stated the care team was responsible for the accuracy of the resident's care plan and intervention. The DON stated she was responsible for ensuring the needs of the resident were addressed and intervention were implemented by the facility staff. The DON was able not a to explain how she ensured the intervention were implemented. The DON stated wound care prevention training had been provided to all direct care staff. The State surveyor requested the wound care policy and documentation of training provided.<br><br>In a telephone interview on 01/13/2025 at 5:00 p.m., the WCN stated she was responsible for completing weekly skin assessments. She stated when she identified a wound, she would notify the resident's primary assigned nurse. She stated the facility police required nurses to contact the resident's physician to obtain a wound consult and wound care orders.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | In a telephone interview on 01/13/2025 at 5:30 p.m., the family member stated on 01/08/2025 at approximately 3:30 p.m. the family was informed CR #1 had a little sore on her bottom and cream was applied to CR #1's bottom. The Family member stated she arrived in the facility approximately an hour later and found CR #1 did not appear well. She stated she requested to CR#1's bottom and noted the wound was a dark black color and the skin was not intact. She stated she feared CR #1 was septic because the wound was draining and appeared to have a foul odor. She stated she requested to have CR #1 transferred to the hospital as she had concerns of CR #1 being septic. She stated she also notified the DON of the concerns, but the DON stated the facility was aware of the wound, but the wound would not make CR #1 septic. The Family member stated a picture of the wound was captured and sent to the DON. The Family member stated CR #1 was admitted to a local hospital and diagnosed with Sepsis and the wound was unstageable on admission to the hospital from the facility.<br><br>In an interview on 01/13/2025 at 6:15 p.m., Hospital Nurse T stated CR #1 was admitted to the hospital critical care unit on 01/08/2025. On admission CR #1 was lethargic and found to have Sepsis and an unstageable pressure injury to CR #1 bilateral buttock. She stated CR #1 was started on antibiotic treatment and the wound care team was following CR #1 for maintenance of the wound. Nurse T stated it was unknown if Sepsis was caused by the wound.<br><br>An interview on 01/15/2024 at 10:30 a.m., CNA V stated she cared for CR#1. She stated CR # 1 required assistance to be turned in bed. She stated when CR #1 was turned, she went back on her back. She stated CR #1 had not been getting out of bed for several days prior to her being sent to the hospital on [DATE]. CNA V stated that she did not know how often CR #1 was turned. She could not recall the last time CR #1 was out of bed in a chair or wheelchair. She stated she did not know why CR # 1 was not get up out bed. She stated CR # 1 would did not require much assistance. She said she assisted the WCN with wound care if she needed help for other residents, but was not aware CR #1 had a pressure wound. She said CR#1's did not seemed to be herself, but she could not provide a timeline. She stated CNAs round every 2 hours for incontinent care and re-positioning. She stated CR #1 would usually be out of bed and did not require frequent turning. She CR #1 could have developed a pressure injury from not be re-positioned frequently because CR #1 usually would be up in her wheelchair.<br><br>In an interview on 01/15/2025 at 11:00 a.m., the WCD, stated she had not been consulted for CR#1 and was not consulted for all facility identified wounds. The WCD stated shear wounds were caused by the sliding or pulling of the skin and tissue in opposite directions, while pressure wounds were caused by prolonged, constant pressure on an area of skin that restricted blood flow. The WCD stated an unstageable wound referred to a wound where the depth could not be determined because the wound bed was covered by necrotic tissue (dead tissue), slough (yellowish tissue), or eschar (black, hard tissue). She stated it was possible for an unstageable wound to develop in a short period (such as two days), particularly if the wound was caused by prolonged pressure (such as in pressure ulcers) or severe shear forces and inadequate or delayed treatment. She stated without proper offloading (relieving pressure), repositioning, or wound care, what started as a minor injury could progress to deeper tissue damage in a matter of days. She stated proper assessment and care were critical in preventing an unstageable wound and pressure wound progression.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | In an interview on 01/15/2025 at 12:00 p.m., the WCN stated she was notified by the primary assigned nurse, Nurse G that CR #1 had a wound on 01/08/2025. She stated a wound consult was submitted by Nurse G for CR#1 on 01/08/2025, she stated an assessment of the wound was completed by her and verified by the DON. She stated at the time of her assessment on 01/08/2025 she observed a shear wound to CR#1 sacrum and the skin was intact. She stated the wound was acquired at the facility. She stated the skin surrounding the wound was pink. She stated the family was at the bedside. She stated CR #1's primary care provider was notified and new orders for zinc oxide cream daily and as needed was provided.<br><br>In interview on 01/15/2025 at 12:30 p.m., Nurse G stated on 01/08/2025 attention was called to CR# 1's room, as CNA T was cleaning her when she heard CR #1 screaming. Nurse G assessed resident and observed an open area on the sacrum. Nurse G stated she was unsure if the wound was infected but there was drainage, the skin in the area was a dark color and was not intact. Nurse G stated pictures of the wound was captured. Nurse G stated she had cared for CR #1 a couple of days prior on 01/06/2025 and did not assess the area and was not sure if the wound was present on 01/06/2025. Nurse G stated CR #1 had experienced generalized weakness since Saturday, 01/04/2025, and not been her usual self. Nurse G stated CR #1 was not able to turn and reposition independently in bed, which may have contributed to the development of the pressure injury. Nurse G stated the wound was a pressure injury, but she was not sure of the stage. Nurse G stated that the wound was acquired at the facility and could have been prevented with frequent repositioning. She stated the facility nurses and CNAs was responsible for repositioning the residents. Nurse G stated wound care was consulted, and the primary care provider coordinator and CR #1 family was notified. The State surveyor was unable to interview CNA T prior to exiting the facility.<br><br>In interview on 01/15/2025 at 3:30p.m., the DON stated there was gaps in both the prevention and management of pressure wounds at the facility. She stated she did not believe the gaps contributed to the development of Sepsis for CR #1. She stated that the wound was acquired at the facility. She stated that CR #1 should have been turned and repositioned timely to prevent the pressure wound. The DON stated she did not have a system in place to monitor that CR #1 was being turned frequently to prevent the pressure wound. The DON stated by not following the facility policy, turning, and repositioning residents it placed residents at risk for skin breakdown and pressure injuries.<br><br>In interview on 01/15/2025 at 3:35 p.m., the unit manager, ADON T stated if the facility failed to properly assess, address, and document wound care and prevention needs it could constitute a violation of care standard and cause the residents to stuffer. She stated the facility policy required stated to prevent facility acquired pressure injury when possible. She stated pressure injuries could be prevented by turning and repositioning residents. She stated that CR #1 developed pressure injury was acquired at the facility and could have been prevented. |