STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676263	A. Building B. Wing	05/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerbrook Skilled Nursing and Rehab Center	9250 Humble-Westfield Rd Humble, TX 77338

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 6 residents (Resident CR# 1) reviewed for neglect.The facility failed to develop and implement an effective system to accurately identify, assess, and treat residents with wounds when CR#1 had wounds (unstageable DTI of the right, medial heel, stage 4 pressure wound of the left hip, stage 3 pressure wound of the right sacrum, and unstageable [due to necrosis] scrotum) that were not identified upon initial assessment, reported to physician, or treated for 12 days which resulted in worsening of wounds and development of new wounds. The facility failed to notify the physician immediately when there were no orders for the skin injuries noted upon admission on [DATE].An Immediate Jeopardy (IJ) situation was identified on 05/15/2026. While the IJ was removed on 05/16/26, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.This failure could place residents at risk of neglect and adverse outcomes.Findings included:Record review of CR#1's face sheet, dated 04/28/26, revealed a [AGE] year-old who was first admitted to the facility on [DATE]. CR #1 had diagnoses which included sepsis (blood infection), muscle wasting, anemia (deficiency of healthy red blood cells), malnutrition (lack of proper nutrition), Dementia (a decline in cognitive function), legal blindness, heart disease, COPD (chronic obstructive pulmonary disease) (a lung condition caused by damage to the airway), partial intestinal obstruction, acute kidney failure, traumatic hemorrhage (bleeding) of brain.Record review of CR#1's admission MDS resident assessment, dated 03/17/26, revealed a BIMS score of 3 out of 15, which indicated severe cognitive impairment. CR#1 had impairment to both sides of the upper extremities. CR #1 was dependent on staff assistance for all ADLs. CR#1 had one unstageable deep tissue injury that was present upon admission and was receiving nutrition interventions to manage skin problems as well as pressure ulcer/injury care. Record review of CR #1's hospital records, dated 3/12/26, revealed a wound first assessed on 3/11/26 and present on original admission: pressure injury to the right posterior hip and a wound first assessed on 3/12/26: pressure injury to the left lateral foot, present on original admission. The CT of the abdomen and pelvis revealed a possible soft tissue abscess over the left lower pelvis or bursitis. CR #1 was receiving Zosyn 3.375g IV every 8 hours starting 03/12/26 for sepsis secondary to suspected skin/soft tissue abscess infection.Record review of CR #1's completed, discontinued, on hold orders with the date range: 02/28/28 to 04/30/26 revealed orders for:Zosyn 3-0.375gm/50ml IV every 6 hours for ischial (bony prominence of the lower pelvis) abscess until 3/24/26.Left lateral foot/DTI: skin prep to area three times a week daily and PRN, order date was 03/16/26. Further review revealed there were no additional treatment orders from 3/13/26 to 3/25/26 for the other wounds until orders were written on 03/25/26 for the following:Right medial heel DTI: apply betadine once daily and PRN, order date was 3/25/26. Left hip/stage 4 wound: apply Daikin's, skin prep to peri wound (the skin immediately surrounding a wound) daily and PRN, order date was 03/25/26.Right sacrum/stage 3 wound: cleanse area with wound cleanser, pat dry, apply leptospermum honey, (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	calcium alginate, skin prep peri wound, daily and PRN, order date was 3/25/26. Scrotum/unstageable necrotic wound: cleanse area with wound cleanser, pat dry, apply calcium alginate/silver, apply abd pad, skin prep peri wound, daily and PRN, order date was 3/25/26. Low air loss mattress to promote wound healing every shift, order date was 3/25/26. Left ischium/stage 4 wound: cleanse area with wound cleanser, pat dry, apply Santyl, calcium alginate, skin prep peri wound, daily and PRN, order date was 4/15/26. Right distal lateral hip wound: cleanse area with wound cleanser, pat dry, apply xeroform, skin prep peri wound, daily and PRN, order date was 4/15/26. Record review of CR #1's March 2026 MAR/TAR revealed three times a week treatment for left lateral foot DTI were documented as started on 3/18/26. Further review revealed documented daily treatments for the right medial heel DTI, left hip stage 4 wound, right sacrum/stage 3 wound, and unstageable scrotum wound were started on 3/26/26. Record review of CR #1's last care plan review completed on 03/23/26 revealed: Focus - CR #1 had a DTI to left lateral foot with potential for further pressure injury development r/t decreased mobility and incontinence, date initiated was 03/18/26. Interventions included - administer medications as ordered, administer treatments as ordered. Focus - CR #1 has infection of the Ischial (lower pelvis bone) Abscess, dated initiated was 03/14/26. Interventions included - give antibiotics as ordered. Focus - CR #1 has the potential to for pressure ulcer development r/t decreased mobility, date initiated was 03/15/26. Interventions included - check for incontinence during rounds, keep skin clean and dry. Further review of the resident centered care plan did not include interventions for the DTI to the right hip, DTI to the right heel, stage 4 pressure injury to the right sacrum and unstageable wound to the scrotum.Record review of Resident CR#1's admission Braden Scale for Predicting Pressure Ulcer Risk written by LVN A and dated 03/13/26 was scored 12. The resident's category was high risk for the development of pressure ulcers.Record review of the facility's admission progress note, dated 03/13/26 and written by LVN A, revealed CR#1 was noted to have a DTI to the right hip and left outer foot.Record review of CR #1's Initial Wound Evaluation and Management Summary by the Wound Care NP, dated 03/16/26, read in part: .Site 1 - unstageable DTI of the left lateral foot. duration >5days, noted to be present upon admission per staff.Wound size (L x W x D): 1.5cm x 1cm x not measurable cm.Skin: intact with purple/maroon discoloration.Record review of CR #1's weekly skin review: effective date 03/20/26 and signed by LVN B (a wound care nurse) revealed a DTI to the right hip and left lateral outer foot. Further review revealed no details such as wound type, stage of the wound or measurements.Record review of CR #1's Wound Care Physician note dated 03/25/26 read in part: .Site 1 - unstageable DTI of the left lateral foot.wound size (L x W x D): 2.7cm x 2.3cm x not measurable cm. Site 2 - unstageable DTI of the right, medial heel, duration >8 days noted to be present upon admission per staff.Wound size (L x W x D): 2.9cm x 2.9cm x not measurable cm. This visit's measurements are noted by the clinician to be exactly the same as the previous visit.Site 3 - stage 4 pressure wound of the left hip.duration >7 days noted to be present upon admission per staff, wound size (L x W x D): 5.8cm x 9.5cm x 0.2 cm.Site 5 - stage 3 pressure wound of the right sacrum. wound size (L x W x D): 2.7cm x 1cm x 0.2 cm. duration >7 days noted to be present upon admission per staff.Site 6 - unstageable (due to necrosis) scrotum. duration >7 days noted to be present upon admission per staff. Wound size (L x W x D): 7cm x 6.5cm x not measurable cm.Record review of CR #1's weekly skin review: effective date 03/27/26 and signed by LVN C revealed redness location to the groin, and sacrum. Wound assessment: wound type was pressure, DTI to the lateral left foot. Measurements: 2.7cm (length), 2.3cm (width) and depth was N/A. Wound #2: wound type was pressure, DTI to the right medial heel. Measurements: 2.9cm (length), 2.9cm (width), depth was N/A. Wound #3: Wound type was pressure, stage 4. Measurements: 5.8 (length), 9.5 (width), depth (0.2cm). Wound #4: wound type as pressure, stage 3 to the sacrum. Measurements: 2.7cm (length), 1cm (width), 0.2cm (depth). Wound #5: wound type was pressure to the groin. Measurements: 7cm (length), 6.5cm (width), depth N/A. The RP and Primary Care Physician were notified on 03/27/26.Record review of the progress notes, dated 04/24/26 and written by LVN I, revealed CR#1 was discharged to the emergency room via 911 due to (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	congestion in both lungs, abnormal vital signs and blood in the urine.In an interview on 4/29/26 at 2:30 PM, LVN C, who was the primary wound care nurse and who worked Monday to Friday, stated there were wound care nurses who worked on the weekends and expected the weekend nurses to do complete nursing treatment tasks. LVN C stated she was off work when CR #1 admitted on Friday (3/13/26) and the weekend wound nurse should have completed a full skin assessment the following day on Saturday (3/14/26) and should have contacted the MD for wound treatment orders and it was not done. LVN C stated the nurse working on 3/14/26 was LVN B. LVN C stated it was the facility policy to do a full skin assessment soon after admission, within the next 36 to 72 hours, was what she was taught to do and that was the purpose of having a treatment nurse daily. LVN C stated when she did a full skin assessment on 3/27/26, she measured all the wounds. LVN C stated she should not have followed the previous skin assessment because it was not a full assessment and did not realize this until recently. LVN C stated she assumed the full skin assessment had already been done. LVN C stated the purpose of full skin assessments were to capture whatever the hospital overlooked or missed. LVN C stated not doing the initial full skin assessment soon after admission affected the residents, because nursing needed to catch skin issues so they could be treated right away, resolved and then move on. LVN C stated CR #1 was in terrible condition when he admitted and he had terrible wounds and was already on antibiotics for sepsis (a systemic blood infection) due to the wounds.In an interview on 4/30/26 at 12:30 PM, the wound care physician stated he could have missed seeing all of CR#1's wounds initially. The wound care physician stated there were times when CR#1 would not allow him to look at all his wounds and that could have been one of the times. The wound care physician stated CR#1 had multiple wounds, and when more developed there were no more places to offload without the opposite side not healing well. The wound care physician stated CR#1 was declining, had multiple comorbidities plus contractures. The wound care physician stated he was particular about his recommendations, especially with large wounds.In an interview on 4/29/26 at 3:30 PM, the DON expected the admitting nurse to conduct the initial head-to-toe assessment, describe what they saw and write a progress note then alert the wound care nurse about the new admit. The DON stated the admitting nurse did only the initial assessment but not the measurements of the wounds. The DON stated it was important to assess the wounds right away because they were an easy portal for infection and nurses needed to know what needed to be done so the facility could implement a plan to attempt to heal the wounds. The wound assessments should be done as early as possible as it could affect the resident as to the reason why the resident was admitted in the first place and to jump start the process of healing. The DON stated on Saturday 3/14/26, LVN B should have completed the full skin assessment and it should have been caught, but it was missed.In an interview on 4/30/26 at 1:26 PM, CNA F stated she was familiar with CR#1 because she worked closely with wound care and only worked with LVN C. CNA F stated when LVN C returned to work after being ill, she recalled CR#1 had wounds to the right hip, left hip, left ischium, right foot and left heel. CNA F stated CR#1 did not always have the podus boots (a medical brace used to protect the ankle and foot) on his feet and after wound care, LVN C would ensure the boots were placed back on CR#1. CNA F stated his boots would be on the floor by the bed and did not know why they were not on his feet. In an interview on 4/30/26 at 1:35 PM, LVN G stated she was familiar with CR#1 and was aware he had several wounds and had an air mattress d/t the wounds. LVN G never conducted a head to toe assessment for CR#1 as it was not needed at the time she took care of him because it wasthe wound care nurses who conducted the weekly skin assessments. In an interview on 5/14/26 at 1:20 PM, LVN A stated CR#1 was admitted later in the day on 3/13/26. LVN A stated CR#1 admitted with a hip wound and wound to the right heel but could not recall which hip. LVN A stated she reported the wounds to the wound care nurse the next day on 3/14/26 but could not recall the name of the wound care nurse. LVN A stated she expected the weekend wound care nurse to lay eyes on newly admitted residents and obtain orders for wounds. LVN A stated she spoke with the on-call doctor to verify orders but did not discuss wounds, because it was the responsibility of the wound care nurses to do (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	so. In a telephone interview on 5/14/26 at 2:10 PM, LVN B stated she worked every other weekend and was the treatment nurse on the weekend of 3/14/26 and 3/15/26. LVN B stated LVN A would put wound orders in and if there were no orders then there was no need for wound care. LVN B stated she did not recall doing a comprehensive skin assessment for CR#1 and could not recall when she saw CR#1 for the first time. LVN B stated if CR#1 admitted on a Friday evening then she would have been responsible for the full skin assessment the next day. LVN B stated she would have asked the charge nurse on Saturday 3/14/26, if there were any new admissions, or saw a note left on the cart, or saw a note in the communication book for wound care nurses or saw a wound care order. LVN B stated she never received any notifications that CR#1 needed a skin assessment on 3/14/26 or 3/15/26. LVN B stated she would be alerted of any new admissions by checking the electronic health care records or report from the charge nurse, but she never received notification. LVN B stated she would have remembered him because his wounds were bad and he admitted with multiple wounds as far as she knew. LVN B stated if there were no wound care orders for a new admission then it was because of poor communication. LVN B stated she did not identify any new wounds, and all the wounds were already there when she started working with him. LVN B stated she remembered he had a wound to the left hip, both ankles, both feet and a sacral wound. LVN B stated it was important to do skin assessments early on to help prevent sepsis. LVN B stated had she been made aware of CR#1 on Saturday 3/14/26 she would have completed a new skin assessment immediately and would not have waited. LVN B stated if there were any concerns she would have notified the wound care physician right away.In an interview on 5/14/26 at 3:50 PM, LVN C stated, as the primary wound care nurse, if she was out sick then one of the weekend nurses would have been asked to come in to do the wound care for the facility. LVN C stated she was not at the facility between 3/13/26 and 3/22/26 but returned on 3/23/26 and did not know how CR#1's wounds were addressed in her absence. LVN C stated whoever was in the position to do wounds should have followed up on getting orders for CR#1. LVN C stated the sooner the full skin assessment was done then wounds could get treatment. LVN C stated by checking the records, she discovered that LVN B clicked on the full skin assessment in the electronic health record on 3/20/26 and conducted a weekly skin assessment which was not the comprehensive assessment. LVN C added when CR#1 was resistant to wound care, she would return later and was always able to complete the daily wound care.In an interview on 5/14/26 at 4:32 PM, CNA H stated she worked with CR#1 and changed his briefs but did not recall seeing any wounds, skin breakdown or wound dressings.In an interview on 05/15/26 at 1:02 PM, the DON stated the wound care nurses would have looked at the from page of the electronic health records for new admissions and that was where CR#1's wound care should have started, and this was what the weekend wound care nurse (LVN B) was educated on during orientation. The DON stated LVN B followed the wound care orders on 3/20/26 and was supposed to do the full skin assessment but did not do so. The DON stated she also expected CNAs to notify the nurse of any skin changes and describe what they saw and for the nurses to assess, document, describe the skin and notify the wound care nurse for MD notification. The DON stated what she expected the nursing staff to do for CR#1 was not put into place until after 4/30/26. The DON stated it was mandated that a full skin assessment be completed upon admission and the staff were not implementing this prior to 4/28/26 and she had to reinforce by conducting in-services, holding the nurses accountable. The DON stated all nurses should be able to assess the skin, describe what was seen and contact the MD for orders if needed. The DON stated the CNAs should have seen CR#1's wounds to the scrotum, sacrum, feet and hips during peri care since they would be the first to see the skin, but it was missed other than the dressings to the left foot. The DON stated communication among the nursing staff was not happening the way she expected. The DON stated she was new to the facility at the time CR#1 was admitted and was in process of addressing the system in question. The DON stated the possible outcomes of not having a system in place for identifying wounds early would be possible neglect.In an interview on 05/15/26 at 1:45 PM, the Administrator stated she was not aware of CR#1's wounds until he was sent out to the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	hospital via 911 on 4/24/26 and during the morning stand up meeting it was mentioned about his wounds. The Administrator stated she heard the nurse filling in for LVN C did not complete the full skin assessment and therefore not aware of the multiple wounds and CR#1 was very sick, he had multiple comorbidities and may have had a significant decline. The Administrator stated during the conversation about CR#1 she was a part of; she did not consider his condition to be neglect. The Administrator stated if the requirement for a head to toe assessment upon admission was not done then it would be detrimental to the resident. The Administrator stated it would put the facility at risk for failing to complete the requirement of a full skin assessment. The Administrator stated she was from the old school of thought that if it was not in writing then it did not happen. The Administrator stated to help prevent further potential neglect the facility re-educated the staff again on full head to toe assessments and the proper procedures for notifying the wound care nurse about new admissions and their wounds. The Administrator stated disciplinary actions were conducted on all the nurses who were responsible for CR#1's care, in-services were started regarding skin changes, reporting to the nurse continued from there. The Administrator stated there was a communication failure because there was not a lot of follow through with his care and a lot of steps were missing. Record review of the facility's policy for abuse and neglect- clinical protocol, revised on date April 2007, read in part: The Administrator is the Abuse Coordinator. If the Administrator is accused of an abusive act or if someone alleges that they have witnessed the Administrator in the act of abuse, you can contact the Corporate Office and/or the Police. Assessment and Recognition: 1. The nurse will assess the individual and document related findings. Assessment data will include a. Injury assessment (bleeding, bruising, deformity, swelling, etc.).2. The nurse will report findings to the physician. As needed the physician will assess the resident to verify or clarify such findings, especially if the cause or source of the problem is unclear.3.b. Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.5. Along with other staff and management, the Medical Director will help identify situations that might constitute or could be construed as neglect; for example, inadequate prevention of care of pressure ulcers.3. The Attending Physician will provide adequate documentation to clarify significant negative outcomes that have resulted from a resident's underlying medical illnesses or conditions, despite appropriate care. Treatment/Management: 1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect.Record review of the facility's policy for Wound Care, revised on December 2011, read in part: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure.Documentation: The following information should be recorded in the resident's medical record: 1. The date the wound care was given. 2. The initials of the individual performing the wound care. 3. Any change in the resident's condition. 4. Any problems or complaints made by the resident related to the procedure. 5. If the resident refused the treatment and the reason(s) why. 6. The signature and title of the person recording the data. Reporting.2. Report other information in accordance with facility policy and professional standards of practice.Record review of the facility's policy for Change in a Resident's Condition or Status, revised on December 2016, read in part: .Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status.1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an).b. discovery of injuries of an unknown source.8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.This was determined to be an Immediate Jeopardy (IJ) on 05/15/2026 at 4:54 PM. The. The Administrator was provided with the IJ template on 05/15/26 at 4:54 PM. The following Plan of Removal submitted by the facility was accepted on 5/16/26 at 2:01 PM:Immediate action:A. CR#1 was discharged to the hospital on 4/24/2026.B. The Medical Director was notified of the IJ for F 600 at 4:48 pm on 5/15/2026.C. On 4/29/2026 the Nurse Managers completed a facility-wide skin assessment audit for all current (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	residents to identify undocumented wounds, untreated wounds, missing physician orders, and missing care plans. No concerns were identified.D. On May 15, 2026, the Administrator received a disciplinary action regarding expectations for oversight, timely follow-up, staff accountability, and compliance with Abuse and Neglect prevention requirements. E. The Regional [NAME] President of Operations re-educated the Administrator, DON, ADON, Unit Manager, and Treatment Nurse on the Abuse and Neglect Policy. Completed on 5/15/2026. F. The Regional [NAME] President of Operations reviewed facility policy on 5/15/2026 regarding Abuse and Neglect and no revisions were deemed necessary. Facility's Plan to ensure compliance quicklyOn 5/14/2026 the Corporate Clinical Services Director reeducated the DON, Nurse Managers, and Treatment Nurse on reviewing the 24-Hour report daily, admission checklist on all admissions, and the wound care policy.ˆAll new admissions will receive a complete head-to-toe skin assessment upon admission by the admitting licensed nurse. Any identified skin alteration will require immediate physician notification, treatment orders, and documentation. To ensure compliance moving forward, the DON, Unit Managers, and Wound Care Nurse will oversee and monitor the admission skin assessment process. The DON, Unit Managers, CSD, and RVP will oversee and monitor compliance through daily review of the Skin Management System audit tool, including admission skin assessments, wound documentation, physician notifications, treatment orders, and care plans to ensure timely identification, treatment, and follow-through of all skin integrity concerns. Any identified concerns or deficiencies will be addressed immediately through corrective action, re-education, and ongoing follow-up monitoring to ensure sustained compliance. The daily review of the Skin Management System audit tool was added and will be reviewed daily for 8 weeks and weekly thereafter for 1 month. This will be reviewed monthly in QAPI until sustained compliance is achieved. ˆThe wound care nurse will complete a comprehensive skin assessment within 24 hours of admission. Any identified skin alteration will require immediate physician notification, treatment orders, documentation, and care plan initiation. Already part of the facility's policy and is on-going. ˆNursing staff (full-time, part-time, and PRN) were re-educated on 5/15/2026 by the Administrator/designee regarding abused neglect prevention, skin assessments, physician notification, treatment initiation, documentation, and care planning requirements. No licensed nursing staff will be allowed to work without receiving the in-service work. Newly hired nurses will be in-serviced by the Administrator/designee on the Abuse and Neglect Policy. Completed 5/15/2026. Staff voiced understanding of the Abuse and Neglect in-service and demonstrated understanding through verbal discussion and examples provided during the education. ˆCNAs (full-time, part-time, PRN) were re-educated on 5/15/2026 by the Administrator/designee on abuse and neglect prevention, resident observation, reporting expectations, and the Stop and Watch Early Warning Tool. No CNAS will be allowed to work without receiving the in-service. Newly hired CNAs will be in-serviced by the Administrator/designee on the Abuse and Neglect Policy. Completed 5/15/2026. Staff voiced understanding of the Abuse and Neglect in-service and demonstrated understanding through verbal discussion and examples provided during the education. ˆA daily Skin Management System audit tool was implemented and will continue as an ongoing practice to ensure assessments, physician notifications, treatment orders, documentation, and care plans are completed timely and accurately. The DON/designee will review the audit tool daily for 8 weeks and weekly thereafter for 1 month. This will be reviewed monthly in QAPI until sustained compliance is achieved. The daily review of the Skin Management System audit tool was added, and it is not part of the wound care policy. Quality AssuranceAn impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 5/15/2026 with the Medical Director. The Medical Director has reviewed and agrees with this plan.Monitoring the POR included the following:Observation on 5/16/26 at 1:25 PM, of wound care for Resident #45, RN T performed hand hygiene and put on appropriate PPE. Resident #45 was alert, oriented and lying on her right side on an air mattress. RN T removed the old dressing, the wound was large with a pink center, and the surrounding skin was appropriate skin color for the resident. Resident #45 denied pain. RN T cleansed the area with wound cleanser, dried area (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	with gauze, applied the collagen sheet, calcium alginate, skin prep to the surrounding skin and applied the new border dressing. No issues were noted with the procedure or with infection control. RN T provided wound care as per physician orders. Observation on 5/16/26 at 6:40 PM, revealed Resident #1 was alert and lying on his back, he denied any skin injuries and had no complaints about his care. The resident was clean and no odors were noted. No issues were noted.Observation on 5/16/26 at 6:50 PM, Resident #74 was lying on his back on an air mattress with feet offloaded. The head of bed was elevated, and the tube feeding was infused. Resident #74 was watching TV and said he had no concerns about his care at the facility. There were no odors and the resident was clean and groomed. Further observation of the residents' rooms in 100, 200, 300 and 400 halls revealed most residents were in bed and safe. Observed staff in the hallways walking in and out of resident rooms checking on residents and asking if they needed anything. Observed a few residents sitting in wheelchairs around the nurse station or sitting at the dining table closest to the entrance to the dining room. Residents were not in any distress, were groomed and staff were present at the nurse station or walking around the nurse station.Interview on 5/14/26 3:50 PM, LVN C, who worked day shift, was the primary wound care nurse, said she reviewed the residents who were being seen by the wound care physician and completed an audit of the wound care physician's evaluations and resident care plans. LVN C stated the audit resulted in no issues and wound care orders.Interview on 5/14/26 at 4:30 PM, CNA E who worked day shift, stated wound care interventions included air mattress, turning every 2 hours, repositioning by use of wedges or pillows and keeping resident's skin clean and dry. CNA E stated she was trained to identify skin breakdown, to use the stop and watch forms (a tool used to communicate any change in condition) and to notify the nurse. CNA E stated the risk of not implementing interventions would be further skin breakdown, infection and the wound not healing.Interview on 05/16/26 at 2:10 PM, CNA J stated she worked 2PM to 10PM shift and recently received numerous in-services that included abuse, neglect, prevention of skin injuries and communicating any changes to the resident. CNA J stated any time there was a change in skin or anything that was different on the resident, any open areas, scraps no matter what size she would report to her floor nurse and would always write a notification in duplicate and give to the nurse. CNA J stated she would document in PCC as well and the message would be seen by the Administrator but would always verbally notify her nurse first. CNA J stated the skin on the resident's bottom could be affected if they were not turned every 2 hours. CNA J stated turning every 1-2 hours would be most important to help prevent skin injuries and if a resident did have a wound and was sitting up she would put the resident to bed after meals. CNA J stated prevention included thorough incontinent care because a wound could worsen quickly. CNA J stated she would get information about a resident's mobility assistance from the binder at the nurse station, from the Kardex, or from a verbal report from the nurse. CNA J stated for a newly admitted resident she would pay more attention to the skin on the buttocks and the feet. CNA J stated she did receive in-service on abuse/neglect prior to starting her shift (sometimes she would get in twice in one day) and was able to verbalize her understanding of neglect and she would report to the Administrator. CNA J stated she would call the 1-800 number if nothing was done by the Administrator. CNA J stated if she heard about abuse or neglect from staff she would also report to the nurse and the Administrator.Interview on 05/16/26 at 2:36 PM, LVN K worked 2 PM to 10 PM stated she recently had an in-service regarding pressure ulcers and skin assessments. LVN K stated she was a certified wound care nurse, but this was not her role at the facility. LVN K stated regarding new admissions she would ensure the resident was in bed, collect the paperwork, complete the head to toe skin assessment, check medications and then call the doctor. LVN K stated if a resident admitted with wounds she would uncover the wound if the wound had a dressing then make her assessment; she would document the wounds accurately then put a communication note for the wound care nurse and place it under the door to the wound care nurse office. LVN K stated if the resident did not have wound orders, she would be responsible to notify the doctor and get orders. LVN K stated she may call the hospital if the resident did not co

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerbrook Skilled Nursing and Rehab Center	9250 Humble-Westfield Rd Humble, TX 77338

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 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 1 of 6 residents (Resident CR# 1) reviewed for pressure ulcers.1. The facility failed to identify and provide wound treatment from 3/13/26 to 3/25/26 for CR #1 who experienced a decrease in skin integrity to the left hip that resulted in a stage 4 pressure wound, stage 3 pressure wound to the right sacrum, unstageable wound to the scrotum and an unstageable DTI of the right heel that were all identified on 3/25/26 by the wound care doctor. 2. The facility failed to complete a comprehensive skin assessment or initiate timely treatment orders for several significant pressure injuries for CR#1. Treatment orders were not obtained for multiple wounds until 03/25/26, approximately 12 days after admission. Additional wounds were not addressed until 04/15/26.3. The facility failed to turn/reposition Resident #13 every 2 hours as stated in the care plan, on 5/13 from 8:00 am-1:30 pm. This noncompliance was identified as non-immediate jeopardy.An Immediate Jeopardy (IJ) situation was identified on 05/14/2026. While the IJ was removed on 05/16/26, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.These failures could place residents at risk of wound deterioration, infection and hospitalization.Findings included:Record review of CR#1's face sheet, dated 04/28/26, revealed a [AGE] year-old who was first admitted to the facility on [DATE]. CR #1 had diagnoses which included sepsis (blood infection), muscle wasting, anemia (deficiency of healthy red blood cells), malnutrition (lack of proper nutrition), Dementia (a decline in cognitive function), legal blindness, heart disease, COPD (chronic obstructive pulmonary disease) (a lung condition caused by damage to the airway), partial intestinal obstruction, acute kidney failure, traumatic hemorrhage (bleeding) of brain.Record review of CR#1's admission MDS resident assessment, dated 03/17/26, revealed a BIMS score of 3 out of 15, which indicated severe cognitive impairment. CR#1 had impairment to both sides of the upper extremities. CR #1 was dependent on staff assistance for all ADLs. CR#1 had one unstageable deep tissue injury that was present upon admission and was receiving nutrition interventions to manage skin problems as well as pressure ulcer/injury care. Record review of CR #1's hospital records, dated 3/12/26, revealed a wound first assessed on 3/11/26 and present on original admission: pressure injury to the right posterior hip and a wound first assessed on 3/12/26: pressure injury to the left lateral foot, present on original admission. The CT of the abdomen and pelvis revealed a possible soft tissue abscess over the left lower pelvis or bursitis. CR #1 was receiving Zosyn 3.375g IV every 8 hours starting 03/12/26 for sepsis secondary to suspected skin/soft tissue abscess infection.Record review of CR #1's completed, discontinued, on hold orders with the date range: 02/28/26 to 04/30/26 revealed orders for:Zosyn 3-0.375gm/50ml IV every 6 hours for ischial (bony prominence of the lower pelvis) abscess until 3/24/26.Left lateral foot/DTI: skin prep to area three times a week daily and PRN, order date was 03/16/26. Further review revealed there were no additional treatment orders from 3/13/26 to 3/25/26 for the other wounds until orders were written on 03/25/26 for the following:Right medial heel DTI: apply betadine once daily and PRN, order date was 3/25/26. Left hip/stage 4 wound: apply Daikin's, skin prep to peri wound (the skin immediately surrounding a wound) daily and PRN, order date was 03/25/26.Right sacrum/stage 3 wound: cleanse area with wound cleanser, pat dry, apply leptospermum honey, calcium alginate, skin prep peri wound, daily and PRN, order date was 3/25/26. Scrotum/unstageable necrotic wound: cleanse area with wound cleanser, pat dry, apply calcium alginate/silver, apply abd pad, skin prep peri wound, daily and PRN, order date was 3/25/26. Low air loss mattress to promote wound healing every shift, order date was 3/25/26. Left ischium/stage 4 wound: cleanse area with wound cleanser, pat dry, apply Santyl, calcium alginate, skin prep peri (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	wound, daily and PRN, order date was 4/15/26. Right distal lateral hip wound: cleanse area with wound cleanser, pat dry, apply xeroform, skin prep peri wound, daily and PRN, order date was 4/15/26. Record review of CR #1's March 2026 MAR/TAR revealed three times a week treatment for left lateral foot DTI were documented as started on 3/18/26. Further review revealed documented daily treatments for the right medial heel DTI, left hip stage 4 wound, right sacrum/stage 3 wound, and unstageable scrotum wound were started on 3/26/26. Record review of CR #1's last care plan review completed on 03/23/26 revealed: Focus - CR #1 had a DTI to left lateral foot with potential for further pressure injury development r/t decreased mobility and incontinence, date initiated was 03/18/26. Interventions included - administer medications as ordered, administer treatments as ordered. Focus - CR #1 has infection of the Ischial (lower pelvis bone) Abscess, dated initiated was 03/14/26. Interventions included - give antibiotics as ordered. Focus - CR #1 has the potential to for pressure ulcer development r/t decreased mobility, date initiated was 03/15/26. Interventions included - check for incontinence during rounds, keep skin clean and dry. Further review of the resident centered care plan did not include interventions for the DTI to the right hip, DTI to the right heel, stage 4 pressure injury to the right sacrum and unstageable wound to the scrotum.Record review of Resident CR#1's admission Braden Scale for Predicting Pressure Ulcer Risk, written by LVN A and dated 03/13/26, was scored 12. The resident's category was high risk for the development of pressure ulcers.Record review of the facility's admission progress note dated 03/13/26 and written by LVN A revealed CR#1 was noted to have a DTI to the right hip and left outer foot.Record review of CR #1's Initial Wound Evaluation and Management Summary by the Wound Care NP dated 03/16/26 read in part: .Site 1 - unstageable DTI of the left lateral foot. duration >5days, noted to be present upon admission per staff.Wound size (L x W x D): 1.5cm x 1cm x not measurable cm.Skin: intact with purple/maroon discoloration.Record review of CR #1's weekly skin review: effective, date 03/20/26 and signed by LVN B (a wound care nurse), revealed a DTI to the right hip and left lateral outer foot. Further review revealed no details such as wound type, stage of the wound or measurements.Record review of CR #1's Wound Care Physician note, dated 03/25/26, read in part: .Site 1 - unstageable DTI of the left lateral foot.wound size (L x W x D): 2.7cm x 2.3cm x not measurable cm. Site 2 - unstageable DTI of the right, medial heel, duration >8 days noted to be present upon admission per staff.Wound size (L x W x D): 2.9cm x 2.9cm x not measurable cm. This visit's measurements are noted by the clinician to be exactly the same as the previous visit.Site 3 - stage 4 pressure wound of the left hip.duration >7 days noted to be present upon admission per staff, wound size (L x W x D): 5.8cm x 9.5cm x 0.2 cm.Site 5 - stage 3 pressure wound of the right sacrum. wound size (L x W x D): 2.7cm x 1cm x 0.2 cm. duration >7 days noted to be present upon admission per staff.Site 6 - unstageable (due to necrosis) scrotum. duration >7 days noted to be present upon admission per staff. Wound size (L x W x D): 7cm x 6.5cm x not measurable cm.Record review of CR #1's weekly skin review: effective date 03/27/26 and signed by LVN C revealed redness location to the groin, and sacrum. Wound assessment: wound type was pressure, DTI to the lateral left foot. Measurements: 2.7cm(length), 2.3cm(width) and depth was N/A. Wound #2: wound type was pressure, DTI to the right medial heel. Measurements: 2.9cm(length), 2.9cm(width), depth was N/A. Wound #3: Wound type was pressure, stage 4. Measurements: 5.8(length), 9.5(width), depth(0.2cm). Wound #4: wound type as pressure, stage 3 to the sacrum. Measurements: 2.7cm(length), 1cm(width), 0.2cm(depth). Wound #5: wound type was pressure to the groin. Measurements: 7cm(length), 6.5cm(width), depth N/A. The RP and Primary Care Physician were notified on 03/27/26.Record review of the progress notes, dated 04/24/26 and written by LVN I, revealed CR#1 was discharged to the emergency room via 911 due to congestion in both lungs, abnormal vital signs and blood in the urine.In an interview on 4/29/26 at 2:30 PM, LVN C, who was the primary wound care nurse and who worked Monday to Friday, stated there were wound care nurses who worked on the weekends and expected the weekend nurses to complete nursing treatment tasks. LVN C stated she was off work when CR #1 admitted on Friday (3/13/26) and the weekend wound nurse should have completed a full skin assessment the following (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	day on Saturday (3/14/26) and it was not done. LVN C stated the nurse working on 3/14/26 was LVN B. LVN C stated it was facility policy to do a full skin assessment soon after admission, within the next 36 to 72 hours, was what she was taught to do and that was the purpose of having a treatment nurse daily. LVN C stated when she did a full skin assessment on 3/27/26, she measured all the wounds. LVN C stated she should not have followed the previous skin assessment because it was not a full assessment and did not realize this until recently. LVN C stated she assumed the full skin assessment had already been done. LVN C stated the purpose of full skin assessments were to capture whatever the hospital overlooked or missed. LVN C stated not doing the initial full skin assessment soon after admission affected the residents because nursing needed to catch skin issues so they could be treated right away, resolved and then move on. LVN C stated CR #1 was in terrible condition when he admitted and was already on antibiotics for sepsis (from the hospital) due to the wounds. LVN C stated she could tell CR #1's wounds were present upon admission when she conducted the full skin assessment on 3/27/26 because of how terrible the wounds were and the severity of the condition of the wounds. Moving forward LVN C stated she would do a facility wide skin audit to ensure residents received correct treatments and correct documentation was in resident records.In an interview on 4/29/26 at 3:30 PM, the DON expected the admitting nurse to conduct the initial head-to-toe assessment, describe what they see and write a progress note then alert the wound care nurse about the new admit. The DON stated the admitting nurse does only the initial assessment but not the measurements of the wounds. The DON stated it was important to assess the wounds right away because they are an easy portal for infection and nurses need to know what needs to be done so we can implement a plan to attempt to heal the wounds. The wound assessments should be done as early as possible as it could affect the resident as to the reason why the resident was admitted in the first place and to jump start the process of healing. The DON stated LVN B on Saturday 3/14/26 should have completed the full skin assessment. The DON stated the initial full skin assessment for CR #1 was not done as early as expected and it should have been caught but it was missed. The DON stated moving forward the facility had already started conducting nursing staff inservices on skin assessments and documentations for new admissions. In an interview on 5/14/26 at 1:20PM, LVN A stated CR#1 was admitted later in the day on 3/13/26. LVN A stated CR#1 admitted with a hip wound and wound to the right heel but could not recall which hip. LVN A stated she reported the wounds to the wound care nurse the next day on 3/14/26 but could not recall the name of the wound care nurse. LVN A stated she expected the weekend wound care nurse lay eyes on newly admitted residents and get orders for wounds. LVN A stated she spoke with the on-call doctor to verify orders but did not discuss wounds. In an interview on 4/30/26 at 12:30 PM, the wound care physician stated he could have missed seeing all of CR#1's wounds initially. The wound care physician stated there were times when CR#1 would not allow him to look at all his wounds and that could have been one of the times. The wound care physician stated CR#1 had multiple wounds, and when more developed there were no more places to offload without the opposite side not healing well. The wound care physician stated CR#1 had multiple comorbidities plus contractures and was declining. In an interview on 4/30/26 at 1:16 PM, CNA E stated she worked with CR#1 and recalled he had bandages one on his bottom and one on the side of the leg for wounds.In an interview on 4/30/26 at 1:26 PM, CNA F stated she was familiar with CR#1 because she worked closely with wound care and only worked with LVN C. CNA F stated when LVN C returned to work after being ill, she recalls CR#1 had wounds to the right hip, left hip, left ischium, right foot and left heel. CNA F stated CR#1 did not always have the podus boots (a medical brace used to protect the ankle and foot) on his feet and after wound care, LVN C would ensure the boots were placed back on CR#1 CNA F stated his boots would be on the floor by the bed and did not know why they were not on his feet. In an interview on 04/30/26 at 1:50 PM, the MDS Nurse stated she was familiar with CR #1 and was aware of his wounds by looking through his chart. The MDS Nurse stated the purpose of the care plan was to give an overall view of what was going on with the resident which included active diagnoses and resident (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	risks so staff would know how to care for the resident. The MDS Nurse stated the wound care nurse was responsible for updating the pressure ulcer care plans as it was part of the assignment. The MDS Nurse stated as changes happened to the resident the care plan should be updated as well. In an interview on 4/30/26 at 1:35 PM, LVN G stated she was familiar with CR#1 and was aware he had several wounds and had an air mattress d/t the wounds. LVN G never conducted a head to toe assessment for CR#1 as it was not needed at the time she took care of him. LVN G stated the wound care nurses conducted the skin assessments. In a telephone interview on 4/30/26 at 2:10 PM, the PCP stated CR #1 was admitted from the hospital for infected wounds from the group home. The PCP stated the facility notified her of all the wounds and he had a DTI to the left foot, left hip, wounds to the sacrum and heels. The PCP stated the Wound Care Physician and wound care nurse regularly gave updates on the status of the wounds.In a telephone interview on 5/14/26 at 2:10PM, LVN B stated she worked every other weekend and was the treatment nurse on the weekend of 3/14/26 and 3/15/26. LVN B stated LVN A would put wound orders in and if there were no orders then there was no need for wound care. LVN B stated she did not recall doing a comprehensive skin assessment for CR#1 and cannot recall when she saw CR#1 for the first time. LVN B stated if CR#1 admitted on a Friday evening then she would have been responsible for the full skin assessment the next day. LVN B stated she would have asked the charge nurse on Saturday 3/14/26, if there were any new admissions, or seen a note left on the cart, or seen a note in the communication book for wound care nurses or seen a wound care order. LVN B stated she never received any notifications that CR#1 needed a skin assessment on 3/14/26 or 3/15/26. LVN B stated she would have remembered him because his wounds were bad and that he admitted with multiple wounds as far as she knew. LVN B stated if there were no wound care orders for a new admission then it was because of poor communication. LVN B stated she did not identify any new wounds, that all the wounds were already there when she started working with him. LVN B stated she remembered he had a wound to the left hip, both ankles, both feet and a sacral wound. LVN B stated it was important to do skin assessments early on to help prevent sepsis. LVN B stated had she been made aware of CR#1 on Saturday 3/14/26 she would have completed a new skin assessment immediately and would not have waited. LVN B stated if there were any concerns she would have notified the wound care physician right away.In an interview on 5/14/26 at 3:50PM, LVN C stated, as the primary wound care nurse, if she was out sick then one of the weekend nurses would have been asked to come in to do the wound care for the facility. LVN C states she was not at the facility between 32/13/26 and 3/22/26 but returned on 3/23/26 and did not know how CR#1's wounds were addressed in her absence. LVN C stated whoever was in the position to do wounds should have followed up on getting orders for CR#1. LVN C stated the sooner the full skin assessment was done then wounds could get treatment. LVN C stated by checking the records, LVN B clicked on the full skin assessment in the electronic health record on 3/20/26 and conducted a weekly skin assessment which was not the comprehensive assessment. LVN C added when CR#1 was resistant to wound care, she would return later and was always able to complete the daily wound care. In an interview on 5/14/26 at 4:32PM, CNA H stated she did work with CR#1 and changed his briefs but did not recall seeing any wounds, skin breakdown or wound dressings.Resident #13 Record review of Resident #13's admission MDS assessment, dated 03/09/2026, revealed a [AGE] year old female, admitted on [DATE], with a BIMS of 13, indicating intact cognition, and diagnoses included multiple fractures of the spine (broken vertebrae in the neck and back secondary to being struck by a vehicle while on foot), neurogenic bladder (lack of bladder control secondary to nerve damage), hypertension (high blood pressure), peripheral vascular disease (condition in which narrowed arteries reduce blood flow to the arms or legs), thyroid disorder (conditions that disrupt the normal function of the thyroid gland, affecting hormone production and metabolism), diabetes mellitus, hyperlipidemia (high cholesterol), and depression. The assessment indicated she had one unhealed unstageable pressure ulcer.During an observation on 05/13/26 at 8:21 a.m. Resident #13 was lying in bed supine with no pillow or wedge behind her/under her back or sides. (continued on next page)

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Resident said she was not able to turn herself because a car hit her and broke her back.During an interview with Resident #13 on 05/13/26 at 10:35 am, she stated she had not been turned and had not seen any staff.During an interview with Resident #13 on 05/13/26 at 11:35 am, she stated she had a staff member come in the room to take her blood sugar and give her medications, but no one turned her.During an interview with Resident #13 on 05/13/26 at 12:35 pm, she stated she had not seen any staff and had not been turned. During an interview with Resident #13 on 05/13/26 at 1:30 pm, she stated she had not been turned. She said CNA A just asked how she was and to refill her water and left the room.During an interview on 05/13/26 at 1:32 pm, CNA A stated that she had a list of which residents needed to be turned and how often. CNA A stated there were a couple of residents who refused all day to be turned. She stated Resident #13 does not like to be turned because it hurts her back. She said Resident #13 had even refused in the past. When told that Resident #13 had not been turned all day, she reiterated that Resident #13 does not like to be turned because it hurts her back and she stated Resident #13 had not asked to be turned. She stated the risks of a resident not being turned were skin breakdown & pain. She said that when a resident refused to be turned/repositioned she should notify a nurse because they chart refusals. She said she had not told a nurse Resident #13 refused. During an interview on 05/13/26 at 1:40 pm, Nurse A stated he was unaware of Resident #13 not being turned & that he was not told by CNA A that Resident #13 did not want to turn. He said that it was a CNA's responsibility, but it was the nurse's responsibility to ensure it was being done. He said that the risks were skin breakdown, pressure ulcers, rashes, discomfort, & pain. He said when a resident refused, nurses were to speak with the resident to find out why, encourage the resident, reeducate them on risks, chart the refusal, and notify the family and physician. During an interview on 05/13/26 at 3:33 pm, the DON stated that the CNAs knew who to reposition & when because it is in their tasks on electronic medical record. She said they can also know by looking at their residents to see if they look uncomfortable or have extra pillows. She stated if they were unsure they can always ask their nurse. She said staff were trained on repositioning/turning with check offs which were just completed last month (April 2026) & her goal was to have check offs done quarterly. She said that if a patient refused, her expectation was for a CNA to let a nurse know. The nurse should then go check with the resident to find out why. The nurse should encourage the resident to allow themselves to be turned/repositioned & reeducate them on the risks of not doing so. If they still refuse, the nurse should chart the refusal, contact the family, the physician, & care plan the refusals. She said her expectation is that all residents should be turned unless there is a contraindication. She said that the risks of not turning a resident are skin breakdown & pressure ulcers.Noncompliance with Resident #13 was found to be non-immediate jeopardy.Record review of the facility's policy for Wound Care, revised on December 2011, read in part: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure.Documentation: The following information should be recorded in the resident's medical record: 1. The date the wound care was given. 2. The initials of the individual performing the wound care. 3. Any change in the resident's condition. 4. Any problems or complaints made by the resident related to the procedure. 5. If the resident refused the treatment and the reason(s) why. 6. The signature and title of the person recording the data. Reporting.2. Report other information in accordance with facility policy and professional standards of practice.Record review of the facility policy for Change in a Resident's Condition or Status, revised on (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	December 2016, read in part: .Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status.1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an).b. discovery of injuries of an unknown source.8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.This was determined to be an Immediate Jeopardy (IJ) on 05/14/2026 at 7:45 PM. The Administrator was provide with the IJ template on 05/14/2026 at 7:45 PM.The following Plan of Removal submitted by the facility was accepted on 5/14/26 at 11:43AM:Immediate action:G.CR#1 was discharged to the hospital on 4/24/2026.H.On 4/29/2026 Medical Director reviewed and approved the RCA and ADHOC facility implemented.I.On 4/29/2026 the Nurse Managers completed a facility-wide skin assessment audit for all current residents to identify undocumented wounds, untreated wounds, missing physician orders, and missing care plans. No concerns were identified.J.On April 29, 2026, the DON, ADON, Unit Manager, Weekend Treatment Nurse, and Treatment Nurse received a disciplinary action regarding failure to follow wound care policy.K.The Clinical Services Director reviewed facility policy on 4/29/2026 regarding the wound care policy and no revisions were deemed necessary. L. DON re-educated the nursing staff on pressure injury prevention and documentation on 4/29/2026.M.The DON/designee re-educated the CNAs on the Stop and Watch early warning tool on 4/29/2026.N.The Medical Director was notified of the IJ for F 686 at 8:30 pm on 5/14/2026. Facility's Plan to ensure compliance quicklyˆOn 5/14/2026 the Corporate Clinical Services Director reeducated the DON, Nurse Managers, and Treatment Nurse on reviewing the 24-Hour report daily, admission checklist on all admissions, and the wound care policy.ˆAll new admissions will receive a complete head-to-toe skin assessment upon admission by the admitting licensed nurse. Any identified skin alteration will require immediate physician notification, treatment orders, and documentation. To ensure compliance moving forward, the DON, Unit Managers, and Wound Care Nurse will oversee and monitor the admission skin assessment process. The DON, Unit Managers, CSD, and RVP will oversee and monitor compliance through daily review of the Skin Management System audit tool, including admission skin assessments, wound documentation, physician notifications, treatment orders, and care plans to ensure timely identification, treatment, and follow-through of all skin integrity concerns. Any identified concerns or deficiencies will be addressed immediately through corrective action, re-education, and ongoing follow-up monitoring to ensure sustained compliance. ˆThe wound care nurse will complete a comprehensive skin assessment within 24 hours of admission. Any identified skin alteration will require immediate physician notification, treatment orders, documentation, and care plan initiation.ˆLicensed nursing staff (full-time, part-time, and PRN) were re-educated regarding skin assessments, physician notification, treatment initiation, documentation, and care planning requirements, completed on 5/14/2026 by the Nurse Managers. Newly hired nurses will be in-serviced by the Director of Nursing or designee on the Wound Care Policy. No licensed nursing staff will be allowed to work without receiving the in-service Wound Care Policy. ˆCNAs (full-time, part-time, and PRN) were re-educated on the Stop and Watch early warning tool, completed on 5/14/2026 by the Nurse Managers/designee. Newly hired CNAs will be in-serviced by the Director of Nursing or designee on the Stop and Watch early warning tool. No CNAS will be allowed to work without receiving the in-service.ˆA daily skin management system audit form was implemented on 4/29/2026 and will be reviewed in the morning meeting to ensure orders, assessments, and care plans are initiated. The DON/designee will complete the daily skin management system audit form daily x 8 weeks. Quality AssuranceAn impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 5/14/2026 with the Medical Director. The Medical Director has reviewed and agrees with this plan.Monitoring of the POR included the following:Interview on 5/14/26 3:50PM, LVN C who worked day shift, was the primary wound care nurse said she reviewed the residents who were being seen by the wound care physician and completed an audit of the wound care physician's evaluations and resident care plans.Interview on 5/14/26 at 4:30PM, CNA E who (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676263	A. Building B. Wing	05/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerbrook Skilled Nursing and Rehab Center	9250 Humble-Westfield Rd Humble, TX 77338

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	worked day shift, stated wound care interventions included air mattress, turning every 2 hours, repositioning by use of wedges or pillows and keeping resident's skin clean and dry. CNA E stated she was trained to identify skin breakdown, to use the stop and watch forms and to notify the nurse. CNA E stated the risk of not implementing interventions would be further skin breakdown, infection and wound not healing.Observation on 5/16/26 at 1:25 PM, of wound care for Resident #45, RN T performed hand hygiene and put on appropriate PPE. Resident #45 was alert, oriented and lying on her right side on an air mattress. RN T removed the old dressing, the wound was large with a pink center, and the surrounding skin was appropriate skin color for the resident. Resident #45 denied pain. RN T cleansed the area with wound cleanser, dried area with gauze, applied the collagen sheet, calcium alginate, skin prep to the surrounding skin and applied the new border dressing. No issues were noted with the procedure or with infection control. RN T provided wound care as per physician orders. Interview on 05/16/26 at 2:10PM, CNA J stated she worked 2pm to 10pm shift and had recently received numerous in-services. CNA J stated that any time there is a change in skin or anything that is different on the resident, any open areas, scraps no matter what size she would report to her floor nurse and would always write a notification in duplicate and give to the nurse. CNA J stated she would document in PCC as well and the message would be seen by the Administrator but would always verbally notify her nurse first. CNA J stated the skin on the resident's bottom can be affected if not turned every 2 hours. CNA J stated turning every 1-2 hours would be most important to help prevent skin injuries and if a resident did have a wound and had been sitting up she would put the resident to bed after meals. CNA J stated prevention included thorough incontinent care because a wound can worsen quickly. CNA J stated she would get information about a resident's mobility assistance from the binder at the nurse station, from the Kardex, or from a verbal report from the nurse. CNA J stated for a newly admitted resident she would pay more attention to the skin on the buttocks and the feet.Interview on 05/16/26 at 2:36PM, LVN K worked 2 PM to 10 PM, stated she recently had an in-service regarding pressure ulcers and skin assessments. LVN K stated she was a certified wound care nurse but this was not her role at the facility. LVN K stated regarding new admissions she would ensure the resident was in bed, collect the paperwork, completed the head to toe skin assessment, check medications and then call the doctor. LVN K stated if a resident admits with wounds she would uncover the wound if the wound had a dressing then make her assessment; she would document the wounds accurately then put a communication note for the wound care nurse and place under the door to the wound care nurse office. LVN K stated if the resident did not have wound orders she would be responsible to notify the doctor and get orders. LVN K stated she may call the hospital if the resident did not come with paperwork from the hospital to find out if there were wound orders. LVN K stated it was her responsibility to document everything and to ensure the CNAs would complete their documentation and communicate with the nurses.Interview on 05/16/26 at 2:54PM, CNA L worked 2 PM to 10 PM, stated he had received many different in-services recently. CNA L stated residents were more prone to developing pressure ulcers if they were unable to reposition themselves. CNA L stated to prevent pressure ulcers he would reposition his residents every 2 hours and change their briefs often because moisture can cause skin breakdown and can make existing wounds worse. CNA L stated wounds develop quickly especially in older individuals. CNA L stated he would report any change in condition including skin changes such as redn