

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER The Atrium of Bellmead		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Development Blvd Bellmead, TX 76705	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0687 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition for 8 of 8 resident. The facility failed to provide continued care for 8 of 8 residents (Resident #1, Resident # 2, Resident # 3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8) after being treated by podiatry. This failure resulted in Resident #1 developing Gangrene which lead to toe amputation. An Immediate Jeopardy (IJ) was identified on 06/17/2026 at 5:14PM. The initial IJ template was provided to the facility on [DATE] at 5:14PM. While the IJ was removed on 06/18/2026 at 7:42PM, the facility remained out of compliance at the scope of pattern and severity of no actual harm due to the facility's need to train all staff. Findings Included: An interview was conducted on 06/16/2026 at 12:45PM with family member for Resident #1 who stated Resident #1 was being seen for issues of her toenails growing weird. A family member stated there were no concerns regarding the resident's toe condition prior to the amputation of the toe. They could not state what caused the amputation of their loved ones' toe. An interview was conducted on 06/16/2026 at 12:50PM with Resident #1 but she could not state what happened to her toe. She stated she had no concerns regarding her care. An interview was conducted on 06/16/2026 at 1:07PM with ADON A revealing that Resident #1 did not have any concerns regarding her toe condition before 06/08/2026. ADON A stated the podiatrist made a visit with Resident #1 on 06/05/2026 and completed an incision and drainage, including a toenail removal. ADON A stated the podiatrist did not leave the orders with a nurse, but at the business office. ADON A stated the facility staff was not aware of the orders until 06/08/2026. ADON A stated on 06/08/2026 Resident #1 had c/o pain in her toe. ADON A took resident to her bedroom and noticed a bandage on Resident #1's right toe. ADON A described the bandage as yellow, which was not a color used at the facility. ADON A stated the bandage appeared tightly wrapped and required soaking of the bandage to be able to remove it from Resident #1's toe. ADON A stated when they removed the bandage, the toe was black and was smaller on the tip. ADON A stated it appeared that Resident #1's toe had lost a lot of blood circulation. ADON A sent Resident #1 to the hospital. ADON A stated that the ADON B had removed the bandage on 06/06/2026 and reapplied he same bandage to the toe. ADON A stated staff were not aware of this being done until 06/09/2026. ADON A stated Resident #1 had circulation issues and believed that the dressing was placed on too tight. An interview was conducted on 06/16/2026 at 1:38PM with MDSC revealed that during the morning meeting on 06/09/2026 it was discussed that a nurse had unwrapped Resident #1's dressing, looked at the toe, and continued with her rounds on 06/06/2026. MDSC stated that the nurse was ADON B, who stated that the podiatrist had done some work on the resident's toe, and ADON B wrapped it back up. An interview was conducted on 06/16/2026 at 3:07PM with ADON B who stated that she was not aware of any orders for Resident #1 following the podiatry appointment on 06/05/2026. ADON B stated that when she made rounds on Resident #1 and observed the dressings on Resident #1's toe on 06/06/2026, she did not check for orders. ADON B stated that the providers would leave orders with the nursing staff. She stated that she did not observe any concerns and did not feel she needed to check the orders. An interview on 06/16/2026 at 3:28PM was conducted with the BOM who stated she (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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NAME OF PROVIDER OR SUPPLIER The Atrium of Bellmead		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Development Blvd Bellmead, TX 76705	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0687 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	electronically signed the Provider Acknowledgement section of the in-service to verify they understood. She stated that they wanted to ensure that the provider gave the orders to the appropriate person.ADM said she, RADM, DON and the ADON completed the following in-services with staff on 06/17/2026:Abuse and neglect policyPressure Prevention policySkin Assessment PolicyProvider processADM said staff who were in-serviced completed a competency test. She said they had to make a grade of 100 or they would be in-serviced again and had to re-take the test until they passed. She said no one could work a shift until they were in-serviced and took the test. If they were in-serviced by phone, they would have to sign the in-service and take the test before starting their next shift.An interview was conducted on 06/18/2026 at 6:54 PM with the FP who stated he was contacted about the IJ on 06/17/2026.RR of skin assessments for all residents who had a podiatry appointment on 06/05/26 revealed there were no additional skin breakdowns as of 06/17/2026.RR of training titled DON, ADON, or treatment Nurse rounding with podiatrist provided on 06/17/26 at 8:00 PM by RDN revealed the following: Effective immediately, the DON, ADON, or Treatment nurse will conduct an entrance conference with the Provider. The Treatment Nurse or ADON will be designated to round with the provider with every visit. The treatment nurse and/or ADON will exit with the provider and enter all orders into PCC to ensure that the treatment orders are implemented. If the provider does not exit, the treatment nurse or ADON will call the provider directly for orders and instructions. Five staff members signed the in-service and there were 5 competency tests with a score of 100.RR of the Root cause Analysis dated 06/17/26, revealed it was conducted by the RDN and RADM. It consisted of the event summary, root cause, contributing factors, and conclusion. It stated the deficient practice occurred due to a system failure in the facility's order-management and communication processes. The lack of a defined procedure for routing, verifying, and implementing physician orders resulted in podiatry orders not being communicated to licensed nursing staff and therefore not implemented in a timely manner.RR revealed there were 73 competency tests with a score of 100 from the in-service completed on 06/17/29 facilitated by the RDN, ADM, DON, and ADON.An Immediate Jeopardy (IJ) was identified on 06/17/2026 at 5:14PM. The initial IJ template was provided to the facility on [DATE] at 5:14PM. While the IJ was removed on 06/18/2026 at 7:42PM, the facility remained out of compliance at the scope of pattern and severity of no actual harm due to the facility's need to train all staff.The IJ was lifted on 06/18/2026 at 7:42PM		