STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676310	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solera at West Houston	2101 Greenhouse Road Houston, TX 77084

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561 Based on record review and interview the facility staff failed to ensure residents with pressure ulcers received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices to promote healing, prevent infection, and prevent new ulcers from developing for one (Resident #1) of 5 residents reviewed for wound care. The facility failed to perform wound care for Resident #1 when her bandages became soiled with urine. The facility failed to request a PRN order to change the bandage on Resident #1's sacral wound if it became soiled. This failure could place residents at risk for infection, deterioration of the wound and diminished quality of care. Findings included: Record review of Resident #1 face sheet reviewed 9/18/24 revealed a forty-year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were an urinary tract infection, osteomyelitis of vertebra (form of spinal infection), pressure ulcer of the sacral region stage IV, and quadriplegia (paralysis of all four limbs. Record review of Resident #1's baseline care plan completed on 9/9/24 documented that Resident #1 needed assist x2 at bed rest, she was a fall risk, her bed should be in the lowest position. Resident #1 had a stage IV pressure ulcer to her sacrum., was a 2 person assist with bathing, and dependent on staff for meals. Her care plan also reflected that Resident #1 wore a nephrostomy (a procedure that creates an artificial opening in the skin and kidney to allow urine to drain directly from the kidney) bag and a colostomy (a surgical procedure that creates an opening in the abdomen to allow stool to pass into an external pouch) bag. Record review of Resident #1's Nursing Admissions assessment dated [DATE] by LVN A, documented that Resident #1 was oriented x4 to person/place/situation, had no memory loss, had clear speech, and she had a stage IV pressure ulcer to her sacrum upon admission. Under the gastrointestinal section, she was identified to be incontinent, and she utilized a colostomy bag. The Indwelling Cather Risk Assessment highlighted that the risks included but were not limited to symptoms of blockage of the catheter associated with bypassing urine, expulsion of the catheter, pain, and discomfort. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676310	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solera at West Houston	2101 Greenhouse Road Houston, TX 77084

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's BIMS score reviewed 9/18/24 undated revealed a score 15 out of 15, meaning the resident was cognitively intact with decision making. Record review of Resident #1's hospital discharge record dated 9/6/24 reflected that Resident #1 was to continue wound care for Stage IV pressure ulcer of sacral region, but she was advised that she would benefit from consulting with a plastic surgeon for flap management of her multiple ulcers. Records stated that her wounds on the sacrum were chronic, but she would also benefit from moisture control and frequent repositioning. Record review of Resident #1's initial wound care progress note dated 9/11/24 by the WCD documented that Resident #1 had a stage 4 pressure wound to the sacrum that measured 23.5x 19.5x 1 cm (LxWxH), with moderate serous (clear watery fluid), and 20% slough (the yellow/white material in the wound be). Treatment was to apply hypochlorous (weak, unstable acid) acid solution vashe and ABD pad once daily for 30 days. The WCD noted the resident had this wound for well over a year and she had written a consultation for a plastic surgeon evaluation. The WCD communicated with Resident #1 that her current treatment was to control infection and drainage, but she would need more aggressive surgical intervention if she attempted to close such a large chronic wound. The objective for wound care was to control infection and manage exudate (drainage). Record review of Resident #1's wound care progress note dated 9/18/24 by the WCD documented that Resident #1 had a stage 4 pressure wound to the sacrum that measured 23x 18x 1 cm (LxWxH), with moderate serous (clear watery fluid), and 20% slough (the yellow/white material in the wound be). Record review of the Resident #1's Physician Orders dated 9/18/24 reflected that wound care orders for stage IV sacral wound were to cleanse with wound cleaner, pat dry, apply Dakin's moist gauze, ABD (pads designed to provide high absorbency of wound exudate), and cover daily. Further review reflected there was not a PRN for this order. In an interview on 9/18/24 at 12:17 pm, CNA A stated she had worked at the facility for [AGE] years and she normally worked the 2pm- 10pm shift, but she had come in the morning of 9/18/24 to assist . She stated when she worked with Resident #1, she used a bed pad and briefs because there was so much water coming out of the wound. She stated the resident she had a colostomy bag coming from her body and she did not require her diaper changed because she did secrete waste (fecal matter or urine) in her diaper . CNA A stated the residents was always wet because of the wound that covered her entire buttock. She stated Resident #1 was total care, able to communicate her needs, and was able to use the call light on her own. In an interview with 9/18/24 at 12:38 pm, LVN A stated he had worked at the facility for [AGE] years and he worked the 6am- 2pm shift. LVN A stated the nurses changed the bandages as needed for wound care residents, but it was mainly done by the wound care nurse. LVN A stated Resident #1 was admitted with wounds and described them as bad. He stated the resident wore a brief just to wear one, but she did not physically need it because she did not use the restroom naturally. He explained because the wound was a stage IV and large, he would think there would be a lot of drainage. LVN A stated when Resident #1 first entered the facility, she had 2 waste bags attached to her, but one of the bags came out and she had to be sent to a urologist to try and get it replaced. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER: Solera at West Houston		STREET ADDRESS, CITY, STATE, ZIP CODE: 2101 Greenhouse Road Houston, TX 77084	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 9/18/24 at 12:48 pm with Resident #1, The room had a strong odor in the air, but it could not be identified of what it was. Resident #1 stated that she was admitted to the facility on [DATE] for wound care. She stated the wound on her bottom caused her a lot of pain and although she had a waste bag (nephrostomy), she would still leak urine to the point where her diaper would be soaked, and the wound would burn. She stated the aides would only change the wetness from under her, but they would not change her bandages because they stated they were not allowed to touch the wound. The male nurse (DON) informed her the wound care nurse had not been available and the facility only had one wound care nurse. Resident #1 stated the DON told her the other nurses could perform wound care, but they had not been doing it. In a follow up interview on 9/18/24 at 1:55pm. Resident #1 stated she did not know when she would leak urine because she was a paraplegic and partially paralyzed from the waist down. However, she was able to tell when she had soiled herself because she would begin to feel icky, it would start to seep out from under the sides of her body, and she would start smelling urine. She explained she had let the aides know she was leaking and she did not know where they thought the fluid was coming from. She said she knew that she was leaking urine and it was not drainage from the wound was because of the smell of urine and she knew the difference. She stated leaking urine had always been an issue and when admitted , she came in with a pure wick (external catheter that allows for simple, non-invasive urine output management in female patients) in between her legs. In an interview on 9/18/24 at 2:21 pm, CNA B stated she had worked at the facility for one month. She stated Resident #1 as a 2-person total assist, and she would be wet on her back and bottom because of the drainage from the wound. She stated the resident's sheets would be wet and they would place a disposable pad on top of her sheets to prevent this. CNA B stated Resident #1's bandage and pads would be wet before she received wound care, but she changed her before wound care started and so the bed pad would be dry. CNA B stated on 9/17/24, Resident #1 was soaked so she changed her brief and repositioned her before she received wound care from the DON. She stated her vaginal area would be wet but expressed Resident #1 had never told her she had an incontinence episode. CNA B believed the drainage was due to her wound. In an interview and observation on 9/18/24 at 1:27 pm, the RRN stated that before she stepped into her current role in November of 2023, she used to be the DON at the facility. She stated if a resident received wound care to their sacral region, the best practice would be to have PRN orders in place. The RRN pulled up the treatment orders for Resident #1 and stated she did not see any PRN orders. The RRN stated because she had a nephrostomy and coloscopy bag, both types of body waste should be excreted in the appropriate bags. She stated a nephrostomy bag was hooked into the left and/or right kidney. She stated if the body was not producing urine, the tubes would take the urine directly from the source. The RRN stated that she believed Resident #1 may had the sensation, but she would not be truly urinating. She called the WCD during this interview and asked her to join them inside of the conference room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Solera at West Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Greenhouse Road Houston, TX 77084	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/18/24 at 1:41 pm, the WCD stated that she had seen Resident #1 in the morning of 9/18/24. She explained Resident #1 was leaking urine from her urethra and the nephrostomy bag would not completely remove it, but urology was not her expertise so she could not explain how or why. The WCD stated Resident #1 was not going to be completely dry and her bandages should be changed if they were soaked through. She stated all sacral wounds have a PRN order to be changed and the RRN informed her that no PRN orders were associated with this treatment. The WCD told the RRN to put in a PRN order for Resident #1's bandage to be changed every time it was soiled and stated the wound did not get worst from last week to the current week. The State Investigator informed the WCD that the aides witnessed a substantial amount of drainage coming from Resident #1's wound and the WCD stated no it's not, it's urine and explained that she knew what urine smelled like. The WCD stated that all urine would soak through the bandage and the aids should have notified the nurse if the bandage was soiled or had fallen off. The WCD explained that if a nurse needed to change a bandage and the did not have an order, they would need to reach out and get one. She would have hoped that a nurse would have gotten a PRN order before changing the bandages on a wound. In an interview on 9/18/24 at 2:54 pm with the DON, he stated that he had been working at the facility for almost 3 months. He stated the admission process for a new resident was the admission department would let the nurses know through text that a new admit was coming to the facility and the nurse working at the time of arrival was responsible for completing the initial assessment. He stated if the wound care nurse was available, she would also do the skin assessment, but if she was not then the nurse doing the admission would put in an interim order for wound care. He stated that as a nurse manager, he would review the admission assessment to make sure it was completed, but he would not preform another evaluation of the resident unless there was a complaint or a concern. He stated when Resident #1 was admitted , she had 2 nephrostomy bags that were positioned into each kidney, but one had fallen out. She did go see a urologist, but they were not able to put the bag back in due to internal damage, so it was left out. Resident #1 was also not able to tolerate a catheter due to previous damage to her urethra. He stated even with the use of a nephrostomy bag, Resident #1 could still experience leakage because the nephrostomy bag would not catch everything. He explained that if her bandages were soiled, there should be a PRN order to address it. The DON stated the facility's wound care nurse was out and the floor nurses were currently completing wound care. He stated the facility did not use a pure wick (an External Catheter for females) and did not know Resident #1 was admitted with a pure wick. He stated he did not know that she was still urinating. The DON stated the harm in a resident having a soiled bandage over a wound could be infection. If a resident had a soiled bandage, it could allow bacteria to grow, infect the skin, and infect the tissues that were trying to heal. In an interview on 9/18/24 at 3:52 pm, LVN A stated she used to be one of the wound care nurses at the facility but currently worked the floor due to a decrease in the census. She stated when she performed the initial assessment with Resident #1, she did notice she had a pure wick in between her legs but she did not think anything of it. The facility did not use pure [NAME], so LVN A took it out and discarded it. LVN A stated the day of the assessment, an aide informed her that when they changed her brief, the brief was soiled, but they said it was due to drainage from the wound and they cleaned her up and put on a new brief. LVN A stated when she did wound care for Resident #1, she did not see a lot of drainage and she was not aware that Resident #1 would leak urine. She stated the harm in a resident having urine-soaked bandages over a wound would be a decline and a decreased healing process. (continued on next page)

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Solera at West Houston	2101 Greenhouse Road Houston, TX 77084

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Wound Care policy revised October 2010 reflected that in preparation for wound care, nurses should: 1. Verify that there is a physician's order for this procedure. 2. Review the resident's care plan to assess for any special needs of the resident. a. For example, the resident may have PRN orders for pain medication to be administered prior to would care.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561 Based on record review and interview the facility staff failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one (Resident #1) of five residents reviewed incontinent care. The facility failed to address the leakage of urine from Resident #1's urethra, causing her stage VI pressure ulcer to the sacrum to burn. This failure could place residents at risk for infection, deterioration of the wound and diminished quality of care. Findings included: Record review of Resident #1 face sheet reviewed 9/18/24 revealed a forty-year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were an urinary tract infection, osteomyelitis of vertebra (form of spinal infection), pressure ulcer of the sacral region stage IV, and quadriplegia (paralysis of all four limbs. Record review of Resident #1's baseline care plan completed on 9/9/24 documented that Resident #1 needed assist x2 at bed rest, she was a fall risk, her bed should be in the lowest position. Resident #1 had a stage IV pressure ulcer to her sacrum., was a 2 person assist with bathing, and dependent on staff for meals. Her care plan also reflected that Resident #1 wore a nephrostomy (a procedure that creates an artificial opening in the skin and kidney to allow urine to drain directly from the kidney) bag and a colostomy (a surgical procedure that creates an opening in the abdomen to allow stool to pass into an external pouch) bag. Record review of Resident #1's Nursing Admissions assessment dated [DATE] by LVN A, documented that Resident #1 was oriented x4 to person/place/situation, had no memory loss, had clear speech, and she had a stage IV pressure ulcer to her sacrum upon admission. Under the gastrointestinal section, she was identified to be incontinent, and she utilized a colostomy bag. The Indwelling Cather Risk Assessment highlighted that the risks included but were not limited to symptoms of blockage of the catheter associated with bypassing urine, expulsion of the catheter, pain, and discomfort. Record review of Resident #1's BIMS score reviewed 9/18/24 undated revealed a score 15 out of 15, meaning the resident was cognitively intact with decision making. Record review of Resident #1's hospital discharge record dated 9/6/24 reflected that Resident #1 was to continue wound care for Stage IV pressure ulcer of sacral region, but she was advised that she would benefit from consulting with a plastic surgeon for flap management of her multiple ulcers. Records stated that her wounds on the sacrum were chronic, but she would also benefit from moisture control and frequent repositioning. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Resident #1's Physician Orders dated 9/18/24 reflected that wound care orders for stage IV sacral wound were to cleanse with wound cleaner, pat dry, apply Dakin's moist gauze, ABD (pads designed to provide high absorbency of wound exudate), and cover daily. Further review reflected there was not a PRN for this order. In an interview on 9/18/24 at 12:17 pm, CNA A stated she had worked at the facility for [AGE] years and she normally worked the 2pm- 10pm shift, but she had come in the morning of 9/18/24 to assist . She stated when she worked with Resident #1, she used a bed pad and briefs because there was so much water coming out of the wound. She stated the resident she had a colostomy bag coming from her body and she did not require her diaper changed because she did secrete waste (fecal matter or urine) in her diaper . CNA A stated the residents was always wet because of the wound that covered her entire buttock. She stated Resident #1 was total care, able to communicate her needs, and was able to use the call light on her own. In an interview with 9/18/24 at 12:38 pm, LVN A stated he had worked at the facility for [AGE] years and he worked the 6am- 2pm shift. LVN A stated the nurses changed the bandages as needed for wound care residents, but it was mainly done by the wound care nurse. LVN A stated Resident #1 was admitted with wounds and described them as bad. He stated the resident wore a brief just to wear one, but she did not physically need it because she did not use the restroom naturally. He explained because the wound was a stage IV and large, he would think there would be a lot of drainage. LVN A stated when Resident #1 first entered the facility, she had 2 waste bags attached to her, but one of the bags came out and she had to be sent to a urologist to try and get it replaced. In an observation and interview on 9/18/24 at 12:48 pm with Resident #1, The room had a strong odor in the air, but it could not be identified of what it was. Resident #1 stated that she was admitted to the facility on [DATE] for wound care. She stated the wound on her bottom caused her a lot of pain and although she had a waste bag (nephrostomy), she would still leak urine to the point where her diaper would be soaked, and the wound would burn. She stated the aides would only change the wetness from under her, but they would not change her bandages because they stated they were not allowed to touch the wound. The male nurse (DON) informed her the wound care nurse had not been available and the facility only had one wound care nurse. Resident #1 stated the DON told her the other nurses could perform wound care, but they had not been doing it. In a follow up interview on 9/18/24 at 1:55pm. Resident #1 stated she did not know when she would leak urine because she was a paraplegic and partially paralyzed from the waist down. However, she was able to tell when she had soiled herself because she would begin to feel icky, it would start to seep out from under the sides of her body, and she would start smelling urine. She explained she had let the aides know she was leaking and she did not know where they thought the fluid was coming from. She said she knew that she was leaking urine and it was not drainage from the wound was because of the smell of urine and she knew the difference. She stated leaking urine had always been an issue and when admitted , she came in with a pure wick (external catheter that allows for simple, non-invasive urine output management in female patients) in between her legs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/18/24 at 2:21 pm, CNA B stated she had worked at the facility for one month. She stated Resident #1 as a 2-person total assist, and she would be wet on her back and bottom because of the drainage from the wound. She stated the resident's sheets would be wet and they would place a disposable pad on top of her sheets to prevent this. CNA B stated Resident #1's bandage and pads would be wet before she received wound care, but she changed her before wound care started and so the bed pad would be dry. CNA B stated on 9/17/24, Resident #1 was soaked so she changed her brief and repositioned her before she received wound care from the DON. She stated her vaginal area would be wet but expressed Resident #1 had never told her she had an incontinence episode. CNA B believed the drainage was due to her wound. In an interview and observation on 9/18/24 at 1:27 pm, the RRN stated that before she stepped into her current role in November of 2023, she used to be the DON at the facility. She stated if a resident received wound care to their sacral region, the best practice would be to have PRN orders in place. The RRN pulled up the treatment orders for Resident #1 and stated she did not see any PRN orders. The RRN stated because she had a nephrostomy and coloscopy bag, both types of body waste should be excreted in the appropriate bags. She stated a nephrostomy bag was hooked into the left and/or right kidney. She stated if the body was not producing urine, the tubes would take the urine directly from the source. The RRN stated that she believed Resident #1 may had the sensation, but she would not be truly urinating. She called the WCD during this interview and asked her to join them inside of the conference room. In an interview on 9/18/24 at 1:41 pm, the WCD stated that she had seen Resident #1 in the morning of 9/18/24. She explained Resident #1 was leaking urine from her urethra and the nephrostomy bag would not completely remove it, but urology was not her expertise so she could not explain how or why. The WCD stated Resident #1 was not going to be completely dry and her bandages should be changed if they were soaked through. She stated all sacral wounds have a PRN order to be changed and the RRN informed her that no PRN orders were associated with this treatment. The WCD told the RRN to put in a PRN order for Resident #1's bandage to be changed every time it was soiled and stated the wound did not get worst from last week to the current week. The State Investigator informed the WCD that the aides witnessed a substantial amount of drainage coming from Resident #1's wound and the WCD stated no it's not, it's urine and explained that she knew what urine smelled like. The WCD stated that all urine would soak through the bandage and the aids should have notified the nurse if the bandage was soiled or had fallen off. The WCD explained that if a nurse needed to change a bandage and the did not have an order, they would need to reach out and get one. She would have hoped that a nurse would have gotten a PRN order before changing the bandages on a wound. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

In an interview on 9/18/24 at 2:54 pm with the DON, he stated that he had been working at the facility for almost 3 months. He stated the admission process for a new resident was the admission department would let the nurses know through text that a new admit was coming to the facility and the nurse working at the time of arrival was responsible for completing the initial assessment. He stated if the wound care nurse was available, she would also do the skin assessment, but if she was not then the nurse doing the admission would put in an interim order for wound care. He stated that as a nurse manager, he would review the admission assessment to make sure it was completed, but he would not preform another evaluation of the resident unless there was a complaint or a concern. He stated when Resident #1 was admitted , she had 2 nephrostomy bags that were positioned into each kidney, but one had fallen out. She did go see a urologist, but they were not able to put the bag back in due to internal damage, so it was left out. Resident #1 was also not able to tolerate a catheter due to previous damage to her urethra. He stated even with the use of a nephrostomy bag, Resident #1 could still experience leakage because the nephrostomy bag would not catch everything. He explained that if her bandages were soiled, there should be a PRN order to address it. The DON stated the facility's wound care nurse was out and the floor nurses were currently completing wound care. He stated the facility did not use a pure wick (an External Catheter for females) and did not know Resident #1 was admitted with a pure wick. He stated he did not know that she was still urinating. The DON stated the harm in a resident having a soiled bandage over a wound could be infection. If a resident had a soiled bandage, it could allow bacteria to grow, infect the skin, and infect the tissues that were trying to heal.

In an interview on 9/18/24 at 3:52 pm, LVN A stated she used to be one of the wound care nurses at the facility but currently worked the floor due to a decrease in the census. She stated when she performed the initial assessment with Resident #1, she did notice she had a pure wick in between her legs but she did not think anything of it. The facility did not use pure [NAME], so LVN A took it out and discarded it. LVN A stated the day of the assessment, an aide informed her that when they changed her brief, the brief was soiled, but they said it was due to drainage from the wound and they cleaned her up and put on a new brief. LVN A stated when she did wound care for Resident #1, she did not see a lot of drainage and she was not aware that Resident #1 would leak urine. She stated the harm in a resident having urine-soaked bandages over a wound would be a decline and a decreased healing process.

Record review of the facility's Wound Care policy revised October 2010 reflected that in preparation for wound care, nurses should:

1. Verify that there is a physician's order for this procedure.

2. Review the resident's care plan to assess for any special needs of the resident.

a. For example, the resident may have PRN orders for pain medication to be administered prior to would care.