

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Amarillo Center for Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 6641 W Amarillo Blvd Amarillo, TX 79106	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative when there is a significant change in the resident's physical status and/or a need to alter treatment significantly for 1 (Resident #1) of 8 residents reviewed for notification. The facility failed to inform Resident #1's physician and family member immediately when a stage 3 pressure ulcer was noted on his tailbone the evening of 07/19/26. This failure could place residents at risk of not receiving timely, appropriate care. Findings Included: Record review of Resident #1's admission record dated 07/24/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, central cord syndrome at unspecified level of cervical spinal cord subsequent encounter (incomplete spinal cord injury resulting in greater motor impairment in the upper extremities than the lower extremities), type 2 diabetes mellitus (insufficient production of insulin, causing high blood sugar), and quadriplegia C1-C4 incomplete (partial paralysis of all four limbs with some preserved motor or sensory function offering potential for recovery through rehabilitation). Resident #1 was discharged to an acute care hospital on [DATE] at 07:14 PM. Record review of Resident #1's admission MDS assessment completed on 07/03/26 revealed a BIMS score of 13 which indicated intact cognition. Section GG Functional Abilities revealed Resident #1 had impairment on both side of upper and lower extremities and utilized a wheelchair. He was dependent (Helper does ALL of the effort.) across all ADLs except for lying to sitting, sitting to lying and rolling left to right. For these three ADLs Resident #1 required substantial/maximal assistance (Helper does MORE THAN HALF the effort.). Section M Skin Conditions revealed Resident #1 was at risk for developing pressure ulcers/injuries and had a Pressure reducing device for bed. Record review of Resident #1's care plan initiated on 06/29/26 revealed he had Hemiplegia/Hemiparesis (paralysis) and would remain free of complications or discomfort. He was noted to have bowel incontinence, and staff were to Apply barrier cream after every incontinent episode. Resident #1 required two staff assistance with bed mobility. Resident #1 was noted to be at risk of developing pressure ulcers and on 07/20/26 the care plan was revised to note he had a stage 3 pressure ulcer on his sacrum (tailbone). One of the interventions initiated on 06/29/26 was to Inform the resident/family/caregivers of any new area of skin breakdown. The care plan had no mention of a pressure relieving device for his bed. Record review of Resident #1's active order summary dated 07/24/26 revealed the following orders with corresponding order dates: 06/26/26 May apply barrier cream as needed 06/26/26 May have pressure relieving mattress 07/20/26 W/C stage 3 sacrum: cleanse with wound cleanser, pat dry, apply medihoney, apply calcium alginate, cover with foam dressing daily and prn Record review of Resident #1's progress notes from 06/26/26 to 07/24/26 revealed the following: A note written by LVN B on (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676347
		If continuation sheet Page 1 of 7

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/20/26 at 10:30 AM Resident [family member] arrived to the facility, reporting to this nurse that resident stated he was told by the night nurse that he has a sore on his buttocks. This nurse advised upon rounding will look at area, as this nurse had not been given information in report by PM shift nurse. This nurse notified Wound care nurse immediately after assessing skin and noticing pressure injury to buttocks. A weekly ulcer assessment note written by WCN on 07/20/26 at 03:47 PM revealed stage 3 pressure ulcer to Resident #1's sacrum which measured 6.5 cm wide by 6 cm long by .2 cm deep. MD/NP notified about the wound on 07/20/26 at 03:50 PM. A transfer notification written by LVN C on 07/20/26 at 06:46 PM revealed Resident #1 was transferred to the hospital due to a change in condition. Record review of Resident #1's hospital records revealed he was admitted to the hospital for sepsis due to unspecified organism the night of 07/20/26. His temperature at 07:50 PM was 99 degrees Fahrenheit. He had a chronic indwelling catheter and no complaints of pain. He was noted to have severe sepsis with septic shock and a catheter associated urinary tract infection. On 07/23/26 the hospital called Resident #1's pressure ulcer unstageable and noted the base of the ulcer was obscured by slough (dead tissue that accumulates on the surface of a wound) and/or eschar (dead tissues that forms firm dry covering over a wound). During an interview on 07/24/26 at 07:37 AM Resident #1's family member stated Resident #1 was supposed to have an air mattress and was not given the air mattress. She stated when he was admitted to the facility on [DATE] she told staff he needed to have an air mattress. She stated Resident #1 developed a pressure ulcer and she was not notified about the pressure ulcer until she arrived to visit Resident #1 the morning of 07/20/26. She stated at that time Resident #1 told her the night nurse told him (Resident #1) about the pressure ulcer on the evening of 07/19/26. She stated she returned to the facility the evening of 07/20/26 and as she was standing in Resident #1's room ADM and some other nurses entered the room and she told them she was worried about Resident #1. ADM told her he could be sent to the hospital if she (Resident #1's family member) wanted him sent to the hospital. She stated she told ADM she did want him sent to the hospital. During an interview on 07/24/26 at 08:43 DOR stated Resident #1 often complained of pain in his left hip but never of pain on his bottom. During an interview on 07/24/26 at 10:28 AM LVN B stated she was the charge nurse for Resident #1 on 07/20/26. She stated RN M who worked the night before did not report to her or document in the EHR Resident #1's pressure ulcer. She stated she found out about the pressure ulcer when Resident #1's family member reported to her that Resident #1 was told by the night nurse he had a pressure ulcer. She stated Resident #1 had labs drawn that indicated elevated white blood cell count and she was confused by the labs due to him having no signs or symptoms or change in condition. She stated NP saw Resident #1 on 07/20/26 and that is when she entered orders for wound care. During an interview on 07/24/26 at 02:53 PM NP stated a stage 3 pressure ulcer could happen in a day or two. She stated it was not likely but was possible. NP stated Resident #1 not having an air mattress as ordered for 3 weeks could have contributed to him developing a pressure ulcer because the mattress would help distribute the pressure. NP stated having the air mattress might not have prevented Resident #1 from developing a pressure ulcer because pressure ulcer development was a result of a combination of things. During an interview on 07/24/26 at 07:13 PM RN M stated he noticed a pressure ulcer on Resident #1's bottom the evening of 07/19/26 and told Resident #1 about the pressure ulcer. He stated he did not think to notify the physician or family regarding the pressure ulcer. He stated a possible negative outcome of not documenting a developing pressure ulcer and not notifying the physician or family of the pressure ulcer was the resident can probably . get sicker. During an interview on 07/24/26 at 07:20 PM ADM stated a possible negative outcome of not documenting a developing pressure ulcer or notifying the family or physician was, Negative resident outcomes and potential delays in treatment or care. She (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident #1's family member was upset she was not notified of the pressure ulcer. During an interview on 07/24/26 at 07:26 PM RN N stated staff would not know how to care for a resident if a developing pressure injury was not documented and the physician and family notified. During an interview on 07/24/26 at 07:29 PM LVN O stated if staff did not document a developing pressure ulcer it might not be cared for, could become infected, and could get worse. She added that family and physician would not be notified. During an interview on 07/24/26 at 07:30 PM ADON A stated family members could be shocked if staff did not notify them of a developing pressure ulcer. She stated it was important to pass the information up the chain so the doctor would be notified. Record review of facility policy titled Pressure Injury: Prevention, Assessment and Treatment and dated 05/25/25 revealed the following: . 3. Upon assessment and identification of a pressure sore the staff nurse will notify the treatment nurse/designee. The treatment nurse/designee will: 1. Notify the physician of pressure sore and obtain and follow any orders as directed by the physician. 2. Notify family and dietary department. Document Notification .Record review of an undated facility policy titled Resident Rights revealed the following: . 14. Notification of changes (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is - . b. A significant change in the resident's physical .status 9that is a deterioration in health.) c. A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment) .Record review of an undated facility policy titled Notifying the Physician of Change in Status revealed the following: The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. 1. The nurse will notify the physician or their delegated nurse practitioner or physician assistant with change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record. 5. The resident's family member . should be notified of a significant change in resident's status unless the resident has specified otherwise.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for 1 (Resident #1) of 8 residents reviewed for pressure ulcers. The facility failed to install an air mattress ordered as an option for Resident #1 on 06/26/26 until 07/20/26 when he was found to have a stage 3 pressure ulcer. This failure could place residents at risk of developing pressure ulcers and of not receiving accurate/necessary care/treatment. Findings Included: Record review of Resident #1's admission record dated 07/24/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, central cord syndrome at unspecified level of cervical spinal cord subsequent encounter (incomplete spinal cord injury resulting in greater motor impairment in the upper extremities than the lower extremities), type 2 diabetes mellitus (insufficient production of insulin, causing high blood sugar), and quadriplegia C1-C4 incomplete (partial paralysis of all four limbs with some preserved motor or sensory function offering potential for recovery through rehabilitation). Resident #1 was discharged to an acute care hospital on [DATE] at 07:14 PM. Record review of Resident #1's admission MDS assessment completed on 07/03/26 revealed a BIMS score of 13 which indicated intact cognition. Section GG Functional Abilities revealed Resident #1 had impairment on both side of upper and lower extremities and utilized a wheelchair. He was dependent (Helper does ALL of the effort.) across all ADLs except for lying to sitting, sitting to lying and rolling left to right. For these three ADLs Resident #1 required substantial/maximal assistance (Helper does MORE THAN HALF the effort.). Section M Skin Conditions revealed Resident #1 was at risk for developing pressure ulcers/injuries and had a Pressure reducing device for bed. Record review of Resident #1's care plan initiated on 06/29/26 revealed he had Hemiplegia/Hemiparesis (paralysis) and would remain free of complications or discomfort. He was noted to have bowel incontinence, and staff were to Apply barrier cream after every incontinent episode. Resident #1 required two staff assistance with bed mobility. Resident #1 was noted to be at risk of developing pressure ulcers and on 07/20/26 the care plan was revised to note he had a stage 3 pressure ulcer on his sacrum (tailbone). One of the interventions initiated on 06/29/26 was to Inform the resident/family/caregivers of any new area of skin breakdown. The care plan had no mention of a pressure relieving device for his bed. Record review of Resident #1's active order summary dated 07/24/26 revealed the following orders with corresponding order dates: 06/26/26 May apply barrier cream as needed 06/26/26 May have pressure relieving mattress 07/20/26 W/C stage 3 sacrum: cleanse with wound cleanser, pat dry, apply medihoney, apply calcium alginate, cover with foam dressing daily and prn Record review of Resident #1's progress notes from 06/26/26 to 07/24/26 revealed the following: A skin assessment note written by ADON A on 06/26/26 revealed no skin concerns except scabbed area to forehead from a fall at home. A skin assessment note written by WCN on 06/29/26 revealed no skin concerns except lacerations to side of face A skin assessment note written by WCN on 07/03/26 revealed no skin concerns except the lacerations to side of face. A skin assessment note written by WCN on 07/14/26 revealed no skin concerns. A note written by LVN B on 07/20/26 at 10:30 AM Resident [family member] arrived to the facility, reporting to this nurse that resident stated he was told by the night nurse that he has a sore on his buttocks. This nurse advised upon rounding will look at area, as this nurse had not been given information in report by PM shift nurse. This nurse notified Wound care nurse immediately after assessing skin and noticing (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure injury to buttocks.A note written by WCN on 07/20/26 at 03:45 PM revealed no skin concerns.A weekly ulcer assessment note written by WCN on 07/20/26 at 03:47 PM revealed stage 3 pressure ulcer to Resident #1's sacrum which measured 6.5 cm wide by 6 cm long by .2 cm deep. MD/NP notified about the wound on 07/20/26 at 03:50 PM.A transfer notification written by LVN C on 07/20/26 at 06:46 PM revealed Resident #1 was transferred to the hospital due to a change in condition.Record review of Resident #1's hospital records revealed he was admitted to the hospital for sepsis due to unspecified organism the night of 07/20/26. His temperature at 07:50 PM was 99 degrees Fahrenheit. He had a chronic indwelling catheter and no complaints of pain. He was noted to have severe sepsis with septic shock and a catheter associated urinary tract infection. On 07/23/26 the hospital called Resident #1's pressure ulcer unstageable and noted the base of the ulcer was obscured by slough (dead tissue that accumulates on the surface of a wound) and/or eschar (dead tissues that forms firm dry covering over a wound).During an interview on 07/24/26 at 07:37 AM Resident #1's family member stated Resident #1 was supposed to have an air mattress and was not given the air mattress. She stated when he was admitted to the facility on [DATE] she told staff he needed to have an air mattress. She stated Resident #1 developed a pressure ulcer and she was not notified about the pressure ulcer until she arrived to visit Resident #1. She stated at that time Resident #1 told her the night nurse told him (Resident #1) about the pressure ulcer on the evening of 07/19/26. Resident #1's family member stated she was upset Resident #1 had not received an air mattress and was in the hallway outside of Resident #1's room expressing her frustration on 07/20/26 when DOR stated Resident #1 should have had an air mattress. She stated she returned to the facility the evening of 07/20/26 and as she was standing in Resident #1's room ADM and some other nurses entered the room, and she told them she was worried about Resident #1. ADM told her he could be sent to the hospital if she (Resident #1's family member) wanted him sent to the hospital. She stated she told ADM she did want him sent to the hospital.During an interview on 07/24/26 at 08:28 AM ADON D stated when a physician ordered an air mattress for a resident HSK was the person who installed the air mattress. She stated all of the facility's mattresses were convertible to air mattresses. HSK would install the portion that converted the mattress to an air mattress when nursing staff requested that she do so.During an observation and interview on 07/24/26 at 08:37 AM HSK pointed to a box hanging off the end of an empty bed. She stated that it was the part that converted a regular mattress to an air mattress. She stated the empty bed belonged to Resident #1. HSK stated she had documentation in a group chat indicating she was asked by management to install the air mattress component on Resident #1's bed on 07/20/26. She stated she installed the component on 07/20/26.During an interview on 07/24/26 at 08:43 AM DOR stated he remembered Resident #1's family member being upset about Resident #1 not receiving an air mattress at admission on [DATE]. He stated he did not say Resident #1 should have had an air mattress. DOR stated he said Resident #1 could benefit from having an air mattress. DOR stated he had worked Monday through Friday each week with Resident #1 on physical therapy and during those 2-4 hours Resident #1 had been sitting up in his wheelchair with an air cushion in the seat of his wheelchair to relieve pressure. DOR stated Resident #1 often complained of pain in his left hip but never of pain on his bottom.During an interview on 07/24/26 at 08:58 AM RN E stated he used to be the wound care nurse for the facility but had transitioned to charge nurse. He stated a possible negative outcome of not giving a resident an ordered air mattress was the resident could develop a pressure wound.During an interview on 07/24/26 at 10:01 AM ADON D stated WCN was not in the building as she was suspended. ADON D stated a possible negative outcome of not giving a resident an air mattress when ordered by the physician was the resident could develop a pressure injury. She stated the charge (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse on duty when a resident was admitted to the facility was responsible for entering physician's orders into the EHR and for ensuring the orders are followed. She stated in the case of Resident #1 the charge nurse should have alerted HSK to Resident #1's need for an air mattress. ADON D stated the charge nurse on duty when Resident #1 was admitted was LVN B. She stated if the charge nurse did not notify HSK of the need for the air mattress ADONs or DON should do so. ADON D stated she did not know why Resident #1 did not get an air mattress at admission as ordered by the physician. During an interview on 07/24/26 at 10:22 AM RN F stated she worked with Resident #1 often and trained SNAs on incontinent and catheter care with Resident #1. She stated the last time she worked with Resident #1 was 07/16/26 and she provided incontinent care for him on that date. She stated she had not noted any redness or skin breakdown to Resident #1's bottom. RN F stated Resident #1 had never complained of pain to her. During an interview on 07/24/26 at 10:36 AM LVN G stated a resident's skin could break down if they were ordered an air mattress and did not receive it for 3 weeks. She stated if she was the admitting nurse for a resident who had an order for an air mattress she would contact HSK and ask her to install the air mattress. During an interview on 07/24/26 at 10:28 AM LVN B stated she was the charge nurse when Resident #1 was admitted to the facility. She stated HSK or ADONs were responsible for getting an air mattress. She stated she did not alert any of them to Resident #1's order for an air mattress because she didn't notice they hadn't gotten it (air mattress) yet. LVN B stated she did not think Resident #1's pressure ulcer was a result of him not getting an air mattress as ordered. She stated there was a multitude of things that need to happen when somebody can't move themselves. LVN B stated staff needed to reposition the resident every 3 hours and place an air cushion in his wheelchair. She stated that would help take the pressure off of his bottom. LVN B stated an air mattress would do the same thing. She stated Resident #1 had labs drawn that indicated elevated white blood cell count and she was confused by the labs due to him having no signs or symptoms or change in condition. She stated NP saw Resident #1 on 07/20/26 and that is when she entered orders for wound care. During an interview on 07/24/26 at 11:39 AM CNA H stated when she provided care for Resident #1, she put barrier cream on his bottom with each brief change. She stated when she cared for him on 07/16/26 she noticed an area the size of a nickel where his butt cheeks met that was red and slightly peeling. She stated she and LVN C changed Resident #1's brief together and she reported the area to LVN C. CNA H stated she was not certain the area was not caused when they used the draw sheet to move Resident #1 side to side. CNA H stated she would reposition Resident #1 approximately 4 times per shift because sometimes when she asked to reposition him, he declined and stated he was comfortable as he was. During an interview on 07/24/26 at 11:54 AM SNA I stated he provided incontinent care for Resident #1 on 07/17/26 and 07/18/26. He stated he applied barrier cream to Resident #1's bottom after each incontinent episode and did not notice any redness or skin breakdown on Resident #1's bottom. He stated he would attempt to reposition Resident #1 every two hours but would only actually reposition him 3-4 times a shift because the other times Resident #1 refused to be repositioned. During an interview on 07/24/26 at 12:08 PM SNA J stated she helped SNA I provide incontinent care to Resident #1 on 07/17/26 and 07/18/26 and did not notice any skin breakdown or redness on his bottom. She stated they applied barrier cream to his bottom after each brief change. During an interview on 07/24/26 at 12:15 PM SNA K stated she bathed and provided incontinent care for Resident #1 on 07/15/26. SNA K stated she did not notice any skin redness or breakdown on his bottom. She stated she repositioned Resident #1 every hour and a half because he asked to be repositioned that often. During an interview on 07/24/26 at 12:42 PM LVN C stated she worked with Resident #1 on 07/15/26 and did not notice any redness or skin breakdown on his bottom. She stated (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she applied barrier cream each time she changed or helped to change his brief. LVN C stated she and the aides who worked with her repositioned Resident #1 at least every 2 hours. During an interview on 07/24/26 at 01:37 PM ADM stated WCN was not suspended for anything to do with Resident #1. During an interview on 07/24/26 at 01:42 PM SNA L stated she worked with Resident #1 and he complained of pain in his legs but not his bottom. She stated she did not notice any redness or breakdown of the skin on his bottom. During an interview on 07/24/26 at 02:53 PM NP stated a stage 3 pressure ulcer could happen in a day or two. She stated it was not likely but was possible. NP stated Resident #1 not having an air mattress as ordered for 3 weeks could have contributed to him developing a pressure ulcer because the mattress would help distribute the pressure. NP stated having the air mattress might not have prevented Resident #1 from developing a pressure ulcer because pressure ulcer development was a result of a combination of things. During an interview on 07/24/26 at 07:13 PM RN M stated he worked with Resident #1 the night of 07/19/26. He stated he told Resident #1 he was developing a pressure ulcer. RN M stated he thought he told the day shift nurse about the pressure ulcer. He stated a possible negative outcome of not documenting a developing pressure ulcer and not notifying the physician of the pressure ulcer was the resident can probably get sicker. RN M stated Resident #1 not having an air mattress as ordered did not contribute to him developing a pressure ulcer because we were turning him. During an interview on 07/24/26 at 07:20 PM ADM stated a possible negative outcome of not documenting a developing pressure ulcer was, Negative resident outcomes and potential delays in treatment or care. She stated she did not think Resident #1 not having an air mattress as ordered for his first three weeks in the facility contributed to him developing a pressure injury. During an interview on 07/24/26 at 07:26 PM RN N stated staff would not know how to care for a resident if a developing pressure injury was not documented and the physician and family notified. During an interview on 07/24/26 at 07:29 PM LVN O stated if staff did not document a developing pressure ulcer it might not be cared for, could become infected, and could get worse. She added that family and physician would not be notified. During an interview on 07/24/26 at 07:30 PM ADON A stated an air mattress as ordered for Resident #1 could assist with pressure ulcer prevention but not having an air mattress does not cause a pressure ulcer. Record review of facility policy titled Pressure Injury: Prevention, Assessment and Treatment and dated 05/25/25 revealed the following: . 1. Nursing personnel will continually aim to maintain the skin integrity, tone, turgor and circulation to prevent breakdown, injury and infection. Residents identified at risk will have person centered care planned approaches to attempt to prevent pressure injuries from developing. 4. Causes of Pressure Injuries: . 3. Paralysis which results in the inability to move off of an area of prolonged pressure. 4. Loss of skin sensitivity with resulting loss of awareness of prolonged pressure.		