

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/20/2025
NAME OF PROVIDER OR SUPPLIER  The Broadmoor at Creekside Park		STREET ADDRESS, CITY, STATE, ZIP CODE  5665 Creekside Forest Drive The Woodlands, TX 77389	

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 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 6 residents (CR #1) reviewed for quality of care.-The facility failed to ensure a thorough head to toe skin assessment was completed on CR #1 on 8/29/25. CR #1 was discharged to an acute care hospital on 8/30/25 and was diagnosed with a left groin abscess.This failure could place residents at risk of delayed treatment, pain and infection.Findings Include:Record review of CR #1's admission record dated 11/10/25 revealed a [AGE] year-old male who admitted on [DATE] and discharged on 8/30/25 to an acute care hospital. His diagnosis included in part, Alzheimer's disease, pain, basal cell carcinoma of skin of left upper limb, and basal cell carcinoma of skin of right upper limb. (Basal cell carcinoma is a type of skin cancer).Record review of CR #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 out of 15 which indicated severe cognitive impairment. He required supervision or touching assistance and setup or clean-up assistance with ADL care. He did not exhibit behaviors of rejection of care during the assessment period.Record review of CR #1's care plan revealed he had impaired urinary elimination related to obstruction of urinary flow secondary to enlarged prostate gland. Interventions were to assess and monitor urinary incontinence and skin condition, assess and monitor urinary status and signs/symptoms of infection, perineal care, date initiated 5/28/25. CR #1 was at risk for pressure ulcer related to decreased mobility, incontinent of bowel and bladder, use of right ankle brace, use of CPAP at bedtime, CR #1 reluctant to allow staff to assist with peri care and/or ADL care, date initiated 12/1/24 and revised on 9/5/25. Interventions were to check skin for redness, skin tears, swelling, or pressure areas. Report any signs of skin breakdown, date initiated 1/3/25. Record review of CR #1's Order Summary Report dated 11/20/25 indicated an order for Weekly Head to Toe Skin Assessment every day shift every Friday, N=new, E=existing skin alteration, C=clear, order date 1/7/25.Record review of CR #1's nursing note dated 8/27/25 written by LVN F read in part, Resident's sitter reported to this writer about 1030 hrs (10:30 a.m.) that resident's pullup had what appears to be a little bit of blood-tinged urine in it. This writer monitored resident for other bleeding the rest of the shift and none was seen. Provider notified of isolated incident and order was given for UA with C&amp;S. [family members] notified.Record review of CR #1's SBAR dated 8/27/25 completed by LVN F revealed the resident had blood in urine and a skin evaluation was not clinically applicable to the change in condition being reported.Record review of CR #1's MAR for August 2025 indicated on 8/29/25 a weekly head to toe skin assessment was documented as completed by LVN J. There was an e documented which indicated existing skin alteration. Record review of CR #1's nursing note dated 8/29/25 written by LVN J read in part, .late entry. skin assessment completed, noted with existing upper back skin abnormalities. No s/s of redness/infection noted to right shoulder biopsy site. Skin intact. Resident schedule for DERM appointment today.Record review of CR #1's nursing note dated 8/30/25 written by LVN F read in part, Resident noted with what appears to be an abscess to the left groin area, between the crease of the left leg and the pubic area. Abscess was draining and had a real foul odor. Resident groaned in pain when palpated (examined by touch). [Family member] at bedside. Vitals stable. NPs of MD J was notified, and they ordered for him to be sent to the ED for further evaluation.Record review of CR #1's hospital records dated 9/4/25 indicated CR #1 was admitted from the ED on 8/30/25 and on 8/31/25 had an incision and drainage of left groin. The infectious disease progress note revealed a 3.6 x 2.3 cm medial (middle) left groin abscess adjacent to hip adductors (a group of muscles located in the medial compartment of the thigh). Assessment/plan: polymicrobial (several types of microorganisms) left inguinal (groin) abscess with enteric flora (bacteria that exist in the intestines of animals and humans) status post-surgical I&amp;D with clinical improvement. CT of the abdomen and pelvis with IV contrast completed on admission without evidence of any perineal or GI tract pathology to explain abscess formation. Exam on admission did show evidence of skin breakdown in the area with 2 wounds which could have led to contamination with enteric flora due to its location and eventual abscess formation.In an interview on 11/18/25 at 2:26 p.m. LVN F said CR #1 had a private sitter and a few days before he was sent out to the hospital the sitter said there was a little bit of blood in his pull up. She said she and another staff did a skin check on CR #1 (on 8/27/25) and did not see any open areas. She said there was no pain or odor. She said she tried to look in the creases but did not pry because CR #1 would not allow it. refused to be touched and was not easy to redirect. CR #1 said no stop and zipped up his pants</p>		