STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676363	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remarkable Healthcare of Prestonwood	4501 Plano Parkway Carrollton, TX 75010

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 - 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** 44405 Based on interviews and record review, the facility failed to notify and consult with the resident's physician of a significant change in the resident's physical, mental, or psychosocial status that is, a deterioration in health, mental, or psychosocial status for 1 (Resident #1) of 5 residents reviewed for Notification of Changes. 1. The facility failed to notify the wound physician on 01/11/24 about an open area discovered on Resident #1's sacrum. The area developed into an unstageable pressure ulcer (PU) (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present) to the sacrum. The WMD assessed and evaluated the sacrum wound on 01/23/24. The WMD categorized the wound as Unstageable (due to necrosis [death of body tissue]) and surgical excisional debridement was performed on the sacrum wound. The WMD categorized the sacrum wound as a Stage 4 pressure wound after the second surgical excisional debridement (cutting away of devitalized [injured, damaged] wound tissue, necrosis, or slough [yellow/white material in the wound bed] down to viable [healthy] tissue, and outside or beyond wound margin using a blade/scalpel) on 01/30/2024. This failure could place residents with wounds at an increased and unnecessary risk of complications such as pain, acquiring new wounds, worsening of existing wounds, and infection. Findings included: A record review of Resident #1's Annual MDS Assessment, dated 01/02/24, revealed a [AGE] year-old female, admitted to the facility on [DATE]. Resident #1 had diagnoses of Alzheimer's disease (a progressive disease beginning with mild memory loss); Encounter for palliative care; Muscle wasting and atrophy; and Muscle weakness (generalized). Resident #1's BIMS Summary Score was 06, which suggested severe impaired cognition. Resident #1's functional abilities required one-person physical assist with ADLs and transfers. Resident #1 was frequently incontinent of bowel and bladder. Section M - Skin conditions of the Annual MDS Assessment revealed Resident #1 had one or more unhealed pressure ulcers/injuries. Resident #1 had a Stage 4 pressure ulcer and an unstageable pressure injury presented as a deep tissue injury over bony prominences; and was at risk for developing pressure ulcers/injuries based on clinical assessment. Pressure reducing devices for chair and bed, pressure ulcer/injury care, a turning/repositioning program, and applications of ointments/medication other than to feet were active skin and ulcer/injury treatments in place. Resident #1 was under hospice services. (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: 676363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remarkable Healthcare of Prestonwood	4501 Plano Parkway Carrollton, TX 75010

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 - Actual harm Residents Affected - Few	Record review of Resident #1's comprehensive care plan [Date initiated: 04/16/2016; Next Review Date: 12/04/23] Focus problem(s) reflected impaired cognitive function; bladder/bowel incontinence; potential for pressure ulcer development; communication problem; unstageable (DTI) pressure injury to right heel; receiving hospice services; Stage 4 pressure injury to left heel; and ADL self-care performance deficit. Resident #1's care plan goals indicated maintain current level of cognitive function; remain free from skin breakdown r/t incontinence; have intact skin, free of redness, blisters, or discoloration; and will be free from infection or complications r/t unstageable DTI pressure injury to right heel and Stage 4 pressure injury to left heel through review date (Target Date: 03/04/24). Resident #1's care plan interventions/tasks revealed bedside care and assistance, medication administration, pain control, fall prevention, position changes, teaching moments, monitoring, and reporting to doctor as needed, to improve the resident's comfort and health. Record review of Resident #1's Wound Evaluation and Management Summary, dated 01/23/24, revealed the WMD performed an initial evaluation of an unstageable (due to necrosis) wound to the sacrum. The WMD documented the etiology (quality) of the wound was Pressure, was Unstageable, a duration of greater than 5 days, measured (LxWxD) 5 cm x 6 cm x Not Measurable [depth is unmeasurable due to presence of nonviable tissue and necrosis (The skin is severely damaged, and the surrounding tissue begins to die)], and light serous exudate. A surgical excisional debridement procedure was performed to the sacrum and a dressing treatment plan was ordered to perform wound care daily for 30 days. Record review of Resident #1's progress notes did not reflected documentation that the WMD was notified of a wound consultation to assess and evaluate the open area to the sacrum. During an interview on 01/29/24 at 11:02 AM, LVN C indicated she was the 6A - 2P nurse Monday through Friday. LVN C indicated the 2P - 10P shift was responsible for providing wound care. LVN C said that skin assessments were completed weekly by the 2P - 10P shift and as needed. LVN C said that although wound care was not scheduled on her shift, she was still responsible for implementing care to prevent skin breakdown and assessing a resident if it was reported to her about a concern about a resident skin noted during a shower or incontinent care. LVN C said that the WMD followed Resident #1 for other wounds and thought ADON A informed the WMD [on 01/11/24] about the open area to Resident #1's sacrum. An outbound call to the WMD on 01/29/24 at 11:09 AM indicated the WMD rounded at the facility every Tuesday. The WMD followed Resident #1 for wounds to the left and right heels. During the wound care visit on 01/23/24, facility nursing staff informed [the WMD] of a wound consultation for Resident #1. The WMD conducted an initial evaluation of Resident #1's sacrum wound on 01/23/24. The WMD indicated the wound exacerbated due to generalized decline of Resident #1, infection, and compromised nutritional status. The WMD ordered Santyl and Xeroform Gauze as a primary dressing and a bordered gauze as a secondary dressing. The WMD recommended to off-load the wound, reposition per facility policy, and low air loss mattress. The WMD anticipated wound healing over two months and would see Resident #1 at the next visit (01/30/24). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Remarkable Healthcare of Prestonwood		STREET ADDRESS, CITY, STATE, ZIP CODE 4501 Plano Parkway Carrollton, TX 75010	

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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 0580 Level of Harm - Actual harm Residents Affected - Few	During a follow-up interview on 02/23/24 at 12:40 PM, ADON A indicated that there were wound and skin management standing delegation orders in place to treat minor skin tears, abrasions, intact and shallow skin impairment with no or minimal drainage. Treatments included cleaning, topical barrier ointments and creams, dressing change frequency, and protecting the site. ADON A said wounds that were open to the level of fatty tissue (or deeper), mostly red, had more than minimal drainage, or non-healing wounds required a consultation with the WMD. ADON A said that he rounded with the WMD during weekly visits to provide support, and complete wound documentation. ADON A said that the WMD needed to assess a wound to determine the appropriate treatment. ADON A said that a nurse would notify him of a change in wound condition or if a wound consult was needed and he would send the face sheet to the WMD as notification. ADON A said that Resident #1 was already followed by the WMD and thought he notified the WMD about the open area discovered to the sacral area. During a follow-up interview on 02/23/2024 at 1:30 PM, LVN C indicated that she vaguely recalled [on 01/11/24] that a CNA (could not recall who it was) called her into Resident #1's room to look at Resident #1's buttocks for possible skin breakdown. LVN C said that she saw a dime-sized open area to the upper midline groove that separates the buttocks. LVN C said that she notified Resident #1's primary physician and received a telephone order to provide treatment [Clean sacrum with wound cleanser, pat dry, apply xeroform and cover with border gauze every evening (2P - 10P) shift] and to consult the WMD. LVN C said that she notified ADON A that Resident #1 needed a wound consult. LVN C said that was the facility protocol to notify the ADON/DON when a resident required a Specialist/Wound Doctor Consultation. The ADON/DON would request the consultation and rounded with the WMD during weekly visits. LVN C said that she did not document the communication with the primary physician or ADON and did not follow-up if the WMD was consulted. LVN C said that documentation was important to ensure continuity of care and consistency. Record review of the facility's Change of Condition and Physician/Family Notification policy, revised 03/25/21, reflected the purpose to ensure resident's family and physician are notified of changes that fall under: - an accident resulting in injury that has the potential for needed physician interventions - a significant change (example given: Abnormal lab results) - a need to significantly alter treatment - transfer of the resident from the facility

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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 - 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** 44405 Based on interviews, observations, and record reviews, the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote the prevention of pressure ulcer/injury development, the healing of existing pressure ulcers/injuries, and prevent development of additional pressure ulcer/injury for 1 (Resident #1) of 5 residents reviewed for quality of care, in that: 1. The facility failed to consistently perform weekly skin assessments for Resident #1. 2. On 01/11/24, LVN C notified the primary physician of a dime-sized open area to Resident #1's sacrum. The facility implemented the interventions/treatment to the open area but failed to consult the WMD (for 12 days, 01/11/24 - 01/23/24) as ordered. 3. The facility failed to monitor and reassess the wound to Resident #1's sacrum for evidence of progress toward healing. The wound developed into an unstageable pressure ulcer (PU) (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present). 4. The WMD assessed and evaluated the sacrum wound on 01/23/24. The WMD categorized the wound as Unstageable (due to necrosis [death of body tissue]) and surgical excisional debridement was performed on the sacrum wound. The WMD categorized the sacrum wound as a Stage 4 pressure wound after the second surgical excisional debridement (cutting away of devitalized [injured, damaged] wound tissue, necrosis, or slough [yellow/white material in the wound bed] down to viable [healthy] tissue, and outside or beyond wound margin using a blade/scalpel) on 01/30/2024. These failures could place residents with wounds at an increased and unnecessary risk of complications such as pain, acquiring new wounds, worsening of existing wounds, and infection. Findings included: A record review of Resident #1's Annual MDS Assessment, dated 01/02/24, revealed a [AGE] year-old female, admitted to the facility on [DATE]. Resident #1 had diagnoses of Alzheimer's disease (a progressive disease beginning with mild memory loss); Encounter for palliative care; Muscle wasting and atrophy; and Muscle weakness (generalized). Resident #1's BIMS Summary Score was 06, which suggested severe impaired cognition. Resident #1's functional abilities required one-person physical assist with ADLs and transfers. Resident #1 was frequently incontinent of bowel and bladder. Section M - Skin conditions of the Annual MDS Assessment revealed Resident #1 had one or more unhealed pressure ulcers/injuries. Resident #1 had a Stage 4 pressure ulcer and an unstageable pressure injury presented as a deep tissue injury over bony prominences; and was at risk for developing pressure ulcers/injuries based on clinical assessment. Pressure reducing devices for chair and bed, pressure ulcer/injury care, a turning/repositioning program, and applications of ointments/medication other than to feet were active skin and ulcer/injury treatments in place. Resident #1 was admitted to hospice services on 07/14/23. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's comprehensive care plan [Date initiated: 04/16/2016; Next Review Date: 12/04/23] Focus problem(s) reflected impaired cognitive function; bladder/bowel incontinence; potential for pressure ulcer development; communication problem; unstageable (DTI) pressure injury to right heel; receiving hospice services; Stage 4 pressure injury to left heel; and ADL self-care performance deficit. Resident #1's care plan goals indicated maintain current level of cognitive function; remain free from skin breakdown r/t incontinence; have intact skin, free of redness, blisters, or discoloration; and will be free from infection or complications r/t unstageable DTI pressure injury to right heel and Stage 4 pressure injury to left heel through review date (Target Date: 03/04/24). Resident #1's care plan interventions/tasks revealed bedside care and assistance, medication administration, pain control, fall prevention, position changes, teaching moments, monitoring, and reporting to doctor as needed, to improve the resident's comfort and health. A record review of Resident #1's current Physician's orders reflected: - Start Date 07/14/23: Complete Weekly Skin Assessment. Every evening shift, every Saturday. - Start Date 11/10/23: No shoe on the left foot in pressure boot. Every shift for wound left heel to decrease pressure to foot. - Start Date 01/11/24 [Discontinued 01/24/24]: Treatment: Clean sacrum with wound cleanser, pat dry, apply xeroform and cover with border gauze. Every evening shift for Wound Healing. - Start Date 01/24/24: [Discontinued 01/30/24] Treatment: Clean sacrum with wound cleanser, pat dry, apply Santyl, xeroform and cover with border gauze. May use Wound Gel if Santyl is unavailable. Every evening shift for wound healing. - Start Date 01/24/24: Clean DTI to the right heel, pat dry and apply skin prep to area. Every evening shift for wound healing. - Start Date 01/24/24 [Discontinued: 01/29/24]: Clean wound to left heel with NS, pat dry, apply Antimicrobial wound gel and xeroform, and secure with border dressing daily. Every evening shift for wound healing. - Start Date 01/29/24: Clean wound to the left heel with NS, pat dry, apply Santyl, xeroform and secure with border dressing daily. Every evening shift for wound healing. - Start Date 01/31/24: Treatment: Clean sacrum with wound cleanser, pat dry, apply Alginate Calcium with Silver. Apply Metronidazole sprinkles and cover with border gauze. Cleanse peri wound with Dakin's [solution]. Every evening shift for wound healing. A record review of Resident #1's TAR for January 2024 and February 2024 revealed wound care orders were completed as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's Wound Evaluation and Management Summary's, dated 01/09/24 and 01/16/24, reflected the WMD evaluated and treated wounds on Resident #1's left and right heels. The left heel was a Stage 4 pressure wound greater than 119 days and the right heel was an unstageable DTI with intact skin greater than 71 days. The WMD did not evaluate or provide further intervention for other wounds in these or previous visits. Record review of Resident #1's Wound Evaluation and Management Summary, dated 01/23/24, revealed the WMD performed an initial evaluation of an unstageable (due to necrosis) wound to the sacrum. The WMD documented the etiology (quality) of the wound was Pressure, was Unstageable, a duration of greater than 5 days, measured (LxWxD) 5 cm x 6 cm x Not Measurable [depth is unmeasurable due to presence of nonviable tissue and necrosis (The skin is severely damaged, and the surrounding tissue begins to die)], and light serous exudate. A surgical excisional debridement procedure was performed to the sacrum and a dressing treatment plan was ordered to perform wound care daily with Santyl, Xeroform gauze, and cover with bordered gauze dressing for 30 days. As a result of the procedure, 20 percent of nonviable tissue was removed. Record review of Resident #1's Wound Evaluation and Management Summary, dated 01/30/24, revealed the WMD performed a surgical excisional debridement procedure of the sacrum wound. As a result of the procedure, the nonviable tissue decreased to 40 percent. A dressing treatment plan reflected: . discontinue Santyl and Xeroform Gauze. Add Alginate Calcium with Silver and Metronidazole Sprinkled, continue secondary bordered gauze dressing. Cleanse peri wound with Dakin's [solution] once daily for 30 days. The WMD indicated Resident #1's wound exacerbated due to generalized decline (increased weakness, fatigue, and drowsiness. Changes in cognitive and functional abilities), bacterial skin infection (inflammation of the skin and subcutaneous tissues), and compromised nutritional status. A record review of Resident #1's clinical assessments revealed Skin Assessments: Type: Weekly Date and time: 01/02/24 at midnight Signed and locked: 01/04/24 at 11:05 PM by LVN E Skin Condition: Intact. Site(s): BLANK Comments: LVN E entered, healing pressure wound on the left heel, boots on the left leg without shoes per order, continue to monitor. Type: Weekly Date and time: 01/11/24 at midnight Signed and locked: 01/21/24 at 10:02 PM by ADON A Skin Condition: Intact. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Site(s): BLANK Comments: ADON A entered, healing pressure wound on the left heel, boots on the left leg without shoes per order, continue to monitor. Type: Admission Date and time: 01/28/24 at 8:00 AM Signed and locked: 01/28/24 at 8:44 AM by LVN F Skin Condition: Bruises . Redness . New Area. Site(s): Right lateral heel - Stage 1 quarter size no drainage, purple discoloration. Left heel - Stage 3, measured (L x W x D) 4.0 cm x 4.5 cm x 0.2 cm, 25% yellow slough, redness to peri wound, moderate amount of serous sanguineous drainage. Left lateral foot - Stage 1, measured 1.5 cm x 1.5 cm x 0 cm. Sacrum - Stage 3, measured 8.0 cm x 7.5 cm x 2.0 cm, eschar, large amount of purulent drainage. Comments: LVN F entered, Need turning Q2H and PRN, will continue to monitor. Neighbor [Resident #1] has poor appetite. Type: Wound Nurse Weekly Skin Assessment Date and time: BLANK Signed and locked: 01/29/24 at 1:16 PM by LVN C Skin Condition: Bruises . Redness . New Area. Site(s): Left heel: Type - Pressure, Stage - IV, measured (L x W x D) 2.0 cm x 2.0 cm x 0.4 cm. Sacrum: Type - Necrosis, Stage - II, measured 5.0 cm x 6.0 cm x N/A. Right heel: Type - Pressure, Stage - Suspected Deep Tissue Injury, measured 3 cm x 2.5 cm x N/. Description of wounds: Stage 4 Pressure Wound of the Left heel full thickness. Exudate light serous drainage. Has no odor. Thick adherent devitalized necrotic tissue, granulation tissue at 40%, other viable tissue at 40%. Unstageable Sacrum Full thickness has some odor, Exudate light serous drainage, and thick adherent devitalized necrotic tissue at 100%. Unstageable DTI Right Heel undermined thickness has no odor or drainage. Skin is intact with purple/ maroon discoloration. Comments: LVN C entered, Recommendation for neighbor are off load wound, Low air loss Mattress, reposition per facility protocol, Float Heels in bed, and wear pressure off loading boats. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A record review of the Weekly Skin Log for January 2024 [01/02/24, 01/09/24, 01/16/24, and 01/23/24] reflected Resident #1 had a wound to the left heel and right foot. The Weekly Skin Logs did not reflect a wound to the sacrum on Resident #1. Record review of Resident #1's progress notes reflected: On 01/04/24 at 10:56 PM, LVN E wrote that a Weekly Skin Assessment was completed. On 01/16/24 at 12:47 PM, a Plan of Care Note entered by Social Services, indicated a Quarterly care conference was held (01/16/24) with the RP and other family members in attendance via telephone. ADON discussed wound care; wounds on heels are improving . Next care conference 04/10/24. On 01/17/24 at 9:41 AM, LVN G wrote, Sacral wound dressing removed and redressed. Redness is minimal with no drainage noted. Monitoring is ongoing. On 01/21/24 at 10:01 PM, ADON A wrote that a Weekly Skin Assessment was completed. Healing pressure wound on the left heel . On 01/24/24 at 12:00 PM, LVN G wrote, [Resident #1] has a new order for treatment. Clean sacrum wound with wound cleanser, pat dry, apply Santyl, xeroform and cover with border gauze. On 01/28/24 at 8:32 AM, LVN C wrote that a Weekly Skin Assessment was completed. Need turning Q2H and PRN, will continue to monitor, [Resident #1] has poor appetite. Observation on 01/29/24 at 10:45 AM, revealed Resident #1 on a low air loss mattress lying on her back with head of bed raised approximately 45 degrees and heel boots applied to both feet. Resident #1 was non-interviewable. Resident #1 did not present with visible injuries or behavior suggestive of abuse, neglect, or SQC. During observation of wound care on 01/29/24 at 10:47 AM, LVN C perform wound care to Resident #1. ADON A assisted LVN C with positioning of Resident #1 during wound care. LVN C observed and assessed wounds to left heel, right heel, and sacrum prior to performing treatment. The old dressings that were removed were dated 01/28/2024. During treatment to the sacrum wound, the old dressing presented a brown discoloration and there was a slight odor to the wound. The wound bed to the left lateral border appeared pink in color. The remaining area of the wound bed was covered with dry, black tissue. LVN C performed wound care in accordance with accepted standards of treatment and per physician's orders. (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 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/29/24 at 11:02 AM, LVN C indicated she was the 6A - 2P nurse Monday through Friday. LVN C indicated the 2P - 10P shift was responsible for providing wound care. LVN C said that skin assessments were completed weekly by the 2P - 10P shift and as needed. LVN C said that although wound care was not scheduled on her shift, she was still responsible for implementing care to prevent skin breakdown and assessing a resident if it was reported to her about a concern about a resident skin noted during a shower or incontinent care. LVN C said that the WMD followed Resident #1 for other wounds and thought ADON A informed the WMD about the open area to Resident #1's sacrum. LVN C indicated that the old dressing removed from Resident #1's sacrum had a brown discoloration, the wound bed presented a partial light red wound bed on the left side, and there was necrotic tissue over the other areas of the wound. LVN C said that she would document her findings on the 24-hour report sheet to communicate with other team members. An outbound call to the WMD on 01/29/24 at 11:09 AM indicated the WMD rounded at the facility every Tuesday. The WMD followed Resident #1 for wounds to the left and right heels. During the wound care visit on 01/23/24, facility nursing staff informed [the WMD] of a wound consultation for Resident #1. The WMD conducted an initial evaluation of Resident #1's sacrum wound. The WMD indicated the wound was unstageable due to necrosis. The WMD spoke to the RP and explained treatment options, risks, benefits, and the need for a surgical excisional debridement procedure to remove necrotic tissue from the sacral wound. The WMD explained to the RP that the necrotic tissue interfered with healing. The RP agreed to the procedure. The WMD performed debridement of the sacrum area and removed over a 5.0 square cm area and 0.3 cm depth of necrotic tissue until healthy tissue (bleeding tissue) was observed. The WMD categorized the wound a Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed or able to directly feel fascia [thin casing of connective tissue] or muscle) to the sacrum after debridement. The WMD ordered Santyl and Xeroform Gauze as a primary dressing and a bordered gauze as a secondary dressing. The WMD recommended to off-load the wound, reposition per facility policy, and low air loss mattress. The WMD anticipated wound healing over two months and would see Resident #1 at the next visit (01/30/24). During an interview on 01/29/24 at 12:38 PM, ADON A said that he was responsible for overseeing that skin assessments and wound care was completed as ordered. ADON A said that the nurses were responsible for completing the skin assessments and wound care. ADON A said that he was familiar with Resident #1. ADON A said that he recalled a CNA [later identified as CNA D] telling him about a wound to Resident #1's sacrum. ADON A said he couldn't remember when the incident occurred, but he remembered telling the CNA to apply barrier cream to the buttocks when incontinent care was performed. ADON A said that Resident #1 was already getting wound care to the area that CNA reported. Record review of Resident #1 orders and TAR with ADON A revealed an order to clean, apply xeroform (occlusive dressing for use on low exudating wounds), and apply a dressing to the sacrum 01/11/24 - 01/24/24. ADON A said that the WMD was not following the wound to the sacrum and the order was obtained from the primary physician. ADON A said that the order was temporary treatment until seen by the WMD for an appropriate treatment plan and to reduce the amount of pressure on the site. ADON A agreed that he completed the weekly skin assessment on 01/21/24 and documented Resident #1's skin was intact because the sacral area was not open. ADON A could not explain why the skin assessment date and time reflected 01/11/24 if he performed, signed, and locked the skin assessment on 01/21/24 at 10:02 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676363	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remarkable Healthcare of Prestonwood	4501 Plano Parkway Carrollton, TX 75010

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 - Actual harm Residents Affected - Few	During an interview on 01/29/24 at 12:51 PM, CNA J said that she worked at the SNF for less than 3 months. CNA J said that she provided care to Resident #1 whenever assigned to the LTC unit. CNA J said that Resident #1 required total assistance by one person with ADLs. CNA J said that Resident #1 had a wound on her bottom and on her heels. CNA J said that she tried to check on residents every two hours or more frequently if a high fall risk or require incontinent care often. CNA J said that she would report to the nurse immediately after provided care to the resident and ensured was safe if discovered a skin tear, redness, a rash, or if a dressing was soiled or came off. CNA J said that she applied barrier cream to Resident #1's buttocks after changing the brief to protect skin when soiled and prevent breakdown of skin. During a phone interview on 01/29/24 at 2:09 PM, CNA D stated she worked at the facility for six months. CNA D indicated on Sunday, 01/21/24, while she provided incontinent care to Resident #1, she saw a green-black discoloration on the tailbone area. CNA D stated she notified ADON A about the findings. CNA D said that ADON A told her to put barrier cream on it. CNA D said she applied barrier cream to Resident #1's buttocks as instructed but not directly on the green-black discolored area. During a follow-up interview on 02/23/24 at 12:40 PM, ADON A indicated that there were wound and skin management standing delegation orders in place to treat minor skin tears, abrasions, intact and shallow skin impairment with no or minimal drainage. Treatments included cleaning, topical barrier ointments and creams, dressing change frequency, and protecting the site. ADON A said wounds that were open to the level of fatty tissue (or deeper), mostly red, had more than minimal drainage, or non-healing wounds required a consultation with the WMD. ADON A said that he rounded with the WMD during weekly visits to provide support, and complete wound documentation. ADON A said that the WMD needed to assess a wound to determine the appropriate treatment. ADON A said that a nurse would notify him of a change in wound condition or if a wound consult was needed and he would send the face sheet to the WMD as notification. ADON A said that Resident #1 was already followed by the WMD and thought he notified the WMD about the open area discovered to the sacral area. During a follow-up interview on 02/23/2024 at 1:30 PM, LVN C indicated that she vaguely recalled [on 01/11/24] that a CNA (could not recall who it was) called her into Resident #1's room to look at Resident #1's buttocks for possible skin breakdown. LVN C said that she saw a dime-sized open area to the upper midline groove that separates the buttocks. LVN C said that she notified Resident #1's primary physician and received a telephone order to provide treatment [Clean sacrum with wound cleanser, pat dry, apply xeroform and cover with border gauze every evening (2P - 10P) shift] and to consult the WMD. LVN C said that she notified ADON A that Resident #1 needed a wound consult. LVN C said that was the facility protocol to notify the ADON/DON when a resident required a Specialist/Wound Doctor Consultation. The ADON/DON would request the consultation and rounded with the WMD during weekly visits. LVN C said that she did not document the communication with the primary physician or ADON and did not follow-up if the WMD was consulted. LVN C said that documentation was important to ensure continuity of care and consistency. Review of the Wound Care policy and procedure provided by the facility, revised September 2016 indicated: - Verify that there is a physician's order. - Review the resident's care plan to assess for any special needs of the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/01/2024
NAME OF PROVIDER OR SUPPLIER: Remarkable Healthcare of Prestonwood		STREET ADDRESS, CITY, STATE, ZIP CODE: 4501 Plano Parkway Carrollton, TX 75010	

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 - Actual harm Residents Affected - Few	- Documentation should include the type of wound care given, date and time, all assessment data, how the resident tolerated the procedure and any problems or complaints made by the resident related to the procedure. If a resident refused and why. Review of the facility's Pressure Ulcers/Skin Breakdown - Clinical Protocol policy and procedure, revised December 2010 indicated: Assessment and Recognition - The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores . - The physician and staff will examine the skin of a new admission for ulcerations or indications of a Stage 1 pressure area that has not yet ulcerated at the surface. - The physician will help the staff define the type and characteristics of an ulceration. Cause Identification - The physician will help identify factors contributing or predisposing residents to skin breakdown . Treatment/Management - The physician will authorize pertinent orders related to wound treatments . - The physician will help identify medical interventions related to wound management. - The physician will help staff characterize the likelihood of wound healing . Monitoring - During resident visits, the physician will evaluate and document the progress of wound healing . - The physician will help the staff review and modify the care plan as appropriate .