STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676381	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Houston Rehabilitation and Healthcare Center	13428 Bissonnet Houston, TX 77083

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 1 of 5 residents (Resident #1) reviewed for ADLs. The facility failed to ensure Resident #1was provided personal grooming (dry patches and flaky skin) by facility staff. This failure could place residents at risk for not receiving care and services for ADL. Findings included: Resident #1 Record review of Resident #1's face sheet dated 12/31/24 revealed a [AGE] year-old male was admitted to the facility initially on 09/23/24 and readmitted on [DATE]. Resident #1 had diagnoses that included: anoxic brain damage, (when brain cells are deprived of oxygen which caused brain cell to die) pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) diabetes mellites (body does not manage blood sugar properly), and hypertension (blood is pumping with more than normal through your arteries). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 had BIMS of 13 out of 15 which indicated intact cognition. Further review revealed Resident #1 was dependent on staff with ADLs with one to two staff assistance. Record review of Resident #1's undated care plan revealed Resident #1 had ADL self-care performance deficit related to muscle weakness. Intervention: personal hygiene, total dependence on staff with one to two staff assistance. During an observation on 12/15/24 at 2:20 p.m. revealed Resident #1 skin from below the knee on the left leg to the foot had dry, patchy skin, the foot was ashy, and the toes had dry, flaky skin which had fallen off on the linen when the Wound care nurse removed Resident #1's boot. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/15/24 at 4:47 p.m., the Wound care nurse said Resident #1 left leg from below the knee to the foot had patches of dry skin, the toes were also ashy, and the skin on the toes was flaky and flaked off on the linen. The wound care nurse said residents were showered three times a week, and the aides were responsible for showering the residents. The wound care nurse said the aides should apply lotion on Resident #1 after showering and as needed. The wound care nurse said if Resident #1's skin continued to be patchy and dry, then Resident #1 skin could open up. The wound care nurse said the floor nurse was responsible for weekly skin assessment and monitored the aides during rounding, and the nurse managers monitored the nurses during random rounding. The wound care nurse said she only came to the facility maybe every other weekend and was unaware that Resident #1 refused to shower or lotion his skin. During an interview on 12/31/24 at 10:20 a.m., The DON said she expected the aides to provide and offer ADL to every resident to prevent the resident skin from being dry. The DON said the aides were responsible for providing ADL care for residents. The DON said the residents should get showers or bed baths three times a week and may require a bath before their shower day (PRN). The DON said the aides should apply lotion on shower days and as needed. The DON said aides should tell the nurse if Resident #1 had refused shower or lotion, and the nurse would go and assess Resident #1 and offer and apply lotion to Resident #1. The DON said she was not aware that Resident 1's skin on his left foot and toes was dry and flakey. The DON stated the nurse on the floor monitored the aides, and the nurse manager monitored the nurses during random rounds. During an interview on 12/31/24 at 10:25 a.m. Resident #1 said the aides applied moisturizer on him sometimes on shower days but not often. Resident #1 stated his skin sometimes itched, and he would ask the nurse to apply lotion. During an observation and interview on 12/31/24 at 10:34 a.m., the DON revealed Resident #1 skin still had patches of dry skin from above the knee to his left foot and toes. The DON said she could see the resident skin had dry patches, and she said they must do better. The DON said Resident #1 skin assessment should be done once a week by the wound car nurse or charge nurse if the wound care nurse. During an interview on 12/31/24 at 12:35 p.m., LVN B said aides are responsible for showering and applying lotion on residents' skin on shower days and as needed. LVN B said the charge nurse monitors the aides when she made rounds. LVN B said none of the staff had told her Resident #1 refused to be showered or applied lotion. LVN B said she did a skin assessment on Resident #1, and she noted his skin was dry and had patches of dry skin. LVN B said she noted Resident #1 lotion the staff applied to Resident #1 was absolved very quickly, and the skin remained dry with patches of dry skin. LVN B said she should have notified Resident #1's physician that the lotion used on the resident was not the best for the resident, but she did not inform Resident #1 physician. LVN B said Resident #1's skin had patches of dry skin, which could cause his skin to break down. LVN B said she had an LVN skills check-off, which included a skin assessment. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/31/24 at 1:02 p.m., the ADON said the nurses monitored the aides and made sure the aides were providing skin care to the residents. The ADON said she was not aware Resident #1 refused ADL care. The ADON said if Resident #1 had dry skin, the facility had in-house moisturizer , which the aides should have applied to Resident #1 skin because it was the facility slandered protocol for skin care. The ADON said if Resident #1's skin continued to dry, the nurse should have contacted the physician about Resident #1's dry skin and see if there was any prescription cream for Resident #1. The ADON said she had not notified the physician about Resident #1's patchy, dry skin because she was not aware of the dry skin. The ADON said if Resident #1 skin continued to be dry, Resident #1 skin could start to peel off, and we do not want that to happen because the skin could open, and if the skin is dry and Resident #1 scratched his skin, then he could break his skin. During an interview on 12/31/24 p.m., at 1:51 p.m., CNA A said Resident #1's shower days were TTHS. CNA A said Resident #1 did not refuse showers, and Resident #1 had dry, patched, and flaky skin. CNA A said she applied lotion on Resident #1 skin on his shower days when she worked but was unsure if other aides applied moisturizer and when the resident asked for the lotion to be applied on his skin. CNA A said Resident #1's skin was dry and flaky, and he could easily tear. CNA A said she told a nurse that the resident skin was still dry, but she could not remember the nurse's name. CNA A said she had a skills check-off, which included skin care. She stated the nurse monitored the aides when the nurse made random rounds. During an interview on 12/31/24 at 2:22 p.m., the DON said if Resident #1's skin was dry, it could cause Resident #1's skin to break down. Record review of the facility policy on skin integrity - foot care dated 02/2023 read in part . it is the policy of this facility to ensure residents receive proper treatment and care . to maintain good foot care . Record review of the facility policy on resident showers policy dated 01/01/23 and revised 04/17/23 read in part it is the practice of this facility to assist resident with bathing to maintain proper hygiene, stimulate circulate and help prevent skin issues .

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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 - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview and record review , the facility to ensure a resident with pressure ulcers received nesessary treatment and services consistant with professional standards of practice, to promote healing, pevent infection a for 1 out of (Resident #1) of 2 residents reviewed for pressure ulcers. -The facility failed to ensure Wound Care Nurse followed proper wound care procedure during Resident #1's wound dressing change. This failure could place residents at risk for worsening existing pressure injuries, infection, pain, and decreased quality of life. Findings included: Resident #1 Record review of Resident #1's face sheet dated 12/31/24 revealed a [AGE] year-old male was admitted to the facility initially on 09/23/24 and readmitted on [DATE]. Resident #1 had diagnoses included: anoxic brain damage, (when brain cells are deprived of oxygen which caused brain cell to die) pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) diabetes mellites (body does not manage blood sugar properly), and hypertension (blood is pumping with more than normal through your arteries). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 had BIMS of 13 out of 15 which indicated intact cognition. Further review revealed Resident #1had two stage pressure ulcer and he was dependent on staff with ADLs. Record review of Resident #1's undated care plan revealed Resident #1 had ADL self-care performance deficit related to muscle weakness. Intervention: personal hygiene, total dependence on staff. Further review revealed Resident #1 had a stage 4 pressure ulcer to the sacrum(most serve type of bedsore, skin damage goes deep to muscle, tendon, or bone): Interventions: perform treatment per order, treatment/wound care per md orders. Record review of Resident #1's order summary report dated December 2024 start date: `read Type of wound: pressure Location of wound: sacrum Irrigate, or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): collagen cover with bordered gauze dressing. Record review of Resident #1's order summary report dated December 2024 start date:11/20/24 read Bactrim DS give one tablet by mouth two times a day to promote wound healing for 10 days. Record review of Resident #1's order summary report dated December 2024 start date:12/04/24 read Bactrim DS give one tablet by mouth two times a day to promote wound healing for 10 days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's TAR dated December 2024 revealed of wound: Stage 4 Pressure Injury location of wound: Sacrum: Irrigate or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): Calcium alginate with silver cover with ABO pad Secure dressing with: Tape. rRecord review of Resident #1's dated December 2024 revealed Type of wound: pressure location of wound: sacrum Irrigate, or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): calcium alginate cover with: ABO Secure dressing with: tape. During an observation and interview on 12/15/24 from 1:40 p.m. through 2:24 p.m., the Wound Care Nurse provided wound care treatment for Resident #1, and it revealed the dressing was saturated with blood and dark yellow and green drainage. When the wound care nurse removed the dressing, the drainage from the wound bed was dripping down to the peri-wound. The Wound Care Nurse took one wet gauze, padded one section of the wound bed three times with the same gauze, then folded the same gauze and padded the wound bed thrice again. The wound care nurse repeated the same method on the other three sections of the wound bed. The wound was large, and it affected both the right and left sacrum. The Wound Care Nurse changed her gloves three times over the clean filed during the wound care treatment. The Wound Care Nurse did not clean the peri-wound and was about to place silver calcium alginate on the wound bed when the Surveyor asked the Wound care Nurse if she had finished cleaning the wound. The Wound care nurse said yes, and she was going to apply the silver alginate and cover the wound, and the peri-wound would be covered with the dressing. Then Wound Care Nurse said she forgot to clean the wound bed. During an interview on 12/15/24 at 3:44 p.m., the Wound Care Nurse said she should have cleaned the wound bed with a gauze and wiped once at 360 degrees, and each gauze is used once. The Wound Care Nurse said she did not realize she dabbed on the wound bed when she cleaned the wound bed. The Wound Care Nurse said dabbing the wound bed would cause injury to the wound, and if the germs are not cleaned off, the wound could be infected. The Wound Care Nurse said she forgot to clean the peri-wound, and that could also infect the wound. The Wound Care Nurse said the dressing was saturated with yellow and green drainage, draining on the peri-wound when she removed the dressing. The wound care nurse said the floor nurse told her Resident #1 had just completed ABT Bactrim DS for the wound infection yesterday. The Wound Care Nurse said she did not have wound certification and did not remember if she had wound care skills check-off or any training on wound care because all nurses do wound care if the wound care nurse does not come to work. The Wound Care Nurse said she did not know who monitored the nurse because she comes here on weekends to do wound care. During an interview on 12/15/24 at 4:47 p.m., the Wound Care Nurse returned and said the Corporate Nurse provided a wound care skills check-off. Record review of the facility skilled services treatment revealed Wound care nurse signed the training on 08/06/2019. Record review of the facility treatment nursing competency read in part . dressing, dry/clean. #15 cleanse the wound with ordered cleanser, if using gauze, use clean gauze for each cleaning stroke .#16 use dry gauze to pat the wound dry . (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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/31/24 at 9:55 a.m., The DON said the Wound care nurse should have wiped Resident #1's wound bed the first time, which would have cleaned the debris from the wound bed. The DON said the Wound Care Nurse could wipe Resident #1 wound bed multiple times but with a different gauze each, then pad dry the wound after she cleaned the wound. The DON said the wound care nurse should have wiped the peri-wound which would had cleaned of drainage and germs to prevent wound infection. The DON said gloves are not removed on the clean field because of cross-contamination which meant the microbes from the dirty gloves contaminate the clean supplies. The DON said she monitored the wound care nurse when she made rounds with wound care once a month. The DON said the wound care nurse had skills - check off on wound care treatment. During an interview on 12/31/24 at 10:02 a.m., ADON said it depends on the type of the wound; if the wound did not have any drainage, the wound care nurse would not clean the peri-wound. ADON said that the peri-wound should be cleaned if Resident #1's wound had drainage. ADON said the Wound Care Nurse should have removed dirty gloves on the dirty side, not the clean side, to prevent cross-contamination of the clean field. ADON said if the Wound care nurse did not correctly clean Resident #1's wound, it could slow the healing process. During an interview on 12/31/24 at 11:50 a.m., the Unit manager said the Wound Care Nurse should have cleaned Resident #1's wound bed with gauze once, threw it away, and repeated the process until the wound bed was cleaned for Resident #1. The unit manager said the wound care nurse should have cleaned Resident #1's peri-wound and pat it dry with dry gauze. The unit manager said the wound care nurse should have wiped Resident #1's wound bed, which she padded, so the microbes and the drainage would be wiped off. The unit manager said if the wound care nurse did not clean Resident #1's wound well, then the bacteria would still be in the wound bed, which could lead to more bacteria and delay in Resident #1's wound healing. The unit manager said the DON monitors the wound care nurse during rounding. Record review of the facility policy on wound treatment management dated 01/20/23 read in part to promote wound healing of various types of wounds .policy explanation and compliance guidelines #1. Wound treatment will be provided in accordance with physician order, including the cleansing method, type of dressing .

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 1 of 2 staff (The Wound care nurse) reviewed for infection control. 1. The facility failed to ensure The Wound care nurse followed proper infection control and PPE procedure during wound care treatment for Resident #1. This failure could place the residents at risk for infection. Findings included: Record review of Resident #1's face sheet dated 12/31/24 revealed a [AGE] year-old male was admitted to the facility initially on 09/23/24 and readmitted on [DATE]. Resident #1 had diagnoses included: anoxic brain damage, (when brain cells are deprived of oxygen which caused brain cell to die) pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) diabetes mellites (body does not manage blood sugar properly), and hypertension (blood is pumping with more than normal through your arteries). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 had BIMS of 13 out of 15 which indicated intact cognition. Further review revealed Resident #1had two stage pressure ulcer and he was dependent on staff with ADLs. Record review of Resident #1's undated care plan revealed Resident #1 had ADL self-care performance deficit related to muscle weakness. Intervention: personal hygiene, total dependence on staff. Further review revealed Resident #1 had a stage 4 pressure ulcer to the sacrum(most serve type of bedsore, skin damage goes deep to muscle, tendon, or bone): Interventions: perform treatment per order, treatment/wound care per md orders. Record review of Resident #1's order summary report dated December 2024 start date: `read Type of wound: pressure Location of wound: sacrum Irrigate, or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): collagen cover with bordered gauze dressing. Record review of Resident #1's order summary report dated December 2024 start date:11/20/24 read Bactrim DS give one tablet by mouth two times a day to promote wound healing for 10 days. Record review of Resident #1's order summary report dated December 2024 start date:12/04/24 read Bactrim DS give one tablet by mouth two times a day to promote wound healing for 10 days. Record review of Resident #1's TAR dated December 2024 revealed of wound: Stage 4 Pressure Injury location of wound: Sacrum: Irrigate or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): Calcium alginate with silver cover with ABO pad Secure dressing with: Tape. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rRecord review of Resident #1's dated December 2024 revealed Type of wound: pressure location of wound: sacrum Irrigate, or cleanse wound bed with Normal saline, Nexodyn solution or wound cleanser, pat dry and apply or pack (if applicable): calcium alginate cover with: ABO Secure dressing with: tape. During an observation and interview on 12/15/24 from 1:40 p.m. through 2:24 p.m., the Wound Care Nurse provided wound care treatment for Resident #1, and it revealed the dressing was saturated with blood and dark yellow and green drainage. When the wound care nurse removed the dressing, the drainage from the wound bed was dripping down to the peri-wound. The Wound Care Nurse took one wet gauze, padded one section of the wound bed three times with the same gauze, then folded the same gauze and padded the wound bed thrice again. The wound care nurse repeated the same method on the other three sections of the wound bed. The wound was large, and it affected both the right and left sacrum. The Wound Care Nurse changed her gloves three times over the clean filed during the wound care treatment. The Wound Care Nurse did not clean the peri-wound and was about to place silver calcium alginate on the wound bed when the Surveyor asked the Wound care Nurse if she had finished cleaning the wound. The Wound care nurse said yes, and she was going to apply the silver alginate and cover the wound, and the peri-wound would be covered with the dressing. The Wound Care Nurse said she forgot to clean the wound bed. During an interview on 12/15/24 at 3:44 p.m., the Wound Care Nurse said she should have cleaned the wound bed with a gauze and wiped once at 360 degrees, and each gauze is used once. The Wound Care Nurse said she did not realize she dabbed on the wound bed when she cleaned the wound bed. The Wound Care Nurse said dabbing the wound bed would cause injury to the wound, and if the germs are not cleaned off, the wound could be infected. The Wound Care Nurse said she forgot to clean the peri-wound, and that could also infect the wound. The Wound Care Nurse said the dressing was saturated with yellow and green drainage, draining on the peri-wound when she removed the dressing. The wound care nurse said the floor nurse told her Resident #1 had just completed ABT Bactrim DS for the wound infection yesterday. The Wound Care Nurse said she did not have wound certification and did not remember if she had wound care skills check-off or any training on wound care because all nurses do wound care if the wound care nurse does not come to work. The Wound Care Nurse said she did not know who monitored the nurse because she comes here on weekends to do wound care. During an interview on 12/15/24 at 4:47 p.m., the Wound Care Nurse returned and said the Corporate Nurse provided a wound care skills check-off. Record review of the facility skilled services treatment revealed Wound care nurse signed the training on 08/06/2019. Record review of the facility treatment nursing competency read in part . dressing, dry/clean. #15 cleanse the wound with ordered cleanser, if using gauze, use clean gauze for each cleaning stroke .#16 use dry gauze to pat the wound dry . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/31/24 at 9:55 a.m., The DON said the Wound care nurse should have wiped Resident #1's wound bed the first time, which would have cleaned the debris from the wound bed. The DON said the Wound Care Nurse could wipe Resident #1 wound bed multiple times but with a different gauze each, then pad dry the wound after she cleaned the wound. The DON said the wound care nurse should have wiped the peri-wound which would had cleaned of drainage and germs to prevent wound infection. The DON said gloves are not removed on the clean field because of cross-contamination which meant the microbes from the dirty gloves contaminate the clean supplies. The DON said she monitored the wound care nurse when she made rounds with wound care once a month. The DON said the wound care nurse had skills - check off on wound care treatment. During an interview on 12/31/24 at 10:02 a.m., ADON said it depends on the type of the wound; if the wound did not have any drainage, the wound care nurse would not clean the peri-wound. ADON said that the peri-wound should be cleaned if Resident #1's wound had drainage. ADON said the Wound Care Nurse should have removed dirty gloves on the dirty side, not the clean side, to prevent cross-contamination of the clean field. ADON said if the Wound care nurse did not correctly clean Resident #1's wound, it could slow the healing process. During an interview on 12/31/24 at 11:50 a.m., the Unit manager said the Wound Care Nurse should have cleaned Resident #1's wound bed with gauze once, threw it away, and repeated the process until the wound bed was cleaned for Resident #1. The unit manager said the wound care nurse should have cleaned Resident #1's peri-wound and pat it dry with dry gauze. The unit manager said the wound care nurse should have wiped Resident #1's wound bed, which she padded, so the microbes and the drainage would be wiped off. The unit manager said if the wound care nurse did not clean Resident #1's wound well, then the bacteria would still be in the wound bed, which could lead to more bacteria and delay in Resident #1's wound healing. The unit manager said the DON monitors the wound care nurse during rounding. Record review of the facility policy on infection control dated 05/20/23 and Revised 1/20/24 read in part . this facility has established and maintained an infection prevention and control program designed to provide safe, sanitary . to help prevent the development and transmission . infection . Record review of the facility policy on wound treatment management dated 01/20/23 read in part to promote wound healing of various types of wounds .policy explanation and compliance guidelines #1. Wound treatment will be provided in accordance with physician order, including the cleansing method, type of dressing .