STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676450	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terra Bella Health and Wellness Suites	12262 Cityscape Ave Houston, TX 77047

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 - 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** 26454 Based on observations, interviews, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming for 1 of 8 residents (CR #1) reviewed for ADL's. 1. The facility failed to ensure CR #1's hair was adequately washed and combed for an unknown period and resulted in a thick accumulation of a brown, flakey substance on her entire scalp, and a large amount of matted hair in the back of her head which had to be cut off. 2. The facility failed to ensure CR #1's nails were cut and appropriately groomed which resulted in an accumulation of a dark brown/black substance underneath the nails. 3. The facility failed to notify CR #1's RP and physician that she had matted hair and an accumulation of a brown, flakey substance on her scalp which resulted in a delay in treatment/care. These failures placed dependent residents at risk of experiencing scalp itch, odors, infection, skin tears, and undesirable haircuts. Findings included: Record review of CR #1's face sheet dated 02/19/2025 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with dementia (the loss of cognitive functioning), hemiplegia (paralysis that affects only one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebrovascular disease (a medical emergency that encompasses a range of conditions affecting the brain's blood vessels and circulation) affecting the left non-dominant side, functional quadriplegia (a condition in which a person is unable to move all four limbs due to factors other than a spinal cord injury), muscle wasting and atrophy (loss of muscle mass and strength), mild protein-calorie malnutrition (a condition where someone is not getting enough protein and calories in their diet), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), chronic kidney disease (longstanding disease of the kidney leading to renal failure), diabetes mellitus (too much sugar in the blood), blindness in one eye, and hypertension (a condition in which the force of the blood against the artery walls is too high). CR #1 was discharged to an acute care hospital on 02/18/2025 (unrelated to the pressure ulcers). (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 - Actual harm Residents Affected - Some	Record review of CR #1's quarterly MDS dated [DATE] revealed her vision was severely impaired; she had a BIMS score of 12 (moderate cognitive impairment); she did not exhibit behaviors related to rejection of care; her upper and lower extremities had limited range of motion; she used a wheelchair for mobility; she required supervision or touching assistance from staff for eating and oral hygiene; she was dependent on staff for toileting, showering/bathing, lower body dressing, sitting to lying/lying to sitting, and transferring; she required substantial/maximal assistance from staff for rolling to the left/right while lying on her back; she required moderate assistance from staff for personal hygiene; she was always incontinent of bowel and blader; and she was at risk for developing pressure ulcers. Record review of CR #1's care plan, revised on 02/14/2025 revealed the following care areas: * Behavioral Symptoms: CR #1 has mood, and behavior needs related to her diagnosis of: Dementia, Blindness, Osteoarthritis (type of arthritis that occurs when flexible tissue at the end of bones wears down), Reduced Mobility as evidenced by agitation, short temper, refusing to get out of the bed, refusing care, medications, lab draws and showers. Goal included: CR #1 will have a reduction in identified behaviors, will allow needed care for health and safety as evidenced by documentation in the medical record. Approach included: Encourage CR #1 to become involved with activities that she enjoys, even in room or one on one as needed. Will respect choice to refuse participation. Ensure all physical needs are met such as pain, hunger, thirst, toileting needs, labs, adequate sleep. Give medications as ordered, monitor for side effects and effectiveness, notify physician of changes, attempt GDR as able. Refer to psych as needed. Resident may refuse to take her medications. Medication Techs must notify Nurse in charge, ADON or DON for refusals. Documentation must be noted at that time. * ADLs Functional Status/Rehabilitation Potential: CR #1 is limited in mobility related to BLE impairments and requires the use of a wheelchair. Goal included: will safely help propel self with the use of wheelchair. Approach included: Allow sufficient time to complete activity. Instruct in proper technique. * ADLs Functional Status/Rehabilitation Potential: [CR #1] will maintain a sense of dignity by being clean, dry, odor free, and well groomed. Approach included: Bathing: Assist of 1 (prefers Bed Bath). Bed Mobility: Assist of 1-2. Eating: Assist of 1 (Blind). Toileting: Assist of 1. Transfer: Assist of 1-2 utilizing Hoyer Lift. Record review of CR #1's Progress Notes for December 2024 - January 2025 revealed no documentation/entries from 12/24/2024 - 01/20/2025. Further review of the progress notes revealed no documentation to indicate CR #1 refused any showers/bed baths, hair washes, hair combing, or nail care. There was no documentation regarding CR #1's thick brown scalp accumulation and none regarding the matted hair on the back of her head. Record review of CR #1's Shower Sheets for January 2025 and February 2025 revealed the following: * 01/01/2025: New Skin Issues? No . Nail Care Complete? No. Comments: Bed bath. Signed by CNA F. * 01/04/2025: New Skin Issues? No . Nail Care Complete? Yes. Comments: None . Signed by CNA G. * 01/04/2025: New Skin Issues? No . Nail Care Complete? No. Comments: Bed bath . Signed by CNA F. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	* 01/14/2025: New Skin Issues? No . Nail Care Complete? No. Comments: Shower . Signed by CNA F. * 01/18/2025: New Skin Issues? No . Nail Care Complete? Yes. Comments: Shower. Signed by CNA F. * 01/25/2025: New Skin Issues? No . Nail Care Complete? No. Comments: bed bath. Signed by an unknown staff member. * 01/28/2025: New Skin Issues? No . Nail Care Complete? Yes. Comments: Blank. Signed by CNA F. * 01/30/2025: New Skin Issues? No . Nail Care Complete? Yes. Comments: Blank. Signed by CNA S. * 02/01/2025: New Skin Issues? No . Nail Care Complete? Yes. Comments: Blank. Signed by CNA F. * 02/04/2025: New Skin Issues? No . Nail Care Complete? Yes. Comments: Blank. Signed by CNA S. * 02/06/2025: New Skin Issues? No . Nail Care Complete? Yes. Comments: Blank. Signed by CNA F. * 02/11/2025: New Skin Issues? No . Nail Care Complete? Yes. Comments: Blank. Signed by CNA F. * 02/15/2025: New Skin Issues? No . Nail Care Complete? Yes. Comments: Blank. Signed by CNA F. Observation and interview with CR #1 on 02/19/2025 at 3:11 p.m. revealed she was in bed at an acute care hospital. CR #1's eyes were closed, and she did not respond verbally or non-verbally to questions. CR #1's hospital nurse touched her head and eyes, and CR #1 began to wave her hand to remove the nurse's hand from her head. CR #1's entire scalp was covered with a thick brown, flakey substance. The hospital nurse said CR #1 may have seborrheic dermatitis on her scalp or she may just have an accumulation of natural oil and hair products. The hospital nurse said it appeared as though nobody had agitated or scratched CR #1's scalp (while washing it) for some time. She said CR #1 may need a special shampoo if she had dermatitis. CR #1 also had a large amount of matted hair in the back of her head. On one side, the matted hair resembled the shape of the palm of a hand and measured approximately 4x3 inches. There was a smaller piece on the other side of CR #1's head that was connected to the larger piece. The smaller piece was shaped like a small, flat light bulb. Observation of CR #1's nails revealed they were all yellowish in color and most of the nails were long and had a dark brown/black substance underneath them. CR #1 never made any sound or gestures to indicate she understood or heard interview questions. The hospital nurse stated CR #1 had been nonresponsive since she was admitted to the hospital. In a telephone interview with LVN I on 02/19/2025 at 10:33 p.m., she stated she worked the night shift and often cared for CR #1. She stated CR #1 required total care and was confused, so staff had to anticipate her needs. She said she witnessed CNAs give CR #1 bed baths and she observed them wash her hair. She stated she observed staff wet CR #1's hair, then scrub her scalp and rinse it by pouring water over it from a basin. She said CR #1's hair had been matted for a while (she could not recall how long). She said they (she did not specify who they was) tried to brush CR #1's hair out. She said she was not sure if anybody ever notified CR #1's RP about the matted hair, but she did not. She said she never observed any accumulation on CR #1's scalp. She said the facility had a beauty shop and the beautician came once per week, but she did not think CR #1 ever went to the beauty shop. She said when a resident's hair was matted, they usually tried to resolve it by cutting it off. She said she was not sure why they never cut CR #1's matted hair off. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Some	In a telephone interview with CNA F on 02/19/2025 at 10:50 p.m., she stated she had worked at the facility for about four months, and she often cared for CR #1 on the night shift. She stated CR #1's hair was matted in the back for as long as she had been caring for her. She said the first time she bathed CR #1, she attempted to wash her hair with warm water and soap. She said she tried to massage CR #1's scalp and used a basin to rinse the soap out. She said she never noticed any accumulation on CR #1's scalp, but her hair could not be combed. She said she never attempted or inquired about cutting CR #1's hair because the matting was there when she started working there. In an interview with CNA B on 02/20/2025 at 10:15 a.m., she stated she had worked at the facility for a year-and-a-half, and she often cared for CR #1 on the day shift. She said CR #1's showers were scheduled for Tuesdays, Thursdays, and Saturdays on the night shift. She said the night shift CNA tried to wash CR #1's hair, but it was already matted. She said CR #1 was the type of resident who really did not want anybody to touch her. She stated CR #1 always had the brown, flakey accumulation on her scalp for as long as she had been working there. She said she did not know if CR #1's RP knew about the matting and brown accumulation, but the RP did know CR #1 refused to get out of bed. She said the facility had a beauty shop, but she was not sure if CR #1 ever went. She said she tried to comb CR #1's hair, but she was tender headed (her scalp was sensitive to pulling) and she did not let her. She said she was responsible for showering CR #1's roommate and she also cleaned CR #1's nails at that time, so the night shift CNA would only have to shower CR #1. In a telephone interview with CR #1's RP on 02/20/2025 at 12:10 p.m., she stated nobody ever called her to let her know CR #1's hair was matted or that she had the thick accumulation on her scalp. She stated CR #1 was always laying down when she visited her, so she never thought to look at the back of her head. She said the front of CR #1's hair always looked combed. She said the facility had a beautician and the staff could have sent CR #1 to the beauty shop any time. She said she had to cut off all CR #1's hair from the back on 02/19/2025. She said she also tried to scratch CR #1's scalp to remove the flakey, brown material, but all of it did not come off. She said she cut and cleaned CR #1's nails at the hospital as well. She said when she saw CR #1 at the hospital on 02/18/2025, she called the facility to ask them about her hair. She said the facility staff (she did not know who she spoke with) told her they bathed and washed CR #1's hair on Tuesdays, Thursdays, and Saturdays. She said the accumulation on CR #1's scalp looked like cradle cap (crusting and white or yellow scales on a baby's scalp which occurs because of excessive oil production by skin glands surrounding hair follicles) that a baby would have. In a telephone interview with CR #1's physician on 02/21/2025 at 10:09 a.m., she stated she had been responsible for CR #1's care for several years. She stated some residents got seborrheic dermatitis on their scalps, but nobody ever notified her that CR #1 had any issues because she would have ordered a special shampoo. She said CR #1 was always in bed, so she never saw the back of her head. In an interview with the ADON on 02/24/2025 at 11:35 a.m., she stated she was not aware CR #1 had matted hair or an accumulation on her scalp. She said she previously told the staff that even when CR #1 refused care, they should keep asking and encourage her. She said she previously called CR #1's RP to ask her about encouraging CR #1 to accept assistance with ADLs and taking medication. She said if she knew about CR #1's scalp and hair, she would have notified her RP. She said the nurses and CNAs were responsible for letting her (the ADON) know about these issues (the matted hair and scalp accumulation) so she could speak with CR #1's RP. She said the brown accumulation was probably caused by not washing CR #1's hair or putting oil on her hair, letting it build-up, and not washing it. She said the build-up could have caused CR #1 to have skin irritation and itch. (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 0677 Level of Harm - Actual harm Residents Affected - Some	Record review of the facility's policy titled, Activities of Daily Living, Optimal Function revised 05/05/2023 revealed, Definition: Activities of daily living (ADLs) refer to tasks related to personal care including, grooming, dressing, oral hygiene, transfer, bed mobility, eating, bathing, and communication system. Policy: The facility provides care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. The facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene . 3. Facility staff develop and implement interventions in accordance with the resident's assessed needs, goals for care, preferences, and recognized standards of practice that address the identified limitations in ability to perform ADLs .

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on observations, interviews, and record review, the facility failed to ensure a resident received care, consistent with professional standards of practice, to prevent ulcers and not develop pressure ulcers for 1 of 8 residents, CR #1, reviewed for pressure ulcers. 1. LVN A failed to follow the facility's protocol and initiate adequate wound interventions when CNA B noted CR #1 had redness to her buttocks area on 01/04/2025 until 01/20/2025 when CR #1 was noted to have a stage 3 (a full-thickness tissue loss where the subcutaneous fat layer is visible within the wound, but the bone, tendon, or muscle is not exposed) sacral pressure ulcer, and an unstageable pressure injury (a type of pressure ulcer where the depth of the wound cannot be determined due to the presence of slough or eschar) (the wound was initially staged as a 3, but was changed to unstageable on 02/06/2025) to her right buttock. 2. The facility failed to ensure nurses completed comprehensive weekly skin assessments for CR #1 and resulted in a delay in initiating wound care. An IJ was identified on 02/20/2025 at 12:48 p.m. The IJ template was provided to the facility on [DATE] at 12:48 p.m. While the IJ was removed on 02/21/2025 at 1:49 p.m., the facility remained out of compliance at a scope of pattern with severity level at a potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on 02/21/2025. These failures placed bedbound residents and those susceptible to skin injury at risk of experiencing pain and possible infection from developing avoidable pressure wounds. Findings included: Record review of CR #1's face sheet dated 02/19/2025 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with dementia (the loss of cognitive functioning), hemiplegia (paralysis that affects only one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebrovascular disease (a medical emergency that encompasses a range of conditions affecting the brain's blood vessels and circulation) affecting the left non-dominant side, functional quadriplegia (a condition in which a person is unable to move all four limbs due to factors other than a spinal cord injury), muscle wasting and atrophy (loss of muscle mass and strength), mild protein-calorie malnutrition (a condition where someone is not getting enough protein and calories in their diet), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), chronic kidney disease (longstanding disease of the kidney leading to renal failure), diabetes mellitus (too much sugar in the blood), blindness in one eye, and hypertension (a condition in which the force of the blood against the artery walls is too high). CR #1 was discharged to an acute care hospital on 02/18/2025 (unrelated to the pressure ulcers). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's quarterly MDS dated [DATE] revealed her vision was severely impaired; she had a BIMS score of 12 (moderate cognitive impairment); she did not exhibit behaviors related to rejection of care; her upper and lower extremities had limited range of motion; she used a wheelchair for mobility; she required supervision or touching assistance from staff for eating and oral hygiene; she was dependent on staff for toileting, showering/bathing, lower body dressing, sitting to lying/lying to sitting, and transferring; she required substantial/maximal assistance from staff for rolling to the left/right while lying on her back; she required moderate assistance from staff for personal hygiene; she was always incontinent of bowel and blader; and she was at risk for developing pressure ulcers. Record review of CR #1's care plan, revised on 02/14/2025 revealed the following care areas: * Pressure Ulcer/Injury: The resident has xerosis (rough, dry skin) with hardened dry skin [and] scaly plaques to bilateral lower legs. Goal included: The resident's wound will decrease in size as evidenced by wound documentation with no complications and comfort will be maintained. Approach included: CNA to inspect skin, especially over bony prominences, during bathing and personal care. Licensed Nurse to complete wound observation weekly. Wound care as ordered. Wound team to determine etiology (the cause of a disease), evaluate wound(s), treatment(s), and healing weekly. * Pressure Ulcer/Injury: CR #1 has a current wound/disruption of skin surface: Stage 3 to the right buttocks. Goal included: The resident's wound will decrease in size as evidenced by wound documentation with no complications and comfort will be maintained. Approach included: Wound care as ordered. * Pressure Ulcer/Injury: CR #1 has a current wound/disruption of skin surface: stage 4 (the most severe of a pressure sore, where the wound extends deep into the tissue, exposing muscle, tendon, or bone, often with significant damage to surrounding tissue and a high risk of infection) to the sacral. Goal included: CR #1's wound will decrease in size as evidenced by wound documentation with no complications and comfort will be maintained. Approach included: Wound care as ordered. * Pressure Ulcer/Injury: CR #1 is at risk for skin breakdown due to impaired mobility and incontinence of bowel and bladder. Goal included: Skin will remain clean, dry, and intact without evidence of breakdown. Approach included: Assist with repositioning as needed. Monitor for incontinence per routine rounds and PRN, change promptly. Monitor for skin break down, report to M.D. and RP. Provide pressure relieving and positioning devices as needed. * Behavioral Symptoms: CR #1 has mood, and behavior needs related to her diagnosis of: Dementia, blindness, osteoarthritis (type of arthritis that occurs when flexible tissue at the end of bones wears down), reduced mobility as evidenced by agitation, short temper, refusing to get out of the bed, refusing care, medications, lab draws, and showers. Goal included: CR #1 will have a reduction in identified behaviors, will allow needed care for health and safety as evidenced by documentation in the medical record. Approach included: Encourage CR #1 to become involved with activities that she enjoys, even in room or one on one as needed. Will respect choice to refuse participation. Ensure all physical needs are met such as pain, hunger, thirst, toileting needs, labs, adequate sleep. Give medications as ordered, monitor for side effects and effectiveness, notify physician of changes, attempt GDR as able. Refer to psych as needed. Resident may refuse to take her medications. Medication Techs must notify Nurse in charge, ADON or DON for refusals. Documentation must be noted at that time. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* ADLs Functional Status/Rehabilitation Potential: CR #1 is limited in mobility related to BLE impairments and requires the use of a wheelchair. Goal included: will safely help propel self with the use of wheelchair. Approach included: Allow sufficient time to complete activity. Instruct in proper technique. * ADLs Functional Status/Rehabilitation Potential: [CR #1] will maintain a sense of dignity by being clean, dry, odor free, and well groomed. Approach included: Bathing: Assist of 1 (prefers Bed Bath). Bed Mobility: Assist of 1-2. Eating: Assist of 1 (Blind). Toileting: Assist of 1. Transfer: Assist of 1-2 utilizing Hoyer Lift * Continence Status (Bowel/Bladder): CR #1 has Functional Incontinence of Bowel and Bladder and is at risk for skin breakdown. Goal included: CR #1 will remain clean, dry, and odor free and no occurrence of skin break down will occur thru the next review date. Approach included: Assess for causes of incontinence. Encourage fluid intake within dietary limits. Monitor for incontinence per routine rounds and PRN, change promptly and apply a protective skin barrier to skin. Monitor for s/s of skin break down - report to physician and responsible party. Record review of CR #1's Observations (the observation tab of the facility's computer system) in the electronic record revealed the following observations: * 01/03/2025, 2:53 p.m. - Form: Focused Observation. Short Description: --Invalid--Skin; Skin. Reason for invalidation: Incorrect Data. Schedule Details: Unscheduled. Created By: LVN A. * 01/04/2025, 12:41 p.m. - Form: Focused Observation. Short Description: Skin; Skin. Schedule Details: Unscheduled. Created By: LVN A. * 01/10/2025, 5:02 p.m. - Form: Focused Observation. Short Description: skin assessment; Skin. Schedule Details: Weekly Skin - 7:00 a.m. - 7:00 p.m. Scheduled: 01/10/2025. Due 01/11/2025. * 01/13/2025, 1:54 p.m. - Form: Braden Scale for Predicting Pressure Sore Risk. Short Description: Braden. Schedule Details: Unscheduled. Created By: Treatment LVN C. * 01/13/2025, 1:55 p.m. - Form: Skin Risk Analysis and Interventions. Short Description: Skin Risk Analysis. Schedule Details: Unscheduled. Created By: Treatment LVN C. * 01/20/2025, 4:37 p.m. - Form: Focused Observation. Short Description: Skin; Skin. Schedule Details: Unscheduled. Created By: Treatment LVN C. Further review of CR #1's Observations revealed no weekly skin assessments/observations were completed for the week of January 12-18, 2025. Record review of CR #1's Focused Observation dated 01/03/2025 at 2:53 p.m. (created by LVN A) revealed . Observation Type: Weekly. Short Description: Skin . Alteration in skin? No. Comments: no new areas. Record review of CR #1's Focused Observation dated 01/04/2025 at 12:41 p.m. (created by LVN A) revealed . Observation Type: Weekly. Short Description: Skin . Alteration in skin? Yes. Comments: Patient has reddish area to left buttock, wound care nurse notified. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's Focused Observation dated 01/10/2025 at 5:02 p.m. (created by LVN D) revealed . Observation Type: Weekly. Short Description: skin assessment . Alteration in skin? No. Comments: no new skin issues. Record review of CR #1's Focused Observation dated 01/20/2025 at 4:37 p.m. (created by Treatment LVN C) revealed . Observation Type: Daily. Short Description: Skin. Reason for Skilled Service: Observation and assessment . Alteration in skin? Yes. Comments: Right buttock and sacrum. Record review of the facility's Activity Report (24-hour Report) dated 01/04/2025 revealed no entries related to CR #1. Record review of CR #1's Progress Notes for December 2024 - January 2025 revealed no documentation/entries from 12/24/2024 - 01/20/2025. Record review of CR #1's Progress Note dated 01/20/2025 revealed Treatment LVN C wrote, CNA reported patient had a wound on her buttock. I went and assessed, and patient has a stage 3 pressure injury to the right buttock, full thickness, light serous exudate (a clear, watery fluid produced in response to inflammation or injury), 2.5x1.5x0.1 cm, no odor or s/s of infection, no pain, granulation (new, pink or red, fleshy tissue that forms in the healing process of wounds) noted, peri wound (the area of skin around the wound) intact and dry. I cleansed with normal saline, patted dry with sterile gauze, applied alginate, and covered with a bordered foam. Patient has a stage 3 pressure injury to the sacrum, full thickness, light serous exudate, 2. 5x1.5x0.1 cm, no odor or s/s if infection, no pain, granulation noted, peri wound intact and dry. I cleansed with normal saline, patted dry with sterile gauze, applied alginate, and covered with a bordered foam. Wound Care Doctor notified, new order. I called and spoke with the patient's RP and notified her of the new skin integrity issues and the plan of care. RP informed that the Wound Care Doctor will further assess patient on Thursday, and she will receive a weekly call with an update on the wounds. RP voiced no concerns. Record review of CR #1's Progress Note dated 01/23/2025 revealed RN E wrote, Patient was seen by Wound Care Doctor during wound rounds. Patient was evaluated and plan of care in place. Patient has stage 3 Pressure injury to sacral measuring 1.5x0.8x0.2 cm with moderate sero-sanguineous exudate (a combination of blood and serum that drains from a wound), red in color, no pain, no odor noted, bright red firm granulation present . Patient has trauma wound to left gluteal fold measuring 2.5x0.9x0.1 cm full thickness with moderate serous exudate . Patient has xerosis to lower extremities . Record review of CR #1's wound care notes for January 2025 and February 2025 revealed the following: . 01/23/2025 (CR #1 was assessed by the facility's regular wound care doctor) . Wound #1: Wound Location: Sacral. Wound Type: Pressure Ulcer. Acquired at Facility: Yes . Wound Measurements: 1.5x0.8x0. 2 cm . Stage: Stage 3 Pressure Injury. Moderate serosanguinous exudate. Color: Bright Red . Wound #2: Wound Location: Left Gluteal fold. Wound Type: Trauma Wound. Acquired at Facility: Yes . Wound Measurements: 2.5x0.9x0.1 cm . Full Thickness, moderate serous exudate . (continued on next page)

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	676450	A. Building B. Wing	02/24/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	. 02/06/2025 (CR #1 was assessed by a wound care doctor filling-in for the regular wound care doctor) . Wound #1. Wound Location: Sacral. Wound Type: Pressure Ulcer. Acquired at Facility: Yes . Wound Measurements: 3x1x0.2 cm . Stage: Stage 3 Pressure Injury. Wound Progress: Improving. Moderate serous exudate. Color: Clear . Wound #3 (unknown why the wound care doctor labeled it #3) Wound Location: Right Buttock. Wound Type: Pressure Ulcer. Acquired at Facility: Yes . Wound Measurements: 1x3x0 cm . Stage: Unstageable Pressure Injury Obscured full-thickness skin and tissue loss. Moderate serous exudate . Record review of CR #1's Shower Sheets for January 2025 revealed the following: * 01/04/2025 (day shift staff 0 7:00 a.m. - 7:00 p.m.): New Skin Issues? No . Comments: None . Signed by CNA G. * 01/04/2025 (night shift staff - 7:00 p.m. - 7:00 a.m.): New Skin Issues? No . Comments: Bed bath . Signed by CNA F. * 01/14/2025 (night shift staff): New Skin Issues? No . Comments: Shower . Signed by CNA F. * 01/18/2025 (night shift staff): New Skin Issues? No . Comments: Shower. Signed by CNA F. Observation and interview with CR #1 on 02/19/2025 at 3:11 p.m. revealed she was in bed at an acute care hospital. CR #1's eyes were closed, and she did not respond verbally or non-verbally to questions. CR #1's hospital nurse touched her head and eyes, and CR #1 began to wave her hand to remove the nurse's hand from her head. CR #1 never made any sound or gestures to indicate she understood or heard interview questions. The hospital nurses stated CR #1 had been nonresponsive since she was admitted to the hospital. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with Treatment LVN C on 02/19/2025 at 11:30 a.m., she stated she was responsible for doing wound care treatments Monday - Friday and another treatment nurse, Treatment LVN H, did wound care on weekends (Saturday and Sunday). She stated floor nurses were responsible for completing each residents' weekly skin assessments. She stated CR #1's wounds (right buttock and sacral) were facility acquired. She said on 01/20/2025, a CNA (CNA B) told her CR #1 had a wound on her buttocks. She said she and CNA B went to assess CR #1 and there were two wounds, a stage 3 on her right buttocks and a stage 3 on her sacrum. She said when the wound care doctor assessed CR #1 on 01/23/2025, he changed the right buttocks wound to an unstageable. She said when she found the wounds on 01/20/2025, she asked the floor nurses and CNA's (she did not specify who she asked) why nobody saw the wounds and reported them to her when they saw redness or excoriation (a wound or abrasion caused by scratching), because the wounds did not just appear overnight. Treatment LVN C said no redness was reported to her regarding CR #1. She said she reviewed CR #1's electronic record and saw that nobody charted/documented about CR #1's skin issue since LVN A wrote she had redness on 01/04/2025. She said Treatment LVN H was the wound nurse on duty on 01/04/2025, she was usually very thorough. She said LVN A probably did not report the redness to Treatment LVN H because she (Treatment LVN H) would have reported it to her, and she would have started a treatment plan. Treatment LVN C said she almost lost her mind (she was very upset) when CNA B reported the wounds on 01/20/2025. She said if the floor nurses and CNAs were doing their jobs, the wounds would not have gotten that bad. She said if the staff saw something, they should have reported it to her or the weekend wound care nurse. She said even though LVN A's note said he reported the redness, she knew he did not. She said he failed to describe the redness he saw. She said something as minor or small as redness could have been eliminated with treatment. She said the CNAs told her either they had not cared for CR #1, or they just did not see it. She stated if the floor nurses were doing their skin assessments, they would have found the wounds. She said CR #1 never said anything about the wounds. She said CR #1 was the type of person who would only speak when you asked her questions. She said if you did not ask, CR #1 would not say anything. She said CR #1 never complained of pain or discomfort once they started treatment. She said once she found the wounds, she contacted the wound care doctor and CR #1's RP. She said after she found the wounds on 01/20/2025, she got CR #1 on an air mattress and wedge. She said she also made sure the CNAs repositioned CR #1 regularly to offload the wounds. She stated she had never seen CR #1 before 01/20/2025 because she only assessed and treated residents with wounds. She said LVN A was a full-time nurse at that time (01/04/2025), but as of 02/14/2025, he was PRN. An attempt was made to contact LVN A by phone on 02/19/2025 at 12:16 p.m. A voicemail message was left. He returned the call on 02/19/2025 at 2:58 p.m. and left a message. More attempts to contact LVN A by phone were made on 02/19/2025 at 3:54 p.m., and 02/21/2025 at 10:45 a.m. A text message was left for him on 02/19/2025 at 6:23 p.m. The calls and text were never returned. In an interview with RN E on 02/19/2025 at 12:10 p.m., she stated she sometimes filled-in for Treatment LVN C when she was off. She stated she treated CR #1's wounds on 02/10/2025 and 02/14/2025. She said CR #1 did not complain of pain or discomfort. She said if a resident was found to have redness, the floor nurse would notify the wound care nurse after doing an assessment. She said the nurse would also contact the wound doctor and get orders to start treating the redness, which would likely be barrier cream. She said if they catch the redness, it does not always turn into a wound. She said the redness would turn into a wound if the skin experiences friction and pressure. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview with Treatment LVN H on 02/19/2025 at 3:56 p.m. she stated she only worked at the facility on Saturdays and Sundays. She said LVN A never told her CR #1 had any redness. She stated she only found out about CR #1's wounds after she showed up on the wound list the weekend after 01/20/2025. She said she never would not have assessed CR #1 otherwise because she only did wound care on weekends and the floor nurses did skin assessments. She said redness did not usually turn into a stage 3 wound overnight. She said some wounds developed quickly, but usually there was a progression from redness to stage 3. She said if the nurses were doing what they were supposed to do, such as doing skin assessments when they pop up on the electronic MAR, they would have caught the issue before it turned into a wound. She said LVN A should have written a progress note describing the redness and noting who it was reported to. She said LVN A should have reported the redness to CR #1's doctor as well. She said if the redness was reported to her, she would have written another progress note and said what treatment she did and who she reported it to. In a telephone interview with LVN I on 02/19/2025 at 10:33 p.m., she stated she worked the night shift and often cared for CR #1. She stated staff repositioned CR #1 regularly prior to finding the wounds and after they found the wounds. She stated CR #1's skin assessments were scheduled for every Friday on the day shift, so she never did one for her. She stated she never observed CR #1 with redness and only found out about the wounds after they were noted on 01/20/2025. In a telephone interview with CNA F on 02/19/2025 at 10:50 p.m., she stated she often cared for CR #1 on the night shift. She stated she did not recall when she observed CR #1's wounds, but approximately 2.5 - 3 weeks ago, she reported the wound to LVN I. She said she thought she observed the wound as soon as it popped up. She said she saw one little spot on CR #1's back sometime in the beginning of January 2025. She said the spot was very small between CR #1's buttocks (cheeks) and it was a little red with a small opening. She said they started doing wound treatments on the wound pretty much immediately after that because she saw the dressings on it. She said she saw one spot and it did not get bigger, but a second spot formed maybe a couple of days after the first spot. She said she did not care for CR #1 that many days in a row. She said LVN I treated the wound right after she reported it. She stated she reported the wound many days before the holiday in January (01/20/2025 was a holiday), but she could not recall what day it was. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the ADON on 02/20/2025 at 9:20 a.m., she stated the facility did not currently have a DON to oversee the wound care program, so they had a consultant or corporate DON (Clinical Services Director) who came in, and the wound care nurse worked with the wound care doctor. She stated the facility's staff worked as a team to oversee the wound care program. She said if redness was observed on a resident, the nurse should alert the wound care nurse, the RP, and the resident's NP so they can all monitor it and get interventions in place. She said if a nurse observed redness, they should complete a skin observation, progress note, and they should document whatever orders came from that. She stated LVN A did not follow normal procedure because he should have made a skin assessment/observation and completed a progress note, which would have alerted the other nurses. She said LVN A should have notified the wound care nurse and then followed up. She said the CNAs should have been looking for skin issues during showers/bed baths too. She said if redness was not reported, assessed, and treated, it could progress into a wound. She said she could not say a stage 3 wound would have progressed overnight. She said a wound could progress rapidly, but she did not have the expertise to say it could happen that fast. She said she never saw CR #1's wounds. She said every resident should have a weekly skin assessment. She said the ADONs (the facility had two ADONs, but this one was responsible for CR #1's care) were responsible for making sure weekly skin assessments were done. She said CR #1's skin assessments were done weekly to her knowledge. She said she ran a report on Mondays (for Monday - Sunday each week), and she checked off the list as the skin assessments were completed and documented for the week. She reviewed CR #1's electronic record and said CR #1 did miss a skin assessment and she could have missed it by mistaking the focused skin observation for a skin assessment (there was no focused skin observation January 12 - 18, 2025). She said she would normally make sure they all got done. In an interview with CNA B on 02/20/2025 at 10:15 a.m., she stated she often cared for CR #1 on the day shift. She said during care, she looked at CR #1's, entire back side. She said before CR #1 had a wound, she noticed redness the second week of January 2025. She said she observed that CR #1 had a bed sore (the redness) on the right-side buttocks and she let LVN A know. She said LVN A told her to use skin protector (barrier cream) on CR #1's sore but it was not working, and it got worse. She said she cared for CR #1 other times, and she saw the sore get worse, so she let Treatment LVN C know. She said when she initially saw the sore, it was like a red baby rash. She said when she told LVN A about it, he went and looked at it, but she was not sure he alerted the wound care nurse. She said she did not think LVN A alerted the wound care nurse because she notified Treatment LVN C in mid-January 2025 because the wound had progressed. She said the redness never went away, it progressed into the wound. She said CNA F also noted the redness because when she switched off with her during shift change, they talked about it and CNA F also used barrier cream on CR #1. She said she and CNA F both repositioned CR #1 every two hours. She said after she notified Treatment LVN C, they started doing wound care on CR #1's wounds. She said prior to seeing CR #1 with redness on 01/04/2025, she never had any skin issues. She said she did not know if LVN A notified CR #1's doctor about the redness. She said after Treatment LVN C started treating CR #1's wounds, they started clearing up. She said CR #1 was scheduled to have showers/bed baths on Tuesdays, Thursdays, and Saturdays during the night shift. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with LVN D on 02/20/2025 at 10:30 a.m., she stated she was familiar with CR #1, and she worked with her a lot in the past. She said she was responsible for doing weekly skin assessments. She said the floor nurses had a set schedule for skin assessments. She said the skin assessment schedule was posted and they were also set on each resident's electronic MAR. She said if the skin assessment popped up on the computer, then they have to do it. She said she had not done many skin assessments on CR #1 because she was not on her regular hall. She said she did not recall the last time she did one for CR #1, but if she wrote no new skin issues, it could have been that she did not see anything. She said CR #1 could have developed something over a couple of days. She said she did not recall seeing any redness or wounds at that time (01/10/2025). She said the nurses had to look between the residents' buttocks during a skin assessment. She said if she saw any redness, she would have documented it. She said if the nurses saw redness, they had to let the wound nurse know, call the doctor, and call the wound doctor. She said if she saw redness, she would have called the doctor then. She said the doctor may have said to add barrier cream and regular repositioning, but they still had to let the wound care nurse know. She said not reporting redness could lead to it getting overlooked and it could turn into a wound or something worse. She stated 01/10/2025 was on a Friday and if that was CR #1's regular day for a skin assessment, it would have popped up on her computer to do it. In an interview with the wound care doctor on 02/20/2025 at 11:15 a.m., he stated he was filling-in for the regular wound care doctor while he was on vacation. He said he recalled CR #1 a little. He said CR #1 had two wounds and both were pressure wounds. He stated he could not say how quickly a stage 3 wound developed because it depended on the patient. He said if someone reported that a patient had redness, he would recommend repositioning regularly and barrier cream. He said relieving the pressure would cause the redness to go away in one day. In a telephone interview with CR #1's RP on 02/20/2025 at 12:10 p.m., she stated nobody ever notified her CR #1 had any redness. She said she was only notified when CR #1 developed wounds two weeks ago (she could not recall the date). In a follow-up interview with Treatment LVN C on 02/20/2025 at 12:31 p.m., she stated after she found CR #1's wounds on 01/20/2025, she spoke to LVN A and asked him how CR #1 got the wounds, and nobody saw them or reported them. She said LVN A said it was just red, the day he saw it. She said she asked LVN A what they were doing about the redness, and he said he told the CNA to do barrier cream. She said she told him CR #1's wounds were more than just red at that time, and he said he had been off a few days and the wounds looked different than when he saw it. Treatment LVN C said for redness, she would have instructed the nurses to do barrier cream with zinc with each incontinence episode. She said the CNAs could only administer regular barrier cream without zinc, but the nurses could administer the cream with zinc. She stated failing to follow-up and monitor CR #1's redness could have resulted in progression into a wound and possible infection if it was not caught in time. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview with CR #1's physician on 02/21/2025 at 10:09 a.m., she stated she had been responsible for CR #1's care for several years. She said to her knowledge, this was the first time CR #1 ever had any skin issues. She said she did not recall anybody notifying her about any skin issue or redness in early January 2025. She said she did not recall anybody telling her about a stage 3 wound, but she worked with eight nurse practitioners, and they may have received notification. She said one NP usually visited CR #1. She said if the facility called her about CR #1's redness, she would have instructed them to use barrier cream, offload the wounds, avoid access moisture with frequent brief changes, and notify the wound care doctor for treatment. She stated failing to monitor CR #1's redness closely for changes could have contributed it to developing into a stage 3 wound. In an interview with the Clinical Services Director on 02/21/2025 at 11:19 a.m., she stated she was a consultant and was not employed through the facility. She stated she helped the facility with systems and made suggestions and recommendations for improvements. She stated she previously looked at the facility's wound care program and put an action plan in place. She said when a CNA observed redness, they should notify the nurse immediately. She said the nurse should assess the resident and notify the doctor, family, and the treatment nurse. She said the nurse should also communicate with the rest of the team, including the oncoming nurses and CNAs. She said the nurse should get orders from the doctor and implement the orders. She said if the redness was noted in the middle of the night, the nurse should leave a note for the treatment nurse notifying they found something on the resident. She said the nurse should also leave a note in the facility's 24-hour communication book. In a telephone interview with CR #1's NP on 02/21/2025 at 12:04 p.m., she stated she rounded at the facility every Monday and Thursday and she visited CR #1 weekly. She stated nobody ever told her CR #1 had any wounds until now (02/21/2025). She stated she laid eyes on CR #1 weekly and checked in with the nurses, but she never did a head-to-toe assessment. She said had the staff told her CR #1 had redness or any skin changes, she would have instructed them to add barrier cream, reposition often, and have the treatment nurse assess and watch to make sure it did not progress. In an interview with the Administrator on 02/24/2025 at 2:15 p.m., she stated she attempted to contact LVN A to speak with him about CR #1, but he had not returned her phone calls. She stated LVN A was a PRN nurse, but she did not plan to call him for work again. Record review of the facility's policy titled, Wound Care Policies and Procedures 03/23/2017 revealed, Policy: Pressure ulcers will be evaluated and treated in accordance with professional standards of practice to heal and prevent pressure ulcers unless clinically unavoidable . Record review of the facility's policy titled, Physician and Other Communication/Change In Condition revised 07/0 [TRUNCATED]