| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676463 | A. Building<br>B. Wing | 12/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crimson Heights Health & Wellness | 19279 McKay Dr.<br>Humble, TX 77338 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249<br><br>Based on observation, interview, and record review, the facility failed to ensure that residents received the necessary treatment and services, to promote healing, prevent infection for 1 of 5 residents (Resident #1) reviewed for pressure ulcers in that:<br><br>-The facility failed to ensure Resident #1's right buttock stage 2 pressure wound had a dressing covering the wound on 12/04/2024.<br><br>This failure could affect residents with wounds placing them at risk of infection, a decline in health, pain, and hospitalization .<br><br>Findings included:<br><br>Record review of Resident #1's (undated) face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included muscle weakness (occurs when your muscles are unable to contract properly, resulting in reduced strength), hypotension (a condition where the force of blood pushing against artery walls is lower than normal) and pain ( a sensory and emotional experience that can be unpleasant and distressing).<br><br>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed she had a BIMS score 07 out of 15 which indicated she had severely impaired cognition. She required partial/maximal assistance with toileting hygiene, shower/bathe self, and personal hygiene. H0300 Urinary continence coded: always incontinent of bowel and bladder. Section M0150 Resident was at risk for developing pressure ulcers/injuries.<br><br>Record review of Resident #1's care plan initiated 10/27/2024 and revised on 12/03/2024 revealed the following:<br><br>Problem: (Resident#1) has a Stage II pressure ulcer on her Right Buttock related to [X] immobility, [X]<br><br>incontinence, [] poor nutrition, [] decreased cognition, [] diabetes, [] heart failure, [] COPD, [] kidney failure<br><br>Goal: Resident's ulcer will decrease in size and will not exhibit signs of infection as evidenced by wound documentation for 90 days.<br><br>(continued on next page) |



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

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interventions: CNAs to inspect skin, especially over bony prominences, during bathing and personal care and report findings to Licensed Nurse. Minimize skin exposure to moisture from incontinence, perspiration, or wound drainage by cleaning with mild cleansing agents and using skin barrier cream for skin protection.<br><br>Record review of the Physician's orders for Resident #1 dated 12/03/2024 revealed an order to cleanse stage ll pressure injury with WC/NC, pat dry, apply collagen then cover with a bordered gauze dressing daily & Prn if soiled or dislodged.<br><br>Observation and attempted interview on 12/04/24 at 9:53 a.m., revealed Resident #1 was resting on an air mattress. She was alert and well groomed. The resident mumbled for 5 minutes while being interviewed and could not make herself understood and did not respond appropriately to asked questions about her pressure sore/injuries.<br><br>Observation on 12/04/24 at 9:59 a.m., revealed the Wound Care Nurse providing wound care for Resident #1. The Wound Care Nurse was assisted by CNA A. An open area of approximately 2.0 centimeters in diameter, was observed without a dressing on the right buttock. The Wound Care Nurse said, Hospice aide just gave bed bath to the resident. She might have taken the dressing off.<br><br>In an interview on 12/04/24 at 10:09 a.m., with the Wound Care Nurse, he confirmed Resident #1's right buttock wound did not have a dressing on it. When asked how do the hospice aides know who to report these type of concerns to, and who is responsible for monitoring these aides when they are in the building, the WCN said the hospice aide should have immediately notified him or the floor nurse because there were prn orders if the dressing became soiled or dislodged. The WCN stated it was important to provide dressings on the wound to keep it protected from infections.<br><br>In an interview on 12/04/24 at 10:21 a.m., with LVN ZZ, she stated the CNA, or the hospice aide did not notify her that Resident #1's dressing had come off. She said the aides were supposed to come and tell the nurses right away so the nurse can dress the wound as there were prn orders for dressing change.<br><br>In an interview on 12/04/24 at 1:53 p.m., the ADON stated the Wound Care Nurse was responsible for wound care Monday through Friday. The Surveyor shared the observation from earlier. The ADON said her expectation was for wound dressings to be changed daily and as needed if soiled or dislodged according to physician's orders. When asked how do the hospice staff know who to notify and when they should be notified, the ADON stated she was going to get with hospice company so they could educate their staff. ADON stated the hospice aide should have notified the floor nurse/wound care nurse so they could dress the wound . She stated it was important to dress the wound to prevent infection. She stated Resident#1 was incontinent of bowel/bladder feces could get in and the wound could get worse.<br><br>Record review of the facility's Wound Care policy dated (Revision: 6/1/2015) revealed read in part: . subject: Pressure ulcers. Policy: Pressure ulcers will be evaluated and treated in accordance with professional standards of practice to heal and prevent pressure ulcers unless clinically unavoidable .<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the facility's Wound Care policy dated (6/1/2015) revealed read in part: . subject: Performing A Dressing Change. Policy: A dressing change will follow specific manufacture's guidelines and general infection control principles. 6. Apply a cover dressing-date and initial cover dressing, place time reference on it . |