STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31882 Based on observation, interview and record review the facility failed to ensure residents receive care consistent with professional standards of practice, to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and once developed, failed to ensure necessary treatment and services to promote healing for one (Resident #1) of nine residents reviewed for pressure ulcers. The facility failed to: A. Ensure Resident #1 who was admitted to the facility without a pressure ulcer did not develop an unstageable pressure ulcer with eschar (a layer of dead skin tissue that forms over a wound) on her coccyx within two weeks of admission. B. Failed to notify the wound care nurse of the ulcer. C. Failed to accurately document Resident #1's skin conditions which caused delayed care for the ulcer. D. Failed to document descriptions of the pressure ulcer which put the resident at risk of worsening pressure ulcer due to not accurately documenting Resident #1's skin conditions. These failures resulted in an Immediate Jeopardy (IJ) situation on 02/20/2025. While the IJ was removed on 02/24/2025, the facility remained out of compliance at a severity level of no actual harm with the potential for more harm than minimal harm that is not Immediate Jeopardy. These failures placed the residents at risk for worsening pressure ulcers, Cellulitis (skin infection), Osteomyelitis (infection of the bone), Sepsis (infection of the blood), severe pain or death. Finding Include: (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of Resident #1's face sheet revealed Resident #1 to be a [AGE] year-old female admitted to the facility for rehabilitation services on 01/27/2025 with a diagnosis of Alzheimer's disease (a progressive disease that destroys memory and other functions), anxiety, chronic pain, high blood pressure, and muscle weakness. Resident #1 had gone to a physician appt on 2/10/25 and was admitted to the hospital for open reduction and removal of femoral component of total hip arthroplasty without allograft. An unstageable pressure ulcer with eschar and tunneling was found upon admission to the hospital on 2/10/25. Resident #1 returned to the facility from the hospital on 2/19/25. An Admission MDS dated [DATE] documented Resident #1 had a BIMS score of 4 out of 15 which indicated cognition was severely impaired. Section H Bladder and Bowel documented resident was always incontinent of bladder and frequently incontinent of bowel. Section M Skin Conditions documented there were no pressure ulcer based on clinical assessment and formal assessment of Braden. An MDS assessment dated [DATE] documented in Section M- 00300 Resident #1 had an unstageable -Slough and Eschar. The MDS further revealed Resident #1 to be totally dependent on staff for ADL care and required two-person assistance with transfer, bed mobility, incontinent care and personal hygiene. Resident #1 was not admitted to the facility with pressure ulcers and was noted to be at risk for development of skin issues. A Baseline Care Plan, used for new admissions, dated 1/27/25 and completed 1/28/25 documented Resident #1 was incontinent, at risk for pain and required assistance with ADL's. Skin conditions were addressed as: Patient skin will remain intact. Document any skin issues in PCC. For pressure related wounds document location, length width and depth. Describe wound in detail, including peri wound. Record Review of the physician orders for 1/1/25 through 1/31/25 documented no orders for wound care for buttocks or weekly skin assessments. Skin tears to shins were addressed. Record Review of the physician orders for 2/1/25 through 2/28/25 documented Licensed Nurse to perform weekly skin assessments every day shift every Friday. Start Date: 2/21/25. Coccyx pressure wound, apply wound cleanser, and pat dry, apply Medi honey to wound bed, then apply Allevyn foam dressing (adhesive dressing for absorption and management of wounds). Every shift for Pressure Ulcer 2/9/25. Facility treatment nurse to evaluate wound on sacral area and treat as needed. Every shift Start date 2/19/25. Record Review of the January 2025 TAR dated 1/1/25 through 1/31/25 TAR documented there were no orders for weekly skin assessments or treatment for a coccyx pressure ulcer. Record Review of the February 2025 TAR dated 2/1/25 through 2/28/25 TAR documented there were no orders for weekly skin assessments or treatment for a coccyx pressure ulcer from 2/1/25 to 2/8/25. Record Review of the facility nurses' notes for Resident #1 revealed no skin assessments had been done since admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of the Hospital records for Resident #1 documented Resident #1 was admitted to the hospital on 2/10/25 for hypotension, left anterior hip dislocation and was noted to have an unstageable pressure injury to the coccyx. Nurses' hospital note stated wound was present upon admission. Wound care was provided on 2/11/25 and was documented as: Wound Treatment Summary Braden Scale Score: 12; Unstageable pressure Injury: Coccyx assessed on 2/11/25 as dark colored superior portion suspect deep tissue unstageable pressure. Wound bed assessment stated area to coccyx noted to have moist, yellow tan adherent slough to 100 percent of wound bed. State of healing: inflammatory stage. Surrounding Skin Assessment: clean dry blanchable red. Dressing Drainage Description: Serosanguineous. Wound Width- 1.5 cm, Wound surface 5.55cm. 2 Debridement: Autolytic; Mechanical. In an interview on 02/18/2025 at 9:30 am Resident #1's RP, who was a nurse, stated Resident #1 had developed an unstageable pressure ulcer on her coccyx since being admitted to the facility. Resident #1s RP stated she had taken Resident #1 to a Dr appointment on 2/10/25 and Resident #1 had been sent to the hospital as the procedure could not be done in the office. Upon admission to the hospital, Resident #1 was found to have an unstageable pressure ulcer on her coccyx. Resident #1's RP stated she saw the ulcer at the hospital on 2/10/25. She stated it was unstageable with eschar and was pretty large. She stated the eschar was thick yellow and the hospital had to work to get all the eschar off. She stated the pressure ulcer had to have been there before the resident went to the hospital that day. She stated the facility never told her about the pressure ulcer. She stated she called the facility and had spoken to the ADM and the DON. The RP stated, Of course they did not want to admit the facility did not do what they were supposed to, but they tried to tell me it started in the emergency room . The RP stated the pressure ulcer was too bad to have started in the emergency room . She stated the hospital put the Thera honey on the wound and could only uncover half of the ulcer. She stated the pressure ulcer had tunneled. The RP stated the Risk Manager (RM) called and said he was very sorry about the pressure ulcer and that Resident #1's treatment did not meet there standard of care. She stated the RM said the pressure ulcer would be investigated and steps would be taken to ensure they got to the bottom of the issue. In an observation and interview on 2/18/25 at 1:10 pm Resident #1 was observed in bed. Resident #1 was talking to people who were not in the room and was not able to be interviewed. In an observation and interview on 02/18/2025 at 1:15 pm, the Hospital RN (RN A) stated she had been taking care of Resident #1 on this date. RN A stated Resident #1 had a pressure ulcer upon admission to the hospital that was necrotic and tunnelling. She stated Resident #1 had to have had the sore for quite some time for it to be tunneling. She stated there was MRSA (a type of staph bacteria resistant to many antibiotics) in the wound. RN A reviewed the hospital records and notes from admission and stated the hospital noted Resident #1 had the pressure ulcer upon admission to the hospital. She showed the computer screen of the pressure ulcer, the admission notes, and the wound measurements. She stated since Resident #1 was still in the hospital, medical records would not print medical records. A picture of the pressure ulcer and the measurements on admission were printed. Review of the picture of the pressure ulcer on the hospital computer screen revealed a large open wound on the coccyx. In an interview on 02/19/2025 at 8:30 am, the ADM stated she had been aware Resident #1 had gone to the hospital and stated the facility did not know she had a pressure ulcer until the family stated the hospital showed it to them. She stated that was why it was not reported. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 2/19/25 at 9:50 am, the DON stated the only Braden assessments (most commonly used assessment for risk of pressure ulcers) for Resident #1 were done on admission 1/27/25 and on 2/3/25. She stated Resident #1 did not have pressure ulcers on those dates. She stated Resident #1 should have been turned and repositioned every 2 hours while she was in the facility. She stated turning and repositioning were standard orders. She stated she did not know if Resident #1 had been turned and repositioned or not. She stated it was not something that was documented. In an interview on 2/19/25 at 10:40 am, RN B stated she had not been aware Resident #1 had a Stage 4 pressure ulcer while she was at the facility. She stated she had done an assessment on Resident #1 when she was admitted . She stated Resident #1 did not have a pressure ulcer upon admission and only had a small red spot on her bottom. She stated no one had informed her of the worsening spot. She stated she did not find out it was an unstageable pressure ulcer until she had been admitted to the hospital on 2/10/25. She stated the normal procedure would be a CNA or nurse informed her she needed to see a resident for a wound. She stated the nurses knew Resident #1 had a pressure ulcer, but the nurses had not let her know. RN B stated she had found a nurses note that a nurse documented a pressure ulcer on 2/8/25. She stated of the note that the nurse documented she had notified her of the pressure ulcer. RN B stated she had not been notified of the pressure ulcer. She stated no one in the facility had verbally told her about the sore until 2/10/25 when the family had called the ADM. When asked if the pressure ulcer could have developed in the emergency room in one day, she stated, No it could not have. She stated there had not been weekly skin assessments done by the nurses for Resident #1 and the skin assessments from the CNA's doing incontinent care had been done incorrectly or were not done at all. She stated the consequences of not having a skin assessment weekly would be missing skin issues causing further skin issues. She stated she had done training with the nurses and the CNAs. She stated the consequences of not finding a pressure ulcer would be poor care, worsening pressure ulcers and medical complications for the resident. In an interview on 2/19/25 at 11:00 am, the Risk Manager (RM) stated he was aware there was an issue with the Resident #1 as the RP had called him. He stated the RP discussed the pressure ulcer. He stated she told him a pressure was found in the emergency room and no one at the facility had told her about it. He stated she was a nurse and was a very reasonable person to him. Then the ADM and the DON called her. The RM stated Maybe we should have seen it. Maybe we should have had better documentation on the skin. I told the RP we do not like unavoidable pressure ulcers. He stated he could not tell the RP if it was avoidable or not. He stated It's on my radar now. As far as the pressure ulcer in the facility that was not documented, I am going to let the ADM and the DON deal with that. They run the building. Not me. I look at trends. In an interview on 2/19/25 at 11:27 am, the ADM stated We did not know about the pressure ulcer. No one laid eyes on it here. We do not know when it started. Whoever the nurses were that were supposed to be doing the weekly skin assessments did not do it or did not check the right box. In an interview on 2/19/25 at 12:10 pm, the DON stated she found a nurses note about the sore, but the nurses had not followed up on it. She stated she did not know when she found the note. She stated RN B, had not been notified about the sore. The DON stated all nurses were supposed to have done weekly skin assessments, but they had not done it. She stated the CNAs had not checked the correct boxes for the toileting either. She stated there were no measurements done for Resident #1's wound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	In a follow-up interview on 02/19/2025 at 3:55 pm,, the DON stated she did not find the paperwork that confirmed Resident #1 had been turned and repositioned every 2 hours. The DON stated a complete skin assessment was not completed for Resident #1 upon admission. The DON stated she did not have any paperwork for toileting. In an interview on 2/20/25 at 10: 37 am, LVN C stated she had not found any weekly skin assessments for Resident #1. She stated she had not found any documentation on turning and repositioning Resident #1 but stated it was standard care and they usually did not have orders for turning. She stated she had not been aware Resident#1 had a pressure ulcer until the 9th of February. Regarding the skin issues, she stated the CNAs looked at skin when they change the residents and when the residents were showered. She stated the CNAs were good about notifying the LVNS about any red spots, changes in skin, bruises, and sores. She stated after a sore was found then the LVN would assess the sore or spot and report to the RN house supervisor or the DON. She stated she would also call or tell the wound care nurse. In an interview on 2/20/25 at 1:45 pm, RN D stated she had seen a note from RN E that stated Resident #1 had a pressure ulcer on 2/8/25. RN D stated she had done a return anticipated to the facility MDS after Resident #1 went to the hospital on 2/10/25. She stated the progress note stated RN E called the on-call Nurse practitioner and got orders for treatment. RN D stated this prompted her to ask RN B about the pressure ulcer. She stated RN B told her she had no idea Resident #1 had a wound. RN D stated she logged into the hospital records and found information on the pressure ulcer from the hospital records. RN D stated the pressure ulcer had been unstageable due to sloth. She stated the usual procedure for wounds would be the nurses would tell RN B about the pressure ulcers which prompted RN B to assess and treat. She stated the nurse's notes did not have specific documentation about the pressure ulcer in the nurses' notes as to size condition and treatment which is why she logged into the hospital records. She stated Resident #1 had returned to the facility on [DATE]. In an interview on 2/20/25 at 2:05 pm, RN F stated Resident #1 would not stay in bed and was always wanting up from the bed. RN F stated she was only in bed for naps and at night. She ate in the dining room and sat in the lobby with the other residents. RN F stated Resident #1 would try to get up on her own without calling for assistance. She stated she found out about the pressure ulcer on 2/8/25 when another RN pointed it out to her. RN F stated the pressure ulcer was not that bad and was not that big. She stated the aides were good about saying something about skin issues. She stated she did not know if the wound care nurse knew about it and she had not notified her. In an interview on 2/20/25 at 2:30 pm, CNA G stated she had taken care of Resident #1 while she was in the facility. She stated she had only seen a red spot-on Resident #1 when she did incontinent care and she put barrier cream on it. She stated there were no open sores that she saw. She stated all the CNAs were to alert the Charge Nurse of any skin issues they see during incontinent care. She stated the CNAs were to mark the Skin Observation Task on PCC after incontinent care as to what they saw. She stated sometimes the documentation would not be accurate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 2/22/25 at 9:20 am RN H stated she was the Weekend House Supervisor and stated she saw Resident #1 when a night nurse asked her to evaluate the sore on Resident #1's coccyx. She stated it was a Stage 2 with slough on 2/9/25. RN H stated the nurses were just doing a topical cream up to that point. She stated she did not know if the wound care nurse had seen the wound before this date, and she stated she left an email for the wound care nurse. She stated the CNAs document the skin issues and are to let the nurses know about any skin issues they see. The nurses report to the house supervisors who pass on the information to the DON. She stated the consequences of not charting correctly would be some form of disciplinary action. She stated the consequences to the resident of not properly assessing skin issues would be not being properly assessed or treated and would result in a pressure ulcer. In a follow-up interview on 2/19/25 at 3:55 PM, the DON stated she did not find the paperwork that confirmed Resident #1 had the pressure ulcers upon admission. The DON stated a complete skin assessment had not been completed for Resident #1 upon admission. In an interview on 2/19/25 at 4:30 pm, LVN E stated she had seen the pressure ulcer on Resident #1's coccyx on the 8th and had left a message for RN B. She stated she had not followed up with RN B to make sure she knew about the sore. She stated she did not measure the wound. LVN E stated the wound was a large open area. She stated she called the NP on duty and had gotten orders to apply a triad (a paste for light to moderate skin breakdown after incontinence). In an interview on 2/22/25 at 4:30 pm, LVN I stated Resident #1's sore had been reported on the 2/9/25 by the night nurse. LVN I stated the night nurse had called the Nurse Practioner for orders. LVN I stated she had not known Resident #1's bottom was red or that she had a pressure ulcer before that day. LVN I stated the bottom had been red but was not open the week before and the CNAs had been putting barrier cream on her. She stated she had left a message for RN B but had not followed up further. In an interview on 2/22/25 at 10:00 am PA stated she is the facility physicians 's PA. She stated she had not seen Resident #1 before she had gone to the hospital. She stated she was not aware Resident #1 had a pressure ulcer before she went to the hospital. She stated Resident #1 had a big pressure ulcer now on her spine. She stated the facility had a wound care nurse that treated the wounds in the facility. She stated she could give no further information on the matter. Record review of Resident #1's facility nursing notes revealed on 1/27/25 at 8:00 pm an admission note stated blanchable redness to bilateral buttocks, no open areas noted. Nurses Note on 2/6/25 documented area to buttocks other skin issue redness/wound was present upon admission. Skin has not been evaluated. Nurses note on 2/8/25 documented Resident #1 had pressure ulcer to coccyx. Triad applied to open area. Nurses note dated 2/8/25 documented redness present at admission. Nurses note dated 2/8/25 at 8:30 pm documented Resident had developed a pressure ulcer to coccyx which appeared to be worsening. Wound cleanser and triad had been used for the past 2 days. On call FNP was contacted about using Medi honey (a wound dressing that reduces bacteria and inflammation in wounds) and dressing on pressure wound. Record Review of the physician orders for 1/1/2025 through 1/31/25 documented no orders for wound care for buttocks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of the physician orders for 2/1/25 through 2/28/25 documented: Licensed Nurse to perform weekly skin assessments every day shift every Friday. Start Date: 2/21/25. Coccyx pressure wound, apply wound cleanser, and pat dry, apply Medi honey to wound bed, then apply a dressing. Every shift for Pressure Ulcer 2/9/25. Facility treatment nurse to evaluate wound on sacral area and treat as needed. Every shift, Start date 2/19/25. Record Review of the facility Treatment Administration Record titled CNA tasks report for Resident #1 documented: 1/27/25 at 2:25 pm documented none of the above observed. 1/27/25 at 11:29 pm redness and discoloration 1/28/25 at 9:58 am documented none of the above observed. 1/28/25 at 9:11 pm documented none of the above observed. 1/29/25 at 8:41 am none of the above observed. 1/29/25 at 7:55 pm documented none of the above observed. 1/30/25 at 9:37 am documented none of the above observed. 1/30/25 at 9:16 pm documented red area 1/31/25 at 8;25 am documented none of the above observed. 2/1/25 1:54 am documented Not applicable 2/1/25 10:03 am none of the above observed. 2/2/25 2:19 am documented none of the above observed. 2/2/25 7:52 am documented none of the above observed. 2/3/25 1:55 am documented a red area. 2/3/25 8:47 am documented none of the above observed. 2/3/25 7:15 pm documented none of the above observed. 2/4/24 5:44 pm documented a red area discoloration and open area. 2/4/25 9:36 pm documented none of the above observed. 2/5/25 9;43 am documented none of the above observed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	2/5/25 7:17 pm not applicable 2/6/25 9:03 am not applicable 2/6/25 8:40 pm documented a red area. 2/7/25 8:28 am documented none of the above observed. 2/7/25 9:02 pm documented red area 2/8/25 8:43 am documented discoloration 2/8/25 at 7:15 pm documented a red area. 2/9/25 7:59 am documented none of the above observed. 2/10/25 3:45 am documented a red area. 2/10/25 10:10 am documented none of the above observed. 2/10/25 at 9:45 pm documented resident not available Record Review of Resident #1's Hospital record dated 2/10/25 documented Resident#1 had been admitted to the hospital for 2/10/25 for hypotension, left anterior hip dislocation and noted to have an unstageable pressure injury to the coccyx. Nurses' hospital note stated wound was present upon admission. Wound care was provided on 2/11/25 and was documented as: Wound Treatment Summary Braden Scale Score: 12; Unstageable pressure Injury Coccyx assessed on 2/11/25 as dark colored superior portion suspect deep tissue unstageable pressure. Wound bed assessment stated area to coccyx noted to have moist, yellow tan adherent slough to 100 percent of wound bed. State of healing: inflammatory stage. Surrounding Skin Assessment: clean dry blanchable red. Dressing Drainage Description: Serosanguineous. Wound Width- 1.5 cm, Wound surface 5.55cm. 2 Debridement: Autolytic; Mechanical. Record Review of Resident #1's admission nurses note on 1/27/25 revealed for skin integrity Resident #1 had normal skin with the only skin issues noted as skin warm and dry with surgical incision 13 cm with striker zip dressing in place. No signs or systems of infection, blanchable redness to bilateral buttocks no open areas noted: left shin skin tear 4 cm with steri-strip, right shin skin tear 8 cm in width. Record review of the facility policy titled Skin Care and Prevention dated 2/17/23 revealed Every effort will be made by the facility to ensure that every resident that moves into the facility without a pressure injury does not develop a pressure injury unless the individuals clinical condition demonstrates the pressure injury was unavoidable. The facility will also ensure that necessary treatment is provided to promote healing, prevent infection, and prevent new sores from developing. Record Review of the facility policy titled Wound Care and Pressure Injury Treatment dated 4/16/24 revealed The facility will ensure that necessary treatment is provided to promote healing, prevent infection and prevent new sores from developing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of the facility policy titled Protocol: Prevention is the Key to Wound Care dated 2/23/23 revealed Prevention is the key to Wound Care. Complete a Braden scale upon admission, weekly, or with any change in condition including new wound. A resident with a BRADEN score of less than 15 will be considered at risk for pressure and breakdown. An Immediate Jeopardy was identified on 02/20/25 at 4:10 pm. The Administrator was notified of the Immediate Jeopardy on 02/20/2025 at 4:10 pm and the IJ template was provided. The Administrator expressed understanding of the Immediate Jeopardy and a Plan of Removal was requested. The Plan of Removal was accepted by the Administrator on 2/21/25 at 3:38 pm and is as follows: Plan of Removal for I J 2/20/2025 Corrective Action: All residents in the building will receive a head-to-toe skin assessment observed by a member of the Nurse Management Team, to be completed 2/21/2025. Any area of concerns will be addressed with pressure prevention interventions and/or orders will be obtained and implemented immediately by the charge nurse. Beginning on 2/21/2025, all new admissions/readmissions to Skilled Nursing or Long-Term Care will receive a head to toes skin assessment, while a member of the Nurse Management Team is present to observe. When any area of concern is noted, pressure prevention interventions and/or orders will be obtained and implemented immediately by the charge nurse. When a change in skin condition is identifies by a CNA during route care or peri care/bathing the change will be reported to the charge nurse, who will ensure pressure prevention interventions and/or orders will be obtained and implemented immediately. Identification of Others: All residents have the potential to be affected by this alleged deficient practice. Systemic Changes: Staff education will be provided to all nurses for proper skin assessments, wound care prevention, treatment protocols, documentation by exception, and importance of communication of resident concerns, to completed on 2/21/2025 or before next shift worked. CNA's will be educated related to Skin Integrity and Wounds, beginning 2/21/2025. All CNA's will receive education prior to next scheduled shift. Monitoring to Sustain Compliance: A member of the Nurse Management Team will continue to be present to observe head to toe skin assessments for new admissions/readmissions to Skilled Nursing or Long-Term Care, for a minimum of 30 days, to be completed on 3/31/2025. Head to toe skin assessments will be monitored by a member of the Nurse Management Team randomly for an additional 30 days, to be completed on 4/30/2025. The Wound Care Nurse or designee will continue to monitor to ensure that skin care preventative interventions are in place, treatments are performed, and skin is monitored for changes in condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S. Van Buren St. Amarillo, TX 79101

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	In a facility monitoring visit on 2/22/25 from 8:45 am to 11:30 am the following interviews were conducted to verify the facility completion of the plan of removal were conducted. The House Supervisor was interviewed and stated all the staff were in the process of being in serviced on documentation and assessing residents' skin during incontinent care, The ADM stated the skin assessments were completed but she had only in serviced 27 CNAs and nurses. She stated she had at least 60 more employees left to in-service. 13 CNAs were interviewed and stated they had been in serviced on pressure ulcers and documentation. 4 LVNS and a Nurse Supervisor were interviewed. All stated they had been in serviced on pressure ulcers and documentation. All staff interviewed could demonstrate compliance with facility policy and inservice recommendations. The ADM stated she would not complete the interviews until Monday 2/24/25. Record Reviews of the resident skin assessments did not reveal any further pressure ulcers not already being treated. In a facility monitoring visit of the night shift on 2/23/25 from 5:00 pm to 6:45 pm the following interviews were conducted to verify the facility completion of the plan of removal were conducted. The ADM stated the in servicing of staff would be completed on 2/24/25. 11 CNAs were interviewed and stated they had been in serviced on pressure ulcers and documentation. 5 LVNS were interviewed. All stated they had been in serviced on pressure ulcers and documentation. All staff interviewed could demonstrate compliance with facility policy and inservice recommendations. In a facility monitoring visit on 2/24/25 from 9:00 am to 10:50 am, the following interviews were conducted to verify the facility completion of the plan of removal were conducted. The ADM stated the in-services were completed with the exception of 4 staff who were either out of town or on FMLA. 14 CNAs and 8 LVNS were interviewed, and all stated they had been in serviced on pressure ulcers and documentation. All staff interviewed could demonstrate compliance with facility policy and inservice recommendations. The IJ was lifted on 2/24/25 at 10:50 am.While the IJ was removed on 02/24/2025, the facility remained out of compliance at a severity level of no actual harm with the potential for more harm than minimal harm that is not Immediate Jeopardy.