

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455533	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Windcrest Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 Fourwinds Dr San Antonio, TX 78239	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366</p> <p>Based on interviews and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 21 residents (Resident #1) reviewed for abuse.</p> <p>The facility failed to ensure CNA B reported when HA A allegedly abused Resident #1 on [DATE].</p> <p>The facility failed to ensure HA A was not working after this alleged abuse and had access to residents for her overnight shift.</p> <p>The facility failed to ensure all staff members were properly educated on abuse, neglect, and exploitation after this incident.</p> <p>On [DATE] at 03:52 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed prior to exit on [DATE], the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.</p> <p>This failure could place residents at risk of abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life.</p> <p>Findings included:</p> <p>Record Review of Resident #1's Admission record, dated [DATE], revealed a female initially admitted [DATE] and expired [DATE] with diagnosis to include dementia (loss of thinking, remembering, and reasoning skills), and major depressive disorder.</p> <p>Record Review of Resident #1's care plan, closed date [DATE], reflected [Resident #1] has a mood problem . with an intervention of Behavioral health consults as needed (psycho-geriatric team, psychiatrist, etc.), initiated [DATE].</p> <p>[Resident #1] has behavior problems . with an intervention of Monitor behavior episodes and attempt to determine underlying cause., initiated [DATE].</p> <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>[Resident #1] has a terminal prognosis r/t family has elected hospice services with [NAME] hospice. With an intervention of Refer to Psychiatric/Psychogeriatric consult if indicated, initiated [DATE].</p> <p>Record Review of Resident #1's annual MDS assessment, dated [DATE], reflected Resident #1 had a BIMS score of 99, indicating the resident was unable to complete the interview. It also reflected Resident #1 exhibited rejection of care 1 to 3 days per week in comparison to:</p> <p>Record Review of Resident #1's quarterly MDS assessment, dated [DATE], resident did not exhibit rejection of care.</p> <p>Record Review of the Provider Investigation Report, dated [DATE] and authored by the ADM reflected,</p> <p>Date/Time you first learned of incident: [DATE], 11:00AM</p> <p>Date/Time the incident occurred: [DATE], 10:45PM</p> <p>Brief narrative summary of the reportable incident: [CNA B] called this administrator to report physical abuse to [resident #1] by [HA A]. [CNA B] witnessed [HA A] slap [Resident #1] on the shoulder twice.</p> <p>.On [DATE], this administrator initiated resident questionnaires, which residents expressed to have been treated with respect, dignity, and no one has hurt them.</p> <p>On [DATE], [HA A] is terminated .</p> <p>I have concluded this allegation is confirmed because new injuries shown in new skin assessment completed on [DATE].</p> <p>Record review of Nurse's Note, dated [DATE] at 11:27 AM and authored by the DON, reflected Resident skin noted to be clean dry and intact. Three small circular bruises noted to left posterior forearm. #1 2.5 x 2.0 cm, #2 0.3 x 0.3 cm, and #3 0.4x 0.3 cm.</p> <p>During an interview on [DATE] at 02:48 PM, the Administrator confirmed there were missing signatures on the in-services for this incident.</p> <p>During an interview on [DATE] at 03:13 PM, HA A could not recall Resident #1.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:01 AM, CNA B revealed she heard a loud thump when she was in the hallway 2 rooms away from Resident #1's room. She revealed she saw the AP in the process of hitting Resident #1 on the shoulder. CNA B witnessed the AP holding Resident #1's forearm while hitting Resident #1 once on the shoulder. She further revealed the AP hit Resident #1 hard enough to produce a loud sound. CNA B described Resident #1 as so small, fragile, and nonverbal. CNA B further revealed a red mark was visible on Resident #1's shoulder because her shirt was hanging off. CNA B could not see any other marks on her body. Resident #1 was not crying but Resident #1 flinched and looked at the AP in shock as if Resident #1 knew something happened to her. CNA B described the incident as an uncomfortable situation. CNA B revealed she told the AP to leave. CNA B stated she told Resident #1 that she would be okay. CNA B revealed the roommate was present in the room, but the curtain was closed. CNA B further revealed Resident #1's roommate was bedbound and had to have heard these thumps, but the roommate was observed sleeping.</p> <p>The administrator revealed in an email correspondence, dated [DATE] at 01:32 PM, Resident #1 never received psych services in the months of November and [DATE], after this incident of alleged abuse.</p> <p>During an interview on [DATE] at 02:11 PM, the Administrator revealed she educated all the staff the next 2 days after the incident, and she knew she educated everyone even though the [DATE] in-service was missing signatures.</p> <p>During an interview on [DATE] at 05:21 PM, the [Medical Doctor] revealed he was contacted when he heard about this incident of abuse. He did not contact or order psych services because he did not think the resident would need or benefit from these services because resident was nonverbal and was not responding to other care. When told about the MDS assessment findings of Resident #1 exhibiting behaviors of rejection of care after this incident of abuse, the [Medical Doctor] revealed he did not know about Resident #1 having new behaviors of rejection of care and would have wanted to know this. He further revealed if he was made aware of this, he would assess the situation, and prodder psychiatric services accordingly.</p> <p>Record Review of HA A's personnel file revealed her employee misconduct registry was clean.</p> <p>Record review of the [DATE] in-service titled Abuse/Neglect/Misappropriation/Reporting reflected 39 out of 104 (37.5%) did not sign that they received this training. Out of the staff members present during this shift 6 out of 12 (50%) did not sign this training. (At the time of this template the Administrator was verifying names.)</p> <p>Record review of facility's policy Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revised [DATE],</p> <p>5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems.</p> <p>8. Investigate and report any allegations within timeframes required by federal requirements.</p> <p>Record review of the facility's policy, revised [DATE], titled Abuse and Neglect-Clinical Protocol reflected: The physician will order measures required to address the consequences of an abuse situation, such as psychological evaluation .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the Texas HHSC Long-Term Care Regulatory Provider Letter, issues [DATE], reflected for an abuse incident the facility was to report immediately, but not later than two hours after the incident occurs or is suspected.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 03:52 PM. The Administrator was notified.</p> <p>The following Plan of Removal submitted by the facility was accepted on [DATE] at 05:02 PM.</p> <p>Date: [DATE]</p> <p>PLAN OF REMOVAL</p> <p>FOR</p> <p>IMMEDIATE JEOPARDY</p> <p>To Whom it may concern,</p> <p>Summary of Details which lead to outcomes:</p> <p>On [DATE], an abbreviated survey was initiated at [Facility]. On [DATE] at 03:52PM, A surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health.</p> <p>The notification of the alleged immediate jeopardy states as follows:</p> <p>F600</p> <p>The facility failed to keep Resident #1 free from abuse and neglect by employees not reporting abuse to the abuse coordinator when abuse occurred. This administrator did not report abuse within the two-hour requirement and in-services were not 100% signed.</p> <p>Identify residents who could be affected:</p> <p>All Residents have the potential to be affected. The Facility census on [DATE] was 88.</p> <p>Identify responsible staff/ what action taken:</p> <p>.</p> <p>DON, ADONS and MDS nurses will conduct 100% skin assessments to all residents by [DATE]. Skin assessments completed.</p> <p>Social Worker, MDS nurses, Activities Director, Admission Coordinator and Human Resources Director will conduct resident questionnaires to all cognitive residents by [DATE].</p> <p>In-Service conducted:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE], abuse, neglect and notification of abuse and neglect to the abuse coordinator to all current team members prior to their shift by [DATE]. The in-services indicate verbal notification to the abuse coordinator. The in-service specifically states allegations need to be verbally and immediate, which includes day, nights, weekends, holidays, vacation, and the abuse coordinator is available ,d+[DATE]. If the abuse coordinator is not available, staff are directed to call the DON. This administrator and DON will be responsible for ensuring staff receive in-service. A current staff roster is printed, and staff will sign off next to their name.</p> <p>Any PRN or Agency staff will be trained in abuse, neglect and notification of Abuse and Neglect prior to their shift and they will sign next to their name or add their name and sign.</p> <p>Implementation of Changes</p> <p>Conduct daily rounds prior to morning meetings, which includes speaking to residents regarding any of their concerns. For non-verbal residents, residents will be monitored for changes in demeanor, changes to their baseline and communicate with family for any noticeable changes. The daily rounds will begin [DATE] (Monday through Friday), manager on duty will round on the weekends and will continue with no end date. Department managers will complete rounds in their assigned resident rooms to rule out abuse and neglect. If any concerns arise it will be addressed immediately per HHSC guidelines. The manager on duty will round on the weekends and will notify this administrator of any concerns of abuse and neglect. The administrator will follow HHSC guidelines. The round of excellence sheet will be completed by department managers and the manager on duty.</p> <p>The administrator will request to be part of resident council to be made aware of any current concerns. If this administrator is not approved to join resident council then the activity director will document any concerns on a grievance form and will provide document to this administrator.</p> <p>Abuse, neglect and reporting protocol to be given during orientation process. This will confirm all staff members will be aware of the Abuse, Neglect and notification of Abuse and Neglect protocol.</p> <p>Any staff member who is an alleged perpetrator for any ANE allegation will be suspended pending investigation and will be advised to leave the premises at that time.</p> <p>The residents who are identified as experiencing abuse or neglect will be referred to psych services by the social worker.</p> <p>Any potential concern of weekly skin observations will be reviewed in morning meetings to ensure residents are not at risk of any type of abuse.</p> <p>Monitoring</p> <p>Administrator/DON/Designee will monitor this process.</p> <p>Any negative outcomes will be reported to QAPI Committee.</p> <p>Involvement of Medical Director</p> <p>The [Medical Director] was notified about the immediate Jeopardy on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Involvement of QA</p> <p>Any issues will be brought to the QA meeting. This plan will be added to QAPI.</p> <p>Who is responsible for implementation of process?</p> <p>[Administrator]</p> <p>The POR verification was accepted on [DATE] at 09:15 PM as follows:</p> <p>Record review reflected the Facility Census on [DATE] was 88 residents.</p> <p>Record review reflected daily care round forms were completed for 88 of 88 residents.</p> <p>Record review reflected skin assessments were completed for 86 of 88 residents (one resident declined to be assessed; one resident was in the hospital) on [DATE].</p> <p>Record review of resident questionnaires reflected 28 of 28 cognitive residents received interviews by staff [DATE].</p> <p>In an interview on [DATE] at 7:30 PM, the Regional RN stated all cognitive residents received safe surveys interviews, with no findings that required follow-up.</p> <p>In-Service conducted:</p> <p>Record review reflected In-Services on Abuse/Neglect, Reporting time constraints, and protocols to protect to residents, completed on [DATE], included all staff, on duty, with a plan to in-service all PRN and staff on leave prior to working with any residents.</p> <p>Interviews conducted between [DATE] and [DATE], with staff who worked ,d+[DATE]p, ,d+[DATE]p, , d+[DATE]a, along with ,d+[DATE] shift, and ,d+[DATE]pm shift; 28 interdisciplinary staff (RNs, LVNs, CNAs, MAs, PTA, Dietary Aides, Social Services/Activity Aides, Maintenance, Administrative). [The facility currently has 105 staff]. Interviews indicated in-servicing topics included Abuse/Neglect that included definitions and examples; immediate interventions; reporting time constraints; and reporting entity requirements.</p> <p>Record review reflected In-Services on Abuse/Neglect, Reporting time constraints, protocols to protect to residents, completed on [DATE] included all agency staff on duty, with a plan to in-service all future agency staff prior to working with residents.</p> <p>Implementation of Changes</p> <p>Record review reflected daily care round forms were completed for 88 of 88 residents on [DATE]. Record review reflected daily care round forms were completed for 90 of 90 (current census) residents on [DATE]. Record review reflect Morning Meeting- Stand Up process template now includes agenda item to include discussion of daily care rounds, which are completed prior to the Morning Meeting.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of email dated [DATE] reflected the ADM requested invitation to future resident council meetings; with the caveat that if invitation request is declined, the activities director will document any concerns and provide the resulting grievance form to the administrator.</p> <p>Record review of the Facility Orientation Outline reflected a checklist that included: policy manual review of resident rights and resident abuse. Record review of facility Orientation In Service document with the topic of Abuse/Neglect, included definitions, examples, and reporting guidelines.</p> <p>Record review of sample personnel file revealed blank forms that required new employee signatures related to receipt and adherence to employee handbook with details related to resident rights including abuse and neglect prohibition. Record review of sample personnel file revealed new employee signature requirements for Senate [NAME] 9 Acknowledgement related to staff liabilities and penalties related to resident rights impingement specific to abuse/neglect.</p> <p>Record review of facility Orientation In-Service document with the topic of Abuse/Neglect, included statement that Nurses were to direct the alleged perpetrator to clock out and leave the premises.</p> <p>In an interview on [DATE] at 6:28 PM, the Regional RN stated that residents experiencing abuse or neglect would be identified in the Daily Care Rounds. The Regional RN stated this information was included in the new Morning Meeting process template. The SW would then make the psychological services referrals as necessary.</p> <p>Record review of Clinical Alerts Skin Observation reflected 13 observations discussed in morning meeting on [DATE]. Record review of Clinical Alerts Skin Observation reflected 13 observations discussed in morning meeting on [DATE].</p> <p>Monitoring</p> <p>In an interview on [DATE] at 6:36 PM, the Regional RN stated that any negative outcomes would be identified in the Daily Care Rounds. The Regional RN stated this information was included in the new Morning Meeting process template. The ADM/DON/Designee would then update the pending QAPI agenda template at each instance.</p> <p>In an interview on [DATE] at 6:40 PM, the Regional RN stated that the MD was notified via telephone on [DATE] at approximately 6:00 PM regarding the Immediate Jeopardy being called on [DATE].</p> <p>In an interview on [DATE] at 6:40 PM, the Regional RN stated that any issues would be identified in the Daily Care Rounds. The Regional RN stated this information was included in the new Morning Meeting process template. The ADM/DON/Designee would then update the pending QAPI agenda template at each instance for follow up at the next regularly scheduled QAPI meeting.</p> <p>In an interview on [DATE] at 6:46 PM, the Regional RN stated that the ADM of the facility is responsible for implementation of process.</p> <p>On [DATE] at 03:52 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed prior to exit on [DATE], the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564</p> <p>Based on interviews and record review, the facility failed to ensure residents had the right to be free of misappropriation of resident property and exploitation for 1 of 4 residents (Resident #4) for misappropriation and exploitation.</p> <p>The facility did not prevent misappropriation when MA G stole Resident #4's debit card and obtained \$5,000 from Resident #4's bank account after the resident passed away.</p> <p>This failure could place residents at risk of misappropriation of money, possessions, and feelings of loss.</p> <p>The findings included :</p> <p>Record review of the facility provider investigation report written by the facility administrator, dated [DATE], reflected: On [DATE] [Police Officer] arrived at facility to have this administrator view photo on camera and confirm it was a current team member. [Administrator] was able to confirm the individual in the photo was [MA G]. [Police Officer] explained [MA G] is being charged with debit/credit card abuse- to an elderly person. This elder was admitted to [The facility] but [Police Officer] was not able to disclose the name of the resident at this time. [Police Officer] said he was going to return tomorrow ([DATE]) with a warrant for [MA G's] arrest and to keep this quiet so [MA G] is not suspicious. [Administrator] advised [MA G] would not be able to clock in to work since this is an allegation of misappropriation of funds. [Administrator] offered to arrive at the community at 6:30AM and stop [MA G] before [MA G] clocks in so [Administrator] can tell [MA G] she is being suspended regarding allegation. It was agreed Officers will be at the facility at 6:45AM for the arrest.</p> <p>On [DATE],- This administrator arrived at [the facility] at 6:30AM. [Police Officer] arrived at 7:15AM and waited for [MA G]. The On call nurse called [MA G] asking for ETA , which was 30 minutes. At this time, [Police Officer] revealed the residents name, [Resident #4], as the elder victim. This administrator was told on [DATE] [MA G] had used [Resident #4]'s debit card at department stores, gas stations, restaurant, multiple atm withdraws at gas stations, and bank transfers. The sum of over five thousand dollars. [Resident #4's family member] suggested [the facility] because this is where he expired. [MA G] arrived at 7:45AM and [Police Officer] met her outside. [MA G] was arrested at this time. Further review reflected that the ADON was aware that Resident #4 kept an address book which included their bank account numbers and routing numbers. Further review reflected that MA G provided post-mortem care to the resident and the ADON noticed that after this Resident #4's address book was missing.</p> <p>During an interview on [DATE] at 10:00 AM, the administrator stated that MA G had stolen approximately \$5, 000 from Resident #4 after Resident #4 passed away and their belongings had not yet been collected by the family .</p> <p>An attempt to contact Resident #4's family was made on [DATE] at 11:30 AM. The phone call was not answered or returned.</p> <p>(continued on next page)</p>		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, undated, reflected Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 48366

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366</p> <p>Based on interviews and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments person-centered care plan to reflect the current condition for 1 of 21 residents (Resident #2) reviewed for care plan revisions.</p> <p>The facility failed to ensure Resident #2's care plan was comprehensive and updated to reflect Resident #2 had a doctor's order of needing honey consistency liquids instead of nectar thick liquids.</p> <p>This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs.</p> <p>The findings included:</p> <p>Record review of Resident #2's admission record revealed a male was admitted on [DATE] with diagnoses that included dementia (loss of thinking, remembering, and reasoning skills), personal history of traumatic brain injury, dysphagia (a condition with difficulty in swallowing food or liquid), cognitive communication deficit, and muscle wasting, and atrophy.</p> <p>Record review of Resident #2's annual MDS, dated [DATE], reflected Resident #2's BIMS score was 99, indicating the resident was not able to complete the interview with short term and long-term memory problems and severely impaired cognitive skills for daily decision making. It further reflected Resident #2 was severely impaired-never/rarely made decisions. The MDS also indicated Resident #2 was on a mechanically altered diet, requiring change in texture of food or liquids.</p> <p>Record review of Resident #2's care plan, accessed 05/23/24, reflected [Resident #2] has potential nutrition problem r/t mechanically altered diet, revised on 03/06/2024, with an intervention of Administer Nectar thick liquid as ordered., initiated 11/30/2021 with no revision date.</p> <p>Record Review of Resident #2's Doctor's diet orders reflected honey consistency liquids since 08/30/22.</p> <p>Record Review of POC Shift Dashboard and interview with CNA D, dated 05/24/24 at 11:01 AM, reflected Resident #2 received NUTRITION- Fluids: NECTAR THICK LIQUIDS QShift. CNA D revealed she was following this directive and giving Resident #2 Nectar thickened liquids.</p> <p>There were no observations of Resident #2 receiving nectar thickened liquids. Meals and snacks included honey thickened liquids.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/24/24 at 11:19 AM, Speech Therapist C (ST C) revealed if a resident was determined to need honey thickened liquids and received nectar thickened liquids there could be a chance of aspiration where solids or liquids could get into the airways. She further revealed this could lead to aspiration pneumonia which could cause a resident to be hospitalized . She revealed if a resident was more compromised there could be more severe health consequences, including death. ST C revealed there had been times where a resident may refuse a liquid if they knew they could not tolerate it, which could cause dehydration. She further revealed she had not heard of a resident at this facility complaining about this scenario, however, you may not be able to know this if a resident was nonverbal.</p> <p>During an interview on 05/24/24 at 03:23 PM, the RD revealed the facility was giving resident honey thickened liquids. She further revealed CNAs were providing liquids to Resident #2 in between meals but would have to ask the DON how the CNAs knew what liquids to give Resident #2.</p> <p>During an interview on 05/24/24 03:54 PM, MDS nurse P and MDS nurse Q confirmed CNAs followed tasks that were developed from care plans. MDS nurse P confirmed Resident #2's care plan reflected an intervention of Administer Nectar thickened liquid as ordered. She further confirmed this would turn into a task on their POC dashboard for the CNAs to follow. MDS nurse Q confirmed Resident #2's POC Shift Dashboard record, accessed on 05/24/24 at 11:01 AM, revealed there was a directive to give Resident #2 Nectar Thick Liquids. MDS nurse P and MDS nurse Q revealed if the resident was receiving Nectar thickened liquids and needed honey thickened liquids, this could cause aspiration.</p> <p>Left VM for doctor and NP on 05/24/24 at 03:20 PM.</p> <p>During an interview on 5/30/24 at 02:33 PM, the administrator and the DON revealed nursing staff received liquids from the kitchen, which would be honey thickened liquids. If the kitchen did not give these liquids, the DON would get involved, and ensure the correct liquid was given.</p> <p>Record review of the facility's policy, titled Care Plans, Comprehensive Person-Centered, revised March 2022, reflected, 7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 6 (Resident #3) reviewed for quality of care.</p> <p>Resident #3 had signs and symptoms of a stroke and was not sent to the hospital for evaluation for approximately 6 hours after a change of condition was reported.</p> <p>The non-compliance was identified as past non-compliance. The immediate jeopardy began on 2/23/2024 and ended on 2/28/2024. The facility corrected the non-compliance before the investigation began.</p> <p>This deficient practice placed all residents at risk of experiencing a delay in treatment that could have resulted in harm or potentially death.</p> <p>The findings included:</p> <p>Record review of the admission record revealed Resident #3 was a [AGE] year-old male, originally admitted on [DATE]. Diagnosis information revealed positive for gastrostomy status with an onset date of 3/04/2024 [date of return from hospitalization after stroke like symptoms reported on 2/23/2024].</p> <p>Record review of comprehensive MDS assessment dated [DATE], revealed Resident #3 had a BIMS summary score of 15, indicative of intact cognition. Resident #3 had active diagnoses that included heart failure, hypertension [high blood pressure], and high cholesterol [diagnoses indicative of higher risk for stroke or heart attack].</p> <p>Record review of an email from COTA K dated 2/26/2024 at 12:26 PM, reflected that COTA K observed on 2/23/2024 at approximately 12:50 PM, Resident #3 was unable to use his left side as per his normal. COTA K informed RN M, who stated the resident was fine. COTA K and PTA L returned to Resident #3 at approximately 2:45 PM, and observed continued left sided weakness, incontinence of bowel and bladder, and reported findings to the DOR .</p> <p>Record review of an email from PTA L dated 2/23/2024 at 8:09 PM, revealed PTA L observed Resident #3 on 2/23/2024 after COTA K had informed PTA L of Resident #3's condition some time shortly after 12:00 PM. PTA L observed Resident #3 being unable to move his left arm and slurring speech. Further record review reflected that PTA L informed RN M of the resident's condition. When PTA L informed RN M of his findings, PTA L was told RN M had assessed Resident #3 and he seemed fine. PTA L returned to Resident #3's room around 3:00 PM, to provide incontinence care, and noticed Resident #3 was more pronounced in being unable to effectively use his left arm, and his voice was weaker than his normal self. PTA L reported the findings to the DOR.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a typed note signed by the DOR revealed the DOR informed RN N on 2/23/2024 at approximately 3:30 PM of the changes in Resident #3 as slurred speech, having to repeat sentences multiple times, unable to lift LUE [left upper extremity], unable to grasp or make a fist with LUE, and overall fatigue.</p> <p>Record review of Nurses Note, authored by RN N on 2/23/2024 at 6:33 PM, reflected that Resident #3 was leaving via contracted service company for transport to ER for further evaluation.</p> <p>The hospital record revealed Resident #3 had an MRI done at the hospital, which found a stroke. The resident was also assessed for dysphagia that resulted in the placement of a gastrostomy tube for hydration, nutrition, and medications.</p> <p>Record review of the Care Plan revealed, Resident #3 .wears a Life Vest [wearable defibrillator for those at risk of sudden cardiac arrest], with a date initiated of 3/05/2024 [day after Resident #3 returned from hospital after stroke like symptoms on 2/23/2024]; additional problem area, .new feeding tube . with a date initiated 3/04/2024.</p> <p>In an observation on 5/20/2024 at 12:46 PM, Resident #3 was laying supine in bed, with the head of bed elevated approximately 60 degrees. Resident #3 had the over head lights off, but the television was playing softly. Resident #3 had his eyes closed but opened them when spoken to. Resident #3 declined to be interviewed stating that he was tired right now.</p> <p>In an interview on 5/24/2024 at 2:35 PM, RN M stated she was not very familiar with any of the residents at the time of the incident with Resident #3 (2/23/2024), as she had only worked at the facility for about a month. RN M stated she was informed by a member of the therapy staff that Resident #3 was not acting his usual self, by declining to attend his therapy session, and had complaints of shoulder pain. RN M stated this occurred just before or during lunch that day [approximately 11:30 AM-12:00 PM]. RN M stated she assessed the resident and recalled that his blood sugar was 77, and therefore he did not require a sliding scale dose of insulin before he could eat the lunch tray that had been delivered. RN M stated that Resident #3 did complain of his shoulder bothering him, and she administered Tylenol in response. RN M stated she felt that many other staff did not like Resident #3 due to him sometimes being mean spirited, and staff avoided taking the time to work with him. RN M stated she felt she had a good rapport with Resident #3, as they had similar back grounds and were jovial with each other in their conversations. RN M stated she did not document the findings of her informal assessment of him, because she, just did not see anything wrong with him. RN M stated at shift change the oncoming nurse (RN N) was running late and was flustered and out of breath when she arrived. RN M stated she reported to RN N about the new admissions they had received, the condition of another resident who had fallen earlier in the day. RN M stated that the unit was notorious for having a lot of stuff going on. RN M explained that the unit where this incident occurred was typically very busy. RN M stated that when the incident occurred the ADON, and the DON were both out. RN M stated no staff ever revisited their concerns that day about Resident #3 to her. RN M stated she observed him throughout the remaining afternoon before the end of her shift. RN M stated she never did see any thing that would have said possible stroke symptoms. RN M stated that looking back on the situation, that she really wished those staff that knew him better than she had at the time, had escalated the issue with her. RN M stated she was devastated by the whole thing. RN M stated that if she had run in to him as a stranger on the street, she would not have thought anything was wrong with Resident #3. RN M stated she was surprised and saddened to hear that Resident #3 had a stroke that day .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/24/2024 at 2:56 PM, NP O stated he was notified just after 3:00 PM by RN N, regarding a change in condition for Resident #3 with stroke like symptoms. NP O stated he was informed by RN N that it had been an ongoing concern since around lunch time. NP O stated he gave orders to send Resident #3 to the ER for further evaluation and treatment. NP O stated he felt that any resident with new onset stroke like symptoms should be sent immediately to the ER via 911/EMS before any further decline.</p> <p>In an interview on 5/24/2024 at 3:15 PM, RN N stated she did not receive any concerning information from RN M regarding Resident #3 during shift change report the day of the incident (2/23/2024). RN N stated she was not told that staff had raised concerns earlier in the day, or that Tylenol had been administered to Resident #3 for shoulder pain by RN M. RN N stated that the DOR came to her at about 3:15 PM, requesting an assessment of Resident #3 due to changes in his condition. RN N stated she was told the changes had been on-going since before lunch. RN N stated she recognized Resident #3 was not his normal self, he appeared fatigued, had some slurred speech, and one-sided weakness. RN N stated the most concerning symptom was that he was really slow to form words and really slow to respond to questions. RN N immediately notified the physician services group and received orders to send Resident #3 to the emergency room . RN N contacted the facility's contracted transportation and Resident #3 was picked up around 6:30 PM to be taken to the emergency room . [approximately 3 hours after she first assessed him for change in condition, and approximately 6 hours after the changes were first reported .] RN N stated she did not send him via EMS because her understanding was that the symptoms had been on-going since early morning, and by the time she assessed Resident #3, it would have been outside the window for the typical treatment associated with stroke.</p> <p>In an interview on 5/24/2024 at 3:32 PM, the DOR stated that two of her staff, COTA K and PTA L reported to her at approximately 2:45 PM on 2/23/2024, that they had concerns regarding Resident #3. The DOR assessed him and noted, slurred speech, unable to reach across his body. The DOR stated Resident #3 reported a headache to her. The DOR stated she requested the oncoming nurse assess Resident #3 right away .</p> <p>In an interview on 5/24/2024 at 3:43 PM, PTA L stated that his co-worker [COTA K] reported to him that she did not like the response the nurse gave when she reported a possible change in condition in Resident #3. PTA L stated he assessed Resident #3 before lunch on 2/23/2024 and then again near shift change [approximately 3:00 PM]. PTA L stated he observed the same changes his co-worker [COTA K] reported: different from his normal self, something off. PTA L stated that closer to shift change, around 2:45 PM, he took the issue to his DOR to escalate the findings. PTA L stated there were no significant changes from what he saw in Resident #3 before lunch and then again near shift change at 2:45 PM. PTA L stated Resident #3 was not any better, but not really any worse either.</p> <p>In an interview on 5/24/2024 at 5:15 PM, the DON stated her expectation was that assessments [NAME] documented as soon as completed, change of conditions were reported to the primary care provider, and that when the primary care provider issued new orders to send a resident with stroke like symptoms to the emergency room for further evaluation and treatment, that was done so via 911 and EMS transportation. The DON stated that in-servicing was initiated immediately in the wake of this event that included the signs and symptoms of a stroke, documenting, and reporting change of conditions. The DON stated Nurse M was suspended and ultimately terminated from employment at the facility upon completion of the internal investigation . The DON stated Resident #3 returned from the hospital with a PEG tube and was in therapy to see if he could return to intake by mouth. The DON stated Resident #3 was not as talkative now after the stroke as he used to be.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of In-Service topic, 911 Transfers, dated 2/23/2024, reflected that medical emergencies are any acute onset of a life-threatening medical problems that cannot be managed in house. Further, signs and symptoms of a stroke include facial drooping, arm weakness, and speech difficulty.</p> <p>Record review of In-Service topic, Change in Condition, undated, reflected includes major decline, unknown injuries, and change in mental status. Anything out of the ordinary with the resident's baseline.</p> <p>Record review of Change in Residents Condition or Status policy, revised February 2021, reflected policy statement of promptly notifies the resident, attending physician, resident representative of changes in the residents medical or mental condition or status. Further review reflected a significant change in the residents physical condition is a major decline .that a.) will not normally resolve itself without intervention; the nurse will record in the resident's medical record information relative to changes in the residents' condition or status.</p> <p>Record review of in-service topic, Stroke Signs and Symptoms, dated 2/23/2024, listed as: numbness or weakness in the face, arm, or leg, especially on one side of the body. Confusion or trouble speaking or understanding speech and severe headache with no known cause.</p> <p>Record review of in-service topic, Change in Condition Reporting, dated 2/23/2024, reflected change of conditions needs to be reported as soon as change is notice. If you report a change of condition or status to a charge nurse and nothing is done, the individual reporting needs to report the change to the DON or Administrator.</p> <p>The facility required immediate action to ensure that changes in condition and emergencies were recognized as such and an appropriate response was initiated.</p> <p>The facility initiated the following training with 100% compliance:</p> <p>Topic - 911 Transfers; target audience: RN and LVNs; started 2/23/2024; no dates next to signatures. Topic - Abuse/Neglect; target audience: all team members; started 2/23/2024; last signature dated 2/26/2024. Topic - Change of Condition; target audience: all team members; started 2/23/2024; last signature dated 2/26/2024. Topic - Change in Conditions: Stroke signs & symptoms; target audience: nursing; started 2/23/2024; no dates next to signatures. Topic - Change of Condition Reporting; target audience: all team members; started 2/23/2024; last signature dated 2/28/2024.</p> <p>Interviews included 20 staff members, across all shifts, confirming they received and understood the topics during the in-servicing (LVNs, RNs, CNAs, SW, PTAs, DOR, ADON/Infection Preventionist, Dietary Mgr, and [NAME]).</p>		