Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455533	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windcrest Nursing and Rehabilitation	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26481 Based on interview and record review, the facility failed to immediately notify a resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 5 residents (Resident #1) reviewed for notification of changes in that: The facility failed to ensure Resident #1's RP (Family Member A) was notified when Resident #1 had a change in her condition on 06/12/24. This deficient practice could place residents at risk of not having their family or legal representative notified when having a change of condition. The findings were: Record review of Resident #1's Admission Record [face sheet], dated 06/24/24 revealed she was admitted to the facility on [DATE], readmitted on [DATE] with diagnoses which included unspecified dementia (general decline in cognitive abilities that affect a person's ability to perform everyday tasks), schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), and high blood pressure; and her RP was Family Member A. Record review of Resident #1's electronic physician orders revealed an order dated 05/14/2024 to admit Resident #1 to Hospice B with diagnoses of Alzheimer's Disease (common type of dementia that results in gradual decline in memory, thinking, behavior and social skills) and to notify Hospice B with any falls or change in condition. Record review of Resident #1's MDS, a Significant Change assessment, dated 05/17/24 revealed her cognitive skills for daily decision making were severely impaired and she received Hospice Services. Record review of Resident #1's care plan for Resident #1 was on services of hospice with Hospice B due to terminal illness, with a start date of 05/20/24 revealed under interventions was Monitor for decreased appetite, weight loss, skin break down, nausea/vomiting .report to hospice. (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurse's note, dated 06/12/24 at 17:32 (5:32 PM) by LVN C revealed CNA got patient up in chair she was very lethargic, vitals taken unable to get BP [blood pressure] oxygen level was 68% [normal is 94-100%] on room air. CNA placed patient in bed [sic] noted patient respirations are 16 applied oxygen and saturation level is 77% [normal is 94-100%] on 3L [liters] of oxygen. Called Hospice B to tell them change of condition and needed nurse visit. The note did not indicate RP Family Member A was notified of Resident #1's change of condition. In a telephone interview on 06/24/24 at 01:02 p.m., Resident #1's RP Family Member A stated she was not contacted on 06/12/24 by the facility to inform her Resident #1 was unresponsive and she found out on 06/13/24, a day later Resident #1's condition had declined, when the hospice chaplain called her. In a telephone interview on 06/24/24 at 10:33 a.m., LVN C stated she called Hospice B when Resident #1 had a change in her condition on 06/12/24 but did not call Resident #1' RP Family Member A because it was up to hospice to notify the resident's family. In an interview on 06/24/24 at 11:22 a.m., the DON stated the nurses should notify the resident's responsible party immediately with any change of condition. The DON reviewed Resident #1's nurses note on 06/12/24 stated the notes indicated the resident was lethargic, hospice had been contacted, and there was no documentation the resident's RP had been notified; and the RP should had been notified. The DON stated LVN C said it was hospice's responsibility to contact the family was the reason why she did not contact Resident #1's RP. The DON said the nurses should contact the family even though hospice said they would because it was the facility's obligation to contact the family as well. The DON stated the harm of not notifying the resident's RP could cause the RP emotional distress if they were not aware there was a change in their loved one's condition and they came to the facility and found the resident transitioning to the end of life, that could be devastating to them. In an interview on 06/24/24 at 12:10 p.m., the Administrator stated a resident's RP would be notified when there was a change in their condition and not being notified could cause the RP to have distress or emotional distraught or cause them to have a lack of trust in the facility. The Administrator stated she thought this failure occurred because the nurse thought hospice would notify the family. Record review of the facility's policy Change in a Resident's Condition or Status, revised February 2021), revealed Our community promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition .