

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  06/28/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564</b></p> <p>Based on observations, interviews, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 8 residents (Resident #39) reviewed for homelike environment.</p> <p>The facility failed to ensure Resident #39's hard-shell helmet was cleaned adequately.</p> <p>These failures could place residents at risk for diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, uncomfortable, and unsafe.</p> <p>The findings included:</p> <p>Record review of Resident #39's face sheet reflected a [AGE] year-old female resident, initially admitted on [DATE], with diagnoses including: unspecified dementia, unspecified severity, with other behavioral disturbance (group of thinking and social symptoms that interferes with daily functioning), dysphagia following cerebral infarction (difficulty swallowing food and/or liquids after a stroke), and type 2 diabetes mellitus without complications (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>Record review of Resident #39's Care Plan, undated, reflected, Resident will remove her helmet often with interventions including, Anticipate and meet the resident's needs.</p> <p>Record review of Resident #39's Orders, dated 06/28/2024, did not reflect an order for Resident #39's hard-shell helmet.</p> <p>Observation on 06/25/2024 at 4:08 PM revealed Resident #39's helmet sitting on the nurse's station desk. Further observation revealed hair, brown and black particulate, and brown stains on the inside of the helmet where it sat atop her head. An interview was attempted with the resident in which she was unable to respond.</p> <p>In an interview on 06/27/2024 at 10:39 AM, CNA S stated they clean resident equipment when it was observed to be dirty, and that they believed overnight staff were tasked with regularly cleaning resident equipment. CNA S stated the dirty helmet could affect the resident by causing her to become dirty and that they were not sure where helmet cleanings would be documented.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An attempt to conduct a phone interview with LVN U, an overnight charge nurse, was unsuccessful on 06/27/2024 at 11:00 AM.</p> <p>In an interview on 06/28/2024 at 7:47 PM, the DON stated that resident equipment such as wheelchairs were ideally cleaned weekly by whatever staff was able to clean them, and resident helmets should be cleaned daily. The DON could not confirm, based on a photo of the dirty helmet, how long it had been since the helmet had been cleaned . The DON stated she was not aware how a dirty helmet could affect a resident.</p> <p>Record review of the facility policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, undated, revealed, Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions.</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>26869</p> <p>Based on interviews and record review the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation of residents, and misappropriation of resident property for 3 of 5 (CNA A, B, C) new hired employee's files reviewed.</p> <ol style="list-style-type: none"> <li>1. CNA A did not have EMR/NAR.</li> <li>2. CNA B did not have EMR/NAR.</li> <li>3. CNA C did not have EMR/NAR.</li> </ol> <p>This could place residents at risk of abuse, neglect, and exploitation.</p> <p>The Findings were:</p> <ol style="list-style-type: none"> <li>1. CNA A (agency staff) the first day on the floor was 6/3/2024.</li> </ol> <p>Record review of CNA A's agency background check to include OIG was dated 6/2/2024.</p> <ol style="list-style-type: none"> <li>2. CNA B (agency staff) the first day on the floor was 6/4/2024.</li> </ol> <p>Record review of CNA B's agency background check to include OIG was dated 6/1/2024.</p> <ol style="list-style-type: none"> <li>3. CNA C (agency staff) first day on the floor was on 6/26/2024.</li> </ol> <p>Record review of CNA C's agency background check to include OIG was dated 6/22/2024.</p> <p>During an interview on 6/28/2024 at 5:54 PM and 7:30 PM with the ADM he stated, the facility did not check CNA A, B, and C's background check for EMR/NAR. The ADM stated the agency that hired CNA A, B, and C did complete an OIG. The ADM stated since the agency was not our team member and were self-contractors, we were not authorized to run EMR/NAR checks. The agency stated this was their reasoning for why they run the state and federal OIG several times a month. ADM was not aware of the OIG checks, included the EMR/NAR checks.</p> <p>Record review of policy Abuse, Neglect, Exploitation, and Misappropriation Prevention program dated April 2021 revealed Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the residents' symptoms. Policy Interpretation and Implementation. 4. Conduct employee background checks and not knowingly employ or otherwise engage any individual who has a finding entered in the stated nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of their property.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41937</p> <p>Based on interviews and record review, in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately to Health and Human Services, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures, for 3 of 10 residents (#15, #140, and #141) reviewed for allegations of abuse, neglect, and exploitation.</p> <ol style="list-style-type: none"> <li>The Administrator, the DON, LVN L, and LVN N failed to report an allegation of an injury of unknown origin on 03/09/2024 when Resident #15 was assessed by LVN L with an unwitnessed injury to Resident #15's forehead and right temple .</li> <li>The Administrator and the DON failed to report an allegation of neglect for Resident #15 on 03/31/2024 when Resident #15's representative alleged Resident was neglected and left in bed all weekend due to the facility had no clean mechanical lift slings.</li> <li>The DON and LVN G failed to report an injury of unknown origin for Resident #15 on 05/15/2024 when LVN G assessed Resident #15 with an abrasion to her right forehead after an assumed unwitnessed fall .</li> <li>The Administrator, the DON, and LVN M failed to report an injury of unknown origin for Resident #15 on 05/23/2024 when LVN M assessed Resident #15 with a skin tear and bruising to her right face after an assumed unwitnessed fall .</li> <li>The Administrator and the DON failed to report an allegation of abuse and neglect for Resident #140 on 05/06/2024 when Resident #140 alleged she had a rude overnight nurse, her lack of an arm sling, and pain medication errors.</li> <li>The Administrator and the DON failed to report an allegation of abuse and neglect for Resident #141 on 05/06/2024 when Resident #141 alleged the overnight nurse was verbally abusive and negligent with pain medication administration.</li> </ol> <p>These failures could place residents at risk for harm by abuse and or neglect.</p> <p>The findings included:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A record review of Resident #15's admission record dated 06/28/2024 revealed an admitted [DATE] with diagnoses which included dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), anxiety, and glaucoma (a group of eye diseases that lead to damage of the optic nerve, which transmits visual information from the eye to the brain).</p> <p>A record review of Resident #15's quarterly MDS assessment dated [DATE] revealed Resident #15 was an [AGE] year-old female admitted on hospice services for long term care and assessed with a BIMS score of 99 which indicated severe cognitive impairment due to her inability to respond in the interview. Further review revealed Resident #15 had both lower extremities impaired and was totally dependent with all transfers and used a wheelchair.</p> <p>A record review of Resident #15's care plan dated 06/28/2024 revealed, Special Instructions: . Hoyer for transfers . Resident #15 has impaired visual function r/t absolute Glaucoma, macular degeneration, and cataracts . Resident #15 has a diagnosis for Osteoporosis: Resident with stiffness in joints, fatigue, pain, and disturbed sleep. Complaints of pain with movement to extremities at times r/t diagnosis . Assist with ADL's, transfers, and mobility as needed . Monitor for verbal and non-verbal signs of pain or discomfort r/t diagnosis</p> <p>A record review of Resident #15's nursing progress note dated 03/10/2024 revealed LVN L documented, Resident's (Representative) came to the nurse's station upset about the fall [Resident #15] had last night. He wanted x-rays done to make sure nothing was broken. This nurse asked if there was a specific body part he would like us to focus on, was she bracing her arm, or saying something hurt. He said no but she hit the floor, and nothing has been done about it. This nurse went with the resident's (Representative) to the room and noted an open wound to the R temple and the center of the forehead between the eyebrows. This nurse called Hospice and left a message with the phone service and has not received a call back. The (Representative) is wanting something done now. This nurse contacted (NP O) and obtained wound care orders, and orders to DC the neuros and monitor the resident for any changes. Wound care nurse to assess the wound tomorrow. There is no indication to x-ray the resident so no orders for X-ray. DON and Administrator notified of the [Resident's Representative] concerns. This nurse will continue to monitor the resident and notify Hospice and or NP of any changes.</p> <p>A record review of Resident #15's fall - Unwitnessed incident report dated 03/09/2024 revealed LVN N documented, . Incident Description Nursing Description: Found lying on her back across bedside table wheel frame . Resident Description: Confused</p> <p>A record review of Resident #15's grievance report documented by the DON, dated 03/31/2024, revealed Resident #15's representative made a grievance and alleged Resident #15 was neglected, Sunday afternoon they couldn't get my (Resident #15) up because there were no clean slings . reportable to the state agency: no</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A record review of Resident #15's nursing progress note dated 05/15/2024 revealed LVN G documented, nurse notified by staff that resident on floor, parallel to her bed laying on her fall mat. Bed was in lowest position and was locked. Resident agitated; resident assessed for injury; small abrasion noted to right eyebrow . resident assisted back to bed x4 staff members, Resident yelling out and combative toward staff while transferring back to bed. resident denied pain when asked. neuros initiated. nurse notified Resident #15's Representative, no answer left voicemail. notified hospice spoke with (hospice RN), notified NP O. DON assisted nurse and staff to transfer Resident back to bed. resident repositioned in bed to comfort, bed remains in lowest position. floor mats in placed. call light within reach.</p> <p>A record review of Resident #15's Fall - Unwitnessed incident report dated 05/23/2024 revealed LVN M documented, Incident Description Nursing Description: arrived in rm . resident on floor in parallel rt side lying position Resident Description: Resident Unable to give Description Immediate Action Taken Description: assessed for injury bruise to rt side of face with pea size skin tear noted, transferred back into bed max assist cleanse skin tear rt side of head with wound cleaner left open to air well tolerated Resident Taken to Hospital? N Injuries Observed at Time of Incident Injury Type Injury Location Injury Type Injury Location Bruise 13) Vertebrae (upper-mid) Bruise 4) Face . Agencies / People Notified Family Member (Representative) 5/23/2024 00:45 Director of Nursing (DON) 5/23/2024 05:52.</p> <p>A record review of the Texas Unified Licensure Information Portal (TULIP) website accessed 06/27/2024 revealed no evidence for allegations regarding Resident #15 from 01/2024 to 06/27/2024.</p> <p>During an interview and record review on 06/26/2024 at 02:00 PM Resident #15's representative stated Resident #15 has had multiple injuries of unknown origin and has been frustrated with the DON and the administrator's inability to ensure Resident #15's safety. Resident #15's representative stated he visited Resident #15 on 03/09/2024 and discovered her sitting in a chair with some dried blood on her face and a small pool of blood on the floor next to her. Resident #15's representative stated he complained to the nurse on duty and wanted a report on what happened to Resident #15 and was not satisfied with the nurse's response and lack of treatment. He stated, I wanted them to get an x-ray of her body . but they did not, and they did not send her to the hospital. Resident #15's representative provided photographic evidence of Resident #15's facial injuries on 05/12/2024 which revealed resident #15 had a bandage to right temple dated 03/12/2024. Resident #15's representative stated, I spoke with the Administrator shortly afterward, I won't even speak to the DON anymore. Resident #15's representative stated he made a grievance to the administrator on 03/31/2024 regarding Resident #15's neglect and that she was left in bed all weekend. Resident #15's representative stated Resident #15 also was found with injuries of unknown origin on 05/15/2024 and on 05/23/2024 and provided photographic evidence which revealed dried scabbed skin abrasions to Resident #15's right temple with right sided bruising to her face. Resident #15's representative stated the Administrator was aware. The representative stated, I just want my (Resident #15) to be safe and cared for, but they seem to be incapable of keeping her safe. I come see her almost every day. I would take her home, but I cannot move her safely by myself.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 06/28/24 at 07:38 PM the DON stated Resident #15's injuries of unknown origin were not reportable incidents to the state agency because she knew Resident #15 was not neglected and or abused and the Resident fell from a bed in a low position on to fall mats at the bedside. The DON stated Resident #15's Representative had made a complaint where Resident #15 was not assisted out of bed and since, the plan has been to have extra mechanical lift slings at the nurses' station .</p> <p>A record review of Resident #140's admission record dated 06/28/2024 revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses which included a fracture of the right shoulder and sepsis (severe infection).</p> <p>A record review of Resident #140's admission MDS assessment dated [DATE] revealed Resident #140 was a [AGE] year-old female admitted for rehabilitation therapy related to a broken shoulder. Further review revealed Resident #140 was assessed with a BIMS score of 10 which indicated moderate cognitive impairment. Resident #140 was assessed to have the ability to understand others and could make herself understood. Resident #140 had clear speech and adequate hearing and vision without the need for eyeglasses and or hearing aids.</p> <p>A record review of Resident #140's physician's orders dated 06/20/2024 revealed Resident #140 was prescribed pain medications, acetaminophen 325mg, hydrocodone-acetaminophen - Give 1 tablet by mouth every 8 hours for pain management and Hydrocodone- 5-325mg hydrocodone-acetaminophen. Give 1 tablet by mouth every 4 hours as needed for chronic back pain. Resident #140 was prescribed a sling, Patient to wear sling on right UE when OOB for comfort . until 06/30/2024</p> <p>A record review of Resident #140's care plan dated 06/20/2024 revealed, The resident has a right arm fracture r/t (related to) fall at home . Give pain, anti-inflammatory medications as ordered. Monitor/document side effects and effectiveness . The resident has chronic pain r/t history of chronic back pain . The resident prefers to have pain controlled by: medication</p> <p>A record review of Resident #140's grievance report dated 05/06/2024 revealed the DON documented Resident #140 made a complaint that the overnight nurse was rude, she needed a sling for her arm, and her pain medication was ineffective. She stated, the overnight nurse is rude every time she comes in here. I've been asking all the nurses to fix my pain medications. I don't have my sling for my arm. Further review revealed the DON documented the incident was not reportable to the state agency. Further review revealed the DON and the administrator signed the document.</p> <p>During an interview on 06/28/24 at 07:38 PM the DON stated Resident #140's complaint of a rude nurse and pain medications were addressed. She stated the nurse was provided with customer service education and the resident was ordered a new sling. The DON stated the physician was contacted and Resident #140 received a new order for pain medications therefore the grievance was not considered a reportable incident to the state agency .</p> <p>A record review of Resident #141's admission record dated 06/28/2024 revealed an admitted [DATE] with a discharge date of [DATE] with diagnoses which included neuropathy (nerve pain), diabetes (too much sugar in the blood), and cellulitis of right lower limb (right leg infected).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A record review of Resident #141's admission MDS assessment dated [DATE] revealed Resident #141 was a [AGE] year-old male admitted for short term rehabilitation care related to an infected right leg complicated by diabetes and high blood pressure. Further review revealed Resident #141 had the ability to make himself understood and could understand others, had clear speech, adequate hearing, and vision without the need for eyeglasses and or hearing aids. Resident #141 was assessed with a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment.</p> <p>A record review of Resident #141's physicians orders dated 04/27/2024 revealed Resident #141 was prescribed pain control medication: acetaminophen-codeine Tablet 300-30mg - Give 1 tablet by mouth every 4 hours as needed for pain; acetaminophen-codeine Tablet 300-30 MG - Give 1 tablet by mouth every 6 hours as needed for Mild / Moderate Pain; and Cleanse surgical incision to dorsal foot with NS, pat dry, apply dry dressing</p> <p>A record review of Resident #141's care plan dated 04/27/2024 revealed, Acute Infection . The resident has acute pain r/t Medical Procedure s/p I&amp;D (incision and drain) right foot wound, cellulitis of right foot . Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.</p> <p>A record review of Resident #141's grievance report dated 05/06/2024 revealed Resident #141 made a complaint to the Director of Rehabilitation (DOR) and the DOR documented, patient reports having trouble with the overnight nurse. Asked for ice water and was given a cup with 2 ice cubes and nurse said, here's your damn ice water. Sunday Resident stated he asked for pain meds and got attitude regarding times of pain meds. States nurse was extremely rude the entire weekend if he asked for anything. Further review revealed the DON documented the incident was not reportable to the state agency. Further review revealed the DON, and the administrator signed the document .</p> <p>During an interview on 06/28/24 at 07:38 PM the DON stated Resident #141's complaint of a rude nurse and pain medications were addressed, and the nurse never provided the Resident with the water, It was a different staff member. The DON stated Resident #141 was requesting medications hourly and received education and the nurse received customer service education. The DON stated the grievance was not considered a reportable incident to the state agency .</p> <p>During an interview on 06/28/24 at 08:00 PM the Administrator reviewed the grievances for residents #15, #140, and #141 and stated the grievances were not reportable events to the state agency, however upon reconsideration of Resident #141's grievance she believed that complaint should have been reported to the state agency .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A record review of the facility's Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated April 2021, revealed, Policy Statement - Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation. The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: Protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff. b. other residents. c. consultants. d. volunteers. e. staff from other agencies. f. family members. g. legal representatives. h. friends. i. visitors; and/or j. any other individual. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26869</p> <p>Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that included services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 16 residents (Residents #1 and #60 ) reviewed for comprehensive person-centered care plans.</p> <p>1.The facility failed to ensure Resident #60's diagnosis and treatment methods of generalized anxiety disorder were included in the resident's comprehensive person-centered care plan.</p> <p>2. Resident # 1 did not have a care plan for use of non-verbal pain scale. Staff did not bath/shower her and facial hair and communication was no care planned.</p> <p>These failures could place residents at risk of not receiving the care needed to maintain their highest, most practicable, physical, social, and psychosocial level of well-being.</p> <p>The findings included:</p> <p>1.Record review of Resident #60's face sheet, dated 06/27/2024, reflected a [AGE] year-old female resident initially admitted on [DATE] with diagnoses including: generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), age-related macular degeneration (an eye disease that causes vision loss), and schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms).</p> <p>Record review of Resident #60's Quarterly MDS Assessment, dated 06/07/2024, reflected Resident #60's BIMS score was 6 indicating severe cognitive impairment. Further review reflected Resident #60 had diagnoses of anxiety disorder and schizophrenia.</p> <p>Record review of Resident #60's Order Summary Report, dated 06/27/2024, reflected an order for Pristiq ER 25 mg tablet twice daily for a diagnosis of generalized anxiety disorder.</p> <p>Record review of Resident #60's comprehensive person-centered care plan, undated, reflected, The resident uses antidepressant medication r/t Depression and poor appetite. With interventions including, Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q -SHIFT. Further review of the care plan did not reveal problems, goals, or interventions for generalized anxiety disorder.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Windcrest Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  8800 Fourwinds Dr San Antonio, TX 78239	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #1's Admission Record dated 6/28/2024 revealed she was admitted on [DATE] with initial admission on 10/15/2017, age 65. Record review of Resident #1's diagnoses of hemiplegia and hemiparesis (Hemiplegia and hemiparesis are similar in that they describe weakness on one side of your body, and they're caused by the same conditions and injuries. Generally, hemiplegia refers to complete paralysis, while hemiparesis refers to partial weakness.) cerebrovascular disease affecting right dominant side, dementia, muscle weakness, lack of coordination, aphasia )(a language disorder that affects how you communicate. It's caused by damage in the area of the brain that controls language expression and comprehension. Aphasia leaves a person unable to communicate effectively with others.), abnormal posture, history of falls, diabetes II, seizures, and anxiety.</p> <p>Record review of Resident #1's Admission MDS dated [DATE] revealed she was cognitively intact. Section F Preferences of Customary Routine and Activities: Should interview for Daily and Activity preferences be conducted? -Answer No Section Functional Abilities and goals revealed she required supervision/touching assistance for oral hygiene and personal hygiene. Resident #1 was dependent on shower/bath, upper body dressing, and lower body dressing.</p> <p>Record review of Resident #1's care plan dated 4/22/2024 revealed Resident #1 had an ADL self-care performance deficit related to hemiplegia, impaired balance, limited mobility, pain, and resident utilities custom wheelchair for locomotion. Interventions to bathing/shower the resident required extensive assistance by 1 staff with bathing/showering as necessary. Resident #1 dressing the resident required extensive assistance by 1 staff to dress. Resident #1 personal hygiene the resident requires extensive assistance by 1 staff with personal hygiene and oral care. Resident level of function varies due to residents' disease process, level of assistance by staff can fluctuate. Record review was documented for communications-Resident #1 had a diagnosis of cerebrovascular disease with hemiplegia interventions were documented to monitor/document communication skill, Document baseline. If resident is presenting problems with cognitive function and communication, obtain order for speech therapy consult to evaluate and treat. Resident #1 has a communication problem related to diagnoses of expressive and reflective aphasia, interventions were conscious of resident position when in groups, activities dining room to promote proper communication with others. Communication: allow adequate time to respond, repeat as necessary, do not rush request clarification from the resident to ensure understanding, face when speaking, make eye contact, turn off TV/radio to reduce environment noise, ask yes/no questions if appropriate, use simple brief, consistent words/cues, use alternative communication tools as needed. Encourage resident to continue stating thoughts even if resident was having difficulty. Focus on a word or phrase that makes sense or responds to the feeling resident was trying to express. Speak on an adult level, speaking clearly and slower than normal. no care plan with staff using the non-verbal pain scale or communication board.</p> <p>Record review of Resident #1's dental referral dated 6/26/2204 for poor oral hygiene and mouth pain.</p> <p>Observation on 6/25/2024 at 4:27 PM Resident # 1 pointed to face scale 8/10 with survey interventions of pain scale for non-verbal residents.</p> <p>Observation on 6/26/2024 at 12:39 PM CNA J getting her a blanket used gestures to communicate.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 6/27/24 at 12:11 PM Resident # 1 was sitting up in her wheelchair, she was wearing her regular clothes, no hospital gown, and eating lunch. Resident # 1 stated she still continued to have pain in mouth. Resident #1 shrugged her shoulder about her next dental appointment. Resident # 1 was able to nod her head, saying yes staff provided her with pain medication, after state surveyor intervention.</p> <p>During an interview on 6/25/2024 at 4:28 PM Resident # 1 was not sure how long she had the mouth pain. The State Surveyor raised her fingers, 1, 2, 3 days or more. Resident #1 shrugged her shoulder, to say not sure., She nodded her head up and down, to say yes to this was the 2nd day with mouth pain Resident #1 nodded her head back and forth, to say No, staff had not used a non-verbal pain scale.</p> <p>During an interview on 6/26/2024 at 10:23 AM LVN G came into Resident #1's room, after resident pushed the call light due to pain in mouth area. The State Surveyor asked LVN G if Resident #1 had partials, and LVN G stated she was not sure. LVN G looked at Resident # 1 as she walked closer to Resident #1's bed. Resident # 1 had her fingers in her mouth, The, nurse asked her if she was, in pain. Resident # 1 nodded her head, yes. LVN G stated she would notify the MD and administer Resident #1 with pain medication .</p> <p>During an interview on 6/26/24 at 10:45 AM with ADON LVN stated Resident # 1 was pointing to her left side, (she is not verbal, need to ask her or point), indicated something was wrong. Resident #1 pointed to her mouth; she was not hurting at the time of her assessment. ADON LVN stated Resident #1 wanted her to look in her mouth. The, gum to the left side noted red, missing teeth, and decay noted on the left lower and upper side, no swelling noted to left side, notified MD and family. Resident denied pain and no orders. ADON LVN stated she notified the SW about a dental consult. ADON LVN stated she worked until 3pm and Resident #1 had no complaints of pain. ADON LVN stated Resident # 1 can raise fingers about the pain level and can answer questions, so they don't use the non-verbal pain scale. ADON stated res #1 put her fingers up to indicate the level of pain she has. When I asked her about pain, she did not use her fingers. Res #1 stated staff had not used the non-verbal facial pain scale.</p> <p>During an interview on 6/26/2024 at 11:06 AM the SW stated the ADON LVN notified her Resident #1 needed a dental referral. The dental referral was completed and waiting for the dentist to respond. The SW stated Resident # 1's communication can be hard. The SW stated Resident # 1 does well with yes and no questions. She stated she used facial expressions, staff were familiar with her needs, and staff had known her a long time. The SW stated Resident #1 communicated nonverbally, with short and simple questions, staff anticipate Resident #1's needs, and staff will continue to ask questions until they find something to meet Resident #1's needs at that moment .</p> <p>During an interview on 6/26/2024 at 12:21 PM, Resident #1 nodded her head in a side-to-side motion representing No, she did not think staff understood about her pain and sometimes did not understand what she needed at the moment.</p> <p>During an interview on 6/27/2024 at 3:18 PM, LVN K stated he would be able to tell if Resident #1 had pain. LVN K stated he worked this last weekend and Resident #1 did not verbalize and had no signs of pain. LVN K stated Resident #1 communicated by shaking her head, she mumbled, and staff could understand, yes and no responses .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 6/28/2024 at 12:11 PM was attempted with the speech therapist. A message was left with no return call by exit.</p> <p>During an interview on 6/28/2024 at 12:24 PM with PT I stated she communicated with Resident #1, yes and no questions, not able to communicate other than that. PT I stated she was working on positioning, bed mobility, working on getting left side stronger, she had a stroke that affected the right side, and she has been doing well. PT I stated Resident #1 was able to scoot herself up, pull herself up with her good arm in her bed.</p> <p>During an interview on 6/28/2024 at 12:49 PM LVN G stated Resident #1 replied yes and no (she was not sure) when asked if she had received a bath or shower. LVN G stated she would check the computer record. Interview with LVN G revealed she looked at bath/shower task and a bath/shower were not documented for Monday or Wednesday.</p> <p>Attempted interview on 06/28/24 at 01:58 PM with CNA H, left a message with no return call.</p> <p>During an interview on 06/28/24 at 04:45 PM MDS RN stated that for Resident #1, staff provide personal care and oral care. MDS RN stated she added communication a new care plan, after surveyor intervention. MDS RN stated she gives Resident # 1 time and can understand, Resident #1 points at what she needs staff to get for her, nothing for gestures, no pain care plan for her tooth/mouth area. RMDS RN stated Resident #1 can tell staff if she had a headache.</p> <p>In an interview on 6/28/24 at 6:13 PM with the Medical Director he stated Resident #1 could say small phrases, points at things, and start asking MD ask Resident #1 different questions, until MD understand what Resident #1 needs at the time. The MD stated staff could use a communication board if they had difficulty communicating with Resident #1 about her needs. The MD stated staff notified him Resident #1 was in pain but did not share that she had a pain level of 8/10. The MD stated Resident #60's anxiety should be on their care plan, as that is why they are taking the medication, and the resident does not have a diagnosis of depression.</p> <p>During an interview on 6/28/24 at 07:44 PM the DON stated Residents wear their gown while in bed. The DON stated some staff understand Resident #1 better than others. They get another staff to help with communication, use a lot of gestures, and had facial communication. The DON stated she expected staff to know she had communication boards. The DON stated the agency staff do a walk through and watch residents in their unit . The DON also stated that Resident #60's Care Plan should reflect any diagnosis they have that requires any psychotropic medication. The DON stated the risk to Resident #60 for her diagnosis of anxiety not being recognized in the care plan could mean the necessary care for her anxiety is not being completed as effectively as it could.</p> <p>47564</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26869</p> <p>Based on observations, interviews, and record reviews the facility failed to provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section . Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: Hygiene -bathing, dressing, grooming, and oral care. Communication, including, Speech, Language, and Other functional communication systems for 1 of 16 (#1) residents reviewed in that:</p> <p>Staff did not use a communications board or a facial pain scale for Resident #1 to prevent a decline in health.</p> <p>This failure could place residents at risk for harm by an undignified lifestyle.</p> <p>The findings included:</p> <p>1. Record review of Resident #1's Admission Record dated 6/28/2024 revealed she was admitted on [DATE] with initial admission on 10/15/2017, age 65. Record review of Resident #1's diagnoses of hemiplegia and hemiparesis (Hemiplegia and hemiparesis are similar in that they describe weakness on one side of your body, and they were caused by the same conditions and injuries. Hemiplegia refers to complete paralysis, while hemiparesis refers to partial weakness), cerebrovascular disease affecting right dominant side, dementia, muscle weakness, lack of coordination, aphasia (a language disorder that affects how you communicate. It was caused by damage in the area of the brain that controls language expression and comprehension. Aphasia leaves a person unable to communicate effectively with others), abnormal posture, history of falls, diabetes II, seizures, and anxiety.</p> <p>Record review of Resident #1's Admission MDS dated [DATE] revealed she was cognitively intact, Section F Preferences of Customary Routine and Activities -Should interview for Daily and Activity preferences be conducted-answer No (reside is rarely/never understood and family /significant other not available) skip to staff assessment for ADL, Section Staff Assessment of Daily and Activity Preferences, receiving shower, residents required a wheelchair to mobilize due to lower/upper extremity impairment on one side. Section Functional Abilities and goals revealed she required supervision/touching assistance for oral hygiene, personal hygiene. Resident #1 was dependent on shower/bath, upper body dressing and lower body dressing.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan dated 4/22/2024 was documented Resident #1 has an ADL self-care performance deficit related to hemiplegia, impaired balance, limited mobility, pain, and resident utilities custom wheelchair for locomotion-interventions to bathing/shower-the resident requires extensive assistance by 1 staff with bathing/showering, as necessary. Resident #1 dressing the resident required extensive assistance by 1 staff to dress. Resident #1 personal hygiene the resident requires extensive assistance by 1 staff with personal hygiene and oral care. Resident level of function varies due to residents' disease process, level of assistance by staff can fluctuate. Record review was documented for communications-Resident #1 had a diagnosis of cerebrovascular disease with hemiplegia interventions were documented to monitor/document communication skill, Document baseline. If resident is presenting problems with cognitive function and communication, obtain order for speech therapy consult to evaluate and treat. Resident #1 has a communication problem related to diagnoses of expressive and reflective aphasia, interventions were conscious of resident position when in groups, activities dining room to promote proper communication with others. Communication: allow adequate time to respond, repeat as necessary, do not rush request clarification from the resident to ensure understanding, face when speaking, make eye contact, turn off TV/radio to reduce environment noise, ask yes/no questions if appropriate, use simple brief, consistent words/cues, use alternative communication tools as needed. Encourage resident to continue stating thoughts even if resident was having difficulty. Focus on a word or phrase that makes sense or responds to the feeling resident was trying to express. Speak on an adult level, speaking clearly and slower than normal. no care plan with staff using the non-verbal pain scale or communication board.</p> <p>Record review of Resident #1's dental referral dated 6/26/2204 for poor oral hygiene and mouth pain.</p> <p>Observation on 6/25/2024 at 4:27 PM Resident # 1 pointed to face scale 8/10 with survey interventions of pain scale for non-verbal residents.</p> <p>Observation on 6/26/2024 at 12:39 PM CNA J getting her a blanket uses gestures and multiple questions asked to understand what Resident #1 needed at the time.</p> <p>Observation on 6/27/24 at 12:11 PM Resident # 1 was sitting up on wheelchair, she was wearing her regular clothes, no hospital gown and eating lunch. Resident # 1 stated she still continues to have pain in mouth. Resident #1 shrugged her shoulder about her next dental appointment. Resident # 1 was able to node her head, saying yes staff provided her with pain medication, after surveyor intervention.</p> <p>Observation on 6/27/2024 at 4:39 PM Resident # 1 shook her head to left to right, saying No shower. Resident #1 was able to communicate staff changed her bed, clothes and combed her hair, and her fingernails needed to be cut on the right hand. Resident #1 pointed to her side table at her toothbrush and toothpaste. Resident #1 shook her finger and pointed to herself, meaning she brushed her own teeth.</p> <p>During an interview on 6/25/2024 at 4:28 PM Resident # 1 was not sure how long she had the mouth pain. Surveyor raised her fingers, 1, 2, 3 days or more. Interview with Resident #1 shrugged her shoulder, to say not sure, she nodded her head up and down, to say yes to this was the 2nd day with mouth pain, she was not sure if she was in pain before Monday. (Surveyors entered facility on Tuesday evening). Interview with Resident #1 nodded her head back and forth, to say No, staff had not used a non-verbal pain scale.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/2024 at 10:23 AM LVN G came into Resident #1's room, after resident pushed the call light due to pain in mouth area. Surveyor asked LVN G if Resident #1 had partials, and LVN G stated she was not sure. LVN G looked at Resident # 1 as she walked closer to Resident #1's bed. Resident # 1 had her fingers in her mouth, nurse asked if she was, in pain. Resident # 1 stated nodded her head, yes. LVN G stated she would notify the MD and administer Resident #1 with pain medication.</p> <p>During an interview on 6/26/24 at 10:45 AM with ADON LVN stated Resident # 1 was pointing to her left side, (she is not verbal, need to ask her or point), indicate something was wrong. Resident #1 pointed to her mouth; she was not hurting at the time of her assessment. ADON LVN stated Resident #1 wanted her to look in her mouth, gum to left side noted red, missing teeth and decay noted on left side lower and upper side, no swelling noted to left side, notified MD and family. Resident denies pain and no orders. ADON LVN stated she notified the SW about a dental consult. ADON LVN stated she worked until 3pm and Resident #1 had no complaints of pain. ADON LVN stated Resident # 1 can raise fingers about the pain level and can answer questions, so do not use non-verbal pain scale.</p> <p>During an interview on 6/26/2024 at 11:06 AM SW stated the ADON notified her Resident #1 needed a dental referral, the dental referral completed and waiting for dentist to respond. SW stated Resident # 1 communication can be hard. SW stated Resident # 1 does well with yes and no questions, she uses facial expressions, being with staff familiar with her needs, staff had known her a long time. SW stated Resident #1 communicates nonverbal, short simple questions, staff anticipate Resident #1's needs, staff will continue to ask questions until they find something to meet with Residents needs at that moment.</p> <p>During an interview on 6/26/2024 at 12:21 PM with Resident #1 nodded her head, No: she did not think staff understood about her pain and sometimes do not understand what she needs at the moment.</p> <p>During an interview on 6/26/2024 at 12:33 PM with Resident #1 she said she did not like that she had hairs on her chin/throat area, a shrug was used to communicate, and she was not sure when staff gave her a bath/shower.</p> <p>During an interview on 6/27/2024 at 3:18 PM LVN K stated he would be able to tell if Resident #1 had pain. LVN K stated he worked this last weekend and Resident #1 did not verbalize and no signs in pain. LVN K stated Resident #1 communicates by shakes her head, mumbles, and staff could understand, yes and no responses.</p> <p>During an interview on 6/28/2024 at 12:11 PM with speech therapist- left a message with no return call by exit.</p> <p>During an interview on 6/28/2024 at 12:24 PM with PT I stated she communicate with Resident #1, yes and no questions, not able to communicate other than that. PT I stated she was working on positioning, bed mobility, working on getting left side stronger, she had a stroke and right side effective, she has been doing well. PT I stated Resident #1 was able to scout herself up, pull herself up with her good arm in her bed in room.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/28/2024 at 12:49 PM LVN G stated when she asked Resident # 1 if she had a bath/shower, Resident #1 replied yes and no, she was not sure. LVN G stated she would check the computer record. Interview with LVN G looked at bath/shower task and a bath/shower were not documented for Monday and Wednesday.</p> <p>Attempted interview on 6/28/24 at 1:58 PM with CNA (agency) H was told she was the agency CNA working and would know if Resident #1 took a shower or not. left a message with no return call.</p> <p>During an interview on 06/28/24 04:45 PM MDS RN and care plans stated for Resident #1 staff do her personal care and oral care. communication added a new care plan, she stated she gives Resident # 1 time and can understand, Resident #1 points at what she needs staff to get for her, nothing for gestures, no pain care plan for her tooth/mouth area. MDS RN stated Resident #1 can tell staff if she had a headache.</p> <p>Interview on 6/28/24 at 6:13 PM with the Medical Director regarding Resident #1 and communications with staff to provide her needs, stated communication, Resident #1 can say small phrases, points at things, start asking her different questions -MD stated staff can use a communications board if having difficulty with Resident #1 communication of needs. MD stated staff notified him Resident #1 was in pain but did not share she had a pain level of 8/10.</p> <p>During an interview on 6/28/24 07:44 PM with DON stated Residents wear their gown while in bed. DON stated some staff understand Resident #1 better than others, they get another staff, use a lot of gestures, and had facial communication, expect staff to know she had communication boards. The DON stated the agency staff do a walk through and watch residents in their unit.</p> <p>A record review of the facility's undated public posting Resident's Rights nursing facilities revealed, Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal in exercising these rights as citizens of the United States.</p> <p>Dignity and respect, you have the right to:</p> <p>Live in safe, decent, and clean conditions.</p> <p>Be free from abuse, neglect, and exploitation.</p> <p>Be treated with dignity, courtesy, consideration, and respect.</p> <p>A record review of the facility's policy Activities of Daily Living (ADLs), Supporting dated March 2018 revealed, Policy Statement: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).</p> <p>Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>Policy Interpretation and Implementation:</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable . 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:</p> <p>a. Hygiene (bathing, dressing, grooming, and oral care).</p> <p>b. Mobility (transfer and ambulation, including walking).</p> <p>c. Elimination (toileting); . 5. A resident's ability to perform ADLs will be measured using clinical tools, including the MDS. Functional decline or improvement will be evaluated in reference to the Assessment Reference Date (ARD) and the following MDS definitions: . b. Supervision - Oversight, encouragement or cueing provided 3 or more times during the last 7 days . c. Limited Assistance - Resident highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight bearing assistance 3 or more times during the last 7 days . 6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. 7. The resident's response to interventions will be monitored, evaluated, and revised as appropriate.</p>

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NAME OF PROVIDER OR SUPPLIER  Windcrest Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  8800 Fourwinds Dr San Antonio, TX 78239	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26869</p> <p>41937</p> <p>Based on observations, interviews, and record review the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 8 residents (Resident #51) reviewed for activities of daily living.</p> <p>1. Resident #51 was observed left in bed from 09:00 AM to 06:00 PM on 06/25/2024 and again from 07:30 AM to 12:00 PM on 06/26/2024.</p> <p>2. Resident #51 was observed with no hydration at his bedside from 09:00 AM to 06:00 PM on 06/25/2024 and again from 07:30 AM to 12:00 PM on 06/26/2024.</p> <p>3. Resident #51 was observed with the remnants of breakfast on his gown on 06/26/2024 from 08:30 AM to 12:00 PM.</p> <p>These failures could place residents at risk for harm by a decline in residents' abilities to perform ADL's.</p> <p>The findings included:</p> <p>A record review of Resident #51's admission record dated 06/28/2024 revealed an admitted [DATE] which included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), anxiety disorder, and weakness.</p> <p>A record review of Resident #51's annual MDS assessment dated [DATE] revealed Resident #51 was an [AGE] year-old male admitted for long term care with supports for Activities of Daily Life (ADL's) complicated by Alzheimer's disease. Resident #51 was assessed with a BIMS score of 02 out of a possible 15 which indicated severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident #51's care plan dated 06/28/2024 revealed, Resident #51 has an ADL self-care performance deficit r/t Alzheimer's, Confusion, Impaired balance, Limited Mobility . DRESSING: The resident requires EXTENSIVE assistance by (X1) staff to dress . EATING: The resident requires limited assistance by 1 staff . PERSONAL HYGIENE: The resident requires EXTENSIVE assistance by (X1) staff with personal hygiene and oral care . TOILET USE: The resident requires EXTENSIVE assistance by (X1-2) staff for toileting . TRANSFER: The resident requires EXTENSIVE assistance by (X1-2) staff to move between surfaces as necessary . The resident is resistive to care, yells out and curses at staff when staff attempts to provide care at times r/t Dementia . If resident resists with ADLs, reassure resident, leave, and return 5-10 minutes later and try again . The resident has a communication problem r/t language barrier . Ensure/provide a safe environment: Call light in reach, adequate low glare light, bed in lowest position and wheels locked, avoid isolation . Resident #51 has potential for fluid volume deficit . Invite the resident to activities that promote additional fluid intake. Offer drinks during one-to-one visits. Ensure that all beverages offered comply with diet/fluid restrictions and consistency requirements . The resident needs activities that minimize the potential for falls while providing diversion and distraction . Encourage fluids during the day to promote prompted voiding responses</p> <p>During an observation on 06/25/2024 at 10:30 AM revealed Resident #51 was in bed awake and drinking water from a small clear plastic cup. Resident #51 had his bed in the lowest position but did not have a fall mat next to his bed.</p> <p>During an interview on 06/25/24 at 10:34 AM Resident #51's roommate, Resident #30 and his representative, stated Resident #51 was often left in bed for days and resident #51 had no one to visit him. Resident #30's representative stated she had pity for Resident #51 since often he had no water to drink so she served him water and offered him bananas when she offered drinks and fruit to Resident #51. Resident #30's representative stated Resident #51 has been in bed this morning without any water to drink since breakfast, so she poured him some water in the small plastic cup he has now.</p> <p>During an observation and interview on 06/25/2024 at 05:55 PM revealed Resident #51 continued in his bed awake without any water by his bed side. Resident #51 could not participate in the interview but continued to smile and nod his head .</p> <p>During an observation on 06/26/2024 at 07:15 AM revealed Resident #51 asleep in his bed without any water by his bedside.</p> <p>During an observation on 06/26/2024 at 07:57 AM revealed Resident #51 was in his bed eating his breakfast alone without assistance. Further observation revealed Resident #51 was spilling some of his food onto himself and his bed .</p> <p>During an observation and interview on 06/26/2024 at 09:00 AM CNA J was observed answering call lights on Resident #51's hall. CNA J stated she was the CNA for Resident #51 had served and recovered Resident #51's breakfast meal.</p> <p>During an observation on 06/26/2024 at 10:10 AM revealed Resident #51 in his bed with remnants of his breakfast on his gown, on his person, and in the bed linens .</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and observation on 06/26/24 at 11:58 AM LVN T stated Resident #51 was in bed with a small cup of water served by his roommates' representative. Resident #51 had food debris on his person, gown, and bed linens. LVN T stated Resident #51 often refused to get out of bed. LVN T stated CNA J had not reported Resident #51's refusal to get out of bed yesterday or today. LVN T stated Resident #51 was a fall risk and should have bedside fall mats when he is in bed. LVN T stated Resident #51 ate alone and his family and or friends often send him a meal via (local delivery service). LVN T stated she did not observe a water tumbler for Resident #51 in his room .</p> <p>During an observation and interview on 06/26/24 at 02:52 PM the Activities Director stated she attended and facilitated an activity with Resident #51 who was observed seated in his wheelchair in the lobby of the facility participating in the activity. Resident #51 was observed dressed in a shirt and pants and was well groomed. Resident #51 was observed smiling.</p> <p>A record review of the facility's Activities of Daily Living (ADLs), Supporting policy dated March 2018, revealed, Policy Statement - Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Policy Interpretation and Implementation. 1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable . 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care). b. Mobility (transfer and ambulation, including walking). c. Elimination (toileting). d. Dining (meals and snacks); and e. Communication (speech, language, and any functional communication systems) . 4. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47564</p> <p>Based on observations, interviews, and record review the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 8 Residents (Resident #53) reviewed for skin integrity.</p> <p>The facility failed to ensure Resident #53's pressure relieving cushion was equipped on her wheelchair.</p> <p>This failure could affect residents' ability to decrease likelihood of pressure ulcers and potentially worsen existing pressure ulcers.</p> <p>The findings were:</p> <p>Record review of Resident #53's face sheet, dated 06/28/2024, revealed an [AGE] year-old woman, admitted on [DATE], with diagnoses including: unspecified dementia (group of thinking and social symptoms that interferes with daily functioning), vitamin d deficiency, and age-related osteoporosis (a condition in which the bones become weak and brittle).</p> <p>Record review of Resident #53's quarterly MDS assessment, dated 04/04/2024, revealed Resident #53's BIMS score was 5 out of 15 indicating severe cognitive impairment, required partial/moderate assistance with toileting, and substantial/maximal assistance with showering. Further review revealed Resident #53 was at risk of developing pressure ulcer/injury and did not actively have a pressure ulcer.</p> <p>Record review of Resident #53's order summary report, dated 06/28/2024, reflected an active order with a start date of 03/14/2024 that read, Pressure Reducing Cushion to wheelchair.</p> <p>Observation on 06/26/2024 at 3:50 PM revealed Resident #53 did not have a pressure reducing cushion on her wheelchair.</p> <p>Observation and interview on 06/28/2024 at 1:21 PM with the Housekeeping Manager revealed Resident #53 did not have a pressure reducing cushion on her wheelchair. The Housekeeping Manager stated she believed physical therapy oversaw ensuring the residents had appropriate pressure reducing cushions to their wheelchairs. The Housekeeping Manager stated she would think if the resident is supposed to have a cushion it would be there.</p> <p>In an interview on 06/28/2024 at 1:25 PM, LVN D stated she was unsure of where Resident #53's pressure reducing cushion was, and that physical therapy was responsible for ensuring any cushions ordered are on wheelchairs .</p> <p>In an interview on 06/28/2024 at 1:28 PM, the ADON stated that it was her expectation that it was every employee's responsibility to ensure pressure reducing cushions were on wheelchairs and that any department could order them depending on the needs of residents . The ADON stated this failure could affect residents by making them more at risk for developing pressure ulcers.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/28/2024 at 7:04 PM, the MD stated that orders for pressure reducing cushions to wheelchairs were determined based on the individual residents needs depending on their sensation in the area, ability to move, and nutritional status. The MD stated their expectation was that the ADON/DON ensure all residents with orders for a pressure reducing cushion have their cushion . The MD stated that the idea of a pressure reducing cushion is to prevent pressure ulcers, and that it could make residents at increased risk for pressure ulcers if they do not have one.</p> <p>In an interview on 06/28/2024 at 7:47 PM, the DON stated that most residents who use a wheelchair should have a pressure reducing cushion unless they need a more specialized cushion, such as a cushion to prevent the resident from sliding off of their wheelchair. The DON stated that her expectation was that all staff were to ensure residents have their wheelchair cushions . The DON stated that the failure could affect residents by not ensuring pressure ulcers were prevented to their best ability.</p> <p>Record review of facility policy titled, Pressure Ulcer/Skin Breakdown - Clinical Protocol, undated, reflected, The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. No policy further detailing ensuring resident pressure ulcer reducing devices was provided.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47564</p> <p>Based on observation, interview, and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #39) of 8 residents reviewed for accidents.</p> <p>The facility failed to ensure Resident #39 was supervised while she was in the dining room.</p> <p>This failure could place residents at risk of injuries and a decline in quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #39's face sheet, dated 06/28/2024, reflected a [AGE] year-old female resident, initially admitted on [DATE], with diagnosis including: unspecified dementia, unspecified severity, with other behavioral disturbance (group of thinking and social symptoms that interferes with daily functioning); dysphagia following cerebral infarction (difficulty swallowing food and/or liquids after a stroke); and type 2 diabetes mellitus without complications (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>Record review of Resident #39's Care Plan, undated, reflected, The resident is at high risk for falls related to frequent falls, poor safety awareness, poor impulse control, unsteady gait, dementia, left eye cataract, use of diuretics, behavioral problems, use of narcotics, and use psychotropics with interventions including, Resident to not be in dining room without constant supervision.</p> <p>Record review of Resident #39's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 99 indicating the resident was not able to complete the interview. MDS reflected Resident #39 required assistance with transferring and partial/moderate assistance with eating. Further review revealed the resident has had 4 falls since the last quarterly MDS assessment, two with injury and two without injury.</p> <p>Observation on 06/26/2024 at 4:00 PM revealed Resident #39 alone in the dining room with no staff within ear or eyeshot. Staff were observed at the nurse's station in the locked unit.</p> <p>Observation on 06/28/2024 at 11:15 AM revealed Resident #39 in dining room, along with other locked unit residents, with no staff within ear or eyeshot. Staff were observed to have occasionally walk in and out of dining room and back down the hallway toward the entrance to the locked unit.</p> <p>Interview on 06/28/2024 at 1:12 PM, LVN D stated she was unaware of any supervision requirement for Resident #39. LVN D stated she attempts to sit with the resident during meals to ensure she is eating enough, but that she has never been informed of any special or extensive supervision Resident #39 required.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/28/2024 at 7:47 PM, the DON stated she would expect the staff members to supervise Resident #39 at all times while she was in the dining room, whether it was mealtime or not. The DON stated the risk to Resident #39 by not being supervised in the dining room according to her care plan included risk of Resident #39 injuring themselves by falling.</p> <p>Record review of facility policy titled, Care Plans, Comprehensive Person-Centered, undated, reflected, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41937</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain, for 1 of 8 (#30) residents reviewed for their right to use the bathroom.</p> <p>The facility failed to support Resident #30's continence and right to use the bathroom and not depend on his adult brief.</p> <p>This failure could place residents at risk for harm by an contributing to incontinence and an undignified lifestyle.</p> <p>The findings included:</p> <p>A record review of Resident #30's admission record dated 06/28/2024, revealed an admitted [DATE] with diagnoses which included fracture part of neck of right femur (broken right hip), hemiparesis following cerebral infarction (weakness to one side of the body after a stroke), and cerebral infarction (stroke).</p> <p>A record review of Resident #30's quarterly MDS assessment dated [DATE] revealed Resident #30 was a [AGE] year-old male admitted for long term care and rehabilitation for a right broken hip and supportive care for a right-side body weakness. Resident #30 was assessed with a BIMS score of 12 out of a possible 15 which indicated a moderate cognitive impairment. Resident #30 was assessed with adequate hearing and speech with the ability to make himself understood and understand others. Resident #30 was assessed with the history of using a wheelchair and a walker. Resident #30 was assessed with the need for Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort for the following activities of daily life:</p> <p>Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.</p> <p>Resident #30 was assessed with the need for Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as Resident completes activity. Assistance may be provided throughout the activity or intermittently, for the following activities of daily life:</p> <p>Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.</p> <p>Toilet transfer: The ability to get on and off a toilet or commode.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.</p> <p>Further review of Resident #30's MDS revealed no toileting program was initiated and Resident #30 was assessed as Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) . Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement). Further review of Resident #30's MDS revealed he was at risk for developing pressure ulcers.</p> <p>A record review of Resident #30's physicians' orders revealed Resident #30 was referred to physical therapy and occupational therapy on 05/31/2023 for an evaluation and treatment.</p> <p>A record review of Resident #30's care plan dated 06/28/2024 revealed, The resident has an ADL self-care performance deficit r/t generalized weakness. s/p (after) cva (stroke) with right sided weakness. Resident utilizes custom wheelchair for locomotion . resident will maintain current level of function in ADL care through the review date .TOILET USE: The resident requires Extensive assistance by (X1) staff for toileting . TRANSFER: The resident requires Extensive assist x1 staff assistance for transfers . resident had a cerebral vascular accident (CVA/Stroke) affecting right dominant side . Monitor/document bladder and bowel function . If incontinent monitor/document for appropriate bowel and bladder training program and implement. Monitor/document resident's abilities for ADLs and assist resident as needed. Encourage resident to do what he/she is capable of doing for self . Educate resident/family/caregivers of causative factors and measures to prevent skin injury</p> <p>A record review of Resident #30's Multidisciplinary Care Conference dated 04/10/2024 revealed topics discussed: What health outcome matters MOST to the Resident? To build up his strength enough to be able to transfer from wheelchair to the toilet again . SUMMARIZE DISCUSSION OF CARE PLAN CONFERENCE; RP attended care plan via phone. RP states resident would like to transfer from wheelchair to toilet. Therapy is currently working on transfers with resident. RP states the resident enjoys working out. RP with no other questions or concerns at this time. Code status confirmed.</p> <p>A record review of Resident #30's FUNCTIONAL ABILITIES-Charge Nurse Documentation-Q (every) shift dated 04/23/2024, revealed, Self-Care. Ask CNA for input on USUAL performance during shift. (Different than POC /ADL documentation where CNAs need to document the MOST assistance needed during ADL self-performance); . Chair/Bed-to-chair transfer-The ability to transfer to or from bed to chair/wheelchair, Substantial/maximal assistance- helper does MORE THAN HALF . Toilet transfer-The ability to get on and off a toilet or bedside commode, Substantial/maximal assistance- helper does MORE THAN HALF</p> <p>A record review of Resident #30's Occupation Therapy Discharge Summary dated 05/08/2024 revealed, standing during ADL's, PLOF (prior level of function) Fair, discharge, Fair (maintains standing balance 1-2 minutes without upper extremities support without loss of balance . toileting, PLOF, minimum assistance, baseline, DNT (did not test), discharge 05/28/2024</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of Resident #30's grievance dated 05/24/2024 revealed Resident #30 had made a grievance to the Administrator who documented, Resident stated he feels captive here because his custom wheelchair doesn't fit in bathroom and believes private skilled rooms have bigger bathroom doors .findings of investigation: I offered for Resident to have old wheelchair back. Resident refused. Offered basin and mirror, but Resident wants to go to the bathroom. Plan to resolve complaint / grievance: Spoke to DOR (director of rehab) who stated Resident is unable to self-transfer. Will work on it in therapy. Expected results of actions taken: Resident will safely be able to transfer so he can go. Complaint / grievance resolved; No, specify follow up: Resident cant transfer safely and he still wants to go into bathroom.</p> <p>During an observation and interview on 06/23/2024 at 10:28 AM Resident #30 and his RP stated there was an important issue he needed addressed. Resident #30 stated in January of 2023 he had fallen and suffered a broken hip. He received surgery to repair the hip and since has been in the facility. Resident #30 went on to explain that prior to January 2023 he was able to transfer from his custom wheelchair to a smaller wheelchair and then staff would assist him to his small bathroom in his room, even though he had right side body weakness. Resident #30 stated since then he had been ignored when he asked for assistance to use the toilet and instead, he was expected to soil himself and then ask for assistance with changing his adult brief. Resident #30 stated the staff would state you cannot go to the bathroom, it is dangerous. Resident #30 stated he had been assessed by the physical therapy department without resolution and has continued in his same dilemma. Resident #30 stated he has voiced his concerns to the Administrator and in care plan meetings without resolution. Resident #30 stated he felt like he was being held captive. Resident #30 and his RP stated the Administrator made an undignified offer for Resident #30 to use a bedside commode and a small vanity mirror in his shared small room.</p> <p>During an interview on 06/27/2024 at 09:50 AM CNA J stated she has provided care for Resident #30, and she does not take him to the toilet when he requests because she has been instructed not to. She stated, he is not safe to transfer to the toilet. CNA J stated, his wheelchair is too big, and he cannot walk to the toilet, so I change his (adult brief) when he is dirty .</p> <p>During a joint interview on 06/27/2024 at 09:00 AM the Director of Rehabilitation and the Physical Therapist (PT) stated prior to Resident #30's broken hip, with assistance, he could use a smaller wheelchair to go into the shared bathroom in his bedroom. The PT stated Resident #30 could not use his smaller wheelchair now due to his need for his larger wheelchair after his broken hip. The PT stated Resident #30 was not safe to use his bathroom toilet because his wheelchair would not fit into the bathroom and his toilet was not fitted with grab bars on both sides, which he needed for support when transferring from a wheelchair to the toilet.</p> <p>During an interview on 06/28/24 at 07:38 PM the DON stated Resident #30 refused to use a small wheelchair to use the bathroom and his larger custom wheelchair will not fit. She stated we are accommodating his needs with a small wheelchair, and he refused.</p> <p>During an interview and observation on 06/28/2024 at 07:54 PM the facility's Maintenance Director measured and stated Resident #30 bathroom in his share bedroom measured 4 feet 3 inches by five feet wide. The maintenance director stated all the facility's bathrooms for residents were the same size.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of the facility's undated public posting Resident's Rights nursing facilities revealed, Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal in exercising these rights as citizens of the United States. Dignity and respect, you have the right to: Live in safe, decent, and clean conditions. Be free from abuse, neglect, and exploitation. Be treated with dignity, courtesy, consideration, and respect.</p> <p>A record review of the facility's policy Activities of Daily Living (ADLs), Supporting dated March 2018 revealed, Policy Statement: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Policy Interpretation and Implementation: 1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable . 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting); 5. A resident's ability to perform ADLs will be measured using clinical tools, including the MDS. Functional decline or improvement will be evaluated in reference to the Assessment Reference Date (ARD) and the following MDS definitions: b. Supervision - Oversight, encouragement or cueing provided 3 or more times during the last 7 days . c. Limited Assistance - Resident highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight bearing assistance 3 or more times during the last 7 days . 6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. 7. The resident's response to interventions will be monitored, evaluated, and revised as appropriate.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26869</p> <p>Based on interviews and record reviews the facility failed to ensure residents were free of any significant medication errors for 1 of 8 residents (Resident #57) reviewed for medication administration.</p> <p>The facility failed to ensure Resident #57 received Midodrine as ordered twice in July 2024.</p> <p>This failure could place residents at risk for not receiving the therapeutic effects of their prescribed medications.</p> <p>The findings included:</p> <p>Record review of Resident #57's Admission record dated 6/28/2024 revealed he was admitted on [DATE], readmitted on [DATE], and his age was [AGE] year-old male. Record review of #57's diagnoses was heart failure, diabetes II with hyperglycemia.</p> <p>Record review of Resident #57's consolidated physician orders dated June 2024 revealed an order for Midodrine HCl Oral Tablet 2.5 MG ; (Midodrine HCl); Give 1 tablet via PEG-Tube two times a day for Hypotension Hold for SBP &gt; 130.</p> <p>Record review of Resident #57's MAR for June 2024 was documented for Midodrine HCl Oral Tablet 2.5 MG; (Midodrine HCl); Give 1 tablet via PEG-Tube two times a day for Hypotension Hold for SBP &gt; 130. This medication was administered on 7/7/204 at 6pm- 1pm shift, B/P was 132/89 and pulse 89 and on 7/12/2024 at 132/89 and pulse 89 by LVN P.</p> <p>Record review of Resident #57's Quarterly MDS dated on 6/72024 revealed he was cognitively intact and had diabetes.</p> <p>Record review of Resident #57's Care Plan dated 5/29/2024 revealed he had a diagnosis of Diabetes Mellitus and intervention Diabetes medication as ordered by doctor.</p> <p>Attempted interview on 6/28/2024 at 2:26 PM with LVN P with no return call .</p> <p>During interview on 6/28/2024 at 7:34 PM with DON stated she was not aware that Resident #57 was administered Midodrine twice when it should have been held, according to MD orders. The DON stated no staff have reported this incident. The DON stated staff should report to the DON and the ADON to review and they did not notify any issues with parameters .</p> <p>Record review of policy [NAME] Pharmacy dated 12/1/2021 titled, Medication Administration revealed Medications were administered as prescribed in accordance with good nursing principles and practices and only by personas legally authorized to do so.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26869</p> <p>Based on interviews and record review, the facility failed to ensure there were no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack was served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span for 4 of 7 residents (confidential residents in group) reviewed for frequency of meals.</p> <p>The facility failed to ensure residents were offered snacks at bedtime as required due to mealtimes being more than 14 hours apart.</p> <p>This failure could affect all residents who received meals served from the facility's only kitchen by placing residents at risk for, unplanned weight loss, and side effects from medication given without food, and diminished quality of life.</p> <p>Findings included:</p> <p>Record review of the resident snack list dated 6/27/2024, was provided by the FSM . There were 38 residents that received HS snacks. The snack list provided by the FSM were for residents that had an order. There was no other resident list with HS snacks provided.</p> <p>Record review of the resident roster dated 6/25/2024 reflected a census of 82 residents.</p> <p>Record review of the Meal Service Times in the dining room proved by the ADM revealed the following.</p> <p>Breakfast - 7:30 AM</p> <p>Lunch - 12:00 AM</p> <p>Dinner -5:30 PM. There was no posting to advise any resident of a snack or availability of type of snack after specified times.</p> <p>During interview on 6/27/2024 at 3: 15 PM with residents in group of 7 residents, it was brought to the attention of the state surveyors that they have not been made aware of options of a snack which were available to residents. Residents said they were not offered any HS snacks by staff.</p> <p>During an interview on 6/27/2024 at 5:30 PM MA/CNA D stated she had also worked as a CNA and worked Monday-Friday for many years. MA/CNA D stated the residents get snacks around 7 or 8 pm, and not all residents get HS snacks. MA/CNA D stated only certain residents get HS snacks, the snacks have resident names on labels of HS snacks. MA/CNA D stated the dietary aide brings the snacks in plastics container with ice, then staff pass out those snacks.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/27/2024 at 5:41 PM CNA E prn (as needed) stated worked for 1 month. CNA stated the HS snacks were given at a scheduled time to bring snacks to the residents. CNA stated residents need to ask for snacks, and residents can come get what they want after, the CNA's have given the labeled HS snacks to residents.</p> <p>During an interview on 6/27/2024 at 5:44 PM FSM stated she had worked for [AGE] years at the facility. The FSM stated the resident snacks had labels on them and were sent out to the nurse's station. The FSM stated the residents that had orders or had requested snacks during a dietary assessment was included on the snack list. The FSM stated the nurses would place an order for snack, especially the diabetic residents.</p> <p>During an interview on 06/27/24 at 05:46 PM LVN F stated she worked on the 3-11 PM shift prn and had started working for month. LVN F stated the resident HS snacks were brought by dietary aides, after supper. LVN F stated the HS snacks that were brought out by dietary had resident name labels on them. LVN stated residents come to nurses' station to ask for snacks if they want any.</p> <p>During an interview on 6/28/2024 at 9:46 AM FSM stated the snacks were left at the nurse's station at 7 PM. The FSM stated the snacks that were available were sandwiches, pudding, jello, fruit cup, ice cream, shakes, graham crackers, and applesauce.</p> <p>During an interview on 6/28/2024 at 8:14 PM the DON stated she was not aware that HS snacks had to be offered by staff to residents. The DON stated the diabetic residents had HS snacks ordered .</p> <p>During an interview on 6/28/2024 at 8:50 PM with ADM stated she was not aware that HS snacks had to be offered to all residents and was not aware, that all residents were not provided HS snacks. The ADM stated the affect residents would be that the residents would be hungry. ADM provided the wrong policy and stated that was all she had for snacks.</p>		