

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Windsor Nursing and Rehabilitation Center of Harli		STREET ADDRESS, CITY, STATE, ZIP CODE 820 Camelot Dr Harlingen, TX 78550	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26920</p> <p>Based on observation, interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for accuracy of records.</p> <p>1)The facility failed to accurately document in Resident #1's clinical records the dark discolorations on bilateral upper and lower extremities.</p> <p>2) The facility failed to document in Resident #1's clinical records her diagnosis of bullous pemphigoid (a rare skin condition that causes, large, fluid filled blisters.)</p> <p>3) The facility failed to properly assess Resident #1's skin conditions.</p> <p>These failures could place residents at risk of not receiving appropriate care resulting in deterioration in condition and exacerbation of disease process due to inaccuracy of the residents' records.</p> <p>The findings included:</p> <p>Review of Resident #1's admission record dated 04/04/24 reflected Resident #1 was an [AGE] year-old female, initially admitted on [DATE] and readmitted on [DATE], with the diagnoses that included rhabdomyolysis (syndrome of muscle necrosis that releases harmful products into the bloodstream), functional quadriplegia (term for patients who are completely immobile due to severe disability or frailty), and history of falling.</p> <p>Record review of the care plans for Resident #1 dated 12/07/23 reflected Resident #1 had a potential for impairment to skin integrity r/t incontinent of bowel and bladder, history of stage 2 pressure ulcer (sacrum) and itching. Interventions included to encourage good nutrition and hydration to promote healthier skin and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.</p> <p>Record review of the clinical records for Resident #1 from December 2023 to 04/04/24 reflected no documentation to reflect Resident #1's dark skin discolorations on bilateral upper extremities or dark gray discolorations on both lower legs .</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 0842</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 quarterly MDS dated [DATE] reflected resident had severe cognitive impairment, was independent for eating, and was dependent for toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear.</p> <p>Record review of Resident 1's last two weekly skin evaluations dated 03/25/24 and 04/01/24 reflected resident did not have any abnormal skin areas, i.e., bruises, skin tears, pressure ulcers, non-pressure wound, and no skin breakdown. The weekly skin evaluations were signed by LVN F.</p> <p>Record review of the physician orders for Resident #1 dated 04/04/24 reflected no documentation for the diagnosis bullous pemphigoid.</p> <p>Record review of the MAR for Resident #1 dated 04/05/24 reflected Prednisone oral tablet 10mg start date 01/02/24 give 1 tablet by mouth one time a day for rash until 01/08/24, was administered. Prednisone oral tablet 10mg start date 01/10/24 give 1 tablet by mouth one time a day for dermal inflammation for 7 days, was administered. Prednisone oral tablet 10mg start date 01/17/24 give 0.5 tablet by mouth one time a day for dermal inflammation for 7 days until, was administered. Clobetasol Propionate Cream 0.05% apply to right leg topically every day and evening shift for rash for 30 days, start 01/10/24, was administered.</p> <p>Observation of Resident #1 on 04/04/24 at 2:15 pm revealed resident lying in bed, upright, alert, and oriented. Resident #1's both forearms were completely covered with dark purple discolorations. Resident #1's both legs from knees to foot were a dark gray color.</p> <p>Interview with Resident #1 on 04/04/24 at 2:15 pm revealed she had both her arms covered with dark discolorations for a long time. Resident #1 said her legs were dark gray and she did not know the reason.</p> <p>Interview on 04/04/24 at 2:25 pm with ADON A revealed the dark purple discolorations on both of Resident #1's arms and her legs had been like that for a long time . ADON A said she did not remember assessing the resident or documenting the dark discolorations or dark gray color on her legs in Resident's clinical records .</p> <p>Attempts to contact LVN F via telephone were unsuccessful on 04/04/24 and 04/05/24, voicemail left both times.</p> <p>Interview on 04/04/24 at 3:25 pm with LVN D revealed she was the charge nurse for Resident #1 for several days training with another charge nurse. LVN D said she had only been working by herself for two days at the facility and was assigned Resident #1. LVN D said she had not noticed Resident #1's skin discolorations and had not asked or documented in the resident's clinical chart the skin discolorations.</p> <p>Interview on 04/05/24 at 9:07 am with LVN C revealed she had documented in Resident #1's progress notes dated 03/26/24 she had contacted Resident #1's physician about an order to discontinue an antibiotic. LVN C said at the time she had provided care to this resident she had not noticed the dark purple skin discolorations on resident's bilateral upper extremities or bilateral lower extremities. LVN C she did not assess or document the skin conditions for Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/05/24 at 10:30 am with ADON C revealed she had documented on progress notes for Resident #1 on 03/29/24 she had removed the resident's midline catheter line from Resident #1's right upper arm. ADON C said she did not remember seeing the discolorations on Resident #1's arms or on her legs. ADON C said she did not document because she did not remember seeing that Resident #1's arms and leg had dark skin discolorations.</p> <p>Interview on 04/05/24 at 10:32 am with the DON revealed Resident #1 had dark purple skin discolorations for a long time , and when they started had not been documented. Resident #1 was sent to a dermatologist on 01/03/24 for assessment of blisters in her bilateral upper and lower extremities. A biopsy was completed, and the diagnosis of bullous pemphigoid was determined. The dermatologist sent in orders for oral steroid and creams to be administered and these orders were added to Resident #1's physician orders and were discontinued after the treatments were completed. The DON said the diagnosis had not been entered into Resident #1's clinical records. The DON said MDS/RN was responsible to enter the diagnosis of bullous pemphigoid into Resident #1's physician orders. The DON said she had been unable to contact LVN F via telephone regarding the weekly skin evaluations. The LVN F did not properly assess Resident #1's skin condition of her bilateral arms and legs on her skin evaluations. The DON said it was her responsibility to ensure that nurses recorded proper documentation on resident's clinical record regarding Resident #1's skin discolorations . The DON said failure to transcribe the diagnosis for Resident #1 of bullous pemphigoid had no adverse effect because treatment had been provided when the diagnosis was received, and the dermatologist prescribed medication on 01/03/24. The DON said failure to properly assess and document the skin conditions for Resident #1 had the potential to miss any deterioration in her skin conditions.</p> <p>Interview on 04/05/24 at 11:30 am with MDS/RN revealed when Resident #1 returned from her dermatologist appointment on 01/03/24, the nurse who received this report should have communicated to her. MDS/RN said after receiving communication from the nurses, she would add the diagnosis to the physician orders when MDS completed another annual, significant change or quarterly assessment. MDS/RN said she had completed a quarterly assessment for Resident #1 on 01/17/24 and she missed the opportunity to enter the diagnosis of bullous pemphigoid into Resident #1's physician orders.</p> <p>Record review of the facility policy titled Documentation in Medical Record dated 10/24/22 reflected Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical records in accordance with state law and facility policy.</p> <p>Record review of the facility policy titled Skin assessment dated [DATE] reflected It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission, readmission, weekly for three weeks and weekly thereafter.</p>		