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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455822	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Harli	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care received such care consistent with professional standards of practice and the comprehensive person-centered care plan for 2 of 6 residents (Residents #84 and Resident #90) reviewed for respiratory care. The facility failed to ensure Resident #84 received oxygen at the prescribed rate. He received oxygen at a rate less than prescribed. The facility failed to ensure Resident #90 received oxygen at the prescribed rate. He received oxygen at a rate higher than prescribed. This failure could place residents receiving oxygen at risk for respiratory distress. The findings included: Record review of Resident #84's Quarterly MDS assessment dated [DATE] revealed resident with a BIMS score of 9 which suggests a moderate cognitive impairment and received oxygen therapy under special treatments/respiratory treatments. Record review of the Face Sheet dated 4/17/24 for Resident # 84 revealed the following diagnosis: Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions) and vascular dementia (brain damage caused by multiples strokes which causes memory loss in older adults). Record review of the Care Plan for Resident #84 revealed resident has oxygen therapy r/t short of breath, hypoxia. Date initiated 8/15/22. Record review of the Doctor's Order Summary revealed Resident # 84 was prescribed O2 at 2LPM via Nasal Cannula Continuous DX: Hypoxia every shift related to COPD Active 03/29/2024. On 04/16/24 at 10:58 AM observed Resident #84 with O2 via nasal cannula at 1.5LPM. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/24 at 11:05 AM interviewed LVN B and she confirmed that Resident #84's order is for O2 at 2 LPM via nasal cannula continuous. She said that all nurses are responsible for ensuring O2 rates are set correctly. LVN B stated she usually checks the rates when she comes on shift. On 04/17/24 at 03:05 PM interviewed LVN H and she stated that all nurses are responsible for ensuring the rates for O2 are correct. LVN H said the O2 setting should be checked every shift. She said that the lack of oxygen could cause a resident to struggle to breathe and not get enough oxygenated blood to the body. LVN H said that she has not seen Resident #84 displaying any adverse symptoms today. On 4/17/24 at 3:35 pm interviewed ADON M and she said that the respiratory therapist has a training for facility staff every year. She said that if O2 is not given as ordered, the resident can have respiratory distress, dizziness, or SOB. On 04/17/24 at 05:37 PM interviewed ADON C and she stated that the nurses are responsible for ensuring the oxygen rates are correct. ADON C said that the nurses should check every shift and every time they enter a resident's room as best practice. ADON C said if a resident receives less oxygen than prescribed, their O2 saturation can go low, and they can experience SOB. ADON C said that she is unaware of Resident # 84 displaying any adverse effects. She said that they have a respiratory therapist that comes to the facility and gives training and certification in O2 therapy every year. On 04/17/24 at 05:45 PM interviewed DON and she said that licensed nurses are responsible to ensure O2 rates are accurate every shift. As best practice, nurses should check every shift, and every time they go into a resident's room. She said that if a resident is receiving O2 that is less than prescribed, the resident's oxygen saturation will go low, or they can have SOB or experience respiratory distress. On 4/19/2024 at 3:00 pm interviewed RT via telephone, and she stated that she completed the Respiratory Training/Certification for the nurses at the facility on 11/29/2023. The RT provided documentation via email. Record review of Resident #90's MDS comprehensive assessment dated [DATE] revealed resident with a BIMS score of 15 which suggests a cognitively intact mental status. Record review of the Face Sheet dated 4/17/24 for Resident # 90 revealed the following diagnosis: Chronic systolic (congestive) heart failure, Obstructive sleep apnea, Chronic Obstructive pulmonary disease, morbid obesity, and muscle weakness. Record review of the Care Plan for Resident #90 revealed resident has congestive heart failure that requires an intervention of the following oxygen settings: O2 via (nasal prongs) @ 2 LPM every shift, as needed for SOB and Hypoxia date initiated 2/28/24, and the resident has oxygen therapy r/t COPD with interventions of the oxygen settings: O2 via nasal cannula at 2 LPM for hypoxia initiated 3/31/24. Record review of the Doctor's Order Summary revealed Resident # 90 was prescribed O2 at 2 LPM via nasal cannula PRN DX: SOB every shift r/t hypoxia started on 04/15/2024. On 04/16/24 at 03:30 PM observed Resident # 90 with O2 at 3LPM via Nasal Cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 03:32 PM interviewed RN L and she read Resident #90's orders at 2 LPM via nasal cannula PRN and states the current O2 rate reads 3 LPM and resident's O2 saturations are 93-94%. When asked by RN L, resident denied any symptoms. RN asked resident #90 if he moved the rate and the resident denied. RN L corrected the O2 rate by lowering it to 2 LPM. RN L said that the nurses are responsible for ensuring the O2 rates are correct. RN L states that she usually checked resident oxygen rates at the beginning of her shift, during completing her rounds. RN L said that if a resident with COPD receives too much O2, they may not be able to get rid of CO2 (carbon dioxide) and could have respiratory issues. RN L said resident #90 is not her patient for this hallway. On 4/17/24 at 03:40 PM interviewed LVN G, she said that she is Resident #90's current floor nurse. LVN G said that it is the nurse's responsibility to ensure O2 rates are accurate. She said that she usually checks the O2 rate during her morning rounds. LVN G said that if a resident with COPD receives O2 higher than prescribed, the resident could get over oxygenated, the COPD can worsen, or they can have respiratory distress. LVN G said that to her knowledge, resident #90 has not exhibited any symptoms. On 04/17/24 at 03:44 PM interviewed LVN K and she said that nurses are responsible for ensuring O2 rates are accurate, but that Resident #90 at times is non-compliant and changes the flow rate. LVN K said that if the oxygen flow rate is above 2 LPM, the resident can desaturate (low blood oxygen saturation). LVN K said he checks everyone's O2 rates when he enters his shift. On 04/17/24 at 03:50 PM interviewed RN F and he said that nurses are responsible to ensure O2 flow rates are accurate every shift when they come in. RN F said that if a resident receives more oxygen than prescribed, they could retain CO2 and experience SOB or other complications. RN F said they have annual in-services done by the Respiratory Therapist. RN F said he remembered the last in-service early this year or late last year. On 04/17/24 at 05:37 PM interviewed ADON C and she stated if a resident receives more O2 than prescribed, they can have too much oxygen in the body and the negative effect is they can experience elevated pulse and respiration rates and experience respiratory distress. ADON C said that she is unaware of Resident # 90 displaying and adverse effects. On 04/17/24 at 05:45 PM interviewed DON and she said if a resident received more O2 than prescribed to it could cause SOB and can cause the resident to receive in excess the oxygenation needed. Record review of In-service for Respiratory Education Training revealed the training is completed annually. The staff trained are checked of on assessment, oxygen administration, basic treatments, suctioning, pulse oximeter, respiratory assist devices and delivery systems skills. A certification test is administered, and the staff receive a certificate for Successful completion of Respiratory Therapy. The last annual training is dated 11/29/24 - 11/30/24 . Record review of the Oxygen Administration policy date revised 7/2015 revealed: The purpose of this procedure is to provide guidelines for safe oxygen administration. Steps in the Procedure 6. Turn on the oxygen. Start the flow of oxygen at the prescribed rate. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. 11. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 Based on interview and record review, the facility failed to ensure each resident's drug regimen must be free of unnecessary drugs for one (Resident #74) of six resident reviewed for medications. The facility failed to have an adequate indication for the use of the medication Rexulti (brexpiprazole- atypical antipsychotic) for Resident #74. This failure could put residents at risk of harm from adverse reactions or harmful side effects. The findings were: Record review of Resident #74's Admission Record dated 04/17/24 indicated Resident #74 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of end stage renal disease (condition in which the kidneys can't filter waste from the blood), hypertensive heart disease with heart failure (is a long-term condition that develops over many years in people with high blood pressure), white matter disease (damage to the white matter in the brain that can lead to problems with thinking, problem solving and balance), dependence on renal dialysis and encounter for screening examination for other mental health and behavioral disorders. The Admission Record did not include a diagnosis of dementia. Record review of Resident #74's quarterly MDS assessment dated [DATE] indicated Resident #74 was able to understand others, was understood by others and had moderate cognitive impairment. Resident #74 had verbal behavioral symptoms directed toward others and had other behavioral symptoms not directed toward others. Resident #74 did receive antipsychotics. Record review of Resident #74's Physician's Orders for April of 2024 revealed an order dated 04/16/24 for Rexulti Oral Tablet 0.5 mg (Brexpiprazole), give one tablet by mouth in the evening for dementia with agitation and psychosis for 30 days with start date of 04/17/24 and end date of 05/17/24, side effect monitoring for Rexulti every shift with start date of 04/17/24 and behavior monitoring-antipsychotic for Rexulti every shift with start date of 04/17/24. Record review of Resident #74's e-MAR dated April of 2024 revealed the medication Rexulti oral tablet 0.5 mg was administered to Resident #74 on 04/17/24 and 04/18/24. Record review of Resident #74's care plan dated 04/16/24 revealed that Resident #74 used anti-anxiety medications r/t anxiety disorder and has attention seeking behavior and will start yelling when staff passed by her room. The interventions were to administer the anti-anxiety medications as ordered by physician, monitor for side effects and effectiveness every shift and monitor/document/report PRN any adverse reactions to anti-anxiety therapy. Record review of the care plan did not reveal any care plan for dementia with agitation and psychosis. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/17/24 at 4:50 PM, Resident #74 said she had anxiety and took medication for the anxiety. Resident said if she did not have the anxiety medication, she would feel restless, nervous and her heart would beat faster. Resident said she would take antianxiety medications when she was at home. Resident said her doctor prescribed the medications. Resident #74 said the staff provided her the medications as scheduled. Resident said she did recall having any episodes of yelling. Record review of Resident #74's electronic medical record did not reveal a diagnosis of Dementia, or a progress note from the physician or the NP providing an explanation for the prescription and the administration of the drug Rexulti to Resident #74. In an interview on 04/18/24 at 10:53 AM, CNA D said Resident #74 has been more tired than usual. CNA D said Resident #74 is usually alert and oriented times three (alert and oriented to time, place and person) but at times she will yell out for her family member or call the CNAs family member. CNA D said Resident #74 does refuse care at times when she is unusually tired, and she will yell when she is anxious. Resident will ask to be transferred to the chair and then she will say she is tired and for them to place her in bed. Resident #74 will do this multiple times. In an interview on 04/18/24 at 1:43 PM, LVN E said there was a change in Resident #74's behavior lately. Resident #74 had become very anxious, asking to be put to bed then getting up to her chair every few minutes. LVN E said Resident #74 has exhibited yelling and anxiousness the last few weeks. In an interview on 04/18/24 2:00 PM LVN E said it was the in-house Psychiatric NP who ordered the Rexulti for Resident #74. In an interview on 04/18/24 at 2:25 PM, ADON F said Resident #74 had episodes of yelling and at times it was non-stop. The NP came to see Resident #74. The NP left an order for the Rexulti. The ADON said there should be a progress note written by the nurse indicating the nurse did not administer the medication. In an interview on 04/18/24 at 2:50 PM, the DON said that Resident #74 had been having episodes of yelling due to anxiety. The NP gave the order for the Rexulti because she believes that Resident #74 had dementia with agitation and psychosis. The DON said they decided to order it because they had tried other medications and they did not work. The DON said she spoke to Resident #74 and asked her if they obtained the medication if she would take it and the resident agreed to take the medication. The DON said she made a late entry progress note and it should be in PCC today. Record review of Resident #74's electronic medical record revealed a progress note written by the DON with an effective date of 04/16/24 at 05:18:00 PM and a created date of 04/17/24 at 12:19:45 AM revealed that the NP was called, and the NP gave order for Rexulti for 30 days to manage current behavioral issues of episodes of severe agitation/panic attacks. NP stated that Resident #74 did not have a psychiatric or mental illness such as bipolar, that it (Rexulti) was for dementia with behavioral issues of severe agitation. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/19/24 at 10:01 AM, LVN G said he administered the Rexulti because he had an order and the consent form. LVN G said if he does not have an order and a consent form, he would not administer a psychotropic medication. LVN G said the past few months Resident #74 had deteriorated mentally with behaviors. LVN G said Resident #74 would start yelling without stopping. LVN G said they have tried music, aroma therapy, and food without success. LVN G said he did not notice that the dementia diagnosis was not in PCC. The consent for the Rexulti was on PCC and he usually did not look at the diagnosis. In an interview on 04/19/24 at 10:30 AM, the NP said she prescribed the Rexulti because Resident #74 was in distress. Resident #74 had been having episodes of yelling off and on and lately had hallucinated. Resident #74 had been anxious and very forgetful, and her recall had declined. The NP said when she asked Resident #74 questions, she was unable to recall the words given to her at the beginning of the interview and unable to recall the month or date. The NP said she would never prescribe a medication if the patient did not need it. The NP said she only prescribed the Rexulti for a brief period of time and at the end of that period she would re-evaluate the patient and make sure her diagnosis was correct. If Resident #74 regains her recall and emotional stability, then the medication would be discontinued, and the diagnosis of dementia with agitation and psychosis would be removed. The NP said sometimes when a patient was under emotional distress and depressed their cognition was affected but once they were on the correct medication, they felt better, and their cognition improved. In an interview on 04/19/24 at 1:45 PM, the DON said as soon as she had the paperwork from the physician, she would upload the diagnosis onto PCC. The DON said she did all the psychotropic medications. The DON said she should have uploaded the progress note right away and input the diagnosis on PCC, but she had been terribly busy lately and she just got behind. The family did not want Resident #74 to be on many antipsychotics. The DON said she had noticed the resident having different behavior. She had episodes of yelling and screaming. The DON said they tried a one dose of Zyprexa, but it did not help Resident #74 with her anxiety and yelling. The DON said she did not see any negative outcome for Resident #74 because the medication has helped her. Record review of progress note provided by DON on 04/19/24 and signed by NP on 04/18/24 revealed the NP assessed Resident #74 on 04/08/24 for frequent panic attacks, bouts of anxiety and occasional hallucinations. Patient is difficult to console and requiring at times 1:1 person intervention. Patient requires frequent redirection. When patient was asked for the reason for anxiety, she is unable to explain the reason why. Hallucinations onset was a few weeks ago. Her BIMS was a 12 last 03/09/24 but patient had moments of confusion and agitation, worst in the evening. ASSESSMENT & PLAN: Vascular dementia, unspecified severity, with psychotic disturbance. (new) Plan: start with Rexulti 0.5 mg PO QHS. Other mode of modalities and medications have failed. Signed by NP on 3:20 PM April 18, 2024 Record review of Facility's undated policy revealed: Upon noting an order for psychoactive medication on admission or initiation of therapy: 1. Complete the Psychoactive Medication Evaluation at the initiation of psychoactive medication therapy. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Complete the Consent for Use of Psychoactive Medication therapy with the resident and/or the resident representative at the initiation of psychoactive medication or off label use of a medication (i.e., Klonopin) educate on the benefits, potential negative outcomes, alternatives, and outcomes of psychoactive medication use. 3. Implement the behavior monitoring/side effects monitoring in PCC on the MAR for psychoactive medications with the targeted behavior for why the resident is receiving the medication as ordered. Initial appropriate observed behaviors or no behaviors observed. 4. Complete baseline Abnormal Involuntary Movement Scale (AIMS) at the initiation of psychoactive medication therapy. 5. Care plan the targeted behavior for why the resident is receiving the medication.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 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, accurately documented, readily accessible, and systematically organized for 1 (Resident #83) of 8 residents reviewed for accurate medical records. The facility failed to correctly transcribe the physician orders for Resident #83 related to oxygen setting. This deficient practice could place residents at risk of having incomplete or inaccurate records and residents receiving inadequate treatment or care. The findings include: Record review of Resident #83's admission record dated 04/17/24, revealed Resident #83 was a [AGE] year-old-male admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses which included, Chronic Obstructive Pulmonary Disease (a chronic lung disease that causes air flow limitation), Chronic Respiratory Failure, Osteomyelitis (inflammation in the bone), Type 2 Diabetes Mellitus, Dysphagia (difficulty swallowing), Peripheral Vascular Disease (reduced circulation of blood to a body part other than the brain or heart), Anemia, Hypothyroidism (underactive thyroid gland). Record review of Resident #83's quarterly MDS assessment dated , 04/08/24 revealed a BIMS score of 13, indicating Resident #83 was cognitively intact. Record review of Resident #83's physician order summary of all orders dated 04/16//24 revealed no order for oxygen setting. Record review of Resident #83's comprehensive person-centered care plan, date initiated 4/06/23 revealed Focus The resident has oxygen therapy r/t obstructive lung disease. Intervention Oxygen settings: O2 via (nasal canula) @ (2-5)L (per min). Observation of Resident #83 on 04/16/24 at 3:00pm revealed Resident #83 asleep, lying in bed. Resident #83 had O2 via nasal cannula. Observed O2 setting on the oxygen concentration machine to be at 3 L/min. Resident#83 was not in distress. Call light was within reach. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/16/24 at 3:02pm with LVN G, stated he was the nurse for Resident #83. LVN G, verified Resident's #83's oxygen setting was at 3 L/min. He then checked Resident #83 clinical record in PCC, the facility's electronic health records system, for the physician's order to confirm the oxygen setting. He stated he could not find the order. LVN G stated the person responsible for entering the oxygen setting physician order was either himself or the admitting nurse. He stated that he checks oxygen settings, only when he has a physician's order, every shift. LVN G stated that he had not checked the oxygen setting today for Resident #83 because he did not have a physician's order to follow. He stated that someone forgot to transcribe the physicians order or forgot to discontinue it. LVN G stated that the negative effect of not having an order to follow would be that he would contact MD to get order. Interview on 4/16/24 at 3:09pm with ADON F, who was the assigned ADON for Resident#83. He checked Resident #83's clinical record in PCC, the facility's electronic health records system, for the physician's order for the oxygen setting and did not find one. He stated that the charge nurses are responsible for checking the O2 settings. The ADONs are responsible for checking the O2 physician orders. He stated he checks them daily but had not checked the 700 hall. ADON F stated that he will notify the physician now. ADON F stated that the negative outcome of not having a physician order in place was that he would in-service staff, make sure they have O2 orders, and follow up on it. Interview on 4/16/24 at 3:20pm with the DON, stated that the nurses are responsible for checking the residents O2 settings. The ADONs are responsible for checking the physician orders. The DON stated that there should be an order for the O2 setting so the nurses know what setting the residents should be on. She stated the negative outcome is that it keeps Resident #83 comfortable, but it would not harm him clinically. The DON said oxygen is still considered a medication, therefore an order is needed. She stated Resident#83 was recently readmitted . Interview on 4/17/24 at 8:36am with the DON, stated admission paperwork was scanned under miscellaneous. The DON stated that the nurse was responsible for transcribing the order into PCC, the facility's electronic health records system. Interview on 4/17/24 at 10:28am with LVN I, stated the physician orders for the O2 settings would be in the resident's clinical record, under orders. LVN I, stated this would be the only place that she would look for the order. LVN I stated if she does not have an order then she would notify MD. Record review of the facility policy titled Receiving/Recording Physician Orders dated July 2015 revealed The purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders. 2. A current list of orders should be maintained in the clinical record of each resident. Record review of the facility policy titled Oxygen Administration dated July 2015 revealed, The purpose of this procedure is to provide guidelines for safe oxygen administration. 1. Verify that there is a physician's order for this procedure. Review the physician's orders .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on observation, interview, and record review, the facility failed to maintain an Infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 3 residents (Resident #49) reviewed for infection control, in that: The facility did not provide Resident#49's contact precaution room with a clinical waste covered cart to properly dispose of PPE. This deficient practice could place residents, staff, and visitors at risk and contribute to the spread of infection due to improper disposal of contaminated PPE. Findings included: Record review of Resident #49's electronic face sheet dated 04/17/2024 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis included ESBL (bacteria that is resistant to antibiotics to wound, Alzheimers Disease, Vascular Dementia, Parkinsons Disease, Major Depressive disorder, Chronic Kidney Disease, Essential Hypertension (high blood pressure). Record review of Resident #49's quarterly MDS assessment, dated 02/08/2024 revealed a BIMS score of 01, indicating Resident #49 was severely cognitively impaired. She required extensive assistance with her ADL's. Record review of Resident #49's physician order dated 4/3/24, revealed contact isolation DX: ESBL to wound. Observation of Resident #49 on 04/17/24 at 10:00am revealed Resident #49 had door closed and a Contact Precautions sign posted on the outside of the door. Contact Precautions sign read 1. Perform hand hygiene. 2. Wear gown to enter the room, Discard gowns in the room. Do not reuse. 3. Wear gloves when entering room. Change after contact with infective material. 4. Discard linen in container in the room until it can be taken to soiled utility room, laundry or other designated area. 5. Discard gloves and other trash in the room until it can be taken to soiled utility room or other designated area. 6. Perform hand hygiene. Gloves, gowns, and red bags were hung on the outside of Resident #49's door. Resident #49 had no clinical waste covered cart to dispose of dirty gowns. Interview on 04/17/24 at 10:04am with CNA A, stated there has not been a trash container with lid in Resident #49s room. She stated that she was told by the nurses to dispose of gowns and gloves in the small trash cans in the room when done with care. She was then to seal the bag and take the bag with her. She stated she had in service on infection control about a week ago and the topic was on transmission-based precautions. (continued on next page)

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 04/19/2024
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/24 at 10:40am with LVN B, stated she has been working at this facility for 19years. She stated she was the nurse for Resident #49. LVN B stated she had voiced to ADON C, that she needed the the clinical waste covered cart and linen cart in Resident #49's room. She stated that these items needed to be accessible. LVN B, stated that she had spoken to ADON C just now. She had not disposed of dirty gowns in Resident #49's room because she had not gone into her room yet. LVN B stated in-service for infection control was done last week and the topics were on hand washing, disposing of linen and donning of gowns/gloves. Interview on 04/17/24 at 10:50am with ADON C, stated that she had no reason why there was no clinical waste covered cart in Resident #49s room. ADON C stated the negative outcome was that it can spread infection. She stated there are no designated staff who are responsible for placing the bins with lids in the isolation rooms and PPE on the doors. ADON C stated that any staff can place the needed supplies in the contact precaution rooms. She stated that she reviews the physician's order for a resident to be placed on contact precautions and she notifies the nurse to put the PPE out. Interview on 04/17/24 at 5:10pm with DON, stated that she, the nurses, and the ADONs are all responsible for placing the clinical waste covered cart in the resident's rooms and PPE on the doors as part of the transmission-based precaution. She stated the negative outcome is the potential of infecting other residents and the challenge of having nowhere to put dirty PPE. Record review of the facility's Infection Prevention and Control Program Policy and procedure dated 05/23/23 revealed Policy: This facility has established and maintains an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standard and guidelines. 5. Isolation Protocol (Transmission-Based Precautions) a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines. CDC guidelines- contact precautions: Donning PPE upon room entry and properly discarding before exiting the resident's room is done to contain pathogens. Remove and dispose of contaminated PPE and perform .