STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455832	A. Building B. Wing	06/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Gardens	2535 W Pleasant Run Lancaster, TX 75146

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs in order attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of eight residents reviewed for care plans. The facility failed to ensure CNA A followed Resident #1's comprehensive care plan to ensure safe mechanical lift transfers. The facility failed to ensure CNA A followed Resident #1's comprehensive care plan which required two-person shower assists, which caused Resident #1 to fall from the shower bed and sustained a frontal scalp hematoma and laceration on her forehead which required 3 stitches. An Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was identified on 06/21/2024. While the IJ was removed on 06/22/2024 at 5:51 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place residents at risk of unsafe transfers resulting in major injuries and / or death. Findings include: Record review of Resident #1's Face Sheet dated 06/21/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: quadriplegia (loss of muscle control, the brain cannot manage any automatic processes that rely on brain signaling), anoxic brain damage (caused be complete lack of oxygen to the brain), anxiety disorder (type of mental health condition), hypothyroidism (thyroid gland does not create and release enough thyroid hormone), tracheostomy status (a hole in the neck to provide oxygen to the lungs safely), gastrostomy status (an artificial entrance to the stomach), and dysphasia (difficulty swallowing). (continued on next page)

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

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's quarterly MDS Assessment, dated 06/13/2024, reflected no BIMS score, indicating it was not completed. She was in a persistent vegetative state. Had functional limitations on both sides for upper and lower extremities. Functional abilities included total dependence for hygiene, toileting, showers, dressing, and all transfers. Record review of Resident #1's Care Plan dated 04/15/2015 - Present, reflected, Problem: [Resident #1's] ADL functions: TOTAL DEPENDENCE STATUS: Intervention: Transfer with Hoyer lift and 2-person assist. Provide 2-person assist with showers. Problem: Transfers (to/from: bed chair wheelchair, standing position) - [Resident #1] is totally dependent on the staff. Intervention: transfer using the transfer board/lift device [mechanical lift] x 2-person. Problem: [Resident #1] has had a fall with injury: Laceration to RT Forehead [Resident #1] had a fall from shower bed while receiving a shower on 6/20/24. Intervention: Assess reason for fall. Provide 2-person assist when giving [Resident #1] a shower. Check shower bed to ensure that it is working properly and locked while giving a shower. Provide 2-person assist with the use of a [mechanical lift] to transfer [Resident #1] to shower bed. Problem: At Risk for Falls R/T impaired mobility, impaired cognition, use of wheelchair. Intervention: May use Hoyer lift x 2-person assist with transfers. Record review of the facility incident report, dated 06/20/2024 at 4:30 PM and signed by LVN D, reflected, [CNA A] called this nurse to shower room. Upon entering shower room noticed [Resident #1] laying on floor on back with legs straight. Open area noticed to mid right side of forehead, appears to be draining red blood. Applied pressure, sent [CNA A] to call other staff for assistance. Another nurse called 911 . Resident going out to Methodist [NAME]. After 911 EMT exited, notified Resident's husband. MD notified. ED notified. DON notified. ADON notified. Record review of the Facility's Investigation Report, dated 06/21/2024, reflected, On 06/20/2024 at 4:30 PM, Nurse Aide was giving the resident her shower on the shower bed. Aide advise she turn resident over to wash her back and the resident rolled off the shower bed. Nurse aide then called for the nurse and the nurse came and found the resident on the floor and she noted the laceration on the head and called 911. Resident #1 was assessed with laceration on forehead and sent to hospital. CNA A was suspended pending the investigation. The facility investigation was ongoing. A written statement from LVN D, dated 06/20/2024, reflected, CNA called this nurse to the shower room. Upon entering shower room noticed res lay on back [with] legs straight out. Open area to mid right side of forehead, appears to be draining red blood. Called for staff to assist STAT. Applied pressure to mid right side. Another nurse called 911. Once 911 exited the facility [with] resident, notified husband. Notified MD. Notified ED, ADON, and DON. A written statement from CNA A, dated 06/19/2024, reflected, I [CNA A] had [Resident #1] on the shower bed in the shower room I turned [Resident #1] over to wash her back and she slid face first on the shower room floor. I immediately notified the nurse. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Hospital Record, dated 06/20/2024 at 12:55 PM, reflected, [Patient] is a [AGE] year-old female PMHx of anoxic brain injury who presents via EMS with head injury post fall that occurred today. Patient has laceration at forehead. Plan: X-ray pelvis, chest x-ray, CT head, CT facial bones, CT cervical spine non-contrast. Will repair laceration with suture. Problems Addressed: Facial laceration, initial encounter: acute illness or injury. Fall, initial encounter: acute illness or injury Head injury, initial encounter: acute illness or injury. Positive for wound (head injury). Areolar (soft) tissue violated, Wound extent: no fascia violation noted, no foreign bodies/material noted, no muscle damage noted, no nerve damage noted, no tendon damage noted, no underlying fracture noted, and no vascular damage noted. Skin repair: Number of sutures: 3. Result Date: Head, Spine, Face 6/20/2024, IMPRESSION: 1. Severely motion degraded exam. 2. No CT evidence of acute intracranial abnormality. 3. Severe global atrophy. The ventricles are dilated greater than the degree of background atrophy. Communicating hydrocephalus is not excluded. 4. No acute fracture or dislocation of the facial bones. 5. Frontal scalp hematoma. 6. No acute fracture or dislocation of the cervical spine. Social Worker consulted: Per RN and Registration, It was told to SW that pt's family unhappy at current nursing home because they have dropped the pt in the shower room of the facility. They report pt was dropped at the facility and the aide doing pt's shower was crying and admitted it to the family. In an interview on 06/21/2024 at 10:01 AM, the Executive Director stated she was informed of the incident on 06/20/2024 about 5:30 PM. She said she was not able to respond to the facility and the DON was on leave. She said neither her nor the DON went to the facility for follow up with the investigation. She said she was told CNA A was showering Resident #1 and Resident #1 fell from the shower bed and had a laceration on her forehead. She said Resident #1 was sent to hospital. She stated that she learned that CNA A transferred Resident #1, using a mechanical lift, on her own. She said all resident transfers that required a mechanical lift needed to be with two staff for safety. She said CNA A also showered Resident #1 on her own when Resident #1 fell from the shower bed. She said Resident #1 was a two-person mechanical lift transfer and two-person assist for showers and all ADLs. She said she asked LVN D to in-services CNA A on transfers and CNA A was suspended and sent home after the incident occurred. She said CNA A will be terminated for not following the facility's policy. In an interview on 06/21/2024 at 10:15 AM, the DON stated she learned that CNA A use the mechanical lift to transfer Resident #1 from her bed to the shower bed, on her own. She said CNA A also showered Resident #1 on her own when Resident #1 fell from the shower bed. The DON stated Resident #1's care plan indicated two-person transfers using a mechanical lift and for showers. She stated CNA A should know this because all CNAs had access to the daily care guide, which indicated care needs for all residents. She stated She learned from LVN D that CNA A said Resident #1 fell over the top of the shower bed rail. The DON said Resident #1 was not able to move at all so she was not sure how she could fall over the rail. The DON said there should have been two people in the shower when showering Resident #1. She said staff were trained on fall precautions and equipment use at hire. Attempted telephone calls to CNA A on 06/21/2024 at 10:45 AM, 3:25 PM (from the DON's phone), and 06/22/2024 at 11:55 AM revealed no response to messages that requested a call back. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 06/21/2024 at 11:04 AM, LVN D stated CNA A called her to the shower room because Resident #1 had fallen. She said when she went into the shower room, Resident #1 was on the floor, on her back, bleeding from her forehead. She said the shower bed was upright, but she did not notice if the rails were up of down. She said she assessed the resident and they called 911 to send her to the hospital. She said CNA A told her Resident #1 fell over the top of the shower bed rails when she turned her over. LVN D said she did not know what happened but though it was impossible for Resident #1 to fall from the shower bed unless the bed rail fell down or was not up. She said the shower beds had rails that attached with clips and if they were not fastened correctly they could have allowed the rail to come down. She said she did not notice anything wrong with the bed but did remove it from use as directed by the ED. She said Resident #1 was a two-person shower assist because she could not move on her own. She stated all nursing staff should know the care needs of all residents because they have access to the daily care guide. LVN D said CNAs could also ask the nurse if they were not sure of care needs. She said she did not know why CNA A used a mechanical lift and showered Resident #1 on her own rather than getting assistance from another staff. She stated when she called the ED and DON, they instructed her to get statements from CNA A and in-service her on safe transfers, then send her home pending the incident investigation. She said she did discuss with CNA A resident safety, fall prevention, and to ensure we followed protocol mechanical lift and care plan policy. LVN D said she was I the halls with CNAs but did not see CNA A get Resident #1 ready for a shower. She said she monitored CNAs by following up on rounding and letting them know they could come to her with any questions. An observation on 06/21/2024 at 12:03 PM, revealed Resident #1 in bed. She had multiple limb contractures, and her left side was propped up with pillows. The head of her bed was elevated, she had a trach and feeding tube. She had a bandage on her right forehead and slightly blackened right eye. She was not able to answer questions and did not make any kind of eye contact. Family Member R was present and did seem to get some reaction from Resident #1, when the family member spoke to Resident #1, she smiled. In an interview on 06/21/2024 at 12:05 PM, with Family Member R (in person) and Family Member S (on the telephone), they said Resident #1 was quadriplegic as a result of a heart attack / stroke which caused brain damage. They said Resident #1 did not move on her own. Family Member S said CNA A told her she dropped Resident #1 from the shower bed which caused the cut on Resident #1's forehead and three stitches. They stated Resident #1 should have two people to transfer and two people for showers. In an interview on 06/21/2024 at 12:15 PM, Resident #1's roommate stated she saw CNA A lift Resident #1 with the mechanical lift, on her own. She said CNA A placed Resident #1 onto the shower bed, in the room, but did not know what happened when they went into the shower room. She said she required a mechanical lift for transfer as well. She said staff often lifted her and Resident #1 on their own, with the mechanical lift. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/21/2024 at 12:58 PM, ADON B said LVN D called him on 06/20/2024 at about 5:00 PM to inform him that Resident #1 fell from the shower bed. ADON B said CNA A was showering Resident #1 on her own and without assistance when Resident #1 fell off the shower bed. He stated Resident #1 was total care and required a two-person shower assist. He said CNA A did not implement the care plan to meet Resident #1's needs safely. He said he had not been able to contact CNA A since she was suspended after the incident. He stated when he heard of the incident he recognized the immediacy to address fall prevention and resident care needs as noted in the care guide. He said LVN D was instructed to start in-services on 06/20/2024, which addressed fall prevention, two-person mechanical lifts and transfers. He said nursing staff know to call for assistance when they need it. He said if they need to get assistance from another hall they could do that as well. He said he did not feel CNA A was not able to get assistance but rather did not seek assistance. He said CNA A place Resident #1 in a hazardous situation and compromised Resident #1's safety which caused her injury. In an interview on 06/21/2024 at 4:26 PM, the MD stated he was made aware of Resident #1's fall. He stated Resident #1 was required two-person mechanical lift transfers and two-person assist for showers. He said these were care planed and he expected staff to follow the care plans for all residents. He said he was not sure why CNA A did not follow the care plan because the care guide was available to all staff to ensure resident needs were met safely. In an interview on 06/21/2024 at 5:42 PM, LVN Q stated she worked on another hall when the incident occurred. She said LVN D called her to call 911. She said she did look into the shower room and saw Resident #1 on the floor and LVN D assessing her. She stated she the shower bed was upright but did not notice if the siderails were up of down. She stated the only way Resident #1 could have fell from the shower bed was if the side rail was not up or secured properly because Resident #1 was a total asset and needed assistance to move. She stated CNA A should have known Resident #1 was a two person assist for mechanical lift / transfers and showers. In an interview on 06/21/2024 at 6:10 PM, the Staffing Coordinator stated the facility did not have any staffing issues. She stated shifts were all covered, and she had little or no issue with staffing call ins. She stated she provided some training to staff and said CNAs know all care needs for residents were found and accessible in the Daily Care Guide. She stated all mechanical lifts and transfers were to be completed by two staff. She said Resident #1 required two-person assist for showers because she was totally dependent. She said two people could ensure Resident #1's safety more easily. In an interview on 06/21/2024 at 6:17 PM, CNA O stated she worked on the same Hall as CNA A, when the incident occurred. She said she was in another resident's room when she heard CNA A calling for LVN D. She said she did not see anything that occurred and was not aware CNA A was showering Resident #1. She said CNA A did not ask her for assistance to transfer or shower Resident #1. She said the care needs for all residents were in the care guide, accessible to all nursing staff. She said Resident #1 required total care and was a two-person assist for transfers and showers. She said staff needed to communicate with each other when they required assistance to meet care needs for residents. She said all mechanical lift / transfers required two staff. She said there should have been two staff assisting with Resident #1's shower to ensure safety in case the rail did fall down. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of initial training for CNA A, dated 05/07/2024, reflected, trainings titled, Fall prevention, General staff guidelines - Gait belt policy, Safe patient / resident handling and movement program, and oral / written fall prevention competency test. All trainings were signed by CNA A on 05/07/2024. Record review https://opwdd.ny.gov/safty+guidlines+for+mechanical+lifts on 06/30/2024 reflected, Safe Mechanical Lift Operation: Before the initial and subsequent use of mechanical lift equipment, a safety check should be completed in accordance with the manufacturer's guidelines and/or agency protocol to ensure the equipment is in good working order. The number of staff required to perform a transfer is at the discretion of the practitioner who prescribed or recommended use of a mechanical lift device. However, it is always best practice to use mechanical lift equipment with a minimum of two staff. Record review of the facility's policy titled, Care Plans, Person Centered, revised March 2022, 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. Services provided for or arranged by the facility and outlined in the comprehensive care plan are, provided by qualified persons The Executive Director, and DON were notified of an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 06/21/2024 at 4:14 PM, due to the above failures and the IJ template was provided. The facility's Plan of Removal was accepted on 06/22/2024 at 10:14 AM and included: How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident sustained a left forehead laceration from the fall and was fully assessed and sent to the ER for further evaluation and treatment. The resident returned the same day, 06/20/2024, with sutures to the forehead, with no further injuries and returned back to their baseline. Immediate ins-services were started on the day of incidence, 06/20/2024, which included Abuse and Neglect and Mechanical Lift/ Transfer with 2 Person Assistance. All direct care staff remaining will be in-service by the DON and/or clinical designee prior to the start of their next shift until complete compliance is met. On 06/20/2024, the day and time of incidence, The C.N.A was interviewed and given a one-to-one in-service by her charge nurse prior to suspension, pending investigation. On the evening 06/20/2024 the questionable shower bed was taken out of rotation and usage and an audit of all other shower beds were examined for any deficits; none were found. The state was notified on 06/20/2024 (Intake #512683). The responsible party was notified immediately, as well as the attending physician. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents who require a two-person assistance with mechanical lifts were reviewed by the Director of Nursing (DON) on 06/21/2024 to determine if there were any other residents that experienced accidents as a result of this same practice. No other issues were found. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur: On 06/21/24, The DON and nurse mangers completed one-on-one education, in person, to Certified Nursing Assistants (CNA), licensed and registered nurses regarding requirement of two-person assistance with any mechanical lift. This was done to ensure understanding that all mechanical lifts and transfer require 2-person assistance. Abuse and neglect in-services were also continued; On 06/21/2024 the facility also added in-serving on Following Resident Care Plans. Direct care staff will be ongoing not in-serviced will be in-serviced prior to the start of their next shift until compliance is met, with a goal date of Monday June 24th, 2024. Any employee that did not receive the education will be removed from the schedule until education is completed. All new nursing employees will be educated, during orientation and prior to taking an assignment the following in-services: 'Abuse and Neglect Prevention', 'Mechanical Lift Transfers with 2-Person Assistance' and 'Following the Residents Care Plan'. Residents that have a fall will be reviewed by the Nursing Administration and any deficiencies noted will be corrected by Unit Manager or designee and new interventions put in place as required. The staff involved will be provided with education or corrective action as necessary. Falls will be reviewed daily in the morning IDT Meeting and as they occur by nursing administration and the Licensed Administrator. The Maintenance Director has completed a safety audit of as of 06/21/2024, with no further findings and will complete safety checks audit all shower chairs shower beds and mechanical lifts on a weekly basis for maintenance and functionality. How the facility plans to monitor its performance to make sure that solutions are sustained: DON/designee will audit 5 falls a week beginning 06/24/24 to ensure interventions and Care Plans are completed weekly for four weeks then twice a month for two months and monthly for three months. The Nurse Managers will observe 5 direct care staff a week beginning 06/24/24, during care, of residents who require mechanical lifts, to ensure that staff are competent and knowledgeable of the 2- Person mandate and that they are following the individual residents Care Plan. This will be done for four weeks, and then 5 staff every two weeks for two months. The findings will be reviewed at the quarterly Quality Assurance/Performance Improvement (QAPI) meetings for 2 quarters. The Administrator is responsible for implementing the acceptable plan of correction. On 06/22/2024 at 12:00 PM the surveyor began monitoring the facility's Plan of Removal. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as is possible; and each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of eight residents reviewed for accidents and hazards. The facility failed to ensure Resident #1 was transferred by two people using a mechanical lift as indicated in the comprehensive care plan. The facility failed to ensure two people assisted Resident #1 during showers as indicated in the comprehensive care plan. Resident #1 fell from the shower bed and sustained a frontal scalp hematoma and laceration on her forehead which required 3 stitches. The facility failed to ensure they had a system in place to monitor equipment (shower beds) for safe working order and log audits on a regular basis. An Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was identified on 06/21/2024. While the IJ was removed on 06/22/2024 at 5:51 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place residents at risk of major injuries and / or death. Findings include: Record review of Resident #1's Face Sheet dated 06/21/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: quadriplegia (loss of muscle control, the brain cannot manage any automatic processes that rely on brain signaling), anoxic brain damage (caused be complete lack of oxygen to the brain), anxiety disorder (type of mental health condition), hypothyroidism (thyroid gland does not create and release enough thyroid hormone), tracheostomy status (a hole in the neck to provide oxygen to the lungs safely), gastrostomy status (an artificial entrance to the stomach), and dysphasia (difficulty swallowing). Record review of Resident #1's quarterly MDS Assessment, dated 06/13/2024, reflected no BIMS score, indicating it was not completed. She was in a persistent vegetative state. Had functional limitations on both sides for upper and lower extremities. Functional abilities included total dependence for hygiene, toileting, showers, dressing, and all transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Care Plan dated 04/15/2015 - Present, reflected, Problem: [Resident #1's] ADL functions: TOTAL DEPENDENCE STATUS: Intervention: Transfer with Hoyer lift and 2-person assist. Provide 2-person assist with showers. Problem: Transfers (to/from: bed chair wheelchair, standing position) - [Resident #1] is totally dependent on the staff. Intervention: transfer using the transfer board/lift device [mechanical lift] x 2-person. Problem: [Resident #1] has had a fall with injury: Laceration to RT Forehead [Resident #1] had a fall from shower bed while receiving a shower on 6/20/24. Intervention: Assess reason for fall. Provide 2-person assist when giving [Resident #1] a shower. Check shower bed to ensure that it is working properly and locked while giving a shower. Provide 2-person assist with the use of a [mechanical lift] to transfer [Resident #1] to shower bed. Problem: At Risk for Falls R/T impaired mobility, impaired cognition, use of wheelchair. Intervention: May use Hoyer lift x 2-person assist with transfers. Record review of the facility incident report, dated 06/20/2024 at 4:30 PM and signed by LVN D, reflected, [CNA A] called this nurse to shower room. Upon entering shower room noticed [Resident #1] laying on floor on back with legs straight. Open area noticed to mid right side of forehead, appears to be draining red blood. Applied pressure, sent [CNA A] to call other staff for assistance. Another nurse called 911 . Resident going out to [Hospital]. After 911 EMT exited, notified Resident's husband. MD notified. ED notified. DON notified. ADON notified. Record review of the Facility's Investigation Report, dated 06/21/2024, reflected, on 06/20/2024 at 4:30 PM, nurse Aide was giving the resident her shower on the shower bed. Aide advise she turn resident over to wash her back and the resident rolled off the shower bed. Nurse aide then called for the nurse and the nurse came and found the resident on the floor and she noted the laceration on the head and called 911. Resident #1 was assessed with laceration on forehead and sent to hospital. CNA A was suspended pending the investigation. The facility investigation was ongoing. A written statement from LVN D, dated 06/20/2024, reflected, CNA called this nurse to the shower room. Upon entering shower room noticed res lay on back [with] legs straight out. Open area to mid right side of forehead, appears to be draining red blood. Called for staff to assist STAT. Applied pressure to mid right side. Another nurse called 911. Once 911 exited the facility [with] resident, notified husband. Notified MD. Notified ED, ADON, and DON. A written statement from CNA A, dated 06/19/2024, reflected, I [CNA A] had [Resident #1] on the shower bed in the shower room I turned [Resident #1] over to wash her back and she slid face first on the shower room floor. I immediately notified the nurse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Hospital Record, dated 06/20/2024 at 12:55 PM, reflected, [Patient] is a [AGE] year-old female PMHx of anoxic brain injury who presents via EMS with head injury post fall that occurred today. Patient has laceration at forehead. Plan: X-ray pelvis, chest x-ray, CT head, CT facial bones, CT cervical spine non-contrast. Will repair laceration with suture. Problems Addressed: Facial laceration, initial encounter: acute illness or injury. Fall, initial encounter: acute illness or injury Head injury, initial encounter: acute illness or injury. Positive for wound (head injury). Areolar (soft) tissue violated, Wound extent: no fascia violation noted, no foreign bodies/material noted, no muscle damage noted, no nerve damage noted, no tendon damage noted, no underlying fracture noted, and no vascular damage noted. Skin repair: Number of sutures: 3. Result Date: Head, Spine, Face 6/20/2024, IMPRESSION: 1. Severely motion degraded exam. 2. No CT evidence of acute intracranial abnormality. 3. Severe global atrophy. The ventricles are dilated greater than the degree of background atrophy. Communicating hydrocephalus is not excluded. 4. No acute fracture or dislocation of the facial bones. 5. Frontal scalp hematoma. 6. No acute fracture or dislocation of the cervical spine. Social Worker consulted: Per RN and Registration, It was told to SW that pt's family unhappy at current nursing home because they have dropped the pt in the shower room of the facility. They report pt was dropped at the facility and the aide doing pt's shower was crying and admitted it to the family. In an interview on 06/21/2024 at 10:01 AM, the Executive Director stated she was informed of the incident on 06/20/2024 about 5:30 PM. She said she was not able to respond to the facility and the DON was on leave. She said neither her nor the DON went to the facility for follow up with the investigation. She said she was told CNA A was showering Resident #1 and Resident #1 fell from the shower bed and had a laceration on her forehead. She said Resident #1 was sent to the hospital. She stated that she learned that CNA A transferred Resident #1, using a mechanical lift, on her own. She said all resident transfers that required a mechanical lift needed to be with two staff for safety. She said CNA A also showered Resident #1 on her own when Resident #1 fell from the shower bed. She said Resident #1 was a two-person mechanical lift transfer and two-person assist for showers and all ADLs. She stated she asked the nursing staff to check all the shower beds to ensure they were in good working condition. She said she asked LVN D to remove the shower bed used in the incident, until it could be checked by Maintenance, and make an entry in the Maintenance Logbook. She said the Maintenance Director checked the shower bed on 06/21/2024 and found no maintenance concerns. She said she did not know when the shower equipment was inspected last and was not sure if there was a record of the equipment inspections. She said she asked LVN D to in-service CNA A on transfers and CNA A was suspended and sent home after the incident occurred. She said CNA A will be terminated for not following the facility's policy. In an interview on 06/21/2024 at 10:15 AM, the DON stated she learned that CNA A use the mechanical lift to transfer Resident #1 from her bed to the shower bed, on her own. She said CNA A also showered Resident #1 on her own when Resident #1 fell from the shower bed. The DON stated Resident #1's care plan indicated two-person transfers using a mechanical lift and for showers. She stated CNA A should know this because all CNAs had access to the daily care guide, which indicated care needs for all residents. She stated She learned from LVN D that CNA A said Resident #1 fell over the top of the shower bed rail. The DON said Resident #1 was not able to move at all so she was not sure how she could fall over the rail. The DON said there should have been two people in the shower when showering Resident #1. She said staff were trained on fall precautions and equipment use at hire. She stated there was no formal training for staff to report maintenance issues, but staff have been verbally instructed to report and log any concerns with maintenance or equipment in the maintenance log at the front desk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/21/2024 at 5:54 PM, the Maintenance Director stated he was asked to follow up with an assessment to the shower bed involved in the incident. He said there were no maintenance concerns when he looked at it earlier today. He said the rails were held up with two pins that slid into the side and then clip to secure them. He said if the pins were not secured, they could fall out and the rail would fall down. He stated when he assessed the shower bed, he noticed one of the pins, on the left side of the shower bed, was not in the rail and the cable that attached it to the shower bed was hanging down the side of the bed. He said there was not a pin attached to the cable. He said he was not sure if someone removed the pin after the incident or if it was not there at the time of the incident. He said he replaced the pin this today. He said his Maintenance Log did not note a missing pin but did note, Shower bed rail broken, dated 06/20/2024. He said he did not have any documented evidence of maintenance checks on equipment but estimated he did checks at least monthly. He said staff were instructed to log any equipment issues in the Maintenance Logbook at the front desk and he reviewed the log daily for follow up. He said staff were not formally trained on documenting in the Logbook but rather verbally instructed to do so. He stated all mechanical lifts / transfers needed to be done by two staff to ensure resident safety. In an interview on 06/21/2024 at 6:10 PM, the Staffing Coordinator stated the facility did not have any staffing issues. She stated shifts were all covered, and she had little or no issue with staffing call ins. She stated she provided some training to staff and said CNAs know all care needs for residents were found and accessible in the Daily Care Guide. She stated all mechanical lifts and transfers were to be completed by two staff. She said Resident #1 required two-person assist for showers because she was totally dependent. She said two people could ensure Resident #1's safety more easily. In an interview on 06/21/2024 at 6:17 PM, CNA O stated she worked on the same Hall as CNA A, when the incident occurred. She said she was in another resident's room when she heard CNA A calling for LVN D. She said she did not see anything that occurred and was not aware CNA A was showering Resident #1. She said CNA A did not ask her for assistance to transfer or shower Resident #1. She said the care needs for all residents were in the care guide, accessible to all nursing staff. She said Resident #1 required total care and was a two-person assist for transfers and showers. She said staff needed to communicate with each other when they required assistance to meet care needs for residents. She said all mechanical lift / transfers required two staff. She said she used the shower bed in the past and knew the rail pins need to be clamped once they were put in place to ensure they stayed in place. She said there should have been two staff assisting with Resident #1's shower to ensure safety in case the rail did fall down. She said she had told a nurse about the missing pin, on the left side of the shower bed, for a few days. She said she did not recall which nurse. She said she did not log the missing pin in the Maintenance Logbook because it was at the front desk and far from the Hall where she worked. Record review of the facility's Maintenance Logbook, between 06/02/2024 and 06/20/2024, reflected one entry related to shower beds. The entry was on 06/20/2024 and stated, Shower bed rail broken - 100 Hall shower bed, entered by LVN D. Record review of initial training for CNA A, dated 05/07/2024, reflected, trainings titled, Fall prevention, General staff guidelines - Gait belt policy, Safe patient / resident handling and movement program, and oral / written fall prevention competency test. All trainings were signed by CNA A on 05/07/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled, Resident Rights, dated November 2016, reflected, .i) Safe environment. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide: (1) A safe, clean, comfortable, and homelike environment . i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Record review of the facility's policy, titled, Accidents and Hazards - Investigating and Reporting, revised July 2017, reflected, All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator . 3. Facility is compliant with current rules and regulations governing accidents and/or incidents involving a medical device The facility's policy on accidents and hazards was requested on 06/22/2024 and a procedure guide was provided, titled, Accidents / Hazards, dated May 2016. The guide outlined the steps to be taken in the event of an accident and did not reflect the facility's role in preventing accidents or hazards. No other policy was received at the time of exit. Record review of the facility's, Safety Policy and Procedure Manual - safe patient handling and movement program, dated January 4, 2010, reflected, 3. Once the Care Plan has been developed, the Resident's Daily Care Guide should be updated to include instructions to staff on how to lift, transfer, reposition and move a Resident. 4. Staff will complete training initially, annually, and as needed for proper equipment use and understanding of safe Resident handling and movement using the Mechanical Lift Skills Competency Checklist. 8. Licensed Nurses, with the assistance of the director of Maintenance, shall ensure that mechanical lifting devices and other equipment/aids are maintained regularly and kept in proper working order. 3. Ensure that all staff is trained on Safe Patient Handling and Movement Practices. QUALITY ASSURANCE COMMITTEE and/or SAFETY COMMITTEE shall: 1. Implement this policy to identify, assess, and develop strategies to minimize risk of injury to Residents and direct-care staff associated with Resident lifting, transferring, repositioning, or movement. 2. Review and analyze the data gathered from the Resident Accident/Incident Reports and/or Employee Incident Reports related to the identification, assessment, and development of strategies to analyze and minimize risk of injury to Residents and direct-care staff associated with Resident lifting, transferring, repositioning, or movement. 3. At least annually, conduct an analysis of risk injury to Residents and direct-care staff posed by the Resident handling of needs of the population served by the Center and the physical environment in which handling, and movement occurs. Record review of the facility's policy, titled, Supplies and Equipment, Environmental Services, revised February 2009, reflected, .equipment shall be readily available so that department personnel can perform necessary tasks. Equipment must be ready for use at all times of the day and night to serve the residents' needs Record review https://opwdd.ny.gov/safty+guidlines+for+mechanical+lifts on 06/30/2024 reflected, Safe Mechanical Lift Operation: Before the initial and subsequent use of mechanical lift equipment, a safety check should be completed in accordance with the manufacturer's guidelines and/or agency protocol to ensure the equipment is in good working order. The number of staff required to perform a transfer is at the discretion of the practitioner who prescribed or recommended use of a mechanical lift device. However, it is always best practice to use mechanical lift equipment with a minimum of two staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Executive Director, and DON were notified of an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 06/21/2024 at 4:14 PM, due to the above failures and the IJ template was provided. The facility's Plan of Removal was accepted on 06/22/2024 at 10:14 AM and included: How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident sustained a left forehead laceration from the fall and was fully assessed and sent to the ER for further evaluation and treatment. The resident returned the same day, 06/20/2024, with sutures to the forehead, with no further injuries and returned back to their baseline. Immediate ins-services were started on the day of incidence, 06/20/2024, which included Abuse and Neglect and Mechanical Lift/ Transfer with 2 Person Assistance. All direct care staff remaining will be in-service by the DON and/or clinical designee prior to the start of their next shift until complete compliance is met. On 06/20/2024, the day and time of incidence, The C.N.A was interviewed and given a one-to-one in-service by her charge nurse prior to suspension, pending investigation. On the evening 06/20/2024 the questionable shower bed was taken out of rotation and usage and an audit of all other shower beds were examined for any deficits; none were found. The state was notified on 06/20/2024 (Intake #512683). The responsible party was notified immediately, as well as the attending physician. How the facility will identify other residents having the potential to be affected by the same deficient practice: Residents who require a two-person assistance with mechanical lifts were reviewed by the Director of Nursing (DON) on 06/21/2024 to determine if there were any other residents that experienced accidents as a result of this same practice. No other issues were found. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur: On 06/21/24, The DON and nurse mangers completed one-on-one education, in person, to Certified Nursing Assistants (CNA), licensed and registered nurses regarding requirement of two-person assistance with any mechanical lift. This was done to ensure understanding that all mechanical lifts and transfer require 2-person assistance. Abuse and neglect in-services were also continued; On 06/21/2024 the facility also added in-serving on Following Resident Care Plans. Direct care staff will be ongoing not in-serviced will be in-serviced prior to the start of their next shift until compliance is met, with a goal date of Monday June 24th, 2024. Any employee that did not receive the education will be removed from the schedule until education is completed. All new nursing employees will be educated, during orientation and prior to taking an assignment the following in-services: 'Abuse and Neglect Prevention', 'Mechanical Lift Transfers with 2-Person Assistance' and 'Following the Residents Care Plan'. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Residents that have a fall will be reviewed by the Nursing Administration and any deficiencies noted will be corrected by Unit Manager or designee and new interventions put in place as required. The staff involved will be provided with education or corrective action as necessary. Falls will be reviewed daily in the morning IDT Meeting and as they occur by nursing administration and the Licensed Administrator. The Maintenance Director has completed a safety audit of as of 06/21/2024, with no further findings and will complete safety checks audit all shower chairs shower beds and mechanical lifts on a weekly basis for maintenance and functionality. How the facility plans to monitor its performance to make sure that solutions are sustained: DON/designee will audit 5 falls a week beginning 06/24/24 to ensure interventions and Care Plans are completed weekly for four weeks then twice a month for two months and monthly for three months. The Nurse Managers will observe 5 direct care staff a week beginning 06/24/24, during care, of residents who require mechanical lifts, to ensure that staff are competent and knowledgeable of the 2- Person mandate and that they are following the individual residents Care Plan. This will be done for four weeks, and then 5 staff every two weeks for two months. The findings will be reviewed at the quarterly Quality Assurance/Performance Improvement (QAPI) meetings for 2 quarters. The Administrator is responsible for implementing the acceptable plan of correction. On 06/22/2024 at 12:00 PM the surveyor began monitoring the facility's Plan of Removal. In an interview on 06/22/2024 at 11:17 AM, with the Executive Director and DON, the DON stated, the Regional Director of Clinical Services in-serviced her and the Executive Director on the failures surrounding the IJ. She said those included abuse and neglect policy, mechanical lift processes, the care guide and how staff need to follow it, resident care plans, and ensuring all equipment was safe for use. She said she then in-serviced ADON B and RN C. She said they had been completing one-on-one in-servicing with staff since 06/21/2024. She stated staff were in-serviced in person and prior to starting their shift. The Executive Director said she estimated at least half their staff had completed in-services and this would be on-going until all staff had been in-serviced. She said her expectation was that the CNAs be trained, and the nurses trained to follow up to ensure everyone was following care plans and meeting resident's needs. She stated it was her expectation that staff followed the care guide and communicate care needs and any changes residents may have to ensure the facility staff meet resident's needs. All staff were expected to tell Administration about any issues - this was part of the abuse and neglect training. She stated staff were trained to report maintenance issues or issues with equipment to maintenance and record those issues in the logbook at the front desk. She said the DON or designee was responsible to monitor all of the plan of corrections put in place. She said the management team was responsible to assess all falls daily to identify issues related to resident care and safety. The DON said she planned to do random skills checkoffs for mechanical lift transfers and random checks to ensure aides were following resident care guides. She said this information would then be reviewed in QUPI and the Executive Director would follow up as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455832	A. Building B. Wing	06/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Gardens	2535 W Pleasant Run Lancaster, TX 75146

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 06/22/2024 between 12:00 PM and 2:53 PM with ADON B, RN C, Social Worker, Human Resources Director, Maintenance Director, Director of Business Development, CNAs E, F, G, H and I, Housekeepers J and K, and LVNs L, M, and N, represented staff who worked 1st, 2nd, 3rd shifts and all days of the week. Staff were able to convey appropriate knowledge of the POR Inservice's including mechanical lift protocol, where to document maintenance or equipment issues, who to report equipment issues to, policies regarding identifying and reporting abuse or neglect, following care plans and where to find resident care plan information. All staff stated the DON and nurse managers would monitor these actions. Observation on 06/22/2024 at 1:40 PM revealed CNAs E and F performed a mechanical lift transfer for Resident #2. Resident #2 did not communicate verbally. Facial expressions from Resident #2 appeared positive in response to verbal ques from CNAs E and F during the transfer. An observation and interview on 06/22/2024 at 1:55 PM revealed CNAs G and H performed a mechanical lift transfer for Resident #3. Resident #3 stated he felt safe when the CNAs transf [TRUNCATED]