STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675139	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Healthcare Residence	1025 W Yeagua Groesbeck, TX 76642

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on observations, interviews, and record review, the facility failed to ensure the residents' right to privacy for 1 of 8 residents (Resident #8) reviewed for privacy. The facility failed to ensure LVN provided privacy by closing Resident #8's door when performing wound care on Resident 8's right heel on 07/25/24 at 9:16 AM. This failure could place residents at risk of having their bodies exposed to the public, resulting in low self-esteem, and a diminished quality of life. The findings included: Record review of Resident #8's face sheet dated 07/25/24 reflected a [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included Alzheimer's Disease (progressive brain disease that causes a mental decline affecting the quality of daily living), COPD (a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitation), pressure ulcer to the right heel (also known as bed sores, localized damage to the skin, and/or underlying tissue that usually occur over a bony prominence as a result of usually long-term pressure, or pressure in combination with shear or friction), and muscle wasting and atrophy (loss of muscle mass and strength). Record review of Resident #8's MDS dated [DATE] reflected a BIMS score of 99 which reflected Resident #8 was not able to complete the assessment. Section GG of the MDS assessment reflected Resident #8 required substantial/maximal assistance with toileting, bathing, and personal hygiene. Section I of the MDS assessment reflected Resident #8 had an active diagnoses of a stage 3 pressure ulcer to the right heel. Section M of the MDS assessment reflected Resident #8 had a pressure ulcer/injury. Record review of Resident #8's care plan dated 03/20/24 and revised on 07/22/24 reflected Resident #8 had a Stage 3 pressure wound of the right heel r/t disease process anemia, COPD, and immobility. Interventions listed include, but were not limited to, administer treatments as ordered, monitor for effectiveness, and follow facility policies/protocols for the prevention/treatment of skin breakdown. Record review of Resident #8's clinical physician orders dated 07/25/24 revealed an active order for Right Heel: Cleanse with WC, pat dry, apply Medihoney, and calcium alginate dressing, cover with silicone foam bordered dressing daily. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 07/24/24 at 9:16 AM, wound care was provided to Resident #8 by LVN A. LVN A washed her hands and prepped the resident for wound care. LVN A performed wound care on Resident #8 with the door not closed during the procedure. Other staff and residents were observed going up and down the hallway in the secured unit and could see inside of Resident #8's room during wound care. In an interview on 07/24/24 at 09:30 AM, LVN A stated she typically closed the resident's doors when providing any type of care, including wound care. She stated it was considered resident privacy to close the door. She stated she had been trained on doors being closed and privacy being provided for residents at any time care or assistance was being provided. She stated she had not closed the door to Resident #8's room during wound care and she felt like she was a maybe little off or nervous due to the state inspector watching her. She stated if a resident's door was left open and Resident #8 was left exposed during wound care, or any care being provided, it could cause embarrassment or self-image disturbance for the resident. In an interview on 07/24/24 at 09:33 AM, Resident #8 stated she was fine, and staff took good care of her. She stated she did not know the door was open during the procedure. In an interview on 07/25/24 at 11:35 AM, the DON stated the staff were all trained on providing privacy for residents at all times, which included during wound care and personal care. She stated staff were just trained about 2 weeks ago regarding privacy. She stated privacy was a resident's right and should have been provided to residents at all times. She stated if a resident was not provided with privacy during wound care, it could have caused an issue with dignity and the resident may not have wanted others to know she had a wound. In an interview on 07/25/24 at 12:43 PM, the ADM stated all staff were trained on resident privacy and all residents should have been provided with privacy at all times, including during wound care. He stated if a resident was not provided privacy during wound care, it could be a dignity issue and residents health information could have been exposed. Record review of facility policy titled Resident Rights and dated 2001 revised February 2021 reflected Policy statement: Employees shall treat with kindness respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; t. privacy and confidentiality .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on interviews and record review, the facility failed to ensure assessments accurately reflected the resident's status for 1 of 8 residents (Residents #25) reviewed for resident assessments. The facility failed to ensure Resident #25's most recent quarterly MDS dated [DATE] reflected that Resident #25 did not have a urinary catheter. This deficient practice could place residents at-risk for inadequate care due to inaccurate assessments. Findings included: A record review of Resident #25's face sheet dated 07/25/24 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #25's diagnoses included muscle wasting and atrophy (loss of muscle mass and strength), anxiety (an emotion which is characterized by an unpleasant state of inner turmoil and includes feelings of dread over anticipated events), atrial fibrillation (an abnormal heart rhythm characterized by rapid and irregular beating of the atrial chambers of the heart), and senile degeneration of the brain (mental deterioration associated with aging that can include brain degeneration). A record review of Resident #25's Quarterly MDS assessment, dated 06/25/24, reflected the resident had a BIMS score of 00, which indicated Resident #25's cognition was severely impaired. Resident #25's Quarterly MDS assessment Section GG reflected Resident #25 was dependent for toileting, bathing, and personal hygiene. Resident #25's Quarterly MDS assessment Section H reflected Resident #25 had an indwelling catheter. A record review of Resident #25's care plan dated 05/23/22, reflected Resident #25 had occasional bladder incontinence with interventions that included but were not limited to, ensure Resident #25 has unobstructed path to the bathroom, and check the resident as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. In an observation on 07/23/24 at 12:50 PM Resident #25 was lying in bed with blankets pulled to her chest area. Resident #25 opened her eyes when her name was called and responded with mumbling words that could not be understood. Resident #25 appeared pleasantly confused. Resident #25 was without signs of pain or distress. No areas of concern were identified with Resident #25. Resident #25 did not have any catheter tubing or an indwelling catheter bag at bedside. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/25/24 at 10:01 AM, the MDS stated she was responsible for completing MDS assessments. She stated Resident #25's MDS assessment should only have reflected an indwelling catheter was in use if Resident #25 had an indwelling catheter. She stated Resident #25 did not have an indwelling catheter. She stated Resident #25's MDS assessment dated [DATE] was coded by error and she was going to modify the assessment. She stated she had been trained on completing MDS assessments correctly and she had a Corporate MDS Case Manager that helped her also. She stated if an MDS assessment was coded incorrectly it would show up and alert her and she would modify the assessment. She stated if a MDS assessment was coded incorrectly, she could get a tag from State, but once it was corrected, there would be no problems. In an interview on 07/25/24 at 11:35 AM, the DON stated the MDS nurse was responsible for completing all of the residents MDS assessments. She stated if a resident did not have an indwelling catheter, it should not be coded on the MDS that the resident had an indwelling catheter. She stated the MDS nurse had been trained on completing MDS assessments accurately and she had received a lot of training. She stated a residents MDS should have reflected the residents care plan, condition of the resident, and what care should be provided to the residents. She stated if a MDS assessment was not completed correctly, something could be missed regarding resident's care. In an interview on 07/25/24 at 12:43 PM, the ADM stated MDS assessments should have been completed accurately and should not have reflected a resident had an indwelling catheter if they did not. He stated the MDS nurse was responsible for completing MDS assessments and she had been trained on completing MDS assessments accurately. He stated it was his expectation that the MDS assessments were completed accurately. He stated if a MDS assessment was completed inaccurately, false information could be provided that may put the resident at jeopardy. A record review of the facility's policy titled Resident Assessments and dated 2001 revised October 2023 reflected: Policy Interpretation and Implementation: 10. Assessments are completed by staff members who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the residents' strengths and areas of decline. 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observation/interviews. 13. All resident assessments completed within the previous 15 months are maintained in the resident's active clinical record. The results of the assessments are used to develop, review, and revise the resident's comprehensive care plan.