STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675309	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Alice	606 Coyote Tr Alice, TX 78332

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 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** 48278 Based on interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 2 (Resident#36 and Resident#27) of 12 residents reviewed for accuracy of assessments. 1.The facility failed to ensure Resident#36's MDS assessment accurately reflected the use of oxygen. 2.The facility failed to ensure Resident#27's MDS assessment accurately reflected the use of oxygen. These failures could place residents at risk for receiving inadequate care and services due to inaccurate assessments. The findings included: 1. Record review of Resident #36's face sheet dated 2/24/2025 reflected an [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included Chronic Pulmonary Disease (a common lung disease causing restricted airflow and breathing problems), Malignant Neoplasm of Larynx (laryngeal cancer), Portal Hypertension (high blood pressure in the portal venous system, Dysphagia (swallowing difficulties), Muscle wasting and Atrophy (the shrinking or wasting away of muscle). Record review of Resident #36 's Admission MDS dated [DATE] revealed: Section O 0110 - Special Treatments, Procedures, and Programs Respiratory Treatments C1. Oxygen therapy. The facility did not check off any. Record review of Resident 36's physician order dated 1/17/2025 revealed, Continuous O2 at 2LPM every shift related to Chronic Obstructive Pulmonary Disease, Unspecified. Record review of Resident #36's comprehensive care plan dated 1/24/2025 revealed: (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #36 had Chronic Pulmonary Obstructive Disease. Interventions Oxygen setting: O2 via NC continuous O2 at 2LPM. Date Initiated: 01/24/2025 Revision on: 01/24/2025. During an interview on 02/24/2025 at 2:48 p.m. with MDS LVN, she stated that for admission assessments she has seven days to complete the MDS. She stated that Resident #36's MDS did not reflect being on oxygen even though Resident #36 was currently on continuous oxygen. MDS LVN stated she was responsible for completing the MDS and the error was an overcite. She stated that she can modify it and enter that information. She stated the MDS was usually used for billing purposes. She stated that the negative outcome of not accurately completing the MDS assessment was that it would be less payment for the facility. During an interview on 02/26/2025 at 3:02 p. m. with the DON, that she does not oversee of MDS assessments. She stated the MDS LVN was responsible for completing the MDS assessment for the facility. She stated she was not sure how many days they had to complete MDS assessment after an admission. DON stated that they have 72 hours for baseline assessment. She stated it was important for MDS assessment to be accurate because it brings in more revenue. DON stated the negative outcome was not having accurate monitory. She stated it did not affect the residents because it was care planned. 2. Record review of Resident #4's face sheet, dated 02/24/2025 revealed a [AGE] year old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease with Acute Exacerbation (a group of lung diseases that cause airflow obstruction and breathing difficulties), Pulmonary Hypertension (a medical condition where the blood pressure in the arteries that carry blood to the lungs is abnormally high, causing strain on the heart and potentially leading to symptoms like shortness of breath, chest pain, and fatigue), Muscle wasting and Atrophy (the shrinking or wasting away of muscle). Record review of Resident #27 's Admission MDS dated [DATE] revealed: Section O 0110 - Special Treatments, Procedures, and Programs Respiratory Treatments C1. Oxygen therapy. The facility did not check off any. Record review of Resident 27's physician order dated 2/24/2025 revealed, Oxygen at 3LPM via nasal canula every shift for Hypoxia Record review of Resident #27's comprehensive care plan dated 1/8/2024 revealed: Resident #27 had Chronic Pulmonary Obstructive Disease. Interventions Oxygen setting: O2 via Nasal canula continuous O2 at 3LPM. Date Initiated: 01/8/2024 Revision on: 02/24/2025. During an interview on 2/25/25 at 5:40pm with MDS LVN said that she usually updates the MDS within 2 weeks of the resident returning from the hospital. MDS nurse said that she had up to 1 year to modify the MDS. MDS nurse said that she did the assessment on 1/2/25 and she did not mark the oxygen on the MDS, she said I forgot. MDS nurse said that it is important to be accurate because of the reimbursement to the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 3:20PM with ADON said that she did not know a lot about the MDS process. ADON said that was usually for coding. ADON said that MDS was for financial purposes. During an interview on 02/26/2025 at 3:02 p. m. with the DON, that she does not oversee MDS assessments. She stated the MDS LVN was responsible for completing the MDS assessment for the facility. She stated she was not sure how many days they had to complete MDS assessment after admission. DON stated that they have 72 hours for baseline assessment. She stated it was important for MDS assessment to be accurate because it brings in more revenue. DON stated the negative outcome was not having accurate monitoring and the facility would not have the reimbursement. DON stated it did not affect the residents because it was care planned. Record review of the CMS's RAI Version 3.0 Manual dated October 2024, revealed section: O0110: Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were performed- a. On Admission, b. While a Resident, c. At Discharge Check all that apply. Respiratory Treatments C1. Oxygen therapy C2. Continuous C3. Intermittent Item Rationale: Health related Quality of Life. The treatments, procedure, and programs listed in Item O0110, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life. Page O-2 O0110, C1 Oxygen therapy Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. 50487

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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** 47828 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 9 residents (Resident #9 and Resident 31) reviewed for care plans. 1. The facility failed to ensure Resident #9's care plan revised on 12/26/24 reflected she was non-compliant with her no added salt diet. 2. The facility failed to ensure Resident #31's care plan revised on 02/06/25 reflected she was non-compliant with her order to wear a palm protector on her left hand. These deficient practices could place residents at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The findings included: 1. Record review of Resident #9's admission record, dated 02/24/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and had an initial admitted [DATE]. Her relevant diagnoses included chronic obstructive pulmonary disease (lung condition caused by damage to the airways that limit airflow), emphysema (lung disease which results in shortness of breath due to destruction and dilation of the alveoli), acute respiratory failure with hypoxia (a condition where there is not enough oxygen or too much carbon dioxide in the body). Record review of Resident #9's MDS annual assessment dated [DATE], reflected a BIMS score of 14, which indicated her cognition was intact. Record review of Resident #9's care plan dated 12/26/24, reflected [Resident #9] had a nutritional problem or potential nutritional problem related to no added salt diet. Mechanical soft texture, nectar thickened liquids consistency, may have chopped salad with gravy on top. Pureed foods if resident ate in bed (date initiated: 01/22/24). One of the interventions were to explain and reinforce to the importance of maintaining the diet ordered, encourage [Resident #9] to comply, and explain consequences of refusal (date initiated: 01/22/24). During an observation on 02/24/25 at 12:10 p.m., Resident #9 was observed in the dining room during lunch time. Resident #9 was being fed by CNA C. CNA C was observed with an 8 ounce can of pasteurized processed cheese. CNA C was observed pouring cheese onto a small bowl of crushed crackers and feeding it to Resident #9. Resident #9 was observed as she gestured CNA C to pour more cheese on the crushed crackers. An observation on 02/24/25 of Resident #9's meal ticket reflected she was on a mechanical soft, no added salt, and fluids-nectar diet. The 8 ounce of pasteurized process cheese reflected it had 430 milligrams of sodium per serving. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 02/24/25 at 12:55 p.m., CNA C said Resident #9's family provided the 8 ounce can of pasteurized processed cheese because Resident #9 liked it. She said the kitchen staff provided crushed crackers with her lunch tray and all she did was added the cheese. She said Resident #9 would request for her to pour cheese on her crushed crackers. An interview on 02/24/25 at 4:05 p.m., LVN E said Resident #9 was on a mechanical soft diet with no added salt when she ate in the dining room and on a puree diet with no added salt when she ate in her room. LVN E said no added salt meant no extra salt. She said Resident #9's family was non-compliant with her diet and would often bring her outside food despite the fact they were educated on the consequences of not following her diet. She said Resident #9 had a high BIMS and had the right to eat whatever she wanted. LVN E said Resident #9's family had provided outside food for some time but was not able to say exactly how long. She said the discussed Resident #9's and family were not compliant with her diet at least one time during the morning meeting but was not able to say how long ago. She said the DON, nursing staff, and MDS were part of the morning meetings and assumed they would include it in Resident #9's care plan. She was not able to say if Resident #9 sustained any negative outcome for being non-compliant with her diet. An interview on 02/24/25 at 4:30 p.m., the DON said Resident #9 was on a no added salt diet. She said Resident #9's family would bring her outside food despite being educated on her diet and on the consequences of not adhering to it. She said there had been times in which she or her staff would call Resident #9's RP to re-educate on her mother's diet and she would tell them the resident had the right to eat whatever she wanted. The DON said Resident #9's and RP's behavior had not been care planned. The DON said the facility did not have a non-compliant form for the resident or their RP to sign when would not follow their ordered diet. She said the nursing home was their home and they could eat whatever they wanted. The DON said Resident #9 had not sustained any negative outcome for not having her non-compliance with her diet care planned. An interview on 02/25/25 at 2:18 p.m., the MDS LVN said she had not been informed Resident #9 was not being compliant with her diet. She said if she had known, she would have care planned their behavior. She said she was part of the morning meetings and did not recall ever discussing their non-compliant behavior. She was not able to say if Resident #9 sustained any negative outcome for not having her care plan include that she and or family were non-compliant with her no added salt diet. 2. Record review of Resident # 31's admission sheet dated 02/25/25 reflected a [AGE] year-old female with an admitted [DATE] and an original admitted [DATE]. Her relevant diagnoses included muscle wasting and atrophy (loss of muscle mass and strength), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), and dementia (loss of memory, language, problem solving skills and other thinking abilities that are severe enough to interfere with daily life). Record review of Resident #31's quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 2, which indicated her cognition was severely impaired. Record review of Resident #31's order summary reflected an order for Resident #31 to use palm protector to left hand continuously, can remove for bathing and cleansing only. Dated order was 03/27/24 with no end date. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #31's quarterly care plan dated 02/06/25 reflected [Resident #31] used palm protectors to left hand continuously (date initiated: 03/27/24). Part of her interventions were for [Resident #31] to use palm protector to left hand continuously, can remove for bathing and cleansing only (date initiated: 03/27/24). An observation on 02/24/25 at 2:00 p.m. and 5:30 p.m., Resident #31 was lying awake in bed, her left hand was contracted. The resident was not wearing a palm protector. An observation on 02/25/25 at 10:00 a.m., revealed Resident #31 was not wearing a palm protector on her left hand. An interview on 02/24/25 at 2:00 p.m. and 5:30 p.m., revealed Resident #31 was not able to answer if the nursing staff would put a palm protector on her left hand. Resident #31 would try to talk but was not able to, she would try to gesture with her left hand but was not able to due to being contracted. Resident #31 was observed holding a stuffed animal on her right hand. An interview on 02/25/25 at 3:00 pm CNA F said she came in at 6 AM and went to see Resident #31 at 6:30 a.m. and at 10 a.m. She said both times she had repositioned her. CNA F said Resident #31 did not like wearing the palm protector on her left hand. She said she would resist and would try to remove it. She said she informed her charge nurse on several occasions that Resident #31 did not like wearing the palm protector on her left hand. An interview on 02/25/25 at 3:10 p.m., LVN E said Resident #31 would be repositioned every 2 hours but refused to wear the palm protector on her left hand. She said she mentioned her behavior in the morning meetings on several occasions. She said the MDS was part of their daily morning meetings and assumed her behavior would be care plan. LVN E said a negative outcome for Resident #31 not wearing a palm protector on her contracted left hand would be her contraction could get worse. An interview on 02/25/25 at 3:30 p.m., the MDS LVN said Resident #31 had an order to wear a palm protector continuously on her left hand. she said she was not informed by the nursing staff that Resident #31 refused to wear a palm protector on her left hand. She said would attend the morning meetings along with nursing staff and other department heads. She said it was during the morning meetings that any behaviors were discussed. The MDS LVN said the negative outcome for Resident #31 not wearing a palm protector would be continuous contractures. An interview on 02/25/25 at 3:40 p.m., the ADON said Resident #31 had an order to continuously wear a palm protector on left hand. She said Resident #31 was not able to tolerate it and refused to wear the palm protector. She said Resident #31 had the right to refuse and that it was just a matter of care plannings her refusal to wear a palm protector. The ADON said a negative outcome for Resident #31 not wearing a palm protector could be continuous contractures. Record review of the facility's policy on Comprehensive Care Plans dated 10/24/22 reflected: Policy: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 3. The comprehensive care plan will describe, at a minimum, the following: b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment.

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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** 47828 Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory was provided such care, consistent with professional standards of practice for 2 of 9 residents (Resident # 9 and Resident #49) reviewed for respiratory care. 1. The facility failed to ensure Resident #9's oxygen was administered at 3 lmp instead of 2 lpm via nasal cannula as ordered by physician. 2. The facility failed to ensure an oxygen sign was hung outside of Resident's #49's room, who received oxygen. These failures could place resident at risk of developing respiratory complications, having a decreased quality of care and expose residents to hazards such as explosions which could lead to physical harm. The findings included: 1. Record review of Resident #9's admission record, dated 02/24/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and an initial admitted [DATE]. Her relevant diagnoses included chronic obstructive pulmonary disease (lung condition caused by damage to the airways that limit airflow), emphysema (lung disease which results in shortness of breath due to destruction and dilation of the alveoli), acute respiratory failure with hypoxia (a condition where there is not enough oxygen or too much carbon dioxide in the body). Record review of Resident #9's MDS annual assessment dated [DATE], reflected a BIMS score of 14, which indicated her cognition was intact. Further review indicated Resident #9 was dependent on oxygen. Record review of Resident #9's care plan dated 12/26/24, reflected Resident #9 had oxygen therapy related to diagnoses of emphysema (a chronic lung disease that permanently damages the lungs' air sacs)/COPD (Chronic Obstructive Pulmonary disease)/acute respiratory failure with hypoxia (when the lungs and blood aren't exchanging gases property) and part of her interventions to have her oxygen setting at 2 lpm via nasal cannula needed for hypoxia (dated 12/22/24). Record review of Resident #9's order summary dated 02/24/25 reflected Resident #9 had an order for oxygen at 2 lpm via nasal cannula effective 12/21/24. During an observation on 02/24/25 at 12:10 p.m., revealed Resident #9 was observed in the dining room. She was sitting in her wheelchair and was receiving oxygen via nasal cannula. Resident #9's oxygenator was set at 3 lpm. Resident #9 was observed eating her lunch and did not show any signs of distress. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 02/24/25 at 12:20 p.m., CNA C said, she transferred Resident #9 and her oxygenator from her room to the dining room. She said when they arrived in the dining room, she just plugged in the oxygenator and made sure Resident #9 had the nasal cannula on correctly. She said she did not touched the lpm settings. An observation and interview on 02/24/25 at 4:30 p.m., revealed LVN E was observed reviewing Resident #9's electronic medical record and said she had an order for oxygen at 2 lmp via nasal cannula. LVN E said when a resident who was on oxygen was taken out of their room, it was the responsibility of the resident's charge nurse to ensure their oxygen setting was set accordingly to their order and to make sure the nasal cannula was on correctly. She said she was the charge nurse for Resident #9 and had gotten distracted with other residents and had failed to go check on Resident #9's oxygen settings while she was in the dining room. She said Resident #9 had not sustained any negative outcome for having her oxygen setting at 3 lpm during lunch on 02/24/25. An observation and interview on 02/24/25 at 4:40 p.m. revealed the DON reviewed Resident #9's electronic medical record and said she had an order for oxygen at 2 lmp via nasal cannula. The DON said it was the responsibility of the hall charge nurse to ensure the resident's oxygen setting was according to the order. She said Resident #9's oxygen setting had been checked immediately after lunch while she was in activities, and it was at 2 lpm. She said Resident #9 had not sustained any negative outcome for not having her oxygen at the ordered setting while she was having lunch on 02/24/25. The DON said the only policy the facility had related to oxygen was oxygen safety. 2. Record review of Resident #49's face sheet, dated 2/24/25 indicated he was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included heart failure (occurs when the heart can't pump enough blood to meet the body's needs), Essential hypertension (a type of high blood pressure where there is no clear identifiable cause). Record review of Resident #49's quarterly MDS assessment dated [DATE] revealed was in process. Record review of Resident #49's physician's order dated 2/24/25 indicated Oxygen at 2 liters per minute as needed via nasal cannula for hypoxia. Record review of Resident #49's comprehensive care plan, dated 1/29/25, indicates was in progress. During an observation on 02/24/2025 at 11:30 a.m. revealed, Resident #49, in his room on in his bed using oxygen. It was noted there was not sign posted outside of his room telling patients, staff, or visitors oxygen was in use. During an interview on 02/24/2025 at 11:40 a.m., LVN A stated the oxygen sign up on the side of the doors meant there was oxygen in use. LVN A stated every resident who used oxygen had to have one posted outside their rooms. LVN A stated even if it was not continuous, as long as oxygen was in the room. LVN A stated the risk to residents was that if it made contact the oxygen could explode or go up into flames. LVN A stated staff, visitors or the patient could trip with the oxygen concentrator or the tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/25 at 4:20 p.m., ADON stated that it was the admitting nurse to place a sign outside the resident's room. ADON stated that by having a sign outside the door would alert staff that resident was on oxygen. ADON said that staff would be extra cautious to prevent tripping. ADON stated the purpose of the sign was safety. During an interview with the DON on 01/05/2023 at 2:00 p.m., the DON stated the oxygen signs posted outside of the resident's room and were for people to be aware that the resident was on oxygen. The DON stated the oxygen signs let staff, residents, and family members know to be careful because there was oxygen in use. The DON stated the risk to the residents having no posted sign(s) would be to make sure not to use anything flammable that could cause a fire. The DON stated that every staff was responsible for ensuring the signs were posted. Record review of the facility policy Oxygen Safety dated 01/26/2024 revealed it is the policy of this facility to provide a safe environment for residents, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment. 6. Oxygen in Use- a. Licensed staffing using oxygen equipment will be trained in its operation, safety precautions and manufacturer's instructions for using the equipment. Training will occur upon hire and periodically for review of safety guidelines and usage requirements. b. Defective cylinders and equipment shall be removed from use. Defective cylinders will be marked so supplier can remove for servicing. c. Only qualified personnel will service equipment (i.e., concentrators). d. Markings on flowmeters and regulators will designate the gases for which they are intended. e. Oxygen-metering equipment, regulators, humidifiers, and nebulizers will be labeled with the name of manufacturer and supplier. f. No Smoking signs will be utilized to clearly identify oxygen is in use before connecting the oxygen supply, and will remain in place until oxygen administration has been discontinued, g. No smoking rules will be strictly enforced while oxygen is in use, including the removal of smoking materials from residents receiving oxygen. 50487

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 47828 Based on observation, interview, and record review the facility failed to post nurse staffing information on a daily basis to include the facility name, the current date, the total number, and the actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift for 3 of 3 days reviewed (02/22/25, 02/23/25, and 02/24/25) for nurse staffing. The facility failed to post the daily staffing information in a prominent place on 02/22/25, 02/23/25, and 02/24/25. This failure could place residents at risk of not being informed of the census and the number of staff working each day to provide care on all shifts. Findings included: Observation on 02/24/25 at 10:30 a.m., a clear frame on the top left of the front receptionist desk which displayed name of the facility and the total number of CNAs, LVNs, and RNs dated 02/21/25. An interview on 02/26/25 at 8:12 a.m., the ADON said she oversaw of posting for the daily staff information. She said she would make sure the daily staff information was posted by 8:30 am on a daily basis. She said the negative outcome for not posting the staff information would be in case of an emergency, the facility would not know how many staff members were in the facility. An interview on 02/26/25 at 8:27 a.m., the Administrator said it was the responsibility of the ADON to post the nursing staffing information. She said the daily postings should be up by 8:30 a.m. She said there were no negative outcome for not having the staff information posted. Record review of the facility's Nurse Staffing Posting Information policy dated 10/24/22 reflected: Policy: It is the policy of this facility to make nurse staff information readily available in a readable format to residents and visitors at any given time. Policy explanation and compliance guidelines: 1. The nurse staffing sheet will be posted on a daily basis and will contain the following information b. the current date

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Windsor Nursing and Rehabilitation Center of Alice	606 Coyote Tr Alice, TX 78332

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview, and record review the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for 1 of 9 residents (Resident #117) reviewed for pharmacy services. The Facility failed ensure Resident #117's controlled medication was signed off on the MAR on 02/23/25 after being administered. This failure could place residents at risk of not receiving their narcotic medications and drug diversion. The findings included: Record review of Resident #117's admission sheet dated 02/24/25, revealed a [AGE] year-old male with an admitted [DATE]. Resident #117's relevant diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that cause airflow obstruction and breathing difficulties), cognitive communication deficit (difficulty communicating that's caused by a brain injury or other cognitive impairment), and hypertension (a condition in which the blood vessels have persistently elevated pressure). Record review of Resident #117's 5-day medicare MDS assessment dated [DATE] reflected he had a BIMS score of 13, which indicated he was cognitively intact. Further review indicated Resident #117 was on PRN pain medication. Record review of Resident #117's base line care plan dated 02/13/25 reflected he suffered from chronic pain related to gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints) and hypertension (date initiated 02/10/25). Resident #117's interventions included to administer analgesia (Tramadol) as ordered. Record review of Resident #117's order summary reflected an order dated 02/18/25 for Tramadol HCl 50 MG, 2 tablets by mouth every 12 hours as needed for breakthrough pain. An observation and interview on 02/24/25 at 3:00 p.m., revealed Resident #117 was observed sitting in his wheelchair in his room. He said he was a new admit and the only concern he had was related to her Tramadol order not being given to him every 12 hours. He said even though the order was PRN, he had been requesting it every 12 hours for back pain. An observation of Resident #117's February 2025 MAR reflected Tramadol was administered twice a day since 02/18/25 with the exception of 02/23/25 which showed it had only been administered in the AM. An observation on 02/24/25 at 3:35 p.m., LVN E reviewed Resident #117's narcotic sheet reflected that on 02/23/25, he had been administered Tramadol at 6:31 a.m. and at 7:00 p.m. and the amount remaining was 10 pills. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 02/24/25 at 3:39 p.m., LVN E reviewed Resident #117's Tramadol blister pack reflected a total of 10 pills remained after his second dose of Tramadol on 02/23/25 at 7:00 p.m. Attempted telephone interview with LVN D on 02/24/25 at 3:20 p.m. was unsuccessful. An interview on 02/24/25 at 3:45 p.m., LVN E said Resident #117 had a PRN order of Tramadol. She said after she reviewed Resident #117's order, narcotic sheet, and blister pack she concluded LVN D had in fact administered Tramadol on 02/23/25 at 7:00 p.m. but had forgotten to sign it off on the MAR. LVN E said there was no negative outcome for Resident #117 not having his second dose of Tramadol signed off on 02/23/25. She said Resident #117's narcotic sheet and the medication count matched and if he had requested another Tramadol on 02/23/25 after 7:00 p.m., the nurse would have caught the mistake when she attempted to administer another Tramadol pill. An observation and interview on 02/24/25 at 4:00 p.m., the DON reviewed Resident #117's electronic medical record (MAR), Tramadol narcotic sheet, and Tramadol blister pack. She said Resident #117's narcotic sheet and blister pack count matched. She said the only thing she concluded was that LVN D had forgotten to sign off on Resident #117's second dose of Tramadol on 02/23/25 at 7:00 p.m. The DON was not able to say if there were any negative outcome to Resident #117 not having his second dose of Tramadol signed off on his MAR on 02/23/25 at 7:00 p.m. Record review of the facility's Medication Administration policy dated 10/24/22 reflected: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this stated, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs on the MAR.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47828 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation, and sanitation. The facility failed to ensure kitchen equipment was in good condition. This failures could place residents at risk for complications from food contamination. The findings included: Observation of the kitchen during initial tour on 02/24/25 at 10:20 AM revealed a 3-door refrigerator and a 2-door refrigerator. The temperature in both refrigerator was below 41 degrees Fahrenheit. It was noted that on both refrigerator's when one door was closed the other door(s) opened. In an interview on 02/24/25 at 10:30 a.m., the DM stated the refrigerator doors in both refrigerators had not been closing properly since December 2024 (when he was hired). He said he had already reported it to the facility's Maintenance Director several times. He said he and his staff had too constantly be checking the doors to make sure they remained closed. The Dietary Manager said there was at least one time since December 2024 that the morning shift called to let him to notify him the night crew had forgotten to check the refrigerator doors and one of them remained opened overnight. He said by the time the morning crew came in the temperature was 60 degrees Fahrenheit. He said when that happened, he had instructed them to dispose all the food in the refrigerator. The Dietary Manager said the negative outcome of the refrigerator doors not closing properly could be all the food had to be disposed. He said had instructed his staff that if the temperature in either refrigerator was more than 41 degrees Fahrenheit, he needed to be notified before using the food. An observation and interview on 02/24/25 at 10:40 a.m., the Maintenance Director said back in December 2024, he ordered and installed a new gasket for the 3-door refrigerator. He was observed checking both refrigerators and said he was not aware the problem continued. The Maintenance Director was asked if he had checked the refrigerator door(s) after installing the new gasket and his response was maybe or maybe not he said he had a lot of work and did not remember. He was observed checking the doors on both refrigerators and said they were not closing properly. The Maintenance Director said he had not been advised the refrigerator doors were not closing properly. He was not able to answer how often he was supposed to check the refrigerator doors to ensure they were closing properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 02/26/24 at 2:30 p.m. the Administrator (acting) said she was informed on 02/25/25 of the 3-door refrigerator not closing properly. She said she was covering for the current Administrator since 02/25/25. She said as soon as she was informed on 02/25/25, she placed a stat request to a local restaurant service company to come service the 3-door refrigerator. She said she was not aware that both facility's refrigerator doors were not closing properly. The Administrator was shown a copy of the work order created 12/13/23 by the Maintenance Director and said, it didn't make sense, she said she could not explain the work order because the dates were off. The Administrator said the negative outcome of not having the refrigerator doors properly closing could be the temperature could rise and would cause the food to spoil. The kitchen equipment policy was requested but not provided. Record review of the Maintenance Director's work order dated 12-13-23 reflected, refrigerator door seal middle one with a medium priority, due date 12/13/24. The workorder also had a timeline created 12/13 (no year) , 12/18 (no year) updated status by Maintenance Director, and 02/24 (no year) updated status by Maintenance Director set to 12/13/24. Record review of the local restaurant service company dispatch ticket reflected on 02/24/25 at 12:40 p.m. the facility's Maintenance Director had called them to request urgent request service ASAP 3 door refrigerator: middle door opens every time another door is opened, and door will not stay closed. On 02/25/25 at 2:49:19, technician ordered (2) door spring hinges. Record review of the facility's Refrigerator and freezer temperature records for the months of 12/24, 01/25 and 02/25 reflected only one time on 12-24-24 in which the temperature was 60 degrees Fahrenheit. Record review of the FDA food code 2022 reflected 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications.

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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** 50487 Based on observation, interview and record review the facility failed to establish and maintain an infection and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of 4 residents (Resident #28) reviewed for infection control. CNA B failed to wash her hands or use hand sanitizer between gloves changes while providing catheter care and perineal care for Resident #28. This failure could place residents at risk for spread of infection and cross contamination. Findings include: Record review Resident #28's face sheet, dated 02/25/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #28 had diagnoses which included diabetes (a chronic condition where the body either doesn't produce enough insulin or doesn't use insulin effectively, leading to high blood sugar levels), hypertension (a condition in which the force of blood against the walls of the arteries is consistently too high) and cognitive communication deficit (a difficulty in communicating effectively due to an underlying cognitive impairment, such as problems with attention, memory, reasoning, or problem-solving, which are typically caused by brain injury and impact a person's ability to understand and express language properly). Record review of Resident #28's care plan, dated 08/01/24, reflected a focus area that Resident #82 had a Foley Catheter 16 French 10 milliliters related to physical and cognitive limitations related to stage IV pressure ulcer. She was at risk for impaired skin integrity and infection. Record review of Resident #28's quarterly MDS assessment, dated 1/24/25, reflected a BIMS score of 8, which indicated cognition was moderately impaired. Section H- Bladder and Bowel reflected Resident #28 had a foley catheter for neuromuscular dysfunction of bladder. During an observation on 02/25/25 at 3:50 PM revealed catheter care and pericare was provided by CNA B. CNA B entered Resident #28's room and placed supplies on the bedside table. CNA B washed her hands, donned gown, and gloves. CNA B removed the soiled brief and placed it in the trash can. CNA B removed the gloves from her hands and donned gloves without washing her hands or sanitize her hands before donning new gloves. CNA B then cleaned Resident #28's pericare-area, removed gloves, but did not wash or sanitized her hands before donning new gloves. CNA B then did the catheter care, CNA B washed her hands before and after the procedure only. During an interview on 02/25/25 at 4:15 PM with CNA B, she stated I should have sanitize or washed my hands before donning new gloves. She stated she should have washed her hands or used hand sanitizer between glove changes. CNA B stated I forgot about it because I was nervous. She stated the potential negative outcome could be the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/25 at 5:20 PM, the ADON said hands should be washed or hand sanitizer used in between glove changes. The ADON said she was the Infection Preventionist and in charge for infection control. The ADON said she was responsible for monitoring the staff for compliance with infection control. The ADON said the potential negative outcome could be the spread of infection to another resident. The ADON said she did in-services on infection control monthly and as needed. During an interview on 02/26/25 at 02:34 PM with the DON, she stated gloves should be changed after going from a dirty area to a clean area. She stated hands should be washed if gloves were visibly soiled or could use hand sanitizer between glove changes. She stated the potential negative outcome could be the spread of microorganisms. The DON said Resident #28's was at higher risk for getting a urinary tract infection because Resident #28 had a foley catheter. Record review of the facility's policy on Infection Prevention Control Program, with a date implemented 5/13/23, reflected This facility has established and maintains 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 infections as per accepted national standards and guidelines. Record review of the Center for Disease Control and Prevention website, (https://www.cdc.gov/handhygiene/providers/index.html), Know when to clean your hands: Immediately before touching a patient. Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or patient's surroundings. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal.