

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Windsor Nursing and Rehabilitation Center of Edinb		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 S Closner Edinburg, TX 78539	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40872</p> <p>Based on record review and interview the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and time frames to meet the residents psychosocial needs for one (Resident#11) of two residents reviewed for comprehensive person centered care plan.</p> <p>The facility did not have interventions in place for Resident #11's behavior of removing peg tube. Resident #11 had removed his peg tube on 2 separate occasions and was sent to hospital.</p> <p>This failure could affect residents and place them at risk of not receiving appropriate interventions.</p> <p>The findings were:</p> <p>Record review of Resident 11's Admission Record dated 09/19/24 revealed a [AGE] year-old male with an original admitted [DATE] and diagnoses of Alzheimer's Disease Unspecified (brain disorder that slowly destroys memory and thinking skills), Gastrostomy Status (surgical procedure that creates an opening in the abdomen & into the stomach to provide nutritional support), Displacement of other gastrointestinal (organs that process food and liquid) Prosthetic Devices (device designed to make a part of the body work better), Chronic Kidney Disease Stage 5, Anxiety Disorder Unspecified, Restlessness and Agitation, and Muscle Wasting and Atrophy.</p> <p>Record review of Resident #11's Quarterly MDS dated [DATE] revealed Resident #11 was severely impaired in cognitive skills, rarely/never makes self-understood, rarely/never understands others. Resident #11 was also coded as having a peg tube in place as a nutritional approach.</p> <p>Record review of Resident #11's Care plan dated 06/28/24 revealed Resident #11 requires tube feeding r/t Dysphagia.</p> <p>Record review of Resident #11's progress note dated 07/26/24 documented by LVN D revealed facility nurse had found Resident #11 had removed his peg tube and was sent to the hospital for reinsertion.</p> <p>Record review of Resident #11's progress note dated 09/13/24 documented by LVN C revealed that Resident #11 had pulled out his peg tube and was sent out to hospital for reinsertion.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #11's Care plan dated 09/03/24 found no documentation of interventions for Resident #11's behavior of removing peg tube.</p> <p>In an interview on 09/17/24 at 4:00 pm, the RP stated Resident #11 had previously removed his peg tube before being admitted into the facility. She said she had told the facility about it when he was first admitted to the facility and that's why she and her family take turns staying with Resident #11 and decided to hire private pay sitters as well.</p> <p>In an interview on 09/18/24 at 10:39 am, LVN C said on 09/13/24 CNA L told her that Resident #11 had removed his feeding tube. LVN C said she immediately went in to assess the resident and had Resident #11 sent out to the hospital to have peg tube reinserted. LVN C said it was not his first time that he had done that, however, she was not working that day it happened. LVN C said those were the only times Resident #11 had done that. LVN C said Resident #11's family private pays a sitter to be with him throughout the afternoon and sometimes at night. She said the family also takes turns staying with him to monitor his behavior.</p> <p>In an interview on 09/18/24 at 11:23 am the MDS nurse said Resident #11's care plan stated that resident removes peg tube. He said he did not know why any interventions were not care planned specifically for that. He said it should have been care planned and said he was responsible for care planning this but did not know why it wasn't but would be reviewing it.</p> <p>In an interview on 09/18/24 at 2:24 pm, the DON said Resident #11 had removed the peg tube on 2 different occasions. She said the family takes turns staying with him and monitoring him. She said the family has hired private pay sitters to stay with him as well. The DON said Resident #11 also has an abdominal binder to prevent him from removing it. The DON said that interventions for Resident #11 removing his peg tube were not documented because the family was providing the monitoring of the resident.</p> <p>A care plan policy was requested on 09/18/24, however was not provided.</p>		