STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675414	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Edinb	1505 S Closner Edinburg, TX 78539

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observations, interview and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preference for one (Resident #23) of four residents reviewed for call light. The facility failed to ensure Resident #23 had a padded call light as indicated on his care plan. This failure could place residents at risk of not having their needs met. Findings were: Record review of Resident #23's face sheet dated 07/24/2024 reflected an [AGE] year-old male with an admitted [DATE]. Resident 23's relevant diagnoses included Parkinsonism (disorder of the central nervous system that affects movement, often including tremors), stiffness of right elbow, vascular dementia (brain damage caused by multiple strokes), hemiplegia of left nondominant side (paralysis of one side of the body), age related physical debility, osteoarthritis (when flexible tissue at the ends of bones wears down) on left hand, muscle weakness and atrophy(decrease in size of tissue; wasting) multiple sites, and reduced mobility. Record review of Resident #23's quarterly MDS assessment dated [DATE] reflected a BIMS score of 02, which indicated he was severely cognitively impaired. Section GG 0115 Functional Limitation in Range of Motion indicated impairment on one side for upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot). Section GG functional abilities and goals identified Resident #23 as being dependent for the following ADL's: eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking of footwear, personal hygiene, roll left/right, sit to lying, sit to stand, chair/bed-to-chair transfer, toiler transfer, and tub/shower transfer. MDS definition of dependent was that resident does none of the effort to complete the activity or, the assistance of 2 or more helpers is required for the resident to complete the activity. Record review of Resident #23's quarterly care plan reflected 06/06/2024 reflected: Problem: [Resident #23] has an ADL self-care performance deficit r/t immobility, cognitive deficit, parkinsonism. Date initiated 01/04/2024 and revised on 01/09/2024. Interventions: Pad call light in place. Date initiated 03/25/24. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Problem: [Resident #23] has limited physical mobility r/t parkinsonism, generalized weakness. Date initiated and revised on 01/10/2024. Interventions: Monitor/document/report PRN any s/sx of immobility: contractures forming or worsening, thrombus formation, skin-breakdown, fall related injury. Date Initiated: 01/10/2024 An observation on 07/21/2024 at 12:05 p.m., revealed Resident #23 was lying awake in bed. His bed was set to the lowest position and his push button call light was within reach. Resident #23's left hand was contracted (closed in a fist), and he had his right hand under his head. An attempted interview and observation on 07/21/2024 at 12:08 p.m., revealed Resident #23 was not interviewable. Resident #23 was asked if he was able to open his left hand, but he just starred and did not answer. Resident #23 was asked if he was able to use his right hand, and he managed to take it out from under his head, but it started shaking and he quickly put it back under his head. An observation on 07/22/2024 at 8:24 a.m., revealed Resident #23 was lying awake in bed, his bed was set to the lowest position and his non-padded call light was within reach. An interview on 07/22/2024 at 8:30 a.m., CNA C said Resident #23 was not able to use the call light due to his left hand being contracted and his right hand would shake a lot. She said as far as she could remember, Resident #23 had never used the call light. CNA C said she would make sure she checked on Resident #23 at least every 30 minutes to see if he needed anything because he was not able to talk or press the call light. CNA C said Resident #23 was a 2 person assist for bathing and was a Hoyer lift assist transfer (the resident is placed in a sling that acts like a hammock raising them up in a cradled position , and allows them to be maneuvered to their new surface). She was not able to say if Resident #23 had ever had a padded call light. An interview on 07/22/2024 at 8:49 a.m., LVN D said Resident #23 was not able to use a regular call light. LVN D said he and the CNAs would check on Resident #23 frequently to see if he needed anything. He said if Resident #23 needed anything he would grunt. LVN D said Resident #23 would benefit from having a padded call light. LVN D was not able to say what the negative outcome for Resident #23 would be if he was not able to use the non-padded call light. An observation on 07/22/2024 at 9:00 a.m., revealed LVN D was observed checking Resident #23's electronic record (care plan) to verify what type of call light he needed. LVN D said he was having difficulty in finding they type of call light Resident #23 required on his care plan, so he called MDS-LVN to assist. They both said Resident #23's care plan indicated he needed a padded call light. An interview and observation on 07/22/2024 at 9:08 p.m., the MDS-LVN said he Resident #23 had a padded call light and proceeded to walk to Resident #23's room to check. The MDS-LVN walked into Resident #23's room and said he should have had a padded call light. He said, Last week he had a padded call light; they must have changed it this week. The MDS-LVN said he was going to immediately meet with the nursing staff, ADON, DON to assess and determine what type of call light Resident #23 needed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview of on 07/22/2024 at 9:20 a.m., the MDS-LVN said after Resident #23 was assessed by himself, the ADON and DON on 07/22/2024, and it was determined Resident #23 was able to press the regular call light, therefore, he no longer needed a padded call light. He said he was not sure why the care plan indicated he required a padded call light. The MDS-LVN said, Resident #23's care plan had been updated. An interview on 07/23/2024 at 3:00 p.m., the ADON-RN said he was present for Resident #23's call light assessment on 07/22/2024. He said Resident #23 was able to press the regular call light when asked and it was determined that he would benefit from a regular call light. An interview on 07/23/2024 at 3:30 p.m., the DON said she was present for Resident #23's call light assessment on 07/22/2024 and said Resident #23 was able to press the regular call light. She said the call light assessment done on Resident #23 was a visual assessment and it had not been documented. Record review of the facility's Call Lights: Accessibility and Timely Response policy dated 10/13/2022 reflected: Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines: 3. Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system.

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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 are identified in the comprehensive assessment for 1 of 4 residents (Resident #23) reviewed for care plans, in that: The facility failed to ensure Resident #23's comprehensive care plan dated 06/06/24 identified him as a one or two person assist for ADL's. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and no having personalized plans developed to address their specific needs. The Findings included: Record review of Resident #23's face sheet dated 07/24/2024 reflected an [AGE] year-old male with an admitted [DATE]. Resident 23's relevant diagnoses included Parkinsonism (disorder of the central nervous system that affects movement, often including tremors), stiffness of right elbow, vascular dementia (brain damage caused by multiple strokes), hemiplegia of left nondominant side (paralysis of one side of the body), age related physical debility, osteoarthritis (when flexible tissue at the ends of bones wears down) on left hand, muscle weakness and atrophy(decrease in size of tissue; wasting) multiple sites, repeated falls, and reduced mobility. Record review of Resident #23's quarterly MDS assessment dated [DATE] reflected a BIMS score of 02, which indicated he was severely cognitively impaired. Section GG identified Resident #23 as being dependent for the following ADL's: eating, oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking of footwear, personal hygiene, roll left/right, sit to lying, sit to stand, chair/bed-to-chair transfer, toiler transfer, and tub/shower transfer. The MDS definition of dependent was that resident did none of the effort to complete the activity or, the assistance of 2 or more helpers was required for the resident to complete the activity. Record review of Resident #23's quarterly care plan reflected 06/06/2024 reflected: Problem: [Resident #23] had an ADL self-care performance deficit r/t immobility, cognitive deficit, parkinsonism. Dated initiated 01/04/2024 and revised on 01/09/2024. Interventions: Bathing/Showering: The resident requires assistance by (1-2) staff with bathing/showering, as necessary. Date initiated/revised 05/22/2024. Bed mobility: The resident requires dependent assistance by (1-2) staff to turn and reposition in bed every two hours and as needed. Date initiated 01/04/2024 and revised on 01/09/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dressing: The resident requires assistance by (1-2) staff to dress as needed. Date initiated/revised 05/22/2024 Personal Hygiene: The resident requires assistance by (1-2) staff with personal hygiene as needed. Date initiated/revised 05/22/2024. Toilet using: The resident is fully dependent on 1-2 staff for toileting. Date initiated 01/04/2024 and revised on 01/09/2024. Transfer: The resident requires complete dependence by 1-2 staff to move between surfaces, as necessary. Date initiated: 01/04/2024 and revised on 01/09/224. An attempted interview and observation on 07/21/2024 at 12:08 p.m., revealed Resident #23 was not interviewable. Resident #23 was asked if he was able to open his left hand, but he just starred at it and not able to answer. Resident #23 was asked if he was able to use his right hand and he managed to take it out from under his head, but it started shaking and he quickly put it back under his head. Resident #23 was asked if he received assistance in feeding and he nodded yes. An interview and observation on 07/22/2024 at 8:30 a.m., CNA C said due to Resident #23's legs being contracted and him not being able to assist, he required a 2 person assist for bathing, transfer Hoyer lift (the resident is placed in a sling that acts like a hammock raising them up in a cradled position , and allows them to be maneuvered to their new surface), and peri-care and a 1 person assist for feeding. She said she knew to check the Kardex to see if he was a 1 or 2 person assist for ADL's. The Surveyor observed CNA C check Resident #23's electronic record (Kardex) under ADL's it reflected that he was a 1-2 person assist for ADL's with the exception of eating and transfer (Hoyer Lift). She said even though the Kardex indicated he was a 1-2 person assist, she knew he required a 2 person assist for bathing and transfer because she had been caring for him since he was admitted to the facility. CNA C said newly hired CNAs shadowed tenured CNAs for two weeks to become familiar with their residents' needs. She said during those 2 weeks, they were able to observe all ADL's for their residents. CNA C showed the Surveyor a list she carried behind her name badge which indicated all the residents who required a Hoyer Lift for transfer and Resident #23's name was on the list. She said if a resident required a Hoyer Lift for transfer that meant a 2 person assist. An interview on 07/22/2024 at 8:49 a.m., LVN D said Resident #23 was a 2 person assist for bathing, transfers, and peri-care. He said for newly hired CNAs he would make sure they became familiar with their residents' needs before he would allow them to go on their own. He said newly hired CNA's shadowed tenured CNAs for 2 weeks. He said he would also make sure newly hired CNAs knew where to check to see if resident required a 1 or 2 person assist. CNA C said even though Resident #23's care plan reflected 1-2 person for ADL's she knew he was a 2 person assist due to his contractures. (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 and observation on 07/23/2024 at 10:16 a.m., the MDS-LVN said he was in charge of completing the MDS and Care plan assessments for the facility. He was observed checking Resident #23's electronic record and said his care plan indicated he required a 1 to 2 person assist for ADL's; however, most of the time he would require a 2 person. The MDS-LVN said the CNAs would determine whether Resident #23 would be a 1 or 2 person assist. He said if the CNA did not feel safe in performing a certain ADL task, then they asked for assistance. He said that was the reason he had indicated a 1 to 2 person assist for ADL's was to allow the CNAs to make that decision. The MDS-LVN said there were several factors a CNA would consider when determining if Resident #23 would be a 1 or 2 person assist. He said their experience was one factor, if the CNA felt they could do it on their own they were allowed. Another factor the CNAs would consider would be their CNAs stature. He said if the CNA were petite and didn't feel safe performing an ADL task on their own, they could ask for assistance. He said there was always someone to assist if the CNAs requested assistance with a resident's ADL's. MDS-LVN said Resident #23's the MDS indicated he was dependent for all ADL's which coincided with a 2 person assist. The MDS-LVN said CNA's did not receive training on how to determine if a resident was a 1 or 2 person assist. He said no training was needed. He said, What determined if a [Resident #23] would be a 1- or 2-person assist was how confident the CNA felt. An interview on 07/23/2024 at 10:52 a.m., the DON said Resident #23 was coded as dependent on his MDS assessment for ADL's, which meant he was dependent on the CNAs for assistance. She said what would determine if Resident #23 was a 1- or 2-person assist was if he were having a good day or not If he were having a good day, which meant he was able to help with his ADL's then he would require a 1 person assist. She said if he were not having a good day then he would require a 2 person assist. The DON said the CNAs already knew Resident #23 and they were able to determine if he was having a good day or not. She said if a there's a new CNA, they would shadow tenured CNAs for 2 weeks to be shown what each resident required. The DON said there were no specific trainings for CNAs to help them determine if a resident was a 1 or 2 person assist. She said, Just personal experience, they gain from working with each other. An interview on 07/23/2024 at 5:00 p.m. the Administrator said the reason Resident #23's care plan said 1 to 2 person assist for his ADL's was to allow the CNAs to determine if they felt safe performing a specific task on their own or ask for assistance. She said a resident was not always going to be a 1 or 2 person assist because it would depend on the CNAs experience and whether or not the resident was able to assist on that particular day. She said if a resident was on a ventilator, then they would always be a 2 person assist. The Administrator said there was no risk in allowing CNAs to determine whether or not a resident would be a 1 or 2 person assist. Record review of the facility's Comprehensive Care Plan policy dated 10/24/2022 reflected: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered plan for each resident, consistent with the resident rights, that includes measurable objectives and time frames to meet a residence medical, nursing, and mental and psychosocial needs that identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlines by the comprehensive care plan, shall be culturally competent and trauma informed. 2. All Care Assessments Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47828 Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals in 1 of 1 medication room review for medication storage . The facility failed to ensure that all medical supplies in the main medication storage room located in the in the front of the building were not past their expiration date. The facility's failure could result in residents receiving expired medical supplies, such as formula, as well as those supplies not being maintained at their best therapeutic level. The findings included: An observation on 07/22/2024 at 2:00 PM of the main medication storage room revealed 6 Aztreonam 500 MG/50 ML NS IV antibiotic medication with an expiration date of 07/18/2024 and 2 Azithromycin 250 MG/250 NS IV antibiotic medication with an expiration date of 07/19/2024 along with non-expired IV medication. In an interview/observation on 07/22/2024 at 2:05 PM, LVN B who witnessed the medication storage and labeling review of the main medication room on 07/22/24 at 2:00 pm first stated expired medication was kept in the refrigerator until they would take them for disposal. The Surveyor then observed LVN B remove the 8 expired IV medication bags and place them in a red bin where he said expired medications were temporarily placed until they were taken to the DON's office. LVN J said a negative outcome of storing expired medication with non-expired medication could results in residents being administered expired medication(s) if nursing staff failed to check expiration dates. An interview on 07/22/24 at 4:00 PM, the DON said expired medications should not be stored with non-expired medications. She said expired non-narcotic medications were stored in a red bin located in the main medication storage room. The DON was not able to say what a negative outcome was for storing expired and non-expired medications together. On 07/24/2024, the Surveyor requested the facility's policy on labeling and storage from the DON but only received a Labeling of Medication policy.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 Based on interview and record review the facility failed to ensure resident who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record for two Residents (R#1, R#16) of 5 residents reviewed for unnecessary medications. The facility failed to ensure that: 1) Resident #1 had an appropriate diagnosis for Risperidone (an antipsychotic used to treat schizophrenia and bipolar disorder). 2) Resident # 16, with a diagnosis of unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety received antipsychotic medication Lurasidone without an additional diagnosis indicating the use for antipsychotic medication. This failure puts residents at an increased risk for adverse consequences such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status from receiving unnecessary antipsychotic medications. The findings included: 1. Review of Resident #1's Face Sheet dated 7/24/24, revealed she was a [AGE] year-old female originally admitted to the facility 3/25/22 with a most recent admitted [DATE]. She had diagnoses which included dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance; major depressive disorder, recurrent, mild; anxiety disorder, unspecified; type 2 diabetes mellitus; and had a need for assistance with personal care. Review of Resident #1's Quarterly MDS Assessment, dated 7/13/24, Section B - Hearing, Speech, and Vision, B0200 revealed resident had minimal difficulty hearing, B0600 revealed resident had unclear speech, B0700 revealed resident is rarely/never understood, B0800 revealed resident rarely/never understands, and B1000 revealed resident has impaired vision - sees large print, but not regular print in newspapers/books. Section C - Cognitive Patterns, C0700 revealed resident had short term memory problem, C0800 revealed resident had long-term memory problem, and C1000 revealed resident severely impaired - never/rarely made decisions. Section GG - Self-Care, GG0130 revealed the resident required maximum assistance or dependent for ADL's except for oral hygiene and eating. Section N - Medications, N0415 revealed resident received antipsychotic, antidepressant, anticoagulant and hypoglycemic medications; and N 0450 revealed an antipsychotic GDR was reflected on 7/3/24 not documented by a physician as clinically contraindicated. Review of Resident #1's most recent Care Plan, revealed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Problem: Resident #1 uses antipsychotic medication (Risperidone) r/t episodes of verbal and physical aggression and diagnosis of dementia. Resident #1 is currently under psychiatric services of Psych MD. Date Initiated: 04/05/2024 Revision on: 04/29/2024. Interventions include the following: o 7/3/24. Gradual Dose Reduction Risperidone 1mg/ mL PO BID to 0.5mL PO BID by Psych MD's P.A. Date Initiated: 07/03/2024. o Administer anti-psychotic medication(s) as ordered by physician. Monitor/document side effects, and effectiveness every shift. Date Initiated: 04/05/2024 Revision on: 04/05/2024. o Educate the Family/ Caregivers about risks, benefits, and the side effects and/ or toxic symptoms of anti-psychotic medication on consent. Date Initiated: 04/05/2024 Revision on: 04/05/2024. o Monitor/ Document/ report adverse reactions to anti-psychotic therapy that include stiff neck, confusion, muscle rigidity, involuntary movements, drooling, tremors, restlessness, sleep disturbance, dry mouth blurred vision, constipation, and/ or sedation as condition warrants and notify physician/ psychiatric consultant. Date Initiated: 04/05/2024 Revision on: 04/05/2024. o Monitor/ Record occurrence of improving/ worsening target behavior symptoms of verbal and physical aggression to Supervisor as indicated. Notify MD/psychiatrist and follow up on any new orders. Date Initiated: 04/05/2024 Revision on: 04/05/2024. o Refer to Psychiatrist/ Psychologist consult per MD order. Follow up on any new orders. Date Initiated: 04/05/2024 Revision on: 04/05/2024. Record review of Resident #1's most recent Care Plan revealed: Risperidone Black Box Warning: Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Risperidone is not approved for the treatment of patients with dementia-related psychosis. Date Initiated: 04/29/2024. Review of Resident #1's Order Summary Report, dated 7/24/24, revealed: Side effect monitoring for stiff neck, confusion, muscle rigidity, involuntary movements, drooling, tremors, restlessness, sleep disturbance, dry mouth, blurred vision, constipation, and sedation every shift for anti-psychotic use related to dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Risperdal Oral Solution 1 MG/ML (Risperidone) Give 0.5 ml by mouth two times a day related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Start date 7/3/24. Review of Resident #1's MAR on 7/24/24 revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675414	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Edinb	1505 S Closner Edinburg, TX 78539

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From July 1st to July 2nd, 2024, she received Risperidone Solution (1 MG/ML) 1 mg by mouth two times a day related to dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. From July 3rd to July 23rd, 2024, she received risperidone 0.5 mg twice a day as related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. This was the most recent order for risperidone which was reduced and started on 7/3/24. Record review of the Gradual Dose Reduction Report for June 2024 revealed that the Pharmacy Consultant made recommendation to the facility that Resident #1 had an improper diagnosis of Dementia in regards the antipsychotic Risperdal she was prescribed. On 7/23/24 at 4:19 pm interviewed LVN A. She said that she worked for the facility as an LVN for 6 months. She said that previously she was an MA for [AGE] years. She said that the Risperidone is being given for Resident #1's Dementia. She said that she knew the resident prior and she was displaying psychotic episodes before, but the medication is helping with those symptoms. She said that the dementia is not an appropriate diagnosis for the Risperidone. She said that an anti-psychotic is not appropriate for a diagnosis of dementia. She said that it is for psychosis or mood disorders. She said that a resident could have an adverse effect from a medication they didn't need. On 7/23/24 at 4:34 pm interviewed the ADON. He said that for Resident #1, Risperidone was not an appropriate medication to be prescribed for her diagnosis of Dementia. He said that she never used the medication before and that it was prescribed to manage her behaviors. He said that Resident #1 was confused, incoherent, and trying to get out of bed on her own. He said that she was initially started on Zyprexa, then changed to liquid Risperdal due to Resident #1 spitting out the tablets. He said that if an antipsychotic was given to a resident without the appropriate diagnosis, they could experience adverse reactions that may be permanent. He said that they used the medication as a last resort and that Resident #1 was already started on a gradual dose reduction. He said that dementia was not treated with an antipsychotic. He said that the Care Plan stated it has a black box warning for an increased risk of death. On 7/24/24 at 2:56 pm interviewed the Pharmacist Consultant. She said that she had noticed that the psychiatrist placed a diagnosis of Dementia and used them for the behaviors. She said that she is aware that the state does not allow for those diagnosis. She said that she does ask the psychiatrist for another diagnosis, but she goes by whatever the doctor writes on her recommendations page. She said that she cannot just stop the medication abruptly. The Pharmacist Consultant said that she places residents on a GDR as soon as possible once the behaviors have subsided. On 7/24/24 at 3:12 pm interviewed the DON. She said that she agreed that Risperidone was not an appropriate medication to be prescribed for a diagnosis of Dementia. She said that if an antipsychotic is given to a resident without the appropriate diagnosis, they could experience adverse reactions that may be permanent. She said that Resident #1 is being given the medication for previous behaviors that are not reflected on the prescribed diagnosis for that medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675414	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Edinb	1505 S Closner Edinburg, TX 78539

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Record review of Resident #16's Admission Face Sheet, dated 07/24/24, revealed he was a [AGE] year-old male admitted to the facility 09/15/27, with the following diagnoses: unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety(a condition characterized by progressive or persistent loss of intellectual functioning resulting from organic disease of the brain); major depressive disorder (a mood disorder that causes persistent feeling of sadness and loss of interest); cognitive communications deficit (difficulty paying attention to a conversation, staying on topic, remembering information, responding accurately, understanding jokes or metaphors, or following directions); anxiety disorder (any group of mental conditions characterized by excessive fear or apprehension about real or perceived threats, leading to altered behavior); and bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows). Record review of Resident #16's quarterly MDS assessment, dated 06/19/24, indicated Resident #16 was sometimes understood by others, would sometimes understand others, had severe cognitive impairment, did not have any behaviors and was antipsychotic medication was received on a routine basis. Record Review of Resident #16's care plan dated 06/10/24 revealed Resident #16 uses antipsychotic medication (Lurasidone) relating to bipolar disorder that included the interventions of Black Box Warning of increased mortality in elderly patients with dementia related to psychosis. To monitor/document/report adverse reactions antipsychotic therapy that includes stiff neck, confusion, muscle rigidity, involuntary movements, drooling, tremors, restlessness, sleep disturbance, dry mouth, blurred vision, constipation, and/or sedation as condition warrants and notify physician/psychiatric consultant. Record review of Resident #16's Physician's Orders, dated July 2024, revealed an order for Lurasidone (antipsychotic medication) 40 mg by mouth at bedtime related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, the order start date was for 06/08/24. Record review of Resident #16's Medication Administration Record, for July 2024 revealed Resident #16 received the antipsychotic medication lurasidone HCl 40 mg by mouth at bedtime from 07/01/24 through 07/23/24 related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review of the Gradual Dose Reduction Report dated June of 2024 revealed the Pharmacy Consultant made a recommendation to the facility that Resident #16 had an improper diagnosis of dementia for the Lurasidone . In an interview on 07/23/24 at 4:18 PM LVN A said the medication for Resident #16 was used for unspecified dementia. LVN A said she did not think the medication should be given for dementia. LVN A said the antipsychotic should be given for psychosis, schizophrenia, bipolar disorder or any mood disorder. LVN A said Resident #16 did have behaviors, but the medication should be administered to residents with psychosis, or another mood disorder. LVN A said if a resident did not have psychosis, or another mood disorder and he was given an antipsychotic it could cause an adverse effect. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/23/24 at 4:32 PM the ADON said Resident #16 was confused and was hallucinating. Resident #16 was on Zyprexa for yelling out, and calling for his spouse several times a night. Resident #16 had a diagnosis of bipolar. The ADON said dementia was not treated with antipsychotics. ADON said the diagnosis for the Lurasidone was not an appropriate diagnosis for the medication Lurasidone. The ADON said he would speak with the physician and ask if the diagnosis could be changed to be given for bipolar disorder. In an interview on 07/24/24 at 8:35 AM, Resident #16 said he did not know what medications he was taking. Resident #16 said the nurse came in and gave him his medications. Resident #16 said he was visually impaired and could not see the medications given to him. Resident #16 said that the nurse might have told him what the medications were for, but he did not remember what the names of the medications were. In an interview on 07/24/24 at 2:56 PM the Pharmacy Consultant said the psychiatrist uses the diagnosis of dementia for residents with behaviors. The Pharmacy Consultant said she was aware that state did not allow the diagnosis of dementia when prescribing antipsychotic medication. The Pharmacy Consultant said she would ask for a different diagnosis, but it is the doctor's decision to write the diagnosis on her recommendation letter. The Pharmacy Consultant said she would request a GDR as soon as possible. In an interview on 07/24/24 at 3:12 PM the DON verbalized she agreed that an antipsychotic was not an appropriate medication to be prescribed for the diagnosis of dementia. The DON said that if an antipsychotic was given to a resident without the appropriate diagnosis, they could experience adverse reactions that may be permanent. The DON said the resident was being given the medication for previous behaviors that were not reflected on the prescribed diagnosis for that medication. Record review of the facility policy Psychotropic Medication implemented 8/15/22 revealed: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). 49301