

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Windsor Nursing and Rehabilitation Center of Raymo		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 S Expressway 77 Raymondville, TX 78580	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737</p> <p>Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 3 Residents (Resident #2) reviewed for medical records accuracy, in that:</p> <p>Resident #2's April and May 2024 Treatment Administration Records documentation was incomplete. Staff did not document or sign off on the administration of physician ordered wound care.</p> <p>This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment.</p> <p>The findings included:</p> <p>1. Record review of Resident #2's face sheet, dated 06/13/24, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: pressure ulcer of sacral region, stage 4 (sores that extend below the subcutaneous fat into deep tissue, including muscle, tendons and ligaments), Alzheimer's disease, unspecified (progressive disease that destroys memory and other important mental functions), chronic kidney disease, unspecified (longstanding disease of the kidneys leading to renal failure), chronic diastolic (congestive) heart failure (when heart cant pump blood well enough to give your body normal supply and your left ventricle becomes stiffer than normal).</p> <p>Record review of Resident #2's state optional Minimum Data Set assessment, dated 04/05/24, revealed Resident #2 had a BIMS score of 03, indicating she was severely cognitively impaired.</p> <p>Record review of Resident #2's care plan, retrieved on 06/13/24 revealed Resident #2 had a focus of, [Resident #2] [has] a stage IV to sacrum r/t immobility with an initiation date of 01/05/24 and an intervention of Administer treatments as ordered and monitor for effectiveness. and Administer medications as ordered. Monitor/document for side effects and effectiveness. Both with an initiation date of 04/25/23.</p> <p>Record review of Resident #2's physician's orders, retrieved on 06/13/24, revealed orders for</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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. SilvaSorb External Gel (Silver) with directions to apply to sacrum topically every shift for wound care. Cleanse with NS, pat dry, apply silvasorb to wound bed, then pack with calcium alginate and cover with bordered dry dressing per NP wound care specialist. with a start date of 03/23/24 and end date of 04/22/24</p> <p>2. SilvaSorb External Gel (Silver) with directions to apply to sacrum topically every shift for wound care. Cleanse with NS, pat dry, apply silvasorb to wound bed, then pack with calcium alginate and cover with bordered dry dressing per NP wound care specialist. with a start date of 04/22/24 and end date of 05/10/24</p> <p>Record review of Resident #2's Treatment Administration Record for April and May 2024 revealed 3 unsigned sections on 04/04/24, 04/25/24 and 05/06/24 for the following physician orders:</p> <p>1. SilvaSorb External Gel (Silver) with directions to apply to sacrum topically every shift for wound care. Cleanse with NS, pat dry, apply silvasorb to wound bed, then pack with calcium alginate and cover with bordered dry dressing per NP wound care specialist, with a start date of 03/23/24 and end date of 04/22/24.</p> <p>2. SilvaSorb External Gel (Silver) with directions to apply to sacrum topically every shift for wound care. Cleanse with NS, pat dry, apply silvasorb to wound bed, then pack with calcium alginate and cover with bordered dry dressing per NP wound care specialist, with a start date of 04/22/24 and end date of 05/10/24.</p> <p>During a telephone interview with LVN A on 06/13/24 at 4:35pm she stated she worked with Resident #2 on 04/04/24 and 04/25/24 and stated she was responsible for signing her TAR on those days. She stated a blank on the TAR signified it was not done. LVN A stated she completed Resident #2's wound care on 04/04/23 and 04/25/24 and stated it should have been documented on the TAR and she did not know what to respond as to why she did not. LVN A stated treatment provided should be documented because it could look like it was not done. LVN A stated she had recently been trained over documentation of treatment provided by her DON and ADON. LVN A stated the facility policy stated if it was not documented it was not done and to document treatment provided. LVN A stated in this specific situation she had not followed the facility policy. LVN A was unable to answer how the resident charts were monitored to ensure accurate documentation and stated that would be a DON question because they monitored it. LVN A stated not completing documentation for treatment provided could negatively impact a resident because it showed that its not being done and if its actually was not being done then it could harm a resident.</p> <p>During a telephone interview with RN B on 06/13/24 at 5:15pm he stated he worked with Resident #2 on 05/06/24 and stated he was responsible for signing her TAR on 05/06/24. RN B stated a blank on the TAR signified that he had not checked it off. RN B stated he had done Resident #2's wound care on 05/06/24 and could not answer why it was not documented. RN B stated he should have documented on the TAR because it would show it was completed. RN B stated he was trained over documentation of treatment provided within the last 3 months by the DON and the ADON. RN B stated the facility policy stated to document anything that was completed. RN B stated the DON would review the resident charts to ensure accurate documentation was completed but did not know how often or when. RN B stated not completing documentation of treatment provided could negatively impact a resident because it might be duplicated if someone else were to do it.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and record review with the DON on 06/13/24 at 6:54pm she stated LVN A worked on 04/04/24 and 04/25/24 with Resident #2 and RN B worked with Resident #2 on 05/06/24. The DON stated LVN A and RN B were responsible for signing off on the TAR on the days they worked on 04/04/24, 04/25/24 and 05/06/24. The DON reviewed Resident #2's April and May TAR and confirmed blanks for Resident #2's physician ordered wound care on 04/04/24, 04/25/24 and 05/06/24. The DON stated a blank on the TAR meant it was not completed or was forgotten to be signed. The DON stated the TAR should have been documented. The DON stated treatment provided should be documented because it showed it was done. The DON stated LVN A and RN B told her they had completed the physician ordered wound care on the days they worked but did not document because they got carried away or forgot to press save. The DON stated LVN A and RN B had been trained and completed their annual skills competency over documentation of treatment provided. The DON stated the facility policy for treatment provided was to document to make sure its updated. The DON stated LVN A and RN B had not followed the facility's policy in this situation.</p> <p>The DON stated to ensure accurate documentation she used their online medical records software that would flag any documentation that was not completed and stated they had started to review the resident charts in the morning for any missed documented. The DON stated they were not doing this back in April or May (2024). The DON stated she could not say that not completing documentation of treatment provided would be detrimental because she did not know if it would have such impact.</p> <p>Record review of facility in-service dated 11/07/23 revealed the training covered documentation and was presented by the DON to staff, which included LVN A and RN B</p> <p>Record review of staff competency skills for RN B revealed a section titled, medication administration that included a sub section titled, documentation of administration that was evaluated on 01/08/24 and signed off by the DON.</p> <p>Record review of staff competency skills for LVN A revealed a section titled, medication administration that included a sub section titled, documentation of administration that was evaluated on 02/12/24 and signed off by the DON.</p> <p>Record review of facility policy titled, Documentation in Medical Record with an implementation date of 10/24/22 included verbiage that reflected, 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred and f. Sign each entry with name and credentials of the person making the entry.</p>		