STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675475	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Raymo	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)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on observation, interviews and record review the facility failed to have physician orders for the residents immediate care at time of admission for 1 of 4 residents (Resident #3) reviewed for physician admission orders. The facility failed to have physician orders in place for care/treatment/monitoring of Resident #3's colostomy. This deficient practice could place residents with a colostomy at risk in delay in treatment/care. The findings were: Record review of Resident #3's face sheet, dated 08/05/24, revealed a [AGE] year old male with an initial admitted [DATE] with diagnoses which included: encounter for surgical aftercare following surgery of the digestive system (organs that are important for digesting food and liquids), acquired absence of other specified parts of digestive tract (made up of organs that food/liquid travel through when they are swallowed, digested, absorbed and leave the body as feces), colostomy (surgery to create an opening for the colon through the belly) status, hemiplegia (paralysis of one side of body) and hemiparesis (one sided muscle weakness) following unspecified cerebrovascular disease (group of conditions that affect blood flow and the blood vessels in the brain) affecting left non-dominant side. Record review of Resident #3's optional state assessment minimum data set assessment (MDS), dated [DATE], revealed Resident #3 had a BIMS score of 10, indicating a moderate cognitive impairment. The MDS assessment reflected Resident #3 was total dependent with 1 person physical assist for toilet use (manages ostomy). Record review of Resident #3's care plan with an initiated date of 06/14/18 revealed a problem of, [Resident #3] was readmitted back to the facility with alteration in gastro-intestinal status r/t (related to) colostomy with an initiated date of 7/24/24. Resident #3's care plan had a goal of, The resident will remain free from discomfort, complications or s/sx (signs and symptoms) related to gastro-intestinal alterations through review date. with an initiated date of 7/24/24 and an intervention to Perform treatment/change in colostomy bag as ordered. Monitor/document BMs (bowel movements) with an initiated date of 7/30/24. (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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's hospital progress notes dated 07/22/24 revealed Resident #3 had an open sigmoid colectomy with end colostomy on 7/14/24. Record review of Resident #3's hospital discharge documents dated 07/24/24 included a section titled, Medication Instructions and did not include any verbiage regarding colostomy care/treatment or monitoring. Resident #3's hospital discharge documents did include a general education on colostomy care in Spanish and when translated stated the following: Summary o Routinely measure the stoma opening and record the size. Be alert to changes. o Empty the bag before sleeping, before physical activity or sexual intercourse, and always when it has been filled one third or up to half of its capacity. Do not let the bag become more than half full of feces or gas. o Replace the bag every 3 or 4 days or as often as directed by your doctor. Record review of Resident #3's initial nursing evaluation completed by LVN A and dated 07/24/24 revealed Resident #3 had a left side colostomy site located on the front left iliac crest. Record review of Resident #3's physician's orders dated 07/01/24 through 08/05/24, revealed no physician's orders for colostomy care/treatment/monitoring. Record review of Resident #3's July 2024 progress notes dated 7/24/24 to 07/31/24 revealed no documentation of colostomy care/treatment/monitoring provided. Record review of Resident #3's progress notes dated 07/24/24 at 21:55 (9:55pm) written by RN B stated [MD E] was made aware of medication orders from hospital. as per [MD E], continue medications as listed on [medical chart software]. During an observation and interview with the DON on 08/06/24 at 12:10 p.m. she confirmed Resident #3 had a colostomy in place. Observation of Resident #3 revealed a colostomy bag on his left lower abdomen that appeared intact with no redness noted, colostomy site and bag were clean and was not full, puffed or leaking any fecal matter or bodily fluids. During an interview with RN B on 08/05/24 at 9:43pm he stated he was not the admitting nurse and stated the admitting nurse was LVN A. RN B stated they helped each other out as far as admissions coming in and stated that was why his note was in Resident #3's chart. RN B stated LVN A did the full admission and stated to look at the initial nursing evaluation to see that it was completed by LVN A. During an interview on 08/06/24 at 11:55 a.m., Resident #3 stated he had a bag on his stomach that was being checked and cleaned in the morning and during the day by staff. Resident #3 stated the bag on his stomach was changed once a day and had not leaked. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 08/06/24 at 1:38pm with LVN A he stated he was the admitting nurse when Resident #3 returned to the facility on [DATE] and stated Resident #3 was admitted with a colostomy in place which was new for him. LVN A stated the nurse was responsible for getting an order and confirming the order with the MD and inputting the order. LVN A stated he notified the MD about Resident #3's colostomy and information he received from hospital but was unable to recall what the MD had said. LVN A stated he and the team working with him that day had split up the orders and stated he would do the assessments and someone else would input orders, however he did not recall who was assisting him with inputting orders and stated he did not recall inputting any orders for colostomy care/treatment/monitoring and had not put them in because he thought someone else had already put them in. LVN A stated orders for Resident #3's colostomy care/treatment/monitoring should have been input. LVN A stated 7/24/24 was the only day he worked with Resident #3 and was unable to detail how often Resident #3 received colostomy care/treatment/monitoring. LVN A stated he was unsure how staff would know how often to complete colostomy care/treatment/monitoring or change out Resident #3's colostomy bag without orders in his chart and stated it would be completed if saturated, dirty or if fecal matter was present. LVN A stated orders needed to be in place prior to providing a resident with care/treatment/services. LVN A was unsure if he followed the facility policy regarding needing physician orders in place to provide care/treatment/services to residents and was unsure what the facility policy stated. LVN A stated he had previously had hands on training with assistance from the nursing leadership and other nurses over inputting orders when residents were admitted to the facility. LVN A stated to ensure physician's orders had been appropriately documented the RNs, ADON and DON would go in and see what was on the order list. LVN A stated providing colostomy care/treatment/monitoring without physician's orders appropriately documented could negatively impact the resident because they might not get the most appropriate care. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 08/06/24 at 3:00pm. The DON stated she began working at the facility on 07/29/24 and was not present when Resident #3 was readmitted to the facility on [DATE]. The DON stated Resident #3 returned to the facility on [DATE] with a colostomy that was new to him. The DON had recently been hired and stated from what she learned the staff had been splitting their admissions by one nurse inputting the medication and the floor nurse doing the assessment and including any extra information such as wounds/colostomy. The DON stated at the end of the night LVN A was responsible for doing the assessment and inputting the colostomy order. The DON confirmed there were not any colostomy care/treatment/monitoring orders in place and had not been put in place until 08/06/24 when she reviewed the record after Surveyor F notified her. The DON stated the orders for colostomy care/treatment/monitoring should have been input and needed to be in place prior to providing a resident with care/treatment services related to a colostomy. The DON stated she did not know why they were not inputted and stated she thought it was due to oversight from the nurse. The DON stated Resident #3's colostomy was being monitored, checked, cleaned and cared for with bag changes and could tell because when it was a new bag it looked clean and stated the bag was being emptied every time he ate because it would get full of air. The DON stated Resident #3 was receiving colostomy care at least every shift and stated the bag was being changed weekly and as needed if it came undone. The DON stated that although there weren't orders in Resident #3's chart the nurses on the floor were veteran nurses and knew when to change and how to follow through with the colostomy. She stated every time Resident #3 got a brief change, they would check the colostomy and would make sure his bag was secure and checked for leaks when he was bathed. The DON stated LVN A and nursing staff in general were oriented upon hire over inputting orders. The DON stated they did not have a general or specific policy for inputting physician orders for colostomy care/treatment/monitoring. The DON stated the ADON and DON would complete an audit to ensure that orders were in place and would try to review the orders as soon as a patient came in and if they arrived at night then they would review orders and pending orders the next day. The DON stated Resident #3 had been receiving his colostomy care but stated providing colostomy care/treatment/monitoring without physician's orders appropriately documented could negatively impact the resident because they could miss their colostomy care. Record review of LVN A's annual check off revealed he had been checked off for inputting order information in software on 04/09/24 by the previous director of nursing, DON D. During an interview with the DON on 08/06/24 at 4:58pm she stated they did not have a general or specific policy for physician's orders needed to provide care/treatment/services.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on observation, 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 4 Residents (Resident #3) reviewed for medical records accuracy, in that: Resident #3's skin assessment documentation was incomplete. Staff did not document Resident #3's surgical incision. 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. The findings included: Record review of Resident #3's face sheet, dated 08/05/24, revealed a [AGE] year old male with an initial admitted [DATE] with diagnoses which included: encounter for surgical aftercare following surgery of the digestive system (organs that are important for digesting food and liquids), acquired absence of other specified parts of digestive tract (made up of organs that food/liquid travel through when they are swallowed, digested, absorbed and leave the body as feces), colostomy (surgery to create an opening for the colon through the belly) status, hemiplegia (paralysis of one side of body) and hemiparesis (one sided muscle weakness) following unspecified cerebrovascular disease (group of conditions that affect blood flow and the blood vessels in the brain) affecting left non-dominant side. Record review of Resident #3's optional state assessment minimum data set assessment (MDS), dated [DATE], revealed Resident #3 had a BIMS score of 10, indicating a moderate cognitive impairment. The MDS assessment reflected Resident #3 was total dependent with 1 person physical assist for toilet use (manages ostomy). Record review of Resident #3's care plan with an initiated date of 06/14/18 revealed a problem of, [Resident #3] was admitted with an abdominal incision. r/t (related to) Recent surgery. with an initiated date of 7/30/24. Resident #3's care plan had a goal of, The resident's surgical incision will be healed by review date. with an initiated date of 7/24/24 and an intervention to Monitor/document location, size and treatment of skin tear. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD with an initiation date of 7/30/24. Record review of Resident #3's hospital progress note dated 07/22/24 revealed Resident #3 underwent an Ex-lap (exploratory laparotomy) and had midline closed with staples on 7/14/24. Record review of Resident #3's initial nursing evaluation completed by LVN A and dated 07/24/24 revealed Resident #3 had 21 staples down middle of his abdomen from top to bottom measuring 27CM long. During an observation on 08/06/24 at 12:10pm. Revealed Resident #3 was noted with a long, clean intact piece of gauze over midline of his abdomen from below his chest to lower his abdomen. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review and interview with LVN C, she reviewed Resident #3's weekly wound progress dated 7/26/24 and Resident #3's weekly skin evaluations dated 7/26/24 and 08/01/24 that were completed by LVN C and confirmed she did not include documentation of Resident #3's surgical incision and stated surgical incisions should be documented. During an interview with LVN C on 08/06/24 at 3:53pm she stated she was responsible for completing Resident #3's skin assessments on 7/26/24 and 08/01/24. LVN C stated when Resident #3 returned to the facility on [DATE] he did have a new surgical incision to his abdomen. LVN C stated she had written down documentation about the surgical incision to Resident #3's abdomen in her journal but did not document it on his skin assessment and stated she did know why she didn't document it and stated she had just missed it. LVN C stated it was important to complete an accurate skin assessment because that was something they monitored, and changes could be noted at any moment such as showing signs of an infection from one day to the next. LVN C stated the facility policy regarding what should be included in a skin assessment/evaluation stated everything that had to do with skin such as skin tears, bruises, and surgical incisions had to be documented. LVN C stated she did not follow the facility policy in this situation. LVN C stated she had been trained at a sister facility with another wound care nurse on 07/01/24 and 07/02/24 and stated she had some in services over documenting complete and accurate skin assessment but could not recall when. LVN C stated she did not know if anyone did or did not monitor and reviewed her skin assessments for accuracy and completion. LVN C stated not documenting accurate and complete skin assessment could negatively impact residents because if no one was monitoring the wounds they could all of a sudden develop an infection and end up in the hospital or worse and die. During an interview with the DON on 08/06/24 at 3:00pm the DON stated LVN C was the treatment nurse and was responsible for completing skin assessments. The DON reviewed Resident #3's skin assessments from 07/26/24 and 08/01/24 that were completed by LVN C and confirmed there was no documentation regarding Resident #3's surgical incision to his abdomen. The DON stated she did not know why the documentation was missed and stated it should be included because a skin assessment should notate anything abnormal. The DON stated it was important to complete an accurate skin assessment so you could see the progress of any wounds. The DON stated she was not previously working at this facility and was unable to say if LVN C had been trained over completing accurate skin assessments, however she did state they had already in serviced LVN C as of 08/06/24. The DON stated monitoring and overseeing the skin assessments for completion and accuracy would fall with the ADON and DON and stated she would be coordinating a specific day of the week to review skin. The DON stated not completing accurate and complete documentation could negatively impact the resident because if staff did not document they could forget what they saw and then won't be able to see what the skin looked like previously. Record review of the facility policy titled, Documentation in Medical Record with an implementation date of 10/24/22 included a section titled, Policy Explanation and Compliance Guideline, that included the following verbiage, 2. Principles of documentation include, but are not limited to: .b. Documentation shall be accurate, relevant and complete, containing sufficient details about the residents care and/or responses to care. Record review of LVN C certifications revealed a certification of completion for, Online Skin, Wound and Ostomy Certification Course completed from 10/05/21-10/07/21.