STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676125	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Atrium	1814 Atrium Place Harlingen, TX 78550

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32107 47828 Based on interview and record review the facility failed to ensure the resident had the right to be free from neglect, for one of four residents (Resident #250) reviewed for neglect: CNA C stated she was aware Resident #250 required 2-person assistance with a bed bath but proceeded to give care to the resident alone resulting in the resident falling and fracturing her left femur. The non-compliance for Resident #250 was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 03/15/2024 and ended on 03/15/2024. The facility corrected the non-compliance before the investigation began. This failure could place residents at risk of neglect resulting in serious injuries, harm, impairment, or death. The findings were: Record review of Resident #250's face sheet dated 06/11/2024 reflected a [AGE] year-old female with an admitted [DATE] and an initial admitted [DATE]. Resident #250 had a discharge date of [DATE]. Resident #250's relevant diagnoses included dementia (memory loss), muscle weakness, contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of left and right knee, lack of coordination, pain to left and right knee, and chronic obstructive pulmonary disease (restricted airflow and breathing problems). Record review of Resident #250's quarterly MDS assessment dated [DATE] reflected a BIMS score 09, which indicated Resident #250's cognition was moderately impaired. Resident #250's functional abilities for shower/bathe was substantial/maximal assist (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) Record review of Resident #250's quarterly Care Plan assessment dated [DATE] revealed an ADL problem Resident #250 has an ADL self-care performance deficit r/t confusion, dementia. Date initiated 12/08/2017 and revised on 08/03/23. ADL interventions, BATHING/SHOWERING: The resident is totally dependent on (2) staff to provide (shower)(M-W-F) and as necessary. Date Initiated: 12/08/2017, Revision on: 08/27/2021. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #250's x-ray report dated 03/15/2024 reflected she had a displaced comminuted slightly overlapped distal left femoral metaphyseal fracture. Fracture was documented on the change of condition. In an interview on 06/12/2024 at 1:35 p.m., CNA C said she had been employed by the facility for 3 years prior to being terminated on 03/15/2024. CNA C said she received training in ADL's when she first got hired and annually. She said she knew where to check to see if a resident was a 1 or 2 person assist when it came to ADL's. CNA C said she would either check the resident's POC or ask the charge nurse. CNA C said she knew Resident #250 was a 2 person-assist for bathing but still decided to bed bathe her by herself on 03/15/2024. She said 03/15/2024 was not the first time she bed bathed Resident #250 by herself. CNA C said the other times, Resident #250 had longer rails and said it was easier. CNA C said on 03/15/2024, Resident #250 had shorter rails. She said she was not sure when the rails were changed. CNA C said on 03/15/2024, while bed bathing Resident #250 she turned her to the side to wash her back and her legs slipped off the bed. CNA C said she tried to grab her, but Resident #250 was wet and slippery and not able to hold on to her. CNA C said resident fell to the floor. CNA C said immediately pressed the call light and started yelling for help. She said she rushed over to where Resident #250 landed and stayed with her until a nurse arrived. CNA C said her charge nurse responded quickly and Resident #250 was assessed. She said once her charge nurse assessed Resident #250, she stepped out of the room. CNA C said she was told Resident #250 was taken the local hospital to be evaluated because she sustained a bump to her face and a scrape to her back. CNA C said she was removed from the floor and later that day was terminated. CNA C the facility was fully staffed, and she was trained to follow the residents care plan. CNA C said she took sole responsibility and knew she did wrong by bathing Resident #250 by herself. CNA C said she thought it would be easy to give Resident #250 a bed bath by herself because she had done it before. CNA C said if she had followed Resident #250's care plan, it could have prevented the fall. An interview on 06/12/2024 at 2:37 p.m., LVN H said Resident #250 was a 2 person-assist for bathing. She said she was the charge nurse for Resident #250 on 03/15/2024. LVN H said she was tending to a resident across from Resident #250's room when she was told by a CNA (does not remember name) Resident #250 had fallen. She said she immediately went to Resident #250's room and found her on the floor. LVN H said Resident #250 was wet and unclothed. She said she noticed Resident #250 had discoloration to her forehead, but her vitals were within range. LVN H said she called Resident #250's doctor who ordered for her to be sent to local hospital for evaluation. LVN H said she asked CNA C to explain what had happened. She said CNA C told her Resident #250 slipped when she tried to turn her sideways to wash her back. She said she immediately removed CNA C from the floor and advised the DON and the Administrator. An interview on 06/12/2024 at 3:37 p.m., the DON said on 03/15/2024, she was informed by LVN H Resident #250 had fallen. She said she immediately started an investigation, and it was concluded CNA C did not follow Resident #250's care plan and bed bathed her alone. The DON said Resident #250 was sent to the hospital because she sustained a deformity on her head and complained of pain. The DON said she immediately pulled CNA C to the side and questioned her as to what happened. The DON said CNA C admitted to knowing Resident #250 was a 2 person assist for showers/baths and took full responsibility. The DON said she sent CNA C home after the incident on 03/15/2024 and upon completing her investigation, CNA C was terminated on same day. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 06/12/2024 at 4:00 p.m., the Administrator said CNA C did not follow Resident #250's care plan which required a 2 person assist for bathing. He said after their investigation, CNA C was terminated on 03/15/2024. He said other CNA's were in-serviced on the following topics: ANE, CNA's to follow care tasks to assist resident according to always care plan and transfers and repositioning. Record review of facility's policy on Abuse, Neglect, and Exploitation dated 08/15/22 reflected: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Policy Explanation and Compliance Guidelines: 3. The facility will provide ongoing oversight and supervision of staff in order to assure that it's policies are implemented as written. The Administrator was notified on 06/26/2024 at 4:45 p.m., that a past non-compliance IJ situation had been identified due to the above failures. It was determined these failures placed Residents #250 in an IJ situation on 03/15/2024. The facility implemented the following interventions: Record review of CNA C Employee Counseling Report, dated, 03/15/2024 reflected she received a level two offense for failure or unwillingness to perform work as required or directed .failing to meet job expectation . failure to comply with safety guideline(s) as outlined in the Employee Guide and Safety. The Incident description indicated failure to follow plan of care per acre task when providing care to resident. Resident had a fall with injury. Record review of CNA's Personnel Action Form dated 03/15/2024 reflected she was terminated. Under manager's comment a note reflected failure to follow proper care plan for care. Employee included in self-report for injury to a resident. CNA's were in-serviced on 03/15/2024 after the incident on CNA's to follow care task to assist resident according to care plan at all times and transfers and repositioning. An observation on 06/27/2024 at 9:10 a.m. Resident #13 was observed during his bed bath and no discrepancies were observed. An observation on 06/27/2024 at 9:45 a.m. Resident #62 was observed during his bed bath and no discrepancies were observed. An interview on 06/12/2024 at 2:15 p.m., CNA E said she received training on ADL's when she was first hired and annually after. She said she knew to check resident's POC and/or ask her charge nurse to see if a resident was a 1 or 2 person assist for their ADL's. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 06/12/2024 at 2:30 p.m., CNA F said she received training on ADL's when she was first hired and annually after. She said she knew to check resident's POC and/or ask her charge nurse to see if a resident was a 1 or 2 person assist for their ADL's.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40872 Based on interviews and record reviews, the facility failed to ensure all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessments for 1 of 3 residents reviewed for PASARR. The facility failed to ensure Resident #33 had an accurate PASARR Level 1 Screening which indicated a diagnosis of mental illness on 12/12/23. This failure could place residents at risk of not receiving specialized services that would enhance their highest level of functioning. The findings were: Record review of Resident #33's Admission Record dated 06/12/24 reflected a [AGE] year-old male with a re-admitted [DATE]. Resident #33 had diagnoses which included Depression (persistent feeling of sadness and loss of interest), Schizoaffective Disorder Bipolar Type (type of schizophrenia, hallucinations and delusions), Post-Traumatic Stress Disorder, Unspecified (disorder developed after experiencing a scary or dangerous event). Record review of Resident #33's PASARR Level 1 Screening dated 12/08/23 reflected Section C C0100. Mental Illness . Is there evidence or an indicator this is an individual that has a Mental Illness? Answer: 0, (0 indicated the answer was No). In an interview on 6/13/24 at 5:00 pm, MDS T said he was assigned to Resident #33 to conduct his assessments. He reviewed Resident #33's diagnoses and stated Resident #33 had a Mental Illness diagnosis. He said he did not know why it was not reviewed when the PASARR Level 1 Screening was completed. In an interview on 6/13/24 at 5:05 pm MDS R said when a Resident was admitted to their facility, they reviewed medical history along with their diagnoses. She said if a Resident had a diagnoses of Mental Illness or Intellectual Disability, they were referred to the Local Mental Health Authority for assessment to determine if they qualified for services or other placement. She said Resident #33's PASARR Level 1 Screening should have indicated mental illness. And he should have been assessed by LMHA for determination of services or other placement. MDS R said they should have caught this error and they would submit a corrected form to indicate mental illness for Resident #33 so he could be properly evaluated by LMHA. MDS R said this error could possibly prevent Resident #33 from receiving services he might need through LMHA. In an interview on 6/13/24 at 7:14 pm the DON said MDS department was in charge of PASARR's. She said if a PASARR was triggered for mental illness or intellectual disability they should be referred to LMHA so they could see if they were eligible for services through them, if this didn't happen then the resident may be missing out on services that they may need. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/13/24 at 7:30 pm the Administrator said they did not have a policy for PASARR's, he said they used the state regulations as reference.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on interviews, and record reviews the facility failed to ensure that the residents environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Residents #250) reviewed for accidents hazards and supervision. The facility failed to ensure Resident #250 was assisted by two care providers during a bed bath which resulted in her rolling out of bed onto the floor and sustaining a left femoral fracture. This failure could place residents at risk of accidents and injury. The non-compliance for Resident #250 was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 03/15/2024 and ended on 03/15/2024. The facility corrected the non-compliance before the investigation began. This failure could place residents at risk of neglect resulting in serious injuries, harm, impairment, or death. The findings include: Record review of Resident #250's face sheet dated 06/11/2024 reflected a [AGE] year-old female with an admitted [DATE] and an initial admitted [DATE]. Resident #250's relevant diagnoses included dementia (memory loss), muscle weakness, contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of left and right knee, lack of coordination, pain to left and right knee, and chronic obstructive pulmonary disease (restricted airflow and breathing problems). Record review of Resident #250's quarterly MDS assessment dated [DATE] reflected a BIMS score 09, which indicated Resident #250's cognition was moderately impaired. Resident #250's functional abilities for shower/bathe was substantial/maximal assist (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) Record review of Resident #250's quarterly Care Plan assessment dated [DATE] reflected an ADL problem Resident #250 has an ADL self-care performance deficit r/t confusion, dementia. Date initiated 12/08/2017 and revised on 08/03/23. ADL goal was Resident #250 will maintain current level of function through the review date. Date initiated: 12/08/2017 and revision date on: 03/15/2024. ADL interventions, functional performance: shower/bathe self: the resident requires substantial/maximal assistance for shower/bathe. Date initiated: 12/14/2023 and revised on 03/15/2024.Bathing/Showering: the resident is totally dependent on (2) staff to provide (shower) (M-W-F) and as necessary. Date initiated: 12/08/20217 and revised on: 08/27/2021. Record review of Resident #250's x-ray report dated 03/15/2024 reflected she had a displaced comminuted slightly overlapped distal left femoral metaphyseal fracture. Fracture was documented on the change of condition. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/12/2024 at 1:35 p.m., CNA C said she had been employed by the facility for 3 years prior to being terminated on 03/15/2024. CNA C said she received training in ADL's when she first got hired and annually. She said she knew where to check to see if a resident was a 1 or 2 person assist when it came to ADL's. CNA C said she would either check the resident's POC or ask the charge nurse. CNA C said she knew Resident #250 was a 2 person-assist for bathing but still decided to bed bathe her by herself on 03/15/2024. She said 03/15/2024 was not the first time she bed bathed Resident #250 by herself. CNA C said the other times, Resident #250 had longer rails and said it was easier. CNA C said on 03/15/2024, Resident #250 had shorter rails. She said she was not sure when the rails were changed. CNA C said on 03/15/2024, while bed bathing Resident #250 she turned her to the side to wash her back and her legs slipped off the bed. CNA C said she tried to grab her, but Resident #250 was wet and slippery and not able to hold on to her. CNA C said resident fell to the floor. CNA C said immediately pressed the call light and started yelling for help. She said she rushed over to where Resident #250 landed and stayed with her until a nurse arrived. CNA C said her charge nurse responded quickly and Resident #250 was assessed. She said once her charge nurse assessed Resident #250, she stepped out of the room. CNA C said she was told Resident #250 was taken the local hospital to be evaluated because she sustained a bump to her face and a scrape to her back. CNA C said she was removed from the floor and later that day was terminated. CNA C the facility was fully staffed, and she was trained to follow the residents care plan. CNA C said she took sole responsibility and knew she did wrong by bathing Resident #250 by herself. CNA C said she thought it would be easy to give Resident #250 a bed bath by herself because she had done it before. CNA C said if she had followed Resident #250's care plan, it could have prevented the fall. An interview on 06/12/2024 at 2:37 p.m., LVN H said Resident #250 was a 2 person-assist for bathing. She said she was the charge nurse for Resident #250 on 03/15/2024. LVN H said she was tending to a resident across from Resident #250's room when she was told by a CNA (does not remember name) Resident #250 had fallen. She said she immediately went to Resident #250's room and found her on the floor. LVN H said Resident #250 was wet and unclothed. She said she noticed Resident #250 had discoloration to her forehead, but her vitals were within range. LVN H said she called Resident #250's doctor who ordered for her to be sent to local hospital for evaluation. LVN H said she asked CNA C to explain what had happened. She said CNA C told her Resident #250 slipped when she tried to turn her sideways to wash her back. She said she immediately removed CNA C from the floor and advised the DON and the Administrator. An interview on 06/12/2024 at 3:37 p.m., the DON said on 03/15/2024, she was informed by LVN H Resident #250 had fallen. She said she immediately started an investigation, and it was concluded CNA C did not follow Resident #250's care plan and bed bathed her alone. The DON said Resident #250 was sent to the hospital because she sustained a deformity on her head and complained of pain. The DON said she immediately pulled CNA C to the side and questioned her as to what happened. The DON said CNA C admitted to knowing Resident #250 was a 2 person assist for showers/baths and took full responsibility. The DON said she sent CNA C home after the incident on 03/15/2024 and upon completing her investigation, CNA C was terminated on same day. An interview on 06/12/2024 at 4:00 p.m., the Administrator said CNA C did not follow Resident #250's care plan which required a 2 person assist for bathing. He said after their investigation, CNA C was terminated on 03/15/2024. He said other CNA's were in-serviced on the following topics: ANE, CNA's to follow care tasks to assist resident according to always care plan and transfers and repositioning. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Facility's policy on Quality of Care revised on 08/20212 reflected: Each resident will receive the necessary nursing, medical, and psychosocial services to attain and maintain the highest possible mental and physical functional status as defined by the comprehensive assessment and plan of care . These nursing, medical and psychosocial needs will be identified in the Resident Assessment, and addressed in the Comprehensive Care Plan and the Medical Record to reflect that the interventions in the following clinical situations were maintained. The Administrator was notified on 06/26/2024 at 4:45 p.m., that a past non-compliance IJ situation had been identified due to the above failures. It was determined these failures placed Residents #250 in an IJ situation on 03/15/2024. The facility implemented the following interventions: Record review of CNA C Employee Counseling Report, dated, 03/15/2024 reflected she received a level two offense for failure or unwillingness to perform work as required or directed .failing to meet job expectation . failure to comply with safety guideline(s) as outlined in the Employee Guide and Safety. The Incident description indicated failure to follow plan of care per acre task when providing care to resident. Resident had a fall with injury. Record review of CNA's Personnel Action Form dated 03/15/2024 reflected she was terminated. Under manager's comment a note reflected failure to follow proper care plan for care. Employee included in self-report for injury to a resident. An interview on 06/12/2024 at 2:15 p.m., CNA E said she received training on ADL's when she was first hired and annually after. She said she knew to check resident's POC and/or ask her charge nurse to see if a resident was a 1 or 2 person assist for their ADL's. An interview on 06/12/2024 at 2:30 p.m., CNA F said she received training on ADL's when she was first hired and annually after. She said she knew to check resident's POC and/or ask her charge nurse to see if a resident was a 1 or 2 person assist for their ADL's. CNA's were in-serviced on 03/15/2024 after the incident on CNA's to follow care task to assist resident according to care plan at all times and transfers and repositioning. An observation on 06/27/2024 at 9:10 a.m. Resident #13 was observed during his bed bath and no discrepancies were observed. An observation on 06/27/2024 at 9:45 a.m. Resident #62 was observed during his bed bath and no discrepancies were observed.