

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Windsor Atrium		STREET ADDRESS, CITY, STATE, ZIP CODE 1814 Atrium Place Harlingen, TX 78550	

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 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>26141</p> <p>Based on observation and interview, the facility failed to ensure that the residents' right to review survey results were readily accessible to residents, family members and legal representatives of residents. For 1 of 1 survey books.</p> <p>The facility failed to make the results of the survey readily accessible for examination to residents and failed to post a notice of availability of the survey results.</p> <p>This failure could prevent residents from exercising their rights to view the survey results and the plan of correction.</p> <p>The findings were:</p> <p>In a confidential interview on 06/11/24 at 2:00 PM, six Confidential Interviewees said that they were not aware of the location of the results of Federal or State surveys and were not aware of their right to review the results of the surveys.</p> <p>Observation on 06/12/24 at 10:00 AM of the reception area and on top of and inside the bureau revealed there was no surveyor binder. Further observation of the facility revealed there was no posted notice of the location for the survey binder.</p> <p>In an interview on 06/12/24 at 10:03 AM Receptionist said the Survey Binder was in the bureau. Receptionist B opened the second drawer of her desk and took out several binders but could not find the binder. Receptionist B said the Administrator would know the location of the binder.</p> <p>In an interview on 06/12/24 at 10:12 AM the Administrator said he had the survey binder in his office because they had just purchased new furniture and painted the walls in the reception area. The Administrator provided the survey binder for Surveyor's review.</p> <p>Observation on 06/13/24 at 8:48 AM revealed there still was not a sign for the location of the survey binder posted in the reception area.</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 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/13/24 at 6:33 PM the Administrator said they were remodeling so everything was taken out. The maintenance director took off the shelf that was holding the Survey Binder. He took off the screws and that was the reason why the Survey binder was in his office. The Administrator said he would have the maintenance director put up the shelf today and he would put the Survey Binder on the shelf today.</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32107</p> <p>47828</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>This failure could place residents at risk of neglect resulting in serious injuries, harm, impairment, or death.</p> <p>The findings were:</p> <p>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).</p> <p>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)</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of facility's policy on Abuse, Neglect, and Exploitation dated 08/15/22 reflected:</p> <p>Policy:</p> <p>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.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>3. The facility will provide ongoing oversight and supervision of staff in order to assure that it's policies are implemented as written.</p> <p>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.</p> <p>It was determined these failures placed Residents #250 in an IJ situation on 03/15/2024.</p> <p>The facility implemented the following interventions:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>An observation on 06/27/2024 at 9:10 a.m. Resident #13 was observed during his bed bath and no discrepancies were observed.</p> <p>An observation on 06/27/2024 at 9:45 a.m. Resident #62 was observed during his bed bath and no discrepancies were observed.</p> <p>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.</p> <p>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.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40872</p> <p>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.</p> <p>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.</p> <p>This failure could place residents at risk of not receiving specialized services that would enhance their highest level of functioning.</p> <p>The findings were:</p> <p>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).</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278</p> <p>Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs and describes the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (Resident #31), reviewed for care plans.</p> <p>The facility failed to develop a comprehensive person-centered care plan for Resident #31 addressing fall mat.</p> <p>These failures could affect residents by placing them at risk of not receiving the care and services for health promotion and continuity of care.</p> <p>The findings included:</p> <p>Record review of Resident #31's electronic facility face sheet, dated 9/19/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #31 had diagnoses which included Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), muscle weakness, muscle wasting and atrophy, unsteadiness on feet, and chronic obstructive pulmonary disease (a chronic lung disease that causes air flow limitation).</p> <p>Record review of Resident #31's quarterly MDS assessment, dated 04/18/24, reflected he scored a 04 on his BIMS, which indicated he was severely cognitively impaired.</p> <p>Record review of Resident #31's care plan, dated 5/06/24, did not address a reflected a fall mat.</p> <p>During an observation on 6/12/24 at 2:58 PM revealed Resident #31 was lying down asleep in her bed. A fall mat was on the left side and the side rail was up on the right side.</p> <p>In an interview on 6/13/24 at 4:50 PM, the DON stated Resident #31 had a fall mat in her room as a fall intervention. She was the one that initiated the care planning. She stated she did not initiate the fall mat in the care plan because she had just started working at the facility. Resident #31 already had the floor mat in her room when she came on board. The resident already had the fall mats. The DON stated she did not know who initiated that for Resident #31. She was responsible for the fall system, meaning she controlled what interventions were put into place immediately. She stated it was important for the fall mat to be care planned because that was what they used to follow on how they cared for a resident. The DON stated the negative outcome of not being in the care plan was that the staff was not going to follow through with it .</p> <p>In an interview on 6/13/24 at 5:50 PM, MDS A stated Resident #31's fall mat was not care planned. She stated if a resident had an acute change, then it should be the nurse who did the care planning.</p> <p>Record review of facility's policy on Quality of Care revised on 08/12 reflected:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 .</p> <p>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.</p> <p>Record review of the facility's Comprehensive Care Plans Policy, dated 10/24/2022, reflected the following:</p> <p>It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment.</p> <p>Policy Explanation and Compliance Guidelines .: #3 (a) The services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. #6 .Alternative interventions will be documented, as needed, #8 . Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives grooming and personal care for 1 of 4 residents (#57) reviewed for ADL care.</p> <p>The facility failed to ensure Residents #57 was provided assistance with nail care.</p> <p>These failures could place residents at risk of scratches, infection, and loss of self-esteem.</p> <p>Findings included:</p> <p>Record review of the Face Sheet for Resident #57 dated 6/13/2024 reflected she was a [AGE] year-old female admitted to the facility on [DATE] and has the following diagnosis information Type 2 diabetes mellitus, hepatic failure, dysphagia, abnormalities of gait and mobility, lack of coordination, muscle wasting and atrophy, contracture of left hand, and need for assistance with personal care.</p> <p>Record review of the Quarterly MDS for Resident #57 dated 05/28/2024 reflected she had a BIMS score of 8 indicating moderate cognitive impairment. Her functional abilities and goals reflected she required supervision or touching assistance for personal hygiene.</p> <p>Record review of the Care Plan for Resident #57 dated 04/18/2024 reflected she had an ADL self-care performance deficit related to limited mobility. Goal: The resident will improve current level of function in bed mobility/transfer task through the target date:</p> <p>08/28/2024. Interventions for Personal Hygiene: The resident requires (assistance) by (X1) staff with personal hygiene and oral care.</p> <p>Record review of Nurses Follow Up document provided dated 6/9 (no year) revealed a note written above Resident #57's room number that said, NO nail care needed. No other documentation provided to indicate name of staff or time completed.</p> <p>Record review of Nurses Follow Up document provided dated 6/2/24 revealed a note written to right of Resident #57's room number that said, Nails cut. No other documentation provided to indicate name of staff or time completed.</p> <p>Observation and interview on 06/12/2024 at 3:24 PM of Resident #57 revealed she had long, pointy, and dirty fingernails. A couple of her fingernails had red nail polish grown out to the tips of her fingernails. Her fingernails were approximately 1/2 inch past her fingertips on both hands. She said that she was supposed to get her nails cut today, but that she was not sure why the staff have not done yet. She said that she was supposed to get her nails done at the beauty salon around 2 weeks ago, but she is not sure why it was not done. She said that she likes to have her nails short to prevent from scratching herself. Resident #57 observed using her right hand to lift her left arm above blanket to show her nails due to hemiplegia to her left side.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/12/2024 at 3:45 PM CNA N said that usually the CNA's will clean the nails, and the Podiatrist will clip due to the Resident is a diabetic. She said the CNAs clean and wash the nails for the Resident when it's their shower/bath time. She said that she is not sure who paints the Resident's fingernails.</p> <p>In an interview on 06/12/2024 at 3:52 pm CNA O said she has been working at the Facility on and off for [AGE] years. She said that the CNAs are responsible for cleaning and washing the Resident's nails. She said they do not clip the Resident's nails due to resident is a diabetic. She said she knows that sometimes the resident goes to beauty shop to get her nails done. She said beauty shop visits go by appointments. The CNA said today is the Resident's bed bath day and it is done in the PMs. She said they will clean and wash her nails during her bath.</p> <p>In an interview on 6/12/24 at 3:58 pm LVN P who was the charge nurse for the floor that day said that the Resident must get her toenails clipped by the podiatrist due to being diabetic. He said that the Podiatrist comes every month or so to clip resident's nails. He said he is the nurse who coordinated the podiatrist rounds and the last time he came was May 17, 2024. The LVN P said that any of the nurses can clip the fingernails for a resident at any time. LVN P could not provide negative effects of resident not getting her fingernails clipped because he said that he was very nervous. He said, I've got nothing. He said that he was very nervous.</p> <p>Observation on 06/12/2024 at 04:29 PM of Resident #57's fingernails which revealed they were cut to both hands.</p> <p>In an interview on 6/12/24 at 4:35 pm LVN Q said she that she had clipped the resident's fingernails. She said Resident #57's fingernails were, not very long, very minimum, less than an inch long and showed me the length of her fingernails and said, like this. LVN Qs fingernails observed clean and shorter in length than Resident # 57's fingernails were observed by this surveyor. LVN Q said that resident's get their fingernails clipped every Sunday at any time by any nurse available. LVN Q said that she did not work last Sunday and was unable to show me a progress note or other documentation that showed resident having her nails trimmed or refusal to trim nails this past Sunday. LVN P and DON could not find an entry for the last time resident had her nails trimmed. Asked DON for policy on ADLs/nail care/trim.</p> <p>Record review of the progress notes on the facility's point click care system, revealed the following notes:</p> <p>6/12/2024 16:46 ACTIVITIES - Activity Note</p> <p>Note Text: AD and Beautician asked Resident #57 if she would like to receive beautician services today and Resident #57 refused the services. Beautician asked if she would like to be put on the schedule for next week and Resident #57 said yes. AD will put Resident # 57 on the beautician list for next Wednesday.</p> <p>6/12/2024 16:23 NURSING - Nurse Note</p> <p>Note Text: trimmed, filed, and cleaned resident's fingernails, resident tolerated well.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Windsor Atrium		STREET ADDRESS, CITY, STATE, ZIP CODE 1814 Atrium Place Harlingen, TX 78550	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/13/24 at 3:37 pm DON said that Resident #57's fingernails should be clipped every Sunday by the floor nurse because the resident is a diabetic. Non-diabetic Resident's nails are trimmed by the CNAs. She said that they do not have any specific written protocols for staff to follow regarding frequency of nail care. She said that staff are made aware of when residents require nail care by referencing a binder at the Nurse's station. She said the binder is for long term care residents. The DON said that the nurses know to look through the binder, so they know who requires care. She said that the binder has a section for non-diabetic residents and for diabetic residents in the long-term care hallways. She said that the logs for short-term care resident's is in the shower binder for CNAs. She said that one way she helps remind staff regarding nail care is through group texts. She will send a group text to staff to remind them today is nail care day. She said they also educate new staff come in. She said the negative effects of not cleaning and/or clipping Resident #57's nails is that it could cause the resident to scratch herself, causing an open wound and possible infection. The DON said that she thinks Resident #57 could cause that injury even if they clip her nails.</p> <p>Record review of the facility Activities of Daily Living (ADLs) Policy date implemented 5/26/23 reflected Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.</p> <p>Care and services will be provided for the following activities of daily living:</p> <ol style="list-style-type: none"> 1. Bathing, dressing, grooming and oral care. <p>and</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> 2. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 6. Documentation shall be completed at the time of service, but no later than the shift in which care service occurred. 		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828</p> <p>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.</p> <p>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.</p> <p>This failure could place residents at risk of accidents and injury.</p> <p>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.</p> <p>This failure could place residents at risk of neglect resulting in serious injuries, harm, impairment, or death.</p> <p>The findings include:</p> <p>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).</p> <p>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)</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Facility's policy on Quality of Care revised on 08/20212 reflected:</p> <p>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 .</p> <p>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.</p> <p>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.</p> <p>It was determined these failures placed Residents #250 in an IJ situation on 03/15/2024.</p> <p>The facility implemented the following interventions:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>An observation on 06/27/2024 at 9:10 a.m. Resident #13 was observed during his bed bath and no discrepancies were observed.</p> <p>An observation on 06/27/2024 at 9:45 a.m. Resident #62 was observed during his bed bath and no discrepancies were observed.</p>		