STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676264	A. Building B. Wing	04/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winchester Lodge Healthcare Center	1112 Smith Dr Alvin, TX 77511

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who needed respiratory care was provided with such care, consistent with professional standards of practice for 1 (Resident #8) of 2 resident reviewed for respiratory care, in that: -The facility failed to set the oxygen flow rate at 3 liters of oxygen per minute as ordered on 11/27/2023 for Resident #8. This deficient practice could place residents at risk of inadequate respiratory support or respiratory infections resulting in a decline in health. Findings included: Record review of Resident #8's Face Sheet (undated) revealed she was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #8's diagnoses included chronic obstructive pulmonary disease (A group of lung diseases that block airflow and make it difficult to breathe) and dementia (A group of thinking and social symptoms that interferes with daily functioning). Record review of Resident #8's Comprehensive MDS assessment dated [DATE] revealed she was assessed as having a BIMS of 03 out of 15 indicting severely impaired cognitively. Further review of Section O- C1. Oxygen therapy revealed: Oxygen in use while a Resident. Record review of Resident #8's care plan dated 12/14/2023 and revised on 04/05/2024 revealed the following: Focus: I use oxygen therapy r/t COPD Goal: The resident will have no s/sx of poor oxygen absorption through the review date. Target Date: 06/04/2024 Interventions/Tasks: OXYGEN SETTINGS: O2 via NC @ 3lpm as needed Record review of Resident #8's Physician's Order Summary Report for the month of April 2024 revealed an order for O2 @ 3L via NC for SOB as needed (delivery of oxygen directly into the nose) Order dated 11/27/2023. (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: 676264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/06/2024
NAME OF PROVIDER OR SUPPLIER: Winchester Lodge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1112 Smith Dr Alvin, TX 77511	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 04/05/2024 at 9:22a.m., revealed Resident#8 was sitting on the side of the bed holding on the NC in her hand. Resident mumbled for about 5 minutes while being interviewed and could not respond appropriately to the questions asked. LVN A stated Resident #8's had an PRN 02 order. She stated Resident#8 due to dementia removed her NC. LVN A stated every time she went into the resident's room, she checked the oxygen concentrator to make sure it was running. LVN A stated Resident quickly de-stats to 87-88%. At this time, LVN A checked Resident#8's O2 level it was 88%. LVN A applied NC on the resident. LVN A stated she saw Resident #8's oxygen was set at 4 liters per minute. LVN A adjusted 02 to 2L. LVN A stated Resident messes with the dial. It should be on 2L. Observation and interview on 04/05/2024 at 3:16 p.m., revealed Resident was standing near her bed holding the NC in her hand. Wound Care Nurse saw Resident #8's oxygen was set at 5 liters per minute. Wound Care Nurse adjusted O2 to 2L. Wound Care Nurse stated, I have taken care of Resident#8 in the past and knew she was on 2L. In an interview on 04/05/2024 at 3:25 p.m., the DON stated Resident #8 was on PRN oxygen, non-compliant and constantly removed NC. The DON stated she was not aware Resident messed with the dial and adjusted her oxygen flow rate. The DON stated the nurses were responsible for monitoring the oxygen flow rate was set at the correct flow ordered by the physician. The DON stated she expected the nurses to follow physician orders. She said the Wound Care Nurse should have checked the orders in the computer prior to adjusting the oxygen flow as the order changes. Record review and interview on 04/062024 at 12:04p.m., LVN A reviewed Resident #8's physician's order with Surveyor A. LVN A stated the physician ordered the oxygen to be at 3 liters not 2 liters. LVN A stated she had not checked the physician's order for the oxygen flow. LVN A stated she thought the order was for 2 liters. She stated she had few other residents on PRN 0xygen on 2L so, I assumed she was also ordered 2L. She stated stat 90% or lower would require oxygen. LVN A stated to prevent an incorrect oxygen flow rate in the future she would monitor the physician's order and the oxygen concentrator more often in her shift. She stated the respiratory therapist was notified the resident adjusted her oxygen flow rate. LVN A stated the outcome of not managing the residents oxygen flow would result in oxygen toxicity (illness caused by a high partial pressure of oxygen during the oxygen therapy). Record review of facility's Oxygen Administration policy undated revealed read in part: .PURPOSE: deliver oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues. PROCEDURE: 1. Check physician's order for liter flow and method of administration. E. Set the flowmeter to the rate ordered by the physician. 6. Nasal Cannula: Connect tubing to humidifier outlet and adjust liter flow as ordered. DOCUMENTATION GUIDELINES: Documentation may include: Date, time, method of delivery and liter flow as ordered .