STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676337	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Houston	6920 T.C. Jester Blvd Houston, TX 77091

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 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** 41392 Based on observations, interviews and record reviews, the facility failed to ensure the resident environment remained free of accidents hazards and each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 5 residents reviewed for accidents hazards. The facility failed to ensure that Resident #1, who was a two-person transfer using the mechanical lift . was transferred using the mechanical lift instead of a one-person manual lift. Resident #1 sustained a tibial plateau fracture to the right knee (a break at the top of the shinbone involving the cartilage surface of the knee joint). An Immediate Jeopardy (IJ) was identified on 03/18/2024 at 2:30PM. The Administrator was notified. The Administrator was provided with the IJ template on 03/18/2024 at 2:30PM. While the immediacy was removed on 03/21/2024 at 6:18PM, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. This failure resulted in Resident #1 sustaining a fracture to the leg and could place other residents at risk of pain, injuries, and hospitalization . Findings included: Record review of Resident #1's electronic face sheet dated 03/16/2024 revealed a [AGE] year-old who was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (a disease in which the immune system attacks the protective layers of the nerve fibers and causes inflammation and lesion making it difficult for the brain to send signals to the rest of the body); paralysis affecting the right and left side of the body; contractures to the left elbow; muscle contractures to multiple sites; disorders of bone density and structure; vitamin D deficiency; bipolar disorder (mental illness characterized by extreme mood swings); Hypertension (elevated blood pressure); anxiety disorder, dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities) and seizure disorders. Record review of Resident #1's undated admission packet revealed she was originally admitted to the facility on [DATE]. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1 annual MDS assessment dated [DATE] revealed a BIMS score of 14 out of 15 indicating intact cognition. Resident #1 had functional limitation in range of motion and had impairment to the upper and lower extremities. She used a wheelchair for mobility. Resident #1 was dependent on helpers when transferring to and from a bed to a chair. Resident #1 provided none of the effort to complete transfer activity. Record review of Resident #1's undated care plan revealed: Focus - Resident #1 had ADL self-care performance and mobility deficit r/t dementia, multiple sclerosis, limited mobility, limited range of motion. Date initiated was 04/03/2017. Interventions included - resident unable to ambulate with or without assistance, resident requires total assistance by 2 staff for transfers with mechanical lift. Date initiated was 04/13/2017 and revised on 07/26/2022. Focus - Resident #1 was at increased risk for stress fractures, pain, falls, impaired mobility secondary to diagnosis of osteoarthritis (inflammation of one or more joints). Date initiated was 05/02/2022. Record review of Resident #1's undated active physician orders revealed an order for mechanical lift for transfers with 2 staff, every shift with the start date of 01/10/2024. Record review of Resident #1's Hospital Discharge Summary with the encounter start date of 03/14/2024 read in part: .Chief Compplaint, Patient presens with Trample/strike injury, complained of right knee pain during transfer at facility from wheelchair to bed, patient's right knee got twisted . Further review revealed a CT scan (computer processing to create cross-sectional images of the bones) result of an acute tibial fracture to the right knee. Further review revealed the resident also complained of pain to the left lower extremity. An x-ray of the left lower leg showed mild soft tissue swelling around the ankle. Resident #1 was admitted to the hospital on 03/14/2024 then released to the facility on [DATE] with a right knee immobilizer. Record review of Resident #1's progress note dated 03/13/2024 at 10:39 PM, written by LVN A, revealed the resident sustained pain to the right leg and swelling to the knee when she was transferred from the wheelchair to the bed. Her pain level was 7 out of 10 and was administered routine pain medication and Tylenol was ordered at 6:30 PM. Later, her right knee was swelling. The resident complained of pain when the knee was touched. RP and MD were notified. Record review of Resident #1's progress note dated 03/15/2024 at 4:19 PM, written by LVN B revealed the resident returned from the hospital, x-rays were done at the hospital and the resident had a fracture to the right leg below the knee, closed splint in place. Record review of the facility's investigation report revealed CNA B transferred Resident #1 due to not being able to locate the mechanical lift. Further review revealed per LVN A, no one reported any issues with locating the mechanical lifts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and Interview on 03/16/2024 at 11:20 AM, Resident #1 was lying in bed on her back and awake. She had a soft leg splint to the right leg that extended from above the knee to the ankle. Resident #1 stated that on Wednesday 3/13/24 at around 4:15 PM, she was transferred from the motorized wheelchair to the bed by CNA A and CNA B. She stated she was told by the CNAs that they could not find the mechanical lift. Resident #1 stated CNA B kept saying, I can transfer her from the chair, I got this, and CNA A kept saying that it was not the right way to transfer her, but CNA B was saying I got this. Resident #1 stated her feet were still on the footrests of the wheelchair and CNA B transferred her by grabbing and lifting under both arms. Resident #1 said she wore shoes on her feet. Resident #1 stated then her right knee would not move, that was when CNA A moved her right leg off the footrest. Resident #1 stated if her feet were on the floor she could have turned. Resident #1 stated she was supposed to be transferred using only the mechanical lift. She stated she felt pain immediately after she was transferred. She stated CNA A told LVN A about her pain and LVN A gave her pain medication. Resident #1 stated she was sent to the hospital and the doctor told her she had a fracture below the right knee and that she did not need surgery, just a splint. Resident #1 stated she was very angry that this happened. She stated she already had anxieties especially after they dropped her once from the mechanical lift in 2021 and she had to go to the hospital. Resident #1 stated she knows there were more mechanical lifts, but some lifts were not good, they did not turn or go all the way down. Resident #1 currently stated her pain level was 7 out of 10 and that the pain meds she had been receiving had not taken away the pain completely. She stated she may not have the use of her legs, but she could definitely still feel pain. Observation on 03/16/2024 at 1:45 PM revealed there was a mechanical lift being used on a resident on the 200 Hall. Observation and interview on 03/16/2024 at 4:25 PM, the Maintenance Assistant demonstrated that two other mechanical lifts were functioning. The Maintenance Assistant said one was found in the shower room on 500 Hall and the second mechanical was on the 100 Hall. Interview on 03/16/2024 at 4:08 PM, the Maintenance Assistant stated there were 3 working mechanical lifts and 2 that were not working. He stated that on 03/13/2024, he found 5 batteries and only one was not charging. He stated the repair service company was scheduled to come to the facility on [DATE]. Interview on 03/16/2024 at 6:00 PM, the Administrator stated she was in the process of conducting the accident investigation involving Resident #1 and that there were 3 mechanical lifts working and available the day of the incident (3/13/2024). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 3/17/2024 at 9:42AM, CNA A stated she started her shift at 2:00 PM on 3/13/2024 and Resident #1 was already in her wheelchair. CNA A stated at around 4:30PM Resident #1 wanted to get back into bed as she had been up all day and her brief was wet. So CNA A searched for the mechanical lift. CNA A stated she always used the mechanical lift to transfer Resident #1. CNA A stated she found one, but it did not have a battery, so she decided to transfer another way but needed help. She stated CNA B told Resident #1 that they could not find the mechanical lift and that she would transfer her. CNA A stated Resident #1 said OK but to watch her legs because they were fragile. CNA A said her plan was to back the wheelchair up to the head of the bed and two people would lift/slide the resident onto the bed by using the mechanical lift sling and pad that the resident was sitting on and this was the safe way to transfer. CNA A said she told CNA B about the plan, so she moved to the other side of the bed waiting to grab the sling and pad. CNA A said CNA B said no, she could transfer the resident herself. CNA A stated she tried to help but CNA B kept saying she got this. CNA A stated she saw that the resident's feet were still on the footrest and that was a mistake, her feet should have been on the ground. CNA A said CNA B was fast and grabbed Resident #1 under both arms and as she was moved, Resident #1 started hollering and said ow, ow! Resident #1's legs were caught between the bed and wheelchair. CNA A stated she lifted both legs and pushed the wheelchair out of the way. CNA A said after CNA B put the resident into the bed, she left the room. CNA A stated, as she was changing Resident #1's brief, the resident was mad and told her that CNA A did offer to help CNA B. CNA A stated she notified the nurse who then gave the resident some Tylenol. CNA A stated she checked on Resident #1 later and noticed her right knee was swollen and she notified the nurse. CNA A stated that during her last round for the evening she decided to search again for the mechanical lift and with the help of another staff, she found one in a bathroom that was locked and needed a code to get in. CNA A stated since she started training at the beginning of March 2024, she was told there was only one mechanical lift. CNA A stated she recalled during orientation receiving papers to read and that information about the mechanical lift was included but did not recall if she had one-on-one training. CNA A stated that where she worked before, if the mechanical lift was unavailable, she would transfer using the pads to slide the resident onto the bed. On 03/17/24 at 11:48AM, an attempt was made to contact CNA B via telephone for an interview. Unable to leave a message. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on 3/17/2024 at 11:05AM, LVN A stated that on 03/13/2024 at 6:00 PM, the caregiver notified him that Resident #1 had complaints of pain to her right leg and he went to the resident's room to assess her. LVN A stated the CNA (he did not recall the name of CNA) told him the resident was transferred to the bed and that they carried her because they could not find the mechanical lift. LVN A stated the CNA told him there were 2 CNAs (he did not know the names of the two CNAs) and she wanted to transfer the resident together, but the other CNA did not want to and transferred the resident by herself instead. LVN A stated he asked both the CNAs why they did not tell him, and they did not reply. LVN A stated he gave Resident #1 Tylenol for pain and at 6:30 PM she denied any pain. LVN A stated at 8:00 PM he gave the resident the scheduled Tramadol and resident denied pain. LVN A stated then the CNA notified him that the resident's leg was swollen. LVN A stated the right knee was swollen, and she screamed when he touched the knee. LVN A stated he placed a call out to the MD, notified the family, and the DON. LVN A stated the DON asked what happened and he stated the aides did a manual transfer. LVN A stated Resident #1 was supposed to be transferred using the mechanical lift because she had MS, was immobile, was total dependent care and was only able to talk and eat. LVN A stated he had only known of one mechanical lift that was on 200 Hall because this was what he saw all the time and aides from other halls would come to 200 Hall and take it when needed LVN A stated the CNAs should have reported to him that they could not find the mechanical lift and that if they had, he would have said not to transfer her that he would find another plan to get the resident to bed safely such as call for more staff to help. Interview on 03/18/2024 at 12:18 PM, CNA C stated there had been issues with the mechanical lifts for about 2 weeks and it started before 03/13/2024. CNA C stated the batteries would die, the feet on the mechanical lifts did not work but she understood they were being repaired. CNA C stated it would take her 45 minutes to find a mechanical lift because everyone needed them. Interview on 03/18/2024 at 12:30PM, Resident #1 stated she had never been transferred manually before this incident since she got the motorized wheelchair 4 years ago. Resident #1 stated she had not been evaluated by Therapy for transfers in the past 4 years. Interview on 3/18/24 at 12:45 PM, the DOR stated that Resident #1 had always been a mechanical lift transfer since she was first admitted due to her medical conditions. The DOR stated the resident would often make her own rehab appointments for offsite therapy and that the only evaluations the facility had for Resident #1 was for splints to the elbows. The DOR stated the facility changed from using PCC (healthcare software provider) to Matrix and it was unknown where, if any, therapy evaluations for transfers would be located for Resident #1. Interview on 3/18/24 at 1:00PM, the Administrator stated she could not recall exactly but thought it was about 2 weeks ago when she was made aware there were issues with the mechanical lifts and did not recall who told her about the issues. The Administrator stated it was during a meeting when it was discussed that new mechanical lifts may need to be purchased The and that there were 2 quotes for new mechanical lifts but needed a 3rd quote. The Administrator stated she was also waiting for Corporate to make the decisions on whether to purchase or make repairs. Interview on 3/18/24 at 1:30PM, the Central Supply Coordinator stated she got 2 quotes for mechanical lifts on 2/8/2024 and was asked by Administrator to get a third which she received the quote on 3/18/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 03/20/2024 at 9:30 AM, the DON stated she was notified that Resident #1 had pain to her leg after being transferred. The DON stated CNA B told her that she was asked to assist with the transfer and that both CNA B and CNA A did the transfer. The DON stated that CNA B was not aware of Resident #1's leg pain. The DON stated CNA A told her she could not locate the mechanica lift and that CNA B decided to transfer Resident #1 herself after CNA A told her she was a 2-person transfer. The DON stated the CNAs should have used the mechanical lift per the resident's care plan and that CNA A should have notified the nurse if she could not find the mechanical lift. The DON stated the risk to the resident if not transferred properly was injury, fall and injury to the employee. The DON stated action was taken to suspend CNA A, CNA B and LVN A pending the investigation. Interview on 3/21/2024 at 2:00 PM, the Administrator stated she was getting another quote because the third quote for mechanical lifts came in high and this was part of the delay in decisions regarding the mechanical lifts when the monthly inspections came up. She stated she was not notified of any issues with the mechanical lifts then the incident with Resident #1 happened. The Administrator stated the incident involving Resident #1 had less to do with the mechanical lifts but more to do with the CNA who did the manual transfer. The Administrator stated she would terminate CNA B. Record review of the facility's mechanical lift service invoice dated 2/21/24 revealed there were 5 of 5 mechanical lifts that were inspected. Two of the 5 mechanical lifts required repairs. Record review of the facility's policy and procedure for Safe Lifting and Movement of Residents, revised on July 2017, read in part: In order to protect the safety and well-being of staff and residents, and to promote quality care, the facility uses appropriate techniques and devices to lift and move residents. Policy Interpretation and Implementation, 1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. 2. Manual lifting of residents shall be eliminated when feasible .8. Mechanical lifts shall be made readily available and accessible to staff 24 hours a day. Back-up battery packs on remote chargers shall be provided as needed so that lifts can be used 24 hours a day while batteries are being recharged . Record review of the facility policy and procedure for Activities of Daily Living, Supporting, revised March 2018, read in part: .Policy Interpretation and Implementation .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: .b. mobility (transfer and ambulation, including walking) . On 03/18/2204 at 2:30 PM, an Immediate Jeopardy (IJ) was identified. The Administrator was notified. The Administrator was provided with the IJ template, and a Plan of Removal (POR) was requested ant the time. The following Plan of Removal submitted by the facility was accepted on 3/19/2024 at 6:00 PM. Immediate interventions: Plan of Removal: All direct care nursing staff will be in-serviced on the following- (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o DON and designees In-serviced direct care clinical staff on Mechanical Lift Transfers (Who requires ML, how many staff assistance is needed, how to use the ML, Resident Profiles to determine residents needs POC), Mechanical Lift Location/Passcodes for shower rooms where/battery stations are located (where to locate and store ML when not in use, where the charging stations are located, the passcodes to shower rooms where charger stations are located). Completion Date: 3/19/2024 o DON and designees audited employee roster to ensure 100% of direct care clinical staff are in serviced regarding Hoyer Transfers, Hoyer Location, Passcodes for shower rooms where battery stations are located. Completion Date: 3/19/2024 o DON and designees in-serviced regarding Abuse/Neglect/Exploitation/Reporting to the Abuse Coordinator (What is abuse, who to report to, reporting immediately), Resident Rights (Review of resident rights), Maintenance Binder to log areas of concerns prompting follow-up (Where binder is located, how to complete log for all issues). Completion Date: 3/19/2024 o DON and designees audited employee roster to ensure 100% of staff are in-serviced regarding Abuse/Neglect/Exploitation and the Reporting of to the Abuse Coordinator, Resident Rights, Maintenance Binder to log areas of concerns prompting follow-up. 3/19/2024 o DON and Designee completed competencies for all direct care clinical staff through Skills Check-Off for Mechanical Lifts. Completion Date: 3/19/2024 o DON and Designee audited employee roster to ensure 100% of direct care clinical staff complete Skills Check-Off for Mechanical Lifts. Completion Date: 3/19/2024 o Administrator/Designee conducted an assessment of working Mechanical Lifts (3 Mechanical Lifts) and total number of residents requiring Mechanical Lift (48 residents) to determine sufficient amount of equipment. Completion Date: 3/19/2024 o Administrator/designee audited and serviced all Mechanical lifts to ensure sufficient number of Mechanical Lifts (3 working Mechanical Lifts) are available. Completion Date: 3/19/2024. o Through observations nurses validated CNAs are utilizing Mechanical Lifts for all residents requiring Mechanical Lifts for transfers. Completion 3/19/2024. o Acknowledgement sheets signed by all direct care staff acknowledging their understanding of the importance of and expectations of how to identify and utilize resident's requiring mechanical lifts, how to use the mechanical lifts, where the mechanical lifts are located, how to charge a mechanical lift, what the codes are for each Shower room, and how and where to report concerns surrounding Mechanical Lifts maintenance issues. Completion Date: 3/19/2024 Demonstration of and acknowledgement that all direct care nursing staff are aware of the above- o DON/ DON Designee will contact all direct care nursing staff to obtain signature and return demonstration on site or via Facetime with demonstration and acknowledgment, however, if unable to obtain face to face or visual presentation a verbal acknowledgement will be obtained along with 2 signatures by DON/DON Designee to serve as a return demonstration of understanding that- (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o they are aware of how to identify and utilize resident's requiring mecq.anical lifts, how to use the mechanical lifts, where the mechanical lifts are located, how to charge a mechanical lift, what the codes are for each Shower room, and how and where to report concerns surrounding Mechanical Lifts maintenance issues. Completion Date: 3/19/2024 o DON/ DON Designee will remove all direct care staff from schedules and will not be allowed to provide direct resident care until all training has been completed. Items discussed were: IJ (Immediate Jeopardy) was cited on 3/18/2024 as evidenced by facility's failure to: F689 Free of Accident Hazard/Supervision The facility failed to use the mechanical lift device as determined necessary by physician orders during a transfer from Resident #1's wheelchair to the bed resulting in the resident sustaining a fracture to the right tibia below the knee requiring hospitalization . Training for all direct care nursing staff will include: o In-serviced all direct care clinical staff on Hoyer Transfers, Hoyer Location, Passcodes for shower rooms where battery stations are located and Maintenance Logs. o All direct care clinical staff are in-serviced regarding Hoyer Transfers, Hoyer Location, Passcodes for shower rooms where battery stations are located. o All direct care clinical staff complete Skills Check-Off for Mechanical Lifts. o DON/designee will randomly observe direct care nursing staff demonstrate how to locate and utilize the Mechanical Lift. o All direct care nursing staff were contacted in person or by phone and verbally in-serviced. o All direct care nursing staff in-services will be completed by 2pm 03/19/2024. Results of all observations will be reviewed by the Interdisciplinary Team to ensure that proper adherence to this process is met. Any deviations or omissions will be addressed immediately with staff member. Monitoring of the POR included the following: On 03/20/2024 at 8:45 AM to 3:00 PM and on 03/21/2024 at 11:30 AM to 5:30 PM, observations were made, records were reviewed, and direct care nursing staff were interviewed. During an observation on 03/21/2024 at 1:00 PM, there was a mechanical lift at the end of 300 Hall, a second at the end of 500 Hall and a third at the end of 100 Hall. Battery charging stations were located at all shower rooms in the 100 Hall, 300 Hall, 400 Hall and 500 Hall. There was no battery charging station at the 200 Hall shower room. Observed the codes to the shower rooms were on the doors to the shower rooms. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 03/21/2024 at 1:30 PM in the 100 Hall, CNA D and CNA E were using a mechanical lift to transfer a resident from the wheelchair to the bed without any issues. During an observation on 03/21/2024 at 5:15 PM, the Maintenance Logbook was located at the nurse station. Direct care nursing staff who worked days, evenings and night shift were interviewed. A total of 15 nursing staff were interviewed: 1 RN, 4 LVNs and 10 CNAs. Nurses and CNAs were able to verbalize their understanding on the use of Mechanical lifts and that 2 staff members were required to operate the lift when transferring. Nursing staff were able to explain where to find the Resident Profiles to determine residents needs on the plan of care. Nursing staff stated they knew there were at least 3 mechanical lifts were functioning and available and that they were stored in the back of each hall. Nursing staff stated they knew the battery charging stations were currently in hall shower rooms. Nursing staff stated they knew the codes to the shower rooms were written on the doors and that the other charging boxes were being repaired. The Nursing staff were able to verbalize their understanding of what to do if the mechanical lifts needed repair and to log the work order promptly into the Maintenance Logbook which was located at the nursing station. The Nursing staff were able to state the inservices for mechanical lift transfers, abuse and neglect, resident rights, abuse reporting procedures were conducted over the last few days and that the mechanical lift inservice was conducted by the DOR and Nurses. The nursing staff were able to state the inservices consisted of verbal, written, and demonstrations with return demonstrations for mechanical lift transfers and manual transfers. On 03/21/2024 at 4:00 PM the DOR stated in person demonstrations and return demonstrations on the use of mechanical lifts and manual transfers were conducted with staff on site. The DOR started the nurse would be able to observe the halls and see when the CNAs were bringing the mechanical lifts into resident rooms. On 03/21/2024 at 4:15 PM the DON stated staff who worked PRN or worked infrequently were inserviced via facetime and videos and were sent inservices and quizzes. The DON stated upon their return to work they would conduct the one-on-one trainings. The staff would double sign by their names when completed. The DON stated if staff were on leave or were absent during the inservices that they would have to do the skills check list before they would be put on the schedule. The DON stated there were currently 4 staff members out on leave. On 03/21/2024 at 4:25 PM The Administrator stated 24 of the 48 residents rarely got out of bed or preferred to remain in bed. The Administrator stated when the Mechanical Lift Assessment Analysis was conducted, the use of mechanical lifts was observed and timed and that was how she knew it would take 15 minutes to transfer a resident. The Administrator stated with the calculation it was determined that 3 mechanical lifts would be enough. On 03/21/2024 at 5:15 PM, LVN C stated he ensures CNAs on his hall were up to date on the residents transfer type needs by communicating with them frequently and throughout the shift. Record review of the undated Mechanical Lift Assessment Analysis revealed it would take 15 minutes to transfer a resident and with 48 residents and 3 mechanical lifts, it would take 4 hours' time to transfer all residents who required the use of a mechanical lift. In an 8-hour shift there would be ample time with 3 mechanical lifts. (continued on next page)

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	676337	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Houston	6920 T.C. Jester Blvd Houston, TX 77091

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the inservice records for Mechanical Lift use, location, passcodes, Resident profiles, Maintenance logbook, Abuse/Neglect/Exploitation, Reporting to the Abuse Coordinator, Resident Rights and skills competency check lists for mechanical lifts were completed by 03/19/2024 and were signed by the staff. Record review of a service invoice dated 3/21/2024 reflected one of the mechanical lifts was removed with plans to be replaced, two other lifts had parts replaced and one mechanical lift had parts that were on order. The 5th and last mechanical lift did not indicate any repairs were needed per the invoice. Record review of the facility's Employee Counseling Report for CNA B dated 03/20/2024 and completed by the Administrator, read in part: .incident description: Improper transfer: Employee did not transfer resident's per resident's care plan . Record review of the sign in sheet, signed by department heads reflected an IDT meeting was held for the IJ F689 on date 03/19/2024. The Administrator was informed the immediate Jeopardy was removed on 03/21/2024 at 6:18 PM. The facility remained out of compliance at a scope of isolated at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy at a scope of isolated with serious injury due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on interview and record review, the facility failed to ensure the nursing staff were licensed for 1 of 10 staff (LVN A) reviewed for competencies. The facility failed to ensure LVN A's license was valid in order to practice as a licensed vocational nurse. This failure could place residents at the facility at risk of not receiving care and services from staff who are properly trained. The findings included: Record review of the current employee roster, provided by the facility via email on [DATE], revealed LVN A, as an LVN, was hired on the date [DATE]. Record review of the employee file for LVN A, revealed that LVN A had an LVN license that expired on [DATE]. Record review of the website on [DATE] https://txbn.boardsofnursing.org/licenselookup revealed that LVN A was listed on the board of nursing as having delinquent license status and an expired license as of [DATE]. In an interview on [DATE] at 6:20 PM, the Administrator stated when the incident on [DATE] occurred, that was when the facility did the audit of licenses and discovered LVN A's expired license. The Administrator stated, at the time of the audit, LVN A told her that he was having issues renewing online. In an interview on [DATE] at 11:05 AM, LVN A stated he had been working full time at the facility for 6 months during the 2:00PM to 10:00PM shift. LVN A stated he was aware his LVN license expired on [DATE] and usually renewed it online. LVN A stated the Texas Board of Nursing changed the online system and when he renewed through the portal, he did not receive an email to proceed. LVN A stated he called the Board of Nursing several times and did not reach anyone. LVN A stated he had to leave the country d/t an emergency from [DATE] to [DATE]. LVN A stated at the beginning of [DATE], he called the Board of Nursing and got someone on the phone and was told his account was blocked and required resetting. LVN A stated he notified the HR Manager last week (week of [DATE]) and he was given the rest of the week to complete the CEUs. LVN A stated he was currently working on the 20 hours of continuing education before proceeding to upload the credits to renew his license. LVN A stated he was working as an LVN at the facility after his license expired. LVN A stated he did administer medications and performed all other LVN tasks. LVN A stated he was not aware he could not work until the DON told him that he could not work with an expired license. (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 4:45 PM, the Texas Board of Nursing stated they had some issues with nurses renewing licenses online d/t operating with incompatible browsers or devices, not typing information correctly or high volumes of submissions. The Texas Board of Nursing stated when that happens the nurses would call for assistance and it would get resolved. The Texas Board of Nursing stated nurses were not required to submit CEUs to renew unless they were being audited or the license was in a delinquent status. The telephone call took a total of 4 minutes including the one-minute wait in the cue. In an interview on [DATE] at 10:49 AM, the DON stated HR would run reports on Licenses and would then send these reports to her. She denied receiving any reports regarding LVN A's license. The DON stated a valid license would indicate that the nurse was trained to practice as a LVN. In an interview on [DATE] at 12:35 PM, the HR Manager stated she started working at the facility on [DATE]. The HR Manager stated Licenses were checked on a monthly schedule and she did the audit last week because she knew some of the CNA licenses were coming up on renewal. The HR Manager stated she was made aware of LVN A's expired license on [DATE] when LVN A's license was audited. The HR Manager stated she did not know when the last time the licenses were audited because she did not start until [DATE]. The HR Manager stated she was aware LVN A was out of the country and that it was not necessary for him to have been at the facility to renew his license. The HR Manager stated that it was important to have a valid nurse license to make sure the staff remained in compliance to provide nursing care to the residents. In an interview on [DATE] at 4:48 PM, the Administrator stated she did not know when licenses were audited prior to the HR Manager. The Administrator stated the Corporate HR staff worked for a month as interim and may know when they were audited last. The Administrator stated it was the responsibility of the staff to ensure their licenses were renewed on time. The Administrator stated the nurses needed a valid license to practice and to be able to provide care to the residents within the nursing scope of practice. The Administrator stated LVN A would be referred to the board of nursing. On [DATE] at 3:10 PM, a call was made to the Corporate HR staff. A message was left to return the Surveyor's call and the Surveyor's state cell number was included. There was no returned call by the time of exit. Record review of the facility's policy for Licensure, certification, and Registration of Personnel, revised in [DATE] read in part: .Employees who require license, certification, or registration to perform their duties must present such verification with their application for employment 3. A copy of recertifications (e.g., annual, b-annual, etc., as applicable) must be presented to the human resources director/designee upon receipt of such recertifications and prior to the expiration of current licensure, certificate, and /or registration. A copy of the recertification must be filed in the employee's personnel record Record review of the facility's policy for Credentialing of Nursing Service Personnel, revised in [DATE], read in part: .Policy Interpretation and Implementation .6. Should the investigation reveal the applicant does not hold a valid license or certification, appropriate state licensing boards and authorities will be notified of the applicant's attempt to practice without a license/certification . (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy for Licensure or Certification, revised on [DATE] read in part: .You are responsible for providing active, clear, and current license or certification as a condition of employment for certain positions, including but not limited to Licensed Administrator, RN, LPN, CNA Renewal requirements are the employee's responsibility. Failure to provide and maintained an active license in required positions will result in being removed from the schedule and disciplinary action up to and including termination of employment