

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Windsor Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454</p> <p>Based on observations, interviews, and record reviews, the facility failed to immediately consult with the resident's physician when there was a need to alter treatment significantly for 1 of 10 residents (Resident #1) reviewed for changes of condition.</p> <p>The facility failed to notify Resident #1's physician when she experienced a change of condition, including SOB and desaturation (low blood oxygen levels) on 06/05/2024.</p> <p>This failure placed residents at risk experiencing a delay in medical treatment and worsening of condition/symptoms.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet dated 06/07/2024 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with dementia without behavioral disturbances (a group of thinking and social symptoms that interferes with daily functioning), psychotic disturbance (a mental disorder characterized by a disconnection from reality), anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), chronic kidney disease (a type of long-term kidney disease in which either there is a gradual loss of kidney function that occurs over a period of months to years, or abnormal kidney stricture), diabetes (a group of diseases that result in too much sugar in the blood), essential hypertension (a type of high blood pressure that develops gradually over time without an identifiable cause), cognitive communication deficit (a communication difficulty caused by cognitive impairment), muscle wasting and atrophy (the loss of muscle tissue or mass which causes a decrease in strength and make it difficult to perform daily tasks), hypotension of hemodialysis (low blood pressure which is a side effect of hemodialysis treatments), and congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should).</p> <p>Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS score of 3 (severe cognitive impairment); Resident #1 did not experience hallucinations or delusions and she did not exhibit behaviors or reject care; Resident #1 required limited assistance from at least one staff for bed mobility and toilet use; and Resident #1 required limited assistance from at least two staff for transfers.</p> <p>Record review of Resident #1's care plan revised 06/06/2024 revealed the following care areas:</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676337
		If continuation sheet Page 1 of 17

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* Resident #1 is on hemodialysis related to end stage renal disease on Mondays, Wednesdays, and Fridays at 9:15 a.m. Goals included: Resident #1 will have no signs and symptoms of complications from dialysis. Approach included: 1 Liter fluid restriction. Administer medications as ordered.</p> <p>* Resident #1 has an ADL self-care performance and mobility deficit. Goals included: Resident #1 will have ADL's and mobility needs met. Approach included: Encourage resident to use the bell to call for assistance. Monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function. Monitor refusals of care. Resident #1 requires minimal to moderate assistance by 1-2 staff to turn and reposition in bed frequently and as necessary. Resident #1 requires minimal to moderate assistance by 1-2 staff for transfers.</p> <p>* Resident #1 has a history of CHF and was at increased risk for pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), pulmonary embolus (a condition in which one or more arteries in the lungs become blocked by a blood clot), anemia (condition in which the blood does not have enough healthy red blood cells and hemoglobin), renal failure (when the kidneys lose the ability to remove waste and balance fluids), CAD (a heart condition that occurs when the coronary arteries have difficulty supplying the heart with enough blood, oxygen, and nutrients), fluid overload (when the liquid portion of the blood is too high), death, edema (when fluid builds up in the body's tissues), increased SOB, decreased appetite, and fluctuating cognition related to unstable oxygen saturation levels, unintended weight gain, impaired skin integrity, and increased edema. Goals included: Resident #1 will have clear lung sounds, heart rate and rhythm within normal limits. Approach included: Administer cardiac medications as ordered. Check breath sounds. Monitor, document, and report labored breathing and the use of accessory muscles while breathing. Monitor vital signs as ordered. Notify doctor of significant abnormalities.</p> <p>Record review of Resident #1's progress notes for June 2024 revealed:</p> <p>* On 06/05/2024 at 2:44 a.m., LVN E wrote, Resident having difficulty sleeping, and is monitored every 2 hours during this shift . Resident on oxygen 3 liters at this time and reports comfortable in bed. Will continue to monitor.</p> <p>* On 06/05/2024 at 9:11 a.m., LVN A wrote, Resident left facility and went to dialysis in stable condition. No signs and symptoms of acute distress noted. Dialysis communication sent with resident and driver voiced that he saw it.</p> <p>Record review of Resident #1's undated General Order form revealed:</p> <p>* Received Date: 05/03/2024. Start Date: 05/03/2024. DC Date: 05/20/2024. Order Description: Continuous oxygen: Oxygen at 2 liters/minute via nasal cannula to relive hypoxia related to diagnosis of SOB . DC Note: Order changed to PRN .</p> <p>Record review of Resident #1's Physician's Orders for June 2024 revealed the following orders:</p> <p>* PRN Oxygen: Oxygen at 2 liters/minute via nasal cannula to relieve hypoxia related to diagnosis of SOB. Special Instructions: Check O2 saturation as needed. Start Date 05/20/2024. End Date: Open Ended.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* Transport to Dialysis Center on Monday, Wednesday, Friday at 9:15 a.m. Start Date: 06/06/2024. End Date: Open Ended.</p> <p>Record review of Resident #1's MAR for June 2024 revealed:</p> <p>* Order: Dialysis Pre-Vitals. Frequency: Once a day on Monday, Wednesday, Friday. Start/End Date: 04/08/2024 - Open Ended. Monday, 06/05/2024 - O2 Saturation Before: 93%</p> <p>Record review of Resident #1's Physician Order Report for May 2024 and June 2024 revealed:</p> <p>* Start Date: 06/14/2024. End date: Open Ended. Description: Portable oxygen tank to be sent with resident on every dialysis day (Monday, Wednesday, Friday) once a day on Monday, Wednesday, Friday; 8:00 a.m.</p> <p>Observation and interview with Resident #1 on 06/07/2024 at 12:54 p.m. revealed she had just been just dropped off by a transportation company following her dialysis treatment. She was sitting in her wheelchair in the hallway near her room. Resident #1 was being administered oxygen via nasal cannula and an oxygen tank behind her wheelchair. Resident #1 was alert and stated her name. She stated she felt safe in the facility and denied any abuse. Resident #1 talked about topics unrelated to the conversation and appeared to be somewhat confused.</p> <p>In an interview with LVN B on 06/07/2024 at 11:45 a.m., he stated Resident #1 had recently declined cognitively and physically. He said Resident #1 had orders for PRN oxygen. He said when Resident #1 returned from dialysis treatments, she was always very weak, so they put her on oxygen and laid her down. He said Resident #1 normally got out of breath and fatigued, so he always sent her to dialysis with oxygen in case she needed it there. He said they had to check Resident #1 before she left for dialysis to make sure her oxygen was good. He said he worked Monday (06/03/2024) morning (6:00 a.m. - 2:00 p.m.) and cared for Resident #1 before she left for dialysis, but he was off on Wednesday, 06/05/2024 and picked up a shift on a different hall from Resident #1 on that day. He said he heard there was a complaint from Resident #1's dialysis center on 06/05/2024 that she did not go to dialysis with oxygen.</p> <p>In an interview with CNA F on 06/07/2024 at 1:30 p.m., she stated Resident #1 recently started dialysis treatments and could stand with staff assistance. She said now that Resident #1 was on dialysis, she was weaker than she was before and needed more help. She stated Resident #1 recently started going to dialysis with an oxygen tank. She said Resident #1 usually had oxygen on when she was in bed.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview with an RN from Resident #1's dialysis center on 06/11/2024 at 3:15 p.m., she stated she was responsible for Resident #1's care at the center on Wednesday, 06/05/2024. She said when Resident #1 arrived, she was grasping for air and struggling to breath. She stated while Resident #1 was still in the lobby of the center, her oxygen saturation was 92% and she looked down and sleepy, like she was not well. She said Resident #1's head kept dropping but she was still able to respond slower than usual. She said Resident #1 usually came to the center with oxygen from the nursing facility, but she did not have it that day. She said that was the only time she worked with Resident #1 when she did not have the oxygen, but she was told by other staff at the center that it had happened before. She could not provide specific days that Resident #1 did not arrive with oxygen from the nursing facility. She said they got Resident #1 over to their clinic and placed her on 2 liters of oxygen. She said Resident #1's oxygen saturation went up to 98% and her condition improved with better responses, and she looked better. She said she called the facility to let them know what happened and that they forgot to send Resident #1 with oxygen. She said Resident #1's family member brought an oxygen tank so Resident #1 could get her treatment. She said after Resident #1 received oxygen, she was able to complete her treatment with no other issues.</p> <p>In an interview with LVN A on 06/14/2024 at 10:00 a.m., she stated she cared for Resident #1 several days the previous week, including Wednesday, 06/05/2024. She said normally, on Resident #1's dialysis days, she is first to get ready. She said she usually checked Resident #1's vital signs, did her finger stick (blood sugar check), gave her medications, and completed her feeding (via g-tube - a tube inserted through the belly that brings nutrition directly to the stomach). She said now, they always send Resident #1 to the dialysis center with an oxygen tank. She stated she did not know this information the previous week on 06/05/2024 when she sent Resident #1 to the center without oxygen. She said she only found out when the dialysis center called to say she did not have the oxygen. She said Resident #1 was not on oxygen until she got pneumonia and was put on continuous oxygen. She said Resident #1 did not want to wear the oxygen and her oxygen levels improved after the pneumonia resolved, so her order was changed to PRN. She said after that, Resident #1 only used the oxygen when she had SOB, which was not often. She said on the morning of 06/05/2024, Resident #1's oxygen saturation was 93% on room air. She said normal oxygen level was above 90%, so Resident #1 did not need the oxygen that morning. She said Resident #1 did not have labored breathing or any other symptoms of SOB. She said on 06/05/2024, the center called the DON who told her to call the dialysis center to check on Resident #1. She said when she called the center, the nurse said Resident #1 was fine but had labored breathing when she arrived. She said the nurse told her Resident #1's oxygen saturation was 94%. She said after that, they are to always send oxygen to the center. She said she called the transportation center and asked them to always make sure Resident #1 had the oxygen tank when they picked her up. She said on 06/05/2024, Resident #1's family member called and said she was coming to pick up the tank so she gathered everything and took them to the front so the family member could grab them when she arrived. She said the dialysis center nurse said Resident #1's oxygen level was at 94%, but she had SOB. She said she did not call Resident #1's NP because she did not desaturate. She said she would have notified the NP if Resident #1 desaturated.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview with Resident #1's NP on 06/14/2024 at 11:07 a.m., she stated Resident #1 previously had aspiration pneumonia and was transferred to the hospital. She said currently, Resident #1 was on oxygen PRN and did not usually need it when she went to dialysis. She said Resident #1 kept taking the oxygen off, so they decided to check her pulse oximetry (a test used to measure the oxygen level of the blood). She said Resident #1's pulse oximetry was fine after the pneumonia resolved, so her order was changed to PRN. The NP said she was not notified that Resident #1 experienced SOB or a decrease in oxygen saturation at dialysis. She said she was not made aware that Resident #1 needed oxygen during dialysis treatments. She said usually, if Resident #1's oxygen saturation was under 93% on room air, she would need oxygen. She said knowing that Resident #1 needed oxygen at dialysis would have definitely made her change the oxygen order. She said the facility should definitely send Resident #1 to dialysis with oxygen. She said if Resident #1's oxygen level was dropping, the facility needed to send the tank with her.</p> <p>In a follow-up interview with the DON on 06/14/2024 at 11:40 a.m., she stated Resident #1's NP just called to give an order to send oxygen with Resident #1 on dialysis days. She said to her, LVN A should have contacted Resident #1's NP to notify her of the incident on 06/05/2024. She stated LVN A should have documented the incident in Resident #1's progress notes.</p> <p>Record review of the facility's policy titled, Change in a Resident's Condition or Status revised February 2021 revealed, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Policy Interpretation and Implementation: 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): . d. significant change in the resident's physical/emotional/mental condition; e. Need to alter the resident's medical treatment significantly; . i. specific instruction to notify the physician of changes in the resident's condition . 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status . 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454</p> <p>Based on observations, interviews, and record review, the facility failed to report an alleged violation of abuse to HHSC for 1 of 10 resident (Resident #1) reviewed for abuse, neglect, and exploitation.</p> <p>The facility failed to report an allegation of abuse to HHSC after Resident #1's family member expressed concerns when CNA C allegedly handled the resident roughly during resident care.</p> <p>This failure placed residents at risk of continued abuse, neglect, or exploitation.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet dated 06/07/2024 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with dementia without behavioral disturbances (a group of thinking and social symptoms that interferes with daily functioning), psychotic disturbance (a mental disorder characterized by a disconnection from reality), anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), chronic kidney disease (a type of long-term kidney disease in which either there is a gradual loss of kidney function that occurs over a period of months to years, or abnormal kidney stricture), diabetes (a group of diseases that result in too much sugar in the blood), essential hypertension (a type of high blood pressure that develops gradually over time without an identifiable cause), cognitive communication deficit (a communication difficulty caused by cognitive impairment), muscle wasting and atrophy (the loss of muscle tissue or mass which causes a decrease in strength and make it difficult to perform daily tasks), hypotension of hemodialysis (low blood pressure which is a side effect of hemodialysis treatments), and congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should).</p> <p>Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS score of 3 (severe cognitive impairment);. Resident #1 did not experience hallucinations or delusions and she did not exhibit behaviors or reject care;. Resident #1 required limited assistance from at least one staff for bed mobility and toilet use; and Resident #1 required limited assistance from at least two staff for transfers.</p> <p>Record review of Resident #1's care plan revised 06/06/2024 revealed the following care areas:</p> <p>* Resident #1 is on hemodialysis related to end stage renal disease on Mondays, Wednesdays, and Fridays at 9:15 a.m. Goals included: Resident #1 will have no signs and symptoms of complications from dialysis. Approach included: 1 Liter fluid restriction. Administer medications as ordered.</p> <p>* Resident #1 has a communication problem related to a hearing deficit and impaired ability to make herself understood or understand others through verbal and non-verbal expression. Goals included: Resident #1 will be able to make basic needs by verbalizing on a daily basis. Approach included: Anticipate and meet needs. Encourage resident to continue stating thoughts even if the resident is having difficulty. Ensure/provide a safe environment. Validate resident's message by repeating aloud.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* Resident #1 is incontinent of bowel and bladder related to intrinsic and extrinsic factors. Goals included: Resident #1 will have minimal to no complications secondary to bowel and bladder incontinence. Approach included: Apply barrier cream after each episode of incontinent care. Encourage physical activity within limits of physical ability, endurance, and activity tolerance. Check resident every two hours and as needed for incontinence.</p> <p>* Resident #1 has an ADL self-care performance and mobility deficit. Goals included: Resident #1 will have ADL's and mobility needs met. Approach included: Encourage resident to use the bell to call for assistance. Monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function. Monitor refusals of care. Resident #1 requires minimal to moderate assistance by 1-2 staff to turn and reposition in bed frequently and as necessary. Resident #1 requires minimal to moderate assistance by 1-2 staff for transfers.</p> <p>* Resident #1 has a history of CHF and was at increased risk for pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), pulmonary embolus (a condition in which one or more arteries in the lungs become blocked by a blood clot), anemia (condition in which the blood does not have enough healthy red blood cells and hemoglobin), renal failure (when the kidneys lose the ability to remove waste and balance fluids), CAD (a heart condition that occurs when the coronary arteries have difficulty supplying the heart with enough blood, oxygen, and nutrients), fluid overload (when the liquid portion of the blood is too high), death, edema (when fluid builds up in the body's tissues), increased SOB, decreased appetite, and fluctuating cognition related to unstable oxygen saturation levels, unintended weight gain, impaired skin integrity, and increased edema. Goals included: Resident #1 will have clear lung sounds, heart rate and rhythm within normal limits. Approach included: Administer cardiac medications as ordered. Check breath sounds. Monitor, document, and report labored breathing and the use of accessory muscles while breathing. Monitor vital signs as ordered. Notify doctor of significant abnormalities.</p> <p>Record review of Resident #1's progress notes for June 2024 revealed the following:</p> <p>On 06/06/2024 at 3:53 p.m., LVN D wrote, . Head to Toe Assessment completed. Resident presents well kept, clothes clean and dry, brief recently changed. Skin warm/dry to the touch. Resident with clear lung fields, heart tones regular, even with S1S2 (heart sounds) heard. Bowel sounds heard x 4 quadrants. G-tube (a tube inserted through the belly that brings nutrition directly to the stomach) in place . Resident ROM continues unchanged or decrease. Resident without signs or symptoms of pain. Resident has no voiced complaints of pain. Resident noted with multiple, documented black heads to entire upper hemisphere; large, raised pink in color raised irregular shaped skin tag (a harmless skin growth) to thoracic spine area of back in between shoulder blade. Round area, brown in color, round in shape noted to left knee. Light colored skin variation noted to left lateral thigh concurrent with definition of birth markings. No other skin issues noted at this time.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a typed statement signed and dated by the Administrator on 06/06/2024 revealed, To Whom It May Concern, At or about 12:30 p.m. [it was] reported to me that Resident #1's family member alleged her aide had been rough with Resident #1. Specifically, removing Resident #1's oxygen cannula, and pulling on and snatching off Resident #1's clothing. During discussion, [I] learned the resident aide has had some performance concerns with attendance and assigned duties, not being rough. Also, the Charge Nurse (LVN B) conveyed that the aide refused to follow instruction in getting resident up and ready for Resident #1's visit. Informed that upon the family member's arrival, she was upset that Resident #1 was not up and ready for her visit. The Charge Nurse faulted his aide for not following his instruction. The aide was located on break and confronted by the Charge nurse and family member for not getting the resident up and ready. Resident #1's family member actively participated in resident ADL care and getting her up and dressed, working with the aide. During that process, the family member became upset with how the aide was dressing Resident #1, dismissing the aide from patient care, stating she was being too rough. According to aide, the family member removed the oxygen cannula from the resident's nose and around the resident's body. Considering aide performance history and failure to follow supervisor instruction will suspend pending outcome of investigation.</p> <p>Observation and interview with Resident #1 on 06/07/2024 at 12:54 p.m. revealed she had just been just dropped off by a transportation company following her dialysis treatment. She was sitting in her wheelchair in the hallway near her room. Resident #1 was being administered oxygen via nasal cannula and an oxygen tank behind her wheelchair. Resident #1 was alert and stated her name. She stated she felt safe in the facility and denied any abuse. Resident #1 talked about topics unrelated to the conversation and appeared to be somewhat confused.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the Administrator and the DON on 06/07/2024 at 10:15 a.m., the DON stated on the previous day, 06/06/2024, they received a concern from Resident #1's family member saying that CNA C was rough while she dressed her. The DON stated the family member was present and assisted CNA C during the incident. The DON stated CNA C was currently suspended pending the investigation. The Administrator stated he was the facility's abuse coordinator, and he would be responsible for reporting incidents to HHSC. The Administrator stated he did not report the incident to HHSC because it was not an abuse allegation. The DON stated the family member did not use the word abuse when she reported the incident. The DON said the family member said CNA C was rough when she pulled off Resident #1's oxygen and clothing, but their investigation indicated it was the family member who pulled off Resident #1's oxygen because it was wrapped around her leg. The DON stated they were still investigating the incident because the family member had a history of exacerbating situations and not being truthful about encounters. The DON said the family member was used to Resident #1 being up out of bed by 11:00 a.m., but on 06/06/2024, Resident #1 was not up by that time. The DON said Resident #1 had an in-house appointment for a barium swallow test and when the family member arrived prior to the appointment, Resident #1 was not up and ready. The DON said the family member went to LVN B who said CNA C failed to follow his instructions to get Resident #1 up and ready for the appointment. The DON said the family member went to their HR department to get the CNA's name to make a complaint. The DON said that was when she took over the investigation. The DON said she sent CNA C home and then reported the allegation to the abuse coordinator who is also the Administrator. The DON said when the family said Resident #1 was treated roughly, she felt it could possibly have been an abuse complaint. The DON said she interviewed Resident #1, who said nobody harmed her and she felt safe. The DON said she interviewed CNA C and LVN B and she had them write statements regarding the incident in case there was a substantiated abuse allegation. The DON said the protocol was to suspend the alleged perpetrator during an investigation. The Administrator said he did not speak to Resident #1's family member and to him, the situation sounded like the family member was not happy about how Resident #1 was being dressed. The Administrator said, She said the aide was too rough, but what did she mean? The Administrator said the family member should have stopped the aide from doing whatever she was doing and removed Resident #1 from the situation if she thought the aide was being abusive. The Administrator stated that his question was, what was the definition of abuse. The DON stated a head-to-toe assessment was conducted and Resident #1 was negative for any injuries.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Windsor Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 6920 T.C. Jester Blvd Houston, TX 77091	
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview with Resident #1's family member on 06/06/2024 at 11:15 a.m., she stated she tried to talk to the Administrator on 06/06/2024, but he did not listen. She said she tried to talk to the DON, but she kept cutting her off while she explained. The family member said the aide snatched Resident #1's legs and was impatient with her. She said the aide told Resident #1 that she needed to cooperate because she had to go pass lunch trays. The family member said Resident #1 was asleep and the aide was trying to change her clothes while she was still sleeping. She said Resident #1 was confused because she was asleep. She said she told the aide she should not do Resident #1 like that because she (the family member) was standing right there. She said she told the aide not to snatch Resident #1 like that. She said when the aide took a cold wipe and snatched Resident #1's legs open to try and clean the feces off of her, Resident #1 said the wipe was cold. She said she took another wipe, ran warm water over it, and told the aide to use the warm wipe, but the aide said she did not have to do anything she told her to do. She said the aide told Resident #1 she had to hurry because she had to go pass lunch trays. She said she told the aide there was a better way to clean Resident #1, but the aide just looked at her. She said she told the aide she could go ahead and pass her trays. She stated she felt Resident #1 was abused but she did not use that word when she expressed her concerns to the DON. She said she was present when the DON asked Resident #1 if she had been abused, but since Resident #1 had dementia, she could not recall incidents minutes after they happen. She told the DON she did not want the aide to help Resident #1 anymore.</p> <p>In a telephone interview with CNA C on 06/10/2024 at 2:42 p.m., she stated on 06/06/2024, when she arrived for her shift around 6:00 a.m., LVN B told her to dress Resident #1 ASAP because she had an appointment. She said when she went to provide incontinent care and dress Resident #1, her family member was there and said to change her adult brief, but not her clothes because she had to do something with her for 14 minutes. She said the family member told her to leave Resident #1 sitting on the bed for 15 minutes. She said when she returned to Resident #1's room after 15 minutes, neither Resident #1 nor the family member were in the room. She said she returned to the room after another 20 minutes, but nobody was in there. She said she passed breakfast trays and went on her break at 11:30 a.m. She said LVN B came and said he told her to change Resident #1 earlier that morning and now her family member was shouting. She said she tried to explain, but LVN B did not give her a chance. She said Resident #1's family member met her down the hall. She said she told the family member she got distracted with other tasks and she was sorry. She said they went to Resident #1's room but she would not turn herself in the bed to allow CNA C to change her adult brief and clean her private parts. She said she stood there 10 minutes asking Resident #1 to turn so she could change her. She said she asked the family member for help, but she just stood there looking at her. She said after standing there for 20-30 minutes, lunch trays were waiting in the hallway. She said she asked the family member for help with changing Resident #1 before lunch got cold. She said the family member got upset and asked why she was talking to her so rudely. She said the family member said she did not have patience with the resident. She said the family member said she was being rough and rude with Resident #1, but she did not know what she was doing that was rough because she was not touching her yet. She said she usually used the bed pad underneath the residents to turn them when they did not want to turn themselves, so she grabbed the bed pad and that was when the family member started shouting. She said the family member noticed Resident #1's oxygen tubing was tangled, so she took it off. CNA C said she tried to take Resident #1's cloths off while the family member had the nasal cannula off. She said she got Resident #1 changed and dressed but eventually, the family member told her to leave and go pass her trays. She said Resident #1 never screamed or made any noise during the process. She said the DON asked her to write a statement and instructed her to go home.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised September 2022 revealed, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation. Reporting Allegations to the Administrator and Authorities. 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for survey/licensing the facility . 3. 'Immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury . 6. Upon receiving any allegation of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents .</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45604</p> <p>Based on interviews and record reviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of ten residents reviewed for quality of care.</p> <p>1. The facility failed to ensure Resident #1, who had a history of SOB, was sent to her dialysis treatment with oxygen equipment on 06/05/2024 and resulted in an episode of desaturation (low blood oxygen levels) and SOB.</p> <p>2. The facility failed to ensure Resident #1 was sent to her dialysis treatment with a mechanical lift pad, as ordered by her physician, on 06/05/2024 and 06/12/2024 and resulted in a delay in receiving her dialysis treatment.</p> <p>These failures placed residents at risk of experiencing exacerbations of symptoms, worsening of condition, and delayed medical services/treatment.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet dated 06/07/2024 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with dementia without behavioral disturbances (a group of thinking and social symptoms that interferes with daily functioning), psychotic disturbance (a mental disorder characterized by a disconnection from reality), anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), chronic kidney disease (a type of long-term kidney disease in which either there is a gradual loss of kidney function that occurs over a period of months to years, or abnormal kidney stricture), diabetes (a group of diseases that result in too much sugar in the blood), essential hypertension (a type of high blood pressure that develops gradually over time without an identifiable cause), cognitive communication deficit (a communication difficulty caused by cognitive impairment), muscle wasting and atrophy (the loss of muscle tissue or mass which causes a decrease in strength and make it difficult to perform daily tasks), hypotension of hemodialysis (low blood pressure which is a side effect of hemodialysis treatments), and congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should).</p> <p>Record review of Resident #1's MDS dated [DATE] revealed she had a BIMS score of 3 (severe cognitive impairment); Resident #1 did not experience hallucinations or delusions and she did not exhibit behaviors or reject care; Resident #1 required limited assistance from at least one staff for bed mobility and toilet use; and Resident #1 required limited assistance from at least two staff for transfers.</p> <p>Record review of Resident #1's care plan revised 06/06/2024 revealed the following care areas:</p> <p>* Resident #1 is on hemodialysis related to end stage renal disease on Mondays, Wednesdays, and Fridays at 9:15 a.m. Goals included: Resident #1 will have no signs and symptoms of complications from dialysis. Approach included: 1 Liter fluid restriction. Administer medications as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* Resident #1 has an ADL self-care performance and mobility deficit. Goals included: Resident #1 will have ADL's and mobility needs met. Approach included: Encourage resident to use the bell to call for assistance. Monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function. Monitor refusals of care. Resident #1 requires minimal to moderate assistance by 1-2 staff to turn and reposition in bed frequently and as necessary. Resident #1 requires minimal to moderate assistance by 1-2 staff for transfers.</p> <p>* Resident #1 has a history of CHF and was at increased risk for pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), pulmonary embolus (a condition in which one or more arteries in the lungs become blocked by a blood clot), anemia (condition in which the blood does not have enough healthy red blood cells and hemoglobin), renal failure (when the kidneys lose the ability to remove waste and balance fluids), CAD (a heart condition that occurs when the coronary arteries have difficulty supplying the heart with enough blood, oxygen, and nutrients), fluid overload (when the liquid portion of the blood is too high), death, edema (when fluid builds up in the body's tissues), increased SOB, decreased appetite, and fluctuating cognition related to unstable oxygen saturation levels, unintended weight gain, impaired skin integrity, and increased edema. Goals included: Resident #1 will have clear lung sounds, heart rate and rhythm within normal limits. Approach included: Administer cardiac medications as ordered. Check breath sounds. Monitor, document, and report labored breathing and the use of accessory muscles while breathing. Monitor vital signs as ordered. Notify doctor of significant abnormalities.</p> <p>Record review of Resident #1's progress notes for June 2024 revealed:</p> <p>* On 06/05/2024 at 9:11 a.m., LVN A wrote, Resident left facility and went to dialysis in stable condition. No signs and symptoms of acute distress noted. Dialysis communication sent with resident and driver voiced that he saw it.</p> <p>Record review of Resident #1's undated General Order form revealed:</p> <p>* Received Date: 05/03/2024. Start Date: 05/03/2024. DC Date: 05/20/2024. Order Description: Continuous oxygen: Oxygen at 2 liters/minute via nasal cannula to relieve hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) related to diagnosis of SOB . DC Note: Order changed to PRN .</p> <p>Record review of Resident #1's Physician's Orders for June 2024 revealed the following orders:</p> <p>* PRN Oxygen: Oxygen at 2 liters/minute via nasal cannula to relieve hypoxia related to diagnosis of SOB. Special Instructions: Check O2 saturation as needed. Start Date 05/20/2024. End Date: Open Ended.</p> <p>* Resident is to use/have [mechanical] Lift pad in wheelchair on Dialysis days. Special Instructions: Place [mechanical] Lift pad on resident on dialysis days Monday, Wednesday, Friday. Start Date: 04/09/2024. End Date: Open Ended.</p> <p>* Transport to Dialysis Center on Monday, Wednesday, Friday at 9:15 a.m. Start Date: 06/06/2024. End Date: Open Ended.</p> <p>Record review of Resident #1's MAR for June 2024 revealed:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* Order: Dialysis Pre-Vitals. Frequency: Once a day on Monday, Wednesday, Friday. Start/End Date: 04/08/2024 - Open Ended. Monday, 06/05/2024 - O2 Saturation Before: 93%</p> <p>In an interview with LVN B on 06/07/2024 at 11:45 a.m., he stated Resident #1 had recently declined cognitively and physically. He said Resident #1 had orders for PRN oxygen. He said when Resident #1 returned from dialysis treatments, she was always very weak, so they put her on oxygen and laid her down. He said Resident #1 normally got out of breath and fatigued, so he always sent her to dialysis with oxygen in case she needed it there. He said they had to check Resident #1 before she left for dialysis to make sure her oxygen was good. He said he worked Monday (06/03/2024) morning (6:00 a.m. - 2:00 p.m.) and cared for Resident #1 before she left for dialysis, but he was off on Wednesday, 06/05/2024 and picked up a shift on a different hall from Resident #1 on that day. He said he heard there was a complaint from Resident #1's dialysis center on 06/05/2024 that she did not go to dialysis with oxygen.</p> <p>Observation and interview with Resident #1 on 06/07/2024 at 12:54 p.m. revealed she had just been just dropped off by a transportation company following her dialysis treatment. She was sitting in her wheelchair in the hallway near her room. Resident #1 was being administered oxygen via nasal cannula and an oxygen tank behind her wheelchair. Resident #1 was alert and stated her name. She stated she felt safe in the facility and denied any abuse. Resident #1 talked about topics unrelated to the conversation and appeared to be somewhat confused.</p> <p>In an interview with CNA F on 06/07/2024 at 1:30 p.m., she stated Resident #1 recently started dialysis treatments and could stand with staff assistance. She said now that Resident #1 was on dialysis, she was weaker than she was before and needed more help. She stated Resident #1 recently started going to dialysis with an oxygen tank. She said she cared for Resident #1 that morning (06/07/2024) and she had the oxygen with her before she went to dialysis. She said Resident #1 usually had oxygen on when she was in bed.</p> <p>In a telephone interview with an RN from Resident #1's dialysis center on 06/11/2024 at 3:15 p.m., she stated she was responsible for Resident #1's care at the center on Wednesday, 06/05/2024. She said when Resident #1 arrived, she was gasping for air and struggling to breath. She stated while Resident #1 was still in the lobby of the center, her oxygen saturation was 92% and she looked down and sleepy, like she was not well. She said Resident #1's head kept dropping but she was still able to respond slower than usual. She said Resident #1 usually came to the center with oxygen from the nursing facility, but she did not have it that day. She said that was the only time she worked with Resident #1 when she did not have the oxygen, but she was told by other staff at the center that it had happened before. She could not provide specific days that Resident #1 did not arrive with oxygen from the nursing facility. She said they got Resident #1 over to their clinic and placed her on 2 liters of oxygen. She said Resident #1's oxygen saturation went up to 98% and her condition improved with better responses, and she looked better. She said she called the facility to let them know what happened and that they forgot to send Resident #1 with oxygen and a mechanical lift pad. She said Resident #1's family member brought an oxygen tank and a mechanical lift pad so Resident #1 could get her treatment. She said after Resident #1 received oxygen, she was able to complete her treatment with no other issues. She said the facility had to send the mechanical lift pad because that was how the center got Resident #1 out of her wheelchair and into the treatment chair. She said the center had a mechanical lift machine, but they did not have pads. She said without the pads, someone would have to lift Resident #1 out of her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview with Resident #1's family member on 06/12/2024 at 11:12 a.m., she stated she received a call from Resident #1's dialysis center earlier that morning (06/12/2024) saying the facility forgot to send Resident #1 with a mechanical lift pad again. She said the center needed the pad to lift Resident #1 out of her wheelchair and into the treatment chair. She stated the facility forgot to send the pad several times, but she could not provide specific dates other than 06/05/2024. She said on 06/05/2024, the facility forgot to send oxygen and the mechanical lift pad to the dialysis center. She said she went to the nursing facility on 06/05/2024 to pick up oxygen and the pad. She said when she arrived at the facility, the person at the front desk said all of the staff were in a meeting, so she went and found an oxygen tank and a mechanical lift pad. She said she arrived at the dialysis center a little after 10:00 a.m. and was told several male staff at the center had to pick Resident #1 up out of her wheelchair and placed her into the treatment chair. She said the center staff said it was dangerous for them to pick Resident #1 up that way and they were not supposed to touch patients like that. She said on that day, 06/12/2024, she was on her way to the nursing facility when the dialysis center called her back and said someone from the nursing facility had already dropped off a mechanical lift pad.</p> <p>In an interview with LVN A on 06/14/2024 at 10:00 a.m., she stated she cared for Resident #1 several days the previous week, including Wednesday, 06/05/2024. She said normally, on Resident #1's dialysis days, she is first to get ready. She said she usually checked Resident #1's vital signs, did her finger stick (blood sugar check), gave her medications, and completed her feeding (via g-tube - a tube inserted through the belly that brings nutrition directly to the stomach). She said now, they always send Resident #1 to the dialysis center with an oxygen tank and mechanical lift pad. She said Resident #1 always got her showers before dialysis and the mechanical lift pad was placed underneath her after the shower. She stated Resident #1 did not require mechanical lift transfers at the facility, but they used it at the dialysis center. She stated she did not know this information the previous week on 06/05/2024 when she sent Resident #1 to the center without oxygen or mechanical lift pad. She said Resident #1 was able to stand and pivot for staff at the facility and it was never made known to her that she was supposed to send Resident #1 to dialysis with a mechanical lift pad. She said she only found out when the dialysis center called to say she did not have the oxygen or the pad. She said Resident #1 was not on oxygen until she got pneumonia and was put on continuous oxygen. She said Resident #1 did not want to wear the oxygen and her oxygen levels improved after the pneumonia resolved, so her order was changed to PRN. She said after that, Resident #1 only used the oxygen when she had SOB, which was not often. She said on the morning of 06/05/2024, Resident #1's oxygen saturation was 93% on room air. She said normal oxygen level was above 90%, so Resident #1 did not need the oxygen that morning. She said Resident #1 did not have labored breathing or any other symptoms of SOB. She said on 06/05/2024, the center called the DON who told her to call the dialysis center to check on Resident #1. She said when she called the center, the nurse said Resident #1 was fine but had labored breathing when she arrived. She said the nurse told her Resident #1's oxygen saturation was 94%. She said after that, they are to always send oxygen and the mechanical lift pad to the center. She said she called the transportation center and asked them to always make sure Resident #1 had the oxygen tank when they picked her up. She said on 06/05/2024, Resident #1's family member called and said she was coming to pick up the tank and pad, so she gathered everything and took them to the front so the family member could grab them when she arrived. She said the dialysis center nurse said Resident #1's oxygen level was at 94%, but she had SOB. She said she did not call Resident #1's NP because she did not desaturate. She said she would have notified the NP if Resident #1 desaturated.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with CNA C on 06/14/2024 at 10:33 a.m., she stated she knew to send Resident #1 to the dialysis center with a mechanical lift pad. She said Resident #1 did not normally use a mechanical lift at the facility, so she did not know why she needed it at the dialysis center. She said when she was hired, she was trained to always send Resident #1 with a pad on dialysis days. She said on 06/05/2024, Resident #1 was difficult and gave her trouble during her shower, so she had to get assistance from the nurse. She said she forgot to place the mechanical lift pad underneath Resident #1 after her shower.</p> <p>In an interview with the DON on 06/14/2024 at 10:50 a.m., she stated she previously thought they were sending Resident #1 with a mechanical lift pad as a courtesy to the dialysis center, and she was not aware it was an order.</p> <p>In a telephone interview with Resident #1's NP on 06/14/2024 at 11:07 a.m., she stated Resident #1 previously had aspiration pneumonia and was transferred to the hospital. She said currently, Resident #1 was on oxygen PRN and did not usually need it when she went to dialysis. She said Resident #1 kept taking the oxygen off, so they decided to check her pulse oximetry (a test used to measure the oxygen level of the blood). She said Resident #1's pulse oximetry was fine after the pneumonia resolved, so her order was changed to PRN. The NP said she was not notified that Resident #1 experienced SOB or a decrease in oxygen saturation at dialysis. She said she was not made aware that Resident #1 needed oxygen during dialysis treatments. She said usually, if Resident #1's oxygen saturation was under 93% on room air, she would need oxygen. She said knowing that Resident #1 needed oxygen at dialysis would have definitely made her change the oxygen order. She said the facility should definitely send Resident #1 to dialysis with oxygen. She said if Resident #1's oxygen level was dropping, the facility needed to send the tank with her.</p> <p>In a follow-up interview with the DON on 06/14/2024 at 11:40 a.m., she stated Resident #1's NP just called to give an order to send oxygen with Resident #1 on dialysis days. She said to her, LVN A should have contacted Resident #1's NP to notify her of the incident on 06/05/2024. She stated LVN A should have documented the incident in Resident #1's progress notes. She stated CNA C and the aide who failed to send the mechanical lift pad on 06/12/2024 were both originally from the night shift and were not totally familiar with Resident #1.</p> <p>Record review of the facility's policy titled, Accommodation of Needs revised March 2021 revealed, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. Policy Interpretation and Implementation: 1. The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. 2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Windsor Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled, Change in a Resident's Condition or Status revised February 2021 revealed, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Policy Interpretation and Implementation: 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): . d. significant change in the resident's physical/emotional/mental condition; e. Need to alter the resident's medical treatment significantly; . i. specific instruction to notify the physician of changes in the resident's condition . 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status . 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status .</p>		