

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  05/23/2024
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722</b></p> <p>Based on interview and record review the facility failed to indicate accurately in the assessment, the resident's cognitive status for one of nineteen residents (Resident #69) reviewed for assessment accuracy.</p> <p>- The facility failed to accurately document in the assessment of Resident #69's impairments of both lower extremities.</p> <p>These failures could place residents at risk of not having accurate assessments, which could compromise their plan of care.</p> <p>Findings include:</p> <p>Record review of Resident #69's face sheet dated 5/22/2024 revealed a [AGE] year-old man admitted on [DATE]. The face sheet documented his diagnoses included cerebral infarction (stroke, blood supply to part of the brain is blocked or reduced), malnutrition (condition that results from lack of sufficient nutrients in the body), adjustment disorder ( short term condition arising due to difficulty in managing the stressful life changes such as coping with work-related problems, loss of loved ones, or relationship issues that leads to significant impairment in functioning), heart failure (progressive heart disease that affects pumping action of the heart muscles), aphasia (comprehension and communication disorder resulting from damage or injury to the specific area in the brain), hemiplegia (one sided-paralysis) and hemiparesis (one-sided muscle weakness), dysphagia (condition with difficulty in swallowing food or liquid), amputation (removal of a limb, completely or partially) of both legs below the knees, dysarthria (difficulty in speech due to weakness of speech muscles) and anarthria (severe form of dysarthria), gastronomy (surgical procedure for inserting a tube through the abdomen wall into the stomach) status, functional quadriplegia (pattern of paralysis from the neck down), polyneuropathy (damage to multiple peripheral nerves), contracture (permanent shortening of muscle, tendon, skin, or other tissue that causes deformity or distortion of a joint) of the left elbow and right hand, tachycardia (heart rhythm disorder with heartbeats faster than usual, greater than 100 beats per minute), and schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #69's quarterly MDS dated [DATE] with an ARD of 5/4/2024 revealed no BIMS was conducted as he was rarely or never understood. The MDS documented he had both long and short-term memory problems, and he was unable to recall the current season, the location of his room, staff names and/or faces, or that he was in a nursing home. Per the MDS, Resident #69 was severely impaired in his ability to make decisions regarding tasks of daily life. The MDS revealed he had an impairment of one upper extremity and one lower extremity, and he did not use any mobility devices. The MDS documented he was totally dependent on staff for all ADL's except eating.</p> <p>Record review of Resident #69's care plan dated 4/1/2024 revealed a focus on his risk of muscle atrophy and muscle spasticity with interventions including passive and/or active range of motion with AM and PM care daily. The care plan documented a focus on his pain and risk of falls related to his amputations.</p> <p>Observation on 5/21/2024 at 9:09 AM revealed Resident #69 was non-responsive to any questions. Resident #69 was lying with the head of the bed elevated. Resident #69 was receiving nutrition via a G-Tube at 55ml/hr. Resident #69 had visible contractions of both hands. Resident #69 was wearing a brace on left hand. Resident #69 had amputations of both legs below the knees.</p> <p>Interview on 5/22/2024 at 3:59 PM with the DON, she said the purpose of the MDS was to accurately assess the residents, inform the care plan, and accurately document any concerns or needs a resident may have. The DON said she was unsure if a resident who was receiving restorative therapy services would have those services documented on the MDS. The DON said a resident who had an amputation of both legs below the knees should have that information accurately documented on the MDS. The DON said Resident #69 had an amputation of both legs below the knees. The DON said the MDS assisted in creation of the care plan for the residents, and if not accurate could lead to inaccurate care plans.</p> <p>Interview on 5/23/2024 at 10:01 AM with the MDS Nurse, she said she had been employed since 2/4/2024. The MDS nurse said she was responsible for completing the MDS assessment for residents correctly. The MDS Nurse said Resident #69's MDS should have clearly documented he had an amputation of both legs, and it did not. The MDS nurse said the Resident #69's MDS noted he had an impairment of one leg only. The MDS nurse said she did not complete Resident #69's quarterly MDS dated [DATE] correctly. The MDS nurse said the incident was an oversight on her part. The MDS nurse said because the MDS was completed incorrectly, Resident #69 would not suffer any consequences as he could not walk. The MDS Nurse said she would be correcting Resident #69's MDS.</p> <p>Record review of the facility's Resident Assessment Policy dated October 2023 revealed a policy statement which read A comprehensive assessment of each resident is completed at intervals designated by OBRA regulations and PPS requirements. Data from the Minimum Data Set (MDS) is submitted to the Internet Quality Improvement Evaluation System (iQIES) as required. The policy documented that all information in the MDS assessment would reflect resident observations and interviews. Per the policy, the MDS assessments would be used to create the residents' comprehensive care plans.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47572</b></p> <p>Based on interviews and record review, the facility failed to refer all residents with newly evident or possible serious mental disorders, intellectual disabilities, or a related conditions for level II resident review upon a significant change in status assessment for one of nineteen residents (Resident #33) reviewed for PASARR evaluations.</p> <p>The facility failed to refer Resident #33 to the appropriate, State-designated authority when she was diagnosed with MI.</p> <p>This failure could place residents at risk for not receiving necessary PASARR mental health services, causing a possible decline in mental health.</p> <p>Findings included:</p> <p>Record review of Resident #33' face sheet dated 5/22/2024 revealed a [AGE] year-old woman admitted on [DATE]. The face sheet documented her diagnoses included multiple sclerosis (a chronic autoimmune disorder affecting movement, ensation, and bodily functions), hemiplegia (one sided-paralysis) and hemiparesis (one-sided muscle weakness) affecting both sides, a contracture (permanent shortening of muscle, tendon, skin, or other tissue that causes deformity or distortion of a joint) of her left elbow, pinguecula (small, yellow, benign growth that develops in the white of the eye) of both eyes, contractures (permanent shortening of muscle, tendon, skin, or other tissue that causes deformity or distortion of a joint) of multiple muscles, myopia (near-sightedness), polyneuropathy (damage to multiple peripheral nerves), bipolar disorder (mental illness characterized by extreme mood swings), dementia (group of symptoms that affects memory, thinking and interferes with daily life), convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking and limb movement), and anxiety disorder (group of mental illnesses that cause constant fear and worry).</p> <p>Record review of Resident #33' quarterly MDS dated [DATE] with an ARD of 3/20/2024 revealed a BIMS score of 15 indicating no cognitive impairment. The MDS documented she had no potential indicators of psychosis, behaviors affecting other residents, rejection of care, or wandering behaviors. Per the MDS, Resident #33 had an impairment of both upper and lower extremities, and she required a wheelchair for mobility. The MDS revealed she required assistance, or was totally dependent on staff, for all ADL's. The MDS revealed she had been administered antipsychotic, antianxiety, and antidepressant medications in the seven days prior to the assessment.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #33' undated care plan revealed a focus on the adverse reactions to her anxiety and antianxiety medication use with interventions including medication administration and monitoring for effectiveness and adverse reactions. The care plan included a focus on her antipsychotic drug use with interventions including medication administration, monitoring for effectiveness and adverse reactions, and quarterly GDR if appropriate. The care plan included a focus on the fall prevention plan that Resident #33 was a part of, with interventions including providing a positive approach to help prevent falls. The care plan revealed a focus on her increased risk of falls with interventions including education related to falls and fall prevention, labs to determine a possible underlying cause, MRR, pharmacy consultant MRR, PT evaluation and treatment as required, and ensuring she had a safe environment. The care plan documented a focus on her dementia with interventions including use of yes/no questions, cuing and reorienting when needed, providing a consistent routine, and task segmentation. The care plan revealed a focus on her bipolar disorder with interventions including medication administration, monitoring and reporting any depressive or manic episodes or mood swings, and a psychiatric health referral.</p> <p>Record review of Resident #33' physician's order's report dated 5/22/2024 revealed orders to monitor for adverse reactions to her antianxiety, antipsychotic, and hypnotic/sedative/tranquilizer medications dated 10/3/2023. The report documented an order for a fall prevention program dated 4/9/2024. The report included an order for psychiatric care services to evaluate and treat Resident #33 dated 10/3/2023. The report documented Resident #33 had prescriptions including Acetaminophen-Codeine 300-30mg tablet one tablet every six hours as needed, Clonazepam 0.5mg tablet one tablet twice daily, Quetiapine 100mg tablet one tablet once daily in the morning, and Quetiapine 200mg tablet one tablet once daily at bedtime, Trazadone 100mg tablet two tablets twice daily at bedtime, and Trazadone 50mg tablet one tablet once daily at bedtime (total of 250mg trazadone at bedtime daily).</p> <p>Observation and interview on 5/21/2024 at 9:22 AM with Resident #33, she said she had lived at the facility for seven years. Resident #33 said the staff provided for all of her needs.</p> <p>Interview on 5/22/2024 at 3:59 PM with the DON, she said the purpose of the PASRR was to obtain outside services for eligible residents. The DON said the MDS nurse was responsible for the PASRR process.</p> <p>Interview on 9/23/2024 at 10:01 AM with the MDS nurse and the Traveling MDS Nurse, the MDS Nurse said she had been employed since February 4, 2024. The MDS Nurse said her primary duties included ensuring MDS assessments were completed and ensuring a resident's PASRR Level 1 (PL1) was completed appropriately and accurately. The Traveling MDS Nurse said the facility was in the process of reviewing all residents with any MI diagnoses were properly identified and had proper PL1's completed. The Traveling MDS Nurse said the facility had residents whose PL1's were not correctly completed and/or coded. The Travelling MDS Nurse said the facility had identified Resident #33 as requiring a new PL1 and a Form 1012 to identify she was not eligible for PASRR services because of her primary dementia diagnosis. The Travelling MDS Nurse said the Form 1012 was a state form which identified residents with MI who had a primary diagnosis of dementia and not eligible for MDS services. The MDS Nurse said Resident #33 Form 1012 required a physician's signature to validate the primary dementia diagnosis. The MDS Nurse said Resident #33 required a new PL1 and Form 1012 because the one on file was inaccurate. The MDS nurse said there had been no adverse results because Resident #33 would not have been eligible for PASRR services and she was receiving psychiatric care services at the facility. The MDS Nurse said the facility used the RAI requirements for PASRR.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38644</p> <p>47722</p> <p>Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs for 2 of 18 residents (Resident #67 and Resident #301) reviewed for pharmacy services.</p> <p>-The facility failed to order Resident #67's medication correctly and he was not getting it for 2 days.</p> <p>-MA A applied Resident #301's Lidocaine patch to the right knee instead of the left thigh according to Physician orders and did not remove the previous Lidocaine patch prior to applying the new one.</p> <p>-The Lidocaine patch was on Resident #301 longer than the recommended timeframe as specified by the Manufacturer instructions and MD.</p> <p>This failure could place residents at risk of inadequate therapeutic outcomes and worsened health conditions.</p> <p>Findings included:</p> <p>1. Record review of Resident #67's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE], with an original date of 5/18/20. He had diagnoses of non-ST elevation myocardial infarction (heart attack), dermatitis (swelling and irritation of the skin), cognitive communication deficit (difficulty with communication that is affected by disruption of cognition), dysphagia (trouble swallowing), hypertrophic disorder of the skin (increased production of dense, tough, hard, scar-like tissue), muscle wasting and atrophy (decrease in size and wasting of muscle tissue), right hand contracture (fingers curl or pull in toward the palm), cerebral infarction (stroke), aphasia (trouble speaking), and hemiplegia/hemiparesis (paralysis and weakness) following stroke on right side.</p> <p>Record review of Resident #67's Annual MDS assessment dated [DATE] revealed a BIMS score that was unable to be determined due to his medical condition. His cognitive skills for daily decision making were moderately impaired. He had impairment on one side of both his upper and lower extremities and used an electric wheelchair. According to the MDS the resident required substantial/max assistance with toileting hygiene, shower/baths, and lower body dressing.</p> <p>Record review of Resident #67's undated care plan revealed a Focus: Resident was at increased risk for tissue death, sores, and poor wound healing secondary to peripheral vascular disease (bad circulation to arms and legs). (Initiated: 5/24/22, Revised: 5/24/22). Goal: Resident would remain free of complications related to PVD through review date (Initiated: 5/24/22, Revised: 5/22/23, Target: 12/19/23). Interventions: Monitored extremities for signs and symptoms of injury, infection, and ulcers.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #67's progress notes revealed a note from LVN D on 5/21/24 at 12:57pm that read, NP [NP B] visited with resident on this shift. New orders received for hydrocortisone cream 0.5% topically to right thigh BID x 7 days. RP [family member] and the ADON notified. Resident presently in electrical wheelchair rolling around.</p> <p>Record review of Resident #67's Physician Orders revealed an order from MD A on 5/21/24 at 12:57pm that read, Hydrocortisone cream OTC 0.5% topical. Apply topically to right thigh BID x 7 days for rash/scratches.</p> <p>Record review of Resident #67's May 2024 MA MAR revealed on 5/21/24 at 4:00pm, MA B documented the hydrocortisone cream was not administered because it was on the Nurse MAR. On 5/22/24 at 7:00am, MA B documented the hydrocortisone cream was not administered because it was on the Nurse MAR.</p> <p>Record review of Resident #67's May 2024 Nurse MAR on 5/22/24, revealed the hydrocortisone cream was not ordered on it.</p> <p>In an observation and interview with Resident #67 on 5/21/24 at 9:49am, the resident was sitting in an electric chair. The resident had aphasia and was unable to speak well but could answer to yes and no questions and could point and use hand gestures. The resident was able to communicate that he had a rash to his right thigh.</p> <p>In an interview with MA B on 5/22/24 at 12:03pm, she said MAs do not give creams and only nurses are able to administer them. She said she marked on the MA MAR not given and that it was on the NMAR, since the nurses had to give it. She said the medication should have been on the Nurse MAR and after she put that she did not administer it, she went and told the nurse so he could add it to his MAR. She said sometimes the doctor would put the order in wrong and put it on the MA MAR not knowing they were unable to give it. She said if it was left that way, the resident would not get their medication.</p> <p>In an interview with LVN N on 5/22/24 at 12:05pm, he said he did not see the order for the hydrocortisone cream on Resident #67's Nurse MAR. He said he had not given the resident any cream that day (5/22/24) and did not know about it. He said the MA was supposed to tell him if there was an order on their MAR that needed to be moved over, so he could switch it over, but no one had told him anything. He said if the order did not get moved over to the Nurse MAR the resident would go without his medicine. He said the person who put the order in was a nurse on the 10pm-2pm shift and she must have made a mistake.</p> <p>In an interview with the DON on 5/22/24 at 4:15pm, she said hydrocortisone cream was given by nurses only. She said if the medication was listed on the MA MAR, she expected the MA to tell the Charge Nurse so they could remove the order from the MA MAR, put it on the Nurse MAR, and correct the order. She said if the medication was on the MA MAR and the med aide did not say anything and kept documenting not given, the resident would not receive their medication. She also said the nurse who entered the order should have known to put it on the Nurse MAR and not the MA MAR.</p> <p>In an interview with Resident #67 on 5/23/24 at 9:07am, he said he received his first dose of the cream to his thigh that morning (5/23/24).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #301's face sheet dated 5/23/24 revealed a [AGE] year-old female readmitted on [DATE]. Her diagnoses included dementia, contracture of the right knee, hemiplegia (paralysis of one side of the body), and hemiparesis (partial weakness on one side of the body) following cerebral infarction (stroke), and pain.</p> <p>Record review of Resident #301's quarterly MDS assessment dated [DATE] revealed a BIMS score of 8 out of 15 which indicated moderate cognitive impairment. She required assistance from staff with ADL care.</p> <p>Record review of Resident #301's care plan dated 4/16/24 revealed she had acute and chronic pain related to multiple disease process, cerebral infarction, contractures, hemiplegia, and hemiparesis and past injuries. The approach was to administer analgesia medication as ordered . Lidocaine patch.</p> <p>Record review of Resident #301's Physician Orders revealed an order for Lidocaine patch 4%, apply to left thigh once a day at 9:00 a.m . special instructions: remove per schedule. Order date 9/29/23.</p> <p>In an observation and interview on 5/22/24 at 9:15 a.m. revealed MA A applied Resident #301's Lidocaine Patch to her right knee. MA A returned to the medication cart and this State Surveyor reviewed the medication orders with MA A. This State Surveyor asked MA A where the patch was applied. MA A returned to Resident #301's room and removed a Lidocaine patch dated 5/21/24 from her left thigh. MA A said he made a mistake and placed it on her knee. He removed the Lidocaine patch from her right knee and applied it to her left thigh.</p> <p>In an observation on 5/22/24 at 9:25 a.m., the Lidocaine 4% box read, .Do not use more than one patch on your body at a time. Use one patch for up to 12 hours .</p> <p>In an interview on 5/22/24 at 9:26 a.m. MA A said he did not check to see if there was an old patch on Resident #301 prior to applying a new one but should have. He said Resident #301 could not wear two Lidocaine patches at the same time because it was like administering the medication twice. He said the evening shift normally removed the patch. He said the Lidocaine patch box said it could be worn up to 12 hours and if a patch was worn longer than 12 hours it may not work. He said he normally reviewed the MAR to ensure he applied the patch to the right place. He said he should have made sure it was placed on the correct leg and the thigh.</p> <p>In an interview on 5/22/24 at 3:58 p.m. the DON said nursing staff should look for and remove an old patch before applying a new one to avoid giving more medication than they were supposed to. She said staff should follow the physician order and check the strength and placement before applying the patch. She said she was unsure of any adverse reactions if placed in the wrong location. She said Lidocaine patches could stay on for 24 hours and it was based on the physician order. She said the patch was to be removed daily.</p> <p>Record review of Resident #301's progress note dated 5/22/24 at 5:58 p.m. written by LVN M read, called physician to get recommendation for removal of lidocaine patch. The physician recommended the patch is to be applied on for 12 hours to resident left thigh and removed for twelve hours .</p> <p>In an interview on 5/23/24 at 9:28 a.m. the DON said MD B clarified Resident #301's Lidocaine patch order to leave the patch on for 12 hours and remove for 12 hours.</p> <p>(continued on next page)</p>		

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<p>F 0755</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 Administering Medications policy dated December 2001 read in part. . Medications shall be administered in a safe and timely manner, and as prescribed . 10. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication .</p> <p>Record review of the facility's policy and procedure on Administering Medications (Revised April 2019) read in part: Medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions .Medications are administered in accordance with prescriber orders, including any required time frame .Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .Topical medications used in treatments are recorded on the resident's treatment record (TAR) .</p> <p>Record review of the facility's policy and procedure on Medication and Treatment Orders (Revised July 2016) read in part: Orders for medications and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record. Drug and biological orders must be recorded on the physician's order sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order .Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date, and the time of the order .</p>		