STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676371	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Quail Valley Post-Acute Healthcare	3640 Hampton Dr Missouri City, TX 77459

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27846 Based on observations, interviews, and record review the facility failed to ensure residents received care, consistent with professional standards of practice to identify, prevent pressure ulcers from developing and promote healing for 1 (Resident CR# 1) of 9 residents reviewed for pressure ulcers. The facility failed to prevent, identify, and treat pressure sores on Resident CR#1's right buttock and right hip. CR #1 was sent to the hospital after family intervention, and there it was determined she had an unstageable wound to her buttocks and a stage 3 wound to her hip. The noncompliance was identified as Past Non-Compliant. The IJ began on 07/13/2024 and ended on 07/16/2024. The facility corrected the non-compliance before the survey began. This failure placed residents who were at risk of developing wounds of delayed identification, treatment, hospitalization , surgeries, infection, a decline in health, and pain. Findings included: Record review of Resident CR #1's admission face sheet undated revealed she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: dementia (general term for loss of memory, language, and thinking ability), Alzheimer's Disease (progressive disease that destroys memory and important mental functioning) , malignant neoplasm of breast (cancerous tumor), cognitive communication deficit, chronic kidney disease, and dysphagia (difficulty swallowing). Record review of Resident CR#1's quarterly MDS dated [DATE] revealed her BIMS score was 99 which meant it was unable to be completed. The resident's cognitive skills for daily decision making were severely impaired. The resident was always incontinent of bowel and bladder. Resident CR #1 was dependent on staff for rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair, and tub shower transfer. The resident was identified as having medically complex conditions. Review of Section M Skin Conditions revealed Resident CR#1 was at risk of developing pressure ulcers. The resident did not have any unhealed pressure ulcers. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676371	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Quail Valley Post-Acute Healthcare	3640 Hampton Dr Missouri City, TX 77459

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident CR#1's care plan date initiated 03/21/2024. Date revised 04/17/2024 revealed: Problem: Resident CR#1 was at risk for pressure ulcer development related to incontinence (trouble controlling elimination) and dependence on staff, cognitive deficit. Goal: The resident would have intact skin, free of redness, blisters, or discoloration through review date 09/01/2024. Interventions: Follow the facility policy and protocols for the prevention and treatment of skin breakdown. Inform the resident, family, caregivers of any new areas of skin breakdown. Monitor, document, report as needed any changes in skin status: appearance, color, wound healing, signs, and symptoms of infection, wound size, and stage (classification of pressure wound injury). Record review of Resident CR#1's Braden Scale for Predicting Pressure Ulcer Risk unsigned dated 06/04/2024 was scored 15 out of 23. The resident's category was at risk for the development of pressure ulcers. Record review of Resident CR#1's Weekly Skin Evaluation dated 07/06/2024 signed by RN A revealed the resident had no abnormal skin areas. Record review of Resident CR#1's Weekly Skin Evaluation dated 07/13/2024 signed by RN A revealed the resident had no abnormal skin areas. Record review of the facility Grievance Log dated 07/14/2024 revealed: Resident involved: Resident CR#1. Report person: RP. Main concern: Wounds. Resolution: Sent to hospital. Record review of the facility Nurse's Progress Notes by RN A dated 07/14/2024 at 2:13 AM revealed 11:42 PM Resident CR#1's Daughter D came to the nurse's station. The Resident CR#1's Daughter D reported she called 911. She wanted her to go to the hospital because she had a bad wound. 11:44 PM the 911 crew picked up the resident. 11:52 PM Resident CR#1 transferred to local hospital emergency room by 911 crew. Record review of local hospital ED Triage (process that prioritizes treatment) Notes dated 07/14/2024 revealed EMS was called for patient with a new wound on the buttocks. Record review of local hospital History and Physical dated 07/14/2024 revealed Resident CR#1 was brought to the ED from a nursing home with a pressure ulcer on the buttocks area. The patient had a stage II right buttock sacral ulcer going into stage III present on admission. Physical Examination revealed Wound: Pressure Injury Right Buttocks. Wound: Pressure Injury Right Hip. Record review of local hospital Wound Care Nurse Evaluation dated 07/15/2024: Wound Assessment revealed: 1.Wound 07/14/2024 Pressure Injury Right Buttocks: Unstageable pressure injury POA. Size 2.5 length cm X 2.5 width cm X 0 depth cm. No undermining (damaged tissue beneath the skin). No tunneling (a tunnel that extended from the wound into deeper tissue). Wound bed (base of wound) was covered with eschar (collection of dried dead tissue within a wound). Edges well defined (edges were flushed with wound base). 2. Wound 07/14/2024 Pressure Injury Right Hip: Stage III POA. Size 2.5 length cm X 2.0 width cm X 0. 1 depth cm. No undermining. No tunneling. Wound bed was pink with minimal necrotic tissue (dead or dying tissue that cannot perform the normal function). Edges well defined. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676371	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Quail Valley Post-Acute Healthcare	3640 Hampton Dr Missouri City, TX 77459

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Hospital Wound care orders dated 07/15/2024 revealed the right buttock and the right hip cleanse with Vashe (wound cleaning solution). Pat dry. Apply Polymem dressing (a dressing that cleans the wound bed). Cover with Mepilex dressing (absorbent foam dressing) every other day . In an interview on 07/17/2024 at 12:53 PM the Interim DON stated the two wound care nurses RN A and LVN B were suspended pending an internal investigation brought to us by Resident CR#1's Daughter D. Resident CR#1's Daughter D reported the resident had a bad wound on her hip. The family member called 911 to have the resident taken to the hospital. She stated LVN B worked Monday through Friday. LVN B was also suspended due to putting a protective padded dressing on the resident's hip without an order. The weekend treatment nurse RN A reported to us she did a complete head to toe assessment on Resident CR#1 prior to her leaving on 07/13/2024. RN A stated the resident did not have any open area. RN A resigned . In a phone interview on 07/17/2024 at 2:00 PM LVN B stated she was not the wound care nurse for the 500 hall where Resident CR#1 was. The week-end nurse RN A was responsible for the 500 hall assessments. LVN B stated as the main treatment nurse she made random assessments of all residents on the 500 hall. LVN B stated Resident CR#1 laid on her right side a lot. The LVN stated she put a protective dressing to prevent breakdown. LVN B stated she did not have any open areas. On 07/06/2024 the resident's right hip was pink but blanched (redness that disappeared when pressure was applied but returned when the pressure was removed. Blood was still inside the vessels). LVN B stated she was aware that if there was a wound, she would notify the physician and family . In a phone interview on 07/17/2024 at 4:11 PM RN A stated she assessed Resident CR#1's skin weekly on the weekends. RN A stated she did a complete head to toe assessment on 07/13/2024 . RN A stated the resident did not have any open areas. RN A stated if she found something it would need to be reported for treatment to start. RN A stated she did not know how this occurred. Observation and interview at the local hospital on 07/18/2024 at 8:22AM revealed Resident CR#1 in bed on her left side. Resident CR#1 was nonverbal. Observation at this time revealed the resident's right hip with an open wound. The wound base was visible and pink. Continued observation revealed an open wound to the resident's right buttocks. The wound base was not visible due to eschar. Resident CR#1's family member was at the resident's bedside. In an interview at this time the family member stated she saw an open sore on her mother's hip. She stated she noticed an odor. In an interview at the local hospital on 07/18/2024 at 8:45AM the Hospital RN stated she was Resident CR#1's nurse for the day. RN C stated the resident was not verbal. The RN stated the resident was admitted for new pressure wounds. RN C stated the dressings were changed every other day. The Wounds were documented as POA which meant present on admission. In an interview on 07/18/2024 at 9:50AM the interim DON stated she began the position on 07/04/2024. The DON stated her expectations, and the facility policy was that all staff would assess the resident's skin. She stated if issues were found it wound be reported and documented in the computer. The DON stated the skin assessments were done weekly. All wounds were expected to be assessed and treated as ordered. The physician and resident's responsible party was to be notified of any skin changes. The DON stated it was the responsibility of the DON to monitor skin assessments and wound care weekly. The DON stated when we received the complaint, we had a QAPI meeting and implemented a plan. The two nurses were interviewed on how this occurred. Both nurses reported they assessed the resident they did not see any open wounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676371	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Quail Valley Post-Acute Healthcare	3640 Hampton Dr Missouri City, TX 77459

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 07/19/2024 at 10:48AM the Regional Clinical Specialist stated the facility policy and expectations were for skin assessments to be done on admission, weekly, and as needed. She stated if something new was identified the nurse, physician, nurse practitioner, and resident's responsible party were notified immediately so treatment could start. She stated she was not sure how this occurred. On approximately 07/03/2024 LVN B was asked to look at the resident's right hip by a CNA. The nurse looked at the resident's hip but did not see a wound. LVN B put a protective dressing on the resident's hip due to her being at risk for wounds. As the interview continued, she stated it was the DON's responsibility for monitoring the skin assessment. The monitoring was to be done by making rounds weekly to follow up after the wound care nurse. In a phone interview on 07/19/2024 at 11:01 AM the facility wound care physician stated he was not caring for Resident CR#1. The wound care physician stated it wound not be possible to determine a shear wound from a pressure wound from a picture. He stated the wound would need to be assessed to determine if it was a sheer wound. He stated in general a stage III wound or a wound with eschar would take more than a few hours to have occurred . In an interview on 07/19/2024 at 11:37 AM the Administrator stated his expectations for skin assessments were done appropriately according to the facility policy. He stated he was not sure how this occurred. He understood wounds could occur quickly within a matter of hours. He stated LVN B put a protective dressing on the resident's hip but did not communicate with the clinical staff. It was RN A's responsibility to assess the residents on the 500 hall. The DON was responsible for monitoring the wound care and skin assessments, and they had weekly skin meetings. Any skin changes were discussed in the meeting. The Administrator stated to prevent this in the future both nurses were suspended and terminated. He stated We hired a new experienced treatment nurse. We were monitoring residents' skin daily. Record review of the facility's policy titled Skin assessment dated [DATE] read in part: . Policy: It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body assessment. Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, weekly for three weeks, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury . The noncompliance was identified as Past Non-Compliant. The IJ began on 07/13/2024 and ended on 07/16/2024. The facility corrected the non-compliance by: Suspended the two wound care nurses. 100% head-to-toe assessments on all residents. Facility self-reported to Health and Human Service Commission. Quality Assurance and Performance Improvement Impromptu meeting (done without planning) with the Administrator, the DON, and the Medical Director. Notified the resident's physician and nurse practitioner. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676371	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Quail Valley Post-Acute Healthcare	3640 Hampton Dr Missouri City, TX 77459

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON assessed the residents with wounds with the facility wound care physician. Educated all staff on abuse and neglect. Identifying, reporting, and documenting changes to include changes in skin condition. Measures to prevent pressure injuries and weekly skin assessment. Actions to take if notified of a change in a resident's skin condition. Staff will report changes in condition to include skin changes to charge nurse and the DON . On 07/18/2024 at 4:36 PM., facility administrator was notified of past noncompliance IJ. A plan of removal was not requested. An IJ template was provided to the administrator via email.