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	08/22/2024

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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45328

Based on interviews and records reviewed, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoteds maintenance or enhancement of his or her quality of life, for 1 (Resident #1) of 6 residents reviewed for resident rights.

-The facility failed to allow Resident #1 to exercise his right to choose that CNA B not provide him care.

This failure could place residents at risk for decreased feelings of self-worth and dignity.

The findings included:

Record review of Resident #1's Admission Record, dated 07/31/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The resident's diagnoses included bipolar disorder (a mental health condition that causes extreme mood swings between emotional highs and lows), intervertebral disc disorders with myelopathy (injury to the spinal cord caused by severe compression), spinal stenosis (condition in which the spaces in the spine narrow, compressing the spinal cord), muscle wasting and atrophy (loss of muscle mass and strength), and unspecified deformity of left finger(s).

Record review of Resident #1's Quarterly MDS assessment, dated 06/06/2024, revealed a BIMS score of 12, indicating moderate cognitive impairment. Further review revealed the resident was dependent with toileting hygiene and showering/bathing.

Record review of Resident #1's undated care plan revealed the resident had an ADL self-care performance deficit r/t limited range of motion and was totally dependent on 1 staff for bathing/showering, dressing, personal hygiene/oral care, and toilet use. Resident needed extensive assistance with bed mobility and required mechanical lift with 2 staff assistance for transfer.

(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

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Windsor Quail Valley Post-Acute Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 3640 Hampton Dr Missouri City, TX 77459	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 07/31/2024 at 7:50 a.m. revealed, Resident #1 was lying in bed watching television. He said he did not want CNA B proving care to him and that CNA B was aware. He said CNA B would go into his room and offer him care but he would refuse. He said when CNA B would offer him care after he told him he did not want care from him it made him feel uncomfortable, like he was being punished, and like CNA B had power over him. He said he told the previous DON that he did not want CNA B assisting him, and he was assigned another CNA. He said when that DON left, CNA B was assigned to him again. He said he reported this to CNA C but was told they were not his CNA, and CNA B would be providing his care. He said he only reported his concern to the previous DON. In an interview at 10:36 a.m., CNA B said Resident #1 told him approximately a month ago that he did not want him providing care to him. He said he let the ADON know, and she suggested for him to switch rooms with the other CNA on the hall. He said for the past couple of days he offered Resident #1 help with his care because his call light would be on, but the resident would refuse his help. He said he first let his coworker know that she was assigned to the resident, but she would give him attitude and deny the resident's room was assigned to her. He said he would find another CNA to assist the resident. He said the ADON told him yesterday not to go into the resident's room. He said he followed CNA C into the resident's room this morning, 07/31/24, to show CNA C that the resident did not want him proving care to him and CNA C was trying to persuade the resident to let him care for him. He said he told the ADON today, 07/31/24, at approximately 8:30 a.m. that CNA C was not cooperating. He said he found another CNA to assist the resident. He said CNA C has since started to provide care to the resident. He said Resident #1 had the right to say he did not want him to assist him with his care. He said it could potentially affect the resident emotionally because they could be afraid something negative could happen to them. In an interview at 11:39 a.m., CNA C said the ADON told her yesterday that CNA B could not work with Resident #1 but did not say why. She said she was assigned to Resident #1 today but was not assigned to him this morning. She said CNA B and her had a discussion in the hallway about who was to provide care to the resident this morning. She said yesterday no one told her about a swap until 11:29 a.m. She said she never refused to provide care to Resident #1 . In an interview on 07/31/2024 at 12:26 p.m., the ADON said Resident #1 had a lot of psych issues and one week he would not have a problem with an assigned aide and the following week he would say he had a problem with the aide. She said CNA B was not to provide care to Resident #1 because her understanding was a charger came up missing but was found. She said the previous interim DON said CNA B was not to provide care to Resident #1. She said she told CNA B not to go into the room because it could put him in a place that he should not even be in. She said CNA B knew he was not to provide care or go into Resident #1's room since at least 07/10/2024. She said it was the right of the resident to specify if they did not want a certain aide to assist them with their care. In an interview on 07/31/2024 at 12:50 p.m., the DON said she has been working at the facility since last Monday, 07/22/24. She said she did not know Resident #1 requested that CNA B not provide him care and said she found out today. She said she was not informed by any of the staff members that CNA B should not be providing care to him. She said residents had the right to say they did not want a particular CNA to provide them care. She said emotional harm could potentially result from receiving assistance from a CNA they did not want, and their BP could go up. She said to her knowledge CNA B went into the resident's room this morning to show CNA C that the resident did not want care from him. She said her expectation was for the CNAs to abide by a resident's request to not have a particular CNA assist them with their care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's document titled Your Rights and Protections as a Nursing Home Resident, undated, read in part . You have the right to .be treated with dignity and respect .