STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676337	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR HOUSTON	6920 T.C. JESTER BLVD HOUSTON, TX 77091

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice to prevent development of pressure injuries to 5 of 9 residents (Resident #1, Resident #2, CR#3, Resident #4, and Resident #5) reviewed for pressure ulcers in that; -The treatment nurse inaccurately documented and assessed Resident #1, Resident #2, CR #3, Resident #4, and Resident #5's wound integrity and wound descriptions on the Admission/Weekly Skin Integrity Assessments. -The treatment nurse failed to update Resident #4's Admission/Weekly Skin Integrity Assessments when his St II PU was healed. These failures could affect residents who had pressure sores and placed them at risk for avoidable and worsening pressure ulcers, pain and hospitalization . Findings include: Resident #1 Record review of Resident #1's face sheet revealed a [AGE] year-old-female admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Care plan read in part, Focus The resident has a stage 4 pressure ulcer to her right distal medial foot, or potential for pressure ulcer development r/t disease process diabetes, hypertension, altered mental status, incontinence, alzheimer's, a-fib, [MEDICAL CONDITION], depression, incontinence, and Immobility Date initiated:08/27/2019 Revision 01/30/2020 .Interventions .Assess/record/monitor wound healing weekly Measure length, width and depth where possible, Assess and document status of wound perimeter, wound bed and healing progress. Report improvement and declines to the MD. Record review of Resident #1's Admission/Weekly Skin Integrity Assessments dated 10/28/19, 11/01/19, [DATE], 11/15/19, 11/22/19, 11/29/19, 12/6/19, 12/13/19, 12/20/19, [DATE], 1/3/20, 1/10/20, 1/17/20, 1/24/20, 1/31/20, 2/7/20, and 2/14/20 revealed the newly identified St IV PU's were documented as Old Open Area, there were no initial or subsequent wound measurements, or wound staging documented on the weekly skin assessments. Record review of the facility's Weekly Skin Report dated 3/2/20-[DATE] revealed, documentation of Resident #1's FA St IV left buttock PU measuring 6 x 4 x 3cm identified on 10/28/19, a St IV FA left lateral foot PU measuring 1.5 x 0.8 x 0.1cm identified on 11/4/19, a St IV FA right distal lateral foot PU measuring 1 x 5 x 0.1cm identified on 10/31/19, and a FA left foot PU measuring 0.3 x 0.5 x 0.1cm identified on 12/29/19. Resident #2 Record review of Resident #2's face sheet revealed, a [AGE] year-old male originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Care plan read in part, Focus; The resident has a stage 3 pressure ulcer to his left buttock or potential for pressure ulcer development r/t Dehydration, disease process of metabolic [MEDICAL CONDITIONS] acute kidney failure, anxiety, hypertension type two diabetes, dysphagia, [MEDICAL CONDITION], altered mental status, dementia, depression, Hx of ulcers, Immobility Date Initiated: 11/13/2019 Revision on: 01/28/2020 .Interventions .Assess/record/monitor wound healing weekly Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD . Further record review of Resident #2's Admission/Weekly Skin Integrity Assessments dated 10/25/19, 11/01/19, [DATE], 11/15/19, and 11/22/19 revealed, an Old Open Area left buttock PU documented. There was not documentation of wound measurements or wound staging. Further record review of Resident #2's Admission/Weekly Skin Integrity assessment dated [DATE] revealed, documentation of a New Open Area and an Old Open Area Right trochanter, left buttock, and right lower leg PU. There were no wound measurements or wound staging for the newly identified or old wounds. Further record review of Resident #2's Admission/Weekly Skin Integrity Assessments dated 12/6/19, 12/13/19, 12/20/19, [DATE], 1/3/20, 1/10/20, 1/17/20, 1/24/20, 1/31/20, 2/12/20, and 2/20/20 revealed, documentation of Old Open Area, left buttock and right trochanter PU's, there were no wound measurements or wound staging on the skin assessments. Record review of the facility's Weekly Skin Report dated 3/2/20-[DATE] revealed, a St III FA right hip PU measuring 0.7 x 0.7 x 0.2cm identified on 11/29/19 and a St III FA left buttock PU measuring 1.8 x 0.8 x 0.2cm identified on 10/17/19. CR #3 Record review of CR #3's face sheet revealed, a [AGE] year-old female admitted originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of CR #3's Care plan revealed, documentation of a St II PU to the right buttock initiated on 2/18/19, there was no documentation of a St III or IV left buttock PU. Record review of CR #3's Admission/Weekly Skin Integrity assessment dated [DATE] revealed, documentation of an Old Open area on the left buttock PU. There was no staging or measurements documented. Further record review of the facility's Weekly Skin Report dated 11/5/19-11/11/19,11/12/19-11/18/19, 11/19/19-11/25/19, and 11/19/19-11/25/19 revealed, documentation of a FA right buttock wound. The wound was described as Other and identified on 10/31/19. Further record review of CR #3's Admission/Weekly Skin Integrity Assessments dated 11/01/19, 11/08/19, 11/15/19, 11/22/19, 11/29/19, 12/6/19, 12/13/19, 12/20/19, [DATE], 1/3/20, 1/10/20, 1/17/20, 2/1/20, 2/14/20 revealed, documentation of left buttock PU. There was no documentation of wound staging or wound measurements. Further record review of the weekly skin assessments revealed, the wound site documented on the left buttock when the wound was on the right buttock. Record review of CR #3's physician Wound Care notes dated 11/11/19 revealed, documentation of a FA St III right buttock PU identified on 10/31/19. Further record of the facility's Weekly Skin Report dated 2/3/20-2/10/20 revealed, a right buttock wound on CR #3 measuring 7 x 11 x 1cm identified on 10/31/19. There was no documentation showing if the wound was FA or community acquired or the wound stage. Further record review of the facility's Weekly Skin Report dated 2/17/20-[DATE] revealed, documentation of a St IV community acquired right buttock PU on CR #3 measuring 9 x 10 x 1cm identified on 10/31/19. Prior measurement of the St IV PU measured 6 x 10 x 1. Further record review of the Weekly Skin assessment dated [DATE]-2/17/19 revealed, a community acquired St IV PU to CR #3's right buttock measuring 6 x 10 x 1cm. Record review of the facility's Weekly Skin Reports dated 3/2/20-[DATE] and [DATE]-3/2/20 revealed, documentation of a right buttock PU identified on CR #3 on 10/31/19. There was no documentation of the PU stage, if it was FA or community acquired. Previous week measurements were documented as 9 x 10 x 1cm. Current Week Size length x width x depth had hospital documented. Interview on 3/4/20 at 1:14 pm with the Treatment nurse, when asked if she was aware CR #3's Weekly Skin integrity assessments showed the residents' wound site was on the left buttock when the wound was on the right buttock and the weekly skin report documentation was inconsistent with some reports showing a FA right buttock PU while other reports showed a community acquired wound, she could not state why there were discrepancies in the documentation other than stating the resident was frequently in and out of the hospital. Resident #4 Record review of Resident #4's face sheet revealed, a [AGE] year-old male admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's Initial Nursing Evaluation dated 1/31/20 revealed, documentation of redness to the right antecubital, left antecubital, and right toe, and black area to the left great toe, dressing to the left leg and [MEDICAL CONDITION] to the right foot. There was no documentation of a St II PU. Record review of the facility Weekly Skin Report dated 2/3/20-2/20/20 revealed, a community acquired St II sacral PU on Resident #2 measuring 1 x 1 x 0.2cm, identified on 1/31/20. Further record review of the facility Weekly Skin Report dated 2/10/20-2/17/20 revealed, documentation showing Resident #2's sacrum PU healed on 2/7/20. Record review of Resident #4's Admission/Weekly Skin Integrity Assessments dated [DATE], 2/12/20, and 2/19/20 revealed, documentation of an Old Open Area, Sacrum PU. There was no documentation of wound measurements or wound staging. Record review of Resident #4's physician Wound Care notes dated 2/7/20 revealed, no wound care notes documenting treatment or progression of a St II PU. Record review of Resident #4's Skin/Wound Note dated 2/7/20 read in part, Wound MD was here 2/7/2020 and resolved pressure area to

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

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.

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) sacrum. Interview on 3/4/20 at 1:14 pm with the Treatment nurse, when she was notified that Resident #4's St II sacral PU measurements were not documented in her wound care notes, or in the MD notes, she stated the wound MD saw the resident on 2/7/20 and resolved the wound. When asked if the St II PU documentation on the weekly skin assessments dated 2/12/20 and 2/19/20 should have been removed on 2/7/20 if the wound resolved, she stated she left it there because there was still some discoloration and wanted to keep the wound note there in case it reopened. When asked if there should have been an updated note either on the weekly skin assessment or wound care progress notes showing the progression of the wound and treatment, she said yes, she should have transcribed her note further stating because the MD had resolved the wound in his notes, she forgot to update the weekly skin assessment and her progress notes. Resident #5 Record review of Resident #5's face sheet revealed, a [AGE] year-old male originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #5's Admission/Weekly Skin Integrity Assessments dated 12/4/19, 12/11/19, 12/18/19, 1/8/20, 1/15/20, 1/22/20, 2/9/20, and 2/19/20 revealed, an Old Open Area sacrum PU. There were no wound measurements or wound staging documented on the skin assessments. Record review of the facility Weekly Skin Report dated 3/2/20-[DATE] revealed, documentation of a chronic community acquired St IV sacral PU on Resident #5 measuring 1.5 x 1.3 x 1cm identified on 2/1/17. Interview on 3/4/20 at 1:13 pm with the DON, when asked who completes the weekly skin assessments, she stated the floor nurses do not complete weekly skin assessments but will complete an initial assessment on paper when there is a new admission. She further stated the nurse would mark on the paper assessment where the wound is and the description. She stated the weekend treatment nurse does everything. She said the treatment nurse completes wound measurements and documents findings on the weekly skin assessments stating she does 99% of wound care. Interview on 3/4/20 at 1:14 pm with the Treatment nurse, when asked which residents receive the weekly skin assessment, she stated all residents receive weekly skin assessments whether they have wounds further stating their assessments are completed Monday through Friday. When asked what is supposed to be documented on the weekly skin assessment, she stated if there is a new or old wound identified, the area of the wound, the type of wound - a PU, vascular, or diabetic wound. She said she just started documenting the wound measurements on the weekly skin integrity assessments about a week or so ago further stating she was only documenting the measurements on the weekly skin report or in her wound care progress notes. Said she was not previously documenting wound measurements on the weekly skin assessments because they were being documented in the nursing wound notes, MD notes, and on the weekly skin report. When asked what the policy was regarding documenting the measurements on the weekly skin assessments, she stated she did not think it had to be in the weekly skin assessments if it was documented in the MD notes, weekly PU report or wound progress notes. Further interview on 3/4/20 at 1:14 pm with the Treatment nurse, when asked if there were other nurses who complete the weekly skin assessments, she stated there is a weekend Treatment nurse also completes the assessment. She stated the weekend treatment nurse is responsible for completing skin assessments for Friday, Saturday, and Sunday, unless it is a Sunday night admission, stating she would be responsible for completing the weekly skin assessment. When asked if the weekend Treatment nurse is documenting measurement on the weekly skin assessment, she was unable to state if the weekend Treatment nurse was documenting measurements on the skin assessments. Interview on 3/4/20 at 2:41 pm with the weekend treatment nurse, RN 1, when asked if a resident is admitted with a new or old wound on the weekend, is the weekly skin assessment completed, she stated whatever wound she finds on the resident during admission, she documents them on the weekly skin integrity assessment, checks the resident's hospital records to see if wound care orders were sent with the resident and follows the orders, writes orders, and documents what treatment was done. When asked if she completes the weekly skin assessment that is in the EHR, she said yes, she completes the weekly admission skin assessment, when asked what is supposed to be documented on the weekly skin integrity assessment, she stated she documents if the skin is intact, or if it's an old or open wound. She stated if there is a wound she would then would go to the anatomical body part and click on wound location, she said she would document the type of wound and wound measurements. When asked if the measurements should always be documented on the weekly skin assessment, she stated they should always be document on the weekly skin assessment for the initial, she further stated she doesn't do subsequent weekly skin assessments only the initial but stated she would guess the measurements needed to be documented. When asked if the wound documentation would only be on the weekly skin assessment or is the assessment documented elsewhere in the EHR, she stated the treatment nurse would also document on the weekly progress note that is completed when the wound MD does rounds with the nurse. When asked if the treatment nurse should ever leave the measurements off the weekly assessment, she again stated the wound measurements should not be left off the assessment. Interview on 3/5/20 at 12:11 pm with the DON, when asked who is responsible for completing the Weekly Skin Integrity Assessments, she stated the treatment nurse is responsible for completing the weekly skin assessment stating they are completed Monday through Friday throughout the week further stating, There is no way the nurse can complete all assessments in one day. She stated if there is a new admission on the weekend, the treatment nurse on the weekend will complete the assessment. When asked what is supposed to be documented on the weekly skin assessment she stated if the resident skin is intact, then the nurse will check intact skin and that's it. She further stated if the skin is not intact, she will document the location. She then stated the treatment nurse was documenting the location but was not documenting the wound measurements or staging, further stating she was only putting measurements in the nursing progress notes when the MD did his weekly measurements. She stated there is not a specific policy stating they must put the measurement in the weekly skin assessment, but they must have weekly measurements documented. She stated the treatment nurse is now putting the measurements and staging on the weekly skin assessments to be consistent. Further interview on 3/5/20 at 12:11 PM with the DON, when the DON was informed the wound measurements were not consistently being documented in the weekly skin assessments, or the nursing progress notes, and new wounds were being documented as old open wounds, and a resident's wound location was documented incorrectly, she stated she was not aware of this, but the weekly skin assessments will now all be documented the same and will include measurements and staging of the wounds. She further stated there will be consistency in documentation making it easier to see the measurements on the weekly assessments instead of trying to find the measurements in the progress notes. Record review of the facility's treatment of [REDACTED].General Guidelines .1. Assess the pressure ulcer(s) for location, size (measure length, width, and depth), sinus tracts, undermining, tunneling, exudate, necrotic tissue, and the presence or absence of granulation tissue and [MEDICATION NAME]. 2. Determine the ulcer's current stage of development .