STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676371	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 2 of 5 residents (Resident #1 and #3) reviewed for comprehensive care plans in that, -The facility did not develop a comprehensive person-centered care plan to address Resident #1's receiving oxygen therapy, [MEDICAL CONDITION] medications, and the use of Prevalon boots. -The facility did not develop a comprehensive person-centered care plan to address Resident #3's use of Prevalon boots. These failures placed all residents at risk for not receiving care according to their individually assessed needs. Findings Include: Resident #1 Record review of Resident #1's face sheet revealed he was a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's plan of care initiated 8/16/18 revealed no care plan for his oxygen use, [MEDICAL CONDITION] medications, or use of Prevalon (pressure relieving boots that strap to the feet and extend above the ankle) boots. Record review of Resident #1's physician's order dated 6/26/20 revealed an order to administer Oxygen at 3 LPM via Nasal Cannula as needed for [MEDICAL CONDITION]. Record review of Resident #1's physician's order dated 6/27/20 revealed an order to administer [MEDICATION NAME] ER Tablet Extended Release 12 Hour 100 MG Give 1 tablet by mouth two times a day for [MEDICAL CONDITION]. Record review of Resident #1's annual MDS assessment dated [DATE] revealed the resident had a BIMS of 11 out of 15 indicating moderately impaired cognitive skills for daily decision making. He required two-person assist with bed mobility, transfers, and toileting. Resident #1 required one-person assist in the areas of locomotion on the unit, dressing, eating, and personal hygiene. He was coded as using a wheelchair for mobility. He had an indwelling urinary catheter. He was not coded on the MDS for oxygen use. Observation and interview on 9/2/20 at 12:38 pm revealed Resident #1 lying on his air mattress bed wearing Prevalon boots on both feet/legs with socks on. He had contractures on both hands. He was receiving oxygen therapy at 3.0 liters. There was a sleep apnea mask on his end table in a bag. The bag was not dated. The resident's cannula was yellow in color. His call light was sitting on his end table beyond his reach. He said he knew how to use the call light. He said he used it when he needed nursing staff to assist. He had a catheter. The resident said he got the sores on his ankles at the facility. Record review of Resident #1's physician's order dated 8/26/20 revealed an order to administer [MEDICAL CONDITION] off at 5PM in the evening. Record review of Resident #1's physician's order dated 8/26/20 revealed an order to administer [MEDICAL CONDITION] ON at 2pm one time a day for Less O2 saturation. Record review of Resident #1's physician's order dated 8/27/20 revealed an order to administer [MEDICAL CONDITION] SETTING: 12/7 every shift for SLEEP APNEA. Record review of Resident #1's physician's order dated 8/26/20 revealed an order to apply [MEDICAL CONDITION] at 8pm at bedtime for [MEDICAL CONDITION]. Record review of Resident #1's physician's order dated 8/27/20 revealed an order to remove [MEDICAL CONDITION] at 8am one time a day for Removal [MEDICAL CONDITION]. Record review of Resident #1's consolidated physician's orders for the months of August and September 2020 revealed Resident #1 did not have an order for [REDACTED]. Interventions: Administer medication/puffers/ oxygen as ordered. Monitor for effectiveness and side effects. [MEDICAL CONDITION]/[MEDICAL CONDITION]/VPAP SETTINGS: Titrated pressure: as ordered. Pace and schedule activities providing adequate rest periods. Respiratory - Monitor respirations, pulse, O2 sat and lung sounds prior to nebulizer treatments. Scheduled and PRN. Use pain management as appropriate. Monitor/document side effects and effectiveness. Focus: Resident has a [MEDICAL CONDITION] disorder Goals: The resident will be free from injury from [MEDICAL CONDITION] activity through the review date. Interventions: Give medications as ordered. Monitor/document for effectiveness and side effects. Give [MEDICAL CONDITION] medication as ordered by doctor. Monitor/document side effects and effectiveness. Monitor labs and report any sub therapeutic or toxic results to MD. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. [MEDICAL CONDITION] PRECAUTIONS: Do not leave resident alone during a [MEDICAL CONDITION], Protect from injury, If resident is out of bed, help to the floor to prevent injury, Remove or loosen tight clothing, Don't attempt to restrain resident during a [MEDICAL CONDITION] as this could make the convulsions more severe, Protect from onlookers, draw curtain etc. Resident #3 Record review of Resident #3's face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 03 out of 15 indicating severe cognitive impairment. A review of Section G: Activities of Daily revealed the resident required 2-person assistance for transfers and bed mobility. He required one-person assistance with locomotion on and off unit, dressing, eating, toileting and personal hygiene. Record review of Resident #3's care plan initiated on 7/13/18 and revised on 5/11/20 revealed Resident #3 was not care planned for the use of Prevalon boots. Observation/Interview on 9/2/20 at 2:00 pm revealed Resident #3 lying down on his bed. The bed had no bed sheets. He had contractures on both hands. He was wearing Prevalon boots on both legs with socks on. He was unshaven. He had dirt underneath his finger nails. He said CNA's did not always do what they were supposed to do. He said he had not been shaved in days. He said he was supposed to get shaved on his shower days. He said he was totally dependent on them for care. He said he got frustrated when they did not do what they were supposed to do. Record review of Resident #3's order summary dated from 6/1/20 to 9/1/20 revealed there were no physician orders for the use of Prevalon boots. In an interview on 9/4/20 at 10:10 am with the DON. She said CNAs were not supposed to apply and/or remove Prevalon boots. She said Resident #1's RP brought the Prevalon boots. She said Resident # 1's RP was very demanding. She said Resident #1's RP probably told the CNA's to put the boots on him. She said the CNAs did whatever the RP told them to do. So, she could believe the CNAs were putting the boots on. She said, but, they are not supposed to do that. She said it was outside of their scope of practice. She said the nurses were responsible for reconciliation of physician orders. She said the ADON still had to go over the orders and initial in the system. She said she was unaware the Resident #1 and Resident #3 had Prevalon boots without orders. In an interview on 9/4/20 at 11:11 am with the DON, she said everything about the resident, such as his medications and ADLs, should have a care plan. She said the MDS nurses were responsible for completing and updating the care plans. She said care plans were important for staff to know how to properly care for resident conditions. She said she reviewed the care plan and the physician orders for Resident #1 and #3. She said some residents did not have a care plan for a Prevalon boot because they did not have an order for [REDACTED]. She said other nurses, including the DON and ADONs, were also capable of revising care plans. She said there was not only one specific person responsible for updating care plans. She said she was reviewing the care plans today to ensure all areas were addressed when she realized that Resident #1's [MEDICAL CONDITION] medication and oxygen therapy were not addressed. Record review of the facility's care planning policy revised December 2017 read in part: .A comprehensive, person-centered care plan is developed and implemented for each resident to meet the resident's physical, psychosocial and functional needs. The care plan is based on the resident's comprehensive assessment and is developed by a

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) care planning/interdisciplinary team which includes, but is not necessarily limited to the following personnel: a. The Registered Nurse who has responsibility for the resident; g. The Director of Nursing (as applicable); h. The Charge Nurse responsible for resident care; j. Other as appropriate or necessary to meet the needs of the resident .
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the services provided by the facility meet professional standards of quality for 2 of 5 residents (Resident #'s 1 and 3) reviewed for professional standards in that: -The facility failed to ensure Resident #1 and Resident #3 had physician orders for the use of Prevalon boots. -The facility failed to ensure trained nursing staff put on and took off Prevalon boots for Resident #1 and Resident #3. These failures placed all residents at risk of unlicensed staff implementing non-physician ordered interventions which could result in injury and a decline in health status. Findings include: Resident #1 Record review of Resident #1 revealed a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's annual MDS assessment dated [DATE] revealed the resident had a BIMS of 11 out of 15 indicating moderately impaired cognitive skills for daily decision making. He required two-person assist with bed mobility, transfers, and toileting. Resident #1 required one-person assist with in the areas of locomotion on the unit, dressing, eating, and personal hygiene. He was coded as using a wheelchair for mobility. He had an indwelling urinary catheter. He was not coded on the MDS for oxygen use. Record review of Resident #1's care plan initiated on 8/16/18 and revised on 9/4/20 revealed Resident #1 was not care planned for Prevalon boots. Record review of Resident #1's order summary dated from 6/1 to 9/1/20 revealed no physician orders for Prevalon boots. Record review of Resident #1's nurse notes from 6/26 to 9/3/20 revealed no nurse notes for orders for Prevalon boots; applying and/or removing and assessing sites. Observation and interview on 9/2/20 at 12:38 pm revealed Resident #1 lying on his air mattress bed wearing Prevalon boots on both feet/legs with socks on. Resident #1 had both feet floating off pillows while wearing Prevalon Boots. Observation of the label on the boots read, Prevalon. Resident #1 was positioned on his side facing the door. His left foot was floating off one pillow that laid underneath his foot. He had his right foot over his left foot with a pillow in between (off floating on pillows). He had contractures on both hands. He was receiving oxygen therapy at 3.0 liters. There was a sleep apnea mask on his end table in a bag. The bag was not dated. The resident's cannula was yellow in color. His call light was sitting on his end table beyond his reach. He said he knew how to use the call light. He said he used it when he needed nursing staff to assist. There was a camera in the room. There was no sign posted that a camera was in the room. He had a catheter. The resident said he got the sores on his ankles at the facility. Observation and interview on 9/2/20 at 1:50 pm revealed Resident #1 lying on his side on his air mattress bed wearing Prevalon boots on both feet/legs with socks on. Resident #1 had both feet floating off pillows while wearing Prevalon Boots. Observation of the label on the boots read, Prevalon. Resident #1 was positioned on his side facing the door. His left foot was floating off one pillow that laid underneath his foot. He had his right foot over his left foot with a pillow in between (off floating on pillows). He was receiving oxygen at 3.0 liters. He said he was doing fine. In an interview on 9/3/20 at 9:40 am with RN, she said she worked at the facility for 3 years. She said she worked with resident's in hallway 500 and she was familiar with Resident #1 and Resident #3. She said CNA's were not supposed to put on and/or take off Prevalon boots. She said the only thing that CNA's could do was to put bariatric cream on residents when they had diaper rash but, they could not touch any resident wounds. She said CNA's applying and removing Prevalon boots was beyond their scope of practice. She said nurses do it because it requires assessment and treatment. In a follow-up interview on 9/3/20 at 1:40 pm with RN, she said that Prevalon boots required an order. She said Resident #1 and Resident #3 did not have orders for Prevalon boots. She said she did not see the boots on Resident #1 when she changed the oxygen tubing at 2:00 pm yesterday. She said the CNA was in touch with the RP and whatever the RP said the CNA did. This Surveyor asked if CNA's were allowed to apply and remove Prevalon boots and she said no. She said, only the charge nurse and/or wound care nurse could do it. In an interview on 9/3/20 at 2:05 pm with Wound Care Doctor, he said Resident #1 had on Prevalon boots when he provided wound care for stage 4 pressure ulcers on Resident #1's right and left ankles. Resident #3 Record review of Resident #3's face sheet revealed a [AGE] year-old male who was admitted on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 03 out of 15 indicating severe cognitive impairment. A review of Section G: Activities of Daily revealed the resident required 2-person assistance for transfers and bed mobility. He required one-person assistance with locomotion on and off unit, dressing, eating, toileting and personal hygiene. Record review of Resident #3's care plan initiated on 7/13/18 revealed Resident #1 was not care planned for Prevalon boots. Record review of Resident #3's order summary dated from 6/1 to 9/1/20 revealed no physician orders for Prevalon boots. Observation and interview on 9/2/20 at 2:00 pm revealed Resident #3 lying down on his bed. The bed had no bed sheets. He had contractures on both hands. He was wearing Prevalon boots on both legs with socks on. He was unshaven. He had dirt underneath his finger nails. He said CNA's did not always do what they were supposed to do. He said he had not been shaved in days. He said he was supposed to get shaved on his shower days. He said he was totally dependent on them for care. He said he got frustrated when they did not do what they were supposed to do. Observation and interview on 9/3/20 at 8:00 am with Resident #3 revealed him sitting up on his wheelchair watching TV. He was wearing Prevalon boots on both legs with socks on. He was unshaven. He had dirt underneath his finger nails. The resident said he was doing fine. He said staff washed his hands one time yesterday. Observation interview on 9/3/20 at 3:00 pm with Resident #3 revealed him sitting up on his wheelchair watching TV. He was wearing Prevalon boots on both legs with socks on. His bed sheets were just getting changed. He was unshaven. He had dirt underneath his finger nails. His hands were sticky to the touch. He said nursing staff only washed his hands once a day at most. He said the nursing staff did not wash his hands before and/or after meals. He said he wanted to be shaved so he could look good. He said he liked looking good. Observation and interview on 9/4/20 at 9:35 am accompanied by RN revealed the resident lying in bed. He was wearing Prevalon boots on both legs with socks on. Resident #3 said in the presence of the RN that the CNA's were the ones that put his boots on in the morning and took them off every night. The RN confirmed Resident#3 had Prevalon boots on both legs. She said he did not have an order for [REDACTED]. In an interview on 9/4/20 at 12:45 pm with CNA #1, she said she would remove Resident #3's Prevalon boots before showers and apply them right back after his shower. She said Resident #3 did not like to be without wearing his boots much. In a follow-up interview on 9/3/20 at 2:45 pm with RN, she said she worked 4-days on and 1 day off. She said when she changed Resident #1's oxygen tubing, the resident did not have boots on his feet. She said she checked his feet to make sure the dressings on his wounds were in-tact. She said she had never seen Prevalon boots on the resident #1's feet. She said the resident had only been in her unit (hallway 500) for about 4 days. She said CNA's were not supposed to put on or take off boots because there were wounds and it was a treatment that required assessing. She said Resident #1 did not have an order for [REDACTED].#3 did not have an order for [REDACTED].#3 always wore the boots and it did not like it when they removed them for showers. In an interview on 9/4/20 at 10:10 am with the DON. She said CNAs were not supposed to apply and/or remove Prevalon boots. She said Resident #1's RP brought the Prevalon boots. She said Resident # 1's RP was very demanding. She said Resident #1's RP probably told the CNA's to put the boots on him. She said the CNAs did whatever the RP told them to do. So, she could believe the CNAs were putting the boots on. She said, but, they are not supposed to do that. She said it was outside of their scope of practice. She said the nurses were responsible for reconciliation of physician orders. She said the ADON still had to go over the orders and initial in the system. She said she was unaware the Resident #1 and Resident #3 had Prevalon boots without orders. During an interview on 9/4/20 at 1:10 pm Surveyors requested policy on following physician's order from the DON. No policy was provided prior to exit. Record review of facility's Physician Services dated (Revised December 2017) read in part: .The medical care of each resident is under the supervision of a Licensed Physician. Physician orders and progress notes shall be maintained in accordance with the current OBRA regulations .
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure a resident who is unable to carry out ADLs received the necessary services to maintain grooming and personal hygiene for 2 of 5 residents (Resident #3 and Resident #4) reviewed for activities of daily living care in that: -Resident #3 and #4 had excessive facial hair; dirt underneath their finger nails and had dirty hands. -Resident #3's was left in a bed with no sheets on it. His bed was not made for him

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) until after 3:00 pm. These failures could place all residents who were dependent on staff for ADLs at risk of not receiving proper care and services and a decreased quality of life. Findings include: Resident #3: Record review of Resident #3's face sheet revealed a [AGE] year-old male who was admitted on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 03 out of 15 indicating severe cognitive impairment. A review of Section G: Activities of Daily revealed the resident required 2-person assistance for transfers and bed mobility. He required one-person assistance with locomotion on and off unit, dressing, eating, toileting and personal hygiene. Record Review of Resident #3's Care Plan for ADL's read in part: Focus: Resident #3 has an ADL self-care performance deficient related to muscle weakness and uncontrollable tremors secondary to [DIAGNOSES REDACTED].#3 will maintain current level of function in (ADL's) through the review date . (date initiated 12/16/18 and revised on 05/11/20) Interventions: Shower and dressing interventions date initiated 12/16/18, revised on 5/24/19 for bathing/showering: check nail length and trim and clean on bath day and as necessary, report any changes to the nurse; provide sponge bath with a full bath if shower cannot be tolerated; the resident requires total assistance by to 2 staff with bathing/ showering Tuesday Thursday on Saturday from 6am to 2pm; resident is totally dependent on one staff for dressing; the resident is totally dependent on 1 staff for eating; and resident is totally dependent on 1 staff for personal hygiene and oral care. Observation and interview on 9/2/20 at 2:00 pm revealed Resident #3 lying down on his bed. The bed had no bed sheets. He had contractures on both hands. He was wearing Prevalon boots on both legs. He had socks on. He had a heavy growth of hair on his face. He had a brownish-black colored substance underneath his finger nails. He said the CNA's did not always do what they were supposed to do. He said he had not been shaved in days. He said he was supposed to get shaved on his shower days. He said he was totally dependent on them for care. He said he got frustrated when they did not do what they were supposed to do. In an interview on 9/3/20 at 8:13 am with, CNA #1, she said the protocol was to ensure that resident beds are made by 10:00 am. She said she strips her beds every day and disinfects them because she hates gritty sheets. Observation and interview on 9/3/20 at 8:00 am with Resident #3 revealed him sitting up on his wheelchair watching TV. He was wearing Prevalon boots on both feet. He had socks on. He had excessive hair growth on his face. He had a brownish-black colored substance underneath his finger nails. The resident said he was doing fine. He said staff washed his hands one time yesterday. Observation and interview on 9/3/20 at 3:00 pm with Resident #3 revealed him sitting up on his wheelchair watching TV. He was wearing Prevalon boots on both feet. He had socks on. His bed sheets were just getting changed. He still had not had his face shaved. He still had the brownish-black colored substance underneath his finger nails. His hands were sticky to the touch. He said nursing staff only washed his hands once a day at most. He said the nursing staff did not wash his hands before or after meals. He said he wanted to be shaved so he could look good. He said he liked looking good. In an interview on 9/3/20 at 8:13 am with CNA #1, she said she worked in hallway 500 today, but she was a restorative aide, so she went wherever needed. She said Resident #3 was total dependent. She said he required 2-person assist for transfer, bathing, feeding and personal hygiene. She said he required one person assist for repositioning because the resident was helpful. She said maybe once she had seen resident beds unmade but that was because there were no linens. She said Resident #3's shower days were Tuesdays, Thursdays, and Saturdays. But, he got bed baths because he did not like the shower chair. She said he got shaved every shower day. She said they trimmed resident's nails as needed. She said the CNA'S were responsible for washing the resident's hands especially if they were diggers. She said she meant, residents who like to scratch themselves underneath their briefs and end up with feces underneath their finger nails. She said they washed resident's hands as necessary. In an interview on 9/3/20 at 3:15 pm with CNA #3, she confirmed Resident #3 had dirt underneath his nails. She touched his hands and confirmed his hands were sticky. She said she worked the 2 pm to 10 pm shift. She said she noticed the day shift did not make his bed, so she was making it now. She said Resident #3 was total dependence for personal hygiene. She said Resident #3 should have been shaved yesterday on his shower day (Tuesday), but they had not shaved him. She acknowledged Resident #3 in the background validating that he had not been shaved in more than one week. She said residents that are total dependent should have their hands washed before and after meals. She could not recall the last time she was in-serviced for ADL care. Resident #4 Record review of Resident #4's Face Sheet revealed a [AGE] year old male who was admitted on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed the resident had a BIMS of 03 out of 15 indicating severe cognitive impairment. He required two-person assist with transfers. He required one-person assist with in the areas of locomotion on unit, toileting, dressing, eating and personal hygiene. Record Review of Resident #4's Care Plan for ADL's read in part: Focus: Resident #4 has an ADL self-care performance deficient related to activity intolerance, impaired balance, abnormal posture, impaired communication related to [MEDICAL CONDITION], [DIAGNOSES REDACTED].#4 will maintain current level of function through the review . (date initiated 10/25/18 revised on 3/5/20) Interventions: Personal hygiene care of the Resident is totally dependent on one staff for personal care and oral care . (date initiated 10/18/18). Record review of Resident #4's ADL log dated from 8/17 to 9/1/20 revealed he went without a shower for 3 days (8/22, 8/23 and 8/24). Observation and interview on 9/2/20 at 2:05 pm revealed Resident #4 sitting in his wheelchair by the window. His family member was on the outside of the window visiting. Excessive facial hair noted. There was a food stain on his T-shirt. He said he was doing fine. Observation and interview on 9/3/20 at 8:03 am revealed Resident #4 sitting in his wheelchair by the window. Excessive facial hair noted. He said he was doing fine. Observation and interview on 9/3/20 at 3:03 pm revealed Resident #4 sitting in his wheelchair by the window. Excessive facial hair noted. He pointed to his family member that was sitting outside his window visiting. He said he had not been shaved in a long time. When this Surveyor asked him if he liked to get shaved, his eyes got big. He made eye contact with this Surveyor and profusely nodding his head he said, YEAH. In an interview on 9/3/20 at 8:13 am with, CNA #1, she said Resident #4 was total dependent. She said he required 2-person assistance for transfer, bathing, personal hygiene and repositioning. She said his shower days were Tuesday, Thursdays, and Saturdays on 2-10 shift. She said he got shaved every shower day. She said she could not say why the resident did not get shaved because she was off on Tuesday. She said the CNA's were responsible for washing the resident's hands. She said Resident #4 sometimes liked to dig into his diaper. She said she knew that she had to check on him more frequently because of it. In an interview on 9/3/20 at 3:18 pm with CNA #3, she confirmed Resident #4 had dirt underneath his nails. She touched his hands and confirmed his hands were soiled acknowledging his left thumb was dirty and he had a food oval shape food stain about the size of a half dollar on the other hand. She said she worked the 2 pm to 10 pm shift. She said she noticed the day shift did not make his bed, so she was making it now. She said Resident #4 was total dependence for personal hygiene. She said it looked like Resident #4 had not had a shave in a long while. She said yesterday was his shower day (Tuesday), but apparently, they had not shaved him. In an interview on 9/3/20 at 8:35 am with CNA #2, said she had worked at the facility for 6 years. She said she worked on the 500 hallway. She said Resident #4 was totally dependent. She said he required 2-person assistance with transfers, reposition and bathing (depended on staff; sometimes would be 1-person assist). She said Resident #4 required 1-person assistance with personal hygiene. She said the residents were supposed to be shaved during showers days and/or when they saw hair growth. She said the protocol for making beds was 10:00 am. She said she did not notice that the resident's bed had not been made because she was not assigned to him yesterday. She said everyone was responsible for washing the resident's hands and face when they see them soiled. In an interview on 9/2/10 at 1:10 pm with ADON, he said nursing staff was supposed to wash total dependent resident's hands before and after meals because they could not do it for themselves. In an interview on 9/3/20 at 9:40 am with RN, she said she worked at the facility for 3 years. She said the charge nurse was responsible for ensuring that the CNA's met the resident's ADL needs. She said the residents that were total dependent on staff were supposed to have their hands washed before and after meals. She said she was unaware that resident #3 and resident #4 had dirty hands and dirt underneath their fingernails. She said she constantly reminded staff to clean resident's hands and nails. She said residents on A side got their showers during the day three times per week and B side got their showers in the afternoon three times per week. She said male residents got shaved 1 to 2 times per week or as needed according to their hair growth so that they could look good. She said sometimes the residents don't have bed sheets until late in the day because housekeeping told them that linen was not available because they were still washing them. She said CNA's were supposed to wash resident's hands before and after meals if they were totally dependent on staff. She said resident's in hallway 500 get repositioned every two hours. She said the charge nurses were responsible for reminding CNA's to reposition residents every two hours. She said the last time she was in-serviced for ensuring CNA provided the proper ADL's for resident was last week. In an interview on 9/4/20 at 2:45 pm with the DON, she said male residents got shaved during shower days. She said nursing staff was supposed to wash the hands of residents that were total dependent in the mornings either through showering and/or bed bath, before and after each meal. She said she wished she could have seen Resident #3 and Resident #4 unshaven, so she could have

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	676371	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) addressed it immediately. She said it was the responsibility of the charge nurses to ensure CNA's were providing proper ADL care. At this time policy on ADLs/ ADLs provided to dependent residents were requested. No policy was provided prior to exit. Record review of Lippincott Nursing Procedures Seventh Edition (not dated) presented by the DON on 9/4/20 at 1:11 pm read in part: .SHAVING-performed with a safety or electric razor, shaving is part of the male patient's usual daily care. Besides reducing bacterial growth on the face, shaving promotes patient comfort by removing facial hair that can itch and irritate the skin and produce an unkempt appearance . Record review of Lippincott Nursing Procedures Seventh Edition (not dated) presented by the DON on 9/4/20 at 1:11 pm read in part: .HAND HYGIENE- the hands are the conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from a staff member to the patient. Because of this, hand hygiene is the single most important procedure in preventing infection .
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 5 (Resident #1) reviewed for pressure ulcers. -The facility failed to prevent Resident # 1 from developing facility acquired Stage 4 deep tissue injuries to left and right ankles. -The facility failed to identify and intervene when CNAs were applying Prevalon boots to Resident #1's feet without training, physician orders, monitoring, or assessment by nursing staff. These failures could place all residents who are at risk for pressure ulcer development at risk for developing pressure sores, pain, infection, and hospitalization and complications to include worsening of the pressure ulcer for residents with existing pressure sores. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's NURSING-Braden Scale for Predicting Pressure Sore Risk - V 2 dated 6/26/2020 read in part: .Score is 11- High risk. SENSORY PERCEPTION 1. Completely Limited: Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface. MOISTURE 4. Rarely Moist: Skin is usually dry, linen only requires changing at routine intervals. ACTIVITY 1. Bedfast: Confined to bed MOBILITY 1. Completely Immobile: Does not make even slight changes in body or extremity position without assistance. NUTRITION 3. Adequate: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs. FRICTION & SHEAR 1. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. [DIAGNOSES REDACTED], contractures or agitation leads to almost constant friction . Record review of Resident #1's annual MDS assessment dated [DATE] revealed the resident had a BIMS of 11 out of 15 indicating the resident had moderately impaired cognitive skills. He required two-person assist with bed mobility, transfer, and toileting. Resident #1 required one-person assist with in the areas of locomotion on unit, dressing, eating and personal hygiene. He was coded for a wheelchair and a catheter. He was not coded for oxygen treatment. Section M0100. Determination of pressure ulcer/injury risk. Resident has a pressure ulcer injury, a scar over bony prominence, or a non-removable dressing/device. C. Clinical assessment M0150. Resident was coded for risk of pressure ulcers and injuries. He was coded for heel pressure ulcer injuries; stage 3. Current number of unhealthy pressure ulcers/injuries at each stage was 1. Section M: Skin conditions. M1200. Skin an ulcer/injury treatments were pressure reducing device for chair; pressure reducing device for bed; and pressure ulcer injury care. Observation and interview on 9/2/20 at 12:38 pm revealed Resident #1 lying in his air mattress bed wearing Prevalon boots on both feet/legs with socks on. Resident #1 had both feet floating off pillows while wearing Prevalon Boots. Observation of the label on the boots read, Prevalon. Resident #1 was positioned on his side facing the door. His left foot was floating off one pillow that laid underneath his foot. He had his right foot over his left foot with a pillow in between (off floating on pillows). The resident said he got the sores on his ankles at the facility. He had contractures on both hands. He was receiving oxygen therapy at 3.0 liters. There was a sleep apnea mask on his end table in a bag. The bag was not dated. The resident's cannula was yellow in color. His call light was sitting on his end table beyond his reach. He said he knew how to use the call light. He said he used it when he needed nursing staff to assist. He had a catheter bag 1/3 full. Record review of Resident #1's order summary dated from 6/1 to 9/1/20 revealed no physician orders for Prevalon boots. Record review of Resident #1's care plan initiated on 7/13/18 and revised on 9/4/20 revealed Resident #1 was not care planned for Prevalon boots. Resident #1's care plan for skin integrity revealed in part: Focus: Resident #1 had potential for impairment to skin integrity related to fragile skin, impaired mobility and incontinence. Further review revealed an unstageable pressure ulcer going to the right and left lateral ankle. Goal: Resident #1 will not have any complications related to any skin injury type and to maintain clean and intact skin. Intervention: Avoid scratching and keep hands and body parts from excessive moisture; keep fingernails short; keep skin clean and dry; use lotion on dry skin .(date initiated 7/13/18). Monitor and document location size and treatment of [REDACTED]. report to medical doctor; cleanse right lateral ankle wound with normal saline, pat dry, apply collagen powder and cover with dressing daily until resolved. Cleanse left outer ankle unstageable pressure injury with normal saline, pat dry, apply calcium alginate dressing; cover with dressing daily until resolved .(date initiated 7/13/18, revised on 9/1/20). Record review of Resident #1's NURSING-Weekly Skin Evaluation -V2 dated 8/31/20 read in part: 3. Are any of these wounds new since last skin assessment? a. Yes Site: 47)Right ankle (outer) Description: unstageable wound to left ankle, measuring 2.0 x 2.0. Site: 48) Left ankle (outer) Description: unstageable wound to left ankle, measuring 2.0 x 2.0. Record review of Resident #1's physician order's dated 8/31/20 revealed orders to Clean outer ankle unstageable pressure injury with normal saline, pat dry, apply calcium alginate dressing, cover with dressing daily every day shift for wound care. Record review of Resident #1's nurses notes dated 8/31/2020 written by the Wound Care Nurse read in part: .during skin assessment nurse noted an unstageble opening to left lateral ankle and right lateral ankle of patient. MD notified, and RP notified Treatment order received and noted. Clean wound with normal saline apply calcium alginate to wound bed daily . Record review of Resident #1's nurses notes dated 9/3/2020 written by the Wound Care Nurse read in part: .wound care doctor was here to see patient regarding pressure injury to left outer ankle, and right outer ankle. Patient has stage 4 pressure injury to his left outer ankle and right outer ankle. New treatment orders received and noted. Clean stage 4 pressure injury to left outer ankle with normal saline, pat dry ,apply calcium alginate then cover with dressing daily. Also clean right lateral ankle pressure injury stag 4 with normal saline, pat dry apply Santyl ointment plus calcium alginate and cover with dressing daily. RP, (name) was notified of the new treatment orders and updated on the wound status . Record review of Resident#1's wound Assessment Details written by the Wound Care Nurse dated 9/3/20 read in part: .Wound location: Left, Lateral Ankle. Wound type: Pressure ulcer. Dated acquired: 8/31/2020. Acquired at facility: Yes. Wound measurement: Length: 1cm, Width: 2cm, Depth: 0.3cm . Record review of Resident#1's wound Assessment Details written by the Wound Care Nurse dated 9/3/20 read in part: .Wound location: Right Ankle. Wound type: Pressure ulcer. Dated acquired: 8/31/2020. Acquired at facility: Yes. Wound measurement: Length: 0.9cm, Width: 1.7cm, Depth: 0.2cm . In an interview on 9/3/20 at 3:10 pm with CNA #3, she said Resident #1 received shower three times a week and bed baths in between. She said Resident wore boots on his legs to prevent pressure ulcer. She said CNAs would remove his boots, place him on a Hoyer lift and take him to the shower room. She said after CNAs were done giving him shower, CNAs would apply lotion and his boots back on. She said she did not receive any training on how to apply and remove those boots. She said CNAs can take off boots for bed baths and showers. Observation on 9/4/20 at 8:30 am revealed Wound Care Nurse performed wound care on Resident # 1 assisted by ADON A. Observation revealed the dressing that was adhered to the resident's right lateral ankle was dated 9/3/20. When the pressure sore wound dressing was removed from the right lateral ankle, observation revealed a stage 4 pressure ulcer to the right lateral ankle area approximately 1 cm in diameter with moderate drainage. Further observation revealed the dressing that was adhered to the resident's left outer ankle was dated 9/3/20. When the pressure sore wound dressing was removed from the left outer ankle area, observation revealed a stage 4 approximately 2 cm in diameter with moderate drainage. Record review of Resident #1's physician's orders dated 9/4/2020 revealed an order to clean right lateral ankle pressure injury with normal saline pat dry apply Santyl ointment plus calcium alginate and cover with dressing daily every day shift for wound care. Record review of Resident #1's physician's orders dated 9/4/2020 revealed an order to clean left outer ankle pressure injury with normal saline, pat dry apply calcium alginate dressing, cover with dressing daily every day shift for wound care. Record review of Resident #1's nurse notes from 6/26 to 9/3/20 revealed no nurse's notes for orders for Prevalon boots; applying and/or removing and assessing sites. Observation and interview on 9/2/20 at 1:50 pm revealed Resident #1 lying on his side on his air mattress bed wearing Prevalon boots on both feet/legs with socks on. Resident #1

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) had both feet floating on pillows while wearing Prevalon Boots. The label on the boots read, Prevalon. Resident #1 was positioned on his side facing the door. His left foot was floating on one pillow that laid underneath his foot. He had his right foot over his left foot with a pillow in between (off loading on pillows). He was receiving oxygen at 3.0 liters. He said he was doing fine. Observation and interview on 9/2/20 at 3:35 pm revealed Resident #1 lying in his air mattress bed wearing Prevalon boots on both feet/legs with socks on. Resident #1 had both feet floating on pillows while wearing Prevalon Boots. The label on the boots read, Prevalon. Resident #1 was positioned on his side facing the door. His left foot was floating off one pillow that laid underneath his foot. He had his right foot over his left foot with a pillow in between (off floating on pillows). He was receiving oxygen at 3.0 liters. He said he was doing fine. In an interview on 9/3/20 at 8:13 am with CNA #1, she said she worked in hallway 500 today, but she was a restorative aide so she goes wherever needed. She said Resident #1 was totally dependent. He required 2-person for changing, bathing, one person for feeding and personal hygiene. She said she repositioned the resident every two hours. She said she noticed a sore on his left ankle when he was on hallway 100. She said she notified the nurse verbally. She could not recall the date she saw the sore on Resident #1's ankle. When asked about the protocol for reporting, she said she did not know beyond her responsibility to notify the charge nurse. In an interview on 9/3/20 at 8:35 am with CNA #2, she said she had worked at the facility for 6 years. She said she worked on the 500 hallway. She said Resident #1 was total dependent. He required 2-person for changing, transfers and repositioning. He required 1-person bathing, feeding and personal hygiene. She said she repositioned the resident every two hours. She said she had seen the resident with a bandage on his ankles. She said she notified the ADON to ensure that they were aware that the resident had a bandage. They were unaware. She said the wound care had placed the bandage because they found out later that he had sores on his ankles. She said residents got facility acquired pressure sores when they were not repositioned at least every two hours throughout the day. In an interview on 9/3/20 at 9:40 am with RN, she said she worked at the facility for 3 years. She said resident's in hallway 500 get repositioned every two hours. She said the charge nurses were responsible for reminding CNA's of their roles and to reposition residents every two hours. She said the possibility of bed sores could occurred when residents were not repositioned every two hours. She said the charge nurse was responsible for ensuring that the CNA's meet the resident's ADL needs. She said CNA #2 brought to her attention that Resident #1 had sores on his ankles. She said she didn't know how he got them because he was new to her unit. She said the reason a resident might have gotten the bed sores because they were not being repositioned or he was not being properly assessed. She said Resident #1 wore booties and maybe heat and/or moisture may have caused the sores if they were not being properly assessed. In a follow-up interview on 9/3/20 at 1:40 pm with RN, she said Prevalon boots required a Physician's order. She said she did not see the boots when she changed Resident #1's oxygen tubing at 2:00 pm. She said the CNA was in touch with the RP and whatever the RP said the CNA did. This Surveyor asked if CNA's could apply and remove Prevalon boots and she said, No. She said, only the charge nurse and/or wound care nurse could do it. She said she was not monitoring for potential complications because Resident #1 was not supposed to be wearing Prevalon boots. In an interview on 9/3/20 at 11:40 pm with the DON, she said Resident #1's RP had instructed the facility not to get the resident up when he was in Hallway 100. She said on 9/1/20, CNA #2 told the ADON that she had seen a bandage on Resident #1's ankles. She said the ADON brought it to her attention. She said at the same time, it just happened that the Wound Care Nurse was doing his rounds and he noticed the pressure sores on Resident #1's ankles and assessed them same day. She said she began questioning the nursing staff to find out how Resident #1 acquired pressures sores on his ankles at the facility. She said the facility had not self-reported because she was getting statements from the nursing staff in Unit 100. She said there was several reasons for how residents could get pressure sores in the facility. She said it could have been from not repositioning residents; not conducting weekly skin assessments; and CNA's not conducting daily checks and reporting a change in condition, so that it could be addressed immediately. In an interview on 9/3/20 at 10:30 am with Wound Care Nurse, he said he had been at the facility since November of last year as the wound care nurse. He said his responsibility was treatment Monday through Friday. Does skin assessment. Does initial skin assessment on resident to see if they have any wounds on top of the wounds that are noted on admission. Updates the wound care doctor that comes every week and makes rounds with residents with PU's. They note changes. He does weekly pressure and non-pressure ulcers. The doctor measures the notes. He said prior to Resident #1 getting here (admitting to the facility), the resident had a wound on his sacrum and on his hip area in stage 2 or 3 that was healed. He said returned from the hospital on [DATE] with a PU stage 3 to the sacrum. He said today the PU on sacrum was healed. He said on Monday, 9/1/20 he conducted a skin assessment on the resident and notice pressure sore on both ankles. He said he could not stage it. Notified MD, DON and RP. He said the wound care doctor was here this morning and the doctor assessed the wounds at stage 4 and new treatment orders were in place. He said they had pillows to elevate his feet but, the RP wanted him to wear booties. He said the doctor said this morning to remove the Prevalon boots and have his feet floating. He said he tells nursing staff to reposition resident's that have sacrum sores as needed and for those that have pressure sores on their legs to floating the legs and put them on pillows. In an interview on 9/3/20 at 12:25 pm with the Facility Doctor, Regional Nurse, and DON. The facility doctor said Resident #1 got pressure sore wounds on both ankles because, while staff was repositioning him on his sides, it disposed the resident to pressure sores on his ankles. He said the facility noticed the wounds on Monday, 9/1/20. He said when residents have darker skin tones/pigmentation, the redness can be missed. He said a pressure ulcer can go from zero to eschar in a couple of days. He said whatever was seen on the skin could be more significant than what was under the skin. He said that was why the pressure sore was staged as unstageable. He said the Wound Care Doctor had to open the wound to stage it. He said today it was at a stage 4. He said the prognosis was good as there was indication of healing on both ankles. He said the left ankle was moving faster than the left ankle. The Regional Nurse said the staff had been making efforts to reposition Resident #1 due to his recent sacrum healing, so the alternative was to reposition the resident on his sides and offload his feet with pillows. She said sometimes ankles could rest on pillows when off loaded. The facility doctor said it was likely what happened. The regional nurse said Resident #1 did not have booties on his feet. She said Resident #1 did not have orders for booties. She said she would not have used Prevalon boots on Resident #1 anyway because he was already on an air mattress and the boots would have caused pressure. The Regional Nurse, DON and the doctor all said that booties were different from Prevalon boots. The Regional Manager and the DON said Resident #1 did not have physician orders for Prevalon boots. The DON said Resident #1 was being repositioned because if he was not being turned the RP had a camera in the room and she would have called already like she had already called three times this morning. In an interview on 9/3/20 at 2:05 pm with Wound Care Doctor, he said wounds were stage 4 and it's the first time he saw them and identified them on Monday, 9/1/20. He said he went to the facility every Thursdays. He said he knew Resident #1 had several wounds in the past. He said he had taken care of Resident #1 for years. He said he tended to get wounds on his tail bone. He said he would eventually resolved all of them. He said recently while at the hospital the pressure sore on his sacrum once healed, reopened, but, eventually sacrum healed. He said in the process of the facility having him side to side he developed the wounds on his ankles. He said when he treated the wounds, Resident #1 had Prevalon boots on. He said he told RP that the boots were not ideal because they were still causing pressure to ankles, but she could be very insistent. He said the RP could be very demanding and persistent. He said, If she wants those boots on she will tell staff to put them on, so I get that the CNA's put them on which makes the wounds worse. He said he told the RP the resident needed to float the legs up with a pillow. He said, Ideally if we could elevate him up in the air like a magician, but we can't do that. He said, the problem was that he had a wound on his tailbone but, turning him side to side was a no-win situation. He said the Prevalon boots could have contributed to the pressure sores because although the boots are soft, it's still creating pressure. In an interview on 9/3/20 at 2:45 pm RN, she said she worked 4-days on and 1 day off. She said when she changed Resident #1's oxygen tubing, the resident did not have boots on his feet. She said she checked his feet to make sure the dressings on his wounds were in-tact. She said she had never seen Prevalon boots on the resident's feet. She said the resident had only been in her unit (hallway 500) for about 4 days. She said CNA's were not supposed to put on or take off boots because there were wounds and it was a treatment that required assessing. She said Resident #1 did not have an order for [REDACTED].Pressure Ulcer Care: pressure ulcers results when pressure-applied with great force for a short period or with less force over a long period- impairs circulation, depriving tissues of oxygen and other life-sustaining nutrients. This process damages skin and underlying structures. Untreated, resulting ischemic [MEDICAL CONDITION] can lead to serious infection. Most pressure ulcers develop over bony prominences, where friction and shearing force combine with pressure to break down skin and underlying tissues. Prevention is the key to avoiding extensive therapy. Preventive measures include off-loading pressure, maintaining adequate nourishment, and ensuring mobility to relieve pressure and promote circulation. Implementation: Turn and reposition the

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F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 5) patient every 1 to 2 hours or more frequently, as required, unless contraindicated. Eliminate .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided with such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 5 residents (Resident #2) reviewed for respiratory care in that: -Resident #2's humidifier on the oxygen concentrator was empty and it was not dated. -Resident #2 was administered oxygen with no Physician's order. These failures could place residents who receive oxygen therapy at risk of therapy complications and pain due to non-humidified continuous oxygen flow. Findings Include: Record review of Resident #2's face sheet revealed a [AGE] year-old female initially admitted on [DATE] and re-admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #2's annual MDS assessment dated [DATE] revealed Resident #2 had a BIMS of 14 out of 15 indicating she was cognitively intact. She required 1-person assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. She required set up assistance for eating. She was not coded for oxygen therapy. Record review of Resident #2's care plan for oxygen therapy read in part: Focus: Resident #2 four has shortness of breath related to [MEDICAL CONDITION]; resident is on oxygen therapy .(date initiated on 9/4/20) Goals: The resident will have no complications related to shortness of breath through the review .(date initiated on 9/4/20) Interventions: monitor document report breathing abnormalities to medical doctor .(date initiated on 9/4/20) Record review of Resident #2's MAR indicated [REDACTED]. Start date: 8/22/20. Oxygen saturation checked at every shift for [MEDICAL CONDITION]. Start date: 8/22/20. Record review of Resident #2's physician order summary report active as of 6/1/20 revealed no orders for oxygen therapy. Observation and interview on 9/3/20 at 11:15 am accompanied by the DON revealed Resident #2, lying in her bed receiving oxygen treatment at 2.5 liters. The resident's oxygen tubing was dated 8/31/20. The humidifier was empty. The humidifier was not dated. It should have been dated. Resident #2 said the water in the humidifier had run out yesterday. Resident #2 said she had returned to the unit about two weeks ago. She said she was in isolation because she had COVID. She said she was still weak and she was going to therapy to build up her strength. In an interview on 9/3/20 at 11:18 am with the DON she said Resident #2 was on continuous oxygen between 2.5 and 3.0 liters. She confirmed that there was no water in the humidifier. She said the humidifier must have just run out of water. She said, but, the humidifier should be dated. She said she would get the LVN on duty to address it right away. At this time policy on changing/dating of oxygen equipment were requested. No policy was received prior to exit. In an interview on 9/4/20 at 10:10 am with the DON. She said the nurses were responsible for reconciliation of physician orders. She said the ADON still had to go over the orders and initial in the system. She said Resident #2 should have had orders for oxygen. She said she was unaware that Resident #2 had no oxygen orders on record. In an interview on 9/4/20 at 10:19 am with the ADON, he said he was responsible for reconciliation of physician orders daily. He said he was not sure why Resident #2 did not have physician orders for oxygen. He said when there are no orders, the nurses were supposed to call the physician to ask for orders to continue or discontinue. During an interview on 9/4/20 at 1:10 pm Surveyors requested policy on changing/dating of oxygen equipment from the DON. No policy was received prior to exit.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections involving 1 of 1 staff (Wound Care Nurse) and 1 of 6 residents (Resident #1) reviewed for infection control in that: -Wound Care Nurse did not follow infection control techniques while performing wound care for Resident #1 by crossing from a dirty part of the procedure to the clean part without. -Wound Care Nurse failed to perform hand hygiene when changing gloves and wash or sanitize her hands when moving from a dirty area to a clean area when providing wound care to Resident #1. -The facility failed to date and change Resident #1's oxygen cannula and humidifier bottle. These failures placed all residents with wounds and oxygen use at risk of cross contamination, infection, and hospitalization . Findings include: Resident #1 Record review of Resident #1's clinical face sheet revealed a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's annual MDS assessment dated [DATE] revealed the resident had a BIMS of 11 out of 15 indicating the resident had moderately impaired cognition. He required two-person assist with bed mobility, transfer, and toileting. Resident #1 required one-person assist with in the areas of locomotion on unit, dressing, eating and personal hygiene. He was coded for a wheelchair and a catheter. He was not coded for oxygen treatment. Record review of Resident #1's care plan initiated on 10/31/2018 and revised on 9/2/2020 revealed the following care plan: Focus: Resident has potential for impairment to skin integrity r/t fragile skin, impaired mobility, & incontinence. unstageable wound to right lateral ankle unstageable wound to left lateral ankle Goal: Resident will have no complications r/t any skin injury type through the review date. Intervention: Resident will maintain clean and intact skin through the review date. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Keep skin clean and dry. Use lotion on dry skin. Monitor/document location, size and treatment of [REDACTED]. to MD. Cleanse right lateral ankle wound with normal saline pat dry apply collagen powder and cover with dressing daily until resolved. Cleanse left outer ankle unstageable pressure injury with normal saline, pat dry apply calcium alginate dressing, cover with dressing daily until resolved. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Record review of Resident #1's care plan revised on 9/4/20 revealed Resident #1 had altered respiratory status difficulty breathing related to sleep apnea and he used oxygen therapy as needed. The goal was for Resident #1 to not have any complications related to shortness of breath; maintained normal breathing pattern as evidenced by normal respirations, normal skin color and regular respiratory rate and pattern. The interventions were to administer medications/puffers/oxygen as ordered; monitored for effectiveness and side effects; [MEDICAL CONDITION]/[MEDICAL CONDITION]/VPAP settings titrated pressure as ordered; pace and schedule activities providing adequate rest periods; and monitor respirations, pulse, O2 sat; lung sounds prior to nebulizer treatments; and document side effects and effectiveness. Record review of Resident #1's physician's orders [REDACTED]. Record review of Resident #1's physician's orders [REDACTED]. Record review of physician orders [REDACTED].#1 had orders for monitoring SPO2 at every shift; apply O2 at 2L/MIN for SPO2 less than 92%. Observation and interview on 9/2/20 at 12:38 pm revealed Resident #1 lying in his air mattress bed wearing Prevalon boots on both feet/legs. He had socks on. He had contractures on both hands. He was receiving oxygen therapy at 3.0 liters. There was a sleep apnea mask on his end table in a bag. The bag was not dated. The resident's cannula was yellow in color. His call light was sitting on his end table beyond his reach. He said he knew how to use the call light. He said he used it when he needed nursing staff to assist. He had a catheter. The resident said he got the sores on his ankles at the facility. In an interview on 9/2/20 at 12:45 pm with LVN, she confirmed Resident #1's cannula was yellow in color. She said she would change it immediately. She said the nursing staff shift 10 to 6 pm changed and dated oxygen tubing every Sundays. She said nursing staff also changed the tubing as needed. She said since it was yellow, it should have been changed. She said it was important to change the tubing's to prevent infection. She said she was in-serviced for infection control daily. In an interview on 9/3/20 at 9:40 am with RN, she said she had worked at the facility for 3 years. She said she worked with resident's in hallway 500 She said resident #1 was continuous oxygen at 2.0 to 3.0 liters. She said the facility protocol was to change the oxygen tubing every Sundays or as needed. She said when the cannula was yellow in color that would be a reason to change the tubing. She said the charge nurse oversaw changing the tubing as needed. In an interview on 9/3/20 at 11:30 am with the DON, she said it was important to date the tubing's and humidifier's on the oxygen concentrators, so they knew when to change them out to prevent infection. She said tubing's and humidifiers get changed every Sundays or PRN. She said if Resident #1's cannula was yellow, it should have been changed as PRN. During an interview on 9/4/20 at 1:10 pm Surveyors requested policy on changing/dating of oxygen equipment from the DON. No policy was received prior to exit. During observation of wound care on 9/4/20 at 8:30 am by the Wound Care Nurse assisted by ADON A, the Wound Care Nurse performed hand hygiene, applied clean gloves to remove the soiled dressing from the right lateral ankle pressure injury dated 9/3/20. WCN threw the soiled dressing into the biohazard bag sitting on the side table crossing over the sterile field. Without removing the soiled gloves and sanitizing his hands, the WCN cleansed the wound with normal saline, patted dry with a clean dry gauze. WCN threw the soiled gauze into the biohazard bag sitting on the side table crossing over the sterile field and applied the Santyl ointment, the calcium alginate and covered it with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676371	A. BUILDING _____ B. WING _____	**09/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) a new dressing. The Wound Care Nurse then removed his soiled gloves, sanitized his hands, donned clean gloves, and removed the soiled dressing from the left outer ankle pressure injury dated 9/3/20. WCN threw the soiled dressing into the biohazard bag sitting on the side table crossing over the sterile field. Without removing the soiled gloves and sanitizing his hands, he cleansed the area with normal saline, patted dry, applied calcium alginate and covered with new dressing. In an interview on 9/4/20 at 9:47 am with the Wound Care Nurse he said he should have changed his gloves after removing the soiled dressing as it posses a risk for infection control. He said he started working at this facility in November 2019. He said when he first started working at this facility the DON accompanied him to see how he performed wound care and if he was following the proper protocol and procedures. He said the DON would also periodically check on him. He said he did not receive training on infection control at this facility and he has been working at this facility for the past 8 months. However, he stated that he received training on infection control and hand hygiene at his previous employment. In an interview on 9/4/20 at 10:09 am with ADON A, this surveyor asked how the Wound Care Nurse performed wound care on Resident #1. ADON A said he did 90% of it correct and messed up on a few things such as crossing over the sterile field to throw the soiled dressing away and forgetting to change gloves and sanitizing or washing his hands while going from the dirty to clean site. He said this created a risk for infection control. He said the DON was in charge of supervising the Wound Care Nurse. He said he was a certified infection preventionist for this facility. He said he was in charge of providing training on infection control and hand hygiene to staff. He said he provided training daily to staff due to COVID. In an interview on 9/4/20 at 11:11 am with the DON, this surveyor shared her wound care observation from earlier. The DON said she would correct the Wound Care Nurse as his actions create a risk for infection control and cross contamination. She said sometime in April 2020 she accompanied the wound care nurse to make sure he was following correct steps and protocols before, during and after each wound care. She said staff were in serviced on infection control/hand hygiene last week. At this time policy on infection control and wound care dressing change were requested. On 9/4/20 at 1:10 pm Surveyors requested policy on infection control and wound care dressing change from the DON. No policy was provided prior to exit. Record review of Lippincott Nursing Procedures Seventh Edition (not dated) presented by the DON on 9/4/20 at 1:11 pm read in part: .HAND HYGIENE- the hands are the conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from a staff member to the patient. Because of this, hand hygiene is the single most important procedure in preventing infection .