STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675847	A. BUILDING _____ B. WING _____	**04/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINTERS HEALTHCARE RESIDENCE	**506 VAN NESS WINTERS, TX 79567**

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 0868 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain an ongoing quality assessment and assurance (QAA) committee that includes at minimum, the director of nursing services, the Medical Director or his/her designee, and at least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and meets at least quarterly. The facility failed to ensure they met quarterly between November 2019 and January 2020 The facility failed to ensure that the minimum committee members were present at the August 2019 and February 2020 meetings. This failure could place residents in the facility at risk for a reduced quality of care and life due to lack of efficiently identifying and resolving facility issues. Findings included: Record review of the Quality Assurance Performance and Improvement Meeting Minutes sign in sheet indicated a meeting on the following dates with the following persons signing in. 8/2/19: Administrator, Assistant Director of Nursing, Dietary Supervisor, Nurse Assessment Coordinator, and Business Office Manager. There was no signature for attendance for the Medical Director. During an interview with the Administrator on 4/2/20 at 2:47 pm, he said the only documentation they had from the previous Administrator was 8/2/19. They said according to the documentation there should have been another QA meeting in January but said they could not verify it happened or where the documentation was to verify. The Administrator said he would try to contact the previous Administrator to see if she could provide documentation of a Quality Assurance Performance Improvement Meeting after 8/2/19. During an interview with the Administrator on 4/3/20 at 8:45 am, he said he spoke to previous administrator who said they did not complete a Quality Assurance Performance Improvement Meeting at the next required date ([DATE]). During an interview with the Local Hospital Director of Nursing on 4/3/20 at 12:22 pm, she said she was acting DON in February 2020 and provided Hospital District Board Meeting dated [DATE]. She said she and the previous administrator were present at the meeting. She said the Hospital Board was present, but the medical director was not. She said no other persons attended the meeting from the nursing home. She said she considered the meeting a QAPI. Record review of the Report to Board of Directors of the Hospital dated February 17, 2020 indicated the following areas reported to the Hospital Board: Marketing Action Plan, Payables, Staffing, Financial Opportunities, Census, and Departmental Overview. Record review of the facility's Quality Assurance and Performance Improvement (QAPI) Committee Policy dated July 2016 indicated the following: Committee Meetings 1.The committee will meet quarterly at an appointed time. Committee Reports and Records 1. The committee shall maintain minutes of all regular and special meetings that include at least the following information: a. The date and time the committee met b. The names of the committee members present and absent

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.