STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675380	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR NURSING AND REHABILITATION CENTER OF SEGUI	1219 EASTWOOD DR SEGUIN, TX 78155

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure that residents had the right to be free from neglect for 1 of 22 residents (Resident #1) whose care was reviewed for neglect, in that: The facility's structure to prevent neglect were not implemented when: 1. a. The facility failed to document or implement interventions for Resident # 1, who they were aware had a history of [REDACTED]. Resident # 1 choked on [DATE], [DATE] and again on [DATE] and subsequently died . b. The facility failed to identify residents who took and ate food from other residents' plates and were at-risk for choking, provide supervision to those residents, and for ensuring inappropriately textured food was not within residents' reach. These failures resulted in identification of Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed [DATE], the facility remained out of compliance at a level of actual harm with a scope identified as a pattern until interventions were put in place for all residents at risk for choking and had behaviors during meal times, staff were in-serviced, and increased supervision was provided in the dining rooms. These deficient practices affected residents in the facility who were at-risk of choking and behaviors during meals, and placed them at-risk for harm, choking or death. The findings were: Record review of Resident #1's face sheet, dated [DATE] revealed an admission date of [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Significant Change MDS dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment for daily decision-making skills. Further review under Functional Status revealed Resident #1 required extensive assistance with eating and one person physical assistance. Review of Resident #1's Care Plan, revised on [DATE], revealed her care plan indicated she was on a pureed diet, but did not reflect her history of choking or behavior of grabbing other resident's food. Review of Resident #1's Physician Order Summary for (NAME)2020 revealed an order for [REDACTED]. Resident #1's diet order further revealed the original revision to pureed texture was on [DATE]. Review of Resident #1's Progress Notes revealed two previous choking incidents documented on [DATE] and [DATE]. Review of Resident #1's Modified [MEDICATION NAME] Swallowing Study, dated [DATE], revealed overall dysphagia severity is severe. Strategies - We recommend the following actions regarding the patient's feedings: Small Bites/Sips - Monitor PO Intake Rate - Positioned Upright - Supervised PO Feeding - Cueing for Strategies - Aspiration Precautions - Monitor [MEDICAL CONDITION] Status. Review of Resident #1's Speech Therapy Discharge Summary, dated [DATE], revealed to facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: general swallow techniques/precautions, alternation of liquid/solids and bolus size modifications. Use of adaptive cup to prevent spills secondary to tremors. Review of Resident #1's progress note, dated [DATE], revealed resident sitting up in chair in dining room, color pale, resident gasping for air. [MEDICATION NAME] maneuver done resident bringing up large amounts of solid food. Further review of the progress note revealed Resident #1 returned from the hospital with no new orders. Review of Resident #1's ER visit note, dated [DATE], revealed Choking episode. Review of the facility's incident reports for Resident #1 revealed an incident report was not completed for Resident #1's choking incident on [DATE] and [DATE]. There was no documentation of an assessment or interventions after Resident #1's choking episode on [DATE]. Review of Resident #1's progress note, dated [DATE], revealed Resident started choking on food she grabbed from another resident's plate with no RR (respiratory rate) and pale to color, proceeded to look for obstruction in throat and could not see or feel when finger swiping. Started [MEDICATION NAME] maneuver and did [MEDICATION NAME] for 5 minutes while resident had food running out of mouth but not yet unobstructed. I then felt for pulse and there was no pulse so that I started CPR until EMS came and was finally able to get a pulse after 20 minutes of working on her themselves. Resident sent to local hospital. Review of Resident #1's local hospital records, dated [DATE]- [DATE] revealed Resident #1 had a [MEDICAL CONDITION] after choking on her dinner. Resident #1 expired on [DATE]. An interview on [DATE] at 9:37 a.m. with the DON revealed Resident #1 had grabbed food from another resident's plate. Resident #1 was on pureed diet and the other resident had mechanical soft diet, except vegetables. The DON further revealed Resident #1 expired Saturday morning ([DATE]) from [MEDICAL CONDITION] and respiratory distress due to choking. An interview on [DATE] at 10:45 a.m. with CNA B revealed she and CNA C were on the Generations (memory care) unit gathering residents for dinner. Resident #1 started to grab other resident's trays. Resident #1 was redirected out of the dining room. After the trays were served, Resident #1 was brought back. CNA B further revealed she then went to assist Resident #5 with eating in his room, leaving only CNA C in the dining room on the Generations unit. CNA B stated she heard CNA C yell that Resident #1 was choking. Resident #1 was already discolored when CNA B arrived at Resident #1's side. CNA B stated she started the [MEDICATION NAME] on Resident #1 while CNA C went to get LVN D. CNA B confirmed Resident #1 had the behavior to grab other resident's food and that this was her third choking incident. An interview on [DATE] at 11:20 a.m. with CNA C revealed before dinner had started Resident #1 was already reaching out for other resident's food on their trays. We had to physically remove her because she was trying to get other resident's food. CNA C further revealed Resident #1 was brought back and given her tray after the other residents were served. CNA B went to assist Resident #5 and CNA C revealed she was feeding Resident #4 in the dining room. CNA C stated she was sitting caddy corner, so she could feed Resident #4 and look around to keep an eye on the other residents. CNA C stated, after feeding Resident #4, she walked by Resident #1 who had a spoon in her mouth. When CNA C picked up a tray she saw Resident #1 grab a cup and noticed the resident was shaking. CNA C stated she hit Resident #1 on the back and food came out. She then yelled for CNA B who performed the [MEDICATION NAME] on Resident #1 while she went to get the nurse. CNA C confirmed Resident #1 had the behavior to grab other resident's food and that she had choked before when she was on a regular diet. An interview on [DATE] at 12:58 p.m., LVD D revealed she had already passed trays on the Generations unit and was in the South dining room. CNA C came out of the Generations unit and stated that Resident #1 was choking. LVN D stated she ran to the Generations unit and took over doing the [MEDICATION NAME]. Another nurse tried to finger swipe and could not get the food. We got the crash cart when I checked, and she had no pulse. LVN D revealed she started CPR on Resident #1 and continued until EMS arrived and took over. LVN D confirmed that Resident #1 should not have been at the same table with a resident that had mechanical soft meat and that Resident #1 had choking episodes in the past. An interview on [DATE] at 3:41 p.m. with the Speech Therapist confirmed that Resident #1 needed supervision if she grabbed other resident's food. An interview on [DATE] at 3:55 p.m. with Case Management Specialist E confirmed Resident #1's choking episodes and behavior of grabbing other resident's food should have been care planned and it was not. An interview on [DATE] at 4:01 p.m. with the DON confirmed that Resident #1's behavior and risk of choking should have definitely been care planned. The DON revealed she was not aware of the extent of Resident #1's behavior of grabbing other resident's food. The DON further revealed she would not have placed Resident #1 with Resident #2 who had the mechanical soft meat. An interview on [DATE] at 4:31 p.m. with the Administrator and DON revealed they monitored and supervised staff through their department heads and nursing management following current or new protocols. They stated that in-services are held to

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

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) provide training to the staff. An interview on [DATE] at 10:30 a.m. with the Administrator revealed he was aware of the choking incident in October and because there was no an adverse effect on her health, it was not reported. It was Resident #1's impulsivity and not following cues to swallow that caused the incident in October. The Administrator confirmed he was notified about Resident #1's current choking incident on Friday ([DATE]) at 6:20 p.m. The Administrator further confirmed he found out Resident #1 passed away on [DATE] at 12:15 p.m. The Administrator revealed he could not say this incident with Resident #1 was neglect because it was one incident that could have been prevented. Observation of noon meal service at 12:16 p.m. on [DATE] revealed four staff members present in the Generations unit dining room. Observation on [DATE] at 12:55 p.m. on the Generations unit revealed Resident #3 stood up from his chair and reached over with his fork to Resident #2's plate and took a fork full of sweet potatoes. Resident #3 ate the sweet potatoes before LVN B could intervene. Record review of care plans for Resident #2, #3, #4, #6, #7, #8, #10, #11, #12, #13, #14, #16, and #17 on the Generations unit revealed their behaviors of grabbing other resident's food, giving food and drinks to other residents, sitting in another residents seating area and eating their food, picking at other resident's food, and risk for choking was not updated until [DATE] and [DATE]. An interview on [DATE] at 10:45 a.m. with CNA B revealed usual staffing was two CNAs on the Generations unit during meals with twenty-something residents with behaviors. One CNA stayed in the dining room and the other went to assist Resident #5. CNA B further revealed all of the residents on the unit required redirecting at times. They were not able to provided one on one supervision and the nurse was not on the unit during meals. We had to clear the tables and we were constantly redirecting. CNA B stated they had to clean their own dining room while constantly redirecting residents and getting them ready for bed. CNA B confirmed everyone was aware of Resident #1's behavior to grab other resident's food. An interview on [DATE] at 11:11 a.m. with CNA F revealed Resident #1 had behaviors of wanting to get other people's food. When Resident #1 was done eating her food, she would go to different tables and take other resident's food. An interview on [DATE] at 11:20 a.m. with CNA C revealed there was one aide in the Generations unit dining room and one feeding Resident #5 in his room. CNA C further revealed that the nurse did not stay on the Generations unit the whole time during the meals. An interview on [DATE] at 12:37 p.m. with CNA F confirmed there were usually only 2 CNAs on the Generations unit during meal service. CNA F stated that the nurse would check the meal tickets and leave. CNA F confirmed during the current meal service that there were never that many staff members present on the Generations unit. An interview on [DATE] at 1:51 p.m. with LVN G revealed she checked the trays on the Generations unit and would have to go to the South dining room to check those trays and sometimes assist in feeding residents in that dining room. An interview on [DATE] at 4:01 p.m. with the DON stated staff needed to be present in the Generations unit dining room to provide assistance with feeding, monitoring if residents were eating and assist if someone choked. The DON confirmed that there definitely needed to be another staff member present in the Generations unit dining room if there was a resident grabbing other resident's food. An interview on [DATE] at 12:23 p.m. during lunch meal service on the Generations unit, the spouse of Resident #6 revealed there was never that many staff members present during lunch as there were now and he would come daily at this time. The spouse further revealed that there were only two staff present during lunch when he would come to see his wife. An interview on [DATE] at 3:55 p.m., the DON revealed they did not have a current list of residents with behaviors during meals or at risk for choking until yesterday evening ([DATE]). An interview on [DATE] at 4:30 p.m., the DON revealed any resident on a special or alternate diet was at risk for choking. An interview on [DATE] at 5:19 p.m., Case Management Specialist H revealed care plans were updated on [DATE] and [DATE] for all residents who had behaviors during meals and residents who were at risk for choking. Review of the facility policy titled Assistance with Meals dated [DATE] revealed Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Review of the facility policy titled Abuse Prevention Program, dated [DATE] revealed Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Under the section titled Policy Interpretation and Implementation 3. j. The implementation of changes to prevent future occurrences of abuse. Under Reporting of Alleged Abuse to Facility Management 2. f. 'Neglect' is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. An interview on [DATE] at 11:06 a.m. the Administrator confirmed the facility did not have a policy on supervision during meals or choking. On [DATE] at 4:31 p.m. the Administrator and DON was notified of an Immediate Jeopardy (IJ) situation for the above failures, a completed IJ template was provided and a Plan of Removal was requested. On [DATE] at 12:27 p.m. the facility's Plan of Removal was approved. The facility's Plan of Removal included the following steps to be taken by the facility: 1. On [DATE] staff re-education was provided to available staff on abuse, neglect and exploitation regarding resident supervision during mealtimes. Staff were re-educated to ensure the new facility policy on providing adequate supervision in the dining room was implemented. 2. Effective [DATE] staffing will be adjusted in the Generations unit and south Dining Rooms to include, 2 CNAs monitoring and assisting at all times during the entire meal service. A licensed staff will also be assigned to monitor residents and assist as necessary during the entire meal service. 3. On [DATE] staff were re-educated to dispose of remaining portions of food and remove trays immediately after each resident has completed their respective meals. 4. Effective [DATE] staff were re-educated on monitoring of meals, residents who are noted to have behaviors that pose a risk will be assessed by the interdisciplinary healthcare team and the care plan will be updated as necessary. The surveyor verification of the Plan of Removal on [DATE] was as follows: Care plans reviewed the residents (#2, #3, #4, #6, #7, #8, #10, #11, #12, #13, #14, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, and #35) identified to ensure the care plans were updated to include behavioral issues and the risk of choking. Observed noon meal service on [DATE] for additional staff members in the dining rooms to include 2 CNAs and 1 LVN were present. In-service sign-in sheets and material covered by the in-services was reviewed onsite on [DATE] included the new seating arrangements, resident's diets, resident rights, number of staff present in the dining rooms, clearer trays as soon as the resident was done eating, supervision, and neglect. Staff interviews were conducted on 4 separate halls on 2 different shifts. Interviews occurred on [DATE] from 2:00 p.m. - 5:20 p.m. with CNA B, CNA, C, CNA I, CNA J, CNA K, CNA M, CNA N, MA P, NA R, CNA S, PTA T, and Cook Q. All stated that they had received in-services regarding adequate supervision to prevent abuse, neglect, and exploitation; an in-service regarding which residents were noted to have behaviors that posed a risk, the new requirements for staff needed in the dining room, and to dispose of leftover food/plates when a resident has completed their meal. Interviews occurred on [DATE] from 2:00 p.m. - 5:20 p.m. with LVN G, LVN L, RN O, the Maintenance Supervisor, the Social Worker, the Housekeeping Supervisor, the Activity Director, Case Management Specialist E & H, and the DON. All stated that they had received in-services regarding adequate supervision to prevent abuse, neglect, and exploitation; an in-service regarding which residents were noted to have behaviors that posed a risk, the new requirements for staff needed in the dining room, and to dispose of leftover food/plates when a resident has completed their meal. On [DATE] at 6:00 p.m., the Administrator, DON, the Director of Clinical Operations, and the Regional Vice-President of Operations were informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm with a scope identified as pattern until all staff were in-serviced.
F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure that residents had the right to be free from neglect for 1 of 22 residents (Resident #1) whose care was reviewed for neglect, in that: 1. a. The facility failed to document or implement interventions for Resident # 1, who they were aware had a history of [REDACTED]. Resident # 1 choked on [DATE], [DATE] and again on [DATE] and subsequently died . b. The facility failed to identify residents who took and ate food from other residents' plates and were at-risk for choking, provide supervision to those residents, and for ensuring inappropriately textured food was not within residents' reach. These failures resulted in identification of Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed [DATE], the facility remained out of compliance at a level of actual harm with a scope identified as a pattern until interventions were put in place for all residents at risk for choking and had behaviors during meal times, staff were in-serviced, and increased supervision was provided in the dining rooms. These deficient practices affected residents in the facility who were at risk of choking and behaviors during meals, and placed them at risk for harm, choking or death. The findings were: Review of the facility policy titled Assistance with Meals dated [DATE] revealed Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Review of the facility policy titled Abuse Prevention Program, dated [DATE] revealed Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Under the section titled Policy Interpretation and Implementation 3. j. The implementation of changes to prevent future occurrences of abuse. Under Reporting of Alleged Abuse to Facility Management 2. f. 'Neglect' is

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. An interview on [DATE] at 11:06 a.m. the Administrator confirmed the facility did not have a policy on supervision during meals or choking. Record review of Resident #1's face sheet, dated [DATE] revealed an admission date of [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Significant Change MDS dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment for daily decision-making skills. Further review under Functional Status revealed Resident #1 required extensive assistance with eating and one person physical assistance. Review of Resident #1's Care Plan, revised on [DATE], revealed her care plan indicated she was on a pureed diet, but did not reflect her history of choking or behavior of grabbing other resident's food. Review of Resident #1's Physician Order Summary for (NAME)2020 revealed an order for [REDACTED]. Resident #1's diet order further revealed the original revision to pureed texture was on [DATE]. Review of Resident #1's Progress Notes revealed two previous choking incidents documented on [DATE] and [DATE]. Review of Resident #1's Modified [MEDICATION NAME] Swallowing Study, dated [DATE], revealed overall dysphagia severity is severe. Strategies - We recommend the following actions regarding the patient's feedings: Small Bites/Sips - Monitor PO Intake Rate - Positioned Upright - Supervised PO Feeding - Cueing for Strategies - Aspiration Precautions - Monitor [MEDICAL CONDITION] Status. Review of Resident #1's Speech Therapy Discharge Summary, dated [DATE], revealed to facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: general swallow techniques/precautions, alternation of liquid/solids and bolus size modifications. Use of adaptive cup to prevent spills secondary to tremors. Review of Resident #1's progress note, dated [DATE], revealed resident sitting up in chair in dining room, color pale, resident gasping for air. [MEDICATION NAME] maneuver done resident bringing up large amounts of solid food. Further review of the progress note revealed Resident #1 returned from the hospital with no new orders. Review of Resident #1's ER visit note, dated [DATE], revealed Choking episode. Review of the facility's incident reports for Resident #1 revealed an incident report was not completed for Resident #1's choking incident on [DATE] and [DATE]. There was no documentation of an assessment or interventions after Resident #1's choking episode on [DATE]. Review of Resident #1's progress note, dated [DATE], revealed Resident started choking on food she grabbed from another resident's plate with no RR (respiratory rate) and pale to color, proceeded to look for obstruction in throat and could not see or feel when finger swiping. Started [MEDICATION NAME] maneuver and did [MEDICATION NAME] for 5 minutes while resident had food running out of mouth but not yet unobstructed. I then felt for pulse and there was no pulse so that I started CPR until EMS came and was finally able to get a pulse after 20 minutes of working on her themselves. Resident sent to local hospital. Review of Resident #1's local hospital records, dated [DATE]- [DATE] revealed Resident #1 had a [MEDICAL CONDITION] after choking on her dinner. Resident #1 expired on [DATE]. 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CNA B stated she started the [MEDICATION NAME] on Resident #1 while CNA C went to get LVN D. CNA B confirmed Resident #1 had the behavior to grab other resident's food and that this was her third choking incident. An interview on [DATE] at 11:20 a.m. with CNA C revealed before dinner had started Resident #1 was already reaching out for other resident's food on their trays. We had to physically remove her because she was trying to get other resident's food. CNA C further revealed Resident #1 was brought back and given her tray after the other residents were served. CNA B went to assist Resident #5 and CNA C revealed she was feeding Resident #4 in the dining room. CNA C stated she was sitting caddy corner, so she could feed Resident #4 and look around to keep an eye on the other residents. CNA C stated, after feeding Resident #4, she walked by Resident #1 who had a spoon in her mouth. When CNA C picked up a tray she saw Resident #1 grab a cup and noticed the resident was shaking. CNA C stated she hit Resident #1 on the back and food came out. She then yelled for CNA B who performed the [MEDICATION NAME] on Resident #1 while she went to get the nurse. CNA C confirmed Resident #1 had the behavior to grab other resident's food and that she had choked before when she was on a regular diet. An interview on [DATE] at 12:58 p.m., LVD D revealed she had already passed trays on the Generations unit and was in the South dining room. CNA C came out of the Generations unit and stated that Resident #1 was choking. LVN D stated she ran to the Generations unit and took over doing the [MEDICATION NAME]. Another nurse tried to finger swipe and could not get the food. We got the crash cart when I checked, and she had no pulse. LVN D revealed she started CPR on Resident #1 and continued until EMS arrived and took over. 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An interview on [DATE] at 4:31 p.m. with the Administrator and DON revealed they monitored and supervised staff through their department heads and nursing management following current or new protocols. They stated that in-services are held to provide training to the staff. An interview on [DATE] at 10:30 a.m. with the Administrator revealed he was aware of the choking incident in October and because there was no an adverse effect on her health, it was not reported. It was Resident #1's impulsivity and not following cues to swallow that caused the incident in October. The Administrator confirmed he was notified about Resident #1's current choking incident on Friday ([DATE]) at 6:20 p.m. The Administrator further confirmed he found out Resident #1 passed away on [DATE] at 12:15 p.m. The Administrator revealed he could not say this incident with Resident #1 was neglect because it was one incident that could have been prevented. Observation of noon meal service at 12:16 p.m. on [DATE] revealed four staff members present in the Generations unit dining room. Observation on [DATE] at 12:55 p.m. on the Generations unit revealed Resident #3 stood up from his chair and reached over with his fork to Resident #2's plate and took a fork full of sweet potatoes. Resident #3 ate the sweet potatoes before LVN B could intervene. Record review of care plans for Resident #2, #3, #4, #6, #7, #8, #10, #11, #12, #13, #14, #16, and #17 on the Generations unit revealed their behaviors of grabbing other resident's food, giving food and drinks to other residents, sitting in another residents seating area and eating their food, picking at other resident's food, and risk for choking was not updated until [DATE] and [DATE]. An interview on [DATE] at 10:45 a.m. with CNA B revealed usual staffing was two CNAs on the Generations unit during meals with twenty-something residents with behaviors. One CNA stayed in the dining room and the other went to assist Resident #5. CNA B further revealed all of the residents on the unit required redirecting at times. They were not able to provided one on one supervision and the nurse was not on the unit during meals. We had to clear the tables and we were constantly redirecting. CNA B stated they had to clean their own dining room while constantly redirecting residents and getting them ready for bed. CNA B confirmed everyone was aware of Resident #1's behavior to grab other resident's food. An interview on [DATE] at 11:11 a.m. with CNA F revealed Resident #1 had behaviors of wanting to get other people's food. When Resident #1 was done eating her food, she would go to different tables and take other resident's food. An interview on [DATE] at 11:20 a.m. with CNA C revealed there was one aide in the Generations unit dining room and one feeding Resident #5 in his room. CNA C further revealed that the nurse did not stay on the Generations unit the whole time during the meals. An interview on [DATE] at 12:37 p.m. with CNA F confirmed there were usually only 2 CNAs on the Generations unit during meal service. CNA F stated that the nurse would check the meal tickets and leave. CNA F confirmed during the current meal service that there were never that many staff members present on the Generations unit. An interview on [DATE] at 1:51 p.m. with LVN G revealed she checked the trays on the Generations unit and would have to go to the South dining room to check those trays and sometimes assist in feeding residents in that dining room. An interview on [DATE] at 4:01 p.m. with the DON stated staff needed to be present in the Generations unit dining room to provide assistance with feeding, monitoring if residents were eating and assist if someone choked. The DON confirmed that there definitely needed to be another staff member present in the Generations unit dining room if there was a resident grabbing other resident's food. An interview on [DATE] at 12:23 p.m. during lunch meal service on the Generations unit, the spouse of Resident #6 revealed there was never that many staff members present during lunch as there were now and he would come daily at this time. The spouse further

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 3) revealed that there were only two staff present during lunch when he would come to see his wife. An interview on [DATE] at 3:55 p.m., the DON revealed they did not have a current list of residents with behaviors during meals or at risk for choking until yesterday evening ([DATE]). An interview on [DATE] at 4:30 p.m., the DON revealed any resident on a special or alternate diet was at risk for choking. An interview on [DATE] at 5:19 p.m., Case Management Specialist H revealed care plans were updated on [DATE] and [DATE] for all residents who had behaviors during meals and residents who were at risk for choking. On [DATE] at 4:31 p.m. the Administrator and DON was notified of an Immediate Jeopardy (IJ) situation for the above failures, a completed IJ template was provided and a Plan of Removal was requested. On [DATE] at 12:27 p.m. the facility's Plan of Removal was approved. The facility's Plan of Removal included the following steps to be taken by the facility: 1. On [DATE] staff re-education was provided to available staff on abuse, neglect and exploitation regarding resident supervision during mealtimes. Staff were re-educated to ensure the new facility policy on providing adequate supervision in the dining room was implemented. 2. Effective [DATE] staffing will be adjusted in the Generations unit and south Dining Rooms to include, 2 CNAs monitoring and assisting at all times during the entire meal service. A licensed staff will also be assigned to monitor residents and assist as necessary during the entire meal service. 3. On [DATE] staff were re-educated to dispose of remaining portions of food and remove trays immediately after each resident has completed their respective meals. 4. Effective [DATE] staff were re-educated on monitoring of meals, residents who are noted to have behaviors that pose a risk will be assessed by the interdisciplinary healthcare team and the care plan will be updated as necessary. The surveyor verification of the Plan of Removal on [DATE] was as follows: Care plans reviewed the residents (#2, #3, #4, #6, #7, #8, #10, #11, #12, #13, #14, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, and #35) identified to ensure the care plans were updated to include behavioral issues and the risk of choking. Observed noon meal service on [DATE] for additional staff members in the dining rooms to include 2 CNAs and 1 LVN were present. In-service sign-in sheets and material covered by the in-services was reviewed onsite on [DATE] included the new seating arrangements, resident's diets, resident rights, number of staff present in the dining rooms, clearer trays as soon as the resident was done eating, supervision, and neglect. Staff interviews were conducted on 4 separate halls on 2 different shifts. Interviews occurred on [DATE] from 2:00 p.m. - 5:20 p.m. with CNA B, CNA, C, CNA I, CNA J, CNA K, CNA M, CNA N, MA P, NA R, CNA S, PTA T, and Cook Q. All stated that they had received in-services regarding adequate supervision to prevent abuse, neglect, and exploitation; an in-service regarding which residents were noted to have behaviors that posed a risk, the new requirements for staff needed in the dining room, and to dispose of leftover food/plates when a resident has completed their meal. Interviews occurred on [DATE] from 2:00 p.m. - 5:20 p.m. with LVN G, LVN L, RN O, the Maintenance Supervisor, the Social Worker, the Housekeeping Supervisor, the Activity Director, Case Management Specialist E & H, and the DON. All stated that they had received in-services regarding adequate supervision to prevent abuse, neglect, and exploitation; an in-service regarding which residents were noted to have behaviors that posed a risk, the new requirements for staff needed in the dining room, and to dispose of leftover food/plates when a resident has completed their meal. On [DATE] at 6:00 p.m., the Administrator, DON, the Director of Clinical Operations, and the Regional Vice-President of Operations were informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm with a scope identified as pattern until all staff were in-serviced.
F 0609 **Level of harm** - Actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure that all alleged violations involving abuse and neglect are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 22 residents (Resident #1) whose care was reviewed for neglect, in that: The facility failed to report Resident # 1's episode of choking on [DATE] that resulted in resident being sent to the hospital then later died within a 2 hour period. These deficient practice could affect residents in the facility who are at risk of choking and place them at risk for abuse and neglect. The findings were: Record review of Resident #1's face sheet, dated [DATE] revealed an admission date of [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Significant Change MDS dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment for daily decision making skills. Further review under Functional Status revealed Resident #1 required extensive assistance with eating and one person physical assistance. Review of Resident #1's Care Plan, revised on [DATE], revealed her care plan indicated she was on a pureed diet, but did not reflect her history of choking or behavior of grabbing other resident's food. Review of Resident #1's physician's orders [REDACTED]. Resident #1's diet order further revealed the original revision to pureed texture was on [DATE]. Review of Resident #1's progress note, dated [DATE], revealed Resident started choking on food she grabbed from another resident's plate with no RR and pale to color, proceeded to look for obstruction in throat and could not see or feel when finger swiping. Started [MEDICATION NAME] maneuver and did [MEDICATION NAME] for 5 minutes while resident had food running out of mouth but not yet unobstructed. I then felt for pulse and there was no pulse so that I started CPR until EMS came and was finally able to get a pulse after 20 minutes of working on her themselves. Resident sent to local hospital. Review of Resident #1's local hospital records, dated [DATE]- [DATE] revealed Resident #1 had a [MEDICAL CONDITION] after choking on her dinner. Resident #1 expired on [DATE]. An interview on [DATE] at 9:37 a.m. with the DON revealed Resident #1 had grabbed food from another resident's plate. Resident #1 was on pureed diet and the other resident had mechanical soft diet, except vegetables. The DON further revealed Resident #1 expired Saturday morning ([DATE]) from [MEDICAL CONDITION] and respiratory distress due to choking. An interview on [DATE] at 10:45 a.m. with CNA B revealed she and CNA C were on the Generations (memory care) unit gathering residents for dinner. Resident #1 started to grab other resident's trays. Resident #1 was redirected out of the dining room. After the trays were served, Resident #1 was brought back. CNA B further revealed she then went to assist Resident #5 with eating in his room, leaving only CNA C in the dining room on the Generations unit. CNA B stated she heard CNA C yell that Resident #1 was choking. Resident #1 was already discolored when CNA B arrived at Resident #1's side. CNA B stated she started the [MEDICATION NAME] on Resident #1 while CNA C went to get LVN D. CNA B confirmed Resident #1 had the behavior to grab other resident's food and that this was her third choking incident. An interview on [DATE] at 11:20 a.m. with CNA C revealed before dinner had started Resident #1 was already reaching out for other resident's food on their trays. We had to physically remove her because she was trying to get other resident's food. CNA C further revealed Resident #1 was brought back and given her tray after the other residents were served. CNA B went to assist Resident #5 and CNA C revealed she was feeding Resident #4 in the dining room. CNA C stated she was sitting caddy corner, so she could feed Resident #4 and look around to keep an eye on the other residents. CNA C stated, after feeding Resident #4, she walked by Resident #1 who had a spoon in her mouth. When CNA C picked up a tray she saw Resident #1 grab a cup and noticed the resident was shaking. CNA C stated she hit Resident #1 on the back and food came out. She then yelled for CNA B who performed the [MEDICATION NAME] on Resident #1 while she went to get the nurse. CNA C confirmed Resident #1 had the behavior to grab other resident's food and that she had choked before when she was on a regular diet. An interview on [DATE] at 12:58 p.m., LVD D revealed she had already passed trays on the Generations unit and was in the South dining room. CNA C came out of the Generations unit and stated that Resident #1 was choking. LVN D stated she ran to the Generations unit and took over doing the [MEDICATION NAME]. Another nurse tried to finger swipe and could not get the food. We got the crash cart when I checked, and she had no pulse. LVN D revealed she started CPR on Resident #1 and continued until EMS arrived and took over. LVN D confirmed that Resident #1 should not have been at the same table with a resident that had mechanical soft meat and that Resident #1 had choking episodes in the past. An interview on [DATE] at 3:41 p.m. with the Speech Therapist confirmed that Resident #1 needed supervision if she grabbed other resident's food. An interview on [DATE] at 10:30 a.m. with the Administrator confirmed he was notified about Resident #1's current choking incident on Friday ([DATE]) at 6:20 p.m. The Administrator further confirmed he found out Resident #1 passed away on [DATE] at 12:15 p.m. The Aministrator revealed he could not say it was neglect because it was one incident that could have been prevented. The Aministrator further revealed he was under the impression that only abuse had to be reported within the two hour window. An interview on [DATE] at 10:45 a.m. with CNA B revealed usual staffing was two CNAs on the Generations unit during meals with twenty-something residents with behaviors. One CNA stayed in the dining room and the other went to assist

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675380	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR NURSING AND REHABILITATION CENTER OF SEGUI	1219 EASTWOOD DR SEGUIN, TX 78155

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F 0609 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) Resident #5. CNA B further revealed all of the residents on the unit required redirecting at times. They were not able to provided one on one supervision and the nurse was not on the unit during meals. We had to clear the tables and we were constantly redirecting. CNA B stated they had to clean their own dining room while constantly redirecting residents and getting them ready for bed. CNA B confirmed everyone was aware of Resident #1's behavior to grab other resident's food. Review of Provider Letter No. ,[DATE] titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property, and Other Incidents that Must Be Reported to the Texas Department of Aging an Disability Services dated [DATE] revealed 2. Neglect: A certified NF must ensure that all alleged violations of neglect are reported to the NF administrator and to other officials in accordance with Texas law no later than two hours after the allegation is made, if the events that cause the allegation results in serious bodily injury.
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 of 22 residents (Resident #1) reviewed for care, in that: 1. a. The facility failed to document or implement interventions for Resident # 1, who they were aware had a history of [REDACTED]. Resident # 1 choked on [DATE], [DATE] and again on [DATE] and subsequently died . b. The facility failed to identify residents who took and ate food from other residents' plates and were at-risk for choking, provide supervision to those residents, and for ensuring inappropriately textured food was not within residents' reach. These failures resulted in identification of Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed [DATE], the facility remained out of compliance at a level of actual harm with a scope identified as a pattern until interventions were put in place for all residents at risk of choking. These deficient practices affected residents in the facility who were at-risk of choking, and placed them at-risk for harm, choking or death. The findings were: Record review of Resident #1's face sheet, dated [DATE] revealed an admission date of [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Significant Change MDS dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment for daily decision-making skills. Further review under Functional Status revealed Resident #1 required extensive assistance with eating and one person physical assistance. Review of Resident #1's Care Plan, revised on [DATE], revealed her care plan indicated she was on a pureed diet, but did not reflect her history of choking or behavior of grabbing other resident's food. Review of Resident #1's Physician Order Summary for (NAME)2020 revealed an order for [REDACTED]. Resident #1's diet order further revealed the original revision to pureed texture was on [DATE]. Review of Resident #1's Progress Notes revealed two previous choking incidents documented on [DATE] and [DATE]. Review of Resident #1's Modified [MEDICATION NAME] Swallowing Study, dated [DATE], revealed overall dysphagia severity is severe. Strategies - We recommend the following actions regarding the patient's feedings: Small Bites/Sips - Monitor PO Intake Rate - Positioned Upright - Supervised PO Feeding - Cueing for Strategies - Aspiration Precautions - Monitor [MEDICAL CONDITION] Status. Review of Resident #1's Speech Therapy Discharge Summary, dated [DATE], revealed to facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: general swallow techniques/precautions, alternation of liquid/solids and bolus size modifications. Use of adaptive cup to prevent spills secondary to tremors. Review of Resident #1's progress note, dated [DATE], revealed resident sitting up in chair in dining room, color pale, resident gasping for air. [MEDICATION NAME] maneuver done resident bringing up large amounts of solid food. Further review of the progress note revealed Resident #1 returned from the hospital with no new orders. Review of Resident #1's ER visit note, dated [DATE], revealed Choking episode. Review of the facility's incident reports for Resident #1 revealed an incident report was not completed for Resident #1's choking incident on [DATE] and [DATE]. There was no documentation of an assessment or interventions after Resident #1's choking episode on [DATE]. Review of Resident #1's progress note, dated [DATE], revealed Resident started choking on food she grabbed from another resident's plate with no RR (respiratory rate) and pale to color, proceeded to look for obstruction in throat and could not see or feel when finger swiping. Started [MEDICATION NAME] maneuver and did [MEDICATION NAME] for 5 minutes while resident had food running out of mouth but not yet unobstructed. I then felt for pulse and there was no pulse so that I started CPR until EMS came and was finally able to get a pulse after 20 minutes of working on her themselves. Resident sent to local hospital. Review of Resident #1's local hospital records, dated [DATE]- [DATE] revealed Resident #1 had a [MEDICAL CONDITION] after choking on her dinner. Resident #1 expired on [DATE]. An interview on [DATE] at 9:37 a.m. with the DON revealed Resident #1 had grabbed food from another resident's plate. Resident #1 was on pureed diet and the other resident had mechanical soft diet, except vegetables. The DON further revealed Resident #1 expired Saturday morning ([DATE]) from [MEDICAL CONDITION] and respiratory distress due to choking. An interview on [DATE] at 10:45 a.m. with CNA B revealed she and CNA C were on the Generations (memory care) unit gathering residents for dinner. Resident #1 started to grab other resident's trays. Resident #1 was redirected out of the dining room. After the trays were served, Resident #1 was brought back. CNA B further revealed she then went to assist Resident #5 with eating in his room, leaving only CNA C in the dining room on the Generations unit. CNA B stated she heard CNA C yell that Resident #1 was choking. Resident #1 was already discolored when CNA B arrived at Resident #1's side. CNA B stated she started the [MEDICATION NAME] on Resident #1 while CNA C went to get LVN D. CNA B confirmed Resident #1 had the behavior to grab other resident's food and that this was her third choking incident. An interview on [DATE] at 11:20 a.m. with CNA C revealed before dinner had started Resident #1 was already reaching out for other resident's food on their trays. We had to physically remove her because she was trying to get other resident's food. CNA C further revealed Resident #1 was brought back and given her tray after the other residents were served. CNA B went to assist Resident #5 and CNA C revealed she was feeding Resident #4 in the dining room. CNA C stated she was sitting caddy corner, so she could feed Resident #4 and look around to keep an eye on the other residents. CNA C stated, after feeding Resident #4, she walked by Resident #1 who had a spoon in her mouth. When CNA C picked up a tray she saw Resident #1 grab a cup and noticed the resident was shaking. CNA C stated she hit Resident #1 on the back and food came out. She then yelled for CNA B who performed the [MEDICATION NAME] on Resident #1 while she went to get the nurse. CNA C confirmed Resident #1 had the behavior to grab other resident's food and that she had choked before when she was on a regular diet. An interview on [DATE] at 12:58 p.m., LVD D revealed she had already passed trays on the Generations unit and was in the South dining room. CNA C came out of the Generations unit and stated that Resident #1 was choking. LVN D stated she ran to the Generations unit and took over doing the [MEDICATION NAME]. Another nurse tried to finger swipe and could not get the food. We got the crash cart when I checked, and she had no pulse. LVN D revealed she started CPR on Resident #1 and continued until EMS arrived and took over. LVN D confirmed that Resident #1 should not have been at the same table with a resident that had mechanical soft meat and that Resident #1 had choking episodes in the past. An interview on [DATE] at 3:41 p.m. with the Speech Therapist confirmed that Resident #1 needed supervision if she grabbed other resident's food. An interview on [DATE] at 3:55 p.m. with Case Management Specialist E confirmed Resident #1's choking episodes and behavior of grabbing other resident's food should have been care planned and it was not. An interview on [DATE] at 4:01 p.m. with the DON confirmed that Resident #1's behavior and risk of choking should have definitely been care planned. The DON revealed she was not aware of the extent of Resident #1's behavior of grabbing other resident's food. The DON further revealed she would not have placed Resident #1 with Resident #2 who had the mechanical soft meat. An interview on [DATE] at 4:31 p.m. with the Administrator and DON revealed they monitored and supervised staff through their department heads and nursing management following current or new protocols. They stated that in-services are held to provide training to the staff. An interview on [DATE] at 10:30 a.m. with the Administrator revealed he was aware of the choking incident in October and because there was no an adverse effect on her health, it was not reported. It was Resident #1's impulsivity and not following cues to swallow that caused the incident in October. The Administrator confirmed he was notified about Resident #1's current choking incident on Friday ([DATE]) at 6:20 p.m. The Administrator further confirmed he found out Resident #1 passed away on [DATE] at 12:15 p.m. The Administrator revealed he could not say this incident with Resident #1 was neglect because it was one incident that could have been prevented. Observation of noon meal service at 12:16 p.m. on [DATE] revealed four staff members present in the Generations unit dining room. Observation on [DATE] at 12:55 p.m. on the Generations unit revealed Resident #3 stood up from his chair and reached over with his fork to Resident #2's plate and took a fork full of sweet potatoes. Resident #3 ate the sweet potatoes before LVN B could intervene. Record review of care plans for Resident #2, #3, #4, #6, #7, #8, #10, #11, #12, #13, #14, #16, and #17 on the Generations unit revealed their

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	675380	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR NURSING AND REHABILITATION CENTER OF SEGUI	1219 EASTWOOD DR SEGUIN, TX 78155

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) behaviors of grabbing other resident's food, giving food and drinks to other residents, sitting in another residents seating area and eating their food, picking at other resident's food, and risk for choking was not updated until [DATE] and [DATE]. An interview on [DATE] at 10:45 a.m. with CNA B revealed usual staffing was two CNAs on the Generations unit during meals with twenty-something residents with behaviors. One CNA stayed in the dining room and the other went to assist Resident #5. CNA B further revealed all of the residents on the unit required redirecting at times. They were not able to provided one on one supervision and the nurse was not on the unit during meals. We had to clear the tables and we were constantly redirecting. CNA B stated they had to clean their own dining room while constantly redirecting residents and getting them ready for bed. CNA B confirmed everyone was aware of Resident #1's behavior to grab other resident's food. An interview on [DATE] at 11:11 a.m. with CNA F revealed Resident #1 had behaviors of wanting to get other people's food. When Resident #1 was done eating her food, she would go to different tables and take other resident's food. An interview on [DATE] at 11:20 a.m. with CNA C revealed there was one aide in the Generations unit dining room and one feeding Resident #5 in his room. CNA C further revealed that the nurse did not stay on the Generations unit the whole time during the meals. An interview on [DATE] at 12:37 p.m. with CNA F confirmed there were usually only 2 CNAs on the Generations unit during meal service. CNA F stated that the nurse would check the meal tickets and leave. CNA F confirmed during the current meal service that there were never that many staff members present on the Generations unit. An interview on [DATE] at 1:51 p.m. with LVN G revealed she checked the trays on the Generations unit and would have to go to the South dining room to check those trays and sometimes assist in feeding residents in that dining room. An interview on [DATE] at 4:01 p.m. with the DON stated staff needed to be present in the Generations unit dining room to provide assistance with feeding, monitoring if residents were eating and assist if someone choked. The DON confirmed that there definitely needed to be another staff member present in the Generations unit dining room if there was a resident grabbing other resident's food. An interview on [DATE] at 12:23 p.m. during lunch meal service on the Generations unit, the spouse of Resident #6 revealed there was never that many staff members present during lunch as there were now and he would come daily at this time. The spouse further revealed that there were only two staff present during lunch when he would come to see his wife. An interview on [DATE] at 3:55 p.m., the DON revealed they did not have a current list of residents with behaviors during meals or at risk for choking until yesterday evening ([DATE]). An interview on [DATE] at 4:30 p.m., the DON revealed any resident on a special or alternate diet was at risk for choking. An interview on [DATE] at 5:19 p.m., Case Management Specialist H revealed care plans were updated on [DATE] and [DATE] for all residents who had behaviors during meals and residents who were at risk for choking. Review of the facility policy titled Assistance with Meals dated [DATE] revealed Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. An interview on [DATE] at 11:06 a.m. the Administrator confirmed the facility did not have a policy on supervision during meals or choking. On [DATE] at 4:31 p.m. the Administrator and DON was notified of an Immediate Jeopardy (IJ) situation for the above failures, a completed IJ template was provided and a Plan of Removal was requested. On [DATE] at 12:27 p.m. the facility's Plan of Removal was approved. The facility's Plan of Removal included the following steps to be taken by the facility: 1. On [DATE] an audit was completed on all residents who have a propensity to choke or have a behavior which could lead to a choking episode. Residents who were identified to display these behaviors care plans were updated as necessary. 2. Effective [DATE] staff will be educated 5 times a week for 4 weeks on care plan changes that relate to diet changes as well as behaviors that could affect meal service of the resident. 3. On [DATE] new seating arrangements for residents with pureed diets were implemented for the South Dining and Generations Dining Rooms. Residents who are on a pureed diet will be sat together during mealtime. In an effort to ensure resident rights, residents how wish to not sit at the recommended table will be educated by licensed staff on the risks of possible harm to the resident's health and safety. 4. Effective [DATE] staffing will be adjusted in the Generations Unit and South Dining Rooms to include, 2 CNAs monitoring and assisting at all times during the entire meal service. A licensed staff will also be assigned to monitor residents and assist as necessary during the entire meal service. 5. On [DATE] staff were re-educated to dispose of remaining portions of food and remove trays immediately after each resident has completed their respective meal. 6. Effective [DATE] departments heads will conduct meal monitoring services for all meals 5 times a week for 4 weeks to ensure new facility protocol is being followed. 7. Re-education of the staff, to include nursing, therapy, dietary, maintenance, administrative and housekeeping was completed on [DATE] to ensure the staff members were educated regarding new dietary procedures to ensure adequate supervision during mealtimes. The surveyor verification of the Plan of Removal on [DATE] was as follows: Reviewed the audit completed by the facility on all residents who had a propensity to choke or had a behavior which could lead to a choking episode. Care plans reviewed for the residents(#2, #3, #4, #6, #7, #8, #10, #11, #12, #13, #14, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, and #35) identified in the audit to ensure the care plans were updated to include behavioral issues and the risk of choking. Reviewed and verified the daily education that would be provided to staff five times a week for four weeks that included resident's behaviors and care plan changes. Observed noon meal service on [DATE] on the Generations unit for new implementation of seating arrangements and how staff handled any residents that did not want to move. Observed noon meal service on [DATE] on the Generations unit for additional staff members in the dining rooms to include 2 CNAs and 1 LVN were present. In-service sign-in sheets and material covered by the in-services was reviewed onsite on [DATE] included the new seating arrangements, resident's diets, resident rights, number of staff present in the dining rooms, clearer trays as soon as the resident was done eating, supervision, and neglect. New scheduled for departments heads and documentation they must complete was reviewed onsite on [DATE]. Observed noon meals service on [DATE] for department heads presence and meal monitoring in the dining rooms. Staff interviews were conducted on 4 separate halls on 2 different shifts. Staff interviews were conducted of department heads regarding new responsibilities in the dining rooms. Interviews occurred on [DATE] from 2:00 p.m. - 5:20 p.m. with CNA B, CNA, C, CNA I, CNA J, CNA K, CNA M, CNA N, MA P, NA R, CNA S, PTA T, and Cook Q. All stated that they had received an in-service regarding which residents were at risk for choking and had behaviors during meals, the new seating arrangements and what to do if the resident did not want to sit at their designated table, the new requirements for staff needed in the dining rooms, and to dispose of leftover food/plates when a resident has completed their meal. Interviews occurred on [DATE] from 2:00 p.m. - 5:20 p.m. with LVN G, LVN L, RN O, the Maintenance Supervisor, the Social Worker, the Housekeeping Supervisor, the Activity Director, Case Management Specialist E & H, and the DON. All stated that they had received an in-service regarding which residents were at risk for choking and had behaviors during meals, the new seating arrangements and their responsibility as charge nurses or department heads on how to handle the situation if the resident did not want to sit at their designated table, the new requirements for staff needed in the dining rooms, to dispose of leftover food/plates when a resident has completed their meal, and the department heads new responsibilities during meal service. On [DATE] at 6:00 p.m., the Administrator, DON, the Director of Clinical Operations, and the Regional Vice-President of Operations were informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm with a scope identified as pattern until all staff were in-serviced.
F 0805 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 of 16 residents (Resident #2) reviewed for meals in that: Resident #2 was served regular sweet potatoes in chunks at lunch on 3/8/2020 instead of pureed sweet potatoes. These deficient practices could affect residents who received pureed diets and could place them at risk for choking. The findings were: Record review of Resident #2's face sheet, dated [DATE] revealed he was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #2's Admission MDS dated [DATE] revealed a BIMS score of 4 which indicated severe cognition impairment for daily decision making. Review of Resident #2's Physician order [REDACTED].#2's care plan updated on [DATE] revealed in part, Resident is on a regular diet, mechanical soft texture, regular liquids consistency, pureed vegetables .at risk for noncompliance with diet, at risk for choking. Interventions revealed in part staff to redirect during mealtimes. Observation on 3/8/20 at 12:25 p.m. revealed Resident #2 received his lunch tray in the secure unit dining room. Further observation revealed Resident #2 was served regular sweet potatoes in chunks instead of pureed sweet potatoes. During an interview on 3/8/20 at 12:31 p.m. with LVN A confirmed Resident #2 received regular sweet potatoes in chunks and that he should have gotten pureed sweet potatoes. During an interview on [DATE] at 10:50 a.m. with the Food Service Supervisor revealed safer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675380	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR NURSING AND REHABILITATION CENTER OF SEGUI	**1219 EASTWOOD DR SEGUIN, TX 78155**

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 0805 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) practice would have been for Resident #2 to have received pureed yams. During an interview on [DATE] at 11:06 a.m. with the administrator revealed there was not a facility policy for residents on special diets.