STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676206	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR ARBOR VIEW	**218 BALTIC EDINBURG, TX 78539**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determine the facility failed to immediately inform the physician and resident representative when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 8 Residents (Resident #1) reviewed for notification of changes. LVN B failed to notify Resident #1's physician and her family immediately when Resident #1 had a change of condition. This failure could affect all residents by causing their physicians and families to not be aware of any changing conditions and/or death. The evidence is as follows: Record Review of Resident #1's clinical record revealed she admitted on [DATE], was [AGE] years of age with the following Diagnoses: [REDACTED]. -An admission MDS/Medicare 5-day resident assessment, dated 5/13/2020, documented the resident had no speech, rarely/never understood and rarely/never understands others, impaired vision, short and long term memory problems, severely impaired cognitive skills for daily decision making, totally dependent by two staff for bathing, totally dependent on one staff for feeding, required extensive assistance by two staff for bed mobility, transfers and toileting, required extensive assistance by one staff for dressing and personal hygiene, limited range of motion of both upper and both lower extremities, used a wheelchair, indwelling catheter, incontinent of bowel, shortness of breath or trouble breathing when lying flat, recent prior surgery before admit (replace g tube), coughing or choking during meals or when swallowing, complaints of difficulty or pain when swallowing medications, 59 inches tall and 66 pounds (via weight records, Resident #1 was 70 pounds when admitted to the hospital), 51% or more to total calories and 501cc/day or more received daily for last seven days via tube feeding, has pressure ulcers, one unstageable, 6 unstageable presenting as deep tissue injury - all present on admission, pressure reducing device for bed and chair, turning/repositioning program, pressure ulcer/injury care. Nursing Note for Resident #1 dated 7/11/2020 at 1:24 p.m. Note Text: resident resting in bed, with wet and rattle sounds when breathing. no emesis 6-2 shift. resident moaning noted to have pain. resident with fever of 100.0 axillary. charge nurse instructed resident on prn medication for pain and fever administration suppository. charge nurse notified np marco of dr.fleming on residents change of condition. resident with chills and cough with sputum. resident unable to cough up sputum. charge nurse received new orders suction resident prn as needed. to start ns for 1 bolus intravenously, [MEDICATION NAME] 1 gm bid intravenously bid for 7 days, [MEDICATION NAME] 500 mg intravenously qd for 5 days, [MEDICATION NAME] 600 mg today then 200 mg one a day for 10 days, [MEDICATION NAME] 6 mg 1 tablet via peg one daily for 10 days, zinc sulfate 220 mg 1 tablet via peg qd DX: fever,cough,suspected covid, and pneumonia. charge nurse notified supervisor and r/p. charge nurse passed on report to oncoming nurse. last temperature for resident was 100.8. suppository given rectally for fever. During an interview on 8/31/2020 at 2:40 p.m., LVN B stated she worked at the facility part time and took care of Resident #1 on the night shift from 10:00 p.m. on 7/10/20 through 6:00 a.m. on 7/11/20. LVN B stated she really did not remember much about that shift but she did remember Resident #1 was throwing up mildly, did not have a cough but she could not remember if Resident #1 had a temperature. LVN B stated she contacted the doctor but did not get a response. LVN B stated she did not contact the family. Reviewed the Change Of Condition, dated 7/11/2020 at 5:46 a.m., for Resident #1 documented the resident had a temperature of 102.0, nursing notes documented an axillary temp of 102. , emesis x 2, productive cough noted, loose stool x 3, administered [MEDICATION NAME] suppository. It documented the responsible party (family member) was notified at 5:59 a.m. and the physician was contacted at 3:25 a.m. (Via interveiw, the incident happened approximately at 2:00 a.m. During an interview on 8/31/2020 at 3:25 p.m., LVN C stated she took care of Resident #1 on the 6:00 a.m. to 2:00 p.m. shift on 7/11/2020. LVN C stated when she got to the facility that morning, the nurse going off shift (LVN B) reported Resident #1 had some emesis during the night and that she was still waiting for a response from the doctor or the nurse practitioner. LVN C stated she thought it was around 9:00 a.m., that she first made contact with the nurse practitioner for Resident #1. LVN C stated she remember reading the Change of Condition Form that Resident #1 was coughing around 2:00 a.m. on the morning of 7/11/20, had a temperature and emesis of two times. During an interview on 9/1/2020 at 11:30 a.m., the DON, stated when a resident has a change of condition like Resident #1 did in the middle of the night, the nurse was supposed to call the doctor and the family to inform them of the medical concern immediately. DON stated the company that owns the facility does not have many policies and procedures but when they need one, they get that out of the Lippincott book. During a confidential interview on 9/1/2020 at 3:25 p.m., A family member stated on 7/11/20 when Resident #1 got so sick, the first contact made to the family by the facility was at 8:57 a.m. when the 6:00 a.m. to 2:00 p.m. nurse called their niece who lives close to the facility.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, for 1 of 8 residents (Resident #1) reviewed for quality of care. The facility failed to provide care to Resident #1 in accordance with professional standards of practice when: LVN B failed to notify Resident #1's physician and/or family in a timely manner when she had a change of condition. LVN A and LVN C failed to order medications and/or administer medications in a timely manner. These failures could place residents at risk of receiving care that is substandard, unable to meet their needs, and inadequate to prevent complications such as infection,[MEDICAL CONDITION], and death. The evidence is as follows: Record Review of Resident #1's clinical record revealed she admitted on [DATE], was [AGE] years of age with the following Diagnoses: [REDACTED]. -An admission MDS/Medicare 5-day resident assessment, dated [DATE], documented the resident had no speech, rarely/never understood and rarely/never understands others, impaired vision, short and long term memory problems, severely impaired cognitive skills for daily decision making, totally dependent by two staff for bathing, totally dependent on one staff for feeding, required extensive assistance by two staff for bed mobility, transfers and toileting, required extensive assistance by one staff for dressing and personal hygiene, limited range of motion of both upper and both lower extremities, used a wheelchair, indwelling catheter, incontinent of bowel, shortness of breath or trouble breathing when lying flat, recent prior surgery before admit (replace g tube), coughing or choking during meals or when swallowing, complaints of difficulty or pain when swallowing medications, 59 inches tall and 66 pounds (via weight records, Resident #1 was 70 pounds when admitted to the hospital), 51% or more to total calories and 501cc/day or more received daily for last seven days via tube feeding, has pressure ulcers, one unstageable, 6 unstageable presenting as deep

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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	676206	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR ARBOR VIEW	**218 BALTIC EDINBURG, TX 78539**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) tissue injury - all present on admission, pressure reducing device for bed and chair, turning/repositioning program, pressure ulcer/injury care. -Care Plan for Resident #1 The resident has a communication problem r/t rarely or never understood or understands. The resident requires tube feeding r/t Oropharyngeal dysphagia The resident has [DIAGNOSES REDACTED]icile. Date Initiated: [DATE] The resident has potential nutritional problem secondary to dependent for nutritional needs via [DEVICE]. The resident has DTI pressure ulcer to right bunion r/t Hx of ulcers The resident has Unstageable pressure ulcer to sacrum area r/t Hx of ulcers The resident has DTI pressure ulcer to right great toe r/t Hx of ulcers The resident has DTI pressure ulcer to left lateral foot (#1) r/t Hx of ulcers, The resident has oxygen therapy r/t [MEDICAL CONDITION] Nursing Note for Resident #1 dated [DATE] Note Text: resident resting in bed, with wet and rattle sounds when breathing. no emesis ,[DATE] shift. resident moaning noted to have pain. resident with fever of 100.0 axillary. charge nurse instructed resident on prn medication for pain and fever administration suppository. charge nurse notified np marco of dr.fleming on residents change of condition. resident with chills and cough with sputum. resident unable to cough up sputum. charge nurse received new orders suction resident prn as needed. to start ns for 1 bolus intravenously, [MEDICATION NAME] 1 gm bid intravenously bid for 7 days, [MEDICATION NAME] 500 mg intravenously qd for 5 days, [MEDICATION NAME] 600 mg today then 200 mg daily for 10 days, [MEDICATION NAME] 6 mg 1 tablet via peg one daily for 10 days, zinc sulfate 220 mg 1 tablet via peg qd DX: fever,cough,suspected covid, and pneumonia. charge nurse notified supervisor and r/p. charge nurse passed on report to oncoming nurse. last temperature for resident was 100.8. suppository given rectally for fever. Failure to Notify: During an interview on [DATE] at 2:40 p.m., LVN B stated she worked at the facility part time and took care of Resident #1 on the night shift from 10:00 p.m. on [DATE] through 6:00 a.m. on [DATE]. LVN B stated she really did not remember much about that shift but she did remember Resident #1 was throwing up mildly, did not have a cough but she could not remember if Resident #1 had a temperature. LVN B stated she contacted the doctor but did not get a response. LVN B stated she did not contact the family. Reviewed the Change Of Condition, dated [DATE] at 5:46 a.m., for Resident #1 documented the resident had a temperature of 102.0, nursing notes documented an axillary temp of 102. , emesis x 2, productive cough noted, loose stool x3, administered [MEDICATION NAME] suppository. It documented the responsible party (family member) was notified at 5:59 a.m. and the physician was contacted at 3:25 a.m. (Via interview the incident happened approximately at 2:00 a.m.) During an interview on [DATE] at 3:25 p.m., LVN C stated she took care of Resident #1 on the 6:00 a.m. to 2:00 p.m. shift on [DATE]. LVN C stated when she got to the facility that morning, the nurse going off shift (LVN B) reported Resident #1 had some emesis during the night and that she was still waiting for a response from the doctor or the nurse practitioner. LVN C stated she thought it was around 9:00 a.m., that she first made contact with the nurse practitioner for Resident #1. LVN C stated she remember reading the Change of Condition Form that Resident #1 was coughing around 2:00 a.m. on the morning of [DATE], had a temperature and emesis of two times. During an interview on [DATE] at 11:30 a.m., the DON, stated when a resident has a change of condition like Resident #1 did in the middle of the night, the nurse was supposed to call the doctor and the family to inform them of the medical concern immediately. DON stated the company that owns the facility does not have many policies and procedures but when they need one, they get that out of the Lippincott book. During a confidential interview on [DATE] at 3:25 p.m., A family member stated on [DATE] when Resident #1 got so sick, the first contact made to the family by the facility was at 8:57 a.m. when the 6:00 a.m. to 2:00 p.m. nurse called their niece who lives close to the facility. Failure to Initiate and/or Administer medications: [REDACTED]. LVN A stated Resident #1 was a long term care resident and was on isolation for an infection and suspected COVID-19. LVN A stated he took care of Resident #1 the same day ([DATE]) she was sent to the hospital and later expired. LVN A stated when he arrived at work, the nurse reported to him that Resident #1 needed an IV started and to start IV antibiotics and fluids for hydration so he got the IV started. LVN A stated the orders for Resident #1 were being initiated when he came on shift. LVN A stated there were several orders that day for Resident #1 and the day nurse, LVN C, initiated all of them. During an interview on [DATE] at 2:40 p.m., LVN B stated she worked at the facility part time and took care of Resident #1 on the night shift from 10:00 p.m. on [DATE] through 6:00 a.m. on [DATE]. LVN B stated she really did not remember much about that shift but she did remember Resident #1 was throwing up mildly, did not have a cough but she could not remember if Resident #1 had a temperature. LVN B stated she contacted the doctor but did not get a response. LVN B stated she did not contact the family. When asked if there was anything else going on, LVN B stated, not that I recall. Reviewed the Change Of Condition, dated [DATE] at 5:46 a.m., for Resident #1 documented the resident had a temperature of 102.0, nursing notes documented an axillary temp of 102. , emesis x 2, productive cough noted, loose stool x3, administered [MEDICATION NAME] suppository. It documented the responsible party (family member) was notified at 5:59 a.m. and the physician was contacted at 3:25 a.m. During an interview on [DATE] at 3:25 p.m., LVN C stated she took care of Resident #1 on the 6:00 a.m. to 2:00 p.m. shift on [DATE]. LVN C stated when she got to the facility that morning, the nurse going off shift (LVN B) reported Resident #1 had some emesis during the night and that she was still waiting for a response from the doctor or the nurse practitioner. LVN C stated the CNAs that morning went and checked on Resident #1 and she had thrown up on her bed so they cleaned the resident up. LVN C stated she checked on Resident #1 and she was not in any distress. LVN C stated she thought it was around 9:00 a.m., that she first made contact with the nurse practitioner for Resident #1. LVN C stated she remember reading the Change of Condition Form that Resident #1 was coughing around 2:00 a.m. on the morning of [DATE], had a temperature and emesis of two times. LVN C stated when she went in to check on Resident #1, she was coughing up phlegm. LVN C stated she got new orders for Resident #1 to give [MEDICATION NAME] for nausea and a KUB around 9:00 a.m. and the doctor wanted to know if staff had done a COVID-19 test on her. LVN C stated A COVID -19 test was done on all the residents on [DATE] but the results were not received yet. LVN C stated the nurse practitioner ordered IV fluids and gave her a bunch of orders. LVN C stated Resident #1 was already on oxygen and the nurse practitioner suspected she had COVID-19 and pneumonia. LVN C stated she saw a change in Resident #1 in the morning around 8:00 a.m. because she was coughing and had yellow phlegm and that was when she called another nurse to bring suction and that nurse suctioned her. LVN C stated the Nurse Practitioner had sent a message to her around 10:00 a.m. on [DATE] for all the new orders (antibiotics and fluid) but she was not aware of the new orders until shift change at 2:00 p.m. LVN C stated she only gave her a Tylenol suppository that day. Review of the MEDICATION ORDERS FOR [REDACTED]. This medication was never given to Resident #1. -initiated at 2:02 p.m. - [MEDICATION NAME] Solution Reconstituted 500 mg - use 500 mg intravenously one time a day for fever, cough, suspected COVID-19, pneumonia for 5 days. This medication was never given to Resident #1. -initiated at 2:07 p.m. - [MEDICATION NAME] Solution Reconstituted 1 gm - use 1 gram intravenously two times a day for fever, cough, suspected COVID-19, pneumonia for 7 days. This medication was never given to Resident #1. -initiated at 2:12 p.m. - [MEDICATION NAME] Tablet 200 mg - give 3 tablets via [DEVICE] one time only for fever, cough, suspected COVID-19, pneumonia for 1 day. (2 tablets of 200 mg to equal 600 mg) NOTE: This was in the nurses notes - They system has identified this order as being outside of the recommended dose for this drug: [MEDICATION NAME] Tablet 200 mg - give 3 tablets via [DEVICE] one time only for fever, cough, suspected, COVID-19, pneumonia for 1 day (3 tablets of 200 mg = 600 mg) Give 1 tablet via [DEVICE] two times a day for fever, cough, suspected COVID-19, pneumonia for 10 days. This medication was never given to Resident #1. -initiated at 2:19 p.m. - [MEDICATION NAME] Tablet 6 mg - Give 1 tablet via [DEVICE] on time a day for fever, cough, suspected COVID-19, pneumonia. This medication was never given to Resident #1. -Initiated at 2:23 p.m. - Sodium Chloride Solution 0.9% - Use 1 liter intravenously one time only for fever for 1 day. This hydration fluid was never given to Resident #1. -Via nursing notes for Resident #1, the physician ordered Zinc Sulfate 220 mg 1 tablet via peg tube one a day for fever, cough, suspected COVID-19 and pneumonia. No order was found for this medication so this medication was also not given. During an interview on [DATE] at 11:30 a.m., the DON, stated most of the medications that that were not given to Resident #1 were in the emergency kit and could have been given from that. DON stated the company that owns the facility does not have many policies and procedures but when they need one, they get that out of the Lippincott book.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined the facility failed to ensure residents remained free of any significant medication errors for 1 of 8 residents (Resident #1) reviewed for medication errors). LVN A and LVN C failed to administer medications to Resident #1 in a timley manner after she had a change of condition. The facility's failure to ensure that residents remained free of any significant medication errors could place all residents receiving oral medication at risk for shallow breathing, [MEDICAL CONDITION], low blood pressure, poor cerebral perfusion, poor blood circulation to other vital organs, peripheral blood clots, deep vein thrombus, [MEDICAL CONDITION] thrombus, coma and death. The evidence is as follows: Record Review of Resident #1's clinical record revealed she admitted on [DATE], was [AGE] years of age with the following Diagnoses: [REDACTED]. -An admission MDS/Medicare 5-day resident assessment, dated

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) [DATE], documented the resident had no speech, rarely/never understood and rarely/never understands others, impaired vision, short and long term memory problems, severely impaired cognitive skills for daily decision making, totally dependent by two staff for bathing, totally dependent on one staff for feeding, required extensive assistance by two staff for bed mobility, transfers and toileting, required extensive assistance by one staff for dressing and personal hygiene, limited range of motion of both upper and both lower extremities, used a wheelchair, indwelling catheter, incontinent of bowel, shortness of breath or trouble breathing when lying flat, recent prior surgery before admit (replace g tube), coughing or choking during meals or when swallowing, complaints of difficulty or pain when swallowing medications, 59 inches tall and 66 pounds (via weight records, Resident #1 was 70 pounds when admitted to the hospital), 51% or more to total calories and 501cc/day or more received daily for last seven days via tube feeding, has pressure ulcers, one unstageable, 6 unstageable presenting as deep tissue injury - all present on admission, pressure reducing device for bed and chair, turning/repositioning program, pressure ulcer/injury care. -Care Plan for Resident #1 The resident has a communication problem r/t rarely or never understood or understands. The resident requires tube feeding r/t Oropharyngeal dysphagia The resident has [DIAGNOSES REDACTED]icile. Date Initiated: [DATE] The resident has potential nutritional problem secondary to dependent for nutritional needs via [DEVICE]. The resident has DTI pressure ulcer to right bunion r/t Hx of ulcers The resident has Unstageable pressure ulcer to sacrum area r/t Hx of ulcers The resident has DTI pressure ulcer to right great toe r/t Hx of ulcers The resident has DTI pressure ulcer to left lateral foot (#1) r/t Hx of ulcers, The resident has oxygen therapy r/t [MEDICAL CONDITION] Nursing Note for Resident #1 dated [DATE] at 1:24 p.m. Note Text: resident resting in bed, with wet and rattle sounds when breathing. no emesis ,[DATE] shift. resident moaning noted to have pain. resident with fever of 100.0 axillary. charge nurse instructed resident on prn medication for pain and fever administration suppository. charge nurse notified np marco of dr.fleming on residents change of condition. resident with chills and cough with sputum. resident unable to cough up sputum. charge nurse received new orders suction resident prn as needed. to start ns for 1 bolus intravenously, [MEDICATION NAME] 1 gm bid intravenously bid for 7 days, [MEDICATION NAME] 500 mg intravenously qd for 5 days, [MEDICATION NAME] 600 mg today then 200 mg daily for 10 days, [MEDICATION NAME] 6 mg 1 tablet via peg for 10 days, zinc sulfate 220 mg 1 tablet via peg qd DX: fever,cough,suspected covid, and pneumonia. charge nurse notified supervisor and r/p. charge nurse passed on report to oncoming nurse. last temperature for resident was 100.8. suppository given rectally for fever. During an interview on [DATE] at 9:15 a.m., LVN A stated he remembered Resident #1 as she was on the hallway he was working but she was only on the hallway a couple of days. LVN A stated Resident #1 was a long term care resident and was on isolation for an infection and suspected COVID-19. LVN A stated he took care of Resident #1 the same day ([DATE]) she was sent to the hospital and later expired. LVN A stated when he arrived at work, the nurse reported to him that Resident #1 needed an IV started and to start IV antibiotics and fluids for hydration so he got the IV started. LVN A stated the orders for Resident #1 were being initiated when he came on shift. LVN A stated there were several orders that day for Resident #1 and the day nurse, LVN C, initiated all of them. During an interview on [DATE] at 2:40 p.m., LVN B stated she worked at the facility part time and took care of Resident #1 on the night shift from 10:00 p.m. on [DATE] through 6:00 a.m. on [DATE]. LVN B stated she really did not remember much about that shift but she did remember Resident #1 was throwing up mildly, did not have a cough but she could not remember if Resident #1 had a temperature. LVN B stated she contacted the doctor but did not get a response. LVN B stated she did not contact the family. When asked if there was anything else going on, LVN B stated, not that I recall. Reviewed the Change Of Condition, dated [DATE] at 5:46 a.m., for Resident #1 documented the resident had a temperature of 102.0, nursing notes documented an axillary temp of 102. , emesis x 2, productive cough noted, loose stool x3, administered [MEDICATION NAME] suppository. It documented the responsible party (family member) was notified at 5:59 a.m. and the physician was contacted at 3:25 a.m. (Via an interview the incident happened at approximately 2:00 a.m. During an interview on [DATE] at 3:25 p.m., LVN C stated she took care of Resident #1 on the 6:00 a.m. to 2:00 p.m. shift on [DATE]. LVN C stated when she got to the facility that morning, the nurse going off shift (LVN B) reported Resident #1 had some emesis during the night and that she was still waiting for a response from the doctor or the nurse practitioner. LVN C stated the CNAs that morning went and checked on Resident #1 and she had thrown up on her bed so they cleaned the resident up. LVN C stated she checked on Resident #1 and she was not in any distress. LVN C stated she thought it was around 9:00 a.m., that she first made contact with the nurse practitioner for Resident #1. LVN C stated she remember reading the Change of Condition Form that Resident #1 was coughing around 2:00 a.m. on the morning of [DATE], had a temperature and emesis of two times. LVN C stated when she went in to check on Resident #1, she was coughing up phlegm. LVN C stated she got new orders for Resident #1 to give [MEDICATION NAME] for nausea and a KUB around 9:00 a.m. and the doctor wanted to know if staff had done a COVID-19 test on her. LVN C stated A COVID -19 test was done on all the residents on [DATE] but the results were not received yet. LVN C stated the nurse practitioner ordered IV fluids and gave her a bunch of orders. LVN C stated Resident #1 was already on oxygen and the nurse practitioner suspected she had COVID-19 and pneumonia. LVN C stated she saw a change in Resident #1 in the morning around 8:00 a.m. because she was coughing and had yellow phlegm and that was when she called another nurse to bring suction and that nurse suctioned her. LVN C stated the Nurse Practitioner had sent a message to her around 10:00 a.m. on [DATE] for all the new orders (antibiotics and fluid) but she was not aware of the new orders until shift change at 2:00 p.m. LVN C stated she only gave her a Tylenol suppository that day. Review of the MEDICATION ORDERS FOR [REDACTED]. This medication was never given to Resident #1. -initiated at 2:02 p.m. - [MEDICATION NAME] Solution Reconstituted 500 mg - use 500 mg intravenously one time a day for fever, cough, suspected COVID-19, pneumonia for 5 days. This medication was never given to Resident #1. -initiated at 2:07 p.m. - [MEDICATION NAME] Solution Reconstituted 1 gm - use 1 gram intravenously two times a day for fever, cough, suspected COVID-19, pneumonia for 7 days. This medication was never given to Resident #1. -initiated at 2:12 p.m. - [MEDICATION NAME] Tablet 200 mg - give 3 tablets via [DEVICE] one time only for fever, cough, suspected COVID-19, pneumonia for 1 day. (2 tablets of 200 mg to equal 600 mg) NOTE: This was in the nurses notes - They system has identified this order as being outside of the recommended dose for this drug: [MEDICATION NAME] Tablet 200 mg - give 3 tablets via [DEVICE] one time only for fever, cough, suspected, COVID-19, pneumonia for 1 day (3 tablets of 200 mg = 600 mg) Give 1 tablet via [DEVICE] two times a day for fever, cough, suspected COVID-19, pneumonia for 10 days. This medication was never given to Resident #1. -initiated at 2:19 p.m. - [MEDICATION NAME] Tablet 6 mg - Give 1 tablet via [DEVICE] on time a day for fever, cough, suspected COVID-19, pneumonia. This medication was never given to Resident #1. -Initiated at 2:23 p.m. - Sodium Chloride Solution 0.9% - Use 1 liter intravenously one time only for fever for 1 day. This hydration fluid was never given to Resident #1. -Via nursing notes for Resident #1, the physician ordered Zinc Sulfate 220 mg 1 tablet via peg tube one a day for fever, cough, suspected COVID-19 and pneumonia. No order was found for this medication so this medication was also not given. During an interview on [DATE] at 11:30 a.m., the DON, stated most of the medications that were not given to Resident #1 were in the emergency kit and could have been given from that. DON stated the company that owns the facility does not have many policies and procedures but when they need one, they get that out of the Lippincott book. During a confidential interview on [DATE] at 3:25 p.m., A family member stated on [DATE] when Resident #1 got so sick, the first contact made to the family by the facility was at 8:57 a.m. when the 6:00 a.m. to 2:00 p.m. nurse called their niece who lives close to the facility.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined the facility failed to ensure that in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete, accurately documented, and readily accessible for 1 of 8 residents (Resident #1) reviewed for clinical records. Resident #1's medication orders were not put in the computer/Resident's clinical record, in a timely manner when a resident had a change of condition. The facility's failure to ensure medical records on each resident were complete, accurately documented, and readily accessible, placed all residents requiring nursing care at risk for incorrect or omitted treatment, duplicated treatments, poor self-esteem and self-worth, and a failure to ensure continuity of care. The evidence is as follows: Record Review of Resident #1's clinical record revealed she admitted on [DATE], was [AGE] years of age with the following Diagnoses: [REDACTED]. -An admission MDS/Medicare 5-day resident assessment, dated 5/13/2020, documented the resident had no speech, rarely/never understood and rarely/never understands others, impaired vision, short and long term memory problems, severely impaired cognitive skills for daily decision making, totally dependent by two staff for bathing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676206	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR ARBOR VIEW	**218 BALTIC EDINBURG, TX 78539**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) totally dependent on one staff for feeding, required extensive assistance by two staff for bed mobility, transfers and toileting, required extensive assistance by one staff for dressing and personal hygiene, limited range of motion of both upper and both lower extremities, used a wheelchair, indwelling catheter, incontinent of bowel, shortness of breath or trouble breathing when lying flat, recent prior surgery before admit (replace g tube), coughing or choking during meals or when swallowing, complaints of difficulty or pain when swallowing medications, 59 inches tall and 66 pounds (via weight records, Resident #1 was 70 pounds when admitted to the hospital), 51% or more to total calories and 501cc/day or more received daily for last seven days via tube feeding, has pressure ulcers, one unstageable, 6 unstageable presenting as deep tissue injury - all present on admission, pressure reducing device for bed and chair, turning/repositioning program, pressure ulcer/injury care. Nursing Note for Resident #1 dated 7/11/2020 at 1:24 p.m. Note Text: resident resting in bed, with wet and rattle sounds when breathing. no emesis 6-2 shift. resident moaning noted to have pain. resident with fever of 100.0 axillary. charge nurse instructed resident on prn medication for pain and fever administration suppository. charge nurse notified np marco of dr.fleming on residents change of condition. resident with chills and cough with sputum. resident unable to cough up sputum. charge nurse received new orders suction resident prn as needed. to start ns for 1 bolus intravenously, [MEDICATION NAME] 1 gm bid intravenously bid for 7 days, [MEDICATION NAME] 500 mg intravenously qd for 5 days, [MEDICATION NAME] 600 mg today then 200 mg for 10 days, [MEDICATION NAME] 6 mg 1 tablet via peg daily for 10 days, zinc sulfate 220 mg 1 tablet via peg qd DX: fever,cough,suspected covid, and pneumonia. charge nurse notified supervisor and r/p. charge nurse passed on report to oncoming nurse. last temperature for resident was 100.8. suppository given rectally for fever. During an interview on 8/31/2020 at 9:15 a.m., LVN A stated he remembered Resident #1 as she was on the hallway he was working but she was only on the hallway a couple of days. LVN A stated when he arrived at work, the nurse reported to him that Resident #1 needed an IV started and to start IV antibiotics and fluids for hydration so he got the IV started. LVN A stated the orders for Resident #1 were being initiated when he came on shift. LVN A stated there were several orders that day for Resident #1 and the day nurse, LVN C, initiated all of them. Reviewed the Change Of Condition, dated 7/11/2020 at 5:46 a.m., for Resident #1 documented the resident had a temperature of 102.0, nursing notes documented an axillary temp of 102. , emesis x 2, productive cough noted, loose stool x3, administered [MEDICATION NAME] suppository. It documented the responsible party (family member) was notified at 5:59 a.m. and the physician was contacted at 3:25 a.m. (Via an interview the incident happened at approximately 2:00 a.m.) During an interview on 8/31/2020 at 3:25 p.m., LVN C stated she took care of Resident #1 on the 6:00 a.m. to 2:00 p.m. shift on 7/11/2020. LVN C stated when she got to the facility that morning, the nurse going off shift (LVN B) reported Resident #1 had some emesis during the night and that she was still waiting for a response from the doctor or the nurse practitioner. LVN C stated she thought it was around 9:00 a.m., that she first made contact with the nurse practitioner for Resident #1. LVN C stated she remember reading the Change of Condition Form that Resident #1 was coughing around 2:00 a.m. on the morning of 7/11/20, had a temperature and emesis of two times. LVN C stated she saw a change in Resident #1 in the morning around 8:00 a.m. because she was coughing and had yellow phlegm and that was when she called another nurse to bring suction and that nurse suctioned her. LVN C stated the Nurse Practitioner had sent a message to her around 10:00 a.m. on 7/11/2020 for all the new orders (antibiotics and fluid) but she was not aware of the new orders until shift change at 2:00 p.m. LVN C stated she only gave her a Tylenol suppository that day. Review of the MEDICATION ORDERS FOR [REDACTED]. This medication was never given to Resident #1. -initiated at 2:02 p.m. - [MEDICATION NAME] Solution Reconstituted 500 mg - use 500 mg intravenously one time a day for fever, cough, suspected COVID-19, pneumonia for 5 days. This medication was never given to Resident #1. -initiated at 2:07 p.m. - [MEDICATION NAME] Solution Reconstituted 1 gm - use 1 gram intravenously two times a day for fever, cough, suspected COVID-19, pneumonia for 7 days. This medication was never given to Resident #1. -initiated at 2:12 p.m. - [MEDICATION NAME] Tablet 200 mg - give 3 tablets via [DEVICE] one time only for fever, cough, suspected COVID-19, pneumonia for 1 day. (2 tablets of 200 mg to equal 600 mg) NOTE: This was in the nurses notes - They system has identified this order as being outside of the recommended dose for this drug: [MEDICATION NAME] Tablet 200 mg - give 3 tablets via [DEVICE] one time only for fever, cough, suspected, COVID-19, pneumonia for 1 day (3 tablets of 200 mg = 600 mg) Give 1 tablet via [DEVICE] two times a day for fever, cough, suspected COVID-19, pneumonia for 10 days. This medication was never given to Resident #1. -initiated at 2:19 p.m. - [MEDICATION NAME] Tablet 6 mg - Give 1 tablet via [DEVICE] on time a day for fever, cough, suspected COVID-19, pneumonia. This medication was never given to Resident #1. -Initiated at 2:23 p.m. - Sodium Chloride Solution 0.9% - Use 1 liter intravenously one time only for fever for 1 day. This hydration fluid was never given to Resident #1. -Via nursing notes for Resident #1, the physician ordered Zinc Sulfate 220 mg 1 tablet via peg tube one a day for fever, cough, suspected COVID-19 and pneumonia. No order was found for this medication on the MAR indicated [REDACTED].