STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455533	A. BUILDING ______ B. WING _____	**02/27/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SENIOR CARE OF WINDCREST	**8800 FOURWINDS DR SAN ANTONIO, TX 78239**

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, interviews, and record reviews, the facility failed to ensure that 3 of 8 residents (Resident #s, 2, 3, and 5) whose care was reviewed had the right to be free from neglect related to falls in that:

1. The facility failed to implement individualized interventions for Resident #2 to prevent further falls. Resident #2 sustained 18 falls within a month and a half, 4 of which involved hitting her head. Fall risk evaluations were not completed after each fall as per facility policy. Resident #2 was sent to out to the hospital for a hematoma to her forehead with swelling on 2/22/18 and passed away at the facility on 2/26/18.

2. The facility failed to implement individualized interventions for Resident #5 to prevent further falls. She sustained 4 falls within a month and a half, one resulting in the need for staples to her head. Fall risk evaluations were not completed after each fall as per facility policy.

3. The facility failed to implement individualized interventions for Resident #3 to prevent further falls. Resident #3 sustained 6 falls within 2 months. Fall risk evaluations were not completed after each fall as per facility policy.

These failures resulted in an Immediate Jeopardy (IJ) situation identified on 2/23/18. While the IJ was removed on 2/26/18, the facility remained out of compliance at a severity level of actual harm with a scope identified as pattern until all staff were in-serviced.

This deficient practice could affect 14 residents with recent falls by placing them at risk for recurrent falls with/without injury.

The findings were:

1. Record review of Resident #2's facesheet (dated 1/24/18) revealed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].

Record review of Resident #2's quarterly MDS assessment (ARD 1/16/18) revealed that she scored a 3 on the BIMS (indicating severe cognitive impairment); had delusions; had physical and verbal behaviors directed toward others, and rejected care; needed the extensive assistance of 1 staff for bed mobility and transfers; needed the extensive assistance of 1 staff for walking in the room and in the corridor and for locomotion on the unit; and was unsteady. A walker and wheelchair were checked as mobility devices. She was not on a toileting program and was frequently incontinent of bladder and occasionally incontinent of bowel. She was on as-needed pain medication. She had 2 or more falls since the previous assessment - none with injury. She received antidepressants 7 days during the lookback period, antianxiety medications 5 days during the lookback period, and opioid medications 2 days within the lookback period. Speech therapy services were provided.

Record review of Resident #2's care plan (undated; printed and provided by MDS RN V on 2/27/18) revealed that her fall risk was addressed with interventions of Assess orthostatic blood pressure to rule out orthostatic [MEDICAL CONDITION], as ordered/needed; Assess for prior history of falls; Assess mental status as needed, Document changes in mental status and notify MD; Ensure that resident is wearing appropriate footwear when ambulating or in wheelchair; If receiving diuretics, schedule administration time so resident won't have to use the bathroom at bedtime, as ordered; PT, OT evaluation and follow-up as indicated; Provide a safe environment with floors that are even and free from spills or clutter, adequate glare-free light, call light within reach; Use mobility monitor or pressure-sensitive pads while in bed/chair, as ordered, to alert staff to resident's movements and self-transfer attempts; Evaluate medications that are potential risk factors - refer to pharmacy consultant as appropriate/indicated; Check brief and restroom/fluids when agitated/restless, Problem solve for other needs, Offer prn (as needed) meds as ordered/appropriate for restlessness/agitation.

Record review of Resident #2's fall risk evaluations revealed that she scored a 14 on 1/1/18 with scores of 10 or above indicating high fall risk.

Record review of Resident #2's incident/accident reports revealed:
1/1/18 - unwitnessed fall in the bathroom - resident noted sitting up on floor next to commode - resident stated My legs are weak - no injury; action taken was care plan update

Record review of Resident #2's immediate needs care plans revealed:
1/1/18 - fall with no apparent injury - continue interventions on the at-risk plan

Record review of Resident #2's investigation follow-ups revealed:
1/1/18 - Past Interventions Attempted (include dates): frequent monitoring, assist with ADLs, provide wheelchair as needed and Recommendations/New Interventions: continue all current interventions There were no new interventions.

Record review of Resident #2's incident/accident reports revealed:
1/2/18 - witnessed fall in the hallway - resident stood up from wheelchair and grabbed on to the med cart trash can and then fell straight down to sitting position - resident complained of pain, and x-ray was ordered - action taken was care plan update

Record review of Resident #2's immediate needs care plans revealed:
1/2/18 - fall resulting in minor injury - hips - modify the at-risk plan; x-ray to area of concern

Record review of Resident #2's investigation follow-ups revealed:
1/2/18 - Past Interventions Attempted (include dates): patient encouraged to use call light, call for help, nonskid socks and Recommendations/New Interventions: staff hourly checks to ensure resident has safe walkway and access to wheelchair

Record review of Resident #2's incident/accident reports revealed:
1/2/18 - unwitnessed fall in resident room - resident found on floor on right side holding head and crying - had been up in wheelchair and watching television - hematoma to right side of head - action taken was care plan update

Record review of Resident #2's immediate needs care plans revealed:
1/2/18 - fall resulting in minor injury - hematoma to right head - continue interventions on the at-risk plan

Record review of Resident #2's investigation follow-ups revealed:
1/2/18 - Past Interventions Attempted (include dates): frequent monitoring, assist with ADLs, provide wheelchair and Recommendations/New Interventions: [MEDICATION NAME] discontinued, [MEDICATION NAME] discontinued, continue all other
current interventions, transferred to room in front of desk

Record review of Resident #2's incident/accident reports revealed:
1/5/18 - witnessed fall in hallway - resident sitting up in wheelchair across from desk; attempted to stand; when redirected to sit, resident sat at edge of seat and slid down to floor - no injury; action taken was care plan update

Record review of Resident #2's immediate needs care plans revealed:
1/5/18 - fall with no apparent injury - continue interventions on the at-risk plan

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) Record review of Resident #2's investigation follow-ups revealed: 1/5/18 - Past Interventions Attempted (include dates): assist with ADLs, offer wheelchair, frequent monitoring and Recommendations/New Interventions: [MEDICATION NAME] 14 milligrams discontinued, [MEDICATION NAME] decreased to 50 milligrams every day, [MEDICATION NAME] decreased to 500 milligrams every day, continue all current interventions Record review of Resident #2's incident/accident reports revealed: 1/10/18 - witnessed fall in hallway - resident sitting up in wheelchair at nurses' desk; noted to stand; nurse instructed her to sit down; when she sat back down, she missed the chair and sat on the floor - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/10/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/10/18 - Past Interventions Attempted (include dates): monitoring, assist with ADLs and Recommendations/New Interventions: continue all current interventions There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/10/18 - witnessed fall in resident room - resident attempted to self-transfer from wheelchair to bed; nurse witnessed resident lower herself to the floor while holding on to the bed and wheelchair - no injury; action taken was care plan update and resident education However, Resident #2 had severe cognitive impairment. Record review of Resident #2's immediate needs care plans revealed: 1/10/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/10/18 - Past Interventions Attempted (include dates): wheelchair, assist with transfers and Recommendations/New Interventions: continue past interventions, reeducation on help with transfers However, Resident #2 had severe cognitive impairment. Record review of Resident #2's therapy notes revealed that she received speech therapy from 1/11/18 through 1/31/18 (when progress ceased) and physical therapy from 1/17/18 through 1/31/18 (when her short-term goals of safely transferring from bed to wheelchair with minimal assistance and propelling her wheelchair 75 feet down the hallway with supervision were met). Record review of Resident #2's incident/accident reports revealed: 1/14/18 - unwitnessed fall in bathroom - resident found sitting up on bathroom floor - no injury; action taken was staff reeducation However, it was not clear as to what staff were reeducated on. Record review of Resident #2's immediate needs care plans revealed: 1/14/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/14/18 - Past Interventions Attempted (include dates): assisted device at all times and Recommendations/New Interventions: patient up at nurses' station, continue to redirect as needed There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/15/18 - unwitnessed fall in hallway - resident was observed lying on the floor in hallway on left side - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/15/18 - fall with no apparent injury - modify the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/15/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: check on resident every 30 minutes to 1 hour to ensure safety and proper use of assistive devices Record review of Resident #2's incident/accident reports revealed: 1/18/18 - witnessed fall in hallway - resident stood up from wheelchair and attempted to sit back down and slipped off wheelchair seat; landed on right side - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/18/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/18/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: slip resistant wheelchair seat Record review of Resident #2's incident/accident reports revealed: 1/22/18 - witnessed fall in resident room - resident began yelling and swinging at hospice CNA while in wheelchair; she kicked night stand, causing her to fall back; unsure if she hit head - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/22/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/22/18 - Past Interventions Attempted (include dates): staff supervision and Recommendations/New Interventions: continue staff monitoring, prn meds, previous interventions Record review of Resident #2's 1/22/18 physician telephone order [MEDICATION NAME] mg by mouth twice daily for 10 days for treatment of [REDACTED]. Record review of Resident #2's 1/25/18 physician telephone order revealed [MEDICATION NAME] 5/325 mg 1 tab po TID scheduled for pain. Record review of Resident #2's incident/accident reports revealed: 1/30/18 - witnessed fall in hallway - resident noted to stand up from wheelchair when hospice nurse instructed her to sit down (although Resident #2 required extensive assistance with transfers according to her quarterly MDS assessment); due to unsteady balance, resident missed the chair and fell to the floor, hitting back of head on door frame - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/30/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/30/18 - Past Interventions Attempted (include dates): frequent monitoring and Recommendations/New Interventions: continue all current interventions There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/31/18 - unwitnessed fall in resident room - resident found on floor in room in sitting position in front of wheelchair, resident noted grabbing or reaching for things that aren't there, [MEDICAL CONDITION] noted - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/31/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/31/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: have possible [MEDICAL CONDITION] assessed by hospice Record review of Resident #2's incident/accident reports revealed: 2/1/18 - witnessed fall in resident room - resident noted reaching forward while sitting in wheelchair when she fell forward on to the floor, resident landed on left side, hematoma to left forehead - minor injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 2/1/18 - fall resulting in minor injury - hematoma to head - cranichecks x 72 hours Record review of Resident #2's investigation follow-ups revealed: 2/1/18 - Past Interventions Attempted (include dates): resident redirection, staff hourly checks and Recommendations/New Interventions: ensure safe passageway, monitor frequently due to high fall risk, utilize wheelchair due to unsteady gait Record review of Resident #2's 2/1/18 physician telephone order revealed Continue to monitor the welt to upper left forehead, continue fall precautions, call hospice with concerns or changes in status, DME: high-back wheelchair with foot rests x 2 Record review of Resident #2's incident/accident reports revealed:

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2)

2/6/18 - witnessed fall in hallway - resident sitting up in wheelchair when she leaned forward and fell out of wheelchair - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
2/6/18 - fall with no apparent injury - modify the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/6/18 - Past Interventions Attempted (include dates): high-back wheelchair and Recommendations/New Interventions: nonskid wheelchair pad There were no new interventions. The nonskid wheelchair pad was supposed to be implemented as an intervention after the 1/18/18 fall.
Record review of Resident #2's incident/accident reports revealed:
2/6/18 - witnessed fall at nurses' station - resident was sitting up in the wheelchair at nurses' station when she slid off the wheelchair and on to the floor - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
2/6/18 - fall with no apparent injury - modify the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/6/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: put to bed when falling asleep in wheelchair
Record review of Resident #2's incident/accident reports revealed:
2/9/18 - unwitnessed fall in resident room - resident heard falling and hitting self against room door, observed resident in sitting position with legs extended out, hematoma to the back of head - minor injury; action taken was care plan update, staff reeducation, resident education However, it was not clear as to what staff were to be reeducated on and Resident #2 had severe cognitive impairment.
Record review of Resident #2's immediate needs care plans revealed:
2/9/18 - fall resulting in minor injury - hematoma to back of head - cranichecks x 72 hours, treatment as ordered
Record review of Resident #2's investigation follow-ups revealed:
2/9/18 - Past Interventions Attempted (include dates): staff hourly checks, incontinent care done frequently and Recommendations/New Interventions: continue hourly checks and resident in view for safety
Record review of Resident #2's 2/9/18 physician telephone order revealed Discontinue 1/4 siderails - scoop mattress to prevent falls.
Record review of Resident #2's fall risk evaluations revealed that she scored a 24 on 2/14/18 with scores of 10 or above indicating high fall risk.
Record review of Resident #2's incident/accident reports revealed:
2/14/18 - witnessed fall in the dining room - resident noted to be sitting on floor, nurse said resident slid out of chair and sat on floor - no injury
Record review of Resident #2's immediate needs care plans revealed:
2/14/18 - fall with no apparent injury - continue interventions on the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/14/18 - Past Interventions Attempted (include dates): frequent monitoring and Recommendations/New Interventions: continue all current interventions There were no new interventions.
Observation of Resident #2 in her room at 4:15 p.m. on 2/22/18 revealed that she was sitting in her high-back wheelchair. The back was reclined so that her head was below her seat. There was no non-slip cushion in her wheelchair. She had a moccasin-type house shoe on her left foot and had no sock or shoe on her right foot. Resident #2 was pulling her legs up and leaning forward with her body, fidgeting with her hands.
During an interview with LVN A at this time, she reported that Resident #2 could not recline her high-back wheelchair into the position it was in and confirmed that staff put her wheelchair in this position.
Observation of Resident #2 in the hallway outside of the nursing station at 4:23 p.m. on 2/22/18 revealed that there was no non-slip cushion on her wheelchair. She had a moccasin-type house shoe on her left foot and had no sock or shoe on her right foot. She was rocking her upper body back and forth.
Observation of Resident #2 sleeping in bed at 10:45 a.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position.
During an interview with LVN B at 10:48 a.m. on 2/23/18, she reported that she thought Resident #2 fell last night. LVN B checked Resident #2's clinical record at this time and confirmed that Resident #2 fell at 9:30 p.m. on 2/22/18, hit her head, and was sent to the hospital. LVN B reported that Resident #2's nursing notes did not specify where the fall occurred but did say that she was found on the floor and that the fall was unwitnessed.
During an interview with LVNs B and D at 10:53 a.m. on 2/23/18, they reported LVN C was Resident #2's charge nurse. However, because LVN C was in the conference room doing paperwork, they were covering her residents.
At 10:55 a.m. on 2/23/18, the investigator asked the DON for Resident #2's 2/22/18 fall incident/accident report. The DON reported that she had not received it yet and that LVN C was Resident #2's charge nurse.
During an interview with LVN C at 10:59 a.m. on 2/23/18, she reported that she was not working on the floor today and that she had no idea where Resident #2's 2/22/18 fall occurred. LVN C reported that LVNs B and D were covering as charge nurses for Resident #2 since she was in the conference room doing paperwork.
During an interview with the DON at 11:01 a.m. on 2/23/18, when asked if the facility had their morning meeting already, she stated Kinda sorta. The nurses are trying to cover for each other because we're having that training - the (electronic records) one. (ADON R) is trying to find the incident/accident report.
Record review of Resident #2's 2/22/18 incident/accident report (given to the investigator by ADON R at 11:04 a.m. on 2/23/18) revealed that she had an unwitnessed fall in her room at 9:30 p.m. Hematoma/Bruise, Major Injury, and Joint Dislocation were checked. Handwritten next to the Joint Dislocation box was possible. Summary of incident was Resident found on floor by (LVN E). This nurse was notified of incident. Head to toe assessment performed. Hematoma to mid-forehead 7.5 centimeters x 6.0 centimeters noted with swelling. Possible right shoulder injury also noted . Resident showed signs of distress. Resident placed by nurse station. Called and notified (hospice) of incident. Treatment was Sent to Hospital. Action taken was Assistive Device, Care Plan Update, and Resident Education.
Record review of Resident #2's 2/22/18 immediate needs care plan revealed a fall resulting in minor injury to hematoma mid-forehead and a fall resulting in serious injury to possible right shoulder injury - crani checks x 72 hours, vital signs every shift x 72 hours, check range of motion daily x 72 hours, treatment as ordered, continue interventions on the at-risk plan.
Record review of Resident #2's 2/22/18 investigation follow-up revealed Past Interventions Attempted (include dates): supervision, place next to nursing station, frequent rounds on resident and Recommendations/New Interventions: Implement floor mats next to resident's bed. Implement bedside railing. Maintain bed at lowest position with call bell within reach. Check resident every 2 hours.
Observation of Resident #2 sleeping in bed at 11:24 a.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position.
During an interview with LVN D at 11:31 a.m. on 2/23/18, when asked if any information had been given to her about new fall interventions for Resident #2, she reported that hospice came and that a new bed was to be delivered today. When asked about fall mats, LVN D stated (LVN C) said no - they would be more of a fall hazard. When asked about bedrails, LVN D stated LVN C said no because she would get trapped in them in the past. When asked if Resident #2's 2/22/18 fall was out of her bed or out of her chair, LVN D reviewed the incident/accident report and stated I don't know. You'll have to ask the nurse who wrote this. The nurse who wrote this put in the interventions.
During an interview with Resident #2's hospice nurse at 12:15 p.m. on 2/23/18, she reported that she ordered a low bed and fall mats for Resident #2 after the 2/22/18 fall. She stated I don't think the fall mats are going to help, but we'll try. Residents have the right to fall. We can't restrain them. Resident #2's hospice nurse reported that Resident #2's medications had been adjusted and that they had put her in a high-back wheelchair. She stated I don't know what else to do. The hospice nurse reported that she did not know whether or not Resident #2's 2/22/18 fall was out of bed or out of the wheelchair. She confirmed that the high-back wheelchair should not have been positioned in such a way that Resident #2's head was below her seat. She stated (Resident #2) and (an unidentified resident) are both one fall away from dying.

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F 0600

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 3)
Observation of Resident #2 sleeping in bed at 1:10 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position.
Observation of Resident #2 sleeping in bed at 1:45 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position.
During an interview with the DON at 2:45 p.m. on 2/23/18, she was asked if she knew whether Resident #2's 2/22/18 fall was out of her bed or out of her wheelchair. The DON responded with No. You have the incident report. You got it before I did.
Observation of Resident #2 sleeping in bed at 4:33 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position. Her call light was on the floor at the foot of her bed.
During an interview with LVN F at 11:31 a.m. on 2/23/18, she reported that she was familiar with Resident #2's needs. She reported that Resident #2 had a wheelchair with a long back. LVN F stated She likes to stand and walk but she is unsteady and needs constant redirection. When asked to define constant redirection, LVN F stated We definitely have to round on her every hour and keep her in plain view as much as possible. LVN F reported that she was unsure if Resident #2 was supposed to have any special wheelchair cushion.
During an interview with LVN E at 4:34 p.m. on 2/23/18, she reported that she was the nurse who found Resident #2 in her room on 2/22/18. She reported that she was in the room next door and heard yelling from Resident #2's room. When she went in to check on Resident #2, she found Resident #2 in a fetal position with her head near the corner of the wall. LVN E reported that she had checked on Resident #2 5-10 minutes before and that Resident #2 was calm and in bed. LVN E reported that the scoop mattress was on the bed, that there were no sheets around Resident #2's feet, and that there were no floor mats. She could not remember whether or not Resident #2 was wearing shoes and reported that she could not figure out what happened.
During an interview with CNAs O and P at 10:21 a.m. on 2/27/17, when asked what kind of fall prevention measures Resident #2 had in place prior to her last fall, they reported that she had a high-back wheelchair that leaned back and that she was always kept at the nurses station. CNA P reported that she did not think Resident #2 had any kind of cushion in her chair, but CNA O reported that when the high-back wheelchair was provided by hospice, it came with a non-slip cushion. CNAs O and P reported that Resident #2 did not require any special shoes and that they weren't really monitoring her to ensure that she was wearing non-skid socks. They reported that she kept her shoes on when walking.
During an interview with LVN C at 11:11 a.m. on 2/27/18, when asked what interventions were in place for Resident #2 prior to the investigator's visit, LVN C reported that they had adjusted her psych medications. They had noticed that she had orthostatic [MEDICAL CONDITION] and discontinued her hypertensive medications. They moved her to a room across from the nursing station. Hospice ordered medications to calm her agitation and provided her with a high-back wheelchair with leg rests to prevent swelling and a scoop mattress. Staff tried to keep her in eyesight. She was put on scheduled pain and anxiety medications. When asked if Resident #2 was supposed to have a low bed or fall mats prior to investigator entrance, LVN C stated I want to say that was after Friday (2/22/18 fall). When asked if Resident #2 was supposed to have a non-slip cushion on her wheelchair prior to investigator entrance, LVN C stated I don't think she had a specific cushion for her chair. LVN C reported that activities were a hit or miss for Resident #2. She reported that staff turned the television in her room on but that it was ineffective and that music sometimes calmed her. When asked about wheelchair brakes, LVN C stated Me personally - it depends on the resident. (Resident #2) was a wheelchair brake person. They should have been locked. I would try to sit her up against the wall so that, if she stood up, the wall would stop her chair from moving back. When asked if Resident #2 was capable of unlocking her wheelchair brakes, LVN C stated I don't think she knew what she was doing but she would fidget with him. I think that caused some of her falls.
During an interview with LVN B at 11:36 a.m. on 2/27/18, she reported that Resident #2 could not self-propel her wheelchair, that Resident #2 needed constant supervision, and that wheelchair brakes were not appropriate for her. She reported that she was unsure about whether or not Resident #2 was supposed to have a non-slip cushion in her wheelchair or a fall mat prior to her 2/22/18 fall.
During an interview with ADON R at 2:37 p.m. on 2/27/18, when asked if Resident #2 was supposed to have a fall mat in place at the time of her 2/22/18 fall, ADON R stated I don't remember. I'd have to look. I think that she didn't. Most of her falls were not in her room. When asked what interventions Resident #2 did have in place prior to her 2/22/18 fall, ADON R reported that she had a special chair with foot rests, a scoop mattress, scheduled pain medications, antitippers on her wheelchair, psych medication adjustments and discontinuations, non-skid socks, check and change every 2 hours, and a bed in a low position. ADON R reported that staff was to let her ambulate but that she wasn't on a scheduled walking program. She reported that staff had tried a toileting program but that Resident #2 then became incontinent. She reported that a helmet had not been tried because she would get violent and throw it. She reported that a lap belt had not been tried because the facility considered it a restraint. ADON R stated We lock her wheelchair brakes, but there's no order for that. It's just common sense. ADON R reported that the facility had tried a wedge cushion and stated It must have worked because we didn't take it away, I don't think. Maybe when we got the new chair, we took it away because the new chair reclined back? ADON R reported Resident #2 did not have a non-slip cushion on her chair because she really didn't slide out and stated I don't think we needed to try that. She would slip off the edge when she would stand up and try to sit back down. At that point, non-slip wouldn't help because she was too close to the edge. ADON R reported that most of Resident #2's falls occurred when she would stand up from her wheelchair.
During an interview with CNA T at 2:59 p.m. on 2/27/18, he reported that Resident #2 was a resident for whom wheelchair brakes should be locked.
2. Record review of Resident #5's facesheet (dated 1/9/18) revealed that she was admitted to the facility on [DATE] and readmitted on [DATE] (after a hospital stay from 1/7/18 to 1/8/18) with [DIAGNOSES REDACTED].
Record review of Resident #5's significant change MDS assessment (ARD 1/9/18) revealed that she was unable to complete the BIMS and had severe cognitive impairment; wandered daily; and had behaviors that put herself and others at risk for injury; needed the extensive assistance of 1 staff for bed mobility and transfers; needed the extensive assistance of 1 staff for walking in the room and in the corridor and for locomotion on and off the un (TRUNCATED)

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, interviews, and record reviews, the facility failed to develop and implement its written policies and procedures that prohibit and prevent neglect for 3 of 8 residents (Resident #s, 2, 3, and 5) whose care was reviewed in that:
1. The facility failed to implement individualized interventions for Resident #2 to prevent further falls. Resident #2 sustained 18 falls within a month and a half, 4 of which involved hitting her head. Fall risk evaluations were not completed after each fall as per facility policy. Resident #2 was sent to out to the hospital for a hematoma to her forehead with swelling on 2/22/18 and passed away at the facility on 2/26/18.
2. The facility failed to implement individualized interventions for Resident #5 to prevent further falls. She sustained 4 falls within a month and a half, one resulting in the need for staples to her head. Fall risk evaluations were not completed after each fall as per facility policy.
3. The facility failed to implement individualized interventions for Resident #3 to prevent further falls. Resident #3 sustained 6 falls within 2 months. Fall risk evaluations were not completed after each fall as per facility policy.
These failures resulted in an Immediate Jeopardy (IJ) situation identified on 2/23/18. While the IJ was removed on 2/26/18, the facility remained out of compliance at a severity level of actual harm with a scope identified as pattern until all staff were in-serviced.
This deficient practice could affect 14 residents with recent falls by placing them at risk for recurrent falls with/without injury.
The findings were:
Record review of the facility's policy to prohibit the mistreatment, neglect, and abuse of residents and the misappropriation of resident property (not dated) revealed Each resident has the right to be free from mental and physical abuse, corporal punishment, involuntary seclusion, unreasonable confinement, intimidation, neglect . No resident will be deprived by any individual of goods and services necessary to attain or maintain physical, mental and psychosocial well-being.
Record review of the facility's fall prevention policy (not dated) revealed A fall risk assessment should be completed .

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SENIOR CARE OF WINDCREST	**8800 FOURWINDS DR SAN ANTONIO, TX 78239**

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 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) after each fall. As part of the initial assessment, the staff will help identify individuals with a history of falls and risk factors for subsequent falling . A care plan for fall risk management and injury prevention should be implemented. Effectiveness of the interventions identified in the care plan are evaluated for effectiveness. 1. Record review of Resident #2's facesheet (dated 1/24/18) revealed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's quarterly MDS assessment (ARD 1/16/18) revealed that she scored a 3 on the BIMS (indicating severe cognitive impairment); had delusions; had physical and verbal behaviors directed toward others, and rejected care; needed the extensive assistance of 1 staff for bed mobility and transfers; needed the extensive assistance of 1 staff for walking in the room and in the corridor and for locomotion on the unit; and was unsteady. A walker and wheelchair were checked as mobility devices. She was not on a toileting program and was frequently incontinent of bladder and occasionally incontinent of bowel. She was on as-needed pain medication. She had 2 or more falls since the previous assessment - none with injury. She received antidepressants 7 days during the lookback period, antianxiety medications 5 days during the lookback period, and opioid medications 2 days within the lookback period. Speech therapy services were provided. Record review of Resident #2's care plan (undated; printed and provided by MDS RN V on 2/27/18) revealed that her fall risk was addressed with interventions of Assess orthostatic blood pressure to rule out orthostatic [MEDICAL CONDITION], as ordered/needed; Assess for prior history of falls; Assess mental status as needed, Document changes in mental status and notify MD; Ensure that resident is wearing appropriate footwear when ambulating or in wheelchair; If receiving diuretics, schedule administration time so resident won't have to use the bathroom at bedtime, as ordered; PT, OT evaluation and follow-up as indicated; Provide a safe environment with floors that are even and free from spills or clutter, adequate glare-free light, call light within reach; Use mobility monitor or pressure-sensitive pads while in bed/chair, as ordered, to alert staff to resident's movements and self-transfer attempts; Evaluate medications that are potential risk factors - refer to pharmacy consultant as appropriate/indicated; Check brief and restroom/fluids when agitated/restless, Problem solve for other needs, Offer prn (as needed) meds as ordered/appropriate for restlessness/agitation. Record review of Resident #2's fall risk evaluations revealed that she scored a 14 on 1/1/18 with scores of 10 or above indicating high fall risk. Record review of Resident #2's incident/accident reports revealed: 1/1/18 - unwitnessed fall in the bathroom - resident noted sitting up on floor next to commode - resident stated My legs are weak - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/1/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/1/18 - Past Interventions Attempted (include dates): frequent monitoring, assist with ADLs, provide wheelchair as needed and Recommendations/New Interventions: continue all current interventions There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/2/18 - witnessed fall in the hallway - resident stood up from wheelchair and grabbed on to the med cart trash can and then fell straight down to sitting position - resident complained of pain, and x-ray was ordered - action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/2/18 - fall resulting in minor injury - hips - modify the at-risk plan; x-ray to area of concern Record review of Resident #2's investigation follow-ups revealed: 1/2/18 - Past Interventions Attempted (include dates): patient encouraged to use call light, call for help, nonskid socks and Recommendations/New Interventions: staff hourly checks to ensure resident has safe walkway and access to wheelchair Record review of Resident #2's incident/accident reports revealed: 1/2/18 - unwitnessed fall in resident room - resident found on floor on right side holding head and crying - had been up in wheelchair and watching television - hematoma to right side of head - action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/2/18 - fall resulting in minor injury - hematoma to right head - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/2/18 - Past Interventions Attempted (include dates): frequent monitoring, assist with ADLs, provide wheelchair and Recommendations/New Interventions: [MEDICATION NAME] discontinued, [MEDICATION NAME] discontinued, continue all other current interventions, transferred to room in front of desk Record review of Resident #2's incident/accident reports revealed: 1/5/18 - witnessed fall in hallway - resident sitting up in wheelchair across from desk; attempted to stand; when redirected to sit, resident sat at edge of seat and slid down to floor - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/5/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/5/18 - Past Interventions Attempted (include dates): assist with ADLs, offer wheelchair, frequent monitoring and Recommendations/New Interventions: [MEDICATION NAME] 14 milligrams discontinued, [MEDICATION NAME] decreased to 50 milligrams every day, [MEDICATION NAME] decreased to 500 milligrams every day, continue all current interventions Record review of Resident #2's incident/accident reports revealed: 1/10/18 - witnessed fall in hallway - resident sitting up in wheelchair at nurses' desk; noted to stand; nurse instructed her to sit down; when she sat back down, she missed the chair and sat on the floor - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/10/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/10/18 - Past Interventions Attempted (include dates): monitoring, assist with ADLs and Recommendations/New Interventions: continue all current interventions There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/10/18 - witnessed fall in resident room - resident attempted to self-transfer from wheelchair to bed; nurse witnessed resident lower herself to the floor while holding on to the bed and wheelchair - no injury; action taken was care plan update and resident education However, Resident #2 had severe cognitive impairment. Record review of Resident #2's immediate needs care plans revealed: 1/10/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/10/18 - Past Interventions Attempted (include dates): wheelchair, assist with transfers and Recommendations/New Interventions: continue past interventions, reeducation on help with transfers However, Resident #2 had severe cognitive impairment. Record review of Resident #2's therapy notes revealed that she received speech therapy from 1/11/18 through 1/31/18 (when progress ceased) and physical therapy from 1/17/18 through 1/31/18 (when her short-term goals of safely transferring from bed to wheelchair with minimal assistance and propelling her wheelchair 75 feet down the hallway with supervision were met). Record review of Resident #2's incident/accident reports revealed: 1/14/18 - unwitnessed fall in bathroom - resident found sitting up on bathroom floor - no injury; action taken was staff reeducation However, it was not clear as to what staff were reeducated on. Record review of Resident #2's immediate needs care plans revealed: 1/14/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/14/18 - Past Interventions Attempted (include dates): assisted device at all times and Recommendations/New Interventions: patient up at nurses' station, continue to redirect as needed There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/15/18 - unwitnessed fall in hallway - resident was observed lying on the floor in hallway on left side - no injury; action taken was care plan update

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NAME OF PROVIDER OF SUPPLIER **SENIOR CARE OF WINDCREST**	STREET ADDRESS, CITY, STATE, ZIP **8800 FOURWINDS DR** **SAN ANTONIO, TX 78239**

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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 5)
Record review of Resident #2's immediate needs care plans revealed:
1/15/18 - fall with no apparent injury - modify the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
1/15/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: check on resident every 30 minutes to 1 hour to ensure safety and proper use of assistive devices
Record review of Resident #2's incident/accident reports revealed:
1/18/18 - witnessed fall in hallway - resident stood up from wheelchair and attempted to sit back down and slipped off wheelchair seat; landed on right side - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
1/18/18 - fall with no apparent injury - continue interventions on the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
1/18/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: slip resistant wheelchair seat
Record review of Resident #2's incident/accident reports revealed:
1/22/18 - witnessed fall in resident room - resident began yelling and swinging at hospice CNA while in wheelchair; she kicked night stand, causing her to fall back; unsure if she hit head - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
1/22/18 - fall with no apparent injury - continue interventions on the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
1/22/18 - Past Interventions Attempted (include dates): staff supervision and Recommendations/New Interventions: continue staff monitoring, prn meds, previous interventions
Record review of Resident #2's 1/22/18 physician telephone order [MEDICATION NAME] mg by mouth twice daily for 10 days for treatment of [REDACTED].
Record review of Resident #2's 1/25/18 physician telephone order revealed [MEDICATION NAME] 5/325 mg 1 tab po TID scheduled
for pain.
Record review of Resident #2's incident/accident reports revealed:
1/30/18 - witnessed fall in hallway - resident noted to stand up from wheelchair when hospice nurse instructed her to sit down (although Resident #2 required extensive assistance with transfers according to her quarterly MDS assessment); due to unsteady balance, resident missed the chair and fell to the floor, hitting back of head on door frame - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
1/30/18 - fall with no apparent injury - continue interventions on the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
1/30/18 - Past Interventions Attempted (include dates): frequent monitoring and Recommendations/New Interventions: continue all current interventions There were no new interventions.
Record review of Resident #2's incident/accident reports revealed:
1/31/18 - unwitnessed fall in resident room - resident found on floor in room in sitting position in front of wheelchair, resident noted grabbing or reaching for things that aren't there, [MEDICAL CONDITION] noted - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
1/31/18 - fall with no apparent injury - continue interventions on the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
1/31/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: have possible [MEDICAL CONDITION] assessed by hospice
Record review of Resident #2's incident/accident reports revealed:
2/1/18 - witnessed fall in resident room - resident noted reaching forward while sitting in wheelchair when she fell forward on to the floor, resident landed on left side, hematoma to left forehead - minor injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
2/1/18 - fall resulting in minor injury - hematoma to head - cranichecks x 72 hours
Record review of Resident #2's investigation follow-ups revealed:
2/1/18 - Past Interventions Attempted (include dates): resident redirection, staff hourly checks and Recommendations/New Interventions: ensure safe passageway, monitor frequently due to high fall risk, utilize wheelchair due to unsteady gait
Record review of Resident #2's 2/1/18 physician telephone order revealed Continue to monitor the welt to upper left forehead, continue fall precautions, call hospice with concerns or changes in status, DME: high-back wheelchair with foot rests x 2
Record review of Resident #2's incident/accident reports revealed:
2/6/18 - witnessed fall in hallway - resident sitting up in wheelchair when she leaned forward and fell out of wheelchair - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
2/6/18 - fall with no apparent injury - modify the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/6/18 - Past Interventions Attempted (include dates): high-back wheelchair and Recommendations/New Interventions: nonskid wheelchair pad There were no new interventions. The nonskid wheelchair pad was supposed to be implemented as an intervention after the 1/18/18 fall.
Record review of Resident #2's incident/accident reports revealed:
2/6/18 - witnessed fall at nurses' station - resident was sitting up in the wheelchair at nurses' station when she slid off the wheelchair and on to the floor - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
2/6/18 - fall with no apparent injury - modify the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/6/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: put to bed when falling asleep in wheelchair
Record review of Resident #2's incident/accident reports revealed:
2/9/18 - unwitnessed fall in resident room - resident heard falling and hitting self against room door, observed resident in sitting position with legs extended out, hematoma to the back of head - minor injury; action taken was care plan update, staff reeducation, resident education However, it was not clear as to what staff were to be reeducated on and Resident #2 had severe cognitive impairment.
Record review of Resident #2's immediate needs care plans revealed:
2/9/18 - fall resulting in minor injury - hematoma to back of head - cranichecks x 72 hours, treatment as ordered
Record review of Resident #2's investigation follow-ups revealed:
2/9/18 - Past Interventions Attempted (include dates): staff hourly checks, incontinent care done frequently and Recommendations/New Interventions: continue hourly checks and resident in view for safety
Record review of Resident #2's 2/9/18 physician telephone order revealed Discontinue 1/4 siderails - scoop mattress to prevent falls.
Record review of Resident #2's fall risk evaluations revealed that she scored a 24 on 2/14/18 with scores of 10 or above indicating high fall risk.
Record review of Resident #2's incident/accident reports revealed:
2/14/18 - witnessed fall in the dining room - resident noted to be sitting on floor, nurse said resident slid out of chair and sat on floor - no injury
Record review of Resident #2's immediate needs care plans revealed:
2/14/18 - fall with no apparent injury - continue interventions on the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/14/18 - Past Interventions Attempted (include dates): frequent monitoring and Recommendations/New Interventions: continue

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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 6) all current interventions There were no new interventions. Observation of Resident #2 in her room at 4:15 p.m. on 2/22/18 revealed that she was sitting in her high-back wheelchair. The back was reclined so that her head was below her seat. There was no non-slip cushion in her wheelchair. She had a moccasin-type house shoe on her left foot and had no sock or shoe on her right foot. Resident #2 was pulling her legs up and leaning forward with her body, fidgeting with her hands. During an interview with LVN A at this time, she reported that Resident #2 could not recline her high-back wheelchair into the position it was in and confirmed that staff put her wheelchair in this position. Observation of Resident #2 in the hallway outside of the nursing station at 4:23 p.m. on 2/22/18 revealed that there was no non-slip cushion on her wheelchair. She had a moccasin-type house shoe on her left foot and had no sock or shoe on her right foot. She was rocking her upper body back and forth. Observation of Resident #2 sleeping in bed at 10:45 a.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position. During an interview with LVN B at 10:48 a.m. on 2/23/18, she reported that she thought Resident #2 fell last night. LVN B checked Resident #2's clinical record at this time and confirmed that Resident #2 fell at 9:30 p.m. on 2/22/18, hit her head, and was sent to the hospital. LVN B reported that Resident #2's nursing notes did not specify where the fall occurred but did say that she was found on the floor and that the fall was unwitnessed. During an interview with LVNs B and D at 10:53 a.m. on 2/23/18, they reported LVN C was Resident #2's charge nurse. However, because LVN C was in the conference room doing paperwork, they were covering her residents. At 10:55 a.m. on 2/23/18, the investigator asked the DON for Resident #2's 2/22/18 fall incident/accident report. The DON reported that she had not received it yet and that LVN C was Resident #2's charge nurse. During an interview with LVN C at 10:59 a.m. on 2/23/18, she reported that she was not working on the floor today and that she had no idea where Resident #2's 2/22/18 fall occurred. LVN C reported that LVNs B and D were covering as charge nurses for Resident #2 since she was in the conference room doing paperwork. During an interview with the DON at 11:01 a.m. on 2/23/18, when asked if the facility had their morning meeting already, she stated Kinda sorta. The nurses are trying to cover for each other because we're having that training - the (electronic records) one. (ADON R) is trying to find the incident/accident report. Record review of Resident #2's 2/22/18 incident/accident report (given to the investigator by ADON R at 11:04 a.m. on 2/23/18) revealed that she had an unwitnessed fall in her room at 9:30 p.m. Hematoma/Bruise, Major Injury, and Joint Dislocation were checked. Handwritten next to the Joint Dislocation box was possible. Summary of incident was Resident found on floor by (LVN E). This nurse was notified of incident. Head to toe assessment performed. Hematoma to mid-forehead 7.5 centimeters x 6.0 centimeters noted with swelling. Possible right shoulder injury also noted . Resident showed signs of distress. Resident placed by nurse station. Called and notified (hospice) of incident. Treatment was Sent to Hospital. Action taken was Assistive Device, Care Plan Update, and Resident Education. Record review of Resident #2's 2/22/18 immediate needs care plan revealed a fall resulting in minor injury to hematoma mid-forehead and a fall resulting in serious injury to possible right shoulder injury - crani checks x 72 hours, vital signs every shift x 72 hours, check range of motion daily x 72 hours, treatment as ordered, continue interventions on the at-risk plan. Record review of Resident #2's 2/22/18 investigation follow-up revealed Past Interventions Attempted (include dates): supervision, place next to nursing station, frequent rounds on resident and Recommendations/New Interventions: Implement floor mats next to resident's bed. Implement bedside railing. Maintain bed at lowest position with call bell within reach. Check resident every 2 hours. Observation of Resident #2 sleeping in bed at 11:24 a.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position. During an interview with LVN D at 11:31 a.m. on 2/23/18, when asked if any information had been given to her about new fall interventions for Resident #2, she reported that hospice came and that a new bed was to be delivered today. When asked about fall mats, LVN D stated (LVN C) said no - they would be more of a fall hazard. When asked about bedrails, LVN D stated LVN C said no because she would get trapped in them in the past. When asked if Resident #2's 2/22/18 fall was out of her bed or out of her chair, LVN D reviewed the incident/accident report and stated I don't know. You'll have to ask the nurse who wrote this. The nurse who wrote this put in the interventions. During an interview with Resident #2's hospice nurse at 12:15 p.m. on 2/23/18, she reported that she ordered a low bed and fall mats for Resident #2 after the 2/22/18 fall. She stated I don't think the fall mats are going to help, but we'll try. Residents have the right to fall. We can't restrain them. Resident #2's hospice nurse reported that Resident #2's medications had been adjusted and that they had put her in a high-back wheelchair. She stated I don't know what else to do. The hospice nurse reported that she did not know whether or not Resident #2's 2/22/18 fall was out of bed or out of the wheelchair. She confirmed that the high-back wheelchair should not have been positioned in such a way that Resident #2's head was below her seat. She stated (Resident #2) and (an unidentified resident) are both one fall away from dying. Observation of Resident #2 sleeping in bed at 1:10 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position. Observation of Resident #2 sleeping in bed at 1:45 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position. During an interview with the DON at 2:45 p.m. on 2/23/18, she was asked if she knew whether Resident #2's 2/22/18 fall was out of her bed or out of her wheelchair. The DON responded with No. You have the incident report. You got it before I did. Observation of Resident #2 sleeping in bed at 4:33 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position. Her call light was on the floor at the foot of her bed. During an interview with LVN F at 11:31 a.m. on 2/23/18, she reported that she was familiar with Resident #2's needs. She reported that Resident #2 had a wheelchair with a long back. LVN F stated She likes to stand and walk but she is unsteady and needs constant redirection. When asked to define constant redirection, LVN F stated We definitely have to round on her every hour and keep her in plain view as much as possible. LVN F reported that she was unsure if Resident #2 was supposed to have any special wheelchair cushion. During an interview with LVN E at 4:34 p.m. on 2/23/18, she reported that she was the nurse who found Resident #2 in her room on 2/22/18. She reported that she was in the room next door and heard yelling from Resident #2's room. When she went in to check on Resident #2, she found Resident #2 in a fetal position with her head near the corner of the wall. LVN E reported that she had checked on Resident #2 5-10 minutes before and that Resident #2 was calm and in bed. LVN E reported that the scoop mattress was on the bed, that there were no sheets around Resident #2's feet, and that there were no floor mats. She could not remember whether or not Resident #2 was wearing shoes and reported that she could not figure out what happened. During an interview with CNAs O and P at 10:21 a.m. on 2/27/17, when asked what kind of fall prevention measures Resident #2 had in place prior to her last fall, they reported that she had a high-back wheelchair that leaned back and that she was always kept at the nurses station. CNA P reported that she did not think Resident #2 had any kind of cushion in her chair, but CNA O reported that when the high-back wheelchair was provided by hospice, it came with a non-slip cushion. CNAs O and P reported that Resident #2 did not require any special shoes and that they weren't really monitoring her to ensure that she was wearing non-skid socks. They reported that she kept her shoes on when walking. During an interview with LVN C at 11:11 a.m. on 2/27/18, when asked what interventions were in place for Resident #2 prior to the investigator's visit, LVN C reported that they had adjusted her psych medications. They had noticed that she had orthostatic [MEDICAL CONDITION] and discontinued her hypertensive medications. They moved her to a room across from the nursing station. Hospice ordered medications to calm her agitation and provided her with a high-back wheelchair with leg rests to prevent swelling and a scoop mattress. Staff tried to keep her in eyesight. She was put on scheduled pain and anxiety medications. When asked if Resident #2 was supposed to have a low bed or fall mats prior to investigator entrance, LVN C stated I want to say that was after Friday (2/22/18 fall). When asked if Resident #2 was supposed to have a non-slip cushion on her wheelchair prior to investigator entrance, LVN C stated I don't think she had a specific cushion for her chair. LVN C reported that activities were a hit or miss for Resident #2. She reported that staff turned the television in her room on but that it was ineffective and that music sometimes calmed her. When asked about wheelchair brakes, LVN C stated Me personally - it depends on the resident. (Resident #2) was a wheelchair brake person. They should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455533**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/27/2018**
NAME OF PROVIDER OF SUPPLIER **SENIOR CARE OF WINDCREST**		STREET ADDRESS, CITY, STATE, ZIP **8800 FOURWINDS DR** **SAN ANTONIO, TX 78239**	

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 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) locked. I would try to sit her up against the wall so that, if she stood up, the wall would stop her chair from moving back. When asked if Resident #2 was capable of unlocking her wheelchair brakes, LVN C stated I don't think she knew what she was doing but she would fidget with him. I think that caused some of her falls. During an interview with LVN B at 11:36 a.m. on 2/27/18, she reported that Resident #2 could not self-propel her wheelchair, that Resident #2 needed constant supervision, and that wheelchair brakes were not appropriate for her. She reported that she was unsure about whether or not Resident #2 was supposed to have a non-slip cushion in her wheelchair or a fall mat prior to her 2/22/18 fall. During an interview with ADON R at 2:37 p.m. on 2/27/18, when asked if Resident #2 was supposed to have a fall mat in place at the time of her 2/22/18 fall, ADON R stated I don't remember. I'd have to look. I think that she didn't. Most of her falls were not in her room. When asked what interventions Resident #2 did have in place prior to her 2/22/18 fall, ADON R reported that she had a special chair with foot rests, a scoop mattress, scheduled pain medications, antitippers on her wheelchair, psych medication adjustments and discontinuations, non-skid socks, check and change every 2 hours, and a bed in a low position. ADON R reported that staff was to let her ambulate but that she wasn't on a scheduled walking program. She reported that staff had tried a toileting program but that Resident #2 then became incontinent. She reported that a helmet had not been tried because she would get violent and throw it. She reported that a lap belt had not been tried because the facility considered it a restraint. ADON R stated We lock her wheelchair brakes, but there's no order for that. It's just common sense. ADON R reported that the facility had tried a wedge cushion and stated It must have worked because we didn't take it away, I don't think. Maybe when we got the new chair, we took it away because the new chair reclined back? ADON R reported Resident #2 did not have a non-slip cushion on her chair because she really didn't slide out and stated I don't think we needed to try that. She would slip off the edge when she would stand up and try to sit back down. At that point, non-slip wouldn't help because she was too close to the edge. ADON R reported that most of Resident #2's falls occurred when she w (TRUNCATED)
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, interviews, and record reviews, the facility failed to ensure that the resident environment was as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for 3 of 8 residents (Resident #s 2, 3, and 5) whose care was reviewed in that: 1. The facility failed to implement individualized interventions for Resident #2 to prevent further falls. Resident #2 sustained 18 falls within a month and a half, 4 of which involved hitting her head. Fall risk evaluations were not completed after each fall as per facility policy. Resident #2 was sent to out to the hospital for a hematoma to her forehead with swelling on 2/22/18 and passed away at the facility on 2/26/18. 2. The facility failed to implement individualized interventions for Resident #5 to prevent further falls. She sustained 4 falls within a month and a half, one resulting in the need for staples to her head. Fall risk evaluations were not completed after each fall as per facility policy. 3. The facility failed to implement individualized interventions for Resident #3 to prevent further falls. Resident #3 sustained 6 falls within 2 months. Fall risk evaluations were not completed after each fall as per facility policy. These failures resulted in an Immediate Jeopardy (IJ) situation identified on 2/23/18. While the IJ was removed on 2/26/18, the facility remained out of compliance at a severity level of actual harm with a scope identified as pattern until all staff were in-serviced. This deficient practice could affect 14 residents with recent falls by placing them at risk for recurrent falls with/without injury. The findings were: 1. Record review of Resident #2's facesheet (dated 1/24/18) revealed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's quarterly MDS assessment (ARD 1/16/18) revealed that she scored a 3 on the BIMS (indicating severe cognitive impairment); had delusions; had physical and verbal behaviors directed toward others, and rejected care; needed the extensive assistance of 1 staff for bed mobility and transfers; needed the extensive assistance of 1 staff for walking in the room and in the corridor and for locomotion on the unit; and was unsteady. A walker and wheelchair were checked as mobility devices. She was not on a toileting program and was frequently incontinent of bladder and occasionally incontinent of bowel. She was on as-needed pain medication. She had 2 or more falls since the previous assessment - none with injury. She received antidepressants 7 days during the lookback period, antianxiety medications 5 days during the lookback period, and opioid medications 2 days within the lookback period. Speech therapy services were provided. Record review of Resident #2's care plan (undated; printed and provided by MDS RN V on 2/27/18) revealed that her fall risk was addressed with interventions of Assess orthostatic blood pressure to rule out orthostatic [MEDICAL CONDITION], as ordered/needed; Assess for prior history of falls; Assess mental status as needed, Document changes in mental status and notify MD; Ensure that resident is wearing appropriate footwear when ambulating or in wheelchair; If receiving diuretics, schedule administration time so resident won't have to use the bathroom at bedtime, as ordered; PT, OT evaluation and follow-up as indicated; Provide a safe environment with floors that are even and free from spills or clutter, adequate glare-free light, call light within reach; Use mobility monitor or pressure-sensitive pads while in bed/chair, as ordered, to alert staff to resident's movements and self-transfer attempts; Evaluate medications that are potential risk factors - refer to pharmacy consultant as appropriate/indicated; Check brief and restroom/fluids when agitated/restless, Problem solve for other needs, Offer prn (as needed) meds as ordered/appropriate for restlessness/agitation. Record review of Resident #2's fall risk evaluations revealed that she scored a 14 on 1/1/18 with scores of 10 or above indicating high fall risk. Record review of Resident #2's incident/accident reports revealed: 1/1/18 - unwitnessed fall in the bathroom - resident noted sitting up on floor next to commode - resident stated My legs are weak - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/1/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/1/18 - Past Interventions Attempted (include dates): frequent monitoring, assist with ADLs, provide wheelchair as needed and Recommendations/New Interventions: continue all current interventions There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/2/18 - witnessed fall in the hallway - resident stood up from wheelchair and grabbed on to the med cart trash can and then fell straight down to sitting position - resident complained of pain, and x-ray was ordered - action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/2/18 - fall resulting in minor injury - hips - modify the at-risk plan; x-ray to area of concern Record review of Resident #2's investigation follow-ups revealed: 1/2/18 - Past Interventions Attempted (include dates): patient encouraged to use call light, call for help, nonskid socks and Recommendations/New Interventions: staff hourly checks to ensure resident has safe walkway and access to wheelchair Record review of Resident #2's incident/accident reports revealed: 1/2/18 - unwitnessed fall in resident room - resident found on floor on right side holding head and crying - had been up in wheelchair and watching television - hematoma to right side of head - action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/2/18 - fall resulting in minor injury - hematoma to right head - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/2/18 - Past Interventions Attempted (include dates): frequent monitoring, assist with ADLs, provide wheelchair and Recommendations/New Interventions: [MEDICATION NAME] discontinued, [MEDICATION NAME] discontinued, continue all other current interventions, transferred to room in front of desk

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) Record review of Resident #2's incident/accident reports revealed: 1/5/18 - witnessed fall in hallway - resident sitting up in wheelchair across from desk; attempted to stand; when redirected to sit, resident sat at edge of seat and slid down to floor - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/5/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/5/18 - Past Interventions Attempted (include dates): assist with ADLs, offer wheelchair, frequent monitoring and Recommendations/New Interventions: [MEDICATION NAME] 14 milligrams discontinued, [MEDICATION NAME] decreased to 50 milligrams every day, [MEDICATION NAME] decreased to 500 milligrams every day, continue all current interventions Record review of Resident #2's incident/accident reports revealed: 1/10/18 - witnessed fall in hallway - resident sitting up in wheelchair at nurses' desk; noted to stand; nurse instructed her to sit down; when she sat back down, she missed the chair and sat on the floor - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/10/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/10/18 - Past Interventions Attempted (include dates): monitoring, assist with ADLs and Recommendations/New Interventions: continue all current interventions There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/10/18 - witnessed fall in resident room - resident attempted to self-transfer from wheelchair to bed; nurse witnessed resident lower herself to the floor while holding on to the bed and wheelchair - no injury; action taken was care plan update and resident education However, Resident #2 had severe cognitive impairment. Record review of Resident #2's immediate needs care plans revealed: 1/10/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/10/18 - Past Interventions Attempted (include dates): wheelchair, assist with transfers and Recommendations/New Interventions: continue past interventions, reeducation on help with transfers However, Resident #2 had severe cognitive impairment. Record review of Resident #2's therapy notes revealed that she received speech therapy from 1/11/18 through 1/31/18 (when progress ceased) and physical therapy from 1/17/18 through 1/31/18 (when her short-term goals of safely transferring from bed to wheelchair with minimal assistance and propelling her wheelchair 75 feet down the hallway with supervision were met). Record review of Resident #2's incident/accident reports revealed: 1/14/18 - unwitnessed fall in bathroom - resident found sitting up on bathroom floor - no injury; action taken was staff reeducation However, it was not clear as to what staff were reeducated on. Record review of Resident #2's immediate needs care plans revealed: 1/14/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/14/18 - Past Interventions Attempted (include dates): assisted device at all times and Recommendations/New Interventions: patient up at nurses' station, continue to redirect as needed There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/15/18 - unwitnessed fall in hallway - resident was observed lying on the floor in hallway on left side - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/15/18 - fall with no apparent injury - modify the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/15/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: check on resident every 30 minutes to 1 hour to ensure safety and proper use of assistive devices Record review of Resident #2's incident/accident reports revealed: 1/18/18 - witnessed fall in hallway - resident stood up from wheelchair and attempted to sit back down and slipped off wheelchair seat; landed on right side - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/18/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/18/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: slip resistant wheelchair seat Record review of Resident #2's incident/accident reports revealed: 1/22/18 - witnessed fall in resident room - resident began yelling and swinging at hospice CNA while in wheelchair; she kicked night stand, causing her to fall back; unsure if she hit head - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/22/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/22/18 - Past Interventions Attempted (include dates): staff supervision and Recommendations/New Interventions: continue staff monitoring, prn meds, previous interventions Record review of Resident #2's 1/22/18 physician telephone order [MEDICATION NAME] mg by mouth twice daily for 10 days for treatment of [REDACTED]. Record review of Resident #2's 1/25/18 physician telephone order revealed [MEDICATION NAME] 5/325 mg 1 tab po TID scheduled for pain. Record review of Resident #2's incident/accident reports revealed: 1/30/18 - witnessed fall in hallway - resident noted to stand up from wheelchair when hospice nurse instructed her to sit down (although Resident #2 required extensive assistance with transfers according to her quarterly MDS assessment); due to unsteady balance, resident missed the chair and fell to the floor, hitting back of head on door frame - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/30/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/30/18 - Past Interventions Attempted (include dates): frequent monitoring and Recommendations/New Interventions: continue all current interventions There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/31/18 - unwitnessed fall in resident room - resident found on floor in room in sitting position in front of wheelchair, resident noted grabbing or reaching for things that aren't there, [MEDICAL CONDITION] noted - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/31/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/31/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: have possible [MEDICAL CONDITION] assessed by hospice Record review of Resident #2's incident/accident reports revealed: 2/1/18 - witnessed fall in resident room - resident noted reaching forward while sitting in wheelchair when she fell forward on to the floor, resident landed on left side, hematoma to left forehead - minor injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 2/1/18 - fall resulting in minor injury - hematoma to head - cranichecks x 72 hours Record review of Resident #2's investigation follow-ups revealed: 2/1/18 - Past Interventions Attempted (include dates): resident redirection, staff hourly checks and Recommendations/New

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0689

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 9)
Interventions: ensure safe passageway, monitor frequently due to high fall risk, utilize wheelchair due to unsteady gait
Record review of Resident #2's 2/1/18 physician telephone order revealed Continue to monitor the welt to upper left forehead, continue fall precautions, call hospice with concerns or changes in status, DME: high-back wheelchair with foot rests x 2
Record review of Resident #2's incident/accident reports revealed:
2/6/18 - witnessed fall in hallway - resident sitting up in wheelchair when she leaned forward and fell out of wheelchair - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
2/6/18 - fall with no apparent injury - modify the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/6/18 - Past Interventions Attempted (include dates): high-back wheelchair and Recommendations/New Interventions: nonskid wheelchair pad There were no new interventions. The nonskid wheelchair pad was supposed to be implemented as an intervention after the 1/18/18 fall.
Record review of Resident #2's incident/accident reports revealed:
2/6/18 - witnessed fall at nurses' station - resident was sitting up in the wheelchair at nurses' station when she slid off the wheelchair and on to the floor - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
2/6/18 - fall with no apparent injury - modify the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/6/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: put to bed when falling asleep in wheelchair
Record review of Resident #2's incident/accident reports revealed:
2/9/18 - unwitnessed fall in resident room - resident heard falling and hitting self against room door, observed resident in sitting position with legs extended out, hematoma to the back of head - minor injury; action taken was care plan update, staff reeducation, resident education However, it was not clear as to what staff were to be reeducated on and Resident #2 had severe cognitive impairment.
Record review of Resident #2's immediate needs care plans revealed:
2/9/18 - fall resulting in minor injury - hematoma to back of head - cranichecks x 72 hours, treatment as ordered
Record review of Resident #2's investigation follow-ups revealed:
2/9/18 - Past Interventions Attempted (include dates): staff hourly checks, incontinent care done frequently and Recommendations/New Interventions: continue hourly checks and resident in view for safety
Record review of Resident #2's 2/9/18 physician telephone order revealed Discontinue 1/4 siderails - scoop mattress to prevent falls.
Record review of Resident #2's fall risk evaluations revealed that she scored a 24 on 2/14/18 with scores of 10 or above indicating high fall risk.
Record review of Resident #2's incident/accident reports revealed:
2/14/18 - witnessed fall in the dining room - resident noted to be sitting on floor, nurse said resident slid out of chair and sat on floor - no injury
Record review of Resident #2's immediate needs care plans revealed:
2/14/18 - fall with no apparent injury - continue interventions on the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/14/18 - Past Interventions Attempted (include dates): frequent monitoring and Recommendations/New Interventions: continue all current interventions There were no new interventions.
Observation of Resident #2 in her room at 4:15 p.m. on 2/22/18 revealed that she was sitting in her high-back wheelchair. The back was reclined so that her head was below her seat. There was no non-slip cushion in her wheelchair. She had a moccasin-type house shoe on her left foot and had no sock or shoe on her right foot. Resident #2 was pulling her legs up and leaning forward with her body, fidgeting with her hands.
During an interview with LVN A at this time, she reported that Resident #2 could not recline her high-back wheelchair into the position it was in and confirmed that staff put her wheelchair in this position.
Observation of Resident #2 in the hallway outside of the nursing station at 4:23 p.m. on 2/22/18 revealed that there was no non-slip cushion on her wheelchair. She had a moccasin-type house shoe on her left foot and had no sock or shoe on her right foot. She was rocking her upper body back and forth.
Observation of Resident #2 sleeping in bed at 10:45 a.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position.
During an interview with LVN B at 10:48 a.m. on 2/23/18, she reported that she thought Resident #2 fell last night. LVN B checked Resident #2's clinical record at this time and confirmed that Resident #2 fell at 9:30 p.m. on 2/22/18, hit her head, and was sent to the hospital. LVN B reported that Resident #2's nursing notes did not specify where the fall occurred but did say that she was found on the floor and that the fall was unwitnessed.
During an interview with LVNs B and D at 10:53 a.m. on 2/23/18, they reported LVN C was Resident #2's charge nurse. However, because LVN C was in the conference room doing paperwork, they were covering her residents.
At 10:55 a.m. on 2/23/18, the investigator asked the DON for Resident #2's 2/22/18 fall incident/accident report. The DON reported that she had not received it yet and that LVN C was Resident #2's charge nurse.
During an interview with LVN C at 10:59 a.m. on 2/23/18, she reported that she was not working on the floor today and that she had no idea where Resident #2's 2/22/18 fall occurred. LVN C reported that LVNs B and D were covering as charge nurses for Resident #2 since she was in the conference room doing paperwork.
During an interview with the DON at 11:01 a.m. on 2/23/18, when asked if the facility had their morning meeting already, she stated Kinda sorta. The nurses are trying to cover for each other because we're having that training - the (electronic records) one. (ADON R) is trying to find the incident/accident report.
Record review of Resident #2's 2/22/18 incident/accident report (given to the investigator by ADON R at 11:04 a.m. on 2/23/18) revealed that she had an unwitnessed fall in her room at 9:30 p.m. Hematoma/Bruise, Major Injury, and Joint Dislocation were checked. Handwritten next to the Joint Dislocation box was possible. Summary of incident was Resident found on floor by (LVN E). This nurse was notified of incident. Head to toe assessment performed. Hematoma to mid-forehead 7.5 centimeters x 6.0 centimeters noted with swelling. Possible right shoulder injury also noted . Resident showed signs of distress. Resident placed by nurse station. Called and notified (hospice) of incident. Treatment was Sent to Hospital. Action taken was Assistive Device, Care Plan Update, and Resident Education.
Record review of Resident #2's 2/22/18 immediate needs care plan revealed a fall resulting in minor injury to hematoma mid-forehead and a fall resulting in serious injury to possible right shoulder injury - crani checks x 72 hours, vital signs every shift x 72 hours, check range of motion daily x 72 hours, treatment as ordered, continue interventions on the at-risk plan.
Record review of Resident #2's 2/22/18 investigation follow-up revealed Past Interventions Attempted (include dates): supervision, place next to nursing station, frequent rounds on resident and Recommendations/New Interventions: Implement floor mats next to resident's bed. Implement bedside railing. Maintain bed at lowest position with call bell within reach. Check resident every 2 hours.
Observation of Resident #2 sleeping in bed at 11:24 a.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position.
During an interview with LVN D at 11:31 a.m. on 2/23/18, when asked if any information had been given to her about new fall interventions for Resident #2, she reported that hospice came and that a new bed was to be delivered today. When asked about fall mats, LVN D stated (LVN C) said no - they would be more of a fall hazard. When asked about bedrails, LVN D stated LVN C said no because she would get trapped in them in the past. When asked if Resident #2's 2/22/18 fall was out of her bed or out of her chair, LVN D reviewed the incident/accident report and stated I don't know. You'll have to ask the nurse who wrote this. The nurse who wrote this put in the interventions.
During an interview with Resident #2's hospice nurse at 12:15 p.m. on 2/23/18, she reported that she ordered a low bed and fall mats for Resident #2 after the 2/22/18 fall. She stated I don't think the fall mats are going to help, but we'll try.

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F 0689

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 10)
Residents have the right to fall. We can't restrain them. Resident #2's hospice nurse reported that Resident #2's medications had been adjusted and that they had put her in a high-back wheelchair. She stated I don't know what else to do. The hospice nurse reported that she did not know whether or not Resident #2's 2/22/18 fall was out of bed or out of the wheelchair. She confirmed that the high-back wheelchair should not have been positioned in such a way that Resident #2's head was below her seat. She stated (Resident #2) and (an unidentified resident) are both one fall away from dying.
Observation of Resident #2 sleeping in bed at 1:10 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position.
Observation of Resident #2 sleeping in bed at 1:45 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position.
During an interview with the DON at 2:45 p.m. on 2/23/18, she was asked if she knew whether Resident #2's 2/22/18 fall was out of her bed or out of her wheelchair. The DON responded with No. You have the incident report. You got it before I did.
Observation of Resident #2 sleeping in bed at 4:33 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position. Her call light was on the floor at the foot of her bed.
During an interview with LVN F at 11:31 a.m. on 2/23/18, she reported that she was familiar with Resident #2's needs. She reported that Resident #2 had a wheelchair with a long back. LVN F stated She likes to stand and walk but she is unsteady and needs constant redirection. When asked to define constant redirection, LVN F stated We definitely have to round on her every hour and keep her in plain view as much as possible. LVN F reported that she was unsure if Resident #2 was supposed to have any special wheelchair cushion.
During an interview with LVN E at 4:34 p.m. on 2/23/18, she reported that she was the nurse who found Resident #2 in her room on 2/22/18. She reported that she was in the room next door and heard yelling from Resident #2's room. When she went in to check on Resident #2, she found Resident #2 in a fetal position with her head near the corner of the wall. LVN E reported that she had checked on Resident #2 5-10 minutes before and that Resident #2 was calm and in bed. LVN E reported that the scoop mattress was on the bed, that there were no sheets around Resident #2's feet, and that there were no floor mats. She could not remember whether or not Resident #2 was wearing shoes and reported that she could not figure out what happened.
During an interview with CNAs O and P at 10:21 a.m. on 2/27/17, when asked what kind of fall prevention measures Resident #2 had in place prior to her last fall, they reported that she had a high-back wheelchair that leaned back and that she was always kept at the nurses station. CNA P reported that she did not think Resident #2 had any kind of cushion in her chair, but CNA O reported that when the high-back wheelchair was provided by hospice, it came with a non-slip cushion. CNAs O and P reported that Resident #2 did not require any special shoes and that they weren't really monitoring her to ensure that she was wearing non-skid socks. They reported that she kept her shoes on when walking.
During an interview with LVN C at 11:11 a.m. on 2/27/18, when asked what interventions were in place for Resident #2 prior to the investigator's visit, LVN C reported that they had adjusted her psych medications. They had noticed that she had orthostatic [MEDICAL CONDITION] and discontinued her hypertensive medications. They moved her to a room across from the nursing station. Hospice ordered medications to calm her agitation and provided her with a high-back wheelchair with leg rests to prevent swelling and a scoop mattress. Staff tried to keep her in eyesight. She was put on scheduled pain and anxiety medications. When asked if Resident #2 was supposed to have a low bed or fall mats prior to investigator entrance, LVN C stated I want to say that was after Friday (2/22/18 fall). When asked if Resident #2 was supposed to have a non-slip cushion on her wheelchair prior to investigator entrance, LVN C stated I don't think she had a specific cushion for her chair. LVN C reported that activities were a hit or miss for Resident #2. She reported that staff turned the television in her room on but that it was ineffective and that music sometimes calmed her. When asked about wheelchair brakes, LVN C stated Me personally - it depends on the resident. (Resident #2) was a wheelchair brake person. They should have been locked. I would try to sit her up against the wall so that, if she stood up, the wall would stop her chair from moving back. When asked if Resident #2 was capable of unlocking her wheelchair brakes, LVN C stated I don't think she knew what she was doing but she would fidget with him. I think that caused some of her falls.
During an interview with LVN B at 11:36 a.m. on 2/27/18, she reported that Resident #2 could not self-propel her wheelchair, that Resident #2 needed constant supervision, and that wheelchair brakes were not appropriate for her. She reported that she was unsure about whether or not Resident #2 was supposed to have a non-slip cushion in her wheelchair or a fall mat prior to her 2/22/18 fall.
During an interview with ADON R at 2:37 p.m. on 2/27/18, when asked if Resident #2 was supposed to have a fall mat in place at the time of her 2/22/18 fall, ADON R stated I don't remember. I'd have to look. I think that she didn't. Most of her falls were not in her room. When asked what interventions Resident #2 did have in place prior to her 2/22/18 fall, ADON R reported that she had a special chair with foot rests, a scoop mattress, scheduled pain medications, antitippers on her wheelchair, psych medication adjustments and discontinuations, non-skid socks, check and change every 2 hours, and a bed in a low position. ADON R reported that staff was to let her ambulate but that she wasn't on a scheduled walking program. She reported that staff had tried a toileting program but that Resident #2 then became incontinent. She reported that a helmet had not been tried because she would get violent and throw it. She reported that a lap belt had not been tried because the facility considered it a restraint. ADON R stated We lock her wheelchair brakes, but there's no order for that. It's just common sense. ADON R reported that the facility had tried a wedge cushion and stated It must have worked because we didn't take it away, I don't think. Maybe when we got the new chair, we took it away because the new chair reclined back? ADON R reported Resident #2 did not have a non-slip cushion on her chair because she really didn't slide out and stated I don't think we needed to try that. She would slip off the edge when she would stand up and try to sit back down. At that point, non-slip wouldn't help because she was too close to the edge. ADON R reported that most of Resident #2's falls occurred when she would stand up from her wheelchair.
During an interview with CNA T at 2:59 p.m. on 2/27/18, he reported that Resident #2 was a resident for whom wheelchair brakes should be locked.
2. Record review of Resident #5's facesheet (dated 1/9/18) revealed that she was admitted to the facility on [DATE] and readmitted on [DATE] (after a hospital stay from 1/7/18 to 1/8/18) with [DIAGNOSES REDACTED].
Record review of Resident #5's significant change MDS assessment (ARD 1/9/18) revealed that she was unable to complete the BIMS and had severe cognitive impairment; wandered daily; and had behaviors that put herself and others at risk for injury; needed the extensive assistance of 1 staff for bed mobility and transfers; need (TRUNCATED)

F 0835

Level of harm - Immediate jeopardy

Residents Affected - Some

Administer the facility in a manner that enables it to use its resources effectively and efficiently.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observations, interviews, and record reviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of 3 of 8 residents (Resident #s 2, 3, and 5) whose care was reviewed in that:
1. The administrator and DON failed to monitor staff to ensure that appropriate interventions were put in place for prevention of falls and fall reoccurrence. Resident #s 2, 3, and 5 continued to fall without effective interventions.
2. The administrator and DON failed to ensure that the facility's fall prevention policy was followed. Fall risk evaluations were not completed after each resident fall and interventions identified in the care plan were not evaluated for effectiveness.
These failures resulted in an Immediate Jeopardy (IJ) situation identified on 2/23/18. While the IJ was removed on 2/26/18, the facility remained out of compliance at a severity level of actual harm with a scope identified as pattern until all staff were in-serviced.
This deficient practice could affect 14 residents at the facility with recent falls by contributing to recurrent falls with/without injury.
The findings were:
Record review of the facility's administrator job description (not dated) revealed Essential Functions: To assure resident safety; Directs the location staff to provide high quality in daily care which meets/exceeds all internal/external standards within budget parameters, including but not limited to nursing services, physical plant and environment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455533**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/27/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SENIOR CARE OF WINDCREST	**8800 FOURWINDS DR SAN ANTONIO, TX 78239**

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 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11)

During an interview with the administrator at 1:16 p.m. on 2/27/18, she reported that she did not agree with the IJ because she felt that the facility had fall prevention processes in place. She reported that she did not feel the facility had an issues with falls and stated This is a large facility. We also have a memory care unit. As the disease progresses, falls happen. It's harder. Those residents are more prone to frequent falls. There are varying degrees of residents that you get. If a resident fell 6 times at home before coming here, we're not going to get that to stop. The administrator reported that she ensured company policies and procedures were followed. She reported that, prior to the IJ, nurses filled out an incident/accident report after a fall and came to the morning meeting the next morning to discuss what happened. She reported that the nurse turned in the incident/accident report to the DON and that the DON logged the incident/accident on a corporate form. She reported that the charge nurses, ADONs, and DON tried to figure out what caused the fall and, as a team, discussed what interventions could be tried. Then the nurses would get orders for needed interventions and relay the information to direct care staff by word of mouth. The administrator reported that the ADONs checked to make sure needed interventions were in place during rounds, that therapy staff were also on the floors to monitor, and that department heads all made quality of life rounds. When asked how the process changed after the IJ, the administrator reported that resident-specific fall care plans were put in a care plan book for aides to look at and that these books were kept at the nursing stations. She confirmed that there was nothing similar to this being used prior to the IJ. She reported that, in addition to the care plan books, fall interventions were being monitored through the MARs and that nurses were having to initial for needed interventions being in place. When asked how she monitored staff (for example, the DON) to ensure the systems they monitored were being done sufficiently, the administrator reported that she and the DON had all-day-long communication and that she asked questions based on complaints. She reported that, at WAR (weekly at risk) meetings, administrative staff talked about what was done during the week. She reported that, as part of QA (quality assurance), administrative staff reviewed incident/accident reports. The administrator reported that she signed off on incident/accident reports for completion. She reported that she reviewed them primarily to make sure that none of them were [MEDICATION NAME] and had not noticed a trend with other interventions besides Care plan update and Continue interventions on the at-risk plan not being checked. When asked what Care plan update on the incident/accident reports meant, the administrator stated The MDS people are in the meeting. I am assuming that means the care plan will be updated. I'm not sure what is meant by 'Modify the at-risk plan'.

Record review of the facility's DON job description (not dated) revealed Responsibilities: Participates as a member of the facilities management team in planning and administrative decision making with particular reference to the role, functions and operations of the facilities nursing services within the framework of the objectives and policies established by Senior Care Centers plans and coordinated nursing services. In summary, is responsible for patient care, management, resource management, and fiscal management and Essential Functions: To assure resident safety; Responsible for managing, directing and supervising nursing services; . Assesses the quality of care rendered . Responsible for staff performance .

During an interview with the DON at 2:02 p.m. on 2/27/18, she reported that she did not agree with the IJ and stated Honestly, I don't think you felt like there was enough documentation to support things we were already doing. When asked if she felt the facility had issues with their fall process, the DON stated Yes, there are issues in every building. Do I think our issues were IJ level? No. When asked if she felt the facility had a problem with reoccurring falls, the DON stated No. Based on our numbers, no. We have certain people with lots of falls, but that's in every building - nothing unusual. We are below the State average on falls. We might not have been as formal as we should have been on documenting care plans but are now. Our falls weren't out of hand. When asked what kind of plan was in place for residents with frequent falls prior to the IJ being called, the DON reported that the charge nurse would call her whenever a fall occurred and that, the next morning, the charge nurse would bring the incident/accident report to the morning meeting. She reported that the charge nurses and administrative nurses would discuss the fall and that she would make notes to take to the WAR meeting on Friday. The DON reported that, on Fridays, the falls were looked at more thoroughly and interventions that the team came up with would be relayed to the floor staff by word of mouth. When asked how the process changed after the IJ, the DON reported that all staff were reeducated on care plans, the facility's fall prevention/management program, assessments after a fall, and looking at outcomes to ensure that the facility's plans were working. She reported that a root cause analysis form had been added to the incident/accident report packets so that, when nurses called her, they would thoroughly review the fall together. The DON reported that the falls care plan had been altered to look more like the traditional care plan - with problem, goals, interventions, etc. - and had replaced the immediate needs care plan that was part of the packet. The DON stated Before, the call to me would not be as thorough. We would discuss the fall more at the morning meeting. The DON reported that there was now a fall intervention resource book at every nursing station and that the resident-specific fall care plans were being kept in a binder at every nursing station as well. She reported that, prior to the care plan binder, the kardex was used to inform staff of residents at risk for falls and that immediate needs care plans were kept in resident charts. She confirmed that the immediate needs care plans that had been kept in resident charts were not usually specific. The DON stated It's basically the same system we were doing. Instead of on WAR meeting notes, information is now in the care plan binder. It's the same information - it's just out there now for the staff to refer to. Instead of just telling them, now it's on paper.

1. Record review of Resident #2's facesheet (dated 1/24/18) revealed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].

Record review of Resident #2's quarterly MDS assessment (ARD 1/16/18) revealed that she scored a 3 on the BIMS (indicating severe cognitive impairment); had delusions; had physical and verbal behaviors directed toward others, and rejected care; needed the extensive assistance of 1 staff for bed mobility and transfers; needed the extensive assistance of 1 staff for walking in the room and in the corridor and for locomotion on the unit; and was unsteady. A walker and wheelchair were checked as mobility devices. She was not on a toileting program and was frequently incontinent of bladder and occasionally incontinent of bowel. She was on as-needed pain medication. She had 2 or more falls since the previous assessment - none with injury. She received antidepressants 7 days during the lookback period, antianxiety medications 5 days during the lookback period, and opioid medications 2 days within the lookback period. Speech therapy services were provided.

Record review of Resident #2's care plan (undated; printed and provided by MDS RN V on 2/27/18) revealed that her fall risk was addressed with interventions of Assess orthostatic blood pressure to rule out orthostatic [MEDICAL CONDITION], as ordered/needed; Assess for prior history of falls; Assess mental status as needed, Document changes in mental status and notify MD; Ensure that resident is wearing appropriate footwear when ambulating or in wheelchair; If receiving diuretics, schedule administration time so resident won't have to use the bathroom at bedtime, as ordered; PT, OT evaluation and follow-up as indicated; Provide a safe environment with floors that are even and free from spills or clutter, adequate glare-free light, call light within reach; Use mobility monitor or pressure-sensitive pads while in bed/chair, as ordered, to alert staff to resident's movements and self-transfer attempts; Evaluate medications that are potential risk factors - refer to pharmacy consultant as appropriate/indicated; Check brief and restroom/fluids when agitated/restless, Problem solve for other needs, Offer prn (as needed) meds as ordered/appropriate for restlessness/agitation.

Record review of Resident #2's fall risk evaluations revealed that she scored a 14 on 1/1/18 with scores of 10 or above indicating high fall risk.

Record review of Resident #2's incident/accident reports revealed:
1/1/18 - unwitnessed fall in the bathroom - resident noted sitting up on floor next to commode - resident stated My legs are weak - no injury; action taken was care plan update

Record review of Resident #2's immediate needs care plans revealed:
1/1/18 - fall with no apparent injury - continue interventions on the at-risk plan

Record review of Resident #2's investigation follow-ups revealed:
1/1/18 - Past Interventions Attempted (include dates): frequent monitoring, assist with ADLs, provide wheelchair as needed and Recommendations/New Interventions: continue all current interventions There were no new interventions.

Record review of Resident #2's incident/accident reports revealed:
1/2/18 - witnessed fall in the hallway - resident stood up from wheelchair and grabbed on to the med cart trash can and then fell straight down to sitting position - resident complained of pain, and x-ray was ordered - action taken was care plan update

Record review of Resident #2's immediate needs care plans revealed:
1/2/18 - fall resulting in minor injury - hips - modify the at-risk plan; x-ray to area of concern

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455533	A. BUILDING ______ B. WING _____	02/27/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SENIOR CARE OF WINDCREST	8800 FOURWINDS DR SAN ANTONIO, TX 78239

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 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) Record review of Resident #2's investigation follow-ups revealed: 1/2/18 - Past Interventions Attempted (include dates): patient encouraged to use call light, call for help, nonskid socks and Recommendations/New Interventions: staff hourly checks to ensure resident has safe walkway and access to wheelchair Record review of Resident #2's incident/accident reports revealed: 1/2/18 - unwitnessed fall in resident room - resident found on floor on right side holding head and crying - had been up in wheelchair and watching television - hematoma to right side of head - action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/2/18 - fall resulting in minor injury - hematoma to right head - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/2/18 - Past Interventions Attempted (include dates): frequent monitoring, assist with ADLs, provide wheelchair and Recommendations/New Interventions: [MEDICATION NAME] discontinued, [MEDICATION NAME] discontinued, continue all other current interventions, transferred to room in front of desk Record review of Resident #2's incident/accident reports revealed: 1/5/18 - witnessed fall in hallway - resident sitting up in wheelchair across from desk; attempted to stand; when redirected to sit, resident sat at edge of seat and slid down to floor - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/5/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/5/18 - Past Interventions Attempted (include dates): assist with ADLs, offer wheelchair, frequent monitoring and Recommendations/New Interventions: [MEDICATION NAME] 14 milligrams discontinued, [MEDICATION NAME] decreased to 50 milligrams every day, [MEDICATION NAME] decreased to 500 milligrams every day, continue all current interventions Record review of Resident #2's incident/accident reports revealed: 1/10/18 - witnessed fall in hallway - resident sitting up in wheelchair at nurses' desk; noted to stand; nurse instructed her to sit down; when she sat back down, she missed the chair and sat on the floor - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/10/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/10/18 - Past Interventions Attempted (include dates): monitoring, assist with ADLs and Recommendations/New Interventions: continue all current interventions There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/10/18 - witnessed fall in resident room - resident attempted to self-transfer from wheelchair to bed; nurse witnessed resident lower herself to the floor while holding on to the bed and wheelchair - no injury; action taken was care plan update and resident education However, Resident #2 had severe cognitive impairment. Record review of Resident #2's immediate needs care plans revealed: 1/10/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/10/18 - Past Interventions Attempted (include dates): wheelchair, assist with transfers and Recommendations/New Interventions: continue past interventions, reeducation on help with transfers However, Resident #2 had severe cognitive impairment. Record review of Resident #2's therapy notes revealed that she received speech therapy from 1/11/18 through 1/31/18 (when progress ceased) and physical therapy from 1/17/18 through 1/31/18 (when her short-term goals of safely transferring from bed to wheelchair with minimal assistance and propelling her wheelchair 75 feet down the hallway with supervision were met). Record review of Resident #2's incident/accident reports revealed: 1/14/18 - unwitnessed fall in bathroom - resident found sitting up on bathroom floor - no injury; action taken was staff reeducation However, it was not clear as to what staff were reeducated on. Record review of Resident #2's immediate needs care plans revealed: 1/14/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/14/18 - Past Interventions Attempted (include dates): assisted device at all times and Recommendations/New Interventions: patient up at nurses' station, continue to redirect as needed There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/15/18 - unwitnessed fall in hallway - resident was observed lying on the floor in hallway on left side - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/15/18 - fall with no apparent injury - modify the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/15/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: check on resident every 30 minutes to 1 hour to ensure safety and proper use of assistive devices Record review of Resident #2's incident/accident reports revealed: 1/18/18 - witnessed fall in hallway - resident stood up from wheelchair and attempted to sit back down and slipped off wheelchair seat; landed on right side - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/18/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/18/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: slip resistant wheelchair seat Record review of Resident #2's incident/accident reports revealed: 1/22/18 - witnessed fall in resident room - resident began yelling and swinging at hospice CNA while in wheelchair; she kicked night stand, causing her to fall back; unsure if she hit head - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/22/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/22/18 - Past Interventions Attempted (include dates): staff supervision and Recommendations/New Interventions: continue staff monitoring, prn meds, previous interventions Record review of Resident #2's 1/22/18 physician telephone order [MEDICATION NAME] mg by mouth twice daily for 10 days for treatment of [REDACTED]. Record review of Resident #2's 1/25/18 physician telephone order revealed [MEDICATION NAME] 5/325 mg 1 tab po TID scheduled for pain. Record review of Resident #2's incident/accident reports revealed: 1/30/18 - witnessed fall in hallway - resident noted to stand up from wheelchair when hospice nurse instructed her to sit down (although Resident #2 required extensive assistance with transfers according to her quarterly MDS assessment); due to unsteady balance, resident missed the chair and fell to the floor, hitting back of head on door frame - no injury; action taken was care plan update Record review of Resident #2's immediate needs care plans revealed: 1/30/18 - fall with no apparent injury - continue interventions on the at-risk plan Record review of Resident #2's investigation follow-ups revealed: 1/30/18 - Past Interventions Attempted (include dates): frequent monitoring and Recommendations/New Interventions: continue all current interventions There were no new interventions. Record review of Resident #2's incident/accident reports revealed: 1/31/18 - unwitnessed fall in resident room - resident found on floor in room in sitting position in front of wheelchair, resident noted grabbing or reaching for things that aren't there, [MEDICAL CONDITION] noted - no injury; action taken was care plan update

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455533**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/27/2018**

NAME OF PROVIDER OF SUPPLIER **SENIOR CARE OF WINDCREST**	STREET ADDRESS, CITY, STATE, ZIP **8800 FOURWINDS DR** **SAN ANTONIO, TX 78239**

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 0835

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 13)
Record review of Resident #2's immediate needs care plans revealed:
1/31/18 - fall with no apparent injury - continue interventions on the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
1/31/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: have possible [MEDICAL CONDITION] assessed by hospice
Record review of Resident #2's incident/accident reports revealed:
2/1/18 - witnessed fall in resident room - resident noted reaching forward while sitting in wheelchair when she fell forward on to the floor, resident landed on left side, hematoma to left forehead - minor injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
2/1/18 - fall resulting in minor injury - hematoma to head - cranichecks x 72 hours
Record review of Resident #2's investigation follow-ups revealed:
2/1/18 - Past Interventions Attempted (include dates): resident redirection, staff hourly checks and Recommendations/New Interventions: ensure safe passageway, monitor frequently due to high fall risk, utilize wheelchair due to unsteady gait
Record review of Resident #2's 2/1/18 physician telephone order revealed Continue to monitor the welt to upper left forehead, continue fall precautions, call hospice with concerns or changes in status, DME: high-back wheelchair with foot rests x 2
Record review of Resident #2's incident/accident reports revealed:
2/6/18 - witnessed fall in hallway - resident sitting up in wheelchair when she leaned forward and fell out of wheelchair - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
2/6/18 - fall with no apparent injury - modify the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/6/18 - Past Interventions Attempted (include dates): high-back wheelchair and Recommendations/New Interventions: nonskid wheelchair pad There were no new interventions. The nonskid wheelchair pad was supposed to be implemented as an intervention after the 1/18/18 fall.
Record review of Resident #2's incident/accident reports revealed:
2/6/18 - witnessed fall at nurses' station - resident was sitting up in the wheelchair at nurses' station when she slid off the wheelchair and on to the floor - no injury; action taken was care plan update
Record review of Resident #2's immediate needs care plans revealed:
2/6/18 - fall with no apparent injury - modify the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/6/18 - Past Interventions Attempted (include dates): nonskid socks and Recommendations/New Interventions: put to bed when falling asleep in wheelchair
Record review of Resident #2's incident/accident reports revealed:
2/9/18 - unwitnessed fall in resident room - resident heard falling and hitting self against room door, observed resident in sitting position with legs extended out, hematoma to the back of head - minor injury; action taken was care plan update, staff reeducation, resident education However, it was not clear as to what staff were to be reeducated on and Resident #2 had severe cognitive impairment.
Record review of Resident #2's immediate needs care plans revealed:
2/9/18 - fall resulting in minor injury - hematoma to back of head - cranichecks x 72 hours, treatment as ordered
Record review of Resident #2's investigation follow-ups revealed:
2/9/18 - Past Interventions Attempted (include dates): staff hourly checks, incontinent care done frequently and Recommendations/New Interventions: continue hourly checks and resident in view for safety
Record review of Resident #2's 2/9/18 physician telephone order revealed Discontinue 1/4 siderails - scoop mattress to prevent falls.
Record review of Resident #2's fall risk evaluations revealed that she scored a 24 on 2/14/18 with scores of 10 or above indicating high fall risk.
Record review of Resident #2's incident/accident reports revealed:
2/14/18 - witnessed fall in the dining room - resident noted to be sitting on floor, nurse said resident slid out of chair and sat on floor - no injury
Record review of Resident #2's immediate needs care plans revealed:
2/14/18 - fall with no apparent injury - continue interventions on the at-risk plan
Record review of Resident #2's investigation follow-ups revealed:
2/14/18 - Past Interventions Attempted (include dates): frequent monitoring and Recommendations/New Interventions: continue all current interventions There were no new interventions.
Observation of Resident #2 in her room at 4:15 p.m. on 2/22/18 revealed that she was sitting in her high-back wheelchair. The back was reclined so that her head was below her seat. There was no non-slip cushion in her wheelchair. She had a moccasin-type house shoe on her left foot and had no sock or shoe on her right foot. Resident #2 was pulling her legs up and leaning forward with her body, fidgeting with her hands.
During an interview with LVN A at this time, she reported that Resident #2 could not recline her high-back wheelchair into the position it was in and confirmed that staff put her wheelchair in this position.
Observation of Resident #2 in the hallway outside of the nursing station at 4:23 p.m. on 2/22/18 revealed that there was no non-slip cushion on her wheelchair. She had a moccasin-type house shoe on her left foot and had no sock or shoe on her right foot. She was rocking her upper body back and forth.
Observation of Resident #2 sleeping in bed at 10:45 a.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position.
During an interview with LVN B at 10:48 a.m. on 2/23/18, she reported that she thought Resident #2 fell last night. LVN B checked Resident #2's clinical record at this time and confirmed that Resident #2 fell at 9:30 p.m. on 2/22/18, hit her head, and was sent to the hospital. LVN B reported that Resident #2's nursing notes did not specify where the fall occurred but did say that she was found on the floor and that the fall was unwitnessed.
During an interview with LVNs B and D at 10:53 a.m. on 2/23/18, they reported LVN C was Resident #2's charge nurse. However, because LVN C was in the conference room doing paperwork, they were covering her residents.
At 10:55 a.m. on 2/23/18, the investigator asked the DON for Resident #2's 2/22/18 fall incident/accident report. The DON reported that she had not received it yet and that LVN C was Resident #2's charge nurse.
During an interview with LVN C at 10:59 a.m. on 2/23/18, she reported that she was not working on the floor today and that she had no idea where Resident #2's 2/22/18 fall occurred. LVN C reported that LVNs B and D were covering as charge nurses for Resident #2 since she was in the conference room doing paperwork.
During an interview with the DON at 11:01 a.m. on 2/23/18, when asked if the facility had their morning meeting already, she stated Kinda sorta. The nurses are trying to cover for each other because we're having that training - the (electronic records) one. (ADON R) is trying to find the incident/accident report.
Record review of Resident #2's 2/22/18 incident/accident report (given to the investigator by ADON R at 11:04 a.m. on 2/23/18) revealed that she had an unwitnessed fall in her room at 9:30 p.m. Hematoma/Bruise, Major Injury, and Joint Dislocation were checked. Handwritten next to the Joint Dislocation box was possible. Summary of incident was Resident found on floor by (LVN E). This nurse was notified of incident. Head to toe assessment performed. Hematoma to mid-forehead 7.5 centimeters x 6.0 centimeters noted with swelling. Possible right shoulder injury also noted . Resident showed signs of distress. Resident placed by nurse station. Called and notified (hospice) of incident. Treatment was Sent to Hospital. Action taken was Assistive Device, Care Plan Update, and Resident Education.
Record review of Resident #2's 2/22/18 immediate needs care plan revealed a fall resulting in minor injury to hematoma mid-forehead and a fall resulting in serious injury to possible right shoulder injury - crani checks x 72 hours, vital signs every shift x 72 hours, check range of motion daily x 72 hours, treatment as ordered, continue interventions on the at-risk plan.
Record review of Resident #2's 2/22/18 investigation follow-up revealed Past Interventions Attempted (include dates): supervision, place next to nursing station, frequent rounds on resident and Recommendations/New Interventions: Implement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455533**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/27/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SENIOR CARE OF WINDCREST	**8800 FOURWINDS DR SAN ANTONIO, TX 78239**

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 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) floor mats next to resident's bed. Implement bedside railing. Maintain bed at lowest position with call bell within reach. Check resident every 2 hours. Observation of Resident #2 sleeping in bed at 11:24 a.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position. During an interview with LVN D at 11:31 a.m. on 2/23/18, when asked if any information had been given to her about new fall interventions for Resident #2, she reported that hospice came and that a new bed was to be delivered today. When asked about fall mats, LVN D stated (LVN C) said no - they would be more of a fall hazard. When asked about bedrails, LVN D stated LVN C said no because she would get trapped in them in the past. When asked if Resident #2's 2/22/18 fall was out of her bed or out of her chair, LVN D reviewed the incident/accident report and stated I don't know. You'll have to ask the nurse who wrote this. The nurse who wrote this put in the interventions. During an interview with Resident #2's hospice nurse at 12:15 p.m. on 2/23/18, she reported that she ordered a low bed and fall mats for Resident #2 after the 2/22/18 fall. She stated I don't think the fall mats are going to help, but we'll try. Residents have the right to fall. We can't restrain them. Resident #2's hospice nurse reported that Resident #2's medications had been adjusted and that they had put her in a high-back wheelchair. She stated I don't know what else to do. The hospice nurse reported that she did not know whether or not Resident #2's 2/22/18 fall was out of bed or out of the wheelchair. She confirmed that the high-back wheelchair should not have been positioned in such a way that Resident #2's head was below her seat. She stated (Resident #2) and (an unidentified resident) are both one fall away from dying. Observation of Resident #2 sleeping in bed at 1:10 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position. Observation of Resident #2 sleeping in bed at 1:45 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position. During an interview with the DON at 2:45 p.m. on 2/23/18, she was asked if she knew whether Resident #2's 2/22/18 fall was out of her bed or out of her wheelchair. The DON responded with No. You have the incident report. You got it before I did. Observation of Resident #2 sleeping in bed at 4:33 p.m. on 2/23/18 revealed that she had a scoop mattress. There was no mat on the floor, and her bed was not in a low position. Her call light was on the floor at the foo (TRUNCATED)