

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455832	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Windsor Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 2535 W Pleasant Run Lancaster, TX 75146	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46486</p> <p>Based on interview and record review the facility failed to ensure residents were free of significant medication errors for 1 (Resident #33) of 9 residents reviewed for medication accuracy.</p> <p>The facility failed to discontinue hydrocodone (pain medication) after it was ordered to be discontinued by the physician on 5/29/24.</p> <p>This failure placed residents at risk for confusion, respiratory depression, kidney damage, and medication interactions.</p> <p>Findings included:</p> <p>Record review of the face sheet dated 6/11/24 for Resident #33 revealed a [AGE] year-old male was admitted to the facility on [DATE] with diagnoses of cellulitis of right lower limb (infection of right leg), and chronic kidney disease. The face sheet also revealed the resident was transferred out of the facility on 6/06/24.</p> <p>Record review of the care plan dated 5/29/24 for Resident #33 revealed pain medications should be assessed and monitored.</p> <p>Record review of Resident #33's physician orders revealed an order dated 5/22/24 for hydrocodone 5mg-acetaminophen 325mg 1 tablet every 6 hours as needed, and the order was discontinued on 5/29/24.</p> <p>Record review of Resident #33's hydrocodone 5mg-acetaminophen 325mg narcotic sheet revealed 1 tablet was signed out and administered on 5/27/24 at 2000 (8:00pm) followed by an entry that revealed 1 tablet was signed out and administered on 5/27/24 1 hour earlier at 1900 (7:00pm). The hydrocodone narcotic sheet also revealed 1 tablet signed out and administered after the discontinue order on 5/30/24 at 2000 (8:00pm) and 6/3/24 at 2000 (8:00pm).</p> <p>Record review of Resident #33's MAR for May 2024 and June 2024 revealed PRN medications administered were blank.</p> <p>In an interview on 6/11/24 at 12:44pm, the DON stated that PRN medication administrations no longer show on MAR reports after the resident has been discharged .</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/11/24 at 1:25 pm, LVN A stated medication orders were checked before administering pain medications.</p> <p>In an interview on 6/11/24 at 3:42 pm, LVN C stated if a controlled medication discontinued, then the narcotic sheet moved to the back of the book, marked as discontinued, and the medication would have been given to the DON to destroy.</p> <p>In an interview on 6/11/24 at 3:44 pm, ADON A stated that when a medication was discontinued, then an order is entered into the computer, and there is no reason for a medication to be given after it had discontinued.</p> <p>In an interview on 6/11/24 at 4:31 pm, the DON revealed that nurses were expected to document pain medications in the computer and on the narcotic sheet. The DON reported that if a medication is discontinued, then it would not come up on the computer to administer. The DON reported that if a medication is administered after being discontinued then it is a medication error. The DON also stated it is important to give the medication as ordered to prevented over medicating the resident, and it is part of the 5 rights of medication. The DON stated the hydrocodone should not had been given since it was discontinued.</p> <p>Record review of policy titled Adverse Consequences and Medication Errors revised on April 2014, stated A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders. Record review of the policy also revealed an example of a medication error is Unauthorized drug- a drug is administered without a physician's order.</p>		