STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455832	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Gardens	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)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403 Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for one of two residents (Residents #01) reviewed for feeding tubes. LVN A failed to monitor and addressed error message of FLOW ERROR: Clog in line downstream of pump for Resident #01 eternal feeding pump on 08/24/26 from 10:50 AM to 11:44 AM. LVN A used a plunger and pushed 10cc of air and 60cc of water in Resident #01 G-Tube without checking for placement. These failures could place residents at risk of tube obstruction and a decrease in hydration. Findings include: Record review of Resident #01's face sheet dated 08/26/24 reflected a [AGE] year-old female with and admitted [DATE]. Resident #01 diagnoses included contracture, legally blind, constipation, other chronic pain, polyneuropathy (multiple peripheral nerves are damaged), Vitamin D deficiency and gastrostomy status (refers to the presence of a surgical opening in the stomach also known as a G-Tube). Record review of Resident #01's annual MDS assessment, dated 07/01/24, reflected Resident #01 had no BIMS completed because Resident#01 was rarely/never understood, which indicated she was severely cognitively impaired. Record review of Resident#01's care plan undated reflected: Problems: [Resident #01] was at risk for impaired nutritional status and complications due to eternal feeding. Tube feeding required r/t Dysphagia (difficulty swallowing). Goals: [Resident#01] maintain weight by next review date. Interventions: Provide water flushes as ordered, check placement of tube as ordered, and monitor for s/s of aspiration . Record review of Resident #01's physician's orders report dated 08/26/24 reflected, .Isosource 1.5cal@ 40cchr x 22hrs ordered on 10/23/23. Observation on 08/24/24 at 10:50 AM revealed Resident #01's G-tube machine was beeping and had an error message that read FLOW ERROR: Clog in line downstream of pump (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/24/24 at 10:55 AM revealed LVN A went into Resident #01's room and walked backed out. Observation on 08/24/24 at 11:44 AM revealed LVN A tried to reset the monitor, when that did not work, he pressed the hold button, and he clamped the hollow tube. Observed LVN A injected 10cc of air into the tubing and the substance did not move. LVN A turned the faucet on and put water into a cup. Observed LVN A filled the plunger with 60 CCs of water and pushed it into the hollow tube. Observed the substance flow into the G-Tube site. Observed LVN A unclamp the line and restart the monitor. Interview on 08/24/24 at 11:47 AM LVN A revealed he did not hear the machine beeping earlier when he went to check on the residents after the surveyor left out the room. LVN A revealed he checked on his residents every 2 hours and the tubing line would have been checked at that time. LVN A revealed he pushed 10cc of air in the tube to see if that would allow the fluid to start back flowing. LVN A revealed he added the 60cc of water to free the clog in the tubing. LVN A revealed that he forgot to check for placement before he added water and air to the tubing, and he was trained to do so before adding water to the tubing. LVN A revealed resident#01 did not get her formula when the system was down. LVN A revealed Resident #01 could had aspirated, and the placement of the G-tube could have been dislodged. Interview on 08/26/24 at 2:48 PM with LVN B revealed that he always kept his own personal stethoscope on him, and the facility stethoscopes were kept at the bottom of the medication cart. LVN B revealed placement of the G-tube should be checked to prevent aspiration. LVN B revealed the G-tube could be dislodged and food would go into a different cavity and could cause a major infection. LVN B revealed a clog in the meant the resident is not receiving the formula she needed. Interview on 08/26/24 at 3:00 PM with the DON revealed that LVN A did not need to add water to the G-tube because Resident #01 had a kink (bend in feeding tube) in the line and not a clog. The DON revealed not checking for G-tube placement could result in respiratory distress and not receiving nutrition. Interview on 08/26/24 at 3:05 PM with the Administrator revealed she expected nursing staff to follow policy and procedures for residents' safety. Record review of the operating manual, dated 03/2020, titled Kangaroo epump enteral feed and flush pump with pole clamp programmable revealed: Feed error (Medium Priority Alarm), the screen appears when the enteral formula is no longer being delivered because off a clog between the pump and the patient. The pump determines the presence of a clog by checking to see if fluid can be pumped away from the sensor below the feeding valve while the valve is closed. Check the to find the occlusion causing the blockage . Record review of in-service dated 06/24, titled Tube feeding reflected: 5. Potential problems and preventive actions: Module 3: H. Check feeding tube placement. Record review of facility policy, revised 03/19, title Restoring Patency of Feeding Tube reflected: purpose to dissolve coagulated formula that is occluding in tubing. Draw up to 20 -60 CC of warm water. Attach syringe to tube, alternately push in and pull back on the plunger to avoid continued excessive pressure.