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	08/28/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46486 Based on interview and record review, the facility failed to ensure the medical record was complete and accurately documented for 1 of 5 residents (Resident #3) reviewed for resident records. 1. The facility failed to ensure LVN A documented emergency medical services notification when Resident #3's family member requested Resident #3 be sent to the hospital because she had not responded to verbal stimuli and looked lethargic. 2. The facility failed to complete an assessment of the resident. 3. The facility failed to ensure physician orders for resident to go to the hospital were in electronic health record. This failure could place residents at risk for not receiving appropriate care due to incomplete/inaccurate information being documented. Findings included : Record review of Resident #3's electronic health record indicated there was no emergency medical service notification in the chart. Record review of Resident #3's electronic health record indicated there was no assessment in the chart Record review of Resident #3's electronic health record indicated there was no orders for the resident to go to the hospital in the chart (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
	455832	A. Building B. Wing	08/28/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's face sheet, dated 08/28/2024, indicated Resident #3 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included Dementia (a decline in cognitive abilities that can make it difficult to perform daily tasks), stage 3 chronic kidney disease (kidneys have mild to moderate damage and they are less able to filter waste and fluid out of your blood), Insomnia (sleep disorder), nontraumatic chronic subdual hemorrhage (rare condition that occurs when blood leaks into the brain without a traumatic cause), Anemia 9blood disorder that occurs when your body doesn't have enough red blood cells or if red blood cells are not functioning properly), urinary tract infection (when bacteria enter the urinary tract through the urethra and begin to spread in the bladder), vitamin d deficiency, ventricular tachycardia (potentially life-threatening heart rhythm that occurs when the lower chambers of the heart beat too fast), depression (mental health disorder), other symptoms and signs concerning food and fluid intake, and Atherosclerosis native arteries of extremities w rest pain, right leg (disease that causes the arteries that supply the legs and feet to narrow and harden). Record review of Resident #3's assessment and care screening MDS assessment dated [DATE] reflected she had a BIMS score of 5, which indicated severe cognitive impairment. Resident #3 did not have any mood issues, delirium, behavioral symptoms, or rejection of care issues. Resident #3 was totally dependent on staff for all her ADLs. Record review of the clinical note entry created by LVN A, dated 12/09/2023, indicated Resident #3's family members requested that [LVN A] call 911 to send Resident #3 to the hospital because she looked lethargic and not responding to verbal stimuli, vital signs 163/66 pulse 130, temperature 97.8 Resident #3 not swallowing her food and spitting her dentures out, swelling noted to left wrist, physician, DON and supervisor notified. Record review of Resident 3's electronic heath record revealed the following vital signs for 12/8/23 were as follows blood pressure1138/84, pulse 76, temperature 98, vital signs for 12/7/23 were as follows blood pressure 133/81, pulse 89, temperature 97.2, vital signs for 12/6/23 were as follows blood pressure 122/69, pulse 95, temperature 98, and vitals for 12/05/23 were as follows blood pressure 129/90, pulse 77, and temperature 97.6. Record review of Resident 3's electronic heath record revealed Resident #3 labs that were completed on 12/1/24 showed red blood cell were 3.26 normal range is 3.62, her hemoglobin was 9.1 and normal range is 10.9, her hematocrit was 28.3 normal range is 31.2, lymph percentage was 14.6 and normal range is 16. All other lab results for Resident #3 were in normal range. During an interview on 08/28/2024 at 3:00 p.m., LVN A stated he was the Nurse on the long-term care hall who worked with Resident #3. LVN A stated that he could not recall 12/09/23. He said it had been a long time ago, and he could not recall how Resident #3 looked or if she responded to verbal stimuli. LVN A stated that he could not recall what time 911 was called or what time the emergency medical services arrived. LVN A stated that nurses were required to chart the time 911 was called and what time emergency medical services came to get the resident. During an interview on 08/28/2024 at 4:46 p.m., LVN B stated that if a resident needed to go to the hospital and emergency medical services picked them up the nurses' note would contain time resident left, what they left for and what symptoms they had. (continued on next page)

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	08/28/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/2024 at 5:03 p.m., the ADON stated that his expectations of documentation were that the staff note assessment of resident, reason resident left, what time resident left and how the resident left the facility. The ADON stated that if there is no nurses note then there should be a SBAR. The ADON reviewed the nurses note and stated that the note was incomplete. The ADON stated that if you did not document you did not do it and it is unacceptable for staff not to complete the nurses note or SBAR. During an interview on 08/28/2024 at 5:15 p.m., the DON stated that her expectation of documentation for a resident who had a change in condition was for the nurses to put in either a nurses note, SBAR or a telehealth visit. The DON stated one of those three would need to be completed. The DON stated that if 911 were called nurses would not have time to complete an SBAR as that would be considered an emergent situation, but the call to 911 for the resident to be sent to the hospital would require physician orders . The DON stated that nurses if able should conduct an assessment, call physician, get orders, place vitals in nurses note. The DON stated that there were no SBAR, no physician orders and the nurse note created by LVN A was incomplete for Resident #3 as note required at least the time 911 came and took the resident. Record review of the facility's policy titled, Change in Resident's Condition of Status, revised on 02/2021 indicated, .2. Prior to notifying the physician or healthcare provider, the nurses will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information promoted by the Interact SBAR Communication Form .6. The nurse will record in the resident's medical record information relative to changes in resident's medical/mental condition or status.