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	05/21/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of five residents reviewed for comprehensive person-centered care plans. The facility failed to ensure Resident #1 had a comprehensive person-centered care plan for Resident #1 during their stay from 2/23/2025 to 3/30/2025 (35 days). This deficient practice could place residents at risk of not being provided with the necessary care or services to address their specific needs. Findings included: Review of face sheet dated 05/21/25 reflected Resident #1 admitted to the facility on [DATE] and dischaged from the facility on 03/30/25. Record review of Resident #1's Comprehensive MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old [AGE] year-old male admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure), diabetes, seizure disorder, a bacterial infection and anxiety. The MDS also revealed a BIMs score of 13 (suggested cognition was intact). Section M revealed Resident #1 was receiving insulin (injectable medication for diabetes), anticonvulsants (seizure medication), an antibiotic (medication for infection), and an anticoagulant (a blood thinner). Section V of the MDS assessment revealed care areas triggered were ADL function/Rehab potential, urinary incontinence or indwelling catheter, nutritional status, and pressure ulcer. The MDS assessment was signed by LVN A and the DON. Review of Resident #1's care plan with effective date of 03.24.25 reflected Resident #1 did not have a comprehensive person-centered care plan. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/21/2025 at 2:01 p.m., MDS A stated there was not a comprehensive care plan for Resident #1, but MDS A stated he had just entered one into their charting system. MDS A stated MDS A was responsible for entering the comprehensive care plan for each resident. MDS A reported the comprehensive care plan was usually completed within 14 days. MDS A stated Resident #1 did not have a care plan while residing in the facility. MDS A stated all nursing staff was responsible for monitoring residents' care plans. MDS A stated if a resident did not have a care plan, then residents care needs, ADL assistance, medications, diets, dialysis, and many other needs would not be brought to the staff's attention. In an interview on 5/21/2025 at 3:06 p.m., the DON reported care plans were completed by unit managers, treatment nurse, the social worker, the MDS nurse, and the DON. The DON reported care plans were also monitored by the unit managers, treatment nurse, the social worker, and the DON. The DON stated if there was not a care plan for a resident then the risk was that there would be no paperwork. The DON stated her expectation for resident care plans was that they were updated and that all residents had a comprehensive care plan in place . A policy for care plans was not received prior to the time of exit on 5/21/2025.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received the necessary treatment and services, to promote healing, prevent infection for two (Resident #3, and Resident #4) of five residents reviewed for pressure ulcers. 1. The facility failed to ensure that Resident #3 had a dressing that covered the wound on Resident #3's lateral right ankle on 5/20/2025. 2. The facility failed to ensure that Resident #4 had a dressing that covered the wound on Resident #4's sacrum on 5/20/2025. These failures could place residents with wounds at risk for infection, a decline in health, and reduce wound healing. Findings included: 1. Record review of Resident #3's Comprehensive MDS assessment dated [DATE] revealed Resident #3 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of unspecified intellectual disabilities, anemia (low levels of healthy red blood cells or hemoglobin), and hypertension (high blood pressure). Section C of the MDS assessment revealed a BIMs score of 15 (suggested cognition was intact). Section M of the MDS assessment revealed Resident #3 had one venous or arterial ulcer that required application of a dressing and ointment/medication. Record review of Resident #3's care plan updated 2/10/2025 revealed an intervention for skin concerns was to perform treatments as ordered by the doctor. Record review of Resident #3's printed physician orders dated 5/21/2025 revealed a physician's order for wound care on Resident #3's lateral right ankle dated 2/19/2025 that stated to cleanse the right lateral ankle with normal saline, pat dry, apply xeroform, and apply a dry protective dressing on Monday, Wednesday, and Friday. Record review of Resident #3's wound assessment dated [DATE] revealed the measurements for Resident #3's right lateral ankle wound was 0.5cm long, 0.4cm wide, and 0.2cm deep. Record review of Resident #3's wound assessment dated [DATE] revealed the measurements for Resident #3's right lateral ankle wound was 0.4cm long, 0.4cm wide, and 0.2cm deep. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 5/20/2025 at 8:50 a.m., revealed Resident #3 reported he had a wound on his right ankle and a nurse used to put a dressing on it. Resident #3 stated they stopped doing it, but Resident #3 did not remember when. Resident #3 stated he wanted them to put a dressing on his wound because it was uncomfortable when it did not have a dressing. Observed an approximately quarter sized area on the lateral right ankle that was open (missing the top layer of skin). No dressing was present. In an observation and interview on 5/20/2025 at 8:58 a.m., revealed Treatment Nurse C entered Resident #3's room and confirmed Resident #3 did not have a dressing on his right lateral ankle. Treatment Nurse C stated Resident #3 was supposed to have a dressing on his right lateral ankle, but it may have fell off when Resident #3 was showered. Treatment Nurse C stated a nurse should have put another dressing over the wound. Treatment Nurse C stated that dressings were important because they promoted healing, and all staff were responsible for monitoring that dressings stayed on the residents. Treatment Nurse C stated the risks to the residents was that they could develop an infection. 23. Record review of Resident #4's Comprehensive MDS assessment revealed Resident #4 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of pressure ulcer of the sacral region (lower back just above the buttocks), chronic kidney disease, and dysphagia (difficulty swallowing). Section C of the MDS assessment revealed Resident #4's BIMs score was 11 (indicated moderate cognitive impairment). Section M of the MDS assessment revealed Resident #4 had an area of moisture associated skin damage and received pressure ulcer/injury care. Record review of Resident #4's care plan with a print date of 5/21/2025 revealed Resident #4 was at risk for infection and staff should use sterile technique policy for any treatments or care where there was an actual/potential for loss of skin integrity. Record review of Resident #4's printed physician orders dated 5/21/2025 revealed a physician's order for wound care on Resident #4's sacrum that stated to cleanse the area with normal saline or skin cleanser, pat dry, apply gauze-soaked Dakin's Solution (topical antiseptic), and cover with a dry dressing. Record review of Resident #4's wound assessment dated [DATE] revealed Resident #4's sacral wound was 8.0cm long, 8.0cm wide, and 3.0cm deep. In an observation and interview on 5/20/2025 at 8:30 a.m., revealed CNA D turned Resident #4 revealing a large, uncovered wound to Resident #4's sacral area. CNA D stated there should have been a dressing and if there was not a dressing on a resident's wound then the nurse should be notified. CNA D stated the nurse would then apply a new dressing. CNA D stated she was not aware Resident #4's dressing was missing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 5/20/2025 at 9:14 a.m., revealed Treatment Nurse C checked Resident #4 for a dressing and confirmed the dressing was missing from the sacral region. Treatment Nurse C stated she had not made her way to Resident #4 yet this morning and was not notified that the dressing was missing. Treatment Nurse C stated the dressing may have fell off when the hospice aide bathed Resident #4 earlier that morning. Treatment Nurse C stated it was not typical for Resident #4 to not have a dressing and the nurse should have put a dressing on Resident #4 if they were aware it was missing. In an interview on 5/20/2025 at 9:39 a.m., LVN E stated no one notified her that Resident #4 did not have a dressing. LVN E stated if she had known Resident #4 did not have a dressing then she would have followed the physician's orders and applied a new one. LVN E stated she would have then notified Treatment Nurse C that a dressing had been applied. LVN E reported the risk to the residents if wounds did not have a dressing was that the wounds could get infected. In an interview on 5/20/2025 at 3:00 p.m., Doctor F reported she visited the facility every Monday to assess the residents' wounds. Doctor F reported that dressings were applied to wounds to protect the area from urine and stool. Doctor F also stated that the dressings optimized healing, and every time a dressing was removed that it took four hours to return to an optimal healing environment. Doctor F reported she expected the wound care nurse to do the treatments when in the building, and the nurses to change the dressings if they became dislodged or dirty. In an interview on 5/21/2025 at 3:06 p.m., the DON reported dressings were applied to wounds to promote healing, and she expected the nursing staff to follow the doctor's orders for wound care. The DON stated CNAs should notify the nurse if they see a dressing was missing or soiled. The DON stated dressing should have the correct date and initials on them. The DON stated the risks to the residents depended on their comorbidities and declined to be more specific. Record review of the facility policy titled Wound Management Policy, copyright dated 2023, revealed The care service ensures that wounds . are managed and dressed appropriately to minimise the distress that they cause and maximise healing.