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	12/08/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident was provided with pharmaceutical services, including procedures that assure the accurate administration of drugs, to meet the needs of each resident for 1 of 7 residents (Resident #1) reviewed for pharmacy services. The facility failed to check Resident #1's BS on six different occasions between the dates of October 1, 2025, through October 23, 2025. This failure has the potential for the resident being placed in a hypoglycemic state or not receiving the therapeutic dosage. The findings include: Record review of Resident #1's admission record, dated 09/17/25, reflected a [AGE] year-old female with diagnoses that included end stage renal disease, atherosclerotic heart disease of native coronary artery without angina pectoris, acute combined systolic (congestive) and diastolic (congestive) heart failure, and type 2 diabetes mellitus with hyperglycemia, with a reported BIMS score of 15. Record Review of Resident #1's care plan, dated 9/17/25, reflected Resident #1 had been admitted with a diagnosis of DM. In the care plan it further reflected the facility was to administer diabetes medication as ordered by the doctor and to monitor/document for side effects and effectiveness. Record review of Resident #1's Order Summary Report, dated 09/17/25, reflected NovoLOG Injection Solution 100 UNIT/ML (InsulinAspart) Inject as per sliding scale: if 60 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401+ = 12 units, subcutaneously four times a day for dm IF BS >401 Re-check in 15 minutes. If Blood Sugar still 401 or greater, CALL MD Record review of Resident #1's MAR, dated 11/07/25, reflected six separate occasions where Resident #1's BS was not checked four times a day as ordered. On 10/04/25 at 11:30 AM, 10/11/25 at 11:30 AM, 10/15/25 at 8:30 PM, 10/18/25 at 11:30 AM, 10/19/25 at 11:30 AM, and 10/22/25 at 8:30 PM Resident #1's BS was not checked. No indication as to why the BS was not attempted was charted. An interview and record review with LPN on 11/07/25 at 3:33 PM was conducted. LPN stated all BS checks should be recorded when performed. LPN was shown the MAR and asked to assist in deciphering what could be inferred from the blank portions of the MAR where no record of BS checks can be observed. LPN stated if the MAR was blank then that would mean the procedure was not attempted. LPN further said if the procedure was attempted but if for some reason could not be completed, then the reason for not completing the BS check would be recorded on the MAR. LPN stated there was risk of harm to patients who needed to get their BS checked but did not. LPN said patients that need insulin need to have the BS checked first. LPN further stated if insulin was not administered as ordered then there was a risk of harm to the patient could be worsening of health conditions. An interview and record review with the DON on 11/07/25 at 4:20 PM. The DON stated all procedures and medication administration should be charted in the residents' records. The DON stated the facility had recently changed over to a new patient records system in June 2025 and she did not believe any BS checks had been missed. The DON was shown the October 2025 MAR for Resident #1 and asked what was to be inferred by the six blank entries. The DON initially stated she believed those BS checks were charted someplace else in the system, but she was unable to locate where they would have been charted. The DON was asked what it would mean if there was nothing recorded on the MAR, and she said it meant nothing had been done or attempted. The DON stated there could be a significant risk of harm to residents if they did not get the insulin based on their BS. The DON stated the risks could include renal and cardiovascular damage. On 11/07/25 at 5:30 PM the Administrator was interviewed. The Administrator stated all procedures, and medical administration was required to be recorded in the resident's medical record. The Administrator further said there was a risk of harm to residents if their medical orders are not followed due to worsening DM symptoms and complicating already existing health conditions. Attempts to contact the ordering physician were unsuccessful during the investigation. Record review of facility policy titled Obtaining a Fingerstick Glucose Level, dated revised October 2011, reflected: Purpose The Purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level As well as: Documentation The person performing this procedure should record the following information in the resident's medical record:1) The date and time the procedure was performed2) The name and title of the individual(s) who performed the procedure.3) All assessment data obtained during the procedure.4) How the resident tolerated the procedure. 5) If the resident refused the procedure, the reason(s) why the intervention taken.6) The blood sugar results. Follow the facility policies and procedures for appropriate nursing interventions regarding blood sugar results (if resident is on a sliding scale coverage, and/or physician intervention is needed to adjust insulin or oral