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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>455832 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>11/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Windsor Gardens |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2535 W Pleasant Run<br>Lancaster, TX 75146 |  |

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46525</p> <p>Based on interview and record review the facility failed to ensure one (Resident #1) of six residents reviewed, received treatment with respect and dignity that promoted maintenance of his or her quality of life.</p> <p>The facility failed to ensure CNA H preserved Resident #1's dignity by not providing her with good customer service on 09/09/2024, evidenced by CNA H stating oh, I sure would like to hit you on that big old booty.</p> <p>This failure places the residents at risk for harm by not protecting and promoting their rights to be treated with respect and dignity and have good customer serviced rendered.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet on 11/07/24 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Unspecified Encephalopathy, Essential (Primary) Hypertension [High Blood Pressure]; Hyperlipidemia [High Cholesterol]; Type II Diabetes Mellitus; Malignant Neoplasm of Unspecified Female Breast [Breast Cancer]; Unspecified Dementia. Resident discharged later that night on 09/09/24.</p> <p>Resident #1's was not in facility long enough to have a MDS completed.</p> <p>Resident #1's was not in the facility long enough to have a Care Plan completed.</p> <p>Review of the discharge hospital medical records Progress notes (for 09/04/24 through 09/09/24) indicated the patient was able to transfer from sit to stand at the edge of the bed with walk, sit&lt;&gt;stand from commode with walker, and stand&gt; sit in chair with walker at supervision level and continued to need step by step cues and instruction on how to complete all transfers safely and appropriately.</p> <p>Attempted to Interview CNA H, on 11/04/2024 at 04:11 PM and 11/05/2024 at 10:10 AM but she did not return the calls.</p> <p>Attempted to Interview Resident #1 or their husband on 11/06/2024 at 12:14 PM but did not receive a return call.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Interview on 11/06/2024 at 01:42 PM with the Executive Director, she stated with the situation regarding Resident #1 (where CNA H exhibited poor customer service), while in the room the family laughed but later that evening, they lodged a complaint with the staff and the staff called the Executive Director. The family felt the comment was in poor taste not good customer service. She said, they (staff) called me around 11, 11-something at night (on 09/09/24) and said that the family member was upset and wanting to take Resident #1 home. I asked that she put me on speaker phone. The family member asked for my number and she called me from her phone and we talked. She explained she was taking Resident #1 to the car. The family member stated she believed that the CNA was gay because one of the CNA's (CNA H) used bad customer service by a comment she made. The family member B stated something about using a belt and the CNA's misread the room. The family member stated she did not feel comfortable with that. The two CNAs were gone off shift that day. The Executive Director stated she tried to get the family member to let Resident #1 stay but Resident #1 &amp; family member B were not sure about staying. The Executive Director said, the family member stated the Resident #1 didn't want to be there anyway. I told the family member I would address her concerns, I explained we did not do that here. I called both CNAs that night, they both lied at the time. I told them they would have to come to do there I statements. I spoke to them separately, one (CNA G) admitted that the incident occurred while the other one (CNA H) did not. I spoke to CNA G and we did an in-service with her and her story was similar to the account of the family member. I talked to CNA H and let her know that CNA G had given me a statement that pretty much mirrored that of the daughter. I informed her of the family's concerns. She stated she did not hear any of that part of the conversations that I was talking about. I suspended both immediately. I called the family member again; her story was still the same. I called CNA H back again to see if she would be willing to tell me what really happened. She told me she had already told me what happened. So, we let her go since she would not admit to any wrongdoing. She was the one that it was stated was making the inconsiderate comments exhibiting the poor customer service, by the family member. The family member stated to me, that Resident #1 didn't want to come to a facility anyway, she wanted to be home, so we just took her back home. We, later in-serviced the whole staff on abuse, neglect and customer service. I did call family member B back to check on the patient, she was fine. My expectation is that staff would speak in a customer friendly manner to all of the families, speaking to them with dignity and respect and just do their jobs and not to get too personal with the families. The Executive Director stated they did in-services with the staff, safe surveys of the resident and do random questioning of staff on customer service and verbal abuse as a way of monitoring for understanding and compliance with good customer service. They also ask residents on how they are being treated.</p> <p>Interview on 11/06/2024 at 01:03 PM with the DON, she stated, now family member B, they (resident #1's family) were joking with the CNAs from the time they arrived but then later the family decided it was something different. Family member B meant the gait belt not a real belt. That was CNA G's first day over there on the short-term hall. She likes to try and build a rapport, but she should haven't said that. Sometimes people do not take things the way you mean if they do not understand you are not being mean or that you are being playful. The other one (CNA H), had to go because she would not admit to the situation occurring. Last in-service on abuse and neglect was probably last week. No further situation of this nature since this occurred. My expectations is for it not to happen. I set boundaries all the time, you know you are not to have those types of conversations like that even in a playing manner. If the family or resident is playing decline to join in on that in the correct manner, do your job. If you need clarification, ask, for example: like what kind of belt?. The DON stated what we did to monitor was that the residents had safe surveys done. We in-serviced staff on abuse/neglect and customer service. They do spot checks with the staff to follow up on customer service &amp; abuse, neglect, exploitation, and customer service training.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Interview on 11/07/2024 at 03:05 PM with CNA G she stated, the resident admitted to the facility that night for rehabilitation. The CNA assigned (CNA G) was trying to help the resident and her family settle in, the family member asked for sheets she wanted to make up the bed. CNA G asked CNA H to assist her with the resident. The resident was sitting on the side of the bed, the family member wanted to straighten out the sheets. The resident needed assistance to stand. Family member B made a comment about getting a belt after her. The Family and CNAs laughed but CNA G told Resident #1's family member B they do not do that there (at the facility). Then when the CNAs got on each side of the resident, CNA H made the comment about the size of the resident's butt, in what she perceived to be a joking manner. CNA H said, oh, I sure would like to hit you on that big ole booty. The CNAs and family members all laughed again. CAN G said, after this we left the room. Later that night I got a call from the Administrator asking did we make any inappropriate comments to resident #1. I told her what happened. She called me in the next day (09/10/2024) to come write a statement and informed me she would be investigating what happened. I was suspended that day for the whole work week (until that Friday). I had to take classes, paperwork I had to do for training. I was educated on customer service, abuse/neglect and one other thing, I can't remember right now. No issues since. I now do about I am supposed to do when it comes to customer service, resident and family members. CNA G stated she now understand why it was a problem-once her co-worker said what she said she should have asked her to exit the room regarding her remarks. CNA G stated due to watching the videos &amp; in-services she understood why the family did not appreciate the remarks about their loved one. She said, now if I hear something inappropriate, I am going immediately to tell the Administrator. Most recent abuse &amp; neglect in-service was approximately 2 weeks ago. I have not witnessed any other customer service issues. When the resident#1's family member B said belt, I did not think he meant a gait belt. At that time, I perceived CNA H was playing trying to make the family feel comfortable.</p> <p>Review of the facility's Residents Rights Policy &amp; Procedures dated 2001: September 2022, reflected The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in the subpart . (a)The facility must- (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; .(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law; . (B)Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the event s that cause the suspicion do not result in serious bodily injury.(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: . (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days or the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> |   |  |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50222</p> <p>Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were labeled properly for one ([NAME] medication room) of three medication rooms and two (300 hall and 500hall) of five medication carts reviewed for medication storage and labeling.</p> <ol style="list-style-type: none"> <li>1. The [NAME] medication room contained one open multi-dose vial of tuberculin without an open date.</li> <li>2. The 300-hall cart contained seven open eye drop medications without an open date.</li> <li>3. The 500-hall cart contained one open eye drop medication without an open date and one bottle of liquid protein without an open date.</li> </ol> <p>These failures could place residents at risk for not receiving the intended therapeutic benefit of their medications and having possible adverse effects.</p> <p>Findings included:</p> <p>In an observation and interview on 11/05/24 at 11:05 a.m., seven open eye drop medications without an open date were stored on the 300-hall medication cart. MA F stated she did not know when they were opened, and eye drops should have had open dates because they were only good for 30 days after being opened. MA F did not state what the effects to the residents were.</p> <p>In an interview on 11/05/24 at 11:13 a.m., ADON D stated it was important to have an open date on eye drops, so they would know when they were opened. ADON D also stated that the medication may not have the desired effect if used after it should have been discarded.</p> <p>In an observation and interview on 11/05/24 at 11:46 a.m., one multi-dose vial of tuberculin was found in the [NAME] medication room without an open date. ADON E stated she did not know when the vial was opened and removed the tuberculin from the refrigerator to be disposed. ADON E stated the vial should have had an open date.</p> <p>In an observation and interview on 11/05/24 at 2:46 p.m., the 500-hall cart contained one open eye drop medication without an open date and one bottle of liquid protein without an open date. ADON E stated the eye drops and liquid medications should have had open dates and that everyone that used the carts should have monitored for proper labeling of medications. ADON E stated it was primarily the responsibility of the MA or nurse who was administering medications. ADON E also stated that the pharmacy reviewed the carts monthly and this failure could have caused a medication error depending on the medication.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>In an interview on 11/06/24 at 3:14 p.m., the DON stated there should be an open date on eye drops, insulin vials, and liquid protein. The DON stated that the MA or nurse that opened the medication should have put an open date. The DON stated the unit managers were responsible for monitoring the medication rooms and carts. The DON also stated the pharmacy checked the medication rooms and carts once a month for appropriate medication storage and labeling. The DON stated improper labeling could lead to the medication not having the desired effect, but it depended on the medication.</p> <p>Record review of facility's policy titled Medication Labeling and Storage with a revision date of February 2023, stated Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. It also stated multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.</p> |   |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>27070</p> <p>46525</p> <p>Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's main kitchen reviewed for food safety.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure the ice machine filters and vent was free from dirt and dust.</li> <li>The facility failed to ensure food items in the refrigerator, freezer and dry storage room were labeled and stored in accordance with the professional standards for food service.</li> <li>The facility failed to discard items stored in refrigerator, freezers or dry storage that were not past the 'best buy', consume by or expiration dates.</li> <li>The facility failed to have Dietary staff wash hands or change gloves when they touched other surfaces while handling food or upon re-entering the kitchen.</li> </ol> <p>These failures could place residents at risk for food-borne illness and cross contamination.</p> <p>Findings included:</p> <p>Observation of the kitchen on 11/05/24 at 09:12 AM revealed the following:</p> <ul style="list-style-type: none"> <li>-Handwashing sink #1, there was no paper towels in the paper towel dispenser to the upper left side of the sink.</li> <li>- Handwashing sink #1's trash receptacle had trash other than paper towels inside. There was a milk carton, extra-large to-go- cup, a sandwich and an empty drink mix packaging.</li> <li>- Ice machine metal vent, located on the back, left and right sides of the machine, the vent grates and filters had dirty &amp; dust on it.</li> <li>-The prep. table across from reach-in refrigerator, under the prep. table there was an extra-large square clear plastic container with a lid labeled cornmeal, dated 03/22/24, no discard by date.</li> <li>-The prep. table across from reach-in refrigerator, under the prep. table there was an extra-large square clear plastic container with a lid labeled sugar, dated 10/31/24, no discard by date.</li> <li>-Kitchen floor unclean, bits of debris noted along with stains on floor.</li> <li>-Large prep table next to extra-large stand mixer, beneath has 3 extra-large bins with lids: -One bin labeled Rice dated 07/04/24, there was no discard by date. -One bin labeled Flour dated 07/04/24 , no discard by date. -One bin labeled Thickener, there was no prep/opened date, no discard by date.</li> </ul> <p>(continued on next page)</p> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-To the left of that prep table, on the floor in front of a large prep. table was a silver stainless steel scouring pad.</p> <p>Observations of Reach-in Refrigerator #2 on 11/05/24 at 09:34 AM revealed the following:</p> <p>-On the right sided-door: -1 Large zip top bag with approximately 11 boiled, peeled eggs, dated 11/04/24. Several of the eggs on top are still hot while others at the bottom of the bag are cold to touch, no discard by date.</p> <p>-Reach-in-Refrigerator #2 was in a separate area within the kitchen, the floor in that area had a slippery residue and the floor had small amounts of small bits of paper and small pieces of food debris on it.</p> <p>-On the left-sided door: -1 large zip top bag with yellow sliced cheese, previously opened, dated 10/26/24, no discard by date.</p> <p>-1 large box of cooked pork topping (crumbled /ground pork) dated 11/04, no opened date, packaged date was 10/19/24.</p> <p>-1- 5lbs. bag of cooked pork topping, open to air, no open date, no consume by or discard by date.</p> <p>Observations of Reach-in-Refrigerator #1 on 11/05/24 at 09:45 AM revealed the following:</p> <p>-On the right-sided door, 2nd shelf, a 2 qt. clear pitcher with light yellow colored drink dated 11/05/24, there was no label of item description, no discard by date.</p> <p>-Bottom shelf: -1 large pitcher of with lid dated 11/05/24 contained dark colored liquid, there was no label of item description, no discard by date.</p> <p>Observations of Walk-in Refrigerator on 11/05/24 at 09:57 AM revealed the following:</p> <p>-The floor of the walk-in is a little slick/slippery, there is a foul odor like old unclean mop water. There was also a soiled mop string on the floor.</p> <p>-The fan grates overhead in the walk-in unit were dusty.</p> <p>-Mobile metal rack in the middle of the floor: 5th row down from the top -1 large zip top bag with Turkey deli meat, previously opened, dated 11/04/24, no discard by date.</p> <p>-7th row down from top -a sheet pan with Turkey deli meat sandwiches (3) and chicken salad sandwiches (2), dated 11/04/24, no discard by date.</p> <p>-On the top shelf in the back of the walk-in unit: -1-16 oz. block of butter, dated 11/04/24, open to air. The packaging was left open, no discard by date.</p> <p>Observations of the Dry storage room on 11/05/24 at 10:10 AM revealed the following:</p> <p>(continued on next page)</p> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>-1 loaf of sliced white sandwich bread in a bin with other white sandwich bread, dated 11/04/24, manufacturer expiration date 10/25/24.</p> <p>-1-25 lbs. bag of coarse bread crumbs, previously opened, dated 02/29/24, no discard by date. The bag was also only rolled over to closed but not secured closed with a airtight closure.</p> <p>-1 Extra-large zip top bag with toasted oats dry cereal, previously opened, dated 10/25/24, no discard by date.</p> <p>-1 Extra-large zip top bag with approximately 12 large tortillas, previously opened dated 11/02/24, no discard by date.</p> <p>-1 large cardboard box, dated 10/19/24 containing 6 tortillas. There were 2- 28 oz. packages of large tortillas dated 07/08/24. The bags the large tortillas were in looked worn, some of the logo was smeared and one of the bags had a dime-sized hole in the bag in the back of package.</p> <p>-1 large zip top bag with yellow cake mix, previously opened, date 11/02/24, no discard by date.</p> <p>1-6lbs. 9oz. can of diced peaches, dated 11/01/24, manufacturer's expiration 02/22/27 had dent at bottom of can.</p> <p>Observations of the main dining room on 11/05/24 at 10:36 AM revealed the following:</p> <p>-On the counter: -1 extra-large clear drink dispenser with clear liquid and ice. There was no label of item description, no prep/open date and no discard by date.</p> <p>Observations of Kitchen on 11/06/24 at 02:10 PM revealed the following:</p> <p>-Handwashing sink #1's garbage receptacle had used gloves, product packaging as well as paper towels.</p> <p>Observation of Reach-in-refrigerator on 11/06/24 at 02:11 PM revealed the following:</p> <p>-Right-sided door: -1 large zip top bag of boiled eggs dated 11/04/24, previously had approximately 11 boiled eggs of hot and cold temperatures not had 30 boiled eggs., no discard by date.</p> <p>-1 small square clear container with lid with chicken salad dated 11/04/24, no discard by date. The green lid also had a crack in it, near one of the corners preventing an airtight seal.</p> <p>-1 small square clear container with lid contained mashed potatoes dated 11/04/24, no discard by date. There was a crack in the lid on the left side, preventing an airtight seal.</p> <p>Observation of the Kitchen on 11/07/24 at 12:05 PM revealed the following:</p> <p>-DM had gone out into the dining room earlier during service. She re-entered the kitchen from the dining room. She went over to the steam table, did not wash her hands then got a plate for a resident in the dining room and took it out to the resident.</p> <p>(continued on next page)</p> |   |  |

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>- Dietary Aide went out into the dining room, touched the door on her way out then place her hands on the wall next to the door as she leaned out of the door placing the resident's plate on aa nearby table. She returned to the kitchen but did not change gloves or wash her hands before getting another plate and taking it to another plate to the dining room.</p> <p>In an interview on 11/05/24 at 11:40 AM with the NSD, she stated when asked how long flour, rice and other dry good areas was placed in the large bins on the floor was kept after opening, the NSD stated they were kept 6-12 months, we go by the list (the storage guidelines). She stated there was a posted list for cleaning assignments and everyone has an assignment for cleaning. The NSD confirmed the storage guideline list was for unopened items since opening items shortens the shelf life of a lot of food items. The NSD stated canned goods without manufacturer's expiration dates were kept in their facility for 12 months. She stated cereals prepackaged in bowls that had no manufacturer's date were kept for 6 months. The NSD stated dry cereals that were opened are kept 4-5 days. She said, dust or surfaces that were not clean could cause harm to the residents by contaminating their food and causing illness. She stated the harm to using poor hand hygiene in the kitchen is cross contamination and illness. The NSD implied she did not know about the lids on the food in the refrigerator was cracked but she stated they should not be on there and moved to go look at the reach-in refrigerator. She stated that the cooks help with inventory</p> <p>Review of the facility's Nutrition Services Policy &amp; Procedures Food Production &amp; Food Safety dated March 2009: Revision March 2019, reflected Food Storage Policy: Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination. Procedure: . 4. All food items should be dated with the received date, unless labeled with a readable label from the food vendor. 5. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables and broken lots of bulk foods. All containers must legible and accurately labeled, including the date the package was opened. 7. Scoops are to be washed and sanitized on a weekly bases, or as needed. 8. Hand s must be washed after unloading supplies and prior to handling food items. 9. All stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods. A. Old stock is always used fist (First in- First out method.) b. Supervision is necessary to make sure that the person designated to put stock away is rotating int properly. 13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 2-3 days or discarded. 15. Refrigeration .e. All foods should be covered, labeled and dated.16. Frozen Foods .c. Foods should be covered, labeled and dated.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Review of the U.S. FDA Food Code 2022 reflected: Chapter 2 . section 2-301 Hands and Arms. 2-301.11 Clean Condition. Food Employees shall keep their hand and exposed portions of their arms clean. 2-301.12 Cleaning Procedure. (C). To avoid recontaminating their hands or surrogate prosthetic devices, food employees may use disposable paper towels or similar clean barriers when touching surfaces such as manually operated faucet handles on a Handwashing Sink or the handle of a restroom door. 2-201.14 When to Wash. Food Employees shall clean their hands and exposed portions of their arms as specified under section 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single-use articles. and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling service animals or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco products, eating, or drinking; (E) After handling soiled equipment or utensils; (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw food and working with ready-to-eat food; (H) Before donning gloves to initiate a task that involves working with food; and (I) After engaging in other activities that contaminate the hands. Section 2-301.15 Where to Wash. Food Employees shall clean their hands in a Handwashing Sink or approved automatic handwashing facility and may not clean their hands in a sink used for food preparation or ware washing, or in a service sink or a curbed cleaning facility used for the disposal of mop water and similar liquid waste. Chapter 3 . section 3-201.11 Compliance and Food Law: . C. Packaged Food shall be labeled as specified in LAW, including 21 CFR 101 Food Labeling [* . (b) A food which is subject to the requirements of section 403(k) of the act shall bear labeling, even though such food is not in package form. (c) A statement of artificial flavoring, artificial coloring, or chemical preservative shall be placed on the food or on its container or wrapper, or on any two or all three of these, as may be necessary to render such statement likely to be read by the ordinary person under customary conditions of purchase and use of such food. The specific artificial color used in a food shall be identified on the labeling when so required by regulation in part 74 of this chapter to assure safe conditions of use for the color additive.], 9 CFR 317 Labeling, [(a) When, in an official establishment, any inspected and passed product is placed in any receptacle or covering constituting an immediate container, there shall be affixed to such container a label .Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. Section 3-302.12 Food Storage Containers, Identified with Common Name of Food: Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food. Section 3-501.17 . Commercial processed food: Open and hold cold . B. 1. The day the original container is opened in the food establishment shall be counted as Day 1. 2. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. C. 2. Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section. 3. Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section. Definitions 3. Food Receiving and Storage - When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated. www.fda.gov</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Review of the USDA website reflected: The United States Department of Agriculture's Food Safety and Inspection Service inspects only meat, poultry and egg products. The United States Food and Drug Administration inspects other foods. Yogurt can be stored in the refrigerator (40 F) one to two weeks or frozen (0 F) for one to two months. Soft cheeses such as cottage cheese, ricotta or Brie can be refrigerated one week but they don't freeze well. Hard cheeses such as cheddar, Swiss and Parmesan can be stored in the refrigerator six months before opening the package and three to four weeks after opening. It can also be frozen six months.</p> <p>Processed cheese slices don't freeze well but can be kept in the refrigerator one to two months. Milk can be refrigerated seven days; buttermilk, about two weeks. Milk or buttermilk may be frozen for about three months. Sour cream is safe in the refrigerator about one to three weeks but doesn't freeze well <a href="http://www.ams.usda.gov">www.ams.usda.gov</a></p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</b></p> <p>Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of three (CNA C) staff members and nine of nine residents (Resident #16, #41, #50, #74, #104, #265, #266, #267, &amp; #268) reviewed for infection control procedures.</p> <p>CNA C failed to perform hand hygiene after direct contact with residents #16, #41, #50, #74, #104, #265, #266, 267, and #268 while serving meals on the rehabilitation hallways.</p> <p>This failure could place residents at risk for healthcare associated cross contamination and infections.</p> <p>Findings included:</p> <p>Record review of Resident #16's admission MDS assessment, dated 10/01/24, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #16 had diagnoses which included: anemia (low iron levels), hypertension (high blood pressure), and heart failure (heart does not pump blood like it should). Resident #11 was cognitive and able to make decisions and required assistance of one staff for activities of daily living.</p> <p>Record review of Resident #41's admission MDS Assessment, dated 10/25/24, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #41 had diagnoses which included: heart failure (inability for the heart to work properly), renal insufficiency (kidneys are weak), and diabetes (high blood sugar). Resident #41's, was cognitive and able to make decisions and required one staff for assistance with activities of daily living.</p> <p>Record review of Resident #50's admission MDS Assessment, dated 11/01/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses which included: renal insufficiency (weak kidneys), heart failure, hypertension (high blood pressure), and deep vein thrombosis (increased sugar levels). Resident #50 was cognitive and able to make decisions and required one staff for assistance with activities of daily living.</p> <p>Record review of Resident #74's admission MDS Assessment, dated 10/24/24, revealed an [AGE] year-old female who admitted to the facility on [DATE]. Resident #74 had diagnoses which included: Heart Failure (inability of the heart to work properly), severe protein-calorie malnutrition (skinny), and seizures (epilepsy). Resident #74 was moderately cognitively impaired and unable to make decisions and required assistance of one staff for activities of daily living.</p> <p>Record review of Resident #104's admission MDS Assessment, dated 10/25/24, revealed an [AGE] year-old female who admitted to the facility on [DATE]. Resident #104 had diagnoses which included: coronary artery disease (arteries are clogged), cirrhosis (liver disease), and hypertension (high blood pressure). Resident #104 was alert and oriented and able to make decisions and required assistance of one staff for activities of daily living.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Record review of Resident #265's 5-day MDS Assessment, dated 11/07/24, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #265 had diagnoses which included: Heart failure (heart weak not working properly), hypertension (high blood pressure), and atrial fib (irregular heart rate). Resident #265 was cognitively able to make decisions and required assistance of one staff for activities of daily living.</p> <p>Record review of Resident #266's admission MDS Assessment, dated 11/06/24, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #266 had diagnoses which included: fracture of the neck of right femur (broken right hip), hypertension (high blood pressure), and hypothyroidism (thyroid slow to function). Resident #266 was moderately cognitively impaired able to make some decisions and required assistance of one staff for activities of daily living.</p> <p>Record review of Resident #267's 5-day MDS Assessment, dated 11/05/24, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #267 had diagnoses which included: Congestive obstructive pulmonary disease (short of breath), hypertension (high blood pressure), and anemia (low iron level). Resident #267 was cognitive able to make decisions and required assistance of one staff for activities of daily living.</p> <p>Record review of Resident #268's 5-day MDS Assessment, dated 11/07/24, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #268 had diagnoses which included: Congestive obstructive pulmonary disease (short of breath), hypertension (high blood pressure), and diabetes (high blood sugar). Resident #267 was cognitive able to make decisions and required assistance of one staff for activities of daily living.</p> <p>Observation on 11/05/24 beginning at 12:20 p.m., revealed CNA C had walked down the hallway, did not use hand sanitizer, and served a lunch tray to Resident #265, touched, and moved the overbed table in the resident's room, touched the hand and shoulder of Resident #265 and prepared the meal tray for the resident to eat her lunch. CNA C did not have on gloves. CNA C was observed to not wash his hands or use hand sanitizer, available in the hallway.</p> <p>Observation on 11/05/24 beginning at 12:22 p.m., CNA C was observed to enter Resident's #266, #267, and #50 rooms setting up the resident's lunch trays, adjusted the overbed table, and unwrapped the utensils, removed tops off drinks for each resident. She did not complete hand hygiene before going to the next resident.</p> <p>Observation on 11/05/24 beginning at 12:25 p.m., CNA C was observed to enter Resident's #104, #268, and #41 rooms setting up the resident's lunch trays, adjusted the overbed table, and unwrapped the utensils, removed tops off drinks for each resident. She did not complete hand hygiene before going to the next resident.</p> <p>Observation on 11/05/24 beginning at 12:27 p.m., revealed CNA C had walked down the hallway, did not use hand sanitizer, and served a lunch tray to Resident #16, and Resident #74. CNA C touched, and moved the overbed table in the resident's room, touched the hand and shoulder of Resident #16 and prepared the meal tray for the resident to eat her lunch. CNA C assisted Resident #74 to sit up straighter in the bed. CNA C did not have on gloves. CNA C was observed to not wash her hands or use hand sanitizer, available in the hallway.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>An interview on 11/06/24 at 1:20 p.m., CNA C stated she did not complete hand hygiene after having direct contact with residents. CNA C stated she was supposed to use the hand sanitizer in between serving each tray or wash her hands. CNA C said she had been educated on completing hand hygiene. CNA C stated she did not sanitize her hands, after the first meal tray that was served because she was nervous and trying to get the lunch trays served. CNA C stated she knew she could spread germs if she did not clean her hands.</p> <p>An interview with the DON on 11/07/24 at 11:30 a.m., revealed that all staff must complete hand hygiene after having contact with residents. She stated CNAs were trained to wash their hands with soap and water prior to tray service, then use hand sanitizer between each tray service. The DON stated if the CNAs do not use appropriate hygiene, they can spread germs to the residents and themselves. The DON was the infection control preventionist and she stated they do yearly competency training on the CNAs each year and new CNAs are trained on handwashing after they are hired and return demonstration.</p> <p>Record review of an in-service dated June 2024 log revealed CNA C received handwashing and hand sanitizing training, to prevent the spread of infection. Further review of in-service logs revealed an in-service conducted in June 2024 reflected: when passing trays in the hallways, sanitize after going in every room. Remember to wash your hands before starting meal service and use hand sanitizer between each tray served.</p> <p>Record review of the Facility's Policy titled Handwashing/Hand Hygiene revised August 2019 reflected: This facility considers hand hygiene the primary means to prevent the spread of infections . 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections .2. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors . 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies .7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . b. before and after direct contact with residents; . p. before and after assisting a resident with meals</p> |   |  |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>27070</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents for one (satellite kitchen on the rehabilitation halls) of one satellite kitchen observed for physical environment.</p> <p>The facility failed to ensure floors, cabinets, walls, sink, and refrigerator were clean, safe, and in good repair in the satellite kitchen on Halls 500, 600, 700, and 800, that were rehabilitation hallways.</p> <p>These failures could place residents at risk for diminished quality of life.</p> <p>Findings included:</p> <p>The sink in the satellite area had dried dark particles in the sink and the drain to the sink had a dark slime area surrounding the drain. The right bottom cabinet had dried dark goeey stains down the front door of the cabinet. There was a missing handle on this cabinet. The two upper cabinets above the refrigerator were missing handles. The area of decorative wood above the sink had the bottom of the wood chipped and missing. The wall next to the portable steam table had dried stains of fluid that was running down the walls. The floor in the kitchen was sticky. There was a dirty shelf from inside the refrigerator on the dirty floor in an open area of the cabinets.</p> <p>In an interview on 11/05/24 at 9:10 a.m. with the Director of Rehabilitation revealed that the therapy department did sometimes use the area to work with residents, but not very often. The area was not used often at all, sometimes families will visit, and the resident and families will eat over there, and sometimes the staff eats in there.</p> <p>An observation and interview on 11/06/2024 at 8:30 a.m. revealed no food in the refrigerator, the pitcher [OJ] was still in the refrigerator. Maintenance Man A was changing light bulbs in the room. He stated his main responsibilities in the facility were to fix the esthetics parts of the facility. Maintenance Man A stated that the cabinets would be something he would fix, he was not aware of the cabinets needing repair, the request had not been placed in the maintenance book at the nurse station. Maintenance man A stated the staff is supposed to write in the book items that need repair.</p> <p>Review of the maintenance logbook at the nurse's stations for Rehab hallway, had no documentation concerning repair to cabinets.</p> <p>In an interview on 11/06/2024 at 8:40 a.m. with Housekeeper B revealed she cleaned the area daily, when she was working. It was the housekeeping department's responsibility to clean the refrigerator and the sink and cabinets. Housekeeper B stated that was her food in the refrigerator yesterday, she always keeps her food there, after she eats she takes it home each day. The housekeeper stated she did not know what the [OJ] was doing in the refrigerator, she did not know who used it. She stated that she never saw there any residents in the dining room, she does eat her lunch in there, the residents eat their meals in their rooms.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>In an interview on 11/06/2024 at 8:50 a.m. with LVN D revealed he was not aware what the room was used for. LVN D stated that he never goes in there. He did not know there was refrigerator in the room. LVN stated he never saw anyone in the room when he walked by. LVN D stated that if something was broken, there was a book at the nurse's station to document in, if something required repair. The LVN stated he had not written anything in the maintenance book concerning the Rehab dining room.</p> <p>In an interview on 11/06/24 at 1:16 p.m. with the Administrator revealed the area should be cleaned daily and she should have been informed that this area required repair. The Administrator stated this was unacceptable, this area should be much cleaner, and the staff should not be leaving any food in the refrigerator. The Administrator stated the cabinet had no hands and she attempted to open one of the cabinets, the administrator did not want to touch the cabinet door due to the dried food on the cabinet. The Administrator stated that there had been consideration of doing away with the area, as it was never used. The Administrator left to go and find housekeeper to come and clean the area.</p> <p>In an interview on 11/07/2024 at 2:00 p.m. with the Medical Director revealed that he did not want the facility to take the rehabilitation dining room away, he felt the space could be used by the rehabilitation team to rehab the residents and it would be a positive move. The Medical Director stated the area should be kept clean and in good repair.</p> <p>In an interview on 11/07/24 at 10:32 a.m., the Housekeeper Supervisor revealed that it was the responsibility of the housekeeping department to clean the rehabilitation dining areas, including the satellite kitchen area. He stated it had not been used in a long time, but it should still be kept clean and in good repair. His staff was to clean the area daily and never keep food in the refrigerator. He stated he was unaware that the area required repair and the refrigerator required cleaning, none of his staff had not mentioned it to him. He stated that he did not follow-up on the area routinely, but he would now.</p> <p>Review of the Policy and Procedure Maintenance Services dated revised November 2022 reflected maintenance service shall be provided to all areas of the building, grounds, and equipment the Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner</p> |   |  |