STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675139	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Healthcare Residence	1025 W Yeagua Groesbeck, TX 76642

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on observations, interviews, and record reviews, the facility failed to ensure residents received services in the facility with reasonable accommodations of each resident's needs for 1 of 11 residents (Residents #1) reviewed for resident rights in that: The facility failed to ensure Residents #1's call light was within reach on 12/04/24. This failure could affect residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: Record review of Resident #1's admission record dated 12/05/24 documented a [AGE] year-old male admitted on [DATE]. Resident #1 had diagnoses which included: gastro esophageal reflux disease without esophagitis (a digestive disorder that occurs when stomach acid flows back into the esophagus without causing inflammation of the esophagus), muscle wasting and atrophy (decrease in size and wasting muscle tissues). cognitive communication deficit (difficulty paying attention to a conversation, staying on topic or remembering information), essential primary hypertension (abnormally high blood pressure that not caused by a medical condition), lack of coordination (not being able to move your body smoothly and precisely, often resulting in clumsiness, stumbling, or jerky movement), and thoracic root disorder (a condition that occurs when a nerve in the upper back is compressed or irritated). Record review of Resident #1's Quarterly MDS assessment, dated 09/19/24, revealed the resident had a BIMS score of 14 indicating the resident was cognitively intact. The MDS also revealed Resident #1 was dependent in the area of shower/bathe self. Resident #1 required supervision or touching assistance in the areas of putting on /taking off footwear, lower body dressing, upper body dressing and personal hygiene. Record review of Resident #1's care plan, dated 12/05/24, revealed Resident #1 was care planned for falls r/t unaware of safety needs and had an intervention of: Be sure the resident's call light is within reach and encourage the resident to use it. Observation on 12/04/24 at 9:24 a.m., revealed Resident #1's call light was placed on a nightstand out of his reach. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 10:18 a.m., Resident #1 stated that his call light has not been within reach for a few days. Resident #1 stated the call light doesn't work and the MS was working on it but never came back. During an interview on 12/04/24 at 2:25 p.m., CNA A stated that CNAs should make rounds at least every two hours. CNA A stated that CNAs should be looking to see if a resident needs assistance, ensuring call lights were within reach, and making sure all residents were comfortable. CNA A stated if a resident's call light was not within reach, then the resident could fall attempting to reach it or the resident would not receive assistance. During an interview on 12/05/24 at 3:45 p.m., the DON stated that anyone that entered the resident's room was responsible for ensuring the call light was within reach. The DON stated the purpose of a call light was for resident to notify staff when they need assistance. The DON stated if a resident's call light was not in reach, then they would not be able to call for assistance. The DON stated her expectation was that all resident's call lights were always within reach so the resident can notify staff they need assistance. An interview with the ADM on 12/05/24 at 4:00pm, the ADM stated that all resident call lights should be always within reach. The ADM stated that is mainly the CNAs responsibility to ensure call lights are within reach. The ADM stated that anyone who entered the residents' rooms should be ensuring call lights were within reach. The ADM stated that if a call light was not within reach, then a resident would not be able to call for assistance when they need it. Review of the facility's Answering the Call Light policy, revised September 2022, reflected, Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines 1. Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident. 2. Ask the resident to return the demonstration. 3. Explain to the resident that a call system is also located in his/her bathroom. 4. Be sure that the call light is pulled in and functioning at all times. 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility, and form the floor.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 4 residents (Resident #1) reviewed for a clean and homelike environment. The facility failed to ensure Resident #1's urinal was emptied appropriately on 12/04/24. This failure placed residents at risk of decreased feelings of self-worth and a diminished quality of life. Findings included: Record review of Resident #1's admission record dated 12/05/24 documented a [AGE] year-old male admitted on [DATE]. Resident #1 had diagnoses which included: gastro esophageal reflux disease without esophagitis (a digestive disorder that occurs when stomach acid flows back into the esophagus without causing inflammation of the esophagus), muscle wasting and atrophy (decrease in size and wasting muscle tissues). cognitive communication deficit (difficulty paying attention to a conversation, staying on topic or remembering information), essential primary hypertension (abnormally high blood pressure that not caused by a medical condition), lack of coordination (not being able to move your body smoothly and precisely, often resulting in clumsiness, stumbling, or jerky movement), and thoracic root disorder (a condition that occurs when a nerve in the upper back is compressed or irritated). Record review of Resident #1's Quarterly MDS assessment, dated 09/19/24, revealed the resident had a BIMS score of 14 indicating the resident was cognitively intact. The MDS also revealed Resident #1 was dependent in the area of shower/bathe self. Resident #1 required supervision or touching assistance in the areas of putting on /taking off footwear, lower body dressing, upper body dressing and personal hygiene. During an observation on 12/04/24 at 10:15 a.m., Resident #1's urinal had a yellowish liquid in it that appeared to be urine. During an observation on 12/04/24 at 12:50 p.m., Resident #1's urinal had a yellowish liquid in it that appeared to be urine. During an interview on 12/04/24 at 12:50p.m., Resident #1 stated that the urinal has had urine in it since around 8:45 a.m. Resident #1 stated his urinal always has urine in it. Resident #1 stated that there are only a few staff the empty his urinal like they are supposed to. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 2:25 p.m., CNA A stated that CNAs should make rounds at least every two hours. CNA A stated that CNAs should be looking to see if a resident needs assistance, ensuring call lights were within reach, and making sure all residents were comfortable. CNA A stated that it's anyone's responsibility that walked into the resident's room to ensure that the urinal was emptied appropriately. CNA A stated the urinal should be emptied once a resident is finished urinating unless told otherwise. CNA A stated if a urinal is not emptied that could cause the room to have bad odor. During an interview on 12/05/24 at 3:45 p.m., the DON stated that anyone that entered the resident's room was responsible for ensuring the resident's urinal is emptied promptly. The DON the CNAs would be ultimately responsible for emptying urinal due to them making rounds frequently. The DON stated a negative outcome of a resident's urinal not being emptied promptly would be the urinal could overflow, spill, cause an odor, or cause an infection control issue. During an interview on 12/05/24 at 4:00 p.m., the ADM stated that a resident's urinal should be emptied as needed or at least every two hours. The ADM stated that it was the responsibility of the direct care staff to ensure resident urinals were emptied promptly. The ADM stated if a resident urinal was not emptied promptly that would be unsanitary or possible spread diseases. Review of the facility's Bedpan/Urinal, Offering/Removal policy, revised February 2018, reflected, Purpose: The Purpose of this procedure is to provide the resident with bedpan and/or urinal assistance. General Guidelines 3. If the resident prefers to keep a urinal at his bedside, check if frequently. Empty and clean it as necessary. Note on the resident's care plan his request to keep the urinal at his bedside.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on observations, interviews and record review, the facility failed to have a policy to ensure safe and sanitary storage of residents' food items for 3 of 7 residents' (Residents #2, #3, and #4) reviewed for food policy, in that: Residents #2, #3, and #4's personal in-room refrigerator was not monitored for safe temperatures. These failures could place residents at risk of food borne illnesses. The findings were: A record review of Resident #2's face sheet dated 12/05/24 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnosis which included: Schizophrenia (mental illness that affects a person's thoughts, feelings and behavior), Dysphagia (having trouble moving food or liquid down your throat when you try to eat or drink), unspecified dementia (loss of memory language, problem solving and other thinking abilities that are severe enough to interfere with daily living), essential primary hypertension (abnormally high blood pressure that not caused by a medical condition), lack of coordination (not being able to move your body smoothly and precisely, often resulting in clumsiness, stumbling, or jerky. movement), A record review of Resident #2's Quarterly MDS assessment, dated 09/21/24, reflected the resident had a BIMS score of 15, indicating the resident was cognitively intact. During an observation on 12/05/24 at 2:45 p.m., revealed Resident #2's personal room refrigerator had a Refrigerator Temperature Monitor Sheet that was last completed on 07/21/24. There were no items observed in Resident #2's personal refrigerator. During an interview on 12/05/24 at 2:45 p.m., Resident #2 stated no staff has ever checked his personal refrigerator temperature. Resident #2 stated that he usually only keeps sodas in his personal refrigerator. Resident #2 stated there was nothing in his personal refrigerator but stated he was getting some items later to put in it. A record review of Resident #3's face sheet dated 12/05/24 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnosis which included: Encephalopathy (any brain disorder or damage that affects brain function or structure), Anxiety Disorder (a condition that causes a person to experience excessive and intense feelings of fear, worry, and dread), major depressive disorder (a mental health condition that involves a persistent low mood and a loss of interest in activities that were previously enjoyable) and essential primary hypertension (abnormally high blood pressure that not caused by a medical condition). A record review of Resident #3's Annual MDS assessment, dated 09/24/24, reflected the resident had a BIMS score of 15, indicating the resident was cognitively intact. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/05/24 at 11:35 a.m., revealed Resident #3's personal room refrigerator had a Refrigerator Temperature Monitor Sheet that was last completed on 07/21/24. There were no items observed in Resident #3's personal refrigerator. During an interview on 12/05/24 at 11:35 a.m., Resident #3 stated she doesn't not remember when the last time someone had checked her personal refrigerator temperature. Resident #3 stated she usually keep sodas, fruits, and meat in her personal refrigerator. Resident #3 stated she only had ranch dressing in her personal refrigerator at the moment. A record review of Resident #4's face sheet dated 12/05/24 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnosis which included: polyneuropathy (damage to many nerves throughout the body at the same time), gastro esophageal reflux disease without esophagitis (a digestive disorder that occurs when stomach acid flows back into the esophagus without causing inflammation of the esophagus), muscle wasting and atrophy (decrease in size and wasting muscle tissues), major depressive disorder (a mental health condition that involves a persistent low mood and a loss of interest in activities that were previously enjoyable) and essential primary hypertension (abnormally high blood pressure that not caused by a medical condition). A record review of Resident #4's Quarterly MDS assessment, dated 10/24/24, reflected the resident had a BIMS score of 15, indicating the resident was cognitively intact. During an observation on 12/05/24 at 3:00 p.m., revealed Resident #4's personal room refrigerator did not have Refrigerator Temperature Monitor Sheet attached to it. Resident #4's personal refrigerator was observed to have what appeared to be grapes and sodas. During an interview on 12/05/24 at 3:00 p.m., Resident #4 stated she has not had a Refrigerator Temperature Monitor Sheet on her refrigerator in a long time. Resident #4 stated that she often keeps sodas, fruits and meats in her personal refrigerator. Resident #4 stated she currently has sodas and grapes in her refrigerator. During an interview on 12/05/24 at 3:45 p.m., the DON stated that in the past that it was the housekeeping supervisor's responsibility to ensure resident's personal refrigerator temp log were completed. The DON stated the facility has had a few housekeeping s supervisors over the last few months. The DON stated a negative outcome of resident refrigerator temps not being completed would be the resident personal food my spoil. The DON stated her expectation for resident's personal refrigerator temperature to be documented on daily by the designee. During an interview on 12/05/24 at 4:00 p.m., the ADM stated that all resident with personal refrigerator should have a Refrigerator Temperature Monitor Sheet attached to it and the temperature should be documented daily. The ADM stated that himself, MS, or designee were responsible for resident's personal refrigerators temperature being checked and documented. The ADM stated that a negative outcome would be that the resident's food could spoil, and the refrigerator may not be working properly. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/24 at 4:15 p.m., the MS stated that previously it was the housekeeping supervisor responsibility to ensure the resident's personal refrigerator temperature log was being completed daily. The MS stated that the facility has had some turnover at the housekeeping supervisor position and was not sure if the new housekeeping supervisor was aware of the task of ensuring the resident's personal refrigerator temperature logs were completed daily. The MS stated a negativity outcome of resident's personal refrigerator temperature log was not completed could be the refrigerator may not be cooling properly or the resident's personal food could go bad. A record review of the facility's Storage Refrigerators policy, dated 2012, reflected All storage refrigerators shall be maintained clean and have a proper temperature for food storage and to ensure a proper environment and temperature for food temperature. Procedure 1. Storage refrigerator shall be well lighted, ventilated, temperature controlled, and must have an internal thermometer. 2. Storage refrigerator shall have thermometer frequently monitored throughout the day and recorded in the am and pm shifts. Temps are recorded on the refrigerator/freezer temperature log. The refrigerator should be 41 degrees F or less, and the freezer should be maintained at less than 0 degrees F.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on observation, interview, and record review, the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a centralized staff work area, for 1 of 11 residents (Resident #1) reviewed for physical environment. The facility failed to ensure Resident #1 had a working call light in his room on 12/04/24. This failure could place residents at risk of not being able to get assistance when needed. Findings included: Record review of Resident #1's admission record dated 12/05/24 documented a [AGE] year-old male admitted on [DATE]. Resident #1 had diagnosis which included: gastro esophageal reflux disease without esophagitis (a digestive disorder that occurs when stomach acid flows back into the esophagus without causing inflammation of the esophagus), muscle wasting and atrophy (decrease in size and wasting muscle tissues). cognitive communication deficit (difficulty paying attention to a conversation, staying on topic or remembering information), essential primary hypertension (abnormally high blood pressure that not caused by a medical condition), lack of coordination (not being able to move your body smoothly and precisely, often resulting in clumsiness, stumbling, or jerky movement), and thoracic root disorder (a condition that occurs when a nerve in the upper back is compressed or irritated). Record review of Resident #1's Quarterly MDS assessment, dated 09/19/24, revealed the resident had a BIMS score of 14, indicating the resident was cognitively intact. The MDS also revealed Resident #1 was dependent in the area of shower/bathe self. Resident #1 required supervision or touching assistance in the areas of putting on /taking off footwear, lower body dressing, upper body dressing and personal hygiene. Record review of Resident #1's care plan, dated 12/05/24, revealed Resident #1 was care planned for falls r/t unaware of safety needs and had an intervention of: Be sure the resident's call light is within reach and encourage the resident to use it. Observation on 12/04/24 at 10:15 a.m., Resident #1 pushed his call button and the light above his door did not light up. During an interview on 12/04/24 at 10:18 a.m., Resident #1 stated his call light doesn't work and the MS was working on it but never came back. During an interview on 12/05/24 at 3:45 p.m., the DON stated that anyone that entered the resident's room was responsible for ensuring the resident's call light is functioning. The DON stated it was the MS responsibility for replacing and fixing call light that aren't functioning properly. The DON stated she was not aware that Resident #1's call light was not working. The DON stated a negative outcome of a resident's call light not functioning would be they would not be able to call for assistance when needed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 4:00 p.m., the ADM stated that all resident call lights should be functioning properly. The ADM stated he was not aware Resident #1 call light was not working. The ADM stated it was maintenance responsibility to ensure call lights were working properly. The ADM stated that he and the maintenance director replaced call light that were not working immediately when notified. The ADM stated that if a resident's call light was not working then the resident would not be able to call for assistance and the residents needs would not be met. During an interview on 12/05/24 at 4:15 p.m., the MS stated that call light functionality was checked weekly by himself, and the ADM. The MS stated during department heads angel rounds they also are checking to ensure residents call lights are within reach and functioning. The MS stated that if a resident call light was not functioning properly the resident wouldn't be able to call for assistance. Review of the facility's Call System policy, dated September 2022, reflected: Residents are provided with a means to call staff for assistance through a communication system that directly call a staff member or a centralized work station. Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistance form his/her bed, from toileting/bathing facilities and from the floor. 3. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily hard. If visual communication is used, the lights remain functional. 5. The resident call system is routinely maintained and tested by the maintenance department.