

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Windsor Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the residents right to be free from abuse for three (Residents #10, #52, and #32) of five residents reviewed for abuse, in that: On 7/28/25, Resident #10 was pushed by Resident #62 after the resident attempted to enter Resident #62's room without permission. On 8/07/25, Resident #52 and Resident #62 were engaged in a pushing match. Resident #62 pushed Resident #52. Resident #52 fell to the floor and hit her head. Resident #52 was sent to ER for evaluation and sustained no injuries. On 08/25/25, Resident #32 was pushed Resident #62 after the resident entered Resident #62's room without permission. Resident #32 fell to the floor and hit her head. Resident #32 was sent to ER for evaluation and sustained no injuries. On 8/26/25 at 6:45 PM, an IJ was identified. The facility was notified of the IJ on 8/26/2025. The IJ template was provide to the facility on 8/26/25 at 8:09 PM. While the IJ was removed on 08/28/25 at 5:56 PM, the facility remained out of compliance at a scope of pattern and a severity level of pattern due to the facility not providing interventions for Resident #62. This failure placed residents at risk of being abused and injured by Resident #62. Findings included: A record review of Resident #62's face sheet dated 8/26/2025 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted [DATE]. Diagnoses included Catatonic Schizophrenia (a mental health condition that affects thoughts, feelings and behavior), Major Depressive Disorder recurrent severe Psychotic Features (depression that causes low mood and lack of interest, loss of reality, delusional and irrational thoughts), Generalized Anxiety Disorder (overwhelming fear and anxiety), Drug Induced Subacute Dyskinesia (uncontrollable movements caused by medication), Insomnia (inability to sleep) and UTI (infection of the urinary tract that may cause confusion). Record review of Resident #62's MDS, dated [DATE] reflected a BIMS score of 10, which indicated moderate cognitive impairment, with disorganized thinking that comes and goes, and changes in severity. Section E- Behavior reflected a score of 0 (zero), which indicated Behavior Not Exhibited, for A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually. A record review of Resident #62's Care Plan dated 7/29/25 and revised on 8/14/25 reflected the following: Focus: The resident has potential to demonstrate physical behaviors related to poor impulse control and paranoia/delusions. Interventions: Assess and address for contributing sensory deficits. Assess and anticipate resident needs: food, thirst, toileting needs, comfort, body positioning, pain, etc. Date initiated: 7/29/2025. Immediately separate residents and assess both residents. Provide 1:1 continuous monitoring. Continue to encourage resident to take medications to control behaviors. Psych visit with NP encouraging resident to take her medications. Refer resident to Behavior Health Hospital per order. Date initiated: 8/7/2025. Modify environment: move resident back to previous room where she resided alone. Date Initiated 7/29/2025, revision on 8/14/2025. Separate residents immediately in the event of resident-to-resident altercation. Encourage resident to accept PRN anxiety medication. Provide close supervision and safety checks every fifteen minutes for 72 hours. Psych tele-visit scheduled and performed. Head to toe assessment for injuries. Medication review. Date initiated 7/29/2025. Tele-visit with psych NP with medication review. New order for (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Risperdal started. Referral to crisis care team with onsite assessment of resident for placement. Date initiated 8/26/2025.Focus: The resident requires antidepressant medication (Zoloft and Trazodone) for diagnosis of depression.Interventions: Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement , agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant. Date Initiated: 12/6/2024.Focus: The resident uses anti-anxiety medications LORAZEPAM r/t anxiety disorder.Interventions: Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. ANTIANXIETY SIDE EFFECTS: Drowsiness, lack of energy, Clumsiness, slow reflexes, Slurred speech, Confusion and disorientation, Depression, Dizziness, lightheadedness, Impaired thinking and judgment, Memory loss, forgetfulness, Nausea, stomach upset, Blurred or double vision. PARADOXICAL SIDE EFFECTS: Mania, Hostility, and rage, Aggressive or impulsive behavior, Hallucinations. Monitor/record occurrence of target behavior symptoms: pacing, wandering inappropriate response to verbal communication and document per facility protocol. Date Initiated: 12/11/2024.Focus: The resident is non-compliant with medication administration related to paranoia and delusions.Interventions: Praise resident for a cooperative attitude towards her acceptance of meds. Talk to resident to determine reasons for refusal of care. Date initiated 7/29/2025.A record review of Resident #62's PCC orders initiated 8/20/2025 thru 8/26/2025 did not reflect a current order for anti-psychotic medication. Active prescriptions reflected Trazodone (for major depressive disorder), and Buspirone and Vistaril (for generalized anxiety). There were previous orders dated 5/31/2025 for Risperdal Consta Intramuscular Suspension Reconstituted ER 25mg; inject 25 mg intramuscularly one time a day every 14 days related to Catatonic Schizophrenia and Risperidone Oral Tablet Disintegrating 1 MG, give one tablet by mouth two times a day related to Catatonic Schizophrenia. A record review of Resident #62's discharge instructions dated 8/20/2025 from the behavior health hospital admission from 8/8/2025 thru 8/20/2025, reflected the following: Continue the following medications: Risperdal 2 MG (1 tablet) by mouth, twice a day for schizoaffective disorder. Risperdal 0.5 MG (1 tablet) by mouth, twice a day for schizoaffective disorder.A record review of Resident #10's face sheet dated 8/28/2025 revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included Alzheimer's Disease (process that causes the brain cells to die and the brain to shrink), Schizoaffective Disorder, Bipolar Type (mental disorder that includes delusions, hallucinations, disorganized thinking), anxiety disorder (overwhelming fear and anxiety), and Major Depressive Disorder, severe with psychotic symptoms (persistent depressive episodes).A record review of Resident #10's MDS dated [DATE] reflected a BIMS of 5, which indicated cognition was severely impaired. Section E0200. Behavioral Symptom - reflected a score of 0 (zero) which indicated Behavior Not Exhibited, for A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually.Section E0900. Wandering - reflected a score of 2 (two) which indicated this behavior occurred 4-6 days each week. A record review of Resident #10's Care Plan dated 8/22/2025 reflected the following: Focus: The resident is an elopement risk/wanderer, exit seeking.Intervention: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books. Focus: Resident involved in resident-to-resident altercation. Dated 7/28/2025.Interventions: Separate residents immediately in the event of resident-to-resident altercation. Provide increased supervision for the aggressor. Assess resident for injuries and emotional needs. Schedule Psychiatric NP tele-visit to assess for residual emotional trauma.Focus: Resident has a mood problem r/t Disease Process Alzheimer's dementia. Interventions:Monitor/record/report to MD prn risk for harming others: increased anger, labile mood, or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons. Focus: Resident is an elopement risk/wanderer exit seeking (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	behavior. Interventions: Assess for fall risk. Assess for secure unit.Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Focus: Resident involved in resident-to-resident altercation. Interventions: Separate residents immediately in the event of a resident-to-resident altercation.Provide increased supervision to the aggressor. Assess resident for injuries or emotional needs. Schedule Psychiatric NP tele-visit to assess for residual emotional trauma. A record review of Resident #52's face sheet dated 8/27/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses include Senile Degeneration of Brain (progressive deterioration of brain tissue), Dementia (symptoms that affect memory, thinking and social ability) and anxiety disorder (overly fearful or anxious). A record review of Resident #52's MDS dated [DATE] reflected a BIMS score of 3, which indicates cognition was severely impaired. Section E09.00. Wandering - Presence and Frequency. Has the resident wandered? The resident scored 0. Behavior not exhibited. A record review of Resident #52's Care Plan dated 7/11/2025 reflected the following: Focus: Resident has had aggressive behavior towards others. Interventions: 1:1 supervision for 72 hours Administer PRN anxiety medication for agitation. Identify trigger if possible and remove trigger. Medication review by Psychiatric NP - increased Depakote sprinkles to TID Psychiatric NP visit/evaluation Redirect and provide activities.Redirect resident during periods of agitation or aggression. Offer fluids/food in separate location within the secured unit. Assess for physical needs (bathroom privileges, comfort/pain).Provide activities for distraction. Separate residents during agitation. A record review of Resident #32's face sheet dated 8/27/2025 reflected a [AGE] year-old female admitted on [DATE]. Her diagnoses included Alzheimer's (common dementia where the brain shrinks) Major Depressive Disorder (depression, loss of self-esteem or low interest), and Lack of Coordination (unorganized movements and actions). A record review of Resident #32's MDS dated [DATE] reflected a BIMS of 4, indicated cognition is severely impaired. Section E0900. Wandering - Presence & Frequency, Has the resident wandered? Resident #32 scored a 2. Behavior of this type occurred 4-6 days, but less than daily. A record review of Resident #32's Care Plan dated 6/9/2025 reflected the following: Focus: The resident has a Skin Tear to right wrist from striking staff member while being redirected out of others' rooms. Interventions: Identify potential causative factors and eliminate/resolve when possible. Focus: Resident was involved in an altercation with another resident. Interventions: Administer PRN anxiety meds if resident is agitated and/or verbally instigating. Check for any physical needs - toileting, pain. Medication review by Psychiatric NP, initiated Vistaril BID Notify Psychiatric NP for med review r/t agitation/altercation. Nurse to assess for injuries and emotional trauma. Provide activities for distraction. Provide fluids and/or snack activity.Psychiatric NP visit to perform med review and evaluate for emotional adverse effects of altercations. A record review of the facility incident investigation dated 7/28/2025 reflected Resident #62 pushed Resident #10 who was attempted to enter the resident's room without permission. The other resident sustained no injury. Resident #62 was placed on 72 hour 1:1 monitoring, and no behaviors were exhibited during this period. A record review of the facility incident investigation dated 8/7/2025 reflected Resident #62 and Resident #52 were engaged in a pushing match. Resident #52 fell on the floor, hit her head, was sent to ER and CT scan revealed no injury. Resident #62 was placed on 72 hour 1:1 monitoring by the facility, evaluated by the NP, and referred and admitted to psychiatric facility, A record review of the facility incident investigation dated 8/25/2025 reflected Resident #62 and Resident #32. Resident #32 fell on the floor, hit her head, was sent to ER and CT scan revealed no injury. Resident #62 was placed on 1:1 monitoring by the facility. PRN medications were given for anxiety, consideration of readmission to behavioral health hospital (resident refused) and consult with the appointed guardian.An observation and interview on 8/26/2025 at 10:35 AM revealed Resident #62 lying on her bed, in her room. Clothing and hygiene were clean and appropriate. Resident interacted with surveyors by responding to assessment questions without hesitation. She (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	stated she was doing okay. There were no visible marks or bruises. An observation and interview on 8/26/2025 at 10:40 AM revealed Resident #32 sitting in wheelchair, pulled up to a table in the main living area. Clothing and hygiene were clean and appropriate. There were no visible marks or bruises. Resident #32 said she does not remember falling or being shoved. During an interview on 8/26/2025 at 11:10AM the DON said Resident #62 was placed on immediate 1:1 monitoring beginning 8/25/2025 at 6:00 PM and would remain on monitoring until alternate placement could be identified for Resident #62. The DON stated the 1:1 monitoring checklist/form was blank from 8/25/2025 at 6:00 PM thru 8/26/2025 at 6:00 AM because the facility did not have the correct forms at the time the 1:1 monitoring was started. She said until about two weeks ago, Resident #62 (the aggressor) did not have a history of physical aggression, and she went to a behavioral health hospital on 8/8/2025 for delusional behaviors after she started refusing her injectable antipsychotic medication. She said, Regarding the incident last night, staff got them separated. We scheduled and conducted a tele-visit and medication review with NP and the preventions/interventions are for medication reviews and management. We are seeking a re-admission to the behavioral health hospital. A psych tele-visit has been planned. A record review of the facility's policy titled Abuse/Neglect, revision date 10/04/22 reflected the following: 1. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Resident-to-resident altercations will be reviewed as potential abuse not assumed as abuse. Resident-to-resident altercations must include any willful action that results in physical injury, mental anguish, or pain. 2. Adverse event: An adverse event in an untoward, undesirable, and usually unanticipated event that causes death or serious injury; or the risk thereof. Procedure: C. Prevention: The facility will provide residents, families, and staff an environment free from abuse and neglect. 4. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect. F. Protection: The facility will take necessary measures to protect residents and employees from harm during and following an abuse, neglect, and exploitation, mistreatment of residents or misappropriation of resident property investigation. On 8/26/25 at 6:45 PM, an IJ was identified. The facility was notified of the IJ and provided the IJ Template 8/26/25 at 08:09 PM. Plan of Removal Version 4 was accepted/approved on 8/27/2025 at 5:39 PM and Version 5 was accepted/approved on 8/28/2025 at 5:45 PM. Immediate Jeopardy Plan of Removal The center Leaderships (Administrator and Director of Nursing) were notified on 8/26/2025 @7:45pm that an Immediate Jeopardy had been issued to the center related to F600 Abuse. Resident #32 attempted to go into Resident #62 room and Resident #62 pushed Resident #32 to the floor. Resident #32 was sent to the hospital on 8/25/2025 after being pushed by resident #62. The Hospital Physician/Staff assessed resident #10 on 8/25/2025 with no signs/symptoms of injury. She returned to the center with no new orders and has resumed her usual activities. Resident #62 being on 1:1 offers protection from abuse for Resident #32 and the other residents residing in the secure unit. The Director of Nursing and Assistant Director of Nursing conducted assessments/evaluations on the residents residing in the secure unit on 8/27/2025, no signs/symptoms of abuse were noted, since none of them can be interviewed. The assessments were documented in the resident electronic medical record. The Director of Nursing and Assistant Director of Nursing reviewed incident reports for the last 6 months on 8/27/2025 to validate incidents that occurred have appropriate interventions in place. Resident #62 was assessed by the Director of Nursing on 8/26/2025 with no signs/symptoms of injury/abuse/neglect. Her discharge orders were reviewed by the Director of Nursing on 8/26/2025 (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	as a discrepancy was identified by a surveyor. Resident #62 had discharge orders for an antipsychotic medication from behavioral hospital on 8/20/2025 that were not implemented (Risperdal 2.5mg by mouth twice a day). The discrepancy was corrected by the Director of Nursing on 8/26/2025 and a medication error report was completed on 8/26/2025 by the Director of Nursing. The responsible party, Administrator, and Medical Director were made aware of the medication error. The center attending Nurse Practitioner assessed the resident on 8/26/2025 and made some antipsychotic medication changes that were implemented. Resident #62 remains on 1:1 monitoring, and this will continue until Resident #62 is discharged from the center or the interdisciplinary team determines discontinuation of the 1:1 monitoring is appropriate. The criteria includes discussion/consultation with the Medical Director, Attending Nurse Practitioner, and Psychiatric Nurse Practitioner. Review of resident behaviors for noted decreases in anxiety, agitation as confirmation of current medication effectiveness. The 1:1 monitoring will be provided by various nursing team members (licensed nurses, certified nursing assistants, certified medication aides, or hospitality aides). The center social worker contacted state hospital on 8/26/2025 and their Crises Care Team came to the center on 8/26/2025 and did an assessment on Resident #62. She is now on the waiting list to admit to state hospital and the center must fax requested documents every 3 days until resident #62 is accepted into the state hospital. The Director of Nursing will be responsible for that. The Psychiatric Nurse Practitioner will continue to provide onsite visits with the resident at least every two weeks until she discharges to state hospital. The attending Nurse Practitioner adjusted Resident #62 Risperdal order on 8/27/2025. The Director of Nursing contacted The Medical Director on 8/26/2025 and had no concerns related to this event and indicated that due to the resident's history and co-morbidities the medication error did not contribute to any behaviors. The Director of Nursing re-educated all staff (full-time, PRN) 8/27/2025 on interventions for Resident #62 including her being on 1:1, giving her opportunity to share her needs/wants, give her space as she is protective of her room/space, and to re-direct other residents away from her room. Those not present will receive the re-education prior to the start of their next shift. The Director of Nursing re-educated all staff (full-time, PRN) on addressing and responding to Resident #62 behavioral needs on 8/27/2025. Those not present will receive this re-education prior to the start of their next shift. The Director of Nursing and Assistant Director of Nursing did an audit of new admissions/re-admissions on 8/26/2025 with no negative findings. The audit consisted of new admissions/re-admissions since 8/1/2025. This was conducted to ensure medication orders were implemented. The Director of Nursing re-educated the Assistant Director of Nursing on the admission/readmission audit process on 8/26/2025. The Director of Nursing re-educated the licensed nurses on the admission/re-admission process related to medication orders on 8/26/2025 (full-time and part-time staff). Those not present will receive this re-education prior to the start of their next shift by the Director of Nursing. The Administrator, Director of Nursing, and Medical Director conducted an AD HOC Quality Assurance Meeting on 8/27/2025 to review the Immediate Jeopardy event. The Administrator/Director of Nursing will conduct random chart audits of readmissions weekly for four weeks to validate those returning from the hospital have their correct orders/order changes implemented. The Administrator/Designee will conduct random interviews/interactions with Resident #62 to validate behaviors are being managed. Negative findings will be addressed at the time of discovery and presented to the center Quality Assurance Program. Plan of Removal Monitoring Included: An observation of and interview on 8/28/2025 at 11:45am Resident #62 was in her room with CNA-A, who was providing 1:1 monitoring. Resident #62 stood by pleasantly, while CNA-A made her bed. Resident #62 spoke with the Surveyor and stated she wanted assistance being placed in a different facility. During an interview on 8/28/2025 at 11:15 AM, the DON stated she in-serviced all staff providing 1:1 monitoring for Resident #62. She stated overnight staff were in-serviced via telephone on 8/27/2025 at 2:30 AM, and they signed documents left at the facility. She stated the in-service included resident-to-resident altercation preventions and how to manage residents who required 1:1 monitoring/supervision. During an interview on 8/28/2025 at 11:38 (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	separation. She stated prevention methods were dependent upon each resident as they had unique needs. She stated 1:1 monitoring with Resident #62 was conducted day and night, and if necessary other residents were redirected away from Resident #62's room. Record review of the medication audit sheets for six residents for admission/re-admission orders compliance. The orders were cross-referenced in the EMR to verify accuracy. Record Review of the assessments/evaluations in the EMR conducted on all residents in the secure unit. Record review of the in-service sheet dated 8/27/2025 and verified via interviews with licensed nurses understanding of medication reconciliation. Record review of the ad hoc QAPI Meeting sign-in sheet dated 8/27/25 reflected signatures of the Medical Director, Administrator, and Director of Nursing. Record review of in-service titled, Resident Specific In-Service - Resident #62, conducted by DON on 8/27/2025 reflected: Please remember these things when caring for Resident #62: 1. Please respect her space, she likes to spend time alone in her room. 2. Please redirect other residents from wandering into her room. 3. Allow her to express herself. 4. Offer activities that interest Resident #62. 5. If she appears anxious or agitated, please try to determine if she needs anything (hungry, thirsty, toileting, discomfort) and report this behavior to the charge nurse. 6. Report ALL refusals to the charge nurse immediately. Thirty-nine staff signatures were included on the in-service. Record review of 1:1 Monitoring Log for Resident #62, dated 8/27/25 and 8/28/25 reflected staff initials in 15-minute intervals to indicate continuous monitoring of Resident #62. Record review of Attestations for 1:1 Monitoring for Resident #62, dated 8/28/2025 and signed by two CNA's verifying they both provided 1:1 monitoring/supervision for Resident #62 during the shifts 6:00 PM - 10:00 PM on 8/25/2025 and 10:00 PM - 6:00 AM on 8/26/2025. Record review of Resident #62's orders in PCC reflected an order dated 8/26/25 for Risperdal Oral Tablet 0.5 MG to be administered 1 tablet by mouth, two times daily for preventative related to major depressive disorder, recurrent severe without psychotic features for three days; Risperdal Oral Tablet 1 MG dated 8/30/25 to be administered 1 tablet by mouth two times a day for Preventative related to major depressive disorder, recurrent severe without psychotic features. On 8/28/2025 at 5:39 PM the ADM, DON, and [NAME] President of Clinical Services were notified the IJ was removed. While the IJ was removed on 08/28/25 at 5:56 PM, the facility remained out of compliance at a scope of pattern and a severity level of pattern due to the facility not providing interventions for Resident #62.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Windsor Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 for 1 of 1 kitchen. The facility failed to ensure the food served was fresh and in an edible condition. The facility failed to ensure food was served in a sanitary manner. This failure could place residents at risk of foodborne illness by serving them expired food and food in unsanitary conditions. Findings included: Observation on 8/26/2025 at 8:33 AM of the cooler revealed the following: - Moldy tomatoes were in a box with no date. - Moldy cucumbers were in a box with no date. - Parmesan Cheese dated 3-23-2025 with a use-by date of 5-29-2025. Observation on 8/26/2025 at 8:47 AM of the pantry revealed the following: - Blueberry Muffin Mix dated 6-18-25 and a use by date of 7-08-2025. - Marshmallows with a use-by date of 8-18-2025. Observation on 8/26/2025 at 11:30 AM revealed CK taking temperatures of the food before serving: - While CK was taking the temperature of the gravy, CK dropped the food thermometer into the brown gravy. CK did not discard the gravy. In an interview on 08/28/2025 at 1:35 PM the DA stated that everyone is responsible for checking for out-of-date items in the kitchen. The DA stated that mainly the CK and the DM are the ones who monitor the dates on the food. The DA stated that if he sees an expired item, he will discard the item and notify the DM. The DA stated that when they receive a delivery, he will place the new food items in the back and the older food items in the front. The DA stated that if expired or moldy food is served to residents, they could get sick. In an interview on 08/28/2025 at 1:43 PM the CK stated that everyone working in the kitchen is responsible for checking for expired and old food items. The CK stated that food should be rotated so that older food is used first. The CK noted that when she sees outdated or moldy food, it is to be thrown away. The CK stated she will let the DM know when she sees expired food. The CK stated that if something is dropped in the food, it should not be used and should be thrown out and remade. The CK stated that residents could get sick if served moldy food. In an interview on 08/28/2025 at 1:58 PM the DM stated that everyone working in the kitchen is responsible for checking for expired and moldy food. The DM stated that staff are to let her know when expired or moldy food is found in the kitchen, then it should be thrown away. The DM stated that old food is to be used before the new food. The DM stated that if a thermometer is dropped in food, then the food should be discarded. The DM stated that residents could get sick if they were served food that was expired, moldy, or if a thermometer was dropped in the food. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Windsor Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 W Yeagua Groesbeck, TX 76642	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's undated policy titled Food Safety and Sanitation, Copyright 2023 [NAME] & Associates, Inc. reflected the following: 4. Food Storage (see Chapter 3: Food Production and Food Safety for Food Storage) a. Stored food is handled to prevent contamination and growth of pathogenic organisms. · Leftovers are used within 72 hours (or discarded). Note: 2022 Federal Food Code guidelines allow 7 days for food safety with the day of preparation counted as day 1 of the 7 days and then food is discarded. Check local and state regulations and if different from the Federal Food Code, determine which regulation should be followed. · Perishable foods with expiration dates should be used prior to the use by date on the package.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide pharmaceutical services including the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 1 (Resident #62) of 4 residents reviewed for pharmacy services. The facility failed to ensure Resident #62 received Risperdal 2mg by mouth twice daily and Risperdal 0.5mg by mouth twice daily between 8/20/2025 and 8/26/2025. This omission could place residents at risk for exacerbation of psychotic symptoms. The findings included: Record review of Resident #62's electronic medical record on 08/26/2025 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted [DATE]. Diagnoses included Schizophrenia (a chronic mental health condition characterized by a combination of cognitive symptoms that significantly impair a person's daily functioning), Major Depressive Disorder recurrent severe Psychotic Features (a severe form of depression where a person experiences symptoms of major depression alongside symptoms of psychosis such as delusions or hallucinations that often align with the depressed mood), Generalized Anxiety Disorder (a mental health condition characterized by excessive, persistent, and uncontrollable worry about everyday events or activities, even with there's little or no clear cause.), Drug Induced Subacute Dyskinesia (a type of involuntary, repetitive muscle movements that develop over a period of weeks to months after taking certain medications), Insomnia and UTI. Review of physician's orders did not reflect a current prescription for anti-psychotic medication. Active prescriptions for psychotropic medications reflected Trazodone (for major depressive disorder), and Buspirone and Vistaril (for generalized anxiety). Record review of Resident #62's MDS, dated [DATE] reflected a BIMS score of 10, which indicated moderate cognitive impairment, with disorganized thinking that comes and goes, and changes in severity. Record review of Resident #62's care plan revised 07/29/2025 and last updated 08/26/25 reflected the following: Problem identification: The resident is noncompliant with medication administration related to paranoia and delusions. Initiated 07/29/2025. Revision 08/14/2025. Goal: Resident's needs will be met during the next 90 days. Interventions: Initiated 07/29/2025: Notify family and physician of behavior/refusal of care, Initiated 07/29/2025 and revised 08/07/2025: Praise resident of a cooperative attitude towards acceptance of meds, Initiated 08/07/2025 and revised 08/14/2025: Report refusal to supervisor, Initiated 08/14/2025: talk to resident to determine reasons for refusal of care. Problem identification: The resident has potential to demonstrate physical behaviors r/t Poor impulse control and paranoia/delusions. Initiated 07/29/2025. Revision 08/14/2025. Goal: The resident will seek out staff when agitation occurs through the review date. Interventions: Initiated 07/29/2025: Assess and address for contributing sensory deficits, modify environment: move resident back to previous room where she resided alone, separate resident immediate in the event of resident-to-resident altercation, encourage resident to accept PRN anxiety medication, provide close supervision and safety checks every fifteen minutes for 72 hours, psych tele-visit scheduled and performed, Head to toe assessment for injuries, medication review Initiated 07/29/2025: Assess and anticipate resident's needs: food thirst, toileting needs, comfort level, body positioning, pain etc. Initiated 08/07/2025: Immediately separate resident and assess both residents, provide one on one continuous monitoring, continue to encourage resident to take medications to control behaviors, Psych tele-visit with NP encouraging resident to take her medications, refer to Behavioral Health Hospital. Modify environment: Move resident back to previous room where she resided alone. Initiated 08/26/2025: Tele-visit with psych NP with medication review, Risperdal started, referral to Crisis Care Team with onsite assessment of resident for placement. Record Review of the discharge orders dated 8/20/2025 that listed the psychotropic medications to be continued following discharge from the Behavioral Health Hospital. The list included Risperdal 2mg by mouth twice daily and Risperdal 0.5mg by mouth twice daily and this was not (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included in the current active orders as of 08/26/2025 or on the MAR for the month of August 2025. Record Review of Resident #62's MAR and active orders for August 2025 and this medication was not included. Record Review of the facility's medication reconciliation policy was requested. During an interview on 8/26/2025 at 10:30 AM the DON stated the facility did not have a medication reconciliation policy. A Record Review of the facility's undated Admissions Checklist reflected the admissions nurses was required to complete Drug Regimen Review ASAP/Medication Reconciliation. On 08/26/2025 at 2:43PM, conducted an interview with the admitting nurse, LVN-G, who described the process of medication reconciliation post discharge from an acute care inpatient setting. She reported that she reviewed the DC orders from the hospital and contacted the NP on call to obtain order the medications as recommended in the DC orders. Upon review of Resident #62's order, LVN-G recognized that she had failed to transcribe an order for Risperdal and, therefore, the resident had not received her antipsychotic medication. On 08/28/25 at 1:30PM conducted a phone interview with the Psychiatric Nurse Practitioner. She stated it is unlikely the lack of this medication caused any untoward effects as Risperdal will stay in the system for approximately 6 days after the last dose. She also stated, they do not make a pill for behavior. On 08/28/2025 at 4:00PM conducted an interview with the DON who stated that an outcome from omitting a medication would depend on the type of medication. It could cause an exacerbation of symptoms.		