STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675356	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Bastr	400 Old Austin Hwy Bastrop, TX 78602

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 0760 Level of Harm - Actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents were free of any significant medication errors for 1 of 5 residents (Resident #1) reviewed for significant medication errors. The facility failed to ensure processes were in place for accurate verification and reconciliation of physician orders and medications upon admission. The DON did not enter the complete medication allergy list into Resident #1's electronic medical record and the facility's NP prescribed an antibiotic that Resident # 1 had a known allergy to. This resulted in Resident #1 having an allergic reaction that led to significant rash over her body. Resident #1 was administered the medication Bactrim DS: Oral Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) a total of 12 different times on: 12/24/2025 (1 time), 12/25/2025 (2 times), 12/26/2025 (2 times), 12/27/2025 (2 times), 12/28/2025 (2 times), 12/29/2025 (2 times), and 12/30/2025 (1 time). The physician order was to give 1 tablet by mouth every 12 hours for 10 days from 12/24/2025.The non-compliance was identified as past non-compliance. The deficient practice at the level of actual began on 12/24/2025 and ended on 12/30/2025. The facility had corrected the noncompliance prior to the start of the survey. The facility had implemented corrective actions and returned to compliance before the investigation began.This failure could place residents at risk of health decline, allergic reactions, hospitalization, and death.Review of the facility's Provider Investigation Report, dated 01/08/26, revealed, Resident #1 first admitted to the facility on [DATE]. On 12/24/2025[Resident #1] was noted with redness and warmth to left lower extremity-the same leg as the fracture. Provider notified and orders obtained for Tramadol for pain, and Bactrim DS for cellulitis. On 12/29/25 [Resident#1] was noted with a rash to back of neck and back. Lab order obtained for STAT WBC with differential. On 12/30/2025 approximately 1:00 PM [Resident#1] was noted with worsening of rash with inflamed pruritus (itchy skin) to the arms, thighs, back and stomach. Nurse practitioner informed and antibiotic was discontinued. NP noted in review of hospital records that resident had an allergy to sulfa medications that was not included in medical record.Record review of Resident #1's MDS Assessment, dated 12/29/25, reflected she was an [AGE] year-old female, admitted [DATE] with a BIMS score of 6, which indicated severe cognitive impairment characterized by loss of core information, inability to focus, and difficulty understanding spoken or written instructions. The resident's diagnoses included displaced comminuted fracture of shaft of left tibia (left shinbone where the bone has shattered into multiple pieces), coronary artery disease (main blood vessels that supply your heart struggle to send enough blood, oxygen, and nutrients to heart muscle, hyperlipidemia (too much fat like cholesterol or triglycerides in the blood, which can raise the risk of heart disease and stroke), and unspecified dementia (significant memory and thinking problems that interfere with daily life).Record review of Resident #1's facility's resident evaluation, dated 12/8/2025, uploaded to Resident #1's electronic file 12/23/25 at 3:54 PM reflected allergies: Pennicillin, Sulfa, Clindamycin Azithromycin.Record review of Resident #1's hospital discharge date d 12/23/25 and uploaded to Resident #1's electronic (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 0760 Level of Harm - Actual harm Residents Affected - Some	on 12/30/25 she asked the facility what medication had been administered to her mother and was told Resident #1 had received Bactrim. The RP reported she and her husband researched the medication and learned it contains sulfa. She stated she informed the facility that Resident #1 had a sulfa allergy. The RP stated the facility did not explain why Bactrim was administered despite the allergy and did not apologize. She reported that a nurse administered Benadryl to Resident #1 for the reaction. The RP stated that when she spoke with the DON, she was told the reaction could be generational. She also stated the NP had ordered Bactrim DS which was double strength on top of that. The RP further expressed concern that she felt Resident #1 was medically neglected by the facility.Interview conducted 2/05/2026 at 3:08 PM, LVN C stated on 12/23/2025 that he completed only the second page of the admission checklist. He reported that the DON completed the first page, which included the admitting medication orders and allergy information. LVN C stated he was not familiar with the facility's protocol for entering information into the electronic medical record. He also stated he did not know who was responsible for providing information to the NP. LVN C reported that Resident #1's allergies were listed on the intake the day of her admission. He further stated that the admission process should have been delegated to one nurse. LVN C indicated that the admission process was changed following the incident and that several in-services had been conducted since that time. He stated he no longer worked for the facility as of 1/09/2026. LVN C stated that failure to properly communicate a resident's allergies could result in an allergic reaction, which could negatively impact the resident.Interview conducted 2/05/2026 at 4:42 PM, LVN A stated in a follow-up interview that on 12/29/2025 she had an interaction with Resident #1's daughter. LVN A reported Resident#1 appeared to have raised hives on her skin. According to LVN A, the resident's daughter mentioned that the facility-provided soap had been used the previous day and questioned whether that soap was the cause of the rash. Additionally, LVN A stated she was unaware on 12/29/25 that the resident was allergic to Bactrim. She explained that the allergy was not listed at the time. LVN A reported that the former DON was responsible for electronically entering Resident #1's allergies on the day of admission along with the physician's orders. LVN A stated that the facility has since implemented a new checklist process due to the incident. This process includes a two-step verification in which a second nurse reviews the checklist for accuracy. She also stated that the admitting nurse reviews all orders with the physician or NP. LVN A acknowledged the potential harm to the resident, explaining that an allergic reaction could result in a rash or other delayed reaction. Interview conducted 2/05/2026 at 4:58 PM, NP stated resident's allergies are normally placed in the computer files. NP stated the nurse did not enter Resident #1's Sulfa or Bactrim allergy into the electronic medical record. The NP reported that NPs typically do not review the full resident chart within the first 24 hours of admission. She stated her usual practice was to have labs completed and then visit the resident at the facility. She indicated that all orders and allergies were normally communicated to her by the nurse. NP stated she ordered Bactrim for Resident #1's leg infection. She reported that LVN D initially informed her that Resident #1 had a rash that appeared to be petechiae. Later, she received a call from LVN E who stated the rash appeared more consistent with an adverse reaction. NP stated she then completed a FaceTime assessment with the resident and LVN E. Upon reviewing the hospital records, NP stated she identified that Resident #1 had a documented sulfa allergy. She stated that the following day she spoke with the DON, who responded, Oh crap, I didn't put all the allergies in. The NP emphasized that the facility should have someone double-checking charts as information is entered. According to the NP, she stopped seeing residents at the facility as of 1/16/2026.Interview conducted 2/05/2026 at 5:06 PM, LVN D stated that she and CNA F assisted Resident #1 with a shower on the 12/29/2025 and did not observe (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	any skin issues at that time. She reported that when the resident's daughter visited later, she asked for a nurse to assess Resident #1's skin. LVN D stated that upon assessment, she observed a rash on the lower portion of the resident's back, which appeared to look like petechial in nature to her. She called and notified the NP. She further stated she was unaware at the time that Resident #1 had a Bactrim allergy until after the medication was discontinued, at which time the allergy was added to the medical record later. LVN D stated the hospital discharge paperwork had the resident's allergies listed on them. LVN D explained that if allergy information is not accurately entered into the medical record, potential harm to the resident could occur, such as allergic reactions including severe hives. She acknowledged that serious outcomes, including life-threatening reactions, could result.An interview conducted on 02/05/2026 at 5:41 PM, the ADM stated he has been employed at the facility for 9 months. He stated that the admitting nurse was responsible for entering new resident information upon admission, including obtaining discharge orders and relevant diagnoses for prompt entry into the electronic health record. He stated this task is generally assigned to the nurse designated to that resident's room on the day of admission. When questioned about the incomplete allergy profile for Resident #1, the ADM stated the information was missed and not accurately transcribed. He reported that the admitting nurse was expected to communicate all clinical information to the physician and NP. The ADM acknowledged that the former DON failed to complete the allergy portion of the ADT process. He stated that, ultimately, he holds responsibility for ensuring this process is completed. He reported having extensive discussions with the DON regarding the incident. The Administrator stated his expectation was that nurses thoroughly review all clinical information, accurately enter it into the electronic health record, and communicate all orders to the physician and NP. He indicated the facility has implemented a new protocol in which two nurses will complete the admission checklist, specifically the DON and a designated nurse. The Administrator further stated that failure to enter accurate allergy information could result in an allergic reaction and potential harm to a resident.Record review of facility policy Medication Administration revised 10/01/19 read: PolicyMedications are administered as prescribed in accordance with good nursing principles and practices andonly by persons legally authorized to do so. Personnel authorized to administer medications do so onlyafter they have been properly oriented to the medication management system in the facility. The facilityhas sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.Procedure1. PreparationA. Medications are prepared only by licensed nursing, medical, pharmacy or other personnelauthorized by state laws and regulations to prepare medications.D.??10 Rights of Medication Administration -Whenever you are preparing to give someone medication, it is important to understand the 10 rights of medication administration. Safety should be the first thing on your mind with medications. There is always a risk of giving the wrong pill, the wrong dose, or the wrongdeadly. While there has always been protocol for giving drugs, it is important for everyone to know the safety rules for medication. In the past, you may have heard of the 5 rights of Medication Administration: right patient, right drug, right route, right time, and right dose.Medical practices have changed to include a few more rights.1.??Right Patient - Make sure you are giving the right medication to the right person. Check the name on the order and the patient. Use 2 identifiers. Always ask the patients name, check an ID band, pictures or whatever form of identification is being used and check the medication bottles/cards/tubes to compare before giving a medication.2. Right Medication-Check the medication supply and compare it to the doctor's order to make sure it is the right one.7. Right Education / Reason - Let your patient know what to expect from the medication:side-effects, benefits, and reactions that might happen. The patient has the right to (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Some	knowexactly what they are taking and why. As the nurse, you need to know why- what is the reason this patient is taking this medication. What is the patient's history? Why is he/she taking this medication? Revisit the reasons for long-term medication use.10. Right Evaluation- Make sure you check for drug allergies and interactions between different medications. Doctors and pharmacists don't always catch them and we need to be a third set of eyes.Prior to the surveyor entry on 2/05/2026, the facility took the following steps to abate the actual harm tag:Review of facility in services dated 01/01/2026 revealed all nursing staff were re-educated on:Abuse Neglect and Exploitation prevention and reportingAdverse drug reaction reportingMedication AdministrationOrder transcription and verificationResident Assessment, change in conditionReview of Ad Hoc QAPI meeting held on 1/02/2026 revealed an QAPI meeting was held to discuss the abatement plan and action review.Review of allergy audit was completed on all current residents and Resident #1 with no additional updates required in the EMR.Review of Long-Term Care New admission Orders and Expectations Quiz revealed all staff passed the quiz to verify comprehension of in-services.Review of Medication Pass Competency Assessments revealed all nursing staff that administer medications completed the assessment. Interviews with facility staff on 02/05/2026 revealed they were educated on Residents, Abuse and Neglect, admission process of documentation of allergies and new orders verification system of being verified for accuracy by two nurses.