STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676318	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windmill Village Rehabilitation & Care Center	507 Martin Luther King Blvd Lubbock, TX 79403

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their own established smoking policy for 1 of 3 residents reviewed for smoking. (Resident #1)The facility failed to ensure staff followed the smoking policy and took residents out to smoke in designated smoking area. This failure could place residents at risk of injury or harm.Findings included:Record review of Resident #1's face sheet undated revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), emphysema (lung condition that causes shortness of breath), hypertension (high blood pressure), shortness of breath, anxiety (feeling of fear and worry), and tobacco use.Record review of Resident #1's quarterly MDS assessment dated [DATE], revealed she had a BIMS score of 12, which indicated she had moderate cognitive impairment. The MDS indicated Resident #1 needed supervision or touching assistance for most ADLs. The MDS did not indicate Resident #1 was using tobacco at the time of the assessment.Record review of Resident #1's Care Plan Report revealed she had a problem attempting to smoke and asking others to take her to smoke. Resident #1 had been educated by ADON and DON that this was a nonsmoking facility dated 10/14/25. Interventions included caregivers to provide opportunities for positive interaction, attention, to stop and talk with him/her as passing by, explain all procedures to the resident before starting, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, and remove from situation and take to alternate location as needed. The care plan further revealed observe and report behavior episodes and attempt to determine underlying causes, consider location, time of day, persons involved, and situations and document behavior and potential causes.Record review of Resident #1's Safe Smoking assessment dated [DATE] revealed Resident #1 was determined to be a safe smoker.Record review the facility's provided undated Smoker List revealed two resident names and Resident #1 was not listed. Smoke schedule 0900, 1400, 1900 and smoke area outside of the dining room.During an interview on 10/14/25 at 09:30 am with the ADM, she stated during her investigation of the fire, CNA A admitted to taking Resident #1 out on the patio at the end of Hall 300 to smoke between 12:00 pm and 1:00 pm. She stated Resident #1 was not a smoker and when admitted was told the facility was a nonsmoking facility. She stated the facility had two residents that were still allowed to smoke in the designated smoking area outside the dinner room.An observation on 10/14/25 at 09:33 am of the patio at the end of Hall 300 revealed the door to patio was keypad locked on inside and outside. The gazebo was located at back right side of patio approximately 25ft. from facility door. The patio railing at the back on the right side and the support post are burnt. A flower planter box located on the back right corner was burnt. There was no observation of ash trays, a fire extinguisher, or red trash can.During an interview on 10/14/25 at 09:35 am with LVN B, she stated they occasionally took residents out on the patio to help with their behaviors. She stated the designated smoking area was located by the dining room. She stated they would occasionally take residents out on the patio at the end of Hall 300 to smoke at night because the lighting was better. She stated they always took the cigarette butts to the red can located in the designated smoking area outside of the dining room.During an interview on 10/14/25 at 01:20 pm with the ADM, she stated CNA A took Resident #1 outside to smoke. She stated CNA A was not aware that Resident #1 was not on the list of smokers. She stated the facility had two residents that were allowed to smoke. She stated when she interviewed Resident #1, Resident #1 stated she had put her cigarette out in the planter box on the patio at the end of Hall 300. She stated CNA B was making rounds and seen flames out at the patio. CNA B got the fire extinguisher, put the fire out and 911 was called. She stated the designated smoking area was located outside of the dining room. She stated the smoking area was for resident-use only.During an observation on 10/14/25 at 01:30 pm, the smoking area outside dining room had an ash tray, red can, and fire extinguisher.During an interview on 10/14/25 at 02:13 pm with CNA A, she stated on Tuesday 10/07/25 Resident #1 asked to go outside on the patio to warm up because she was cold. She stated she went back inside to get another resident and when she returned to the patio Resident #1 was down at the gazebo smoking. She stated she did not think anything about it because they occasionally took residents outside on patio to smoke. She stated Resident #1 put the cigarette out in pot inside of planter box and had the top part of cigarette in her hand when she went back inside facility. She stated she was not sure where Resident #1 got the cigarette and lighter. She stated she told the receptionist that Resident #1 went outside and smoked. She stated the receptionist told