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	07/09/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and record reviews, the facility failed to treat residents with respect, dignity, and care in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality for 11 of 11 confidential residents in that: The facility failed to ensure staff were not utilizing their personal cell phones while providing care, which included assisting residents with their showers and performing peri-care. The deficient practice could place residents at risk for diminished quality of life, loss of dignity and self-worth. Findings include:At an undisclosed date and time eleven confidential residents stated the use of cell phones by CNAs while performing care made them feel ignored, not a priority, embarrassed, concerned that the CNA could make a mistake due to distraction by the cell phone conversation, and, most of all, their privacy was violated. The eleven confidential residents stated the use of cell phones by CNAs occurred on every shift. The confidential residents stated staff utilized their cell phones while performing showers, when performing care in resident rooms, and while performing peri-care. The confidential residents stated the staff texted and talked on their phones while walking down hallways, at the nurses' stations, and while in the dining area during meals. The confidential residents stated the phone calls occurred through earpieces. The eleven residents stated they did not know the names of the CNAs who utilized their cell phones while performing care. The confidential residents stated cell phone usage of the CNAs while performing care happened in the facility often, and every CNA in the facility utilized their cell phone while performing care. During an interview on 07/09/26 at 12:25pm, the DON stated residents should be provided with privacy during resident care; the staff should provide residents with their full attention, and HIPAA rules should be followed. She stated all staff were trained in privacy, resident rights, dignity, and cell phone usage during orientation and through continuous education by department heads and the DON. She stated staff were monitored by rounds completed by the DON, ADON, and the ADM. She stated cell phones should never be used in patient care areas; cell phones should only be used in the break room. She stated the potential negative outcome would be residents losing dignity and mistakes could be made the staff member. During an interview on 07/09/2026 at 1:05pm, the ADM stated staff should never be distracted by cell phones while providing care; the residents should receive the attention of the staff performing care. The ADM stated she and the DON were responsible for training staff on resident rights, cell phone usage, and dignity. She stated the staff were trained at least every 90 days on resident rights, cell phone usage, and dignity. She stated cell phones should only be used during breaks; cell phones should be kept in breakroom lockers. Staff were monitored for cell phone use by rounding completed by the ADON, DON, and the ADM. The ADM stated the potential negative outcome for residents, if staff are using their cell phones, was residents could feel embarrassed and they could suffer from a loss of dignity. Record review of the facility policy dated October 2022 titled Resident Rights revealed the following: Policy: Employees shall treat Residents with kindness, respect, and dignity. Policy Interpretation and ImplementationA dignified existence:Privacy and confidentiality;Be free of abuse, neglect, misappropriation of property, and exploitation

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 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 observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: The facility failed to ensure the fryer was free of build up and grime. The facility failed to ensure the toaster was free of build-up and grime. The facility failed to ensure the wall behind the dishwashing station was free of build-up and grime.The facility failed to ensure hot holding pans/cookie sheets were free of build-up and grime.The facility failed to ensure all canned food items had expiration or use-by dates. The facility failed to ensure all pantry food items had expiration or use-by dates. The facility failed to ensure prepared gravy had an expiration or use-by date. The facility failed to ensure prepared pureed chicken had an expiration or use-by date. These failures could place residents who received meals and/or snacks from the kitchen at risk of food contamination and food borne illness.Findings included: During the initial tour and observation of the kitchen on 07/07/2026 at 9:15 AM the following were revealed: The fryer in the kitchen area was observed to be soiled with a thick coating of grease and grime on both sides of the outside of the fryer.The toaster oven was observed to be soiled with a thick layer of grime and grease throughout the machine. The wall behind the dishwashing station contained a yellow layer of grease and grime, and a layer of hardwater stains. Hot holding trays/cookie sheets were observed with a thick layer of black and brown grease build-up, coating the entirety of the pans. 3 cans of tomato soup, 3 cans of chicken noodle soup, and 2 cans of cream of mushroom soup were observed without use-by dates. A container of prepared gravy was observed without an expiration or use-by date. 10 individual containers of prepared pureed chicken were observed in the refrigerator without an expiration or use-by date. During an observation of the kitchen on 07/08/2026 at 10:00 AM revealed the following:The fryer in the kitchen area was observed to be soiled with a thick coating of grease and grime on both sides of the outside of the fryer.The toaster oven was observed to be soiled with a thick layer of grime and grease throughout the machine. The wall behind the dishwashing station contained a yellow layer of grease and grime, and a layer of hardwater stains. Hot holding trays/cookie sheets were observed with a thick layer of black and brown grease build-up, coating the entirety of the pans. 3 cans of tomato soup, 3 cans of chicken noodle soup, and 2 cans of cream of mushroom soup were observed without use-by dates. A box of fig [NAME] bars were observed without use-by dates. A box of individual ritz crackers were observed without use-by dates. During an interview on 07/07/2026 at 11:00 AM, DA A stated all dietary staff were responsible for ensuring the kitchen area was kept clean. DA A stated the dietary staff followed a cleaning schedule to ensure all surface areas were maintained. DA A stated all staff were responsible for putting up food storage in the pantry area. DA A stated they received regular training on food storage and all food items had to be labeled and dated. DA A stated all food stored in the dry pantry was supposed to be labeled with a received date or use-by date. DA A stated all prepared food items were supposed to be labeled with a prepared date or a use-by date. DA A stated it was important for the kitchen to be maintained and clean for the health of the residents. DA A stated it was important to label and date all food items to ensure residents did not get sick from eating expired food. During an interview on 07/09/2026 at 10:40 AM, DA B stated all staff were responsible for putting away food items when they received their inventory. DA B stated she was primarily responsible for the walk-in refrigerator and freezer. DA B stated she was also responsible for labeling and dating food items in the dry storage any time she went into the dry storage and saw something undated. DA B stated they have received numerous trainings on labeling and storage, and all staff were aware all food items should be labeled or dated. DA B stated she was not aware of the unlabeled/undated canned items or snacks in the dry storage. DA B stated she was not aware of the unlabeled container of gravy. DA B stated she was aware of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the unlabeled pureed chicken, and she stated she thought since one item was labeled the other items were considered labeled, although they were wrapped individually. DA B stated she was trained to label/date each food item as it was prepared and stored. DA B stated the dietary manager usually made rounds to double check that everything was labeled and dated. DA B stated the dietary manager was on leave. DA B stated it was important to ensure all food items were labeled and dated to prevent expired food from being served to the residents. DA B stated residents could get sick if they ate old food. DA B stated all dietary staff were responsible for cleaning and maintaining the kitchen area. DA B stated they usually had a cleaning schedule to complete deep cleaning tasks. DA B stated she did not know where the cleaning schedule was. DA B stated the dietary staff tried to deep clean the kitchen area twice a month, depending on how busy they were. DA B stated she was not aware of the grease and grime build up on the hot holding pans/cookie sheets, the toaster oven, the fryer, or the oven. DA B stated she was not aware of the grease and grime build up or hardwater stains on the wall behind the dishwashing station. DA B stated all dietary staff were responsible for deep cleaning equipment in the kitchen. DA B stated it was important to ensure the kitchen was clean and maintained to ensure residents did not get sick. DA B stated if the kitchen were not kept clean residents could get sick, and it was the dietary staff's goal to prevent that from happening. During an interview on 07/09/2026 at 10:55 AM, DA C stated all dietary staff were responsible for labeling and dating food items when they were received and as they were prepared and stored. DA C stated all dietary staff took turns putting up food items as they were received. DA C stated the dietary manager also helped with this task and double checked to ensure all food items were labeled and dated. DA C stated she was not aware of the unlabeled/undated canned foods or unlabeled/undated snacks in the dry storage. DA C stated she was not aware of the unlabeled/undated gravy and pureed chicken. DA C stated she did not know why these items were not labeled or dated. DA C stated staff received regular training on labeling and dating food items and all dietary staff were responsible for ensuring all food items were labeled and dated. DA C stated if food items were not labeled or dated residents could be served expired food, causing them to get sick. DA C stated all staff were responsible for cleaning and maintaining the kitchen. DA C stated the dietary manager assigned deep cleaning tasks regularly, but she did not know where the schedule was. DA C stated she was not aware of the grease and grime build up on the hot holding pans/cookie sheets, the toaster oven, the fryer, or the oven. DA C stated she was not aware of the grease and grime build up or hardwater stains on the wall behind the dishwashing station. DA C stated it was important to ensure the kitchen was clean and maintained to ensure the kitchen was sanitary, and to prevent residents from getting sickDuring an interview on 07/09/2026 at 11:40 AM, the ADM stated the dietary manager was out of the country. The dietary manager was unavailable for interview. The ADM stated all dietary staff were responsible for food storage. The ADM stated all dietary staff received regular training on food storage and they were trained to label and date all prepared and stored food items. The ADM stated she was not aware there were items in the dry storage [NAME] were not labeled or dated. The ADM stated it was her expectation that the dietary staff labeled and dated all prepared and stored food items. The ADM stated if residents were served something out of date, they had the potential to get sick The ADM stated all dietary staff were also responsible for cleaning and maintaining the kitchen area and equipment. The ADM stated it was her expectation that the kitchen area was clean and sanitary. The ADM stated residents could potentially get sick from a build up of bacteria if the kitchen was not maintained. Record review of the facility's policy titled, Sanitation, dated October 2008, revealed the following: Policy Statement:The food service area shall be maintained in a clean and sanitary manner.Policy Interpretation and Implementation:1- All kitchens, kitchen area and dining areas shall be kept clean, free from litter and rubbish and protected f1om rodents, roaches, flies, and other insects.2. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions,, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair.16. Kitchen and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.17. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. Record review of the facility's policy titled, Food Receiving and Storage, dated October 2017, revealed the following: Policy Statement:Foods shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation:l. Food Services, or other designated staff, will maintain clean food storage areas at all times.6. Dry foods that are stored in bins will be removed from original packaging, labeled, and dated (use by date). Such foods will be rotated using a first in - first out system.7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that its medication error rate was less than 5 percent. The facility had a medication error rate of 15.38 percent based on 4 errors out of 26 opportunities, which involved 2 (Resident #107 and Resident #45) of 3 residents reviewed for medication administration.-MA A failed to give Resident #107's dose of the medication Metoprolol Tartrate at the ordered time, resulting in a late dose. -MA A failed to give Resident #45's dose of the medication Levetiracetam at the ordered time, resulting in a late dose. -MA A failed to give Resident #45's medication Lisinopril according to physician's orders when she administered the medication outside the ordered vital sign parameters. -MA A failed to verify the correct dosage for Resident #45's medication Pantoprazole prior to administering the medication, resulting in Resident #45 being underdosed. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and a decline in health.Findings included: Resident #107Record review of Resident #107's admission Record dated 07/07/2026 revealed a [AGE] year-old female with an original admission date of 08/14/2025. Resident #107 had diagnoses which included: metabolic encephalopathy (brain dysfunction caused by an underlying systemic illness), cognitive communication deficit (difficulty with communication caused by disrupted thinking skills), and hypertension (high blood pressure). Record review of Resident #107's Quarterly MDS assessment, dated 04/07/2026, revealed a BIMS score of 10 indicating the resident had moderate cognitive impairment. Record review of Resident #107's current physician's orders, dated 07/08/2026, revealed an order with a start date of 06/02/2026 for Metoprolol Tartrate oral tablet 12.5 mg. Give one tablet by mouth two times a day for hypertension. Record review of Resident #107's July 2026 MAR revealed Metoprolol Tartrate oral tablet 12.5 mg was ordered to be administered at 8:00 AM. During a medication administration observation on 07/08/2026 at 9:35 AM for Resident #107, MA A dispensed one Metoprolol 12.5 mg tablet and administered the medication to Resident #107. Resident #45Record review of Resident #45's admission Record dated 07/07/2026 revealed a [AGE] year-old female with an admission date of 03/04/2025. Resident #45 had diagnoses which included: unspecified convulsions (sudden, uncontrollable, involuntary shaking), cerebral infarction (stroke), Gastro-esophageal reflux disease (a digestive disorder that occurs when stomach acid repeatedly flows back up into the esophagus, causing irritation), and hypertension (high blood pressure). Record review of Resident #45's Annual MDS assessment, dated 02/24/2026, revealed a BIMS score of 12 indicating the resident had moderate cognitive impairment. Record review of Resident #45's current physician's orders, dated 07/08/2026, revealed the following orders:-Levetiracetam Oral Tablet 500 mg. Give 500 mg by mouth two times a day for seizure activity related to unspecific convulsions. -Lisinopril Oral Tablet 10 mg. Give 10 mg by mouth one time a day related to hypertension. Hold if blood pressure is less than 100/60 or if heart rate is less than 55. -Pantoprazole Sodium Oral Tablet Delayed Release. Give 30 mg by mouth one time a day related to Gastro-esophageal reflux disease. Record review of Resident #45's July 2026 MAR revealed Levetiracetam oral tablet 500 mg was ordered to be administered at 8:00 AM During a medication administration observation on 07/08/2026 at 9:49 AM for Resident #45, MA A dispensed one Levetiracetam 500 mg tablet, one Lisinopril 10 mg tablet, and one Pantoprazole 20 mg tablet into a dispensing cup and took the cup into Resident #45's room. MA A placed a wrist blood pressure cuff on the right wrist of Resident #45 and obtained the following vital sign readings: blood pressure 99/72; pulse 69. MA A administered the medications from the dispensing cup to Resident #45 and exited the room. During an interview on 07/08/26 at 12:23 PM, MA A stated it was the responsibly of the MAs and nurses to ensure medications were given on time, and at the correct dosage, according to physician's orders. MA A stated she was trained on accurate medication administration during her MA training and through ongoing training at the facility. She stated the pharmacy consultant conducted medication pass observations during the onsite visits. MA (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A reopened her MAR and reviewed the medications for Resident #107 and Resident #45. She stated she administered Resident #107's 8:00 AM dose of Metoprolol and Resident #45's 8:00 AM dose of Levetiracetam late due to running behind on medication pass and having to look for the correct dosage of a medication in the medication room. MA A stated medication could be given one hour before and up to one hour after the ordered time of administration. MA A stated she gave Resident #45's Lisinopril medication outside the ordered parameters for blood pressure. She stated she should have held the medication, based on the resident's blood pressure reading. MA A stated she usually double checked any parameters before administering a medication, but she got in a hurry and was nervous and failed to check it again prior to administering the medication. MA A stated she administered the incorrect dose of Resident #45's Pantoprazole medication when she gave a 20 mg dose instead of the ordered 30 mg dose. She stated the dosage must have recently changed and she failed to compare the dose on the card with the dose on the MAR. MA A stated the protocol when a medication error was made was to report the error to the charge nurse or DON so the doctor could be notified of the error. MA A stated a potential negative outcome for failure to administer medications according to physician's orders was that a resident could die. During an interview on 07/09/2026 at 12:57 PM, the DON stated she was made aware by staff of medication errors made during the medication pass observation on 07/08/2026. She stated all staff were trained on accurate medication administration upon hire and through ongoing facility training. The DON stated the facility utilized rounds and competency checks for training and monitoring of accurate medication administration. She stated nursing administration was responsible for ensuring accurate and timely medication administration. She stated the pharmacy consultant conducted monthly competency checks for medication administration. She stated medication errors were reported to the provider and noted in the health record. The DON stated the provider was notified of the errors made during the medication pass observation on 07/08/2026 and a dosage order was verified and updated in the health record. The DON stated Resident #107 and Resident #45 were monitored following the medication errors without any adverse events. The DON stated a potential negative outcome for failure to follow physician's orders during medication administration was that a resident could become sick or have an adverse reaction to a medication. During an interview on 07/09/2026 at 1:13 PM, the ADM stated she was made aware by the DON of medication errors made during the medication pass observation on 07/08/2026. She stated nursing administration was responsible to ensure staff were administering medications accurately and according to physician's orders. The ADM stated all nursing staff and MAs were trained on accurate medication administration upon hire and through ongoing facility training. The ADM stated the system for monitoring the accuracy of medication administration was through monthly competency checks by the pharmacy consultant and through reports generated by the electronic medical record regarding timeliness of medication administration. She stated her expectation of staff for medication administration was that orders were followed and medications were given according to ordered timeframes. The ADM stated a potential negative outcome for failure to administer medications according to physician's orders was medication errors and missed doses. During a telephone interview on 07/10/2026 at 1:27 PM, the Medical Director stated his expectation for ordered medication was that the medication was given within one hour prior to or one hour following the scheduled administration time. He stated he was made aware of medication errors made during the medication pass observation and orders were verified by facility staff. He stated a potential negative outcome for failure to administer medications according to physician's orders would depend on the medication, but it was important to follow the orders for timing and accuracy of all medications. Record review of the facility policy titled Administering Oral Medications Level III (revised October 2010) revealed: PurposeThe purpose of this procedure is to provide guidelines for the safe administration of oral medications. Steps in the Procedure .6. Check the label on the medication and confirm the medication name and dose with the MAR.8. Check the medication dose. Re-check to confirm the proper dose. 9. Prepare the correct dose of medication.13. Perform any pre-administration assessments.