STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676371	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Quail Valley Post-Acute Healthcare	3640 Hampton Dr Missouri City, TX 77459

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Quail Valley Post-Acute Healthcare	3640 Hampton Dr Missouri City, TX 77459

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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 0755 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 provide pharmaceutical services including procedures to accurately administer medications to meet the needs of each resident 1 (Resident #1) of 6 reviewed for pharmacy services. -RN A instructed CNA B to administer Resident #1's medication Eliquis. This failure placed residents at risk for medication errors. Findings: Record review of Resident #1's face sheet dated 12/02/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted again on 09/08/25. Resident #1's diagnoses included the following: chronic kidney failure, colostomy (surgical procedure that creates a new way for waste to exit the body into a bag), sepsis (infection), type 2 diabetes mellitus (when the body does not utilize sugar efficiently in the body for energy), abnormalities of gait and mobility, and rhabdomyolysis (condition where damaged muscle tissue breaks down, releasing harmful proteins and electrolytes {tiny particles in the body that carry electrical charges to aide in keeping the muscles working, nerves sending signals, and keeping the body hydrated} into the blood stream that could lead to heart problems, kidney failure, seizures or death}). Record review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 13 indicating that resident cognition was intact. Record review of Resident #1's Comprehensive Care Plan dated 10/27/25 reflected that Resident #1 was care planned for anticoagulant (medicine that helps prevent blood clots) therapy Eliquis. An intervention included administering anticoagulant medication as ordered by the physician and monitor for side effects and effectiveness Q shift. Record review of Resident #1's Physician Order Summary for the month of December 2025 included the following order: -Dated 11/10/25 Eliquis oral tablet give 1 tablet by mouth two times a day to prevent blood clot for 60 days. Record review of Resident #1's MAR for the month of November and December 2025 reflected that Resident #1 was receiving the medication Eliquis 5mg by mouth two time a day for the prevention of clots at 9:00AM and 5:00PM. Observation on 12/02/25 at 1:44PM revealed Resident #1 resting in bed on an air mattress with the call light in reach watching TV.[BR1] Interview on 12/02/25 at 1:50PM with Resident #1 said he was receiving the medication Eliquis. Resident #1 said one time RN A gave the medication Eliquis to a CNA to administer him on the evening shift. Resident #1 said he could not remember the CNA's name or the day that had happened. Interview on 12/02/25 at 3:56PM with RN A said he worked the evening shift full time on the 2:00PM-10PM shift. RN A said he had been working at the facility for 2 years. RN A said he had taken care of Resident #1 in the past but not at the present time. RN A said approximately 2 days ago or so he was preparing to administer Resident #1's evening medication Eliquis. Resident #1 told him that he did not want him to come in his room. RN A said he had already pulled the medication Eliquis. RN A said at the time, CNA B was entering Resident #1's room with his dinner tray. RN A said he told CNA B to just give the medication to Resident #1. RN A said he did not want to waste the medication and therefore gave the medication to CNA B to administer to Resident #1 while he stood at the doorway and watched. CNA B said he knew that CNAs were not supposed to administer medications due to a safety issue. RN A said he just wanted to make sure that Resident #1 received his medication. RN A said he should have called the DON, and he could have also called another nurse to administer the medication. The DON was asked for the facility policy on medication administration and CNAs scope of practice as well as CNA's B training. Interview on 12/02/25 at 4:30PM with the DON said RN A should have called another nurse to administer the medication to Resident #1 or just discard the medication. The DON said RN A could have had the medication aide to administer the medication while he observed at the doorway. The DON said CNAs could not administer medications. The DON said that would place the resident(s) at risk for medication error. The DON said she was never told about the incident. Interview on 12/02/25 at 4:45PM with CNA B said he worked at the facility full time on the 2:00PM-10PM shift. CNA B said he had been working at the facility for a little over month. CNA B said he had been a CNA since February of 2025. CNA B said he should not have administered the medication because he was not certified to administer medications. CNA B said he administered the medication because RN A instructed him to do so. CNA B said that occurred about 2 or 3 days ago but could not remember the exact day. CNA B said RN A was standing in the doorway watching. CNA B said by him administering the medication, he did not know what it placed Resident #1 at risk for. Record review of facility Job duties/ Primary Responsibilities/Essential Functions for CNA, not dated, reflected in part: . Assist resident in customary daily requirements and tasks in care and treatment such as bathing, feeding, dressing, observing intake of food, care of hair, nails, moving residents from area to area