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	06/05/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that Resident#1 received treatment and care in accordance with professional standards of practice and the residents' choices for 1 of 10 residents (Resident# 1) reviewed for quality of care. The facility failed to provide necessary care and services to maintain the highest practicable physical well-being for Resident #1, who was totally dependent on staff for all ADL's, failing to provide adequate bathing, hygiene, and skin care services. This failure placed residents at risk for development of infection, pain, impaired skin integrity, and a decreased quality of care, resulting in actual harm and the potential for further physical decline.Findings included:Record review of Resident #1 undated face sheet revealed an [AGE] year-old female who was admitted to the facility initially on 3.16.22 and re-admitted on 5.13.26 with diagnosis of Non-Alzheimer's Dementia (declined in cognitive abilities), and Epilepsy (recurrent, unprovoked seizures).Record review of Resident #1's MDS assessment dated [DATE], Section GG-Functional Abilities revealed Resident #1 was totally dependent on staff for all ADL's (Self-Care), including bathing, dressing, toileting, grooming, eating, and other self-care needs.Observation and Record Review of Resident #1's Bathing task dated 5.9.29 revealed Resident #1 refused her shower/bed bath and did not receive a bath.Record review of EMS Run Report dated 5.9.2026, revealed, injury began at 2030 (8:30pm) and EMS dispatched notified at 2234 (10:34pm) and arrived at the facility 2239 (10:39pm) and contact with Resident #1 at 2242 (10:42pm).Record review of admission to Hospital report by ER Nurse noted, May 9 at 11:38 PM, patient sent from nursing home with no report or paperwork. Per EMS, symptoms began in 2030 (8:30 PM). The patient was not received until 11:30 PM. Patient had dried feces and possible yeast in her groin, wounds with no dressings. Pt G-tube dressing covered and dried brown substance with new dressing placed on top of dirty dressing. Pt caregiver notified. The admission diagnosis was Aphasia [impaired ability to comprehend or speak]. Facial droop, stroke-like symptoms].Record review of Resident#1's care plan revealed Resident#1 was totally dependent on staff for meeting emotional, intellectual, physical, and social needs (date initiated and revised 8.10.22). Resident #1 required tube feeding r/t poor intake (dated initiated 4.10.26 and revised 4.23.26). Resident #1 had cellulitis of the peg site (skin infection), antibiotic therapy augmentin and doxycycline (antibiotics) started (date initiated and revised 5.14.26). Resident #1's May 2026 care plan revealed nursing staff were to monitor/document/report PRN any signs/symptoms of: Aspiration-fever, SOB, Tube dislodged, infection at the tube site, self-extubation, Tube dysfunction, or malfunction, abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration (Date Initiated: 4.29.2022); Provide local care to G-Tube site as ordered and monitor for signs/symptoms of infection (Date Initiated:4.29.22 Revision 4.29.26); Record Review of May Care plan dated 5.13.26 revealed additional care areas that were not present prior to Resident#1's hospitalization on 5.9.26:Problem: Resident #1 has cellulitis or the peg site, antibiotic therapy Augmentin and Doxycycline started. Date Initiated 5.14.26 and revision on 5.14.26; Goal: Resident #1 will have no complications resulting from the cellulitis through the review date. Date initiated 5.14.26. Target Date: 7/16/26; Interventions: Give antibiotics for infection and mild analgesics to relieve discomfort as (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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	prescribed by Physician. Monitor/document side effects and effectiveness. Date Initiated: 05/14/2026; Identify and document risk factors; peripheral arterial disease, chronic use of steroids, weakened immune system, chickenpox, shingles, or chronic edema. Date Initiated: 05/14/2026; Monitor /document healing of the cellulitis. Any new or worsening symptoms sho1 be reported to MD. Date Initiated: 05/14/2026; Monitor/document and report to MD the following symptoms of Cellulitis: Red, Swollen, Tender Skin, May be accompanied by a fever, Reddened area begins to spread, Small red spots that appear on the reddened skin, Small blisters which mc= form and burst, Swollen lymph glands. Date Initiated: 05/14/2026; Monitor/document/report to MD any side effects of the antibiotics and over-the-counter pain medications: gastric distress, rash, or allergic reactions. Date Initiated: 05/14/2026; Weekly treatment documentation to include measurement of each area of skin cellulitis width, length, colour and exudate and any other notable changes or observations. Date Initiated: 05/14/2026Record review of Resident #1's May Orders dated 5.13.26, revealed the following: Tube Feeding-Change piston, syringe, and feeding set every night shift (Start Date-5/15/26 10:00pm); Doxycycline Hyclate Oral Capsule 100 MG Give 1 capsule by mouth two times a day for skin infection for 5 Days (Start date-5/14/26 8:00am-D/C Date-5/15/26 12:17pm); Doxycycline Hyclate Oral Capsule 100 MG Give 1 capsule via PEG-Tube tow times a day for cellulitis for 5 days (start date-5/16/26 6:00pm); Enteral Feed Order every shift Complete tube site care (Start date-4/10/26 10:00pm-D/C 5/10/26 11:53pm); Enteral Feed Order every shift Prior to use check placement of g-tube by observing change in external length or marking on the tube at the exit site to determine if tube has migrated AND observe for increase of volume of aspirate of gastric contents. Notify physician of change (start date-4/11/26 6:00am-D/C Date 5/10/26 11:53); Enteral Feed Order every 4 hours Flush tube with water via stationary pump at 180ml (6x/day) (start date-4/11/26 1200am-D/C date-5/10/26 11:53pm); Enteral Feed Order every 4 hours Flush tube with water via stationary pump at 180ml (6x/day) (start date-5/14/26 1200am-D/C date-5/18/26 10:35am); Enteral Feed Order as needed Complete tube site care q shift (Start date-5/15/26 10:00am); Enteral Feed Order as needed Prior to use check placement of g-tube by observing change in external length or marking on the tube at the exit site to determine if tube has migrated AND observe for increase of volume of aspirate of gastric contents. Notify physician of change_PRN (Start date-4/11/26 6:00am-D/C date-5/10/26 11:53pm). An interview with CNA B on 6/4/26 at 3:17 pm revealed that when a resident refused a shower, the CNA must notify the nurse, and it must always be documented. She stated, if residents changed their mind, then arrangements were made to complete shower the same day. CNA B stated no matter the response of resident, documentation will not be done until either a resident takes a shower/bed bath or refused the ADL task. On 6.4.26 at 5:29pm in an interview with CNA A, stated she was familiar with Resident #1. CNA A stated she gave Resident #1 a bed bath on the evening of 5/9/26 after dinner. She stated she gave her a bed bath between 7pm-7:30pm. CNA A stated Resident#1 was nice and allowed her to give her a bed bath on 5.9.26. CNA A stated during the bed bath she washes around the G-tube area. She stated the nurses would usually clean that area and around the area during night shift. The CNA A stated Resident #1 was pleasant and did not refuse on this date. She stated during the bed bath she observed Resident#1's bandage to be clean. She stated if the bandage had been dirty, she would have informed the nurse in charge. She stated she did not notice any drainage around the bandages. CNA A was asked why she marked the task that Resident #1 had refused her bath on that day and she responded, well I must've asked her earlier and she refused so I probably came back later and Resident #1 allowed me to give her a bed bath.On 6.5.26 at 3:36pm Interviewed with WCN who stated the brown substance around the tube could have been the tube was not inserted properly or an infection was in that area. She stated if that was happening the physician should have been notified immediately. WCN stated she had not received any notification of infection in that area, but it could take 24 hours to start showing. WCN stated if the area had been cleaned nightly, it could have been caught. The infection could have resulted in serious injury if left long enough without being cleaned. WCN stated there should never have been a new dressing placed (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	on top of a dirty one. On 6.14.26 at 4:40pm a Text message was received from EC#2 who stated on 5.10.26 she was informed that Resident #1 had been transferred to the hospital ICU and that hospital staff were requesting someone who was familiar Resident #1 was needed. Upon her arrival, EC#2 stated she was informed by ER staff, and she observed Resident #1's body temperature was significantly below the recommended range as she was shivering and trembling and appeared unable to focus or communicate coherently. The only information she repeatedly provided to hospital staff was her name and date of birth . EC#2 stated the ER Nurse discussed Resident #1's condition and stated that, in his (ER Nurse) professional opinion, Resident #1should not have deteriorated to that state within such a short period of time. EC #2 state ER Nurse also told her that Resident #1 was dirty, had dried feces on her body, and exhibited other signs that raised concerns about possible neglect. She stated due to Resident #1's condition, she was being evaluated and monitored as a potential stroke patient.Record review of ADL policies:3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.