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	05/14/2026

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

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review program (PASARR) to the maximum extent practicable to avoid duplicative testing and effort for 1 of 1 (Resident #2) reviewed for PASARR. The facility failed to ensure Resident #2 who had a diagnosis of mental illness, received a positive PASARR Level I and PASARR Level II screening. This failure could place residents at risk of not receiving needed care and services, causing a possible decline in mental health. Findings include: Record review of Resident #2's face sheet reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnosis included depression (serious mood disorder that causes persistent sadness, and loss of interest in activities), mood disorder due to known physiological condition with mixed features (symptoms of depression and mania or hypomania), memory deficit following cerebral infarction other symptoms and signs involving cognitive functions following cerebral infarction (difficulty maintaining, creating and recalling memories), paranoid schizophrenia (delusions, and hallucinations), other impulse disorders (repeated inability to resist intense urges or impulses that may harm oneself or others), and drug induced secondary parkinsonism (reversible condition where medications cause Parkinson's-like symptoms by blocking dopamine receptors in the brain). Record review of Resident #2's Quarterly MDS dated [DATE], reflected resident had readmitted from an inpatient psychiatric facility. The resident had a BIMS score of 04 reflecting the resident had sever cognitive impairment. Resident #2's diagnoses were listed as depression, bipolar disorder, and schizophrenia, drug induced secondary parkinsonism, impulsive disorder, and insomnia. Record review of Resident #2's care plan undated, reflected the following: The resident was physically aggressive; he was kicking at staff r/t poor impulse control. The resident had a behavior of screaming outburst and swinging at staff, date initiated on 09/17/2025 and revised on 01/09/2026. The resident had impaired cognitive function or impaired thought processes r/t neurological symptoms (CVA) date initiated on 08/27/2025 and revised on 09/16/2025. The resident had used antidepressant medication Trazodone r/t depression and insomnia, date initiated on 09/16/2025 and revised on 05/12/2026. The resident had used psychotropic medications Risperdal r/t behavior management, date initiated on 02/21/2026 and revised on 02/21/2026. The resident had mood problems r/t depression and mood disorder, date Initiated: 09/16/2025 Revision on: 09/16/2025. Record review of Resident #2's PASARR Level I dated 02/26/2025 reflected the resident had a dx of MI only. Record review of Resident #2's PASARR Level I dated 08/26/2025 reflected the resident had a dx of MI only. Record review of Resident #2's Change of Condition Communication dated 02/24/2026 at 10:47 a.m., reflected, s/sx were reported of resident having a behavior of throwing personal foods and personal items throughout the room creating a safety hazard for roommate and self. The resident was allowed to express his feelings, and medication was increased to help the behavior. These conditions, symptoms, or signs had occurred before. Treatment for last episode required changes to medication changes and an inpatient psych stay. Record review of Resident #2's progress note dated 02/26/2026 at 09:31 p.m., reflected MD attempted to have a (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussion with resident related to his behavior of throwing personal items, the resident declined. During an interview on 05/13/2026 at 02:12 p.m., the MDS Nurse stated Resident #2 had an inpatient stay at a psychiatric hospital from [DATE] to /202/2026 due his schizophrenia diagnosis. She stated that inpatient stay should have qualified the resident for PASARR services. She stated she was unaware what disqualified him from services and had not questioned the PASARR evaluated. She stated that she receives the evaluation results and adds the information to Resident #2's clinicals. During an interview on 05/13/2026 at 04:03 p.m., the PASARR Evaluator stated Resident #2 had been admitted to the facility in 2025 with a MI diagnosis of schizophrenia. She stated on 01/27/2026 to 02/20/2026 the resident had an inpatient stay with a psychiatric hospital. She stated that inpatient stay initiated the need for a new PASARR Level I evaluation. She stated on 03/25/2026 she completed the resident's latest PASARR Level I evaluation. She stated during the completion, she missed keyed that the resident had not had an inpatient stay at a psychiatric hospital which resulted in the resident having a negative PASARR Level I and not making him eligible for additional MI services. She stated on this date, MDS Nurse called questioning how the resident had become negative, when she found her error. She stated on 05/14/2026, she would have revaluated the resident, and he would have been found positive. She stated once the evaluation was submitted to the facility and an IDT meeting was scheduled with the resident, resident's RP, MDS Nurse, SW, MD, and DON to discuss what additional MI services could be provided and accepted by the resident and generate the PASARR Level II evaluation. She stated she was apologetically regretful for the error that was completely her fault. During an interview on 05/13/2026 at 04:13 p.m., the MDS Nurse stated she had worked for the facility for 3 years and had been an MDS Nurse for 15 years. She stated during that time as an MDS Nurse it had been her understanding that residents who had MI diagnosis and a psychiatric inpatient stay received a positive PASARR Level I evaluation and were eligible for PASARR Level II services. She stated the resident admitted with an MI diagnosis. She stated on 01/27/2026 to 02/20/2026, the resident had an inpatient stay with a psychiatric hospital and prompted a new PASARR Level I evaluation that was performed by the PASARR Evaluator on 03/25/2026. She stated Resident #2's results were received on 04/01/2026. She stated when she received results, she looked to see if positive or negative results were received and went with whatever the evaluator's decision concluded because the PASARR Evaluator was responsible for the evaluation. During an interview on 05/13/2026 at 04:31 p.m., with the ADM and DON, the DON stated that it was the PASARR Evaluator's responsibility to perform and determine when a resident was PASARR positive or negative. She stated the importance of a PASARR evaluation was to determine if residents qualify for additional services designed or their MI diagnosis. The DON stated that Resident #2 had received multiple psychiatric service visits, psychiatric medication monitoring to include GDR since admittance to the facility. The DON stated the MDS Nurse was responsible for ensuring resident's PASARR evaluations were scheduled, received, and the specialized services offered to the PASARR positive residents. The DON stated the resident's behaviors had improved since his inpatient psychiatric stay. The DON stated the facility used the RAI manual for PASARR policy and procedure guidance.

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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	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Residents #21) and 1 of 3 (CMA Q) staff observed during medication administration. The facility failed to ensure staff clarified the order for Resident #21's Miralax prior to administering the medication on 05/13/2026. The failure could place residents at risk of not receiving the intended therapeutic benefit. Findings included: Record review of Resident #21's undated admission record revealed a [AGE] year-old female with an admission date of 05/31/2024. Resident #21 diagnoses included dysphagia (trouble swallowing), gastro-esophageal reflux disease (a chronic digestive condition where stomach acid or bile repeatedly flows back into the food pipe, irritating its lining), muscle wasting, and cerebral infarction (blockage in blood vessels supplying the brain, resulting in tissue death). Record review of Resident #21's annual MDS dated [DATE] revealed a BIMS (a score is interpreted by assessing cognitive function, ranging from 0 to 15, with higher scores indicating better cognition. A score of 13-15 suggests intact cognition, 8-12 indicates moderate impairment, and 0-7 indicates severe impairment) score of 14 meaning the resident was cognitively intact. The resident often required assistance with toileting hygiene. Record review of Resident #21's Care Plan initiated on 05/13/2024 and last revised on 04/28/2026 read, resident had constipation r/t decreased mobility. The intervention read, give Miralax (a powder used to relieve constipation) as ordered. Record review of Resident #21's Physician Orders, dated 02/28/2025, revealed an active order of polyethylene glycol 3350 (the generic name for Miralax) oral (by mouth) powder 17 gm/scoop. Give 1 scoop by mouth daily for constipation. The order did not specify how much fluid to mix the powder with. During observation on 05/13/2026 at 8:55 a.m., CMA Q poured and mixed polyethylene glycol powder with an unmeasured amount of water and gave it to Resident #21. In an interview on 05/13/2026 at 9:00 a.m., CMA Q stated she should have held Resident #21's medication administration and contacted the provider for clarification on the polyethylene order. CMA Q stated she checked orders for instructions on how to administer medications. She stated she did not follow the proper procedure this time. CMA Q stated the order was incomplete and that could cause Resident #21 to receive a medication that was ineffective. CMA Q stated she received training on medication administration last month. In an interview on 05/13/2026 at 9:30 a.m., the DON stated he expected CMA Q to call the provider to request medication verifications on all incomplete orders when those orders missed instructions on how to administer them. She stated CMAs should have sought clarification about the amount of fluid required to mix the powder with before each administration. The DON stated the amount of fluids should have been 4-8 oz., she stated using the wrong amount of fluids to mix the powder could prevent the medication from working as prescribed and could cause fluid overload for residents with fluid restrictions. The DON stated the ADON performed reviews on residents' medication orders two times daily. The DON stated CMA Q last received in-service training on medication administration in December of last year. In an interview on 05/13/2026 at 9:45 a.m., the ADON stated using the wrong amount of water to mix the powder could prevent the medication from working as it was supposed to and could cause fluid overload for residents with fluid restrictions. The ADON stated she performed reviews on residents' medication orders two times daily and spot checked as well. She stated the incomplete Miralax order must have been missed during the review. In an interview on 05/13/2026 at 10:02 a.m., the MD stated polyethylene glycol orders should have included between 4 and 8 oz. of fluids to mix the powder with. The MD stated, ideally, the prescribing provider; who was not available to interview; should have included the amount of fluid required to mix the powder with. The MD stated he expected nurses and CMAs to contact the provider for clarification about medication orders when (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	those orders missed instructions on how to use them. He stated mixing the MiraLAX powder with fluids without specifying the amount could not cause harm if residents required fluid restrictions. Record review of Miralax manufacturer's recommendations dated 2026, revealed, .Take 17 gram of powder once a day. Use the Miralax bottle top to measure 17gram by filling to the indicated line (white section in cap). Mix and dissolve into 4-8 ounces of any beverage (hot, cold or room temperature). Record review of the facility's Medication Administration Policy dated 10/24/2022, revealed, .14. Administer medications as ordered in accordance with manufacturer specifications.a. provide appropriate amount of fluids or food. Record review of the facility's Prescriber Medication Orders Policy dated 10/01/2019, revealed, Policy: medications are administered only upon the clear complete and signed order of a person lawfully authorized to prescribe. Record review of In-service training titled The 10 Rights of Medication Administration dated 12/03/2025, revealed, RNs, LVNs and CMAs received the training.The training included. Clarify unclear or questionable orders .The list of staff names who received the training included CMA Q.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews and record reviews the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 (WCN) staff observed for infection control practices. The facility failed to ensure WCN followed proper infection control procedures after she completed a wound care procedure on 05/14/2026. The failure could place residents and staff at risk of infections. Findings included:During an observation on 05/14/2026 at 9:12 a.m., the WCN completed wound care, and while she still had her yellow gown on, and held a trash bag that contained the soiled supplies and dressings. The WCN left the room and went to the treatment cart, she logged in to her computer that was on top of the cart, opened the treatment cart using the cart key, and grabbed a red trash bag (used to dispose trash from isolation rooms) out of the treatment cart and disposed the regular trash bag inside the red trash bag and placed it on the floor. The yellow gown and the regular trash bag both rubbed against the treatment cart . The resident's room had signage of EBP (an infection-control measure used in nursing homes and skilled nursing facilities to prevent the spread of multidrug-resistant organisms) posted outside. In an interview on 05/14/2026 at 9:24 a.m., the WCN stated she should have made sure she had the red trash bag that was ready to use, before she started the wound care for the resident. She stated she should have disposed of the trash bag while her gloves were still on, and then took her gloves off, the yellow gown, performed hand hygiene, and then proceeded to perform any other activities she needed to do, afterward. She stated she received training on EBP and PPE use recently. She stated she had been working as the facility's WCN since 2024. She stated not following the proper procedures for taking off PPE and not performing hand hygiene could put residents at risk of infections. In an interview on 05/14/2026 at 9:30 a.m., the facility's ICPN stated she expected the WCN to ensure she completed wound care and did not engage in any other activity until she took off her PPE, performed hand hygiene, and made sure trash was disposed properly. She stated not following the proper infection control protocols could put residents and staff at risk of infection. The ICPN stated she completed random infection control audits to ensure proper infection control practices in the facility. The audit included PPE use and hand washing. The ICPN stated the WCN received in-service training on infection control recently. In an interview on 05/14/2026 at 9:36 a.m., the DON stated she expected the WCN to follow the proper infection control procedures in taking off PPE and performing hand hygiene. The DON stated not following the proper infection control procedures could put residents and staff at risk of infections. The DON stated the WCN received in-service training on infection control in May of this year. The DON stated she performed random audits on infection control practices to ensure staff followed those practices. The audit contained PPE use and hand hygiene. Record review of the facility's Enhanced Barrier Precautions Policy dated 11/24/2025, revealed .Definitions: Enhance Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .Initiation of Enhanced Barrier Precautions: .b. An order for Enhanced Barrier Precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers.3. Implementation of Enhanced Barrier Precautions:.b. Personal Protective Equipment (gown and gloves) for Enhanced Barrier Precautions are only necessary when performing high contact care activities.d. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room .4. High contact resident care activities include:.h. Wound care. Record review of the facility's In-service named Infection Control-Hand Washing-PPE dated 05/08/2026, revealed staff received training on the following: 1. Handwashing must be performed before and after each procedure.2. Handwashing is performed prior to taking care of a resident3. Wash hands prior to donning PPE4. Wash hands after doffing PPE5. Wash hands at (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	least 20 seconds6. PPE must be donned prior to going into isolation/EBP rooms7. All PPE must be doffed prior to leaving isolation/EBP rooms.The list of staff names who received the training included the Wound Care Nurse.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to dispose of garbage and refused properly for trash bins A and B reviewed for garbage disposal. - The facility failed to ensure the dumpster doors were secured on trash bin. - The facility failed to ensure trash bags were off the ground and in dumpster trash bins. This failure could place residents at risk of infections, pests and rodents from improperly disposed garbage.Findings included: Observation on 05/12/2026 at 07:46 a.m., multiple trash bags were observed on the ground in front of the 2 dumpster trash bins located outside of the facility. One of 2 doors open were left open. During an interview on 05/12/2026 at 01:08 p.m., the Regional Director of dietary services stated the trash was normally not left in that condition. She stated it may have been a new staff member who left the trash bags in front of the bins. She stated the kitchen staff were aware that trash bags should not be left outside of the trash bins, however multiple departments utilized garbage disposal bins. She stated it was important to keep the trash bin lids closed to ensure trash was not left on the ground. She stated that leaving trash on the ground and trash bin lids open may attract pests and contribute to infection control risks due to soiled briefs and linen. She stated she is going to re-educate staff and conduct in-service to prevent this from happening again. During an interview on 05/14/2026 at 09:13 a.m., the Housekeeping Supervisor stated the housekeepers staff moved trash from residents' rooms, the nurse's station, and the main bathrooms each shift. She stated housekeeping staff do not remove briefs, chuck pads, PPE, or wipes. As nursing staff are responsible for disposing of those items. She stated the risks for trash being left on the ground include infection control concerns and attracting rodents, dogs, and cats. She stated animals could potentially tear into and spread the trash. She stated an in-service training was conducted with all staff on 05/12/2026 to ensure the issue does not re-occur. During an interview on 05/14/2026 at 11:33 am., the DON stated, she observed the trash on the ground while driving into the facility on this date and immediately texted the maintenance staff to have the trash removed. She stated it was her expectation that trash was to be taken out every shift. She stated the trash bin lids were to remain closed at all times and not to be left on the ground. She stated open trash bins could encourage pests and create an infection control concern if visitors and staff came into contact with the trash. She stated the staff received an in-service re-education to ensure trash bin lids remained closed at all times and no trash was left on the ground. She stated the in-service education would be ongoing to reinforce compliance. During an interview on 05/14/2026 at 12:36 pm, the ADM stated, his expectation was for the dumpster area to always remain free from trash and debris. He stated trash was to be taken out after each shift by each department and should never be left on the ground. He stated the garbage disposal company serviced the dumpsters every Monday evening. He stated that leaving trash on the ground could create environmental concerns, including attracting rodents and other animals. He stated daily trash rounds were conducted by maintenance and kitchen staff to monitor the trash disposal area. He stated staff would be re-educated regarding proper trash disposal procedures and expectations. Record Review of the in-service training titled Topic Dumpster: Keep Lid Closed and no Trash on the Ground, date completed on 05/12/2026, reflected: The contents or summary read in part. All staff are responsible for the dumpsters. The dumpster must remain closed at all times. No trash is allowed on the ground. Please ensure that when you take out trash, please ensure all trash is in the dumpster. Record review of policy tilted Garbage Receptacles and dated 2018, revised date June 2019, reflected, Policy Statement. The facility will maintain garbage receptacles in a clean and sanitary manner to minimize the risk of food hazards. Outdoor receptacles: outdoor storage for refuse shall be constructed of nonabsorbent material such as concrete or asphalt and shall be smooth, durable and sloped to drain. It shall be constructed to have tight fitting lids, doors or covers and stored in a manner that is inaccessible to insects and rodents with doors/lids kept closed and no waste outside of the receptacle. All shall be maintained in good repair.