

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455533	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Windcrest Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 Fourwinds Dr Windcrest, TX 78239	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety. 1. The facility failed to label the name of food products (ice cream) in the food preparation refrigerator. 2. The facility failed to label dates on cheese and butter in the food preparation refrigerator. 3. In the walk-in refrigerator, the facility failed to keep food products 12 inches away from the ceiling and there was not a discard date on a pack of tortillas. These failures could place residents at risk for food borne illness. The findings included: 1. Interview and observation, during the initial kitchen tour, on 08/12/25 at 09:43AM, in the food preparation area freezer, there were containers of ice cream for lunch that were not labeled ice cream, but there was a label for the date 08/12/25. The CDM revealed sometimes they put labels of the names of the food products and sometimes they don't. (There was no reason given as to why). 2. Interview and observation, during the initial kitchen tour, on 08/12/25 at 09:43AM, in the food preparation area refrigerator, there was a clear container with butter and cheese in it. The cheese was labeled with cheese and 08/09/25. The container was labeled butter and 07/22/25. [NAME] C revealed the butter was opened today and the label 07/22/25 was probably an old label. He further revealed the date 08/09/25 for cheese was the open date and was supposed to be placed back in the freezer. He revealed there were no discard dates on either food product. 3. Interview and observation, during the initial kitchen tour, on 08/12/25 at 09:43AM, in the walk-in refrigerator, there were boxes on the top shelf that were less than 12 inches from the ceiling. The CDM revealed these boxes should be moved to lower shelves and moved them. There was a package of tortillas labeled with date 07/30/25 and no discard date. The CDM revealed the kitchen staff did not write discard dates on food products because the kitchen staff knew when to throw food products away. Interview on 08/14/25 at 10:36 AM, [NAME] C revealed he was trained to label names, dates food products were stored, and discard dates on foods. He revealed this was to ensure the proper foods were used. He revealed if a wrong food was used for meal this could also affect residents' allergies. He revealed discard dates ensured foods were thrown out correctly to prevent contamination and food poisoning. He revealed they did not have to move food products from the top shelf in the walk-in refrigerator because these food products could not catch on fire because the walk-in refrigerator had doors to prevent a fire from starting or spreading. Interview on 08/14/24 at 10:43 AM, the RD revealed food products only had to be labeled by it's name if you could not identify what the food product was. She further revealed food products did not have to be labeled with the discard dates. She revealed food products needed to be labeled with the open date and staff knew when to throw the foods out. Record review of facility's policy Food Storage, dated 2018, reflected 2. Refrigerators . c. Do not over stock the refrigerator and leave space between items to further improve air circulation, d. Date, label and tightly seal all refrigerated foods. e. Use all leftovers within 72 hours. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Discard items that are over 72 hours old. 3. Freezers . e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated. Record review of the FDA Food Code 2022 reflected, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal hygiene for 3 of 8 residents (Residents #28, #69, and #76) reviewed for ADLs in that: The facility failed to ensure Resident #76 received consistent showers during August and July 2025. The facility failed to ensure Resident #28 was provided with appropriate feeding assistance for 08/14/25 lunch meal. The facility failed to help Resident #69 with eating on 08/14/25 lunch meal per his care plan. These failures could place residents at risk of not receiving care and services to meet their needs, including nutritional needs and/or a diminished quality of life. Findings included: 1. Record review of Resident #76's face sheet, dated 8/12/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included Parkinson's Disease (a progressive neuromuscular disorder that causes tremors and weakness) and adult failure to thrive (a syndrome of decreased appetite, reduced physical activity, and/or cognitive decline). Record review of Resident #76's quarterly MDS dated [DATE] reflected a BIMS score of 10, indicating moderately impaired cognition. Record review of Resident #76's comprehensive care plan, dated 8/12/2025, revealed the resident is dependent on staff with shower (initiated 3/24/2025). Record review of Resident #76's electronic shower record, dated 8/12/2025, revealed the resident was scheduled for showers on Tuesdays, Thursdays, and Saturdays of every week. Documentation of Resident #76's showers was as follows: 8/9/2025 (Saturday) not applicable 8/7/2025 (Thursday) resident refused 8/5/2025 (Tuesday) total dependence 8/2/2025 (Saturday) resident refused 7/31/2025 (Thursday) not applicable 7/29/2025 (Tuesday) supervision-oversight help only and physical help in part of bathing activity Record review of Resident #76's progress notes revealed no bathing documentation from 7/29/2025 through 8/12/2025. Resident #76 was interviewed on 8/12/2025 at 2:57 PM. He stated he frequently went without bathing and was not consistently offered the opportunity to shower. He stated his last shower was 2 weeks prior. He denied refusing bathing when offered by staff during the 2-week period. He stated he asked the nurse for assistance with bathing and was told yes, but he was still waiting. He asked the CNA on shift if he could take a shower, and she told him that he was not scheduled for a shower that day. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA K was interviewed on 8/14/2025 at 10:18 AM. She stated she was the CNA for Resident #76's hall on 8/9/2025 and 7/31/2025. She stated she had not assisted him with a shower on those days because she was given direction by the Administrator not to provide care for Resident #76 due to personality conflicts. She was unsure if she asked another CNA to assist him with a shower on those days. The DON was interviewed on 8/14/2025 at 10:38 AM. She stated residents were able to take showers outside of their scheduled day/time depending on the workload of the staff. She was unaware of Resident #76's complaint that he had not consistently received showers. She also stated that the CNA should switch residents if they have been directed not to work with a particular resident to ensure that all residents receive showers. Record review of the facility policy titled Activities of Daily Living, Supporting (revised March 2018) revealed the following: Appropriate care and services will be provided for residents who are unable to carry out ADLs independent, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care). 2. Record review of Resident #28's admission Record, dated 08/13/25, reflected Resident #28 was an [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include weakness, protein-calorie malnutrition (11/29/23), and Alzheimer's disease (a degenerative brain disorder that primarily affects memory, thinking, and cognitive abilities). Record review of Resident #28's quarterly MDS assessment, dated 05/21/25, reflected resident needed setup or clean-up assistance for eating. Record review of Resident #28's care plan, undated, reflected "EATING: The resident requires supervision to limited assistance by 1 staff" and "EATING: The resident requires supervision to limited assistance by 1 staff", revised 03/06/25. Record review of Resident #28's weight history for the past 6 months reflected no significant weight loss. 3. Record review of Resident #69's admission Record, dated 08/13/25, reflected Resident #69 was a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include dysphagia (difficulty swallowing), dementia (loss of cognitive functioning), and cognitive communication deficit. Record review of Resident #69's quarterly MDS assessment, dated 05/07/25, reflected resident had a BIMS score of 99, indicating resident was unable to complete the interview. It further reflected resident was dependent for eating. Record review of Resident #69's care plan, undated, reflected Resident #69 had a focus "Resident #69 has an ADL self-care performance deficits and require staff assist r/t impaired balance, limited mobility, pain." and "EATING: The resident requires [extensive] assistance by (x1) staff to eat. Resident will sometimes attempt to eat without assistance.", revised 02/26/20, with intervention "EATING: The resident requires [extensive] assistance by (x1) staff to eat. Resident will sometimes attempt to eat without assistance.", revised 09/10/24. Record review of Resident #69's weight history for the past 6 months reflected no significant (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weight loss. Interview and observation on 08/13/25 at 12:12 PM, Nursing student G revealed Resident #28 was not able to feed himself today's lunch meal, so he was sitting down and feeding Resident #28. Attempted interview with Resident #28 and he was unable to participate. He revealed Resident #69 was able to feed himself. (Resident #28 and Resident #69 were roommates) Observation on 08/14/25 at 12:31 PM, Resident #69 was eating his lunch meal and Resident #28 appeared to be having trouble eating. It was observed there were no staff inside their room helping Resident #69 and Resident #28 with eating their lunch meal. Observation on 08/14/25 at 12:36 PM, the Reg NS went into Resident #28 and Resident #69's room, asking them if they needed help eating. Combined interview on 08/14/25 at 03:37 PM, Reg NS revealed Resident #69 appeared to have increase in alertness and did not need a lot of help eating his lunch meal today. She further revealed Resident #28 may need help with eating. Reg NS revealed there was no one in their room helping feed these residents for 08/14/25 lunch. ADON A revealed CNAs were to communicate with nurses if a resident required more or less assistance with ADLs. ADON A revealed she oversaw residents' change in assistance with feeding and would update care plans in care plan meetings. The Reg NS revealed when MDS assessments were completed it was expected for the MDS nurse to physically assess residents to ensure their ADL assistance was up to date. From assessing Resident #28 and Resident #69 today, the Reg NS revealed Resident #28 needed someone to sit down and feed him while Resident #69 appeared he could feed himself. The Reg NS revealed if Resident #69 needed extensive assistance with eating, then a staff member would need to be in his room and would be able to notice Resident #28 needed assistance in eating. Interview on 08/14/25 at 04:25 PM, CNA H revealed Resident #69 needed extensive assistance with eating when she worked with him. She revealed Resident #28 was starting to need extra assistance when eating so when she was feeding Resident #69, she would also help Resident #28 when he allowed. She further revealed sometimes Resident #28 would refuse help at times. Record review of facility's policy, revised March 2018, reflected, "2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Bathing (shower and tub); b. Dressing (clothing and undergarments); c. Grooming (hair and nails); d. Dining (meals and snacks); e. Mobility (transfers and walking); f. Personal care (toileting and continence); g. Safety (falls and fire drills); h. Transportation (rides to appointments and errands); i. Volitional care (activities of daily living); j. Wound care (wound care and dressing changes); k. Other (as needed)." The record review revealed that the facility's policy is consistent with the requirements of the Code of Federal Regulations, 42 CFR 483.12(c)(1)(ii).		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record reviews and interviews the facility failed to ensure the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, for 1 of 1 facility's reviewed for nursing staffing. The facility failed to have the services of an RN (Registered Nurse) 04/13/2025, 04/19/2025, 04/27/2025, 05/04/2025, 05/10/2025, and 05/11/2025. This failure could place residents at risk of not having the critical skills of a RN. Findings included: A record review of the facility's RN staff payroll hours for the period of 1/1/2025 - 8/14/2-25 revealed no RN Services on the following dates: 04/13/25, 04/19/25, 04/27/25, 05/04/25, 05/10/25, and 05/11/25. Record review of Incidents & Accidents for April 2025 and May 2025 did not reveal any negative outcomes to residents related to not having RN services. In an interview on 8/14/25 with the Administrator, the Administrator stated she was not aware there was no RN coverage on those dates. Administrator stated the former Director of Nurses was available on-call as needed. The Administrator stated she was aware of the importance of having an RN at the facility for clinical management. The Administrator stated the Director of Nurses was responsible for ensuring RN coverage as required and notifying Administrator of non-coverage. The Administrator stated the facility follows the TAC guidelines to utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles; included the appropriate accessory and cautionary instructions and the expiration date when applicable; and under proper temperature control for 2 of 3 medication aide carts (B and C hall carts) reviewed for medication storage. The facility failed to ensure 3 vials of the medication Latanoprost, including one with no open date, were discarded within 6 weeks (42 days) of removal from refrigeration. These failures could lead to residents receiving ineffective medications and not receiving the intended therapeutic effect. Findings included: In an observation and interview on 8/13/2025 at 8:46 AM, one vial of Latanoprost was observed in the B hall cart with an opened date of 6/28/2025 (56 days). MA L stated she was unsure when the medication was supposed to be discarded after being removed from refrigeration. In an observation and interview on 8/13/2025 at 8:55 AM, one vial of Latanoprost was observed in the C hall cart without a date indicating when the vial was opened. A second vial was dated with an opened date of 7/7/2025 (47 days). RN B stated the undated vial should have had a date and would be discarded because she was not sure when it was opened. She stated the vial dated 7/7/2025 should also have been discarded. RN B stated the potential harm to residents receiving improperly stored eye drops was the medication could have degraded and not work as intended. The DON was interviewed on 8/14/2025 at 10:38 AM. She stated the Latanoprost eye drops were able to be stored at room temperature for six weeks. She was unaware that multiple vials of Latanoprost were being stored in medication carts past 6 weeks. She reported the potential harm to residents was ineffective medication. Record review of the facility policy titled Delivery, Receipt, and Storage of Medication (undated) revealed the following: The facility should ensure the medications requiring refrigeration are stored appropriately .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, 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 3 of 4 CNAs (CNAs M, N, and O) observed for infection control. The facility failed to: Ensure CNAs M and N bagged soiled linen prior to transporting. Ensure CNA O donned PPE properly and performed hand hygiene and glove changes while performing care to a foley catheter. These failures could lead to the spread of infection. Findings included: 1. In an observation and interview on 8/12/2025 at 10:24 AM, CNA N was observed leaving a resident's room with unbagged linen in the B hallway while wearing gloves. CNA N stated that she was assisting a resident with incontinent care and linen change. She stated the facility policy was that soiled linen should be bagged prior to leaving a resident's room and gloves should not be worn in the hallway. She stated she was in a hurry and did not bag the linen. CNA N reported the potential harm to residents by wearing soiled gloves and carrying unbagged, soiled linen in the hallway was the spread of infection. In an observation on 8/14/2025 at 9:16 AM, CNA M was observed carrying unbagged linen from out of a resident's room in the acute rehabilitation hall. He stated he had assisted the resident with a linen change, and the facility policy was that soiled linen should be bagged prior to transporting it. He said he did not have a trash bag in the room, so he chose to carry it out. He stated the potential harm to residents was cross contamination. The DON was interviewed on 8/14/2025 at 10:38 AM. She stated the facility expectation was for all soiled linen to be bagged before exiting a resident's room. She stated the potential harm to residents was the spread of infection. Record review of the facility policy titled Infection Control (revised October 2018) did not reveal guidance related to transporting soiled linen. 2. In an observation on 8/14/2025 at 10:08 AM, CNA O was observed preparing to provide care for a resident with a foley catheter. As the resident required EBP precautions, CNA O donned PPE prior to entering the room. CNA O donned gloves and then put on a disposable gown. She told CNA K that the picture on the EBP sign indicated the PPE items needed as well as the order in which to put the items on. CNA K stated she was taught to put on a gown and then don gloves, but CNA O reiterated the gloves are applied first. CNA O then entered the room and was observed assisting the resident with removing his clothing and repositioning in the bed. CNA O did not change gloves or perform hand hygiene prior to providing care to the foley catheter. Using multiple disposable cleansing wipes, CNA O then cleaned the resident's groin and the catheter but was not observed changing gloves or performing hand hygiene before grasping the catheter tube. After completing the cleansing, CNA O was observed assisting the resident with repositioning in the bed and applying new clothing. CNA O did not change gloves or perform hand hygiene before these tasks. CNA O was interviewed on 8/14/2025 at 10:15 AM. She stated she should have changed gloves and performed hand hygiene after removing the resident's clothing. She again stated that the picture on the EBP sign indicated the order in which PPE should be applied. She reported the potential harm to residents by not performing glove changes and hand hygiene appropriately was cross contamination. The DON was interviewed on 8/14/2025 at 10:38 AM. She stated the order of PPE application that was taught to staff was gown and then gloves, and that she would meet with CNA O to reinforce the proper application. She also stated the facility expectation during foley catheter care was glove changes and hand hygiene before and after performing catheter care and during the procedure. She stated the potential harm of not donning PPE properly or performing hand hygiene was cross contamination. Record review of the facility policy CNA catheter care (undated) revealed the following: 7. Lower head of bed and position [the resident] on back 8. Wash hands and put on gloves 9. Expose area surrounding catheter 10. Apply soap to wet washcloth of use wipes . clean at least four inches of catheter . 11. Remove gloves and wash hands and don new gloves		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable and homelike environment for residents for 1 of 4 rooms reviewed for physical environment. room [ROOM NUMBER] had a broken drawer placed on top of the dresser. This failure could place residents at risk for injury and experiencing a diminished quality of life. Findings included: During an observation on 8/12/25 at 10:55 a.m., a broken drawer with the drawer front of the drawer hanging off and joints bent was located on top of a dresser in room [ROOM NUMBER]. During an interview on 8/12/25 a 10:30 a.m., HSKPR A stated she would notify her supervisor if equipment was broken. She stated she was not aware the drawer was broken. During an interview on 8/12/25 at 11:00 a.m., CNA A stated that maintenance should be notified right away if something was broken so a resident could not get hurt. CNA A stated she would write it down in the maintenance book, and she did not see the broken drawer. During an interview on 8/12/25 at 11:15 a.m., RN B stated she would notify the maintenance staff right away if she saw something was broken. She stated she was not aware the drawer was broken. During an interview on 8/12/25 at 3:30 p.m., LVN A stated she would submit a work order in the electronic reporting system to notify maintenance. LVN A stated she was not aware the drawer the broken. During an interview on 8/13/25 at 9:45 a.m., Maint A stated he had not been notified that a drawer was broken, stated he would remove from room and repair right away. During an observation on 8/13/25 at 10:10 a.m. of room [ROOM NUMBER], the broken drawer was no longer present. Record review of the facility policy titled Environmental Services (dated 05/2022) revealed. resident equipment and equipment used by the residents should be clean and properly maintained		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 9 residents (Resident #76) reviewed for assessments. The facility failed to ensure the MDS accurately reflected Resident #76's diagnosis depression. This failure could lead to residents not receiving necessary care. Findings included: Record review of Resident #76's face sheet, dated 8/12/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included Parkinson's Disease (a progressive neuromuscular disorder that causes tremors and weakness) and adult failure to thrive (a syndrome of decreased appetite, reduced physical activity and/or cognitive decline). Record review of Resident #76's quarterly MDS submitted 7/4/2025 reflected a BIMS score of 10, indicating moderately impaired cognition. Section I (active diagnoses) of the MDS reflected Resident #76 did not have a diagnosis of any psychiatric/mood disorders. Record review of Resident #76's active orders reflected the following: Buspirone HCl tablet 5mg, give 1 tablet by mouth three times a day for anxiety (order date 4/01/2025) Sertraline HCl Tablet 25mg, give 1 tablet by mouth one time a day for depression (order date 3/27/2025) Record review of Resident #76's progress notes revealed documentation from a psychiatric nurse practitioner evaluation dated 8/06/2025. The documentation included diagnosis: F33.1 major depressive disorder, recurrent, moderate and assessment/plan . depression: sertraline 15mg Qd/ Buspirone 5Mg TID. In an interview with MDS NS on 8/14/2025 at 11:30 AM, she stated the diagnoses related to psychotropic medications were drawn from the documentation provided by the physicians and nurse practitioners. She said discrepancies between orders and progress notes were resolved using the physician query process. She was unsure how Resident #76's MDS was completed as she had not been the nurse who completed the documentation. She stated the MDS should accurately reflect the diagnoses given by a resident's provider, and inaccurate diagnoses could potentially lead to resident's not receiving proper care. In an interview with the DON on 8/14/2025 at 1:35 PM, she stated the MDS nurse would obtain the diagnoses list from the provider's documentation. She stated the diagnoses on the MDS should match a resident's orders and diagnoses given by the provider. She stated the potential harm to a resident by having an inaccurate or missing diagnosis, was improper monitoring of psychotropic medications. The DON also stated she does not participate in the MDS report process. Record review of the facility policy titled Resident Assessments (revised March 2022) reflected the following: All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.		

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NAME OF PROVIDER OR SUPPLIER Windcrest Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 Fourwinds Dr Windcrest, TX 78239	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interviews and records review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 3 residents (Resident #10) reviewed for oxygen use. The facility failed to ensure Resident #10 was monitored for oxygen saturation levels per physician's order to maintain oxygen saturations about 92%. This failure could place residents with respiratory illnesses at risk for a decline in health. Findings included: Record review of Resident #10's face sheet, dated 8/14/2025, revealed a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and made it difficult to breathe), atrioventricular block (a condition where the electrical signals in the heart are completely blocked), and peripheral autonomic neuropathy (a condition where damage to the nerves affect the peripheral nervous system). Record review of Resident #10's MDS dated [DATE] revealed BIMS score of 8 indicating moderate cognitive impairment, received no special treatments and oxygen was not in use. Review of Resident #10's active physician orders, dated 8/14/2025, revealed the following: O2 @ 2L/min via nasal cannula to maintain O2 sats >92% as needed for SOB (Oxygen at 2 liters per minute by nasal cannula to maintain oxygen saturations greater than 92% as needed for shortness of breath). Record review of Resident #10's Medication Administration Record and Treatment Administration Record on 8/14/25 at 8:44 a.m. revealed no monitoring of oxygen saturation levels to ensure oxygen saturation levels remain above 92%. During observation of Resident #10 on 8/12/25 at 10:03 a.m., resident lying in bed, awake, requesting to get out of bed. No signs of respiratory distress, no oxygen in use. During an observation of Resident #10 on 8/14/25 at 7:58 a.m., resident lying in bed, anxious verbalizations and requesting assistance to get out of bed. No oxygen in use. During an interview on 8/14/25 at 8:14 a.m., RN B revealed that she does not check Resident #10's oxygen routinely and that she would monitor for shortness of breath or difficulty breathing and provide oxygen as needed to maintain saturations above 92%. During an interview on 8/14/25 at 3:30 p.m., LVN A revealed that she does not monitor Resident #10's oxygen levels and did not realize there was not an order to monitor oxygen levels. During an interview on 8/14/25 at 4:15 p.m., the ADON stated failure to monitor oxygen levels to ensure vital signs were within normal limits could result in shortness of breath, dizziness or possibly cyanosis (a medical condition when the lips, skin and/or nails turn a bluish tone due to lack of oxygen). ADON stated she would expect nursing staff to monitor the oxygen saturations levels of all residents with orders for PRN (as needed) oxygen at least one time per shift. During an interview on 8/14/25 at 5:00 p.m. with the REG NS, she stated the facility does not have a specific policy for following physician's orders.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 of 8 residents (Resident #69) reviewed for dietary services. The facility failed to ensure Resident #69 received their prescribed diet (pureed diet) for 08/15/25 lunch meal service. This deficient practice could place residents, who were provided a mechanically altered diet, at risk of choking, aspiration (inhaling food), and diminished quality of life. The findings included: Record review of Resident #69's admission Record, dated 08/13/25, reflected Resident #69 was a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include dysphagia (difficulty swallowing), dementia (loss of cognitive functioning), and cognitive communication deficit. Record review of Resident #69's care plan, undated, reflected Resident #69 had a focus [Resident #69] has a diagnosis for Dysphagia: Resident is at risk for aspiration, weight loss and complication r/t diagnosis, initiated 04/18/19, with interventions to include Educated resident on importance of adhering to ordered diet and potential complications with non-compliance., initiated 04/18/29, and Provided diet as ordered., initiated 04/18/29. Record review of Resident #69's quarterly MDS assessment, dated 05/07/25, reflected resident had a BIMS score of 99, indicating resident was unable to complete the interview. It further reflected resident had a mechanically altered diet. Record review of Resident #69's order summary report, dated 08/13/25, reflected resident's diet was Pureed texture, regular consistency, start date 09/16/24. Interview and observation on 08/13/25 at 12:12 PM, Nursing student F confirmed Resident #69 had 2 baked cookies (not pureed texture) on his 08/13/25 lunch meal tray. He revealed there was a nurse who reviewed this resident's tray ticket before he gave Resident #69 his meal tray. He revealed he was unsure if Resident #69 was allowed to have cookies on his meal tray ticket, but was going to check. It was further observed Nursing student F took Resident #69's lunch meal tray (with the cookies) out of his room. Attempted interview with Resident #69 and he was unable to participate. Interview on 08/13/25 at 12:35 PM, the CDM revealed the kitchen staff checked the tray tickets before they passed out to the nursing staff to pass out to the residents. She revealed it was important to ensure the tray tickets matched the meals. Interview on 08/13/25 at 01:05 PM, ADON B revealed she checked the lunch meal tray ticket for Resident #69 and may have missed the cookie that was not pureed on his plate. She revealed she thought she had missed something when passing out the meal trays today. Interview on 08/14/24 at 10:43 AM, the RD revealed it was important to follow the texture of foods that were on the residents' diet orders. She revealed if the texture of the diet was not followed the risk could vary from person to person. Interview on 08/14/25 at 11:45 AM, [NAME] D and Dietary Aide E revealed they were trained to read the meal tray tickets before they left to ensure the tickets matched what was on the trays. They revealed it was important for pureed diets to have pureed foods on the tray to prevent possible choking. Record review of facility's policy, dated 2018, reflected 3. For tray line service, Nutrition & Foodservice staff will check each resident's tray card prior to service to ensure that preferences and dislikes are honored, the correct diet is served.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 8 residents (Resident #6) reviewed for clinical documentation and medical records accuracy. The Electronic Health Record for Resident #6 did not reflect a diagnosis of depression on her admission record as was indicated for taking Remeron Oral Tablet 15 MG. Resident #6's care plan did not accurately reflect that she had a history of claiming someone beat her up when no one was around her. This failure could place residents at risk for incomplete or inaccurate clinical records, which could lead to miscommunication, a delay in services, or a potential decline in the resident's health. The findings included: Record review of Resident #6's admission record, dated 08/12/25, reflected Resident #6 was a [AGE] year-old female initially admitted on [DATE] and re-admitted on [DATE], with diagnoses to include dementia (loss of cognitive functioning), psychotic disorder with hallucinations (an experience involving the apparent perception of something not present) due to known physiological condition, and schizophrenia (a serious mental health condition that affects how a person thinks, feels, and behaves). It did not reflect a diagnosis of depression. Record review of Resident #6's quarterly MDS assessment, dated 07/03/25, reflected resident had a BIMS of 09 out of 15, indicating moderate cognitive impairment. It did not reflect a diagnosis of depression. Record review of Resident #6's care plan, undated, reflected focus The resident uses antidepressant medication r/t poor appetite., initiated 06/28/25, with intervention Administer ANTIDEPRESSANT medications as ordered by physician. Record review of Resident #6's Order Summary Report, dated 08/12/25, reflected Remeron Oral Tablet 15 MG Give 1 tablet by mouth at bedtime for depression, with started date 07/02/25. Record review of Resident #6's care plan, undated, reflected focus The resident has a behavior problem. Resident reports she has been beat up when nobody is around her., initiated by 06/09/25 and revised on 06/29/25. Record review of Resident #6's progress notes reflected nothing noted about allegation of being beat up when nobody is around her. Interview on 08/14/25 at 12:41 PM, LVN J revealed she was not aware that Resident #6 had any incidents or allegations of abuse while she was a resident at this facility. She revealed Resident #6 had a history of abuse and she had to adjust Resident #6's care accordingly. Interview on 08/14/25 at 02:56 PM, CNA I revealed he was not aware that Resident #6 had made an allegation of abuse as a resident at this facility. Interview on 08/14/25 at 03:06 PM, MDS nurse B saw Resident #6 had medication Remeron for a diagnosis of depression but could not find in the medical record where Resident #6 had a diagnosis of depression. She revealed she left MD a note to verify if Resident #6 had a diagnosis of depression so they can add the diagnosis if Resident #6 had a diagnosis of depression. She revealed Resident #6's care plan mentioning Resident #6 reporting she had beat up did not occur at this facility and the care plan should read Resident #6 had a history of reporting she had been beat up when no one was around her. She further revealed it was important to have care plans be accurate because it allowed staff to treat the whole resident. She revealed there could be some risks but did not state specifics. Interview on 08/14/25 at 03:37 PM, ADON A revealed Resident #6 had a history of claiming she was being beat up when nobody was around her, but nothing has happened in this facility. She revealed her care plan was going to be updated. Record review of facility's policy Resident Assessments, revised March 2022, reflected . 3. A comprehensive assessment includes: a. completion of the Minimum Data Set (MDS). c. development of the comprehensive care plan. Record review of (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's policy Psychotropic Medication Use, dated July 2022, reflected 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: b. Anti-depressants.		