STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455662	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of McAll	900 S 12th St McAllen, TX 78501

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure the residents had the right to be free from abuse, neglect and misappropriation of property for 8 of 16 residents (Resident #4, Resident #9, Resident #12, Resident #15, Resident #20, Resident #23, Resident #27, and Resident #31) reviewed for abuse, in that: The facility failed to ensure Resident #4, Resident #9, Resident #12, Resident #15, Resident #20, Resident #23, Resident #27, and Resident #31 were free from abuse when:-Resident #9 touched/rubbed Resident #4's private area with his hand on 10/19/24.-Resident #12 kissed Resident #20 on her mouth and forehead on 04/03/25.-Resident #12 kissed Resident #4 on her mouth on 04/05/25.-Resident #23 kissed Resident #4 on her mouth on 05/02/25.-Resident #31 punched Resident #15 on her lower back/buttocks area and Resident #15 hit Resident #31 on his shoulder blade on 06/21/25.-Resident #27 kissed Resident #23 on his mouth on 06/25/25. These deficient practices could affect residents and place them at risk for abuse, trauma, psychosocial harm, injuries, or hospitalization. The findings included: 1. Record review of Resident #4's face sheet, dated 07/08/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), chronic atrial fibrillation (irregular heartbeats), chronic obstructive pulmonary disease (lung disease), acute kidney failure (kidney disease), major depressive disorder, bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and anxiety disorder. Record review of Resident #4's quarterly MDS assessment, dated 05/09/25, revealed Resident #4 had a BIMS score of 00, indicating her cognition was severely impaired. Record review of Resident #4's care plan dated 07/08/25 revealed [Resident #4] has a behavior problem related to dementia, history of alcohol abuse and bipolar disorder. Interventions: administer medications as ordered, anticipate and meet needs, explain procedures to the resident, followed up by psych services, intervene as necessary to protect the rights and safety, divert attention, remove from the situation, monitor behavior episodes, and provide a program of activities. Date initiated: 12/30/22. Record review of Resident #4's change of condition for resident-to-resident incident completed by the DON on 10/19/24 revealed inappropriate sexual behaviors towards Resident #4. Showing no signs or symptoms of distress and clothes intact. Head to toe assessment done, no pain or distress noted, resident confused to needs, unable to make needs known. MD made aware of incident and psych eval in place. Continue to monitor. No injuries noted. Record review of Resident #4's change of condition for resident-to-resident incident completed by LVN C on 04/05/25 revealed CNA A came to notify LVN C that Resident #12 was seen kissing Resident #4 in the mouth, CNA A called Resident #12's name out and he stood straight up and walked away to hall. LVN C asked Resident #4 about incident, resident unable to give description of any kind. Head to toe assessment on resident, no new visual injury noted, resident showing no signs or symptoms of pain or discomfort, and no distress at this time. Clothing intact and resident continues up to wheelchair in dining area. RP made aware, DON, and MD notified. No injuries noted. No pain noted. Record review of Resident #4's change of condition for resident-to-resident incident completed by LVN G on 05/02/25 revealed Resident #4 was seen being kissed by Resident #23 and was reported to LVN G. Kiss was described as being fast and no saliva was seen on Resident #4. Resident #4's mouth area was dry and intact. Resident #4's clothes were on properly and intact. When incident occurred, residents were immediately separated from each other. After being separated, Resident #4 was back to participating in activity and watching tv in the dining room. Resident #4 showed no signs or symptoms of pain or discomfort. No other injuries noted. No pain noted. Transferred out of the unit to the regular hall after this incident. 2. Record review of Resident #9's face sheet, dated 07/08/25, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder, delusional disorders (mental health condition that causes beliefs in something that is untrue), anxiety disorder, and cognitive communication deficit. Record review of Resident #9's quarterly MDS assessment, dated 04/08/25, revealed Resident #9 had a BIMS score of 2, indicating his cognition was severely impaired. Record review of Resident #9's care plan dated 07/08/25 revealed [Resident #9] had a behavior problem (history of inappropriate sexual behaviors towards staff and residents) related to diagnosis of unspecified dementia. Interventions: administer medications as ordered, behavior monitoring, intervene as necessary to

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 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 observations, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment, were reported immediately to the State Survey Agency, within two hours if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for 2 of 16 (Resident #15 and Resident #4) residents reviewed for abuse/neglect, in that: The facility failed to report allegations of resident abuse for Resident #15 and Resident #4 to the State Survey Agency within the allotted time frame of 2 hours on 04/24/25 when Resident #15 pulled Resident #4's hair. This failure could place all residents at increased risk for potential abuse due to unreported allegations of abuse and neglect. The findings included: 1. Record review of Resident #15's face sheet, dated 07/08/25, revealed the resident was an [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease (decline in memory, thinking, and behavior), unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), cognitive communication deficit, delusional disorders (mental health condition that causes beliefs in something that is untrue), major depressive disorder, and emotional lability (neurological condition that causes uncontrollable laughing or crying). Record review of Resident #15's quarterly MDS assessment, dated 06/11/25, revealed Resident #15 had a BIMS score of 00, indicating her cognition was severely impaired. Record review of Resident #15's care plan dated 07/08/25 revealed [Resident #15] has a behavior problem of physical aggression (hitting, pulling hair, towards staff and residents) related to anger, dementia, and poor impulse control. Interventions: the resident's triggers for physical aggression are looking at her. The resident's behaviors is de-escalated by giving her space or leaving her alone. Interventions also included: administer medications as ordered, analyze triggers, assess resident's needs, monitor behaviors, psych consult, and one to one monitoring. Date initiated: 04/24/25. [Resident #15] had a resident-to-resident incident on 06/21/25. Interventions: labs as ordered and one to one monitoring. Date initiated: 06/21/25. Record review of Resident #15's psych NP consult dated 04/22/25 revealed Resident #15 was evaluated due to refusing meals at times, mood is labile (easily changed) and yelling at staff. Medications adjusted. Record review of Resident #15's change of condition for resident-to-resident incident completed by ADON J on 04/24/25 revealed CNA A stated that upon entering Resident #15's room, Resident #15 was standing behind her roommate, Resident #4, pulling her hair back and complaining that Resident #4 talks too much. MD notified of Resident #15's behavior. New orders for urine analysis. RP attempted to be notified of incident and new orders. No answer at this time. No injuries noted. No pain noted. 2. Record review of Resident #4's face sheet, dated 07/08/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), chronic atrial fibrillation (irregular heartbeats), chronic obstructive pulmonary disease (lung disease), acute kidney failure (kidney disease), major depressive disorder, bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and anxiety disorder. Record review of Resident #4's quarterly MDS assessment, dated 05/09/25, revealed Resident #4 had a BIMS score of 00, indicating her cognition was severely impaired. Record review of Resident #4's care plan dated 07/08/25 revealed [Resident #4] has a behavior problem related to dementia, history of alcohol abuse and bipolar disorder. Interventions: administer medications as ordered, anticipate and meet needs, explain procedures to the resident, followed up by psych services, intervene as necessary to protect the rights and safety, divert attention, remove from the situation, monitor behavior episodes, and provide a program of activities. Date initiated: 12/30/22. Record review of Resident #4's change of condition for resident-to-resident incident completed by ADON J on 04/24/25 revealed as per CNA A, upon entering room, Resident #15 was noted to be standing behind Resident #4, pulling her hair back, and complaining that Resident #4 was too loud. DON made aware of incident. RP attempted to be notified, no answer. MD notified and pending response. No injuries noted. No pain noted. On 07/08/25 at 10:45 AM, in an attempted interview and observation with Resident #4, she was not interviewable. Resident #4 did not answer baseline questions or questions related to the incidents. Resident #4 sat in her wheelchair, in the hallway. Resident #4 appeared with good personal hygiene, no injury, and not in distress. On 07/08/25 at 11:45 AM, in an attempted interview and observation with Resident #15, she was not interviewable. Resident #15 did not answer