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	11/21/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 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 interviews and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated and failed to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress for 1 of 4 residents (Resident #1) reviewed for neglect. The facility failed to thoroughly investigate a reported fall which could have led to a correlation of a fracture which was confirmed on 09/29/25. This failure could place residents at risk of further abuse, physical harm, mental anguish and emotional distress.Review of Resident #1's face sheet dated 11/06/25 revealed a [AGE] year-old man admitted on [DATE] with a discharge day of 10/28/25 with a diagnoses of unspecified dementia, need for assistance with personal care, age related physical debility, syncope (temporary loss of consciousness caused by a decrease in blood flow to the brain) and collapse, muscle wasting and atrophy (gradual wasting away or shrinkage of an organ, tissue, or muscle), and muscle weakness. Diagnoses included unspecified trochanteric fracture of right femur with an onset date of 09/29/25. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 0 which indicated severe cognitive impairment. Record review of Resident #1's quarterly MDS dated [DATE] revealed Resident #1 required substantial/ maximal assistance (helper does more than half the effort) for shower/bath. Record review of Resident #1's care plan, revealed Resident #1 was at risk for falls related to gait/balance problems, incontinence, poor safety awareness, dementia, history of syncope and collapse. Record review of Resident #1's care plan, revealed Resident #1 with an alteration in musculoskeletal status related to a right femur intertrochanteric fracture; Date Initiated: 09/29/2025 Record review of progress note dated 09/26/25 at 1:40 pm revealed LVN C was called into the restroom by CNA B to check on Resident #1 after Resident #1 appeared weak, tilted to the right side and had bumped his head on the wall that divides the shower space. Resident#1 was dressed, placed back on his wheelchair and assessed. Record review of progress note dated 09/28/25 at 9:57 pm revealed Resident #1 complained of pain to right upper leg. NP was notified and gave order for STAT x-ray. Record review of progress note dated 09/29/25 at 7:55 am revealed Resident #1 was transferred to [NAME] Medical Center emergency room at 7:30 am. Record review of progress note dated 09/29/25 at 1:03 pm revealed Resident #1 was being admitted to [NAME] Medical Center for right femur intertrochanteric fracture, pending to have surgery. Record review of employee statements for restroom incident investigation dated 09/26/25, revealed CNA B had stated Resident #1 had sustained a fall in the restroom while she and CNA A were preparing Resident #1 for a shower. Statement included CNA B and CNA A lifted Resident #1 off the floor and repositioned him back into the wheelchair. CNA B then called LVN C to assess Resident #1 in the restroom. There was no documentation of statements by CNA A or LVN C related to Resident #1's fall. No PIR was provided by the facility for Resident #1's reported fall. Record review of the facility's incident reports with a date range of 09/01/25 to 09/30/25, had no report of a fall for Resident #1 dated 09/26/25. Record review of Resident #1's [NAME] Medical Center - Emergency Department Summery of Care dated 09/29/25 revealed diagnosis of Trochanteric fracture of right femur During an interview on 11/04/25 at 2:22 PM, CNA B stated she and CNA A had transferred Resident #1 from his wheelchair into the shower chair. CNA B stated she had turned around to pick up a soap bottle when she heard a hit. CNA B stated when she turned to look, Resident #1 was on the floor. CNA B stated she and CNA A lifted Resident #1 off the floor and placed him back into the shower chair. During an interview on 11/04/25 at 3:10 PM, the DON stated on the day of the reported incident, Resident #1 had a light syncope (a temporary loss of consciousness caused by a decrease in blood flow to the brain) episode. The DON stated that upon investigation, CNA A and CNA B were asked if any body part of Resident #1 had changed surfaces, in other words, had Resident #1 fallen to the floor. The DON stated that CNA A had stated no but CNA B had stated yes. The DON stated the investigation moved forward with CNA A's statement that it was not a fall. The DON stated she could not confirm as to how Resident #1 sustained the fracture. The DON stated that CNA B's statement was followed up by conducting abuse/neglect and fall prevention in-services (trainings). The DON stated she was unaware as to why CNA B's statement that Resident #1 had sustained a fall was not investigated. The DON stated that the Administrator conducts all investigations. During an interview on 11/04/25 at 3:33 PM, the Administrator stated he was not able to determine whether Resident #1 had sustained a fall or not. The Administrator stated that CNA A had stated that Resident #1 had not fallen while CNA B had stated that Resident #1 had. The Administrator stated he opted to follow through with the investigation using CNA A's

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for one of four residents (Resident#1) reviewed for accidents and supervision. The facility failed to provide adequate supervision to Resident#1. Resident #1 fell from the shower chair while care was being provided by CNA A and CNA B and sustained a fracture to right hip. This failure could place residents who require supervision at risk of accidents or injury. Review of Resident #1's face sheet dated 11/06/25 revealed a [AGE] year-old man admitted on [DATE] with a discharge day of 10/28/25 with a diagnoses of unspecified dementia, need for assistance with personal care, age related physical debility, syncope (temporary loss of consciousness caused by a decrease in blood flow to the brain) and collapse, muscle wasting and atrophy (gradual wasting away or shrinkage of an organ, tissue, or muscle), and muscle weakness. Diagnoses included unspecified trochanteric fracture of right femur with an onset date of 09/29/25. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 0 which indicated severe cognitive impairment. Record review of Resident #1's quarterly MDS dated [DATE] revealed Resident #1 required substantial/ maximal assistance (helper does more than half the effort) for shower/bath. Record review of Resident #1's care plan, revealed Resident #1 was at risk for falls related to gait/balance problems, incontinence, poor safety awareness, dementia, history of syncope and collapse. Record review of Resident #1's care plan, revealed Resident #1 with an alteration in musculoskeletal status related to a right femur intertrochanteric fracture; Date Initiated: 09/29/2025 Record review of progress note dated 09/26/25 at 1:40 pm revealed LVN C was called into the restroom by CNA B to check on Resident #1 after Resident #1 appeared weak, tilted to the right side and had bumped his head on the wall that divides the shower space. Resident#1 was dressed, placed back on his wheelchair and assessed. Record review of progress note dated 09/28/25 at 9:57 pm revealed Resident #1 complained of pain to right upper leg. NP was notified and gave order for STAT x-ray. Record review of progress note dated 09/29/25 at 7:55 am revealed Resident #1 was transferred to [NAME] Medical Center emergency room at 7:30 am. Record review of progress note dated 09/29/25 at 1:03 pm revealed Resident #1 was being admitted to [NAME] Medical Center for right femur intertrochanteric fracture, pending to have surgery. Record review of employee statements for restroom incident investigation dated 09/26/25, revealed CNA B had stated Resident #1 had sustained a fall in the restroom while she and CNA A were preparing Resident #1 for a shower. Statement included CNA B and CNA A lifted Resident #1 off the floor and repositioned him back into the wheelchair. CNA B then called LVN C to assess Resident #1 in the restroom. There was no documentation of statements by CNA A or LVN C related to Resident #1's fall. No PIR was provided by the facility for Resident #1's reported fall. Record review of the facility's incident reports with a date range of 09/01/25 to 09/30/25, had no report of a fall for Resident #1 dated 09/26/25. Record review of Resident #1's [NAME] Medical Center - Emergency Department Summery of Care dated 09/29/25 revealed diagnosis of Trochanteric fracture of right femur During an interview on 11/04/25 at 2:22 PM, CNA B stated she and CNA A had transferred Resident #1 from his wheelchair into the shower chair. CNA B stated she had turned around to pick up a soap bottle when she heard a hit. CNA B stated when she turned to look, Resident #1 was on the floor. CNA B stated she and CNA A lifted Resident #1 off the floor and placed him back into the shower chair. During an interview on 11/04/25 at 3:10 PM, the DON stated on the day of the reported incident, Resident #1 had a light syncope (a temporary loss of consciousness caused by a decrease in blood flow to the brain) episode. The DON stated that upon investigation, CNA A and CNA B were asked if any body part of Resident #1 had changed surfaces, in other words, had Resident #1 fallen to the floor. The DON stated that CNA A had stated no but CNA B had stated yes. The DON stated the investigation moved forward with CNA A's statement that it was not a fall. The DON stated she could not confirm as to how Resident #1 sustained the fracture. The DON stated that CNA B's statement was followed up by conducting abuse/neglect and fall prevention in-services (trainings). The DON stated she was unaware as to why CNA B's statement that Resident #1 had sustained a fall was not investigated. The DON stated that the Administrator conducts all investigations. During an interview on 11/04/25 at 3:33 PM, the Administrator stated he was not able to determine whether Resident #1 had sustained a fall or not. The Administrator stated that CNA A had stated that Resident #1 had not fallen while CNA B had stated that Resident #1 had. The Administrator stated he opted to follow through with the investigation using CNA A's statement that