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	12/03/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure that a resident who was incontinent of bladder with a suprapubic catheter (flexible tube inserted into the bladder through the abdomen to drain urine) received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #27) of 1 resident reviewed for urinary catheters (a flexible tube used to empty the bladder and collect urine in a drainage bag). The facility failed to place Resident #27's urinary catheter drainage bag below the bladder. This failure could place residents with urinary catheters at risk for urinary tract infections. Record review of Resident #27's face sheet dated 12/03/25 revealed a [AGE] year-old male admitted on [DATE] with an original admission date of 02/02/25. Resident #27 had diagnoses of unspecified dementia, hypospadias (a congenital condition in males in which the opening of the urethra is on the underside of the penis), and neuromuscular disfunction of the bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should). Record review of Resident #27's Physician's Order dated 11/27/25 revealed SUPRAPUBIC CATHETER: Irrigate (procedure used to clear the bladder of mucus and debris) suprapubic catheter twice a day with 60ml NS two times a day. Record review of Resident #27's Quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident's cognition was intact. Further review of section H - Bladder and Bowel, revealed Resident #27 had an indwelling catheter. Record review of Resident #27's comprehensive care plan initiated on 02/03/25 and revised on 06/12/25 revealed Resident #27 is at risk for urinary tract infection related to the Foley catheter. Observation on 12/01/25 at 9:02 am revealed Resident #27 was sitting in his wheelchair, and the Foley drainage bag was hooked onto a pocket located mid-back of his wheelchair. The Foley tubing was running through his legs, under the wheelchair and hooked to the back of the wheelchair. The Foley drainage bag rested above Resident #27's bladder. In an interview on 12/01/25 at 9:03 am revealed Resident #27 was unaware the catheter bag was hung to the back of his wheelchair. Resident #27 stated Oh, I didn't know it was back there. In an interview and observation on 12/01/25 at 9:18 am, RN L was informed and shown the catheter bag hanging from the mid back of Resident #27's wheelchair. RN L stated when residents sat in a wheelchair, the Foley drainage bag should be placed somewhere but did not know where to place it. RN L stated, I know it has to be below the bladder but I'm not sure of the placement in a wheelchair. RN L stated a negative outcome for the Foley drainage bag above the bladder was that the backflow of the urine could cause infection. RN L was observed placing the bag on a low metal bar of the wheelchair, but the Foley drainage bag touched the floor. RN L was observed again placing the Foley drainage bag on another metal bar higher on the wheelchair. The Foley drainage bag hung below Resident #27's bladder and did not touch the floor. In an interview on 12/03/25 at 6:58 am, LVN J stated the Foley drainage bag should be placed below the patient's abdomen. LVN J stated that when a resident is sitting in a wheelchair, the Foley drainage bag should be below the bladder but not touching the floor nor the wheels. LVN J stated the Foley bag should not be hung above the bladder. LVN J stated a negative outcome would be that the urine would flow back into the bladder causing infection. LVN J (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated training was given to the nurses on different topics and Foley care was one of the trainings. LVN J stated the DON checked off the nurses for their nursing skills. In an interview on 12/03/25 at 2:39 pm, the DON stated nurses were checked off on nursing skills. The DON stated the nurses received in-services (training) whenever there was a need to re-educate the nurses. The Foley training included placement of Foley, care of Foley, privacy, and making sure the Foley did not touch the floor. Record review of the facility's Incontinent Care Skills Checklist revealed it did not address Foley catheter care or placement. Record review of the facility's policy on Perineal Care implemented on 10/24/22 revealed did not address the proper placement of a Foley drainage bag.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure foods were properly labeled and dated.This failure placed all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness.Observation of the kitchen wall on 12/01/25 at 8:25 AM revealed a jar of spice that was not labeled or dated when opened. Observation of the kitchen preparation counter on 12/01/25 at 8:26 AM revealed a loaf of bread was not labeled or dated when opened. Observation of the freezer on 12/01/25 at 8:27 AM revealed 3 packages of hot dog buns not labeled or dated when opened.Observation of the dry storage room on 12/01/25 at 8:30 AM revealed a can of cranberry sauce not dated when delivered. In an interview on 12/01/25 at 8:47 AM, the DM stated that all staff were responsible for ensuring items were stored, labeled and dated. The DM stated every item opened should have an open date in the refrigerator, freezer, and dry storage. The DM stated if food items were not properly labeled and dated, staff may be unaware of when the items were opened, increasing the risk of food spoilage and potential illness for residents. The DM stated dates should have been legible to read to make it easy for staff to discard when needed. The DM stated if food items were not properly labeled, it would have increased the risk of food getting spoiled or it would cause potential illness for the residents. Record review of the Food Storage Policy dated 06/01/19 revealed the following: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines.1. Dry storage room d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. 3. Freezerse. Store frozen foods in moisture-proof wrap or containers that are labeled and dated.