STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455822	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Harli	820 Camelot Dr Harlingen, TX 78550

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 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)

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 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 interview and record review the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provided jurisdiction in long-term care facilities) in accordance with state law through established procedures for 1 of 5 residents (Resident #1) reviewed for abuse and neglect. The facility failed to ensure all alleged violations or allegations involving abuse for Resident #1 were reported to the proper entities immediately or as required by law on 08/19/2025. This failure could place residents at risk for abuse or further potential for abuse due to unreported allegations of abuse and neglect.Findings include: Record review of Resident #1's face sheet, dated 11/19/2025, revealed an [AGE] year-old male who was originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE]. Resident #1's pertinent diagnoses included PTSD (a mental health condition which was caused by an extremely stressful or terrifying event), Dyspnea (commonly known as shortness of breath, or the sensation of not being able to get enough air into the lungs), Depression (a mood disorder which causes a persistent feeling of sadness and loss of interest and could interfere with daily living), and Chronic Systolic Heart Failure (a condition in which the left ventricle of your heart was weak and cannot pump blood efficiently). Record review of Resident #1's change of condition note, dated 08/19/2025, revealed Resident #1 reported another resident wandered into his room and hit him on the right side of his forehead when he told him to leave. No injuries were noted. Record review of Resident #1's progress note, dated 08/19/2025 at 3:00 AM, revealed LVN-C heard Resident #1 yelling help, get him out of my room. Upon arrival to the room, LVN-C noticed Resident #2 standing at the foot of Resident #1's bed. Resident #1 told LVN-C he hit me. Resident #2 appeared to be confused, and was escorted back to his room by CNA-D. Record review of Resident #1's Provider Investigation Report, CNA-D's Investigation Statement, dated 08/19/2025, revealed she was the CNA primarily assigned to the 100 hall at the time of this incident, and when she entered Resident #1's room, Resident #2 was standing at the end of Resident #1's bed. Resident #1 yelled get him out of here, he already hit me one time. Record review of Resident #1's annual MDS assessment, dated 10/07/2025, revealed a BIMS score of 15, which indicated intact cognition. Record review of Resident #2's face sheet, dated 11/19/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2's pertinent diagnoses included Major Depressive Disorder (a persistent feeling of sadness and loss of interest), Anxiety (intense, excessive and persistent worry and fear about everyday situations), Dementia (a condition which affects memory, thinking, and the ability to perform daily activities), PTSD (a mental health condition which was caused by an extremely stressful or terrifying event), Depression (a mood disorder which causes a persistent feeling of sadness and loss of interest), and Alzheimer's Disease (a progressive disorder which was the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes). Resident #2's face sheet also revealed he had been discharged to another nursing facility on 08/28/2025. Record review of Resident #2's quarterly MDS assessment, dated 08/20/2025, revealed a BIMS score of 03, which indicated severely impaired cognition. The MDS also revealed Resident #2's active diagnoses of Anxiety, Depression, PTSD, Alzheimer's and Dementia. MDS section P0100 revealed wander/elopement alarm used daily. Record review of Resident #2's care plan, dated 03/06/2025, revealed Resident #2 was an elopement risk and wanderer. Interventions included the use of a wander guard, identify patterns of wandering and intervene as appropriate, provide structured activities, as well as distract Resident #2 by offering pleasant diversions, structured activities, food, conversation, television, and/or books. Interventions revealed the facility was working on finding appropriate placement in a secured unit for Resident #2. Resident #2 had a care plan dated 08/19/2025, which revealed Resident #2 had an episode of wandering into another resident's room and allegedly hitting him on the right side of his forehead. Care Plan revealed it was suspected Resident #2 thought he was in his room since it was directly across the hall from his room. Interventions included placing a picture of Resident #2 and his motorcycle outside of his room to help him identify the room, psychiatric consult to review medication regimen, lab work ordered, to include CBC and CMP, and continue to monitor Resident #2 for increased wandering episodes. Record review of PIR revealed the incident between Resident #1 and

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to establish and 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 13 of 13 residents reviewed for infection control practices. The facility failed to ensure all EBP residents in the facility had PPE available immediately near the residents' rooms. This failure could place residents at risk for cross contamination and infection.Findings included: Record review of the list of residents on precautions, from the ICN, dated 08/20/2025, revealed 13 residents in the facility were on EBP, and 4 residents were on contact precautions. In an observation on 11/17/2025 at 1:45 PM, it was observed multiple rooms, to include rooms on Halls 100, 300, 400, 500, 600 and 700, had EBP signage which revealed providers and staff must wear gloves and gown for the following high contact activities: dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care, and/or wound care. The rooms that were on EBP had appropriate signage located on the doors, but there was no PPE located on the doors or next to the rooms. It was observed the rooms which had contact precaution signs on the doors had PPE located on the doors or next to the rooms. In an interview on 11/19/2025 at 3:05 PM, ADON-A stated only residents on contact precautions had PPE on their doors or next to their rooms because it had to be utilized every time someone entered that room, but PPE for residents on EBP was kept in the supply closet located on each unit, as well as on the linen carts, since it only had to be utilized for high contact activities. After reviewing all of the linen carts on each hall, ADON-A stated there was no PPE on the carts, only in the supply closets located on the 200 hall on Unit A, and the 800 hall on Unit B. ADON-A stated she knew EBP required PPE for high contact activities for residents with wounds, indwelling medical devices, or certain contagious illnesses, but was not sure about policies, guidelines, or recommendations for where it should be kept or placed for residents on EBP. In an interview on 11/19/2025 at 3:15 PM, ADON-B stated PPE was not kept next to any of the EBP rooms or on their doors; he stated PPE was only kept on the door of or next to residents' rooms on contact precautions. ADON-B stated there was a supply closet located on the 200 hall in Unit A and the 800 hall in Unit B which had PPE in it, and the staff knew to go to these closets to get PPE prior to going into the EBP rooms to provide care. ADON-B stated visitors knew which PPE to utilize in rooms on EBP because the signage on the door notified visitors to check with the nurses' desk prior to entering the room, and they were then instructed on and provided the appropriate PPE to use if they were going to provide any care. Upon looking at the signage on the door, ADON-B stated it did not reveal visitors were to come to the nurses' station prior to entering the room. ADON-B stated he was not sure what the recommendations were for the facility infection control policy or enhanced barrier policy in regard to placing or storing PPE for EBP rooms, as well as he was not sure what the CDC guidelines or recommendations for placing or storing PPE for EBP rooms were other than it should be made available and utilized with high contact activities for residents with draining wounds, certain infections, and/or indwelling medical devices. In an interview on 11/19/2025 at 4:05 PM, LVN-E stated EBP precautions were used for high contact on residents with draining wounds, certain infections, and indwelling medical devices, and the PPE involved was typically gown, gloves, and sometimes face shields. LVN-E stated the PPE for residents on EBP was located in the supply closet on the 300 hall, and it was tedious to go back and forth to the area to grab supplies for the EBP rooms. She stated she believed the PPE was supposed to be kept right outside of the residents' rooms which were on EBP just like residents on contact precautions, but she was not sure. In an interview on 11/19/2025 at 4:13 PM, CNA-F stated EBP precautions were used for residents with wounds or things such as foley catheters or g-tubes to keep from spreading infection to these residents. She stated she had to go to the supply room on the 300 hall to get PPE supplies each time she went in to care for a resident on EBP. She stated it was difficult to go back and forth so much to get new PPE supplies every time she had to provide care. She was not sure where they were supposed to be kept, but the supply room on the 300 hall was where they were kept on her side of the facility. CNA-F stated the residents who were on contact precautions had the PPE located on the door of their room, and it was much easier to grab it at the door to put on prior to entering their room for anything. In an interview on 11/19/2025 at 4:44 PM, the DON stated residents who were on EBP did not have PPE kept at or close to their room since it was only required for staff rendering high contact activities. The DON stated staff knew they had to go to the supply room to grab PPE prior to going into a resident's room which was on EBP. The DON also stated families of these