

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

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2026
NAME OF PROVIDER OR SUPPLIER Windsor Nursing and Rehabilitation Center of Harli		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure that a medication was properly labeled for 1 of 2 residents (Resident #1) that were reviewed for pharmacy services. The facility failed to ensure that a tube of Permethrin External Cream 5% (a topical medication primarily used to treat scabies (skin rash)) was labeled with Resident #1's name. This failure could place residents at risk of not receiving prescribed medications as ordered and adverse effects of medications due to incorrect labeling. Findings included: Record review of Resident #1's admission Record, dated 05/07/26, revealed an [AGE] year-old female. Resident #1 was admitted to the facility on [DATE] with an original admission date of 10/19/24. Record review of Resident #1's Diagnosis Report, reflected a primary diagnosis of vascular dementia (result from conditions that damage the brain's blood vessels), muscle wasting and atrophy (partial or complete wasting away of a part of the body), Type 2 diabetes (condition where the body develops insulin resistance, causing high blood sugar levels), hemiplegia paralysis affecting one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction affecting right dominant side, and heart disease (conditions affecting the heart's structure and function). Record review of Resident #1's Quarterly MDS assessment, dated 04/20/26 revealed Resident #1 had a BIMS score of 01, which indicated she was severely cognitively impaired. Record review of Resident #1's Completed Orders for October 2025 revealed an order for Permethrin External Cream 5% dated 10/27/25: Apply to affected area topically for one time only for Rash for 1 day. Record review of Resident #1's MAR for October 2025, revealed Permethrin External Cream 5% had been administered on 10/28/25 by LVN B. Record review of Resident #1's Progress Note by LVN B dated 10/28/25 stated, Permethrin treatment done today at 7:15pm. During a record review on 05/05/26 at 8:42am of a photograph that was submitted for review from Resident #1's RP. The photograph was time-stamped Tuesday October 28, 2025, 7:17pm. The photograph revealed a tube of Permethrin External Cream 5% that did not have Resident #1's name on the label. During an interview on 05/05/26 at 8:42am with Resident #1's RP revealed she was aware that Resident #1 received a topical medication that did not have Resident #1's name on the label. The RP stated Resident #1 received the order for Permethrin in late October of 2025 but Resident #1's name was not on the label. RP stated she was in the room when LVN B administered the medication. RP stated when LVN B was not looking, she took a photograph of the medication tube when she noticed it did not have Resident #1's name on it. RP stated she did not alert LVN B that the medication tube did not have Resident #1's name on it because it was still the correct medication ordered. During an interview on 05/07/26 at 2:15pm, LVN B stated he remembered that he administered Permethrin once to Resident #1. LVN B stated he did not recall seeing Resident #1 name on the label. LVN B stated it was important to check the name on the label because the medication could be used for a different purpose. LVN B stated results of that could have caused an allergic reaction. During an interview on 05/07/26 at 5:03pm, the DON stated she was not aware that the medication administered did not have Resident #1's name on the label. She stated had she known, she would have addressed it right away. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 455822
		If continuation sheet Page 1 of 4

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated facility nurses were educated to ensure that the medications were given to the correct resident. DON stated it was important to ensure that medications indicated were to treat whatever it was indicated for. Review of the facility's Labeling of Medications with revision date of 10/01/19 revealed: Policy: All drugs and biological in the Facility are labeled in accordance with all Federal and State regulations. Procedure: 2. Prescription medications will be labeled with the following information B. Name of Resident		

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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** Based on record review and interviews, the facility failed to maintain clinical records on each resident that were complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for administration. The facility failed to document skin integrity findings into the skin assessments for continued monitoring. This deficient practice could affect residents who require care and monitoring and place them at risk of not receiving the care to meet their needs. Findings included: Record review of Resident #1's admission Record, dated 05/07/26, revealed an [AGE] year-old female. Resident #1 was admitted to the facility on [DATE] with an original admission date of 10/19/24. Record review of Resident #1's Diagnosis Report, reflected a primary diagnosis of vascular dementia (result from conditions that damage the brain's blood vessels), muscle wasting and atrophy (partial or complete wasting away of a part of the body), Type 2 diabetes (condition where the body develops insulin resistance, causing high blood sugar levels), hemiplegia paralysis affecting one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction affecting right dominant side, and heart disease (conditions affecting the heart's structure and function). Record review of Resident #1's Quarterly MDS assessment, dated 04/20/26 revealed Resident #1 had a BIMS score of 01, which indicated she was severely cognitively impaired. Record review of Resident #1's Total Body Skin assessments dated 06/06/25, 06/13/25, 06/20/25, 06/21/25, 06/27/25, 07/04/25, 07/11/25, 07/19/25, 07/26/25, 08/02/25, 08/11/25, 08/13/25 and 08/20/25 indicated no new skin findings. Record review of Resident #1's skin checks dated 09/11/25, 09/18/25, and 09/29/25 indicated no new skin findings. Record review of Resident #1's progress note dated 07/10/25 revealed a nursing note by ADON A. Under the skin section, the following was noted: Skin: Skin Color: Normal for ethnic group Skin Temperature: Warm/dry Skin Turgor: Normal Skin intact: Yes During an interview on 05/05/26 at 8:42am with Resident #1's RP, RP stated she notified staff in June of 2025, that resident had developed a rash on her legs. RP stated rash was not properly addressed until October of 2025. RP stated she was aware that Resident #1 had a skin scrape test (a quick, minimally invasive diagnostic test where a healthcare provider gently scrapes the surface of a skin lesion to collect skin cells. It is primarily used to check for fungal infections like parasites such as scabies) done and the results were negative, but RP insisted Resident #1 needed to be treated. RP stated the rash had since resolved. During an interview on 05/07/26 at 11:48am with ADON A stated he would round with the Wound Care NP and would document wound progressions, changes, and new skin issues. ADON A stated he was aware that resident had something on her skin in June of 2025. ADON A stated that what he saw on resident was not a rash but more like petechiae (tiny, non-raised red, purple, or brown spots caused by small broken blood vessels leaking blood under the skin). ADON A stated he did not document the finding because it was being monitored weekly by the NP and himself while doing wound care rounds. ADON A stated it was not until October of 2025 that Resident #1 received an order for a skin scrape test. ADON A stated he was the one that performed the test and results came back negative for scabies. ADON A stated that even though the results were negative, Resident #1's RP insisted for Resident #1 to be treated for scabies. ADON A stated a few weeks after the treatment, the rash resolved. ADON A stated Resident #1 did not have a rash at this time. ADON A stated it is important to document all new skin findings because it established a baseline to track changes over time and diagnose underlying diseases. During an interview on 05/07/26 at 5:38pm, the NP stated she did not remember if Resident #1 had a rash or skin issue in June or July of 2025. The NP also stated she did not remember if she had documented it or not. The NP stated that if Resident #1 had a skin issue, she would have expected ADON A to document it on his notes for continued monitoring. Review of the facility's Documentation in Medical Record policy, dated 10/24/22, reflected: Policy Explanation and Compliance Guidelines: 1. Licensed staff and interdisciplinary team (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.		