

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

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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 07/02/2026
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Residents #1), reviewed for pharmaceutical services, in that: The facility failed to ensure Resident #1's Morphine orders included pain parameters for when the medication should be given. This failure could place residents at risk for not receiving medication as ordered. Findings included: Record review of Resident #1's admission record, dated 07/02/26, reflected a[AGE] year-old male who was re-admitted on [DATE] and an original admission date of 05/20/26. His relevant diagnoses included Parkinson's disease (a progressive neurological disorder that primary affects movement), dementia (a decline in mental ability severe enough to interfere with daily life), and abnormalities of gait and mobility (any irregular walking pattern or difficulty moving). Record review of Resident #1's 5-day Medicare MDS assessment, dated 06/08/26, reflected a BIMS score of 07, which indicated his cognition was moderately intact. Record review of Resident #1's comprehensive care plan, dated 06/16/26, reflected: Problem: [Resident #1] is on pain medication therapy morphine r/t hip surgery. Date initiated: 07/01/26. Interventions: Administer analgesic (any medication designed to relieve pain without causing a loss of consciousness) medications as ordered by physician. Record review of Resident #1's physician order summary, dated 07/02/26, reflected 3 morphine orders: Morphine Sulfate (concentrate) oral solution 20 mg/ml (morphine sulfate) give 0.75 ml by mouth every 1 hours as needed for pain/sob. Start date 07/02/26. Morphine Sulfate (concentrate) oral solution 20 mg/ml (morphine sulfate) give 0.50 ml by mouth every 1 hours as needed for pain/sob. Start date 07/02/26. Morphing Sulfate (concentrate) oral solution 20 mg/ml (morphine sulfate) give 1 ml by mouth every 1 hours as needed for pain. Start date 07/02/26. Record review of Resident #1's July 2026 MAR, reflected Morphine Sulfate oral solution 20 mg/ml had not yet been administered. Record review of Resident #3's vital pain history reflected he had not been in pain since re-admission [DATE]. During an observation on 07/02/26 at 10:58 a.m., Resident #1 was observed lying in bed asleep. No facial grimacing was observed and no signs of distress were noted during the observation. During an interview and record review on 07/02/26 at 11:50 a.m., LVN A said Resident #1 was re-admitted on [DATE] after a short hospital stay. She said Resident #1 had been placed under hospice services while hospitalized and upon readmission, the hospice agency ordered prn morphine for pain and sob. She reviewed Resident #1's electronic medical record and said he had 3 PRN orders for morphine and all 3 were missing pain parameters. LVN A said it was the facility's protocol to have an order for each dose of narcotics for monitoring purposes. LVN A said Resident #1 was non-verbal and nursing staff relied on facial grimacing to determine his pain level. She said Resident #1's prn morphine order required pain parameters to know much to administer. She said Resident #1 had not been administered morphine since he was re-admitted . She said she was familiar with the pain management parameters and the appropriate morphine dose to administer based on Resident #1's facial grimacing. She said she would administer 0.50 ml of morphine for a pain level of 1-3, 0.75 ml for (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a pain level of 4-7, and 1 ml for a pain level of 8-10. LVN A said there were no negative outcomes to Resident #1 not having his morphine order include pain parameters because he had not been administered morphine yet and she would know who much to give. During an interview and record review on 07/02/26 at 12:10 p.m., the ADON said Resident #1 had a diagnosis of dementia and had difficulty verbalizing his pain. She said nursing staff relied on his facial grimacing to determine his level of pain. The ADON reviewed Resident #1's electronic medical record and said Resident #1 was readmitted on [DATE] after a short hospital stay. She said Resident #1 had been placed under hospice services while hospitalized and upon readmission to the facility, the hospice agency ordered prn morphine for pain and sob. The ADON said Resident #1's morphine orders were missing pain parameters. She said pain parameters were important to determine how much medicine to give. She said it was the responsibility of the admitting nurse to ensure all orders were clear and complete. The ADON said Resident #1 had not yet been administered morphine since his readmission. The ADON said one of her morning responsibilities was to review all re/admitted residents orders to ensure they were written and followed correctly. She said she had not had time yet to review any orders today (07/02/26). She said nursing staff were frequently in-serviced on physician orders and medication administration. She said a negative outcome for Resident #1 not having pain parameter on his morphine order would be that he could be over sedated. During an interview and record review on 07/02/26 at 12:50 p.m., the DON was observed as she reviewed Resident #1's electronic medical record and said Resident #1 had been readmitted to the facility on [DATE] after a short hospital stay. She said Resident #1 had been placed under hospice care while hospitalized and upon admission, the hospice agency had ordered prn morphine for pain and sob. She said Resident #1 had a diagnosis of dementia and had difficulty communicating his pain level. She said nursing staff relied on Resident #1's facial grimacing to determine his pain level. The DON said upon his readmission, Resident #1 had not yet been administered morphine. She said Resident #1's morphine orders were missing pain parameters. She said it was the facility's protocol to have pain scale for residents who had dementia or have difficulty verbalizing pain. The DON said it was the responsibility of the admitting nurse to ensure all orders were clear and complete. She said Resident #1 had just been admitted last night and said as soon as the ADON or herself reviewed Resident #1's order, they would have determined the pain parameters were missing but state surveyor saw it first. The DON said a negative to Resident #1 not having pain parameters on his morphine orders would be the potential of being under or over dose and not given the adequate dose to meet his needs. Record review of the facility's Medication Orders policy, revised on 10/01/2019, reflected: Policy: Medications are administered only upon clear, complete, and signed order of a person lawfully authorized to prescribe. Procedure: 1. Elements of the medication order Medication orders specify the following.c. dosage.		