STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675309	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Alice	606 Coyote Tr Alice, TX 78332

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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 each resident had the right to be free from abuse for seven residents (Resident #2, Resident #3, Resident #4, Resident #5, Resident#15, Resident #20 and Resident #23) of 7 residents reviewed for abuse/neglect. 1. The facility failed to ensure Resident #2 was free from abuse, Resident #2 sustained a right hip fracture from being pushed by Resident #3 on 04/22/25. 2. The facility failed to ensure Residents #2 and #5 were free from abuse, Resident #4 hit Resident #3 in the back of the head causing a bump to her head and pushed Resident #5 that caused him to fall on top of another resident on 06/07/25 at 4:50 PM. 3. The facility failed to ensure Resident #15, Resident #20, and Resident #23 were free from abuse when Resident #15 struck Resident #20 on the back of his head with her phone causing an abrasion; and struck Resident #23 on his face with her phone on 03/24/25. The noncompliance was identified as PNC at an Immediate Jeopardy level. The Immediate Jeopardy event began on 04/22/25 and ended on 04/23/25 when it became PNC. The facility had corrected the noncompliance before the investigation began. These failures have the potential to result in serious injury or death as a result of abuse and neglect. The findings included: Record review of Resident #2's Face Sheet dated 07/01/25 revealed an [AGE] year-old male admitted on [DATE] with the diagnosis of: psychotic (a mental disorder characterized by disconnection of reality) disturbance and hypertension (high blood pressure). Resident #2 resided in the facility's secured unit. Resident #2 was discharged on 04/22/25.Record review of Resident #2's acute care plan dated 04/21/25 reflected he:- had impaired thought processes .- was an elopement risk/wanderer .Interventions: Distract resident from wandering by offering pleasant diversions; Identify pattern of wandering .- needs structured environment in secure unit related to cognitive deficit .- had a resident to resident; female went into resident's room and then told resident to leave her room she then pushed resident causing resident to lose balance and fall . Record review of Resident #2's Minimum Data Set assessment revealed there was no assessment available due to he was recently admitted on [DATE]. Record review of Resident #3's Face Sheet dated 07/01/25 revealed a [AGE] year-old female admitted [DATE] with the pertinent diagnoses of: Dementia, Cognitive Communication Deficit (communication difficulties stemming from impairments in cognitive processes), and degenerative disease of nervous system. Resident #3 resided in the facility's secured unit. Resident #3 was discharged on 06/10/25.Record review of Resident #3's comprehensive care plan dated 03/18/25 reflected Resident #3:- has impairment cognitive function/dementia or impaired thought process related to Dementia .- had a behavior problem, she walked into other residents' room, repetitive questions related to Dementia .Interventions: Caregivers to provide opportunity for positive interaction, attention, stop and talk to her when passing by; explain all procedures to resident before starting .; if reasonable, discuss the resident's behavior, explain why behavior is inappropriate; intervene as necessary to protect the rights and safety of others, speak in calm manner and divert attention, remove from situation and take to alternate location; monitor behavior episodes ; provide program of activities .-is an elopement risk .Interventions: Distract resident from wandering; Identify pattern of wandering; redirection; provide structural activities .- needs structural environment in secure unit related to cognitive deficit .- [Resident #3] stated during interview with the social worker that in the past she had traumatic experiences with men .Interventions: Staff to monitor resident for behavior such as pushing, yelling, and cursing at others, staff to redirect as needed .- had a resident to resident, she walked into a male resident's room she then pushed resident causing him to lose his balance and fall .Record review of Resident #3's admission Minimum Data Set assessment dated [DATE] reflected she:-had clear speech-usually made self-understood and usually understood others-her BIMS summary score was 5 (indicating severe cognitive impairment)-did not have potential indicators of psychosis. She had other behavior symptoms not directed to others 1 to 3 days-had wandering behaviors that placed the resident at significant risk of getting to a potentially dangerous place-required partial to moderate assistance for personal care.Record review of the facility's Provider Investigation Report reflected Incident Date/Time: 04/22/25 at 1:10 AM. [Resident #3] was ambulatory, not interviewable, not able to make informed decisions, had no special supervision. Resident #3 was the alleged perpetrator.Resident #2 was ambulatory, interviewable, not able to make informed decisions, had no special supervision. Resident #2 was the alleged victim. Description of allegation: Female resident wandered into male resident room. She believed the room to be hers and yelled at the male resident to get out of her room. The male resident was awake and standing

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, for 3 Residents (Resident #4, Resident #15, and Resident #3) out of 4 investigated for abuse in the facility, in that: The facility failed to enforce the abuse policy correctly during investigations of abuse for Resident #'s 3, 4 and 15. Investigations were found to be inconclusive based on an incorrect interpretation of the definition of abuse and willful. The ADM and DON were not able to define abuse or willful correctly, making them incapable of determining whether abuse occurred at the facility or not. The ADM was the abuse prevention coordinator at the facility in charge of investigating abuse allegations. This failure could place residents at risk of abuse and neglect.The findings included:Record review of Resident #4's Face Sheet dated 07/01/25 revealed a [AGE] year-old female initially admitted on [DATE] and re-admitted on [DATE] with the diagnoses of: Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows and manic highs), hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there), unspecified intellectual disability, Schizoaffective disorder (a combination of schizophrenia and mood disorder- disorder that affects a person's ability to think, feel, and behave clearly). Record review of Resident #5's admission MDS assessment dated [DATE] reflected she had a BIMS score of 14 (cognition intact). Record review of the provider investigation for intake 1015113 on 07/02/25 with an allegation of Resident Abuse by Resident #4 revealed the following conclusion: Investigation is inconclusive. The residents have diminished capacity to willfully intend any harm, The residents in question had no pain, mental anguish or emotional distress. Record review of Resident #15's Face Sheet, dated 07/02/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: cerebral infarction (stroke), schizophrenia (disorder that affects a person's ability to think, feel and behave clearly), bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning) without behavioral disturbance, and major depressive disorder. Resident #15 was discharged to another facility on 05/17/25.Record review of Resident #15's quarterly MDS assessment, dated 02/18/25, revealed Resident #15 had a BIMS score of 13, indicating her cognition was intact. Record review of the provider investigation for intake 573006 on 07/02/25 with an allegation of Resident Abuse by Resident #15 revealed the following conclusion: Investigation is inconclusive. The residents have diminished capacity to willfully intend any harm, The residents in question had no pain, mental anguish or emotional distress. Record review of Resident #3's Face Sheet dated 07/01/25 revealed a [AGE] year-old female admitted [DATE] with the pertinent diagnoses of: Dementia, Cognitive Communication Deficit (communication difficulties stemming from impairments in cognitive processes), and degenerative disease of nervous system. Resident #3 was discharged on 06/10/25.Record review of Resident #3's admission Minimum Data Set assessment dated [DATE] revealed Resident #3 had a BIMS score of 5 (severe impairment). Record review of the provider investigation for intake 1005690 on 07/02/25 with an allegation of Resident Abuse by Resident #3 revealed the following conclusion: Investigation is inconclusive. The residents have diminished capacity to willfully intend any harm, The residents does not have previous history of aggressive behaviors. In an interview with the DON at 10:15 AM on 07/02/25, the DON stated residents had a right to be free from abuse and neglect at the facility. The DON stated residents needed to act willfully for an action to be considered abuse. The DON stated residents who were confused or had a diminished ability to understand their actions could not act willfully. The DON stated it was important to investigate all allegations of abuse thoroughly to understand why it occurred and to prevent it from happening again. The DON stated failing to identify abuse correctly could lead to implementing incorrect interventions to protect residents leading to further abuse in the future.In an interview with the ADM at 12:20 PM on 07/02/25, the ADM stated she was the abuse prevention coordinator at the facility. The ADM stated it was her responsibility to educate the staff on what abuse means and how to report allegations of abuse. The ADM stated she coordinates all investigations of abuse at the facility. The ADM stated she wrote the summaries in the provider investigations for intake numbers 1015113, 573006, and 1005690. The ADM stated for her to substantiate an abuse finding in a provider investigation she would need to have evidence that the perpetrator intended to cause harm to the victim. The ADM stated in cases where the resident had a

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews the facility failed to ensure residents received adequate supervision to prevent accidents and/or hazards as possible for 1 of 12 residents (Resident #1) reviewed for supervision and accident hazards. The facility failed to ensure Resident #1 received adequate supervision in allowing Resident #1 to exit the facility without the knowledge of staff sometime between 6:30 PM and 7:00 PM on 05/16/25. An IJ was identified on 07/01/25. The IJ template was provided to the facility on [DATE] at 8:15 PM. While the IJ was removed on 07/03/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because new polices implemented to prevent future errors were still in process. This failure could place residents at risk for injuries and a decline in health. 1. Resident #1:Record review of Resident #1's face sheet dated 07/01/25 revealed a [AGE] year-old male with an admission date of 03/28/25. Pertinent diagnoses included Unspecified Dementia, Other Abnormalities of Gait and Mobility, and Other Lack of Coordination. Record review of Resident #1's Comprehensive Care Plan dated 07/02/25 revealed the problem [Resident #1] had an elopement through the front door initiated on 05/16/25. Interventions listed for the problem included: Increase supervision when resident is observing doors for long period of time initiated on 05/17/25. Redirect resident if he is having any wandering or exit seeking behaviors initiated on 05/17/25. Secure Unit initiated on 05/17/25. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 5 (severe impairment). Further review revealed Resident #1 had wandering behaviors one to three days in the last week. Further review revealed Resident #1 had not used a cane, walker, or wheelchair to move in the last seven days. Record review of the provider investigation revealed the following summary: CNA [N] reported at approximately 7:30 to charge the nurse that the resident was missing. Upon interview she stated she clocked in to work at approximately 6:15-6:30pm and began doing her round. During her rounds she noticed that the resident was not in his room. She went to the secure unit and [CNA O] in that hall told her he was not on the unit. CNA [N] then went to the resident's room again to find the resident was not in his room or bathroom. She immediately reported to DON who was the charge nurse at the time. At approximately 7:34 DON reported to Admin they were unable to locate the resident and she was currently searching the outside of the facility. Facility called code for elopement and department managers started searching the vicinity of the town. Admin notified police [case number] of missing resident. At approximately 8:07pm [staff] notified that the resident was with his family at his previous address in [City Name]. Family returned the resident to the facility, and he was admitted to the secure unit at approximately 10:11pm. Resident assessed head to toe and no signs of injury or emotional distress. Investigation to conclude that the resident had walked out the front door during the timeframe of two ambulances coming to the facility. The resident confirmed he went out the front door when it was open. Resident was picked up by a passing citizen and drove the resident to his address on his driver license. All staff in-services on front door engagement and assuring it is locked prior to leaving. Record review of Resident #1's wandering evaluation dated 05/13/25 revealed Resident #1 was deemed to not be a wandering risk In an interview with Resident #1's RP at 11:09 AM on 07/01/25, RP 1 stated he received a phone called from his Resident' #1 neighbor at his old address in [City Name]. RP 1 stated the neighbor told him a gentleman had driven his father to his old house in [City Name]. RP 1 stated the gentleman that drove his father told him he picked Resident #1 up, called the police, and the police told him to drive Resident #1 to the address on his Identification Card. RP 1 stated the address in [City Name] was about 25 minutes away from the facility. RP 1 stated he drove to the address to pick up Resident #1 RP 1 stated his father was physically fine and not in pain. RP 1 stated he drove his father back to the facility and they put him back in the locked unit. In an interview with Resident #1 at 11:35 AM on 07/01/25, Resident #1 was not able to provide any details of the incident due to cognitive deficits. In an interview with the DON at 2:18 PM on 07/01/25, the DON stated she was the charge nurse at the time of Resident #1's elopement. The DON stated it was busy at the front door that evening. The DON stated CNA N told her she could not find Resident #1 at around 7:00 PM and she immediately initiated a head count of all residents. The DON stated she called the administrator and then began searching outside the facility. The DON stated there is no telling what could have happened to Resident #1 during his elopement, especially since he was given a ride by a stranger. The DON stated Resident #1 was admitted to the locked unit on 03/28/25 and had just been let out of the locked unit on 05/13/25. The DON no resident centered plan was put in place to transition residents