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	03/03/2026

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary drugs for 1 (Resident #2) of 3 residents reviewed for medications. The facility failed to have an adequate indication for the use of the medication Risperidone (an antipsychotic with black box warning) for Resident #2 before administering the medication. This failure could put residents at risk of harm from adverse reactions or harmful side effects. Findings included: Record review of Resident #2's admission record dated 03/03/26, reflected a [AGE] year-old female with an admit date of 02/19/26 and an initial admission date of 04/11/22. Her relevant diagnoses included anxiety disorder (persistent, excessive fear or worry that interferes with daily life), major depressive disorder (a serious, common mood disorder characterized by persistent sadness, loss of interest in activities, and fatigue), dementia with behavioral disturbance (agitation, aggression, psychosis, depression, and apathy). Record review of Resident #2's quarterly MDS assessment dated [DATE], reflected a BIMS score of 12, which indicated her cognition was moderately impaired. It further indicated Resident #2 received antipsychotic and antidepressant medications. Resident #2's MDS did not indicate behaviors. Record review of Resident #2's quarterly care plan dated 12/19/25 reflected a:Problem: [Resident #2] uses antipsychotic medication.Risperdal r/t dementia.Interventions in part included Risperidone tablet 0.5 mg, give 1 tablet by mouth at bedtime, date initiated 02/23/2026. Problem: [Resident #2] has behaviors of calling/yelling out for help related to (unspecified dementia, unspecified severity, with other behavioral disturbances) (Resident on hall screaming I need help, however when you ask what help, she has no direction) date initiated 05/31/2024. Interventions in place were nursing staff to monitor behavior redirect as needed and document behaviors and administer medication as ordered, date initiated 05/31/2024. Record review of Resident #2's order summary dated 03/03/26 reflected an active order for Risperidone Tablet 0.5 MG give 1 tablet by mouth at bedtime relate to unspecified dementia, unspecified severity, with other behavioral disturbance, order date 0223/26 and start date 02/23/26. In an interview on 03/03/26 at 4:00 p.m., LVN D said if a resident's psychiatrist ordered an antipsychotic with an indication of dementia, she would ensure the order indicated it said it was for behaviors also. She said if she had any questions related to antipsychotic medications, she would ask her DON. LVN D was not able to say what the negative outcome to Resident #2 having an antipsychotic order with an indication of dementia. In an interview on 03/03/26 at 4:15 p.m., ADON C said it was her responsibility ensure all antipsychotic orders had the correct indication. She said Resident #2's order for Risperidone with the indication of dementia was correct because that's what the doctor had indicated that way. She said the facility's contracted Pharmacist reviewed all orders to ensure proper indication and dosage. ADON C said Resident #2's Risperidone order was effective 02/19/26 for 1 mg. She said the facility's contracted pharmacist had initiated a gradual dose reduction on 02/23/26 and had lowered her dosage to 0.5 mg. She said the gradual dose reduction had been initiated because [Resident #2] does not have a diagnosis that fits that medication. ADON C said there were no negative outcomes to Resident #2 because her order for Risperidone was a low dosage and gradual dose reduction had been initiated. In a telephone interview on 03/03/26 at 4:41 p.m., the Pharmacist said Resident #2's order did not have the correct indication, and she had initiated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a gradual dose reduction effective 02/23/26. The Pharmacist said there were no negative outcomes to Resident #2 for not having a correct indication on her Risperidone medication because Resident #2 had experienced behavioral issues due to her diagnosis of schizoaffective disorder. In a telephone interview on 03/03/26 at 4:51 p.m., NP E said he was Resident #2's Psychiatric NP. He said he had ordered Risperidone on 02/19/26 with an indication of schizoaffective disorder. He said, I would never prescribe an antipsychotic with an indication of dementia. He said whoever had taken the phone order must have entered the wrong indication. He said there were no negative outcomes to Resident #2 not having the correct indication on her Risperidone order because what the medication was treating was her diagnosis of schizoaffective disorder. In an interview on 03/03/26 at 5:12 p.m., the DON said Resident #2's order for Risperidone did not have the correct indication. She said Resident #2 had a diagnosis of schizoaffective disorder prior to being re-admitted on [DATE]. She said when she was readmitted , that diagnosis must have been struck out. The DON said there were no negative outcomes to Resident #2 not having the correct indication for her Risperidone order. Record review of the facility's Use of Psychotropic Medication(s), dated 03/05/2025 reflected:Policy: It is the intent of this policy to ensure that resident only receive psychotropic medication when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used to discipline or staff convenience, which would deem it a chemical restraint. Definitions: adequate indications for use refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and after any other treatment have been deemed clinically contraindicated.Policy Explanation and Compliance guidelines: 2. Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(is beneficial to the resident, as demonstrated by monitoring and documenting of the resident's response to the medication(s).