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	04/01/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews and record review, the facility failed to store food in accordance with professional standards for food service safety in the facility kitchen for 2 of 3 facility refrigerators, and 1 of 2 facility freezers reviewed for storage, preparation and sanitation. -The facility failed to ensure containers of tuna, corn, chocolate pudding, vanilla pudding, chilled fruit, and jello that were dated past the 72-hour used by date were thrown away.-The facility failed to ensure the safe storage of a bag of onions sitting next to the pail with cleaning chemical solution and a rag for cleaning purposes.-The facility failed to ensure 2 boxes of hashbrowns, and 1 box of bread dough were sealed and protected from cross contamination and exposure to splash, dust, or other contamination. These failures could place residents who receive meals and/or snacks from the kitchen at risk for food contamination and food borne illness. Findings included: Observations during the initial tour of the kitchen on 03/30/26 at 8:30 AM revealed a bag of onions sitting next to a pail of cleaning solution and rag on the bottom shelf of a kitchen counter. Two of three refrigerators stored a container of corn, tuna, chocolate pudding, vanilla pudding, and chilled fruit dated 03/24/26, and jello dated 03/26/2026. In observation of 1 of 2 facility freezers revealed a box of raw bread loaves and 2 boxes of hashbrowns with plastic bag unsealed and box open and exposed to air and possible contaminantes. In an interview on 03/30/26 at 9:12 AM with the DA he said all kitchen staff were responsible for cleaning the refrigerator and made sure that all food was labeled, sealed, had not expired and had a use by date. The DA stated the refrigerator, and freezer was cleaned, and all expired food was thrown out daily. The DA could not explain why the containers dated 03/24/26 of corn, tuna, chocolate pudding, vanilla pudding, and chilled fruit and Jello dated 03/26/2026 were not seen and thrown away. The DA stated the staff must have forgotten to check dates on the items that were expired according to the 72-hour rule. The DA stated the pail with cleaning solution must have just been put there because it is normally not placed near food because the onions could be contaminated by the cleaning chemicals. The DA stated that he knew it was important to throw out expired food so that it is not served to residents, making them sick. The DA stated he knew that chemicals or cleaning solutions are never to be stored next to food as it can contaminate food and make residents ill. The DA stated the unsealed boxes of hashbrowns, and bread must have been left open recently because he does make sure the items are sealed so that they do not get freezer burn or exposed to air that can contaminate the food. In an interview on 03/30/26 at 09:28 AM the cook stated she could not recall when the boxes of hashbrown and raw bread loaves were left open in the freezer. She stated she did not make sure all food items were closed and sealed or sealed correctly in the freezer but she knew that all items in the refrigerator were to be sealed and not exposed to dampness and air. The cook stated the staff throw away all expired food daily and clean the refrigerator and freezer weekly but she did not know about or see the expired canisters of corn, tuna, chocolate pudding, vanilla pudding, and chilled fruit dated 03/24/26, and Jello dated 03/26/2026 or why they were not thrown away. The [NAME] stated the pail with cleaning solution was always stored in correctly aways from food but the person who last used it did not store them correctly, so the onions were not exposed. In an interview on 03/30/26 at 10:01 AM the DM stated she and the (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff clean out the refrigerator daily and the expired canister of corn, tuna, chocolate pudding, vanilla pudding, and chilled fruit dated 03/24/26, and Jello dated 03/26/2026 must have been overlooked by staff therefore remained in the refrigerator. The DM said these open items had not been used in the menu previously but not used recently for them to have been left in the refrigerator and not thrown away. The DM stated the boxes of hashbrowns and bread dough in the freezer seemed protected but at closer inspection the bag inside the box was not sealed properly and the box was not enough protection from food being exposed to air and contaminated was overlooked. The DM said the pail with the rag was used that morning, and staff in a rush did not ensure the proper placement of the pail and rag away from food. The DM said she will retrain on dating items and making sure they are all covered and throwing out expired foods for all forms of storage. The DM also stated there will be an inventory of all food in both the refrigerator and freezer to ensure all items are not expired. The DM said she will do an in-service on the importance of storing chemicals away from food. Record review of the Food Storage Policy reflected: 1. dry storage rooms i. Do not use or store cleaning materials or other chemicals where they might contaminate foods. Label and store them in their original containers when possible. Store in a locked area away from any food products. 2. Refrigerators e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. 3. Freezers e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated. To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP Guidelines. FDA Food Code 2022 Ch. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. to (E) and (F) of this section, refrigerated, Ready-To-Eat, Time/Temperature control for safety food prepared and held in a Food Establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the Food shall be consumed on the Premises , sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise the comprehensive care plan after each assessment, including both the comprehensive and quarterly review assessments for 1 (Resident #5) of 5 residents reviewed for care plans. The facility failed to review and revise Resident #5's care plan with the current code status.This failure could place residents at risk of not receiving adequate or required care. The Findings included: Record review of Resident #5's face sheet dated [DATE] revealed Resident #5 was a [AGE] year-old male with an original admission date of [DATE], and a current admission date of [DATE]. Pertinent diagnoses included: Acute Respiratory Failure with Hypercapnia, (a life-threatening condition characterized by the inability to eliminate carbon dioxide). Chronic Obstructive Pulmonary Disease (COPD), (a progressive, irreversible lung disease that restricts airflow, causing severe breathing difficulties); Major Depressive Disorder (MDD), (a serious, common mental health condition characterized by persistent low mood, loss of interest in activities, and low energy lasting at least two weeks); Insomnia (a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking too early, leading to daytime fatigue, irritability, and cognitive impairment); Vascular dementia, (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain cells of oxygen and nutrients).Record review of Resident #5's Annual MDS assessment dated [DATE] revealed a BIMS score of 06, which indicated severely impaired cognition. Record review of Resident #5's care plan dated [DATE] revealed Resident #5 had a code status of Do Not Resuscitate listed on the care plan. Some interventions listed for the Do Not Resuscitate care plan were: ensure signed DNR is in medical record; if resident has a cardiac arrest (a medical emergency where the heart unexpectedly stops beating, cutting off blood flow to the brain and organs), do not call 911 or initiate CPR, notify MD/RP and follow instructions after notification. Record review of Resident #5's Physician Order Summary Report dated [DATE] indicated Full Code Status, (a patient chooses to receive all possible life-saving interventions if their heart or breathing stops) ordered [DATE]. In an interview on [DATE] at 11:47 AM the MDS coordinator stated, she put the code status updates in the care plan, and she provided oversight to ensure advance directive/code status updates were added to the MDS. She stated the SW obtained signatures from the families and placed the forms into the chart. She also stated she updated the physician orders on the header of the electronic chart in PCC and obtained the orders, as well as wrote and updated the care plan. The MDS Coordinator stated the resident would not have received CPR (Cardiopulmonary Resuscitation) and could have died. She stated the DON and the Regional Nurse provided oversight to ensure updates were implemented and revisions were completed. In an interview on [DATE] at 11: 47 AM, the SW stated he followed up with the doctor to make sure DNR got signed and the MDS coordinator wrote the order. The SW stated the MDS coordinator reviewed records and care plans to ensure accuracy of code status. The SW stated the MDS coordinator obtained the physician's order first, then the SW gets the family's signature on the advanced directives. SW stated he lets the MDS coordinator know face to face when the signatures have been obtained on the advance directive. The SW stated, he did not email her. The SW stated the resident could have died if the wrong Code Status was on his Care Plan. In an interview on [DATE] at 12:01 PM, the Regional Nurse stated it was her responsibility to oversee the SW, the MDS coordinator and the advance directive completed by the SW. The Regional Nurse stated, once the advance directives were completed in the care plan then she in conjunction with DON and the ADON provided the oversight to ensure the care plans were revised with the updated information. In regard to providing the surveyor with the Stand Up form the Regional Nurse stated, she would ask the regional office if she could provide a copy because the form is protected by QAPI. In an interview on [DATE] at 12:04 PM the DON stated, it was the responsibility of whoever found the code status to revise the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan. The DON stated, ultimately it was her responsibility to ensure the code status was updated on the care plan. In morning meeting, she would find out about code status, and checked the care plans to make sure it was updated. She stated she followed the same process for people coming back from the hospital and for new admissions. She did not have meeting minutes to indicate what was discussed at the meeting but stated she documented any changes on the Clinical Stand-Up form. Record review of the Comprehensive Care Plan Policy, dated [DATE], revealed The Medical, Nursing, Dietary & Social Services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychological well-being. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible for 1 of 3 residents (Resident#33) reviewed for indwelling catheters. The facility failed to prevent Resident#33's urinary catheter bag from touching the floor. This failure could place residents at risk for cross contamination and urinary tract infections. Findings included: Record review of Resident#33's face sheet dated 03/30/2026 revealed a [AGE] year-old male admitted on [DATE]. Resident#33 admitted with diagnosis of obstructive and reflux uropathy (when flow of urine was blocked in the bladder, ureter. Record review of Resident #33's MDS dated [DATE], Section C-Cognitive patterns revealed Resident #33 had a BIMS score of 9 which indicated Resident #33 had moderately impaired cognition. Section H-Bladder and bowel revealed Resident #33 had an indwelling catheter. Record review of Resident #33's most recent care plan not dated revealed Resident #33 has a suprapubic foley catheter 16 French 10 milliliters(a soft, flexible tube placed directly into your bladder through a small incision in your lower belly above the pubic bone to drain urine, rather than going through the urethra) related to Obstructive and reflux uropathy. Interventions: Monitor that collection bag was off the floor and hung below bladder level, check suprapubic foley catheter every shift use statlock(plastic device that securely anchors medical tubes like IV lines to a patient's skin without using tape or stitches) to secure Foley in place, check tubing for kinks each shift, and monitor for privacy bag placement. Record review of Resident #33's Order Summary printed 03/30/2026 revealed an order to Change Foley Catheter 16 # French with 10milliliters balloon every 6 weeks for foley patency(the state of being open, clear, or unobstructed) and every 42 days for patency. During an observation conducted on 03/30/2026 at 11:56 a.m., Resident #33's indwelling catheter bag was noted laying on the floor on the right side of Resident #33's bed. In an interview with LVN B on 03/30/2026 at 11:59 a.m., LVN B verified that the foley catheter bag was on the floor. She stated it should not be on the floor. LVN B stated she had collected urine this morning, 03/30/2026 and the bag was not on the floor. She stated it was everyone's responsibility to make sure that the bag was properly placed and off the floor. LVN B stated it was important to have the bag off the floor, so it does not get bacteria and so that it does not get pulled. She stated the negative outcome of a foley catheter bag being on the floor was infection. She stated she was to monitor the bag placement every shift. LVN B stated she receives infection control training frequently. In an interview with CNA C on 03/30/2026 at 12:03 p.m., CNA C stated the CNAs were responsible for the residents' foley bags to be properly placed by not touching the floor and being below the bladder. She stated she laid Resident #33 down a while ago and she hung it on the bed frame. CNA C stated it was important for the foley catheter bag not to be touching the floor to prevent contamination and for infection control. In an interview with the DON on 03/30/2026 at 3:01 p.m., she stated that foley catheter bags should not be on the floor. The DON stated, she and floor staff were responsible for making sure the foley bag was not on the floor. She stated staff were constantly rounding and always passing by residents' rooms and that was one thing that they looked at. The DON stated that it was important for the foley catheter bag not to be touching the floor for infection control. Record Review of Policy Titled Infection Prevention and Control Program with date implemented 05/13/2023, revealed: Policy: This facility has established and maintains 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 as per accepted national standards and guidelines. Policy Explanation and Compliance Guidelines: 2. All staff are responsible for following all policies and procedures related to the program. 16. Staff Education c. Direct care staff shall demonstrate competence in resident care procedures established by out facility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who needed respiratory care were provided with such care, consistent with professional standards of practice, for 2 (Resident #56 and Resident #8) of 5 residents reviewed for respiratory care. 1.The facility failed to ensure Resident #56's oxygen was administered at the correct setting of 3 liters per minute on 03/30/2026 as ordered by the physician. 2.The facility failed to ensure Resident #8 had an emergency tracheostomy kit at the resident's bedside on 03/30/2026. These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications, a decreased quality of care, and a delayed lifesaving intervention.Findings included: 1.Record review of Resident #56's face sheet dated 03/30/2026 revealed a [AGE] year-old female with an admission date of 12/30/2024 and an original date of 07/27/2023. Resident #56 had diagnoses of Respiratory Failure (condition where the lungs cannot properly exchange gases, leading to low oxygen or high carbon dioxide in the blood), and Chronic Obstructive Pulmonary Disease (a progressive and irreversible lung disease that makes breathing difficult by damaging airways and air sacs, causing inflammation). Record review of Resident #56's Quarterly MDS assessment, dated 03/07/2026, revealed Resident #56 had a BIMS score of 15, indicated intact cognition. In Section O- Special Treatments, Procedures, and Programs, Respiratory Treatments indicated Oxygen therapy was checked off. Record review of Resident #56's active orders as of 03/30/2026 revealed Oxygen at 3 LPM via nasal cannula every shift for hypoxia(a condition where your body tissues do not receive enough oxygen to function properly). Record review of Resident #56's most recent care plan not dated revealed Problem: Resident#56 has oxygen therapy related to COPD. Interventions: .Give medications as ordered by physician. Oxygen at 3 LPM via nasal cannula every shift. During an observation of Resident #56 on 03/30/2026 at 11:26 a.m. revealed the oxygen level on the portable oxygen cylinder regulator was at 2 Liters Per Minute via nasal cannula. Observation of Resident #56 revealed the resident was sitting up in her wheelchair. No signs of respiratory distress were noted. In an interview on 03/30/2026 at 11:28 a.m., Resident #56 stated she did not move the setting on the oxygen regulator. She then demonstrated that she was not able to reach it behind her wheelchair. Resident #56 stated that she only knew that she was supposed to be on 2 liters. In an interview on 03/30/2026 at 11:31 a.m., LVN B stated she was the nurse for Resident #56. LVN stated she was not sure what the oxygen setting was supposed to be at without looking at the computer. She verified physician order and said the oxygen setting was to be at 3 Liters Per Minute. She stated that she was not aware that Resident #56 was in her wheelchair and that it could have been another nurse who set the oxygen setting. LVN B stated that it was her responsibility for putting the correct oxygen setting when Resident #56 was in her wheelchair. LVN B stated that not receiving the prescribed dose of Oxygen can cause oxygen de-saturation. LVN B adjusted the Oxygen setting to 3 liters and assessed Resident #56. In an interview on 03/30/2026 at 3:01 p.m., the DON stated that oxygen settings were checked by the nurses every shift and documented. She stated that maybe someone from outside might have messed with Resident #56's oxygen setting. She stated that they do provide in-services for oxygen administration. The DON stated that the negative outcome would be not getting the oxygen that she needs causing oxygen depletion. 2. Record review of Resident #8's face sheet dated 04/01/2026 revealed a [AGE] year-old male with an admission date of 12/15/2025 and an original date of 11/25/2025. Resident #8 had diagnoses of Tracheostomy (a surgically created hole in the front of the neck leading directly into the windpipe to help a person breathe), Acute Respiratory Failure with Hypoxia (condition where the lungs cannot properly exchange gases, leading to low oxygen), and Chronic Obstructive Pulmonary Disease (a progressive and irreversible lung disease that makes breathing difficult by damaging airways and air sacs, causing inflammation). Record review of Resident #8's MDS assessment, dated 12/27/2025, revealed Resident #8 had a BIMS score of 0, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which indicated he was not able to be understood to complete BIMS. In Section O- Special Treatments, Procedures, and Programs, Respiratory Treatments indicated Tracheostomy care was checked off. Record review of Resident #8's care plan, dated 03/30/2026, revealed his tracheostomy related to impaired breathing mechanics and COPD. The care plan reflected intervention, Keep extra trach tube and obturator(a small guiding tool designed to plug or block a hole) at bedside. Same size and one smaller. Observation on 03/30/2026 at 2:30 p.m., revealed Resident #8 had no tracheostomy emergency kit easily accessible at bedside. LVN B looked through several drawers in Resident #8's room for the emergency supplies to include the Ambu bag(a hand-held, portable device used to manually force air into a person's lungs when they cannot breathe on their own) but was not able to find them. In an interview on 03/30/2026 at 2:52 p.m., LVN B revealed there was no emergency trach kit containing an Ambu bag (manual resuscitation bag) at Resident #8's bedside and the next lower size trach was not easily accessible. Observed LVN B could not find the Ambu bag, the extra trach tube or the obturator easily in the room. LVN B stated that the Ambu bag should be easily accessible in the resident's room as well as the extra trach tube for emergency purposes. LVN B stated she could not recall an emergency trach kit in Resident #8's room, but she would go get the Ambu bag from the crash cart (a specially organized, wheeled trolley used in hospitals to bring life-saving equipment and medication directly to a patient's bedside during a cardiac arrest or similar emergency)f needed for an emergency. LVN B stated that it was the nurse's responsibility to ensure that the emergency kit was at the resident's bedside. LVN B stated that Resident #8 was the only resident in the building with a tracheostomy. LVN B stated that she should check every shift to ensure these items were in the room and easily accessible for emergency purposes. She stated that the importance of the Ambu bag was so that in an emergency if the resident's respirations decrease, the resident could receive oxygen. LVN B stated that the negative outcome of not having the trach emergency kit easily accessible was that Resident #8 could go into respiratory distress. She stated she has had in-services on respiratory care. LVN B walked into Resident #8's room with a plastic bag which contained an Ambu bag. In an interview on 04/01/2026 at 3:05 p.m., the DON stated that the extra trach tubes were in a drawer in Resident #8's room. She stated that she was not aware that the Ambu bag was not in Resident #8's room. The DON stated that the extra trach tubes and the Ambu bag should be kept at bedside easily accessible in Resident #8's room. She stated that he was the only resident in the facility with a tracheostomy. The DON stated that staff gets in-serviced on respiratory training annually and as needed by the respiratory therapist. She stated the most recent one was one last month, March 2026. In an interview on 04/01/2026 at 3:35 p.m., RNC stated that the facility has no Policy for Oxygen Administration, only for Oxygen Safety and no Policy for Respiratory Care Services Tracheostomy Care. Record review of the facility's Clinical Competency Tracheostomy Care reflected: Knowledge Based CompetencyContinue to manually ventilate until EMS arrives and takes over ventilation.Make sure extra tracheostomy tubes, obturator and resuscitation bag are readily available in case of emergency. Record review of the facility's Tracheostomy Care Competency Assessment revealed: 23. Make sure all necessary supplies are readily available at bedside. Record review of the facility's in service titled Yearly Respiratory Training completed on 03/10/2026 and 03/11/2026. Record review of the facility's policy titled Medication Administration dated 10/24/22 revealed Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: 14. Administer medication as ordered in accordance with manufacturer specifications.Record review of the facility's policy titled Prescriber Medication Orders dated 10/01/2019 revealed Policy: Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal orders are received only by licensed nurses or pharmacists and confirmed in writing by the prescriber within 48 hours.

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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 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 observation, interview, and record review, the facility failed to ensure all drugs and biologicals were secured and stored in accordance with currently accepted professional principles and standards for 1 of 2 medication storage rooms (C Hall Medication Storage Room) reviewed for medication storage. The facility failed to ensure the C Hall Discontinued Medication cabinet was locked and secured. This failure could place the residents at risk of gaining access to unlocked medications that were not prescribed to them and place the facility at risk of drug diversion. Findings included: During an observation on [DATE] at 1:30 p.m., in the C hall medication strorage room,a cabinet that had discontinued medications was not locked and secured. In an interview on [DATE] at 1:35 p.m., LVN D stated he knew that the cabinet that stored the discontinued medications was supposed to be locked. He stated that he was not aware of the cabinet not being locked. He stated that he does not have a key for it but maybe the DON had them. LVN D stated that if the cabinet was left unlocked that anyone could get into it and administer a wrong medication or an expired medication. In an interview on [DATE] at 1:44 p.m., the DON stated that the cabinet that stored the discontinued medications was supposed to be locked. She stated that the nurses should have a key. She stated that the staff will insert the medications through a small opening at the top of the cabinet door. The pharmacist would be the only person who unlocks the cabinet to remove the discontinued medications and lock it back up when done. The DON stated the ADON was in charge of medication destruction. She stated that it was the nurse's responsibility to make sure that it was locked. The DON stated if kept unlocked then anyone can grab a medication out of the cabinet. In an interview on [DATE] at 1:49 p.m., the ADON confirmed that the cabinet that stored the discontinued medications was supposed to be locked. She stated that the nurses pull the discontinued medications from the cart and put them in the discontinued cabinet. The ADON stated that the person with the cabinet key was the DON. The ADON stated that the discontinued medications cabinet was to be kept locked because anyone that comes in would have access to the medications. Record Review of the facility's Medication Storage and Disposal: Discontinued Medication policy, dated revised [DATE], revealed Policy When medications are discontinued by physician order, a resident is transferred or discharged and does not take medication with him/her, or in the event of resident's death, the medications are marked appropriated and destroyed, unless unopened and/or are returnable to the pharmacy. Procedure 2. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until disposed of, or retuned to the pharmacy if credit is allowed. Medications are removed from the medication cart immediately upon receipt of an order to discontinue to avoid inadvertent administration.

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	675309	A. Building B. Wing	04/01/2026

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

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based 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 3 (Resident #38, #14, and #66) of 8 residents reviewed for infection control practices.1. The facility failed to ensure MA A changed gloves after touching multiple surfaces during administration of eye drops on 03/31/2026 for Resident #38.2.The facility failed to ensure Resident #14 had EBP orders.3.The facility failed to ensure Resident #66 received safe and adequate wound care when the WCN failed to perform hand hygiene between glove changes, failed to allow hand sanitizer to dry on hands, failed to place a clean barrier between wound and bed, failed to use a clean cotton tip applicator when re-entering the medication cup, and failed to cleanse the wound adequately. These failures and deficient practices could place residents at risk for healthcare associated cross-contamination and the spread of infection.The findings included: 1. Record review of Resident #14's face sheet, dated 04/01/2026, revealed a [AGE] year-old female with an original admission date of 11/24/2021, and a current admission date of 01/14/2026. Pertinent diagnoses included Sepsis due to Enterococcus (a life-threatening bloodstream infection). Record review of Resident #14's physician orders on 03/31/2026 revealed there was no order for EBP. Record review of Resident #14's Quarterly MDS Assessment, dated 02/27/2026, revealed a BIMS score of 04, indicating severely impaired cognition. Record review of Resident #14's care plan, initiated 07/24/2024, revealed Resident #14 had the need for EBP due to indwelling medical device. Interventions included place on enhanced barrier precautions and ensure a sign was placed on the door. Gown and gloves only for high contact resident care activities. Use a mask, goggles, or eye shield as indicated. 2. Record review of Resident #66's face sheet, dated 04/01/2026, revealed a [AGE] year-old male with an original admission date of 04/22/2021, and a current admission date of 09/04/2025. Pertinent diagnoses included Chronic Venous Hypertension with Ulcer of Left Lower Extremity (a condition characterized by high blood pressure in the veins, leading to skin changes and ulcer formation). Record review of Resident #66's current physician orders, with a start date of 03/27/2026, revealed an order for EBP for high contact care activities, as well as an order to cleanse venous ulcers to LLE with wound cleanser and 4x4 gauze, pat dry with 4x4 gauze, apply plurogel (a gel used to keep the wound bed moist), collagen powder (a topical treatment which accelerates wound healing), xeroform (a special gauze with petroleum on it), calcium alginate (a dressing used for high exudate, or wound drainage) and cover with Opti-lock (an absorbent wound dressing); wrap with Kerlix (rolled gauze used to wrap wounds) and secure with tape. Record review of Resident #66's Quarterly MDS Assessment, dated 03/17/2026, revealed a BIMS score of 04, indicating severely impaired cognition. MDS also revealed Resident #66 had 2 wounds and required application of nonsurgical dressings. Record review of Resident #66's current care plan, initiated 11/22/2023, and revised on 02/24/2026, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed ulcers to left lower extremity with interventions to include weekly skin evaluation and wound care. In an observation on 03/31/2026 at 2:35 PM, the WCN was observed to have performed hand hygiene, cleaned her table and placed her clean barrier/field for her wound care supplies on the table. She then placed her wound care supplies onto the clean barrier, to include gloves, gauze soaked with wound cleanser, a med-cup with a gel in it, a med cup with a powder in it, cotton tipped applicators, and the rest of the dressing supplies. WCN performed hand hygiene with alcohol-based hand sanitizer but only rubbed hands for approximately 5 seconds. She then donned appropriate PPE and proceeded with wound care. She did not put a clean barrier or pad between Resident #66's wounds and bed/sheet. After removing the outer layer of the soiled dressing, the WCN removed gloves and re-gloved without sanitizing her hands. She then cut the Kerlix off the wound, discarded Kerlix, performed hand hygiene (for approximately 5 seconds) with alcohol-based hand sanitizer, and applied clean gloves. The WCN proceeded to clean the wound by wiping down the wound from top to bottom one time with a gauze soaked with wound cleanser. She then dried the wound by wiping with a single, dry gauze. She then removed her gloves and performed hand hygiene with alcohol-based hand sanitizer for approximately 5 seconds, then re-applied clean gloves. She then applied the gel in the medicine cup to the wound bed, but she only applied the gel to approximately half of the wound bed. She was noted to re-enter the gel in the med-cup multiple times with the same, soiled, cotton tipped applicator. She then removed her soiled gloves and re-gloved with clean gloves without performing hand hygiene. The WCN then applied the powder in the other med-cup to the wound bed, but she only sprinkled the powder on half of the wound. She then applied a lotion to Resident #66's leg. She then removed her gloves, performed hand hygiene with alcohol-based hand sanitizer, only rubbing her hands for approximately 3 seconds, then, donned clean gloves, and finished putting on the rest of the dressing. She then removed her gloves, sanitized her hands for approximately 5 seconds, and then she took out the trash. The WCN then sanitized her hands again for approximately 5 seconds, then she cleaned her table and equipment. In an interview on 03/31/2026 at 3:15 PM, the WCN stated she should have placed a clean barrier or pad between Resident #66's wounds and his bed to keep the wound from touching the dirty sheets, and to prevent the sheets from getting any drainage from the wound on them. The WCN explained she did not cleanse the wound well because it hurt the resident, but she stated she knew she was supposed to clean it well from the inside to the outside, going from cleanest to dirtiest. She stated by not cleaning the wound appropriately she could re-introduce bacteria in the wound causing an infection or poor wound healing. The WCN also stated she had a hard time getting the gel to spread across the wound which was why she did not cover the entire wound bed like she was supposed to, as well as knew she was supposed to sprinkle the powder over the entire wound but had not. The WCN stated she should have sanitized hands by rubbing alcohol-based hand sanitizer all over hands until it was completely dry, which was typically at least 20 seconds, and she should always perform hand hygiene after removing dirty, soiled gloves. She also stated she should have used a clean cotton tipped applicator each time she re-entered the med-cup with the gel in it. The WCN stated not following proper hand hygiene and wound care techniques could have caused cross-contamination or infection. The WCN also stated the charge nurse or the infection control nurse were the ones who typically put in the orders for residents who needed EBP. In an interview on 03/31/26 at 3:47 PM, the ADON stated nurses should be performing hand hygiene after removing soiled gloves and before applying clean gloves. She stated they should be rubbing the alcohol-based hand sanitizer over the entire surface area of the hand until dry, which was typically 20 seconds or more. The ADON also stated the WCN should have utilized a clean cotton-tipped applicator (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each time she removed the medicated gel from the medication cup instead of using the same soiled applicator each time, as well as put a clean barrier between the resident's wounds and the bed. The ADON stated the appropriate way to cleanse the wound was from the inner to outer, or cleanest to dirtiest area of the wound, and if hand hygiene and wound care were not performed appropriately it could lead to cross contamination, infection, and poor wound healing. Record review of the facility's Enhanced Barrier Precautions policy, implemented 11/24/2025, revealed Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 2. B. An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds., indwelling medical devices., infection or colonization with a CDC-targeted MDRO. Record review of the facility's Wound Treatment Competency, no date indicated, revealed 6. Position area to be treated. Place a clean barrier next to the resident to protect the bed linen. 7. Remove soiled dressings and discard. 8. Remove gloves, perform hand hygiene, and don clean gloves. Findings included: Record review of Resident #38's face sheet dated 04/01/2026 reflected a 63 -year-old male, admitted on [DATE] and an original admit date of 02/02/2023. Resident #38's diagnoses included Transient Visual Loss, Left Eye (temporary, sudden loss of sight in one or both eyes, often described as a dark curtain, blurring, or dimming that lasts seconds to minutes before returning to normal) and Type 2 Diabetes Mellitus. Record review of Resident #38's Quarterly MDS assessment, dated 03/17/2026, reflected he scored a 3 on his BIMS which reflected severely cognitively impaired. During an observation on 03/31/2026 at 4:25 p.m., MA A donned (put on) gloves and touched the bed remote to move the bed up to working height and touched the light cord. She then proceeded to touch Resident #38's face and administered his eye drops with the same pair of gloves. During an interview on 03/31/2026 at 4:31 p.m., MA A stated that after touching the bed remote and the light cord, she was to remove gloves, sanitize, and put on new gloves. She stated that everybody touches the bed remote and the light cord. CMA A stated that it was important to change gloves after touching multiple surfaces for infection control. During an interview on 04/01/2026 at 3:15 p.m., the DON stated, staff should change gloves when they touch something dirty or touch any other surface that was not the procedure they were performing. She stated MA A should have changed her gloves prior to the administration of the eye drops. The DON stated infection control in-services were done frequently. The DON stated MA A was to change gloves after touching the bed remote and the light cord to prevent cross contamination. Record review of the facility's Medication Administration Policy, date implemented 10/24/2022 revealed Policy: Medications are administered by license nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination of infection. Record review of the facility's Infection Prevention and Control Program date implemented 05/13/23 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Policy: This facility has established and maintained 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 as per accepted national standards and guidelines. Policy Interpretation and Implementation: 2. All staff are responsible for following all policies and procedures related to the program. 16. Staff Education: a. All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. b. All staff shall demonstrate competence in relevant infection control practices. c. Direct care staff shall demonstrate competence in resident care procedures established by our facility.