STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675363	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Wesla	721 Airport Dr Weslaco, TX 78596

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 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. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 10 residents (Resident #1) reviewed for medical records accuracy, in that: The facility failed to document Resident #1's physician ordered 1 to 1 constant observation every hour on 12/08/25 from 3:00pm - 9:00pm. This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment. The findings included: Record review of Resident #1's face sheet, dated 12/17/25, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: vascular dementia (decline in thinking skills from conditions damaging brain blood vessels, reducing oxygen and causing issues with memory, planning, focus and mood), moderate, with other behavioral disturbance, and unspecified psychosis (disconnect from reality, may involve hallucinations or delusion) not due to a substance or known physiological condition Record review of Resident #1's quarterly MDS assessment, dated 11/27/25, revealed Resident #1 had a BIMS score of 03, indicating severe cognitive impairment. Record review of Resident #1's care plan with an initiation date of 01/13/25 reflected a focus of the resident was physically aggressive r/t Dementia and thinking that other people steal from her with intervention of, Resident was placed on a 1 to 1 for 72 hours both with an initiation date of 12/06/25. Record review of Resident #1's physician's orders revealed orders to, Place resident on 1:1 constant observation every hour. Including during all activities, toileting, and sleeping x72 hours, with a frequency of every hour for aggressive behaviors with an end date of 12/10/25. Record review of Resident #1's December 2025 MAR reflected her order to Place resident on 1:1 constant observation every hour. Including during all activities, toileting, and sleeping x72 hours, with a frequency of every hour for aggressive behaviors was not signed hourly on 12/08/25 from 3:00pm - 9:00pm. During an interview with LVN A on 12/18/25 at 4:11pm she stated on 12/08/25 staff including herself completed a 1 to 1 with Resident #1 and made sure they knew where she was at all times. LVN A stated she was the staff member monitoring Resident #1 during the unsigned times on the MAR from 3:00pm-9:00pm on 12/08/25 and stated she was responsible for documenting it as well. LVN A stated she had reviewed Residents #1's December 2025 MAR and did see that she had not signed it. LVN A stated when you see a blank on the MAR it meant it had not been signed and could mean that it was not done. LVN A clarified that in this situation the monitoring was completed by her and Resident #1 did not have any aggressive behaviors during those times. LVN A stated she thought the floor nurse at the time, LVN B was going to sign off on the MAR but stated the person who is completing the monitoring should be the one signing off and stated in this situation it was her. LVN A stated it was important to sign off on the MAR to ensure they are documenting any behaviors and to show they were compliant with the physician's orders. LVN A stated the DON or ADON C would review the MAR for any omissions but did not know how often or how they did that. LVN C stated she had been trained over documentation on the MAR by the DON within the previous 30 days but did not recall an exact date. LVN A stated the facility policy regarding documentation stated the moment the order was completed they needed to sign it. LVN A stated she did not follow the policy because she did not sign the MAR. LVN A stated not signing off on behavior monitoring on the MAR could negatively impact residents because if they were not documenting behaviors the following nurses would not know what to look for and when the physician reviewed the behaviors would not be documented. During an interview and record review with the DON on 12/18/25 at 6:27pm she stated LVN B was technically responsible for signing the MAR between 3:00pm and 9:00pm on 12/08/25 for Resident #1 because he was the hall nurse but stated herself and LVN A had volunteered to sit with Resident #1 and LVN A was the one sitting there with Resident #1 at that time. The DON reviewed Resident #1's December 2025 MAR and confirmed Resident #1's order for her 1 on 1 for behavior monitoring was not signed from 3:00pm-9:00pm on 12/08/25. The DON stated an unsigned section on the MAR indicated that the order was not completed, but stated during those times the monitoring was completed, and Resident #1 did not have any aggressive behaviors at those times. The DON stated she did not know why it had not been signed but stated it was important to do so to make sure there were no aggressive behaviors because it was for the safety of the patient and the residents. The DON stated the facility policy regarding documentation stated documentation needed to be completed at time of service. The DON stated the facility staff did not follow the policy in this situation. The DON stated both LVN A and B had