

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Windsor Nursing and Rehabilitation Center of Wesla		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #1) reviewed for infection control.1. The facility failed to inform all staff that Resident #1 was on droplet precautions.2. The facility failed to ensure that Resident #1 had a droplet precaution sign at the door.This deficient practice could place residents at-risk for cross contamination and the spread of infection.Findings included: Record review of Resident #1's face sheet, dated 01/3/2026, revealed the resident was a [AGE] year-old male, admitted [DATE], readmitted [DATE] with diagnoses that included: transient cerebral ischemic attack (mini-stroke/temporary blockage of blood flow to the brain, causing stroke-like symptoms), hypertension (high blood pressure), dementia (significant decline in mental abilities such as memory, thinking, and reasoning, severe enough to disrupt daily life), and dysphagia (difficulty swallowing). Record review of Resident #1's quarterly MDS assessment, dated 11/19/2025, revealed a BIMS score of 03, indicating severe cognitive impairment and was dependent on staff for all self-care needs. Record review of Resident #1's undated comprehensive care plan revealed Resident #1 was on Enhanced Barrier Precautions and interventions included: Place on Enhanced Barrier Precautions, ensure a sign was placed on the door to notify staff and visitors of the precautionary measures: Gown and gloves only for high-contact resident care activities (dressing, bathing/showering, personal hygiene, changing linens, assisting with toileting, perineal/incontinent care, medical device care or use, wound care), no room restriction and might participate in communal activities. Use a mask, goggles/eye shield as indicated. Date Initiated: 11/14/2024 Provide the resident and family member with education on and the reason and for EBP.Date Initiated: 11/14/2024 Use non-shared resident medical equipment if possible. Disinfect shared resident use equipment with the appropriate disinfectant. Date Initiated: 11/14/2024Record review of Nursing - Initial Baseline/Advanced Care Plan for readmission dated 1/12/2026 revealed the resident had a clinical condition that required special precautions of Rhino Virus (a group of viruses that are the primary cause of the human common cold and upper respiratory infections that are highly contagious and spreads easily through droplets, contaminated surfaces, and direct contact) which required droplet transmission-based precautions (precautions, such as placing the patient in a private room, wearing a surgical mask when within 3-6 feet of the patient, and requiring the patient to wear a mask during transport, that prevent the spread of pathogens (microorganisms or germs) transmitted through close respiratory contact). Record review of Resident #1's daily skilled progress note, dated 1/12/2026, revealed resident was on single room isolation. Record review of Resident #1's nursing progress note, dated 1/13/26 at 12:25 a.m., revealed the NP approved the facility to follow hospital discharge orders for readmission. Record review of Resident #1's Orders Summary report revealed Droplet Precautions (precautions, such as placing the patient in a private</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675363
		If continuation sheet Page 1 of 6

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>right away. She said usually the nurse applied the precaution signs and PPE. She said when she used to work mornings, housekeeping did that or sometimes they told the CNAs to do it. She said while she worked the 600 hallway last night (1/12/2026), there was no PPE or isolation precaution signs in front of Resident #1's room. She said if the proper sign and PPE were not posted, staff that were unaware could provide care without appropriate PPE worn and transfer the infection to another resident. She said if a resident was on isolation/contact precautions, she did not notify someone that the signs and PPE were not there, Because the nurses are supposed to know right? CNA C knew what the precautions were and what PPE she needed to use. She said usually those items were in a locked room, so if they need her to place the precautions, they asked and provided the items. She said they had infection control in-services frequently and were annually trained. She said training included the different types of precautions, how to complete proper hand hygiene, the different types of PPE and proper disposal of PPE. During an interview on 1/13/26 at 12:07 p.m., LVN D said she was working when Resident #1 was admitted . She said she stayed late to assist the floor nurse with his admission. She said she entered Resident #1's room to complete his skin evaluation. She said she received report from the hospital DC nurse, so she was aware he was on droplet precautions. She said she placed a mask, gown, hat, goggles, and gloves on before entering his room. She said she completed hand hygiene before and after. She said she disposed of the PPE in the room, since it had not been set up yet. She said she tied the bag, removed it from the room, and placed new bag. She said she did not place the signs or PPE but did not recall if they were already there. She said she got her PPE from the building, and she had a pack of gowns at the nurse's station. She said it was all the staff's responsibility to place signs and PPE when a resident was on precautions. She said that usually the admitting nurses ensured it got done. She said the signs and PPE were usually always up as soon as they were made aware the resident was on isolation precautions. She said if she was the admitting nurse who received the information that the resident was on droplet precautions, they would had prepared the room, placed all the appropriate precautions, monitored and used appropriate precautions. She said they would also notify the staff. She said she was not the admitting nurse. She said she knew they notified the CNAs for Resident #1. She said she heard the nurses give the report to the CNAs. She said the signs were always located in the nurse's station and not locked up. She said if precaution signs and PPE were not placed it could place staff and others at risk for spreading the droplets. She said the facility had annual infection control training and frequent in-services on infection control. She said they go over hand hygiene, the purpose of wearing PPE, where to get PPE, how to prevent the spread of infection, and the different types of isolation. During an interview on 1/13/25 at 3:50 p.m., RN H said he came in at 5 am this morning. He said LVN E, the night nurse, provided him with report. She said Resident #1 was on isolation precautions because of a virus but we know now it was not a virus. He said he received the results of an x-ray today and the results said it was pneumonia. He said it was actually him that told them there was no precautions up at the resident's room, so they were just getting it on. He said the person responsible for placing all precautions was the admitting nurse. He said if the resident was already in the facility, then the nurse who receives the order should be responsible. He said the signs were located at the nurse's station in a drawer. He said the door was not locked. He said they had them everywhere. He said he was a new employee and he knew where they were located. RN H said he should had been the one to inform the CNAs Resident #1 was on isolation precautions. He said usually the the signs and PPE are already in place upon admission. He said if he was working upon the resident admission, he would have had it all ready before the resident came in because they get report prior to a resident being admitted . He said even though they</p> <p>(continued on next page)</p>		

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