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	03/03/2026

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to have physician orders for the resident's immediate care at time of admission, for 1 (Resident #1) of 3 residents reviewed for physician admission orders. The facility failed to have physician orders in place for Resident #1's enhanced barrier precautions. This failure could place residents at risk of developing infections. Findings included: Record review of Resident #1's face sheet, dated 03/02/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: cerebral infarction (stroke), metabolic encephalopathy (brain dysfunction caused by chemical imbalances), dysphagia (trouble swallowing), cognitive communication deficit (difficulties in communication that arise from impaired cognitive functions), muscle wasting and atrophy (loss of muscle mass and strength), and gastrostomy status (surgically created opening into the stomach, typically with a feeding tube in place for nutrition, hydration, or medication delivery). Resident #1 was discharged to the hospital on [DATE]. Record review of Resident #1's MDS assessment, dated 02/15/26, reflected Resident #1 had a BIMS score of 4, indicating severe cognitive impairment. Resident #1's MDS reflected the use of a feeding tube noted on admission. Record review of Resident #1's baseline care plan, dated 02/12/26, reflected [Resident #1] required tube feeding and was dependent with tube feeding and water flushes. See orders for current feeding orders. Record review of Resident #1's order summary report, on 03/02/26 at 1:20 PM, reflected Resident #1 had an active order for, Enteral Feed Order every shift, Glucerna 1.5 at 55ml/hr via feeding tube stationary pump with a start date of 02/12/26. Record review of Resident #1's physician's orders, on 03/02/26 at 3:30 PM, reflected there were no orders for EBP for the resident's admission from 02/12/26-02/15/26. During an interview with the DON on 03/02/26 at 11:00 AM, she said Resident #1 required EBP since admission because he had a feeding tube which was considered an indwelling device. The DON said she reviewed the physician's orders for Resident #1 and he did not have an order for EBP. The DON said the team reviewed new admissions during the meetings and ensured all orders were in place. The DON said although the order was not in place for Resident #1's EBP, the staff were aware that Resident #1 required EBP and followed the precautions. The DON said there was no negative outcome for Resident #1, however, it was important to have an order for EBP to ensure staff followed the precautions to prevent infection. During an interview with the ADON on 03/02/26 at 12:00 PM, she said she did not remember who Resident #1 was. The ADON said a resident with a feeding tube required EBP because the feeding tube was an invasive device. The ADON said the team reviewed the physician's orders during the meetings and ensured everything was accurate. During an interview with the ADM on 03/03/26 at 2:00 PM, she said the team reviewed the physician's orders for new admissions and ensured all orders were in place as needed. The ADM said for the residents with feeding tubes, they needed to be on EBP which required an order. The ADM said there was no negative outcome for Resident #1, however, it was important to have the order to ensure Resident #1 received the appropriate care. Record review of the facility's Enhanced Barrier Precautions policy, dated 11/24/25, reflected - Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of MDRO. EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	targeted gown and gloves use during high contact resident care activities. b. An order for EBP will be obtained for residents with any of the following: i. Wounds, indwelling medical devices (including feeding tubes), even if the resident is not known to be infected or colonized with a MDRO.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (Resident #1) of 3 residents reviewed for baseline care plans. The facility failed to ensure Resident #1's baseline care plan reflected enhanced barrier precautions.This failure could place residents at risk of not receiving appropriate interventions and care to meet their needs.Findings included:Record review of Resident #1's face sheet, dated 03/02/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: cerebral infarction (stroke), metabolic encephalopathy (brain dysfunction caused by chemical imbalances), dysphagia (trouble swallowing), cognitive communication deficit (difficulties in communication that arise from impaired cognitive functions), muscle wasting and atrophy (loss of muscle mass and strength), and gastrostomy status (surgically created opening into the stomach, typically with a feeding tube in place for nutrition, hydration, or medication delivery). Resident #1 was discharged to the hospital on [DATE]. Record review of Resident #1's MDS assessment, dated 02/15/26, reflected Resident #1 had a BIMS score of 4, indicating severe cognitive impairment. Resident #1's MDS reflected the use of a feeding tube noted on admission. Record review of Resident #1's baseline care plan, dated 02/12/26, reflected [Resident #1] required tube feeding and was dependent with tube feeding and water flushes. See orders for current feeding orders. Resident #1's baseline care plan did not reflect the EBP. Record review of Resident #1's order summary report, on 03/02/26 at 1:20 PM, reflected Resident #1 had an active order for, Enteral Feed Order every shift, Glucerna 1.5 at 55ml/hr via feeding tube stationary pump with a start date of 02/12/26. During an interview with the DON on 03/02/26 at 11:00 AM, she said Resident #1 required EBP since admission because he had a feeding tube which was considered an indwelling device. The DON said a baseline care plan was developed within 48 hours of admission and the comprehensive care plan was developed with more time. The DON said Resident #1 was only at the facility for about three days, so he had the baseline care plan completed. The DON said she reviewed the baseline care plan and signed off on it. The DON said the baseline care plan did not reflect the EBP because the question that asked if the resident required any special precautions was marked no. The DON said although the baseline care plan did not reflect the EBP, the staff were aware that Resident #1 required EBP and followed the precautions. The DON said there was no negative outcome to Resident #1, however, it was important to have the EBP in the baseline care plan to ensure staff followed the precautions to prevent infection. During an interview with the ADON on 03/02/26 at 12:00 PM, she said she did not remember who Resident #1 was. The ADON said a resident with a feeding tube required EBP because the feeding tube was an invasive device. The ADON said the baseline care plan was done within 48 hours of admission and the comprehensive care plan was developed with more time. The ADON said if the resident was admitted with the feeding tube, then the EBP should have been noted on the baseline care plan. During an interview with the ADM on 03/03/26 at 2:00 PM, she said the team reviewed new admissions and ensured everything was in place as needed for their care. The ADM said for the residents with feeding tubes, they needed to be on EBP. The ADM said the baseline care plan was done within 48 hours of admission and they had a longer timeframe to complete the comprehensive care plan, but the EBP would at least be noted in the baseline care plan. The ADM said there was no negative outcome for Resident #1, however, it was important to have the EBP in the baseline care plan to ensure Resident #1 received the appropriate care. Record review of the facility's Baseline Care Plans policy, dated 06/06/25, reflected - Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. 1. The baseline (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan will: A. Be developed within 48 hours of a resident's admission. B. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders.