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	05/29/2026

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 4 residents (Resident #1) reviewed for pharmacy services. Facility failed to acquire and administer physician ordered anti-seizure medication phenytoin (Dilantin) to treat Resident #1's seizure disorder. Resident #1 suffered a seizure and was sent to hospital on [DATE] with impression of Status Epilepticus, Subtherapeutic phenytoin (Dilantin) levels, Active infection (UTI/Sepsis/Pneumonia). The noncompliance was identified as PNC. The IJ began on 3/12/26 and ended on 4/9/26. The facility had corrected the noncompliance before the survey began.These failures could place residents at risk of complications, as well as jeopardize their health and safety. Findings included: Record review of Resident #1's face sheet, dated 5/28/26, revealed a [AGE] year-old female with an admission date of 3/12/26. Resident #1's diagnoses included unspecified convulsions. Record review of Resident #1's admission MDS assessment, dated 3/16/26, revealed Resident #1 never/rarely made decisions due to severely impaired cognitive skills. The Brief Interview for Mental Status was skipped and not conducted. Resident # 1 had active diagnosis of seizure Disorder or Epilepsy and high-risk drug classes included anticonvulsant. Record review of Resident #1's care plan revealed Resident #1 had a seizure disorder initiated 3/30/26. Goal included: Resident #1 will be/remain free of seizure activity through review with a target date of 6/21/26. Interventions included: Give seizure medication as ordered by doctor.Record review of Resident #1's hospital record dated 3/11/26 reflected Resident #1's phenytoin level at 21.43 mcg/mL (normal range 10.00 - 20.00).Record review of Resident #1's physician's orders for discharge received from the hospital on 3/12/26 reflected continued medications:Phenytoin (phenytoin 25 mg/mL oral suspension) 4 mL, oral, daily, andPhenytoin (phenytoin 25 mg/mL oral suspension) 8 mL, oral QHSRecord review of Resident #1's physician orders reflected phenytoin oral suspension 100 mg/4mL give 4 mL (100 mg) by mouth one time a day with a start date of 3/12/26. The physician orders did not reflect the order for phenytoin 25 mg/mL oral suspension 8 mL (200 mg) oral QHS. Record review of Resident #1's March 2026 MAR revealed Resident #1's phenytoin oral suspension 100 mg/4mL give 4 mL by mouth one time a day for anticonvulsant was administered daily from 3/14/26 to 3/31/26. Record review of Resident #1's April 2026 MAR revealed Resident #1's phenytoin oral suspension 100 mg/4mL give 4 mL by mouth one time a day for anticonvulsant was administered daily from 4/1/26 to 4/8/26. Record review of Resident #1's March and April MAR did not reflect the order for Phenytoin (Dilantin) Oral Suspension 100 MG/4ML Give 8 ml by mouth QHS for anticonvulsant for a total of 27 days. Record review of Resident #1's progress note dated 4/8/26 revealed Resident #1 had a seizure that lasted approximately 4 minutes. NP, ADON and family member were notified. Orders from NP were carried out and Resident #1 was transferred to the hospital after. Record review of Resident #1's hospital record dated 4/9/26 revealed Resident #1's Impression:Status Epilepticus (life threatening medical emergency defined as either a continuous seizure lasting more than 5 minutes, or recurrent seizures without the person regaining full consciousness in between)- This presentation is most consistent with breakthrough status epilepticus in the setting of subtherapeutic antiseizure medication levels and systemic infection (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(UTI/sepsis).Subtherapeutic (dose, concentration, or level of a drug or treatment that is too low to produce the intended medical effect or to effectively treat a disease) phenytoin (anti-seizure medication) level (2.4)Active Infection (UTI/sepsis/? pneumonia)In an interview on 5/28/26 at 2:05 p.m., LVN A said Resident #1 received one dose of Dilantin at 5 p.m. daily. LVN A said she was informed by administration that she forgot to enter the hour of sleep Dilantin order. LVN A said she was also informed the order was reviewed by other staff and they missed it also. LVN A said she received 1 to 1 education on obtaining labs and verifying medication orders. LVN A said not providing Resident #1 her QHS Dilantin placed her at risk for seizures.In an interview on 5/28/26 at 4:00 p.m., the DON said upon admission of Resident #1 on 3/12/26 the admitting nurse forgot to place the correct order for Dilantin. The DON said as per hospital DC orders, Resident #1 should have been given 25mg/mL 4 mL (100mg) q day and 8 mL (200mg) QHS. The DON said Resident #1 only received Dilantin 4 mL (100mg) QD. The DON said Resident #1 did not receive the ordered 8 mL (200mg) QHS because it was not entered into the system by the admitting nurse. DON said that type of med error could cause a resident seizures. The DON said Resident #1 ultimately had a seizure on 4/8/26. The DON said they did an in-service for nurses, informed them there should always be baselines for certain medications, and conducted med competencies when it was discovered.In an interview on 5/29/26 at 8:35 a.m. the NP stated she reviewed Resident #1 medication list from the hospital, and she did not give any orders to DC Dilantin 8mL QHS. She said the adverse outcome of not receiving Dilantin as ordered was different in every case. The NP said Resident #1 had not had a seizure in a very long time, but omission of the nighttime Dilantin could potentially cause a seizure. The NP said she rounded with Resident #1 and she showed no changes, was pleasant, and doing well throughout her stay. The NP said she did not order Dilantin levels for Resident #1 since they were drawn on 3/11/26 at the hospital and did not indicate a need. The NP said if the level on Resident #1's Dilantin level on 4/8/26 showed 2.4 (low) it could indicate she was not receiving the proper dose. The NP said residents with a history of seizures would have had a seizure even with normal levels. The NP said Resident #1 was also started on Rocephin ABX for a UTI on 4/5/26 which could also affect the threshold and triggered the seizure. In an interview on 5/28/26 at 10:24 a.m., the Pharmacist stated there were many things that could cause a seizure. He said, Could that have directly contributed to the seizure, he said he did not think so. The Pharmacist said he did not know if a UTI would cause Dilantin levels to go low. The Pharmacist said there was no interaction between Dilantin and the ABX Rocephin, so it did not appear that it would have lowered the Dilantin levels.Record review of the facility's Medication Reconciliation policy implemented 4/10/23 reflected, Policy:This facility reconciles medication frequently throughout a resident's stay to ensure that the resident is free of any significant medication errors, and that the facility's medication error rate is less than 5 percent. Definitions: Medication reconciliation refers to the process of verifying that the resident's current medication list matches the physician's orders for the purposes of providing the correct medications to the resident at all points throughout his or her stay. Policy Explanation and Compliance Guidelines: .4. admission Processes:a. Obtain current medication list from referral source (i.e. hospital, home health, hospice, or primary care provider).b. Compare orders to hospital records, etc. Obtain clarification orders as needed.c. Transcribe orders in accordance with procedures for admission orders.Record review of the facility's Medication Monitoring Preventing Adverse Consequences and Med Errors policy original/revised date of 10/1/2019 reflected, Policy:The facility employs a system to assure that medication usage is evaluated on an ongoing basis.6. In the event of a significant medication-related error or adverse consequence, immediate action is taken, as necessary to protect the resident's safety and welfare. Significant is defined as: .B. Requiring hospitalization.The Administrator was notified on 5/29/26 at 7:39 p.m. that a past noncompliance Immediate Jeopardy situation had been identified due to the above failures. It was determined these failures placed Resident #1 in an Immediate Jeopardy situation on 3/12/26. The facility had corrected the noncompliance before investigation began.The facility had implemented the following (continued on next page)

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