

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Windsor Nursing and Rehabilitation Center of Edinb		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 S Closner Blvd Edinburg, TX 78539	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review and observation, the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 3 residents (Resident #1) reviewed for change in condition. The facility failed to notify Resident #1's MD when she fell on 6/17/26 at around 12:00am. Resident #1 did not sustain any injury due to fall. This failure could place residents at risk of not receiving the appropriate care and services to maintain their health and safety. Finding included: Record review Resident #1's face sheet, dated 07/03/26, revealed an [AGE] year-old female, admitted [DATE], with diagnoses which included type 2 diabetes mellitus (a chronic condition where the body either does not produce enough insulin or does not use insulin effectively, leading to high blood sugar levels), Dementia (a decline in mental ability severe enough to interfere with daily life), history of falling, and impaired balance (a reduced ability to maintain stability and spatial orientation). Record review of Resident #1's quarterly MDS assessment, dated 06/25/26, reflected a BIMS of 3, indicated cognition was severely impaired. Section B (hearing, speech and vision) stated Residents #1's ability to express ideas, needs and wants was sometimes understood. Section J (Health Conditions) revealed Resident #1 had a history of 2 falls with no injury (April and May 2026) and 1 fall with major injury (June 2026 at 5:30am) The MDS section J did not reflect the fall that CNA C, D, E stated occurred on 06/17/26 at around 12:30am with no injury. Record review of Resident #1's care plan, dated 03/30/2026, reflected a focus area that Resident #1 had a risk for falls related to impaired balance, confusion, and self-transfers. Goal: the resident will be free of falls through the review date. Interventions: review on past falls and attempt to determine cause of falls. Record review of Resident #1's nursing notes from 06/16/26 to 06/17/26 did not reflect documentation of a fall at around 12:00am as stated by CNA C, D and E. Record review of incident/accident log list from the facility did not reflect Resident #1 having a fall on 06/17/26 around 12:00am. Record review of Resident #1's assessment list did not reflect documentation of any post fall assessment on 06/17/26 at around midnight. Record review of Resident #1's electronic medical record did not reflect any documentation or notifications made regarding a fall on 06/17/26 at around midnight. During an observation and interview on 07/01/2026 at 12:30 p.m., Resident #1 was on her bed. Resident #1 said that she did not fall and that she did not have pain. Resident #1 had fall interventions in place as reflected on her care plan, to include bed wedges, bed to lowest position, floor mats on both sides, room was free of clutter, the room was well lit, resident did not have any visible injuries noted, and call light within reach. During an interview on 07/02/2026 at 1:30 p.m., the NP stated she was notified of Resident #1's fall that happened on 06/17/2026 at 5:30 a.m which resulted in fracture to shoulder. NP stated (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she was not aware that Resident #1 had a previous fall earlier that night on 06/17/26. During an interview on 07/03/26 at 09:30 a.m., CNA C stated that she worked the night when Resident #1 had an unwitnessed fall on 06/17/2026 approximately at midnight. CNA C stated that CNA D found her on the floor mat next to the bed. CNA C stated that CNA D called for help and that she went to notify the nurse. CNA C stated that after the nurse assessed Resident #1 she was told to put Resident #1 back to bed. CNA C stated Resident #1 did not have any injury after her fall at 12:00am and did not express any pain. CNA C stated that Resident #1 had 2 falls the same night, with the first one occurring at around 12:00am and stated that both falls were reported to LVN B. CNA C stated that Resident #1 had her fall interventions in place at time of this fall. CNA C stated Resident #1 had a wet brief when she was found and stated she was last rounded at around 10:00pm and was dry at that time. During a phone interview on 7/3/26 at 9:47 a.m., CNA D stated that she worked with Resident #1 when she had an unwitnessed fall I after midnight on 06/17/2026. CNA D stated she found Resident #1 on the floor mat next to her bed. CNA D stated Resident #1 fell two times during the night, with her first fall occurring around or after 12:00am. CNA D stated that she called the nurse for help and LVN B assessed Resident #1 and, after the assessment, Resident #1 was put back to bed as per care plan stated. CNA D stated the nurses assessment did not identify any injury or pain to Resident #1. CNA D stated that Resident #1 had her fall interventions in place at time of this fall. During an interview on 07/03/2026 at 02:13 p.m., CNA E stated that she worked the night when Resident #1 fell twice during the night. CNA E stated that on the first fall at around 12:00am Resident #1 had an unwitnessed fall and was found next to her bed by CNA D. CNA E stated that she heard that Resident #1 fell around 12:00 a.m. on 6/17/2026 the first time and she went into the room to help with transferring Resident #1 back to bed. The second fall happened around 05:00 a.m. CNA E stated that LVN B was notified on both falls, and Resident #1 was assessed both times by LVN B. CNA E stated after Resident #1's first fall around 12:00am LVN B's assessment of Resident#1 after her fall found no injury or pain present. CNA E stated that Resident #1 had her fall interventions in place at time of this fall. During an attempted telephone interview on 07/02/2026 at 10:54 a.m., LVN B was called unsuccessfully. Voice message was left requesting a call back from LVN B. During an attempted telephone interview on 07/02/2026 at 02:05 p.m., LVN B was called unsuccessfully. Voice message was left requesting a call back from LVN B. During an attempted telephone interview on 07/03/2026 at 10:15 a.m., LVN B was called unsuccessfully. Voice message was left requesting a call back from LVN B. During an interview on 07/03/2026 at 04:27 p.m., the DON said it was the responsibility of the charge nurse to notify the physician about the fall. The DON said she expected the nurse to notify the physician when the incident happened or as soon as the resident was stable. The DON said she was not aware LVN B had not notified Resident #1's physician of her first fall occurred on 06/17/26 at around 12:00am The DON stated she was not aware Resident #1 fell twice on 06/17/2026. The DON said that she was aware of the fall on 6/17/2026 at 5:30 a.m and stated the provider was notified and an order for imaging was given and carried out. The DON stated she was not aware of the fall that occurred previously at around 12:00am. She said she expected the charge nurse to fill out the incident reports accurately. The DON stated that all falls had to be reported to the physician. The DON stated LVN B was out and not able to be reached. Record review of facility's policy titled, Notification of Changes, with an implemented date 10/24/2022 reflected: the purpose of this policy is to ensure the facility promptly informs the resident consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.		

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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 observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs for 1 (Resident #1) of 3 residents reviewed for care plans. The facility did not develop and implement a comprehensive person-centered care plan to address Resident #1's order and non compliance with use with a sling to left arm due to an acute fracture to left humerus head/neck after a fall on 06/17/26 at 05:30 a.m. This failure could place residents at risk for their needs not being met. Finding included: Record review Resident #1's face sheet, dated 07/03/26, revealed an [AGE] year-old female, admitted on [DATE], with diagnoses which included type 2 diabetes mellitus (a chronic condition where the body either does not produce enough insulin or does not use insulin effectively, leading to high blood sugar levels), Dementia (a decline in mental ability severe enough to interfere with daily life), history of falling, and impaired balance (a reduced ability to maintain stability and spatial orientation). Record review of Resident #1's care plan, dated 03/30/2026, reflected a focus area that Resident #1 had an actual fall on 6/17/2026 related to poor balance and confusion with a goal of the resident would resume usual activities without further incident through the review date. Interventions included review of past falls and attempt to determine cause of falls, xrays, neuro checks, wedges, and to send out to the emergency room. Record review of Resident #1's quarterly MDS assessment, dated 06/25/26, reflected a BIMS of 3, indicated cognition was severely impaired. Section B (hearing, speech and vision) stated Residents #1's ability to express ideas, needs and wants was sometimes understood. Section J (Health Conditions) revealed Resident #1 had a history of 2 falls with no injury (April and May 2026) and 1 fall with major injury (June 2026 at 5:30am) The MDS section J did not reflect the fall that CNA C, D, E stated occurred on 06/17/26 at around 12:30am with no injury. During an observation and interview on 07/01/2026 at 12:30 p.m., Resident #1 was on her bed. Resident #1 said that she did not fall and that she did not have pain. Resident #1 had fall interventions in place as reflected on her care plan, to include bed wedges, bed to lowest position, floor mats on both sides, room was free of clutter, the room was well lit, resident did not have any visible injuries noted, and call light within reach. Record of Resident #1's nursing notes dated 06/17/26 at 6:26 a.m. created by LVN B reflected At approximately 0530, CNAs notified SN that resident was found on the floor at bedside, upon entering room resident noted to be in supine position on the floor next to roommates' bed. Residents bed was at the lowest position. Head to toe assessment complete, noted with skin tears to left elbow and minor swelling to left shoulder. Resident safely transferred to bed x 2 staff assist, while attempting to provide wound care resident pulled away and c/o pain to left arm. Wound cleansed gently, gauze applied and secured with tape. Neuro checks initiated, bed lowered at lowest position, call light left within reach. PRN pain medication administered. ADON, NP and RP notified. Oncoming nurse made aware. Record of Resident #1's imaging report dated 06/17/26 reflected impression: acute fracture to the left humeral head/neck. Record review of Resident #1's discharge hospital records dated 06/17/26 stated Resident discharged with sling to left arm Record review of Resident#1's care plan did not include any verbiage related to Resident #1's arm sling or non-compliance with arm sling. Record review of Resident #1's nurse progress notes, 06/17/26 at 10:35 p.m., created by LVN G, reflected, Resident returned from ER via EMS with no additional orders. Resident has bruising to left shoulder, skin tear (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to left elbow, right forearm was bandaged from IV insertion, no other skin issues noted, sling to left arm was not applied upon arrival, EMS stated that Resident #1 took off the sling during transport, nurse reapplied. Arrival vital signs T97.7, O2 at 98% on RA, HR 95, BP 167/83, resident had complained of pain on face scale of 3 when nurse reapplied sling but denied pain medication. During an interview on 07/02/2026 at 11:11 a.m., LVN F stated he was notified during report at the beginning of his day shift on 06/17/26 from 6:00 a.m. to 2:00 p.m. that Resident #1 fell. LVN F stated he went to assess Resident #1 with the DON. LVN F stated the DON contacted the NP and got orders for x-rays. LVN F stated that after his shift, Resident #1 was sent out to the hospital for further evaluation. LVN F stated that the nurse (LVN B) that received Resident #1 when she returned from the hospital and was responsible for entering the new orders and updating the care plan. LVN F stated Resident #1's sling had to be care planned and added as an order. During an interview on 07/02/2026 at 1:30 p.m., the NP stated she was notified of Resident #1's fall that happened on 06/17/2026 at 5:30 a.m. The NP stated she called the DON and gave orders for x-rays of her left shoulder. The NP stated she was notified of the Xray results and said she gave an order for Resident #1 to be sent to the hospital for further evaluation. During an interview on 7/3/26 at 12:35 p.m., MDS RN stated all nurses were responsible for inputting new orders in the resident's electronic medical chart. MDS RN stated he was not aware of the order for the sling to left arm. MDS RN stated that he was responsible for updating Resident #1's care plan. MDS RN stated that he did not see the order on Resident #1's electronic medical chart and was not aware Resident #1 returned from hospital with a sling. MDS RN stated the negative outcome was that the facility did not carry over the correct orders from Resident #1 discharge the hospital on [DATE]. The MDS RN stated he goes by the orders that the nurse put in and did not review the discharge paperwork. The MDS RN stated because the nurse did not input the order for Resident #1's sling he missed it. During an attempted telephone interview on 07/02/2026 at 10:54 a.m., LVN B was called unsuccessfully. Voice message was left requesting a call back from LVN B. During an attempted telephone interview on 07/02/2026 at 02:05 p.m., LVN B was called unsuccessfully. Voice message was left requesting a call back from LVN B. During an attempted telephone interview on 07/03/2026 at 10:15 a.m., LVN B was called unsuccessfully. Voice message was left requesting a call back from LVN B. During an interview on 07/03/26 at 04:27 p.m., the DON said Resident #1 had some history of falls and tried to get out of bed without assistance. (Resident #1's care plan included risk of falls due to self transfer) The DON said that nurses were responsible for updating the care plan. The DON said Resident #1 had dementia and that was a disease process not a behavioral issue. The DON said there was not a negative outcome from her not using the sling. The DON said that Resident #1 did not want to use the sling. The DON stated that the sling was supposed to be care planned and stated orders should have been put in place for use of the sling. Record review of the facility's policy titled, Care Plan Revisions Upon Status Change, implemented date 10/24/2022, revealed: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. The care plan will be updated with the new or modified interventions.		

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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. Based on observation and interview, the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles reviewed for medications stored in 1 (B hall cart) of 4 medication carts reviewed for storage. The facility failed to ensure that the nurses medication cart for B hall was secured by a lock when it was left unattended by RN A. This failure could place residents at risk of injury if medication left unsecured were consumed. Findings included: During an observation on 7/1/26 at 2:48 p.m., revealed the B Wing Hall nurse's medication cart was left unlocked and unattended against the nurse's station. During the observation RN A was in the nurses' station and left the medication cart unlocked and with the keys attached to the lock. During an interview on 7/1/26 at 2:48 p.m., RN A revealed he was responsible for the nurse's medication cart that was left unlocked. He stated he was expected to lock the nurse's medication cart when he walked away from it. He stated if it was left unlocked then a resident could open a drawer and take anything that was not for them. He stated he had left the cart unlocked because he just went to show a coworker something. During an interview on 7/3/26 at 4:27 p.m., with the DON revealed numerous staff, including her and the ADON, were responsible for ensuring medications carts were locked. The DON stated her expectation of staff when they walk away from the medication cart was to lock it. DON stated that the negative outcome for leaving the cart unlocked was that a resident or visitor could grab the medication from the cart, and it could harm them. She stated she had provided in-services to the staff. Record review of facility's policy Medication Administration with a revised date 10/01/2019 revealed The facility maintains equipment and supplies necessary for the preparation and administration of medications of residents. The mobile medication cart will be used to facilitate administration of medications to residents. the purpose of the mobile medication system is to insure appropriate control and surveillance of resident assigned medications. 2. The medication cart is locked at all times when not in use.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records that were complete and accurate in accordance with accepted professional standards and practices for 1 of 3 residents (Resident #1) reviewed for accuracy. The facility failed to add a physician's order for a sling to Resident #1's left shoulder after she returned from the hospital on [DATE]. This failure could place residents at risk for errors in care. Finding included: Record review Resident #1's face sheet, dated 07/03/26, revealed an [AGE] year-old female, admitted on [DATE], with diagnoses which included type 2 diabetes mellitus (a chronic condition where the body either does not produce enough insulin or does not use insulin effectively, leading to high blood sugar levels), Dementia (a decline in mental ability severe enough to interfere with daily life), history of falling, and impaired balance (a reduced ability to maintain stability and spatial orientation). Record review of Resident #1's care plan, dated 03/30/2026, reflected a focus area that Resident #1 had an actual fall on 6/17/2026 related to poor balance and confusion with a goal of the resident would resume usual activities without further incident through the review date. Interventions included review of past falls and attempt to determine cause of falls, xrays, neuro checks, wedges, and to send out to the emergency room. Record review of Resident #1's quarterly MDS assessment, dated 06/25/26, reflected a BIMS of 3, indicated cognition was severely impaired. Section B (hearing, speech and vision) stated Residents #1's ability to express ideas, needs and wants was sometimes understood. Section J (Health Conditions) revealed Resident #1 had a history of 2 falls with no injury (April and May 2026) and 1 fall with major injury (June 2026 at 5:30am) The MDS section J did not reflect the fall that CNA C, D, E stated occurred on 06/17/26 at around 12:30am with no injury. During an observation and interview on 07/01/2026 at 12:30 p.m., Resident #1 was on her bed. Resident #1 said that she did not fall and that she did not have pain. Resident #1 had fall interventions in place as reflected on her care plan, to include bed wedges, bed to lowest position, floor mats on both sides, room was free of clutter, the room was well lit, resident did not have any visible injuries noted, and call light within reach. Record of Resident #1's nursing notes dated 06/17/26 at 6:26 a.m. created by LVN B reflected At approximately 0530, CNAs notified SN that resident was found on the floor at bedside, upon entering room resident noted to be in supine position on the floor next to roommates' bed. Residents bed was at the lowest position. Head to toe assessment complete, noted with skin tears to left elbow and minor swelling to left shoulder. Resident safely transferred to bed x 2 staff assist, while attempting to provide wound care resident pulled away and c/o pain to left arm. Wound cleansed gently, gauze applied and secured with tape. Neuro checks initiated, bed lowered at lowest position, call light left within reach. PRN pain medication administered. ADON, NP and RP notified. Oncoming nurse made aware. Record of Resident #1's imaging report dated 06/17/26 reflected impression: acute fracture to the left humeral head/neck. Record review of Resident #1's discharge hospital records dated 06/17/26 stated Resident discharged with sling to left arm Record review of Resident#1's care plan did not include any verbiage related to Resident #1's arm sling or non-compliance with arm sling. Record review of Resident #1's nurse progress notes, 06/17/26 at 10:35 p.m., created by LVN G, reflected, Resident returned from ER via EMS with no additional orders. Resident has bruising to left shoulder, skin tear to left elbow, right forearm was bandaged from IV insertion, no other skin issues noted, sling to left arm was not applied upon arrival, EMS stated that Resident #1 took off the sling during transport, nurse reapplied. Arrival vital signs T97.7, O2 at 98% on RA, HR 95, BP 167/83, (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had complained of pain on face scale of 3 when nurse reapplied sling but denied pain medication. During an interview on 7/3/26 at 12:35 p.m., MDS RN stated all nurses were responsible for inputting new orders in the resident's electronic medical chart. MDS RN stated he was not aware of the order for the sling to left arm. MDS RN stated that he was responsible for updating Resident #1's care plan. MDS RN stated that he did not see the order on Resident #1's electronic medical chart and was not aware Resident #1 returned from hospital with a sling. MDS RN stated the negative outcome was that the facility did not carry over the correct orders from Resident #1 discharge the hospital on [DATE]. The MDS RN stated he goes by the orders that the nurse put in and did not review the discharge paperwork. The MDS RN stated because the nurse did not input the order for Resident #1's sling he missed it. During an attempted telephone interview on 07/02/2026 at 10:54 a.m., LVN B was called unsuccessfully. Voice message was left requesting a call back from LVN B. During an attempted telephone interview on 07/02/2026 at 02:05 p.m., LVN B was called unsuccessfully. Voice message was left requesting a call back from LVN B. During an attempted telephone interview on 07/03/2026 at 10:15 a.m., LVN B was called unsuccessfully. Voice message was left requesting a call back from LVN B. During an interview on 07/03/26 at 04:27 p.m., the DON said Resident #1 had some history of falls and tried to get out of bed without assistance. (Resident #1's care plan included risk of falls due to self transfer) The DON said that nurses were responsible for updating the care plan. The DON said Resident #1 had dementia and that was a disease process not a behavioral issue. The DON said there was not a negative outcome from her not using the sling. The DON said that Resident #1 did not want to use the sling. The DON stated that the sling was supposed to be care planned and stated orders should have been put in place for use of the sling. Record review of the facility's policy titled, Documentation in Medical Record, with implemented date 10/24/2022, reflected, each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.		