

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2025
NAME OF PROVIDER OR SUPPLIER Windsor Las Palmas Nursing and Rehabilitation Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 E Quebec Ave McAllen, TX 78503	

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>(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

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 resident of 3 (Resident #1) residents reviewed for EBP. The facility failed to post EBP signage for Resident #1 when she had a permcath (a flexible tube used for dialysis treatment) to right chest. This failure could place residents at risk of MDRO contamination. The findings included: Record review of Resident#1's admission sheet, dated 09/05/25, revealed the resident was a [AGE] year-old female with an admit date of 09/02/25 and an original admission date of 08/20/25. Her relevant diagnoses included: dependence on renal dialysis (a process of removing excess water, solutes, and toxins from the blood), diabetes mellitus (a disease that result in too much sugar in blood), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), and hypertensive heart disease (a long-term condition that develops from chronic high blood pressure, or hypertension). Record review of Resident #1's electronic medical record revealed Resident #1 had not been at the facility long enough for an admission MDS assessment. Record review of Resident 1's comprehensive care plan initiated on 08/20/25 reflected a Focus of the resident needs hemodialysis (a machine that filters waste, salts, and fluid from the blood) r/t acute kidney failure. Interventions in part included monitor/document/report PRN any s/sx of infection to access site: redness, swelling, warmth or drainage. Record review of Resident #1's active orders as of 09/06/25, reflected dialysis: permcath right chest restrictions: no heavy lifting effective 09/02/25, dialysis: check shunt for s/s of infection or bleeding effective 09/02/25. EBP: use gown and gloved for high contact resident care activities for those known to be colonized or infected with a CDC targeted MDRO as well as those with increased risk of MDRO (residents with wounds or indwelling medical devices) effective 09/06/25 at 6:00 a.m. In an observation and interview on 09/06/25 at 9:45 a.m., Resident #1 said in late August 2025, she had a permcath inserted to her right chest due to her diagnosis of kidney failure and required dialysis. Resident #1 was observed with a white gauze on her right chest. Resident #1 said that was where she had her permcath for dialysis. No EBP signage was seen on her door. An observation and interview on 09/06/25 at 10:02 am, LVN A said Resident #1 was under EBP because she had a permcath to her right side (for dialysis). She said she remembered seeing an active order for EBP effective 09/06/25. LVN A said a resident was required to be under EBP whenever they had a foley, permcaths, midlines, IV's, or open wounds. She said having an EBP sign on their door would advise staff if they were going to touch the resident, they needed to wear ppe. LVN A was observed in front of Resident #1's door and said, there's no EBP sign. She said the order for EBP was effective 09/06/25 but it should have been effective from her re-admission date (09/02/25). LVN A said a negative outcome for Resident #1 not having an EBP sign could be that staff would not know to take proper precautions when touching Resident #1 and the risk of infection for both staff and residents. An interview on 09/06/25 at 10:08 a.m., the ADON/LVN said while she did her monthly audits the morning of 09/06/25 (6:00 am) and she discovered Resident #1 did not have an order for EBP due to her having a permcath for dialysis. She said the order for EBP should have been requested upon re-admission [DATE]]. The ADON/LVN said it was her responsibility to ensure an EBP sign was posted by Resident #1's door as soon as she received the order for EBP. She said the sign would advise staff to wear proper PPE. She said she forgot to place an EBP sign on her door. She said the negative outcome for Resident #1 not having an EBP sign would be the risk of infection for residents and staff. In an observation and interview on 09/06/25 at 10:18 a.m., the DON said Resident #1 was under EBP due to having a permcath for dialysis. The DON was observed in front of Resident #1's door and said, there's no sign. The DON said an EBP sign should have gone up as soon as the order was received. She said the negative outcome for Resident #1 not having an EBP sign in front of her door could be the spread of infection for her and staff. In interview on 09/06/25 at 11:45 am, LVN B said he was the nurse who re-admitted Resident #1 on 09/02/25. He said the protocol when residents were re/admitted was to conduct a total head-to-toe assessment (skin and pain). He said if the resident had a foley, wounds, permcaths, and/or g-tubes they were required to be under EBP. He said Resident #1 had a permcath on her chest for dialysis. He said it was his responsibility to ensure an EBP order was obtained, and proper signage was placed on her door effective the date of re-admission [DATE]]. LVN B said a negative outcome for Resident #1 not having an EBP sign on her door would be infection</p>		