STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675475	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Raymo	1700 S Expressway 77 Raymondville, TX 78580

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47573 Based on observations, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment, were reported immediately to the State Survey Agency, within two hours if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for 1 (Resident #1) of 5 residents reviewed for abuse/neglect. The facility failed to report allegations of resident neglect for Resident #1 to the State Survey Agency within the allotted time frame of 2 hours on 08/07/24 when Resident #1 had a fall at around 5AM and sustained a serious bodily injury (laceration to her head), which required 22 sutures/staples. This failure could place all residents at increased risk for potential neglect due to unreported allegations of abuse and neglect. The findings included: Record review of Resident #1 's file dated 08/19/24 reflected [AGE] year-old female with original admitted [DATE] and last admitted [DATE]. Her diagnosis included: laceration without foreign body of other part of head, type 2 diabetes, Alzheimer's disease, anxiety disorder, bipolar disorder (mental illness with mood swings), osteoporosis (weak bones), hypertension, insomnia, and vitamin deficiency. Record review of Resident #1's MDS assessment dated [DATE] reflected a BIMS score of 00 (severe cognitive impairment). Resident #1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity, assistance may be provided throughout the activity or intermittently) for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, walk 10 feet, walk 50 feet with two turns, and walk 150 feet. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Raymo	1700 S Expressway 77 Raymondville, TX 78580

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan dated 08/19/24 reflected [Resident #1] was at risk for falls/injury, but she preferred to get on her knees on the floor and clean the floor or pick up things from the floor without help due to her dementia. She cannot recall that she is at risk for injury. Date initiated: 09/23/21. Interventions included: [Resident #1] did not want any staff help and knew the risks and preferred to get on her knees and clean floor/pick up things even if it leads to harm, injury, or even death. Date initiated: 09/23/21. Make rounds and frequent supervision throughout the day. Date initiated: 09/23/21. Attempt to maintain her busy with preferred activity and have staff members monitoring and supervising resident. Date initiated: 02/15/22. Bed against the wall. Date initiated: 05/01/23. [Resident #1] unable to use the call light. Interventions included: Monitor and round frequently. Date initiated: 12/22/21. [Resident #1] had an ADL self-care performance deficit related to dementia, Alzheimer's, and impaired balance. Interventions included: Reapply head helmet and explain why she needs it. Date initiated: 03/24/24. May wear head helmet as tolerated. Date initiated: 03/27/24. [Resident #1] had the tendency to remove her helmet in which she requires redirection for helmet placement. Date initiated: 08/15/24. [Resident #1] had an actual fall. Interventions included: May use helmet as she tolerates for safety. Date initiated: 01/08/24. Ensure resident is using her head helmet. Date initiated: 03/27/24. Therapy to evaluate and treat for strengthening. Date initiated: 05/28/24. Psych to review medications and adjust as needed. Date initiated: 06/05/24. Continue to use nonskid socks and ensure she is using them properly. Date initiated: 07/19/24. Sent to hospital. Date initiated: 08/07/24. [Resident #1] was at high risk for falls related to confusion, gait/balance problems, and unaware of safety needs. Interventions included: anticipate and meet the resident's needs. Date initiated: 03/30/23. Ensure hallways are clutter free since she wanders most of the day. Date initiated: 08/16/23. Ensure that the resident is wearing helmet if she allows it and appropriate footwear. Date initiated: 03/30/23 and revised on 08/15/24. Record review of progress notes for Resident #1 reflected - On 08/07/24 at 5:20 AM, documented by LVN A: LVN A was called to Resident #1's room by CNA G and stated when CNA G entered Resident #1's room to render care, he noted Resident #1 sitting on the floor, holding her face and there was blood on the floor where she was sitting. When LVN A entered the room, Resident #1 was sitting on the floor facing her roommate's bed and there was blood on the floor. LVN A assessed Resident #1 to find exactly where the blood was coming from. There were 2 large open areas to the top of Resident #1's head and 1 smaller open area more towards the right side of her head. Pressure was applied to the areas. 911 was activated, and LVN A continued to render first aid until EMS arrive. RP was notified and made aware of Resident #1's condition. Resident #1 was transported via EMS to the emergency room . ADON was made aware of Resident #1's condition. NP was also notified. On 08/07/24 at 1:45 PM, documented by LVN B: Resident #1 was admitted to hospital for observation. Diagnosis: head laceration. On 08/08/24 at 1:11 PM, documented by ADON: ADON spoke with RP. RP stated Resident #1 was doing well and that he was looking forward to Resident #1 leaving hospital and for her to return to the facility. ADON received a call from FM 1. FM 1 stated she was also eager for Resident #1 to return to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Raymo	1700 S Expressway 77 Raymondville, TX 78580

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 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 08/12/24 at 10:00 AM, documented by DON:

Telephone call placed to the hospital. DON spoke with hospital RN for follow up on hospitalization . Hospital RN stated Resident #1 was diagnosed with a UTI and was currently on IV antibiotics. Resident #1 continued on a 1:1.

On 08/13/24 at 4:49 PM, documented by LVN C:

Resident #1 returned from hospital stay and was transferred by FM 1 in his personal vehicle. LVN C received report from hospital RN. Resident #1 was alert and ambulated in the secure unit. Resident #1 was in the dining area with other residents for dinner. No signs of pain or discomfort were noted.

On 08/14/24 at 1:33 PM, documented by DON:

Rounded to Resident #1's room for follow up after readmission. Resident #1 noted with helmet on and ambulated in room. Assisted Resident #1 with reapplying nonskid socks. Resident #1 independently ambulated out of the room and down the hallway.

Record review of the skin evaluation dated 08/07/24 at 5:20 AM reflected Resident #1 had a laceration to the top of the scalp and 2 lacerations to the right side of her head. Documented by: LVN A.

Record review of hospital records dated 08/08/24 reflected Resident #1's CT scan from the hospital on 08/07/24 at 6:26 AM. Impression: 1. No acute intracranial bleed was seen. 2. Atrophy with white matter changes. History included notes stated sudden onset of a fall hitting her scalp having a scalp laceration and hemorrhage that required stitches and during the emergency room visit she was acting confused, disoriented, agitative, and aggressive. Ativan was given after discussion with family that her normal meds include Ativan and has a history of depression and psychosis. Resident baseline is mite nonverbal but will laugh at jokes. 1. Assessment Plan-Acute metabolic encephalopathy caused by UTI in a resident with dementia. If UTI was confirmed, start antibiotics accordingly.

Record review of the initial nursing evaluation (for readmission) dated 08/13/24 at 4:48 PM reflected admitting diagnosis: post fall, head injury, UTI. Continued care for Resident #1. Injuries/body marks noted: top of scalp - laceration to crown of head, has 7 staples to left half of laceration and 9 stitches to right half of laceration. Area dry, no drainage, redness, heat or swelling noted. 7cm x 0.1cm; top of scalp - laceration to top right of head with 6 staples present. Area dry, no drainage noted, no redness or swelling. 2.5cm x 0.1cm; other - left arm discoloration: 7.5cm x 4.5cm and right arm discoloration: 7.5cm x 1cm.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER: Windsor Nursing and Rehabilitation Center of Raymo		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 S Expressway 77 Raymondville, TX 78580	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Provider Investigation Report dated 08/14/24 reflected incident was on 08/07/24 at 2:00 PM, and incident reported to HHSC on 08/07/24 at 2:30 PM. Incident description: On 08/07/24, Resident #1 sustained an unwitnessed fall in her room. Resident #1 was found sitting on the floor by CNA G, CNA G notified LVN A. LVN A performed head to toe assessment and noticed blood on her head. Resident #1 was unable to describe what happened. Resident #1 scored a 0 on BIMS. LVN A called NP and gave orders to transfer to ER for further evaluation. RP notified. Incident reported to state. Investigation initiated. Staff interviews initiated. Resident #1 received staples/sutures on the head. Staff re-educated on Abuse/Neglect policies and Fall Prevention in-service initiated. On 08/12/24, the DON called the hospital and was informed Resident #1 was diagnosed with a UTI and was currently on IV antibiotics. On 08/13/24, Resident #1 was readmitted to the facility. No systemic issues identified. After an internal investigation, the facility concluded that the allegation of neglect was unfounded. The unwitnessed fall with injury was accidental and unavoidable due to Resident #1's underlying medical condition. Record review of the state reporting system completed on 08/19/24 at 12:00 PM reflected the incident and injury for Resident #1 on 08/07/24 at around 5 AM was not reported to the State Survey Agency within 2 hours. Interview and observation of Resident #1 on 08/08/24 at 11:40 AM at the hospital revealed Resident #1 did not respond to questions. Resident #1 had a head laceration which was wrapped with bandages. According to hospital staff, Resident #1 had psychosis and was at high risk for falls, so the hospital staff did not unwrap the head laceration to avoid Resident #1 becoming agitated. An interview with RP on 08/08/24 at 11:45 AM revealed RP had no concerns with the care provided to Resident #1 at the facility. RP wanted Resident #1 to return to the facility. RP verified he was notified of the incident and had been updated of all changes or incidents prior as well. Interview and observation of Resident #1 on 08/19/24 at 2:20 PM revealed Resident #1 was in the common area of the secured unit and got her nails polished. Resident #1 was asked basic questions such as her name or how she was doing. Resident #1 did not respond to questions. Resident#1 appeared with good personal hygiene. Resident #1 wore a soft-shell helmet. Sutures/staples were observed under the helmet as the helmet had slits on the top where the sutures/staples were visible. Resident #1's hair was growing back. Resident #1 was not in distress. Resident #1 was engaged with activities such as dancing with staff and staff rounded on Resident #1 frequently. An interview with HA B on 08/19/24 at 3:15 PM revealed he worked on 08/06/24-08/07/24 from 10 PM-6 AM. HA B said at around 5 AM, he and CNA G were going to do their last round. HA B said CNA G walked into Resident #1's room and found Resident #1 sitting on the floor. HA B said CNA G told HA B to stay with Resident #1 while CNA G called the nurse. HA B said he stayed in the hallway by the door and ensured Resident #1 was okay. HA B said he recalled Resident#1's hair looked dark and wet, but he did not see if she had blood, cuts, or injuries. HA B said the light was on above Resident #1's bed but the room was still somewhat dim. HA B said CNA G and LVN A arrived quickly to the room. HA B said LVN A checked Resident #1, and CNA G stayed to help. HA B said he continued with his job duties and assisted other residents. HA B said during their rounds throughout that night, Resident #1 had been asleep in bed and was doing well. HA B said Resident #1 was not on any special supervision and they rounded on her appropriately throughout the shift. HA B said he was informed that Resident #1 was sent to the hospital, but he was not sure why. HA B said he was in-serviced on abuse/neglect and knew to report to the administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Raymo	1700 S Expressway 77 Raymondville, TX 78580

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with CNA G on 08/19/24 at 3:35 PM revealed he worked on 08/06/24-08/07/24 from 10 PM-6 AM. CNA G said at around 5:15 AM, he walked into Resident #1's room to start the last round because he always started in Resident #1's room. CNA G said he saw Resident #1 sitting on the floor, near her roommate's bed, facing her roommate's bed. CNA G said Resident #1 was not wearing the helmet but was wearing the nonskid socks. CNA G said he saw blood coming out from Resident #1's head but he did not know exactly from where because he did not see clearly with her hair. CNA G said it happened fast and his first reaction was to call the nurse. CNA G said he told HA B to stay with Resident #1 to ensure she was okay and so he could call the nurse. CNA G said he called LVN A who was about to walk into the unit. CNA G said LVN A went to the room and assessed Resident #1. CNA G said LVN A applied pressured to Resident #1's head to try to get the bleeding to stop. CNA G said LVN A also called 911. CNA G said EMS arrived in about 10 minutes and in the meantime, LVN A continued to apply pressure and continued to redirect Resident #1 to stay still because she tried to get up. CNA G said EMS arrived and transported Resident #1 to the hospital. CNA G said before he found Resident #1 on the floor, they had seen her and rounded on her at around 4-4:30 AM. CNA G said she was asleep at that time and was okay. CNA G said Resident #1 was not wearing her helmet when she was asleep, but Resident #1 sometimes took the helmet off to sleep. CNA G said they would redirect Resident #1 to wear the helmet if she was out of bed, but she was able to take it off. CNA G said when he found her on the floor, Resident #1 was not wearing the helmet. CNA G said Resident #1 was not on any special supervision and they rounded on her appropriately throughout the shift. CNA G said he was in-serviced on abuse/neglect and knew to report to the administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Raymo	1700 S Expressway 77 Raymondville, TX 78580

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LVN A on 08/19/24 at 3:55 PM revealed she worked on 08/06/24-08/07/24 from 10 PM-6 AM. LVN A said at around 5:15 AM, CNA G called her to go to Resident #1's room and CNA G said that there was a lot of blood. LVN A said she hurried to Resident #1's room with CNA G where she saw Resident #1 sitting on the floor and there was blood on her head and on the floor. LVN A said she believed it was fresh blood like it had just happened within 5 or 10 minutes from CNA G finding her. LVN A said there was so much blood, and she could not figure out where it was coming from. LVN A said she applied pressure to the top of her head because she figured that was where it was coming from. LVN A said the bleeding finally slowed down and she was able to see on the crown of her head, Resident #1 had a big gash. LVN A said Resident #1 was known to like to clean so she thought maybe she hit her head on the bed while she was cleaning, but she was not there to witness what happened. LVN A said the gash was maybe a few inches wide, but she did not know for sure since Resident #1's hair was in the way. LVN A said she finally got the top part to stop bleeding by holding pressure, but once she got it to stop dripping on the top, there was blood coming from the right side. LVN A said she found another spot on the side that was bleeding, so she believed she had 2 cuts. LVN A said since the first aid they were providing was not stopping the bleeding, she had decided to activate 911. LVN A said it took 18 minutes for EMS to arrive. LVN A said she stayed in the room with Resident #1 the entire time and redirected her to not get up. LVN A said she sat on the floor with Resident #1 and leaned her head on her to calm her down. LVN A said she could not get a blood pressure reading because Resident #1 kept moving but her other vital signs were normal. LVN A said she thought Resident #1 did not even realize she was hurt and she did not act like she was in pain. LVN A said Resident #1 was not in distress. LVN A said it was around the time that Resident #1 got her morning medications which helped her not be anxious, but that morning she had not received the medications yet since the incident happened. LVN A said she could see the gash where the blood was coming from, it was big, and there was a lot of tissue under there. LVN A said EMS finally arrived and transported Resident #1 to the hospital. LVN A said she called the hospital to get an update before she left that morning at around 6-6:30 AM. LVN A said she was told by the hospital staff that there was no update, not sure if they were going to keep her or send her back to the facility. LVN A said the next day was her last day working at the facility. LVN A said during report the next day, 08/07/24 at 10 PM, she found out Resident #1 was kept at the hospital and that she ended up getting 22 sutures/staples. LVN A said she followed the protocol for the fall/incident. LVN A said she was in-serviced on abuse/neglect and knew to report to the administrator as she was the abuse coordinator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER: Windsor Nursing and Rehabilitation Center of Raymo		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 S Expressway 77 Raymondville, TX 78580	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the ADON on 08/19/24 at 4:00 PM revealed the ADON said on 08/07/24, LVN A called him at around 5 AM to inform him that Resident #1 was sent to the hospital via EMS. The ADON said when LVN A called him, they were in the process of transferring Resident #1 out. The ADON said 911 had been activated and LVN A had already called the RP/NP, so he ensured that process was done. The ADON said he went to the facility and spoke to the staff. The ADON said CNA G explained that he was doing his final round and found Resident #1 sitting on the floor with a laceration to the head. The ADON said HA B was with CNA G, so HA B stayed with Resident #1 while CNA G called the nurse to assess Resident #1 which was the proper protocol. The ADON said he was not sure if the staff had rounded on Resident #1 recently or how she was doing during the shift, but staff could not leave the secured unit alone at any time. The ADON said even during the night shift, he had 2 staff working the unit, and 1 staff had to always be in the unit. The ADON said because of the population in the unit, they tried to keep the doors open, and rounded on the residents more frequently, to prevent falls or incidents. The ADON said Resident #1 had a helmet that she wore as tolerated. The ADON said Resident #1 kept the helmet on during the day, but especially at night, she fidgeted with it. The ADON said he worked last night in the unit, and she wore it fine, but it depends on the nights. The ADON said Resident #1 was not on any special supervision, but the staff rounded on her every 2 hours and more, constant rounding in the unit especially. The ADON said since Resident #1 returned from the hospital, he instructed the staff to round more often, at least every hour. The ADON said they also in-serviced the staff on fall precautions and abuse/neglect. The ADON said another intervention they implemented for Resident #1 was for therapy to evaluate and treat. The ADON said Resident #1 did not use the call light as she did not understand but they already knew that and that was already care planned as well. The ADON said Resident #1 was sent to the hospital because of the lacerations to her head and because the staff could not get the bleeding to stop. The ADON said originally, the staff thought Resident #1 had 2 cuts but from the hospital records, she only had 1. The ADON said the staff are in-serviced at least once a month or as needed. The ADON said the staff know what to report, what was abuse/neglect, and who was the abuse coordinator. The ADON said the abuse coordinator was the administrator. The ADON said the staff would inform the administrator of any incidents or concerns and the administrator would decide what was reportable to the state or not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Raymo	1700 S Expressway 77 Raymondville, TX 78580

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DON on 08/19/24 at 5:00 PM revealed staff notified the ADON about the incident regarding Resident #1 on 08/07/24 at around 5 AM. The DON said she spoke to the staff that worked and asked what happened. The DON said LVN A told her she walked towards the unit when CNA G rushed towards the door to let LVN A know that Resident #1 sustained a fall, and she had blood to her head. The DON said the staff rushed to Resident #1's room and saw Resident #1 sitting in front of the roommate's bed, facing the roommate. The DON said LVN A applied pressure and tried to clean the blood, and the staff activated 911. The DON said Resident #1 was not easily redirectable as she had her morning medications yet. The DON said it was not time for her medications yet as it was still early in the morning. The DON said CNA G and HA B had conducted their rounds appropriately during the overnight shift and noted Resident #1 asleep without issue. The DON said the staff last rounded on her around 4:30 AM, and Resident #1 was asleep. The DON said based on the information she gathered, the staff followed the protocol and there were no concerns of neglect. The DON said EMS arrived, picked Resident #1 up and took her to the hospital. The DON said she called the hospital to see if they had done any diagnostics because they were going to have to report it. The DON said she kind of figured it would have to be reported because of the injury. The DON said Resident #1 had a cut on her head so she called the hospital to check if Resident #1 got staples because chances were, the incident would have to be reported to the state. The DON said the hospital did not have an update yet. The DON said the administrator was also notified about the incident, but she did not recall at what time. The DON said the helmet was already implemented before the incident, but depending on her days, on her mood, some days she wore the helmet more than others. The DON said the staff knew to redirect her or tried to get her to wear it as much as she tolerated. The DON said there were no concerns as far as staff following the protocol and procedure for the incident. The DON said the staff were in-serviced for this incident and the topics were abuse/neglect and falls. The DON said the administrator was the abuse coordinator and the administrator decided what to report to the state or when to report. The DON said the head was a highly vascular part of the body and any small cut could have caused a lot of bleeding. The DON said not all cuts required sutures or staples. The DON said in Resident #1's case, she required staples/sutures for the laceration to be closed. The DON said because of the staples/sutures Resident #1 sustained, it was considered a major injury. The DON said Resident #1 did not have a subdural bleed or other injury. The DON said Resident #1 was also diagnosed with a UTI at the hospital and the UTI could have caused her to be more anxious than usual. The DON said they had decided to wait to verify what treatment Resident #1 received for the laceration. The DON said they had called the hospital to ask for updates. The DON said the ER nurse had said they were still waiting to see if they were going to put Resident #1 staples or sutures because Resident #1 was not letting the hospital staff do much as Resident #1 did not cooperate. The DON said it took more time than they expected to get verification on the treatment provided. The DON said the way the ER nurse said was that she's (Resident #1) still here in the ER, going to need staples or sutures, still trying to work with her as she is not easily redirectable. The DON said that was around 10 AM when she called the hospital. The DON said they had to wait a little longer to see what was going to happen. The DON said the RP called the facility to inform them that Resident #1 had gotten staples and that the hospital was going to keep Resident #1 for observation. The DON said that was around 2 PM and that was when the administrator was informed so she reported it to the state. The DON said she called the next day so the hospital medical records department could fax any diagnostics, to see what the results were. The DON said initially, medical records told her she had to wait until Resident #1 was discharged but she explained the situation and then the hospital agreed to send the records. The DON said the results for the CT scan were negative for bleeds or other head/brain injury. The DON said was kept at the hospital for 2-3 days and returned on 08/13/24. The DON said the RP had to transport Resident #1 in his vehicle because Resident #1 did not cooperate to be transported via EMS. The DON said when Resident #1 returned, they implemented rehab services and reviewed/revised her care plan/interventions. The DON said the importance of reporting to the state would be to rule out abuse or neglect for the residents, and to ensure the ongoing monitoring of the residents was done by the state. The DON said the incident was considered an unwitnessed fall, and Resident #1 and her roommate could not say what happened. The DON said she believed not self-reporting within required timeframes, would not place Resident #1 or the residents at risk of injury/harm as the staff followed the protocols, provided medical attention, called EMS, sent her to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675475	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Raymo	1700 S Expressway 77 Raymondville, TX 78580

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the ADM on 08/19/24 at 5:35 PM revealed she was the abuse coordinator and would ensure reportable incidents were reported to the state survey agency within required timeframes. The ADM said the required timeframes were 2 hours after they found out about the incident or 24 hours if it was not an emergency. The ADM said on 08/07/24, Resident #1 fell and was sent out to the hospital. The ADM said they had called the hospital for updates and the hospital had not updated them yet as far as treatment or results. The ADM said at around 2 PM, she found out that the hospital was going to place sutures/staples and admitted Resident #1 for observation. The ADM said as soon as the facility heard from the hospital at 2 PM, she treated that as the start of the 2-hour window, but it was reported about 20-30 minutes after that. The ADM said before that update at 2 PM, nobody knew Resident #1 was going to need staples/sutures. The ADM said they knew Resident #1 had a laceration, but they did not know how deep the cut was so that was why Resident #1 was sent to the hospital for further evaluation. The ADM said if Resident #1 had not needed staples, but the hospital would have still admitted her for observation, then she would have still reported that. The ADM said an injury that required staples/sutures was a serious injury. The ADM said she had asked the regional consultant who instructed her to wait on the report to see what the hospital ended up doing or if there were any findings, so they waited to report until they received confirmation of the treatment (staples/sutures). The ADM said self-reporting was important because if there was an injury of unknown source or they did not know what happened, then they would need to investigate. The ADM said even if it was not a self-report, they would have investigated. The ADM said the incident was an unwitnessed fall and they completed their investigation with no concerns of abuse/neglect. The ADM said the risk of injury/harm to the residents if incidents were not self-reported timely would be that they might not investigate in time and ensure a similar incident did not happen to another resident. Record review of the Abuse, Neglect, and Exploitation Policy (implemented 08/15/22) Reporting/Response: The facility will have written procedures that include: 1. Reporting of all alleged violation to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.