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	11/15/2024

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** 41761 Based on interview and record review, the facility failed to ensure that all alleged violations involving neglect, were reported immediately to the State Survey Agency, 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 of 3 residents (Resident #2) reviewed for abuse/neglect. The facility failed to report Resident #2's unwitnessed fall with injury on 01/04/24, where Resident #2 sustained a 4 cm laceration to the back of her head that would not stop bleeding and sent out to the hospital. State Survey Agency was not notified of the fall with injury within 2 hours. The incident occurred on 01/04/24 at 7:30 a.m. and was not reported. This failure could place all residents at increased risk for potential abuse to unreported allegations of abuse and neglect. The findings included: Record review of Resident #2's Admission Record dated 11/07/24, revealed a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included: : Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), type 2 Diabetes Mellitus with diabetic neuropathy (a type of nerve damage that can occur with diabetes that most often affects the legs and feet), chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe), heart disease, Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), primary osteoarthritis, left hand (type of arthritis that occurs when flexible tissue at the tends of bones wears down), cerebral infarction due to thrombosis of left vertebral artery (stroke due to blood clot). Record review of TULIP (Texas Unified Licensure Information Portal) on 11/07/24, did not show any notifications for Resident #2 on or around 01/04/24. Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 01, indicating severe impaired cognition. Record review of Resident #2's Care Plan dated 09/25/24, revealed no mention of the fall on 01/04/24 with focus, goals, and interventions/tasks. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's progress notes written on 01/04/24 at 12:00 am DOCTOR - MD/Ext Notes: Note Text: Contacted by on-call NP regarding resident who sustained unwitnessed fall, and sustained a laceration to the back of the head 4 cm x 1 cm. Reported no LOC, dizziness, or drowsiness. Contacted residents nurse, the patient is on ASA daily, is still bleeding, and due to wound length, requested send out to ED for wound repair. Record review of Incident/Accident Report dated 01/01/24 - 01/31/24 unwitnessed falls for Resident #2, revealed a fall on 01/04/24 at 07:30 am. Record review of Resident #2's 12/25/23 Fall Risk Assessment 11 High Record review of Resident #2's 01/04/24 Fall Risk Assessment 13 High Record review of Resident #2's 01/16/24 Fall Risk Assessment 13 High In an interview on 11/14/24 at 03:35 pm, CNA D stated if she would see a resident was on the floor or had seen them fall, she would call the nurse. CNA D stated she would not move the resident or leave the resident. CNA D stated she would leave when the nurse said she could go which was after the nurse assessed and she told the CNA the resident could be moved to their bed or a chair. CNA D stated if a resident had a broken hip, she would check more often to see if they needed anything so they would not hurt themselves trying to do by themselves. CNA D stated she would take slower time during care to prevent reinjury. In an interview on 11/15/24 at 12:18 pm, MA C stated she had been working at the facility for three years. MA C stated she had worked with Resident #2. MA C stated Resident #2 was difficult to work with. MA C stated Resident #2 knows how to get off her wheelchair and she does it all the time. MA C stated they know the level of care the resident needed because it was on the Kardex. MA C stated they would also exchange information when they rounded at the beginning and end of shift. In an interview on 11/15/24 12:46 pm, CNA E stated she had been a CNA E for [AGE] years. CNA E stated she has worked at this facility for [AGE] years. CNA E stated if a resident could not do anything for themselves, she had to do everything for them. She said the ones who could speak, could tell her what they needed, but the others who could not speak, you just had to know what needed done. CNA E stated the Kardex was valuable information for how to take care of residents. CNA E stated if a resident had fallen on the floor, she will go over to the resident and send her partner to get the nurse. She said she stays with the resident and does not move the resident. The nurse is the one who assesses and tells her when she can move the resident to their bed or wheelchair. CNA E stated she had worked with Resident #2 when she was back in the unit. CNA E stated Resident #2 was always hyper in the locked unit. CNA E stated she worked with Resident #2 after they moved her out of the unit with the broken hip. CNA E stated Resident #2 had Alzheimer's and forgets she cannot walk. She said Resident #2 was always trying to walk and she was really good at sliding out of the wheelchair. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/15/24 at 01:13 pm, PT F stated she saw Resident #2 on one day and during the evaluation, she was ok, and during her evaluation the next time, she noticed swelling and discomfort to Resident #2's right hip. She said she could not move it without Resident #2 yelling. PT F stated she notified the nurse. PT F stated the day before or even before that, she had not noticed it. PT F stated before that day when she noticed the edema and pain, Resident #2 had not guarded or complained about right hip pain. In an interview on 11/15/24 at 01:25 pm, LVN A stated she has worked at the facility for a year and a half. LVN A worked in the memory unit. LVN A stated Resident #2 was a frequent faller. LVN A stated she could not remember Resident #2's fall back on 01/04/24. In an interview on 11/15/24 at 01:50 pm, RN H stated he did not remember the fall with Resident #2. RN H stated Resident #2 thought of him as one of her favorite people. RN H stated Resident #2 has sundowners (sundowners dementia is a set of behaviors that can occur in people with dementia in the late afternoon or early evening) really bad and could act out. In an interview on 11/15/24 at 02:10 pm, LVN B stated she had been working at the facility for almost [AGE] years. LVN B stated Resident #2 was challenging. She said Resident #2 was a handful, highly anxious, physically aggressive, verbally aggressive, cannot be still, screamed a lot, and had repetitive behaviors that were distracting. LVN B stated administration, DON, many were aware of Resident #2's behaviors. LVN B stated Resident #2 was very able to get out of her wheelchair. LVN B stated she had not been working when Resident #2 fell on [DATE], or when she broke her hip. In an interview on 11/15/24 at 02:48 pm, ADON G stated he had worked at the facility for three years, with just passing the one-year anniversary of his being an ADON. ADON G stated the nurses reported all changes in condition to him. ADON E stated all falls were reported to either him or the DON. ADON G stated the administrator was the one who reported to State. ADON G stated when a fall was reported to him, if on the weekends, they have VPN access and could do the report to State from home. ADON G stated if he were to receive a text on the weekend, he would also notify administration. ADON G stated the nurses were the ones who updated care plan. On Monday after a weekend fall, they review during their meeting. ADON G stated if a resident had many falls, they put interventions in place. ADON G stated if a resident falls and was sent out to the hospital with injury, it should be reported to State within two hours. ADON G stated the fall Resident #2 had in January 2024 where she had been bleeding from her head, should have been reported within two hours. ADON G stated if they do not report allegations of abuse or neglect in the correct timeframe, it was the resident who suffered. ADON G stated he believed it was better to over report than under report. In an interview on 11/15/24 at 03:10 pm, Administrator stated the timeframe for reporting allegations of abuse and neglect was 2 hours. Administrator stated she believed the incident with Resident #2, on 01/04/24, where she fell , hit her head, was bleeding profusely, and was sent out to the hospital, should have been reported within the two hour timeframe. Administrator stated if they did not report allegations of abuse or neglect, it could cause damage or harm to the residents. Review of facility's Abuse, Neglect, Exploitation policy, not dated, revealed: VII. Reporting/Response A. The facility will have written procedures that include: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Reporting of all alleged violations 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 not 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.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on interview and record review, the facility failed to provide the resident and/or resident representative written notice which specified the duration of the bed-hold policy at the time of transfer of a resident for hospitalization for 1 of 3 residents (Resident #1) reviewed for transfers, in that: The facility did not ensure Resident #1's RP was provided with a written bed-hold policy on 11-06-2023 when Resident #1 was transferred to the hospital. This failure could place residents at risk of being improperly discharged and placed in unsafe conditions. The findings included: Record review of Resident #1's face sheet dated 11/12/2024 reflected Resident #1 was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), seizers (uncontrolled jerking, loss of consciousness, blank stares, or other symptoms caused by abnormal electrical activity in the brain), hyperlipidemia (High levels of blood lipids (fats and waxes such as cholesterol), and hypertension (high blood pressure). Record review of Resident #1's quarterly MDS assessment, dated 09/04/204 reflected a BIMS score of 04 which indicated her cognition was severely impaired. Record review of facility Bed Hold Agreement dated 11/07/2023 reflected it did not include any information such as the duration of bed hold, or the daily rate beyond the allowable days that the state plan would cover. The Bed Hold Agreement only included Resident #1's name and Resident #1's responsible party's name. Resident #1's RP signature was not on form titled Bed Hold Agreement, instead Verbal Authorization given by: over the phone Family Member was noted. The word no was written over the Resident and Family Member/Legal Representative lines. Facility BOM signed the document tiled Bed Hold Agreement. Record review of Resident #1's Progress Notes authored by LVN A dated 11/06/2023 reflected: Resident found laying on floor supine with legs in flexed position and left hand behind head, crying and moaning reporting pain .Resident was log rolled to left side and red drainage was noted to back of head in center of purple discoloration. Back of head inspected. Swelling noted induration of 6.5cm x 5.5cm with purple discoloration measuring 1.5cm x 1.0cm in center draining serosanguinous drainage coming from an open area. Posterior torso and buttocks noted no acute visible injuries, but resident nodded when asked if she was hurt to areas as nurse palpated . 10:24 Received orders to sent out to ER via EMS . (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/14/2024 at 11:50 p.m., LVN A said Resident #1 sustained a fall on 11/06/2024 and received orders from her NP to be transferred out to the emergency room . She said Resident #1 was admitted to the hospital. LVN A said when a resident was transferred to the hospital the charge nurse would call the RP and provide information via phone. LVN A said The BOM was responsible for initiating the bed hold agreement. A phone interview on 11/15/2024 at 12:09 p.m., The BOM said when a resident was transferred to the hospital and admitted , she would contact their RP to see if they were interested in a bed hold request. She said if their RP requested a bed hold, she would obtain verbal consent and file the form in her office. The BOM said she did not know she had to obtain the resident's or RP's signature, she said she had only been obtaining verbal consent. The BOM said each morning, she would check the Admission/Discharge To/From Report to determine which residents required a bed hold agreement. The BOM said there were no negative outcome for not having the resident or their RP sign the bed hold agreement form because the facility had plenty of room available. A phone interview on 11/15/2024 at 12:45 p.m., Resident #1's RP said she remembered a facility's nurse called her on 11/06/2023 to let her know Resident #1 had fallen and was being transferred out to the hospital. Resident #1's RP said the facility did not provide her with any written document regarding their bed hold policy nor was it explained to her. An interview on 11/15/2024 at 3:06 p.m., The DON said the bed hold agreement forms were completed by the BOM. The DON said there were no negative outcome to Resident #1 not having a signed bed hold agreement form for when she was sent to the hospital on 11/06/2023 because the facility had plenty of rooms available. Record review of the facility's Bed Hold Notice Upon Transfer policy dated October 24, 2022, reflected: Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed . Bed Hold Notice Upon Transfer: 2. In the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan. 5. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file .