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	08/11/2025

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported 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 not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (which included to the State Survey Agency) in accordance with State law through established procedures for 1 of 4 residents (Resident #1) reviewed for reporting alleged allegation of abuse. CNA A failed to report an allegation of abuse to the Administrator involving Resident #1 being tucked into bed with a blanket tucked behind her shoulders sometime in March of 2025. This failure could place residents at risk for undetected abuse and neglect, and a decline in feelings of safety and well-being. The findings included: 1. Record review of Resident #1's face sheet, dated 08/22/25, revealed the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease (progressive brain disorder that gradually destroys memory and thinking skills) unspecified dementia (a group of thinking an social symptoms that interferes with daily functioning), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety and need for assistance with personal care (ADLs) Record review of Resident #1's annual MDS assessment, dated 06/05/25, revealed Resident #1 had a BIMS score of 00, indicating her cognition was severely impaired. Resident #1's MDS reflected she had unclear speech, was rarely/never understood, and rarely/never understood others. Resident #1's MDS reflected she required supervision or touching assistance to roll left or right in bed, to go from lying to sitting on the side of the bed, to sit to stand and to complete chair/bed to chair transfers. Record review of Resident #1's care plan with an initiation date of 11/21/19 reflected a problems of [Resident #1] has an ADL self -care performance deficit r/t Alzheimer's, impaired balance. Requires a lot of encouragement and guidance to complete a task. With an initiation date of 08/03/23 and intervention of, BED MOBILITY: The resident requires assistance by 1 staff to monitor for safety in bed as necessary. and TRANSFER: The resident requires assistance by 1 staff to move between surfaces necessary. with an initiation date of 08/03/23. During an attempted interview with Resident #1 on 08/06/25 at 2:35pm, she would not respond to any introduction or question. Record review of Resident #1's medical chart from March to May did not reveal any verbiage related to the allegation of Resident #1 being tucked in except for a note written by the DON on 06/18/25 when the facility received a compliance call that mentioned the incident with Resident #1. The note written by the DON stated, A head to toe assessment was performed with no open areas noted. Resident was noted to have red scratch marked to right buttock and right upper thigh with no broken skin. During n interview with CNA A on 08/08/25 at 3:31pm, he said he was no longer employed at the facility as of July, 2025. CNA A stated that sometime in March of 2025 around 3:00am or 4:00am, he was completing his rounds and noticed that Resident #1 was asleep and had 3 or 4 blankets in use and was restrained with some type of blanket. CNA A initially stated it was a blanket with a knot and then stated it was not a knot, but two ends of the blanket were tied, and the blanket was on top of Resident #1's shoulders with the corners crossed in back of her on her back but not in a knot just crossed. CNA A stated the blanket was tucked behind her shoulder blades. CNA A stated, at the time he found Resident #1, he removed the blanket. CNA A stated he did not know who placed the blanket like that and did not know if there was anyone else working with Resident #1 at that time. CNA A stated he never showed a photo of Resident #1 and never had a photo of Resident #1. CNA A stated he had completed 2 prior rounds on her during his shift and had checked her brief each time and did not see a blanket tucked behind her shoulder blades during those rounds. CNA A stated Resident #1 would not have been able to remove the blanket and stated his initial thought was that Resident #1 looked restrained. CNA A stated he considered restraints as a form of abuse. CNA A stated after he removed the blanket from Resident #1, he reported it to LVN B as a safety precaution. CNA A stated he did not report to the Administrator because he did not have her number. CNA A stated he had previously been trained over immediately reporting allegations of abuse to the abuse coordinator who was the Administrator but could not recall who provided him with that training or when. CNA A stated the facility policy stated he needed to report allegations like this one to the administrator immediately, and stated he felt he did not follow the facility policy. CNA A stated not reporting allegations of