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	01/21/2026

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 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 observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need that were identified in the comprehensive assessment for 1 of 3 residents (Resident #1) reviewed for comprehensive person-centered care plans.1.The facility failed to ensure Resident #1's care plan included he was under EBP (refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloved use during high contact resident care activities) due to having an Indwelling/foley catheter.2.The facility failed to ensure Resident #1 had an order for EBP (refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloved use during high contact resident care activities).This deficient practice could place residents at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The findings included:Record review of Resident#1's admission sheet, dated 01/21/26, revealed a [AGE] year-old male with an admit date of 12/15/25 and an original admission date of 05/29/24. His relevant diagnoses included; dementia (a progressive aging condition involving significant cognitive decline-memory loss, impaired language, and behavioral changes), bladder-neck obstruction (blockage where the bladder's opening to the urethra doesn't open properly during urination, hindering urine flow),urinary incontinence (involuntary loss of bladder control, resulting in the unintentional leakage of urine), and cognitive communication deficit (an impairment in communication caused by underlying, disruptive cognitive process such as memory loss, attention, organization, and reasoning).Record review of Resident's #1's quarterly MDS assessment dated [DATE], reflected a BIMS score of 09, which indicated his cognition was moderately impaired. It was also noted Resident #1 had an indwelling/foley catheter (a flexible tube (often a foley catheter) inserted into the bladder to continuously drain urine into an external bag).Record review of Resident #1's quarterly care plan dated 12/26/25 failed to include he required EBP due to his indwelling/foley catheter.In an observation on 01/21/26 at 12:47 p.m., Resident #1 had EBP signage on his door, gloves and gowns were available outside his room and a trash can inside his room near the exit. Resident #1 was observed lying in bed awake. He had an indwelling/foley catheter and his drainage bag had a privacy cover. In an interview on 01/21/26 at 1:20 p.m., RN B/MDS said Resident #1 had an indwelling/foley catheter which required him to be under EBP. She said if a resident required to be under EBP, it needed to be care planned. She was observed as she reviewed Resident #1's electronic medical record and said she did not see where EBP had been care planned nor an order for EBP. RN B/MDS said a negative outcome for Resident #1 not having his EBP care planned could be that staff would not know to take precautions when they conducted high-contact care to him. In an interview on 01/21/26 at (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4:00 p.m., the DON said the facility's protocol regarding EBP was that an order was required and it needed to be care planned. She said that would ensure staff would know what precautions to take when providing high-contact care. The DON said a negative outcome to Resident #1 not having his EBP care planned could be that staff might not take the necessary precautions when providing care. The DON said the facility did not have a policy related to physician's orders. Record review of the facility's Comprehensive Care Plans policy dated 10/24/22, reflectedPolicy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines:3. The comprehensive care plan will describe, at a minimum, the following:The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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 interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) of 2 residents reviewed for accuracy and completeness of clinical records. The facility failed to ensure Resident #1 had an order for EBP (refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloved use during high contact resident care activities). This failure could place residents at risk for not receiving nursing services by adequately trained nurses and could result in a decline in health.The findings included:Record review of Resident#1's admission sheet, dated 01/21/26, revealed a [AGE] year-old male with an admit date of 12/15/25 and an original admission date of 05/29/24. His relevant diagnoses included; dementia (a progressive aging condition involving significant cognitive decline-memory loss, impaired language, and behavioral changes), bladder-neck obstruction (blockage where the bladder's opening to the urethra doesn't open properly during urination, hindering urine flow),urinary incontinence (involuntary loss of bladder control, resulting in the unintentional leakage of urine), and cognitive communication deficit (an impairment in communication caused by underlying, disruptive cognitive process such as memory loss, attention, organization, and reasoning). Record review of Resident's #1's quarterly MDS assessment dated [DATE], reflected a BIMS score of 09, which indicated his cognition was moderately impaired. It was also noted Resident #1 had an indwelling/foley catheter (a flexible tube (often a foley catheter) inserted into the bladder to continuously drain urine into an external bag). Record review of Resident #1's quarterly care plan dated 12/26/25 failed to include he required EBP due to his indwelling/foley catheter.In an observation on 01/21/26 at 12:47 p.m., Resident #1 had EBP signage on his door, gloves and gowns were available outside his room and a trash can inside his room near the exit. Resident #1 was observed lying in bed awake. He had an indwelling/foley catheter and his drainage bag had a privacy cover. In an interview on 01/21/26 at 1:20 p.m., RN B/MDS said Resident #1 had an indwelling/foley catheter which required him to be under EBP. She said if a resident required to be under EBP, an order was needed. She was observed as she reviewed Resident #1's electronic medical record and said she did not see an order for EBP. RN B/MDS said a negative outcome for Resident #1 not having an order for EBP could be that staff would not know to take precautions when they conducted high-contact care to him. In an interview on 01/21/26 at 4:00 p.m., the DON said the facility's protocol regarding EBP was that an order was required. She said that would ensure staff would know what precautions to take when providing high-contact care. The DON said a negative outcome to Resident #1 not having an order for EBP could be that staff might not take the necessary precautions when providing care. The DON said the facility did not have a policy related to physician's orders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 of 3 (Resident #1) residents reviewed for EBP.The facility failed to ensure CNA A wore proper PPE during peri-care for Resident #1 who required enhanced barrier precautions (EBP). This failure could place residents at risk of MDRO contamination. The findings included: Record review of Resident#1's admission sheet, dated 01/21/256, revealed a [AGE] year-old male with an admit date of 12/15/25 and an original admission date of 05/29/24. His relevant diagnoses included; dementia (a progressive aging condition involving significant cognitive decline-memory loss, impaired language, and behavioral changes), bladder-neck obstruction (blockage where the bladder's opening to the urethra doesn't open properly during urination, hindering urine flow), and urinary incontinence (involuntary loss of bladder control, resulting in the unintentional leakage of urine).Record review of Resident's #1's quarterly MDS assessment dated [DATE], reflected a BIMS score of 09, which indicated his cognition was moderately impaired. It was also noted Resident #1 had an indwelling catheter (a flexible tube (often a foley catheter) inserted into the bladder to continuously drain urine into an external bag).Record review of Resident #1's quarterly care plan dated 12/26/25 reflected a problem of [Resident #1] has an indwelling catheter r/t bladder neck obstruction, other obstructive and reflux uropathy, date initiated 12/15/25 and revised on 01/20/26. His interventions in part included a 16 French indwelling catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door, check tubing for kinks each shift, Monitor and document intake and output as ordered, and monitor for s/sx of discomfort on urination and frequency.In an observation on 01/21/25 at 12:45 p.m., there was an EBP signage on Resident #1's door along with gowns and gloves available outside his room. This surveyor observed CNA A walking out of Resident #1's room. She had a clear plastic bag that contained a soiled brief and gloves only. This surveyor observed Resident #1's room and the trash can positioned inside his room near the exit for discarding PPE after removal was empty. This surveyor did not observe a used gown in the clear plastic bag nor in the trash can inside Resident #1's room.In an interview on 01/21/25 at 12:47 p.m., CNA A said she had transferred Resident #1 from the living room back to his room and performed peri-care. CNA A was asked if she had gowned up when she had performed peri-care and she said no. CNA A said she was in hurry and had forgotten to gown up, she said she had only worn gloves. CNA A said the negative outcome of not gowning up could be the possibility of cross-contamination. CNA A said she had been regularly in-serviced on the topic of infection control which included enhanced barrier precautions. In an interview on 01/21/25 at 1:20 p.m., RN B/MDS said she was covering Resident #1's floor during the lunch hour. She said Resident #1 was under EBP due to having an indwelling/foley catheter. She said EBP guidelines should be followed when performing peri-care or any other high contact activities. She said CNA A should have worn gloves and a gown when she performed peri-care on Resident #1. RN B/MDS said the negative outcome of not following EBP could be cross-contamination.In an interview on 01/21/25 at 4:00 p.m., the DON said Resident #1 was under EBP due to having an indwelling/foley catheter. She said CNAs and nursing staff should follow EBP guidelines when they conducted high contact activities which included peri-care. The DON said the negative outcome when CNAs and/or nursing staff do not follow EBP guidelines was an increased risk of cross-contamination. Record review of the facility's Enhanced Barrier Precautions policy dated 11/24/25 reflected:Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of multidrug-resistant organisms.Definition: enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organism that employs targeted gown and gloves use during high contact resident care activities.Policy Explanation and Compliance Guidelines: 3. Implementation of Enhanced Barrier Precautions:b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities.4. High-contact resident care activities include:f. changing briefs or assisting with toileting.