

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 04/30/2026
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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide reasonable accommodation for resident needs and preferences for one (Resident #1) of 8 residents reviewed for call light placement. The facility failed to ensure Resident #1's call light was within reach. This failure could place residents at risk of needs and accommodation being unmet. Findings included: Record review of a face sheet dated 4/29/2026 indicated Resident #1 was a [AGE] year-old female, re-admitted on [DATE] (initial admission date 5/7/2010), with diagnoses of Dementia (a condition characterized by progressive of persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), Schizophrenia (chronic, severe mental disorder characterized by disruptions in thought processes, perceptions, and emotional responsiveness, often involving hallucinations, delusions, and disorganized thinking), Type 2 Diabetes Mellitus (a chronic metabolic condition where the body cannot effectively use or produce enough insulin, leading to high blood sugar levels), Neurocognitive Disorder (decreased mental function due to acquired brain disease, injury, or medical conditions, rather than psychiatric illness), Cognitive Communication Deficit (communication impairment resulting from underlying cognitive issues rather than primary language or speech muscle dysfunction), and Arthritis (a general term for joint inflammation, pain, and stiffness). The face sheet reflected Resident #1 was also listed as her own resident representative. Record review of a quarterly MDS assessment, dated 4/13/2026, indicated Resident #1 had a BIMS score of 03 which indicated severe problems with thinking and memory. The MDS indicated Resident #1 was totally dependent on staff for toileting, showering, and dressing. The MDS also indicated Resident #1 used a wheelchair and was dependent on staff for locomotion. Record review of Resident #1's care plan, undated, revealed, a problem listed for Resident #1 revealed she was unable to use the call light due to her Dementia. Resident #1's goal for the problem was for the call light to be reachable for family or staff to request assistance with an intervention of monitoring and rounding frequently. During an observation on 4/28/2026 at 12:04 p.m., revealed Resident #1 was in her room wiggling in her bed and calling out. Resident #1 did not have a call light within reach. Resident #1's call light was on the floor beside her nightstand. During an interview on 4/28/2026 at 12:05 p.m., Resident #1 stated she wanted some cookies and milk. During an interview on 4/28/2026 at 12:07 p.m., the ADON stated CNA A must not have placed the call light in reach of when assisting Resident #1. The ADON stated call lights were to be in reach of all residents, including Resident #1. During an interview on 4/28/2026 at 12:30 p.m., CNA A stated he was unaware Resident #1's call light was not within her reach, but that it should be within her reach. CNA A stated Resident #1 moved a lot in the bed when repositioning the resident and the call light must have fallen. CNA A stated Resident #1 could have tried to get out of bed unassisted and hurt herself. During an interview on 4/29/2026 at 3:30 p.m., the DON stated it was expected that every time a staff member exited a resident's room, they needed to ensure all frequently used items are within reach, to include the call light, including Resident #1. The DON stated a resident may need something and staff wouldn't know or be able to meet their needs. The DON stated Resident #1 would normally call out if she needed something, but the call light still needed to be within her reach. Record (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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>review of facility policy titled, Call Lights: Accessibility and Timely Response implemented on 10/13/2022, reflected The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. The policy also revealed 5. Staff will ensure the call light is within reach of resident and secured, as needed</p>		