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	12/04/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487 Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 7 Residents (Resident #5 and Resident #12) who were observed for ADL care. 1. CNA D stood while feeding Resident #5 her lunch meal on 12/2/24. 2. CNA D stood while feeding Resident #12 her lunch meal on 12/2/24. These deficient practices could affect dependent residents and contribute to feelings of shame or feeling uncomfortable and could place residents at risk of embarrassment, lack of privacy, and loss of dignity. The findings were: Review of Resident #5's face sheet, dated 12/3/24, revealed she was initially admitted to the facility on [DATE] with diagnosis including Alzheimer's Disease (A progressive disease that destroys memory and other important mental functions), Chronic Obstructive Pulmonary Disease (A group of lung diseases that block airflow and make it difficult to breathe), Chronic Kidney Disease (a condition where the kidneys are damaged and can't filter blood properly, which can lead to a buildup of waste and fluid in the body), Need for assistance with personal care, all dated 8/11/2021. Review of Resident #5's quarterly MDS assessment, dated 11/13/24, revealed her BIMS was 3 meaning she was unable to complete the Brief Interview for Mental Status. Further review revealed she had a diagnosis of Alzheimer's Disease and required assistance with eating. Review of Resident #5's Care Plan, initiated on 11/12/23, revealed she had an ADL self-care performance deficit r/t General Weakness, Decreased Mobility, ALZHEIMER's, and the resident requires assistance by 1 staff to eat. Observation on 12/2/24 at 12:30PM to 1:00 PM revealed CNA D standing while feeding Resident #5. Resident #5 was eating all of her food while periodically looking up at CNA D. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #12's face sheet, dated 12/3/24, revealed she was admitted to the facility on [DATE] with diagnoses including Dementia (a general term for a range of neurological conditions that cause a decline in mental ability and interfere with daily life) and Cerebral infraction (a general term for a range of neurological conditions that cause a decline in mental ability and interfere with daily life). Review of Resident #12's quarterly MDS assessment, dated 09/7/24, revealed her BIMS was 2 meaning she was unable to complete the Brief Interview for Mental Status. Review of Resident #12's Care Plan, initiated on 12/29/2017, revealed she had has an ADL self-care performance deficit r/t Activity Intolerance, Dementia, Limited Mobility and the resident requires assistance by 1 staff to eat. Observation on 12/2/24 at 12:30PM to 1:00 PM revealed CNA D standing while feeding Resident #12. Resident #12 was eating all of her food while periodically looking up at CNA D. Interview on 12/2/24 at 1:00 PM with CNA D revealed that he knew that he had to be sitting down, and he said that today his back was hurting and that was why he was standing up while feeding the residents. He said that he had training but was not able to recall when the training took place. Interview on 12/2/24 at 4:10PM with ADON said that feeding the residents standing up is not respectful to the residents. He said that by sitting down while feeding residents shows dignity and respect to the residents. Interview on 12/4/24 at 12:00 PM with the DON revealed staff should be sitting down while feeding residents because it shows respect and to prevent violating the resident's dignity. DON said that managers on duty are responsible to make sure staff is sitting down when feeding the residents. Review of a facility policy, Promoting/Maintaining Resident Dignity During Mealtimes, implemented on 1/13/23 read: It is the practice of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life, recognizing each resident's individuality and protect the rights of each resident. All staff will be seated, if possible, while feeding a resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 2 of 8 residents (Resident #157 and Resident #27), staff, and the public in that: The facility failed to ensure bathroom sinks hot water temperatures were below 110 degrees Fahrenheit in occupied room for Resident #157 and Resident #27. This failure could affect residents by placing them at risk for diminished quality of life and at risk for burn injuries. Findings Included: Record review of Resident #157's , electronic face sheet dated 12/04/2024 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Unspecified Dementia, Mixed Receptive Expressive Language Disorder (problems with speaking), Muscle wasting and Atrophy (loss of muscle tissue), Hyperlipidemia (high cholesterol), and Polyosteoarthritis (arthritis that affects five or more joints at the same time). Record review of Resident #157's comprehensive MDS assessment, dated 11/20/2024 revealed a BIMS score of 05, indicating Resident #157 was severely cognitive impaired. Minimal assistance for mobility. Record review of Resident #157's care plan revised dated 11/29/24 revealed she had Dementia. Intervention included the resident was able to ambulate with supervision. Record review of Resident #27's, electronic face sheet dated 12/04/2024 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE], with original admitted [DATE]. Her diagnoses included Alzheimer's Disease, Type 2 Diabetes Mellitus, Muscle wasting and Atrophy (loss of muscle tissue), Anxiety Disorder, Bipolar Disorder, and schizoaffective disorder, and Dysphasia (communication disorder). Record review of Resident #27's comprehensive MDS assessment, dated 11/14/2024 revealed a BIMS score of 00, indicating Resident #27 was severely cognitive impaired. Supervision for mobility. Record review of Resident #27's care plan revised dated 08/07/24 revealed she had Alzheimer's and ambulates in hallway most of the day. Observation on 12/02/24 at 4:15pm with the Maintenance Director and using the maintenance director's digital thermometer revealed the bathroom sink hot water temperature on 12/02/24 at 4:15 PM were: room [ROOM NUMBER]- bathroom sink was 114 degrees Fahrenheit for Resident #157 and Resident #27. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/02/24 at 4:20pm the Maintenance Director at time of observation stated he did rounds every day in the morning. The Maintenance Director stated he checks at least one room in each hall every day and the last time he checked them was this morning (12/02/24) but he checked the rooms furthest in the hall. The Maintenance Director stated that he documented the temperature readings in the logbook. The Maintenance Director stated the temperature should be between 100-110 degrees Fahrenheit. He stated that he moved the water heater temperature this morning to make sure the temperature was good. The Maintenance Director stated the negative outcome of the water temperature being too hot in the resident's restroom was that the residents can burn themselves. In an interview on 12/04/24 at 11:40a.m. with the Administrator, stated that she was not sure on what the procedure was for how often the maintenance director checks water temperatures. She stated that it might be done daily but maybe one room from each hall. She stated they have a system in place called TELS (a platform designed to help maintenance teams' efficiency). The administrator stated she usually gets an alert if something was not completed on time. She stated the hot water temperature should be at 110 degrees Fahrenheit. She stated if the hot water was too hot then it can be dangerous for the residents when they wash their hands and/or their face. Record Review of the Logbook documentation dated 12/02/24 revealed room [ROOM NUMBER] was 119 degrees F. Further review of Logbook for month of November revealed minimal variation of temperature between 106 to 108 degrees F. Review of facility's incident and accidents logs dated 10/2024, 11/2024, and 12/2024 did not reveal any injuries to residents due to hot water. Review of the facility's Grievance logs dated 10/2024, 11/2024, and 12/2024 did not reveal any complaints of water temperature being too hot. Review of the facility's Instructions Direct Supply TELS provided the following information: 1. Ensure patient room water temperatures are between 100 degrees and 110 degrees Fahrenheit. Record results in the water temperature log. 2. Adjust water heater setting as required. 3. Retest as necessary

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on interviews and record review, the facility failed to develop a baseline care plan within 48 hours of a resident's admission that included the instructions needed to provide effective and person-centered care plan and provide a summary of their baseline care plan to residents for 1 (Resident #161) of 8 residents reviewed for care plan completion. The facility failed to complete a baseline care plan that addressed enhanced barrier precautions for Resident #161 within the required 48-hour timeframe of admission. This deficient practice could place newly admitted residents at risk of not being provided with the necessary care and having personalized plans developed to address their specific needs. Findings included: Record review of Resident #161's face sheet dated 12/02/2024 revealed the resident was an [AGE] year-old male admitted on [DATE] with the following diagnoses: Urinary tract infection- ESBL(bacteria resistant to most antibiotics), Metabolic Encephalopathy (a disorder that affects brain function), Type 2 Diabetes Mellitus, Transient Cerebral Ischemic Attack (mini stroke), Chronic Kidney Disease, Stage 4, and Cystitis (infection in the urinary bladder). Record review of Resident #161's BIMS dated 11/30/2024 revealed he scored of 08, which indicated he had moderately cognitive impairment. Record review of Resident #161's medical record on 12/02/2024 revealed no evidence of the completion of a baseline care plan for enhanced barrier precautions. In an interview on 12/04/2024 at 11:09 a.m. with the ADON, stated there should be a baseline care plan in place for the enhanced barrier precautions. He stated the care plan was in place because it was the picture of what the nurses are doing for the resident. It was what the nurses follow to adequately care for their residents. He stated that he can add to the care plan, but the DON was the one who completes the baseline care plan. ADON stated that Resident #161 was admitted over a holiday weekend and maybe that was why it got overlooked. In an interview on 12/4/24 at 11:20 a.m. with the DON stated that she was responsible for completing the baseline care plan for the enhanced barrier precautions as well as the admitting nurses. She stated when they do the baseline care plan, it was a quick assessment, and they did not look at the ESBL and E. coli information. The DON stated that Resident #161 was admitted over the weekend, and it got overlooked. She stated that it was important to have the enhanced barrier precaution care planned because that was how they know how they will work with the resident. The care plan was what they follow for what care they are providing for the resident. (continued on next page)

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	675475	A. Building B. Wing	12/04/2024

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled, Baseline Care Plan date reviewed/revised 10/05/2023, revealed Policy: The facility will level and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Policy Explanation and Compliance Guidelines: a. Be developed within 48 hours of a resident's admission.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 Based on observation, interview and record review, the facility failed to store all drugs and biologicals in a locked compartment under proper temperature controls and permit only authorized personnel to have access to the keys for one (Resident #53) of seven residents reviewed for medications. Resident #53 had an unidentified medicated cream in a small plastic cup sitting on his nightstand. This failure could put residents at risk of unauthorized use of medication and accidental ingestions/use of an unprescribed medication. The findings were: Record review of Resident #53's Admission Record dated 12/02/24 revealed Resident #53 was admitted to the facility on [DATE] with diagnoses of acute kidney failure with medullary necrosis (a severe condition where the kidneys suddenly lose their ability to filter waste products from the blood, specifically caused by damage and cell death in the inner part of the kidney), essential (primary) hypertension (high blood pressure that has no identifiable cause), other specified malignant neoplasm of skin (the most common type of skin cancer, usually developing in areas exposed to the sun). Record review of Resident #53's physician's orders dated 12/02/24 revealed orders for Betadine External Solution 5% (Povidone-Iodine), apply to right heel topically one time a day for arterial ulcer to right heel. Cleanse with NS, pat dry, apply betadine, cover with dry dressing, and wrap with kerlix. Venelex External Ointment ([NAME]-[NAME] Oil) Apply to sacrum topically four times a day for redness to sacrum. Record review of Resident #53's physician's orders did not reveal orders for zinc oxide. Record review of Resident #53's Admission MDS dated [DATE] revealed Resident #53 able to understand others, was understood by others, and was cognitively intact. Record review of Resident #53's care plan initiated on 10/03/24 and revised on 10/04/24 revealed Resident #53 has risk for impaired skin integrity related to impaired mobility with interventions to administer medications as ordered to address medical diagnosis/conditions, monitor for effectiveness and adverse effects, conduct skin inspections/examinations weekly and as needed, document findings, and educate and reinforce on risk factors associated with resident and/or family's choice to not adhere to IDT recommendations per the plan of care. Observation on 12/02/24 at 10:21 a.m. revealed Resident #53 in bed, in a semi-sitting position. Surveyor observed a small plastic cup with white cream and a wooden stick sticking up from the center of the cup on resident's nightstand. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/02/24 at 10:21 AM Resident #53 said he had spots, and they used the cream to treat them. Resident #53 said he could not recall the nurse that placed the cream on the nightstand. In an interview on 12/02/24 at 11:22 a.m., LVN A said she did not do the wound treatment for Resident #53 . LVN A said she did not do the wound treatment because they have a wound treatment nurse. LVN A said she did not leave the cream in the room and did not know who might have left the cream in the resident's room. In an interview on 12/02/24 at 11:33 a.m., LVN B said she was the wound treatment nurse, but she did not leave the cream in the room for Resident #53. LVN B said Resident #53 does have wounds on his back and he has a wound on his heel, but he does not use the barrier cream zinc oxide. The resident uses Venelex, and it was not white. LVN B said she has not provided the wound care to Resident #53 today yet. In an interview on 12/02/24 at 04:11 p.m., the ADON said they do not use the zinc oxide in the nurse's carts, it was only kept in the treatment cart. The ADON said it could have been the weekend treatment nurse that left the zinc oxide in Resident #53's room. The ADON said he did not think any of the staff were going to confess to leaving the cup with the zinc oxide in the resident's room. The zinc was not used frequently it was only used for wounds. The key was kept at the nurse's station so that it could be used by other nurses. The ADON said there were no adverse effects if a resident uses it on their skin. The nurse would hand the zinc oxide to the CNA and the responsibility was the floor nurses to make sure the CNA did not leave the zinc oxide in the resident's room. Resident #53 did not have an order for the zinc oxide. Resident #53 was alert but did have some forgetfulness. Resident #53 was alert and oriented times two. The ADON said they do not have residents that wander, the residents that wander were in the memory unit. There were residents with dementia in the other halls, but they do not wander or go into other residents' rooms. In an interview on 12/04/24 at 08:11 a.m., the DON said only the nurses had access to the zinc oxide. The nurses were supposed to apply the zinc oxide to the resident and not the CNAs. The nurses should not give the zinc oxide to the CNAs to apply to the resident's skin because it was a medication, and the CNAs should not administer medications. The DON said the zinc oxide was only used for residents with wounds. Resident #53 did have a wound to his heel, but he did not have orders for the zinc oxide. Resident #53 had orders for the Venelex. The DON said the nurses should not be applying zinc oxide to Resident #53 because zinc oxide was a medication and there should be orders for the nurse to apply it onto the resident. The DON said she questioned the nurses for that hall and the wound care nurse, but they all said they had not used the zinc oxide. The DON said they do not have residents that wander into other residents' room. The facility has a memory unit. The DON said the only side effect to using the zinc oxide without an order would be dry skin. In an interview on 12/04/24 at 02:00 p.m., the ADON and DON revealed the wound care nurse had done Resident #53's wound care and did not see any zinc oxide on Resident #53 skin. Record review of the facility's Medication Administration policy dated 10/24/22 revealed: Policy: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. 14. Administer medication as ordered in accordance with manufacturer specifications. 15. Observe resident consumption of medication. Record review of facility's Bedside Medication Storage dated 10/01/19 revealed: 6. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standard or food service safety for 1 of 1 kitchen reviewed for food service safety in that: The facility failed to ensure all food items were labeled and dated in the refrigerators and in the dry storage. This failure could place residents at risk of foodborne illnesses. The findings included: An observation and interview during the initial tour of the facility's #2 refrigerator on 12/02/24 at 8:53 a.m. revealed on opened one gallon container of Dijon honey mustard salad dressing with the dates of 04/23 and 05/17 on the lid. The Dietary Manager said they do not use the Dijon dressing that often. An observation of the facility's #1 refrigerator on 12/02/24 at 8:54 a.m. revealed a 17 oz container of Siracha hot chili sauce without a date. An observation of the facility's dry storage on 12/02/24 at 8:56 a.m. revealed six loaves of bread that were not dated. In an interview on 12/02/24 at 8:56 a.m. the Dietary Manager said all the staff were responsible for receiving food items form vendors and have been trained to label and date all foods items in the refrigerator, freezer, or dry storage. In an interview on 12/03/24 at 11:40 a.m., the Consultant Dietician said he sent in in-services monthly for the Dietary Manager to conduct with the staff. The Consultant Dietician said he also did monthly sanitation reviews where he observed different areas such as hand hygiene, safe food handling and temperature control. The Consultant Dietician said all staff knew to date and label all food items when received and stocked. It is important to date and label all food items to prevent food expiration or spoilage or food contamination and prevent the residents from getting sick. In an interview on 12/03/24 at 12:56 p.m., Dietary Aide H said all staff were responsible for receiving and stocking food items. Once they received the items they had to date and label all merchandise. Dietary Aide H said they had an in-service two months ago on that. Dietary Aide H said it is important to date items so they can know if the food is still good to use. Dietary H said they did not want the residents to get sick from food they provided. In an interview on 12/03/24 at 1:09 p.m., Dietary Aide I said everyone is responsible for storing food and other items. Dietary Aide I said they [NAME] to write the date before storing the food in the refrigerator, freezer, or pantry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/04/24 at 4:15 p.m., the Administrator said the Dietary Manager oversees the kitchen staff and the staff have trainings and should be following policies. Record review of facility's policy titled Policy: Food Storage date revised: June 1, 2019, stated: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. 1. Dry Storage g. Use the first-in, first-out (FIFO) rotation method. Date packages and place new items behind existing supplies, so that the older items are use first. 2. Refrigerators d. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent covered containers that are approved for food storage.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based observation, interview, and record review, the facility failed to 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 4 (Resident #161, Resident #33, Resident #53, and Resident #15) of 8 residents observed for infection control. 1. The facility failed to post the enhanced barrier precaution sign and no PPE gowns noted in the room or nearby Resident #161's room. 2. During Gtube medication administration for Resident #33, RN K did not sanitize hand after touching the privacy curtain. Then while wearing gloves, he touched the bed remote and with the same pair of gloves, he proceeded to touch the residents Gtube. 3. CNA F failed to wash her hands or use hand sanitizer between glove changes during wound care for Resident #53. 4. The facility failed to change gloves and perform hand hygiene when moving from a clean to a dirty area during wound care for Resident #15. 5. The facility failed to ensure Resident #33 was identified for and had implemented Enhanced Barrier Precautions. These deficient practices could place residents at-risk for healthcare associated cross contamination and the spread of infection due to improper care practices. Findings included: 1. Record review of Resident #161's face sheet dated 12/02/2024 revealed the resident was an [AGE] year-old male admitted on [DATE] with the following diagnoses: Urinary tract infection- ESBL(bacteria resistant to most antibiotics), Metabolic Encephalopathy (a disorder that affects brain function), Type 2 Diabetes Mellitus, Transient Cerebral Ischemic Attack (mini stroke), Chronic Kidney Disease, Stage 4, and Cystitis (infection in the urinary bladder). Record review of Resident #161's BIMS dated 11/30/2024 revealed he scored of 08, which indicated he had moderately cognitive impairment. Record review of Resident #161's comprehensive care plan, dated 12/02/2024, reflected Resident #161 was on antibiotic therapy (Meropenum) r/t ESBL UTI. Interventions: Monitor/document/report as needed signs and symptoms of secondary infection r/t antibiotic therapy . Observation on 12/02/24 at 10:22 a.m. Resident #161 sitting in a wheelchair in his room with IV lock on right forearm. There were no EBP signs or any indication that the resident was on EBP. No PPE gowns noted in the room or nearby. (continued on next page)

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	675475	A. Building B. Wing	12/04/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/02/24 at 2:45 p.m. with LVN J stated that the person responsible for posting the EBP sign outside of Resident #161 room was the admitting nurse. If the admission was done at night, then the ADON puts it up, but the floor nurse can put it up as well. She stated she has no idea what Resident #161 was being treated for nor half of the residents she was assigned to because they are all new residents to her. LVN J stated she has not had a chance to look at Resident #161 because he was in physical therapy. She stated that it was important to have the EBP signage to keep infection from spreading. LVN J stated in service for infection control was done about 2-3 months ago. In an interview on 12/02/24 at 3:00 p.m. with the ADON, stated that the nurses and him were responsible for putting up the EBP sign on the outside of the resident rooms if they know the resident needs it. He stated that he rounds when he comes in and makes sure the EBP signs are there. The ADON stated that they had a lot of admits last week. He stated that he was not sure why the nurse did not catch that the EBP sign was not posted. He stated they have infection control trainings via online through health stream. In an interview on 12/02/24 at 3:10 p.m. with the DON, stated that when new admissions come in then the floor nurses are responsible for putting up the EBP sign if needed but the infection preventionist should follow up as well as the treatment nurse. She stated they are all responsible for posting the EBP sign. The DON stated that it was important for the EBP sign to be posted for the staff to be made aware of any type of precaution regarding the infection that a resident has. She stated she was not sure when the most recent in service for infection control was done. 2. Record review of Resident #33's face sheet dated 12/04/2024 revealed the resident was a [AGE] year-old female admitted on [DATE], initial admitting date of 10/12/24 with the following diagnosis: Gastrostomy (which was a surgical opening in the stomach that can be used for nutritional support or to decompress the stomach), Cerebral Infarction (stroke), Type 2 Diabetes Mellitus, Muscle wasting and Atrophy (loss of muscle tissue), Dysphagia (difficulty swallowing), Psoriasis (chronic skin disease). Record review of Resident #33's quarterly MDS dated [DATE] revealed BIMS score of 00, which indicated he had severely cognitive impairment and his nutritional approaches via feeding tube. Record review of Resident #33's Comprehensive Care Plan, dated 12/03/2024, revealed Resident #33 requires tube feeding r/t Dysphagia. Interventions: Monitor/document as need any signs and symptoms of . infection at tube site. Record review of Resident #33's physician order summary dated 12/04/2024 revealed Resident #33 Enteral Feed Order every shift flush feeding tube with 10mls of water before and after medication administration. Observation on 12/03/24 at 11:36 a.m. RN K touched privacy curtain, then donned gloves without sanitizing hands. He then touched the bed remote to adjust the height of the bed to working level, and with the same pair of gloves he proceeded to touch the residents Gtube prior to medication administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/03/24 at 11:55 a.m. with RN K, stated he did well during the Gtube medication administration. RN K stated he was to sanitize hands in between glove changes. He stated that they are to wash their hands before anything they do prior to patient care. RN K stated he did not think he needed to change his gloves after touching bed remote. He stated that they are to sanitize hands in between glove changes because hands can be contaminated from sweat. He stated that he was supposed to sanitize hands after touching privacy curtain prior to putting on gloves. RN stated sanitizing hands was important to prevent transmission of bacteria. In service for infection control was done maybe like 2 weeks ago. He stated in services for infection control are done often. In an interview on 12/03/24 at 12:01 p.m. LVN C, was present with RN K when doing the Gtube medication administration for Resident #33. She stated that they are to sanitize hands all the time before patient care, after patient care and in between glove changes. She stated this was important, so they do not pass infection and germs to other residents, to prevent infection. In service for infection control training was done online on the computer, maybe 2 weeks ago. In an interview on 12/03/24 at 12:05 p.m. with the ADON, stated staff was trained to sanitized hands in between glove changes and if they touch a resident's surrounding surfaces to where they break barrier. If they touched any surface that was not the resident, then they cannot touch the resident again with the same pair of gloves. Staff was to sanitize hands prior to putting a new pair of gloves. This was important to make sure not to pass any infection or introduce any pathogens to other residents with EBP. In an interview on 12/03/24 at 12:09 p.m. with the DON, stated staff was trained to sanitized hands right before working with a resident, before administrating medication, or if they touch any surface like the bed. They are to remove their gloves and either sanitize or wash their hands. If they touch a surface prior to touching the resident, they must re-sanitize. The DON stated that this was important, so they do not introduce any microbes or bacteria to the residents. 3. Record review of Admission Record, dated 12/4/2024, reflected Resident #53was a [AGE] year-old male, originally admitted [DATE]. Diagnosis include Acute Kidney Failure with medullary necrosis (a severe condition where the kidneys suddenly lose function due to damage specifically to the inner part of the kidney, called the medulla, resulting in cell death (necrosis) in that region, often leading to significant complications like decreased urine output and fluid buildup in the body), Orthostatic Hypotension (a condition where a person experiences a sudden drop in blood pressure when standing up from a sitting or lying position, often causing dizziness or lightheadedness due to reduced blood flow to the brain), and need assistance with personal care. Record review of the quarterly MDS assessment dated [DATE], reflected Resident #53 did not have a BIMS assessment conducted. Record review of the Care Plan reflected Resident #95 was at risk for impaired skin integrity related to Impaired mobility Date Initiated: 10/03/2024. During an observation on 12/3/24 at 10:30 AM, of incontinent care performed on Resident # 53 CNA F and CNA G prepared all supplies, while performing incontinent care CNA F failed to wash her hands or use hand sanitizer between glove changes during wound care for Resident #53, no handwashing or hand sanitized used throughout the incontinent care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/3/24 at 11:20AM CNA F said that she knew she was supposed to wash her hands or use hand sanitizer in between gloves change but she said she was nervous and forgot. CNA F said that the last inservice on infection control was done last week. CNA F said that was very important to wash hands or use hand sanitizer because failed to do that would put resident at risk for getting an infection. During an interview on 12/3/24 at 11:30AM CNA G said she was supposed to use hand sanitizer between change of gloves and failing to do that the resident would be at risk for infection or urinary tract infection. CNA G said that the last in-service on infection control was done a week ago. During an interview on 12/3/24 at 11:45 AM ADON said that handwashing or hand sanitizer should be used in between every glove changes or when gloves comes visible contaminated. ADON said that by doing handwashing would prevent any infection. ADON said that he tried to do an in-service on infection control at least every month. ADON said that staff skilled check off were done twice per year. During an interview on 12/4/24 at 12:00PM DON said that was important to practice handwashing to prevent spreading any germs from resident to resident because that would put the residents at risk for infection. 4. Record review of Resident #15's Face sheet, dated 12/3/2024, revealed Resident #15 was a 57 -year-old male, with an admitted [DATE]. Diagnoses included Type 2 diabetes (adult-onset diabetes), Cerebral infraction (a general term for a range of neurological conditions that cause a decline in mental ability and interfere with daily life), Gastrostomy status (was the presence of a gastrostomy, which was a surgical opening in the stomach that can be used for nutritional support or to decompress the stomach). Record review of Resident #15's Quarterly MDS assessment, dated 8/26/2024, revealed Resident #15's BIMS score was 2 meaning he was unable to complete the Brief Interview for Mental Status. Record review of Resident #15's care plan initiated 5/24/23 revealed Resident's#15 has a stage III pressure ulcer to his Sacrum area r/t Immobility and contractures. The resident's #15 Pressure ulcer will show signs of healing and remain free from infection by/through review date. Record review of physician's orders revealed Resident #15 had has a stage III pressure ulcer to his Sacrum area r/t Immobility and contractures. Orders were Medi honey Wound &Burn Dressing External Paste (Wound Dressings) Apply to sacrum topically one time a day for stage III sacral wound Cleanse with NS, pat dry with dry gauze, apply medihoney and cover with foam bordered dressing. During observation on 12/3/2024 at 9:10AM of wound care, the Wound Care Nurse cleanse the wound with Normal Saline and failed to maintain infection control prevention by using contaminated gloves when going from dirty to clean area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/03/2024 at 9:55AM Wound Care Nurse stated she forgot to perform hand hygiene and changing gloves between cleaning and pat dry wound. The Wound Care Nurse stated not washing hands and changing gloves at the appropriate intervals could put residents at risk of getting their wounds infected or slow the healing process. The Wound Care Nurse stated she was nervous and did not realize she had skipped a step. The WCN could not state when the last in-service on performing hand hygiene was. In an interview on 12/4/2024 at 12:00PM the DON stated all staff are expected to wash hands for at least 20 seconds or greater to maintain infection control measures and stop the spread of germs. The DON stated not performing hand hygiene and wearing gloves as recommended could cause the resident's wounds to get infected. The DON stated she was going to conduct a one-on-one training with the Wound Care Nurse and in-service all staff on hand washing and changing gloves. DON stated the nurses are to follow Wound Care procedure with regards to infection control. 5. Record review of Resident #33's face sheet dated 12/04/2024 revealed the resident was a [AGE] year-old female admitted on [DATE], initial admitting date of 10/12/24 with the following diagnosis: Gastrostomy (which is a surgical opening in the stomach that can be used for nutritional support or to decompress the stomach), Cerebral Infarction (stroke), Type 2 Diabetes Mellitus, Muscle wasting and Atrophy (loss of muscle tissue), Dysphagia (difficulty swallowing), Psoriasis (chronic skin disease). Review of Resident #33's Care Plan revealed: Revised on 11/15/24 Focus: The resident requires tube feeding r/t DYSPHAGIA, ORAL PHASE Goal: The resident will maintain adequate nutritional and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date. Interventions included the resident needs the HOB elevated 45 degrees during and thirty minutes after tube feed. Check for tube placement and gastric residual volume and record. Hold feed if greater than 100 cc aspirate. (There was nothing about Enhanced Barrier Precautions either as its own focus or as an intervention for the gastrostomy status). Review of Resident #2's Order Summary Report, dated 12/4/24, revealed active enteral feedings (Glucerna 1.5 bolus feeding via peg tube. 1 carton per feeding at 0500,1100,1700,2300. There were no orders about enhanced barrier precautions. Observation on 12/2/24 at 3:37 PM revealed Resident #33 in bed facing up. There was nothing posted at the door or at Resident #33's bedside notifying anyone of Resident #33's Enhanced Barrier Precaution status. LVN B entered the room without PPE and gave resident #33 her scheduled feeding bolus. Interview o 12/2/24 at 3:45PM LVN B said that she was not aware that she needed to use PPE with resident that had a G-Tube. LVN B said that she thought she was supposed to use EBP only if she got close to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/2/24 at 3:50 PM the ADON said he was the ICP. The ADON stated for EBP, there was PPE on the linen carts. The ADON said staff were supposed to wear them for chronic wounds, catheter, ostomy care. The ADON stated the staff knew and had been in-serviced the gowns were on the linen carts. ADON said the last in-service on EBP was in November 2024. The ADON it was important to use PPE to prevent introduce any infection to the body through the open wounds or the ostomy. Interview on 12/4/24 at 11:55AM LVN C said that it was important to use the EBP to protect residents from whatever microorganisms that she could carry and to protect other residents. LVN C said residents could be at risk of infection. In an interview on 12/2/24 at 12:26 AM, DON stated EBP was staff needed to wear gown and gloves for individuals with a urinal, feeding tube, or wounds. DON said that it was important to use PPE to prevent introducing any kind of infection to residents, DON said that by not using EBP could put residents at higher risk for infection. Record review of RN K, Hand Hygiene Competency Assessment was completed on 12/03/24, revealed he performed and passed the hand washing procedure in accordance with the facility's standard of practice. Record Review of the facility's Infection Prevention and Control Program dated 05/13/23 revealed Policy: This facility has established and maintains 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 as per accepted national standards and guidelines. Policy Explanation and Compliance Guidelines: 2. All staff are responsible for following all policies and procedures related to the program. Record review of the facility's Enhanced Barrier Precautions Policy dated 04/05/24 revealed Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 2. Initiation of Enhanced Barrier Precautions: i.Indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. 50487