STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare	250 W British Flying School Blvd Terrell, TX 75160

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 - Some	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 observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs, for 4 of 6 (Resident ?s#12, #64, #7 and #38) residents reviewed for care plans.1. The facility did not ensure that Residents #12, #64, and #7's care plan included significant weight loss. 2. The facility failed to follow Resident #38's care plan for health shakes. These failures could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings included: 1. Record review of Resident #12's face sheet, dated 02/27/26, reflected Resident #12 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of Resident #12's quarterly MDS assessment, 12/07/25, reflected Resident #12 usually made herself understood and usually understood others. Resident #12 BIMS score was 00, which reflected her cognition was severely impaired. Resident #12 has not had a weight loss of 5% or more in the last month or 10% or more in the last 6 months. Record review of Resident #12's comprehensive care plan, revised on 02/13/26, reflected Resident #12 has potential nutritional problems related to protein calorie malnutrition. The care plan interventions included: divided plate for all meals, provide adaptive equipment as ordered and serve supplement as ordered. The care plan did not address the severe weight loss of 10.42% over 3 months. Record review of Resident #12's order summary report, dated 02/27/26, reflected an active physician's order for regular diet, puree texture, thin liquids consistency, divided plate, assistance with all meals, health shake all meals, magic cup lunch/dinner with a start date 12/21/25. Record review of Resident 12's weight summary report, dated 02/25/26, reflected a 10.42% weight loss in 3 months. Resident #12 weighed 138.2 on 12/9/25 and 131.1 on 02/08/26. Resident #12 weighed 123.89 on 02/25/26. 2. Record review of Resident #64's face sheet, dated 02/27/26, reflected Resident #64 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included cerebral infarction (stroke). Record review of Resident #64's quarterly MDS assessment, dated 12/24/25, reflected Resident #64 usually made himself understood and sometimes understood others. Resident #64 had a BIMS score of 04, which reflected his cognition was severely impaired. Resident #64 has not had a weight loss of 5% (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or more in the last month or 10% or more in the last 6 months. Record review of Resident #64's comprehensive care plan, revised on 02/13/26, reflected Resident #64 had a potential nutritional problem related to weakness. The care plan interventions included provide and serve supplements as ordered. The care plan did not address the severe weight loss of 13.01% over 6 months. Record review of Resident #64's order summary report, dated 02/27/26, reflected an active physician's order for NAS diet, regular texture, thin liquids consistency, health shake at lunch and dinner with a start date 04/21/25. Record review of Resident #64's weight summary report, dated 02/25/26, reflected a 13.01% weight loss in 6 months. Resident #64 weighed 166 on 9/2/25 and 148.2 on 02/08/26. Resident #64 weighed 144.4 on 02/25/26. During an interview on 02/27/26 at 2:50 p.m., ADON O stated she was aware of the weight loss, but the DON was ultimately responsible for updating the care plan related to weight loss. ADON O stated the care plan should have reflected the significant weight loss. ADON O stated the care plan was to notify staff there was a change that needed to be addressed. ADON stated not updating the care plan put residents at risk for skin breakdown, decreased activity and socialization. During an interview on 02/27/26 at 4:34 p.m., the Administrator stated he was aware of Resident #12 and Resident #64's significant weight loss. The Administrator stated he expected the care plan to address weight loss because it was a communication tool and it reflected the residents' issues and/or problems. The Administrator stated the DON was responsible for monitoring and overseeing the weight management system. The Administrator stated it was important to address the weight loss to reflect on any changes. 3. Record review of Resident #7's face sheet, dated 02/26/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia (loss of memory), Dysphagia (problem swallowing), and depression(sadness). Record review of Resident #7's significant change MDS assessment, dated 12/27/25, indicated Resident #7 was rarely understood and was rarely understood by others. Resident #7's BIMS score was 02, which indicated she was severely impaired. The MDS indicated Resident #7 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and for eating. The MDS during the 7-day look-back period did not indicate Resident #7 had weight loss. Record review of Resident #7's care plan revised date of 02/13/26, indicated, Resident #7 had nutritional problems due to risk of aspiration, malnutrition, depression, acid reflux, and oropharyngeal dysphagia (difficulty swallowing). The intervention was for staff to provide and serve diet and supplements as ordered. The care plan did not address weight loss. Record review of Resident #7's physician orders dated 02/23/25 indicated No Added Salt, puree diet texture, health shakes with all meals and magic cup for nutrition. Record review of Resident #7's weights indicated she had a 14.5 percent weight loss in 6 months. Her weight on 09/25 was 169.2, and on 02/26 was144.6. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and attempted interview on 02/23/26 at 12:15 p.m., Resident #7 was in the main dining room eating lunch. Her tray card read health shake with meals. Resident #7 did not have a health shake on her tray. Resident #7 did not answer when asked about her health shake. During an observation and interview on 02/23/26 at 12:20 p.m., LVN T said she realized Resident #7 did not have her health shake. She said she had asked the kitchen staff about the health shakes and they told her they were out. During an interview on 02/24/26 at 11:30 a.m., DA Y said they did not have health shakes for the 02/23/26 lunch. She said they had run out during breakfast. She said she informed [NAME] W they were out. 4.Record review of Resident #38's face sheet, dated 02/26/26 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included, dementia (the loss of cognitive functioning — thinking, remembering, and reasoning), hypertension (high blood pressure), and syncope and collapse (is a temporary loss of consciousness and collapse caused by a sudden, temporary drop in blood flow to the brain, lasting typically less than two minutes). Record review of Resident 38's quarterly MDS assessment, dated 12/12/25, indicated Resident #38 understood and was understood by others. Resident #38 BIMs score was 08 indicating he was moderately cognitively impaired. The MDS indicated Resident #38 required maximum assistance with his ADLs and independent with eating. Record review of Resident 38's Physician order dated 03/26/24 indicated regular diet regular texture, add health shake with every meal, magic cup with lunch and super. Record review of Resident #38's comprehensive care plan revised date of 02/24/26 revealed Resident #38 had potential nutritional problems related to dysphagia (swallow problems). The interventions for staff to provide and serve supplements as ordered. During an observation and interview on 02/24/26 at 9:23 a.m., Resident #38 was in his bed with his breakfast tray. Resident tray card read strawberry health shake with all meals. Resident #38 did not answer when asked about his shake. During an observation and interview on 02/24/26 at 9:24 a.m., CNA M walked into the room and verified that Resident #38 did not have a strawberry health shake or any other health shake on his breakfast tray. She said she passed Resident #38's breakfast tray and he did not have the health shake. She said usually the nurse checked the trays and then she would pass them out. She said she did not know why Resident #38 had a heath shake but assumed it was because he was thin and needed extra protein. During an interview on 02/24/26 at 11:17 a.m., LVN A said the nurses checked the trays and the aides passed them out. She said she did not check the hall trays for breakfast because she was in the main dining room. She said she was unsure who did. She said she was Resident #38's nurse and said he needed the health shakes because it was ordered by the dietitian and could potentially lead to weight loss if not given. During an interview on 02/24/26 at 11:30 a.m., DA Y said they did not have strawberry health shakes, so she did not send it. She said Resident #38 does not like chocolate or vanilla health shakes. She (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said [NAME] W was the person who ordered the shakes and was aware they were out. During an interview on 02/27/26 at 3:25 p.m., ADON O said if Resident #38 had an care plan, order or preference for strawberry health shakes then she expected him to receive them. She said if Resident #7 had an order for health shake, she should receive them. She said it should be a 2-way system for ensuring the residents receive what was on their tray card. She said the dietary staff were supposed to read the card and place the health shake on the tray and then the nurses were supposed to check the trays to ensure what was on their tray ticket matched what was on the tray. She said health shakes were given for weight loss, hydration, and extra calories. She said if the residents were not receiving them consistently it could lead to weight loss. During an interview on 02/27/26 at 4:34 p.m., the Administrator stated he was aware of the significant weight loss. The Administrator stated he expected the care plan to address weight loss because it was a communication tool and it reflected the residents' issues and/or problems. He said he expected staff to follow the care plan for Resident #38. The Administrator stated the DON was responsible for monitoring and overseeing the weight management system. The Administrator stated it was important to address the weight loss to reflect on any changes. Record review of facility's policy titled Comprehensive Resident Centered Care Plan, revised 12/2023 reflected. it is the policy of this facility that the IDT shall develop a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 6. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both comprehensive and quarterly review assessments.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure that the resident environment remains as free of accident hazards as possible for 3 of 6 residents (Resident #8, #38, and #58) reviewed for accidents. 1.The facility failed to ensure Resident #8 wander guard was functioning properly on 02/26/26. 2. The facility failed to ensure Resident #38 had a fall mat when he fell out of bed on 02/19/26. 3.The facility failed to ensure Resident #58's fall mat was beside her bed on 02/23/26 and 02/24/26. These failures could place residents at risk of elopement, injury, or harm. Findings included: 1. Record review of Resident #8's face sheet, dated 02/27/26, indicated an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory), stroke, depression(sadness), and high blood pressure. Record review of Resident #8's quarterly MDS dated [DATE] indicated she understood and was understood by others. The MDS indicated she had a BIMS score of 05 which meant she was severely cognitively impaired. The MDS indicated Resident #8 required assistance with her ADLs. The MDS indicated she wore a wander guard bracelet. Record review of Resident #8's comprehensive care plan revised date of 02/16/26 indicated she had a history of elopement as evidence by wandering at home and being disoriented. Her wander guard had been placed on her right ankle. The care plan interventions included: checking wander guard for placement every shift and checking function every Sunday night to verify it was in proper working order. Record review of Resident #8's physician order dated 08/18/25 indicated as follows: * check the function of the wander guard on Sunday nights. * check placement of wander guard to right ankle every shift. During an observation and interview on 02/25/26 at 9:00 a.m., Resident #8 was in her bed with a wander guard bracelet to her right ankle. Resident #8 said she was not aware why she had that bracelet on her leg. During an observation and interview on 02/25/26 at 11:50 a.m., the Maintenance Supervisor checked the wander guard system on the front door, the side door, and the back door and non-alarmed. He then evaluated Resident #8's wander guard bracelet and it did not work. The Maintenance Supervisor said he checked the wander guard system on 2/23/26 as part of his duties and it was functioning properly. He said he would take the wander guard tester around to each door and to Resident #8 to check for functioning. He said his tester was blinking red, which indicated the battery was low. He said he did not have any extra wander guards or testers in the facility. He said he would call a sister facility to see if they had any wander guards or testers. During an observation and interview on 02/25/26 at 12:30 p.m. the Regional Nurse Consultant said they initiated a 15-minute check on Resident #8 as she was the only resident who had a wander guard bracelet and showed the state surveyor the paperwork for the 15-minute check which started at 12:00 p.m. During an interview on 02/26/26 at 10:55 p.m., LVN A said she was Resident #8's day shift nurse and she said her responsibilities were to check for placement of the bracelet every shift. She said she was not aware of any device for checking the function of the wander guard. She said Resident #8 does get confused at times and thinks she needs to find her dog but was easily redirected. She said she had never left the facility to her knowledge. During an attempted interview on 02/26/26 at 11:33 a.m., LVN FF (nigh shift nurse) did not answer the phone, but a message was left. During an interview on 02/26/26 at 11:37 a.m., LVN P said she was Resident #8's night shift nurse and checked placement of the wander guard every night shift. She said she was not aware of any device for checking the function of the wander guard. She said no one had told her about checking the function of the wander guard. She said Resident #8 does wander at times looking for her dog but had never left the facility to her knowledge. During an observation and interview on 02/26/26 at 3:30 p.m., the Maintenance Supervisor said he received a wander guard from a sister facility. He checked the wander guard system on the front door, the side door, and the back door and they were functioning properly. He checked Resident # 8's wander guard and it did not alarm. He replaced Resident #8's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wander guard and all were functioning properly. He said the risk of the wander guard system or wander guard bracelet not functioning properly could lead to a resident eloping. 2.Record review of Resident #38's face sheet, dated 02/26/26 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included, dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), hypertension (high blood pressure), and syncope and collapse (is a temporary loss of consciousness and collapse caused by a sudden, temporary drop in blood flow to the brain, lasting typically less than two minutes). Record review of Resident 38's quarterly MDS assessment, dated 12/12/25, indicated Resident #38 understood and was understood by others. Resident #38 BIMs score was 08 indicating he was moderately cognitively impaired. The MDS indicated Resident #38 required maximum assistance with his ADLs and independent with eating The MDS indicated he had a fall since admission. Record review of Resident #38's comprehensive care plan revision dated 01/09/26 revealed Resident #38 had a fall on 11/14/25, and 12/27/25. The interventions for staff to have fall mats in place beside the bed to prevent injury started 12/27/25. Record review of Resident 38's Physician order dated 02/24/26 did not reveal an order for fall mats. Record review of Resident #38's incident report revealed he had a fall on 02/19/26. The interventions were to place fall mats. During an observation and interview on 02/26/26 at 3:00 p.m., LVN A said she was the nurse when Resident #38 fell on [DATE]. She said he fell out of bed on the floor. She said he did not have fall mats beside the bed. She said she was not aware he should have had fall mats. She reviewed his care plan and saw where his care plan indicated fall mats noted on 01/09/26. She said she asked hospice to bring him fall mats after the incident on 02/19/26. She said since he had a care plan for fall mats dated 01/09/26 then the falls mats should have been in place prior to his fall on 02/19/26. She said since Resident #38 did not have the fall mats it placed him at risk for injury. 3. Record review of Resident #58's face sheet, dated 02/27/26 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included high blood pressure, Parkinson's disease (a progressive movement disorder of the nervous system), and scoliosis (a side-to-side curve of the spine). Record review of Resident 58's quarter MDS assessment, dated 02/06/26, indicated Resident #58 usually understood and was usually understood by others. Resident #58's BIMS score was 01 indicating her cognition was severely impaired. The MDS indicated Resident #58 required total assistance with her ADL's. The MDS did not indicate she had a fall in the prior assessment. Record review of Resident #58's comprehensive care plan revised date of 01/11/26 indicated, Resident #58 had falls 11/4/25, and 01/10/26. She was at risk for further falls related to decreased mobility and weakness. The intervention was for staff to apply a fall mats X2 at the bedside. Record review of Resident 58's Physician order dated 02/03/26 indicated fall mats X 2 for safety, check every shift. Record review of Resident 5's incident report revealed she had a fall from her bed on 11/04/25 and 01/10/26. The intervention was for staff on 11/25/25 was to implement the falling star indicator to better assist facility staff indentifying that the resident was at high risk of falls and needs increased visual monitoring. Provide reorientation as needed to facilitate integration into new environment on 01/12/26. During an observation and interview on 02/23/26 at 3:53 p.m., Resident #58 was in her bed with eyes closed. She had a fall mat down on one side but on the other side of the bed the fall mat was against the wall. During an observation and interview on 02/24/26 at 10:03 a.m., CNA U verified Resident #58's fall mat was against the wall and not beside the bed. She said Resident #58 was new to this hall. She said she would go ahead and place the fall mat beside her bed and then go ask or look and see if she was supposed to have two fall mats. She came back and notified this surveyor that Resident #58 was supposed to have two fall mats. She said the risk without the fall mats could be an injury. During an interview on 02/25/26 at 4;55 p.m., LVN T said she was Resident #58's nurse. She said Resident #58 was supposed to have two fall mats. She said she made random rounds but was unaware Resident #58 did not have both fall mats. She said failure to have both fall mats placed the resident at risk for injury. During an interview on 02/27/26 at 3:25 p.m., ADON O said Resident #38 and Resident #58 were supposed to have a fall mat beside their beds. She (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the nursing staff was responsible for ensuring the fall mats were beside their beds. She said the fall mat was for fall prevention and to prevent injury. ADON O said the Maintenance Supervisor was responsible for checking the wander guard system doors and the nurses were supposed to be checking the wander guard for function on Sunday night shift. ADON O said Resident #8 was the only resident who required a wander guard. She said if the system or wander guard itself was not functioning properly it placed Resident #8 at risk for elopement. During an interview on 02/27/26 at 4:21 p.m., the Administrator said if Resident #38 and Resident #58 had an order or care plan for a fall mat to be at their bedside, then he expected it to be there. He said nursing staff were responsible for ensuring it was beside their beds. He said fall mats were to prevent injury. He said the Maintenance Supervisor was responsible for ensuring the wander guard system functioned properly. He said he became aware of the wander guard system not functioning properly on 02/26/26. He said staff initiated a 15-minute check on Resident #8 until they could get the system fixed. He said the system was functioning properly the same day identified. He said failure of the wander guard or wander guard system not functioning properly could lead to elopement. Record review of the TELS (a building maintenance Platform that is a leading web-based technology designed to tackle the day-to-day challenges of building operations) logbook report indicated on 02/21/26 all doors were checked and working properly. Record review of the facility's policy titled, Elopement, revised October 2024, indicated, Policy: It is the policy of this facility to provide a safe environment for all residents. The facility will assess residents and plan their care to prevent accidents related to wandering behavior or elopement. Wandering is defined as movement about the area without a fixed goal, and elopement is defined as slipping away secretly, running away, leaving without accompaniment or knowledge of the staff. Procedure: #1. Residents whose assessment identified wandering behavior shall also be considered at risk for elopement. If a resident is identified at risk for elopement, the following steps will be taken: A. An alarm bracelet may be placed on the resident to audibly alert staff of attempts by the resident to exit, in facilities with this capability. B. The resident's care plan shall address behavior using resident specific goals and/or approaches as assessed by the interdisciplinary team.D. A current picture of the resident will be maintained in the facility. E. Facility staff will ensure that all exit alarms are responded to immediately. Record review of the facility's policy titled, Fall Management System, revised 04/2025, indicated, Policy: It is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Procedure.#2. Residents with high risk factors identified on the Fall Risk Evaluation will have an individualized care plan developed that includes measurable objectives and timeframes. A. The care plan interventions will be developed to prevent falls by addressing the risk factors and will consider the particular elements of the evaluation that put the resident at risk. #6. Resident's care plan will be updated. #7. The OAA Committee will analyze trends related to falls and will determine if further intervention is needed.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this was not possible or resident preferences indicate otherwise for 5 of 8 residents (Resident's #7, #12, #56, #64 and #72) reviewed for nutrition. 1.The facility did not ensure Resident #7, #12, #56, #64, and#72, received their health shake on 02/23/26. 2. The facility did not ensure 4 oz of glazed ham was given to residents who received a regular diet on 02/23/26. 3. The facility did not ensure the #12 scoop was used for the mechanical soft glazed ham on 02/23/26. 4.The facility did not ensure 2 #8 scoops were used for the pureed glazed ham on 02/23/26. These failures could place residents at risk for decreased nutritional status, weight loss, decline in health, skin breakdown, and decreased quality of life. Findings included: 1.Record review of Resident #7's face sheet, dated 02/26/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia (loss of memory), Dysphagia (problem swallowing), and depression(sadness). Record review of Resident #7's significant change MDS assessment, dated 12/27/25, indicated Resident #7 was rarely understood and was rarely understood by others. Resident #7's BIMS score was 02, which indicated she was severely impaired. The MDS indicated Resident #7 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and for eating. The MDS during the 7-day look-back period did not indicate Resident #7 had weight loss. Record review of Resident #7's care plan revised date of 02/13/26, indicated, Resident #7 had nutritional problems due to risk of aspiration, malnutrition, depression, acid reflux and oropharyngeal dysphagia (difficulty swallowing). The intervention was for staff to provide and serve diet and supplements as ordered. The care plan did not address weight loss. Record review of Resident #7's physician orders dated 02/23/25 indicated No Added Salt, puree diet texture, Health shakes with all meals and magic cup for nutrition. Record review of Resident #7's weights indicated she had a 14.5 percent weight loss in 6 months. Her weight on 09/25 was 169.2,10/25 was 167.4, 11/25 was 168, 12/25 was 160, 01/26 was162.4 and on 02/26 was144.6. Record review of the facility diet roster printed on 02/23/26 by [NAME] W revealed they had 20 residents who received health shakes. Some residents had orders for health shakes daily while others were for 2 or 3 times a day with a total of 49 health shakes per day. Record review of the facility's order summary guide starting on 01/27/26 revealed they ordered 225 health shakes. According to the facility's roster of 49 health shakes per day this supply would last 4 days with 29 left over. Record review of the facility's order summary guide starting on 02/03/26 revealed they ordered 200 health shakes. According to the facility's roster of 49 health shakes per day this supply would last 4 days with 4 leftovers left. According to the resident roster and order guide they would be short 2 full (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare	250 W British Flying School Blvd Terrell, TX 75160

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	days and partial of a day. Record review of the facility's order summary guide starting on 02/10/26 revealed they ordered 225 health shakes. According to the facility's roster of 49 health shakes per day this supply would last 4 days with 29 left over. According to the resident roster and order guide they would be short 2 full days and partial of a day. Record review of the facility's order summary guide starting on 2/17/26 revealed they ordered 225 health shakes. According to the facility's roster of 49 health shakes per day this supply would last 4 days with 29 left over. According to the resident roster and order guide they would be short 2 full days and partial of a day. During an observation and attempted interview on 02/23/26 at 12:15 p.m., Resident #7 was in the main dining room eating lunch. Her tray card read health shake with meals. Resident #7 did not have a health shake on her tray. Resident #7 did not answer when asked about her health shake. During an observation and interview on 02/23/26 at 12:20 p.m., LVN T said she realized Resident #7 did not have her health shake. She said she had asked the kitchen staff about the health shakes and they told her they were out. During an observation on 02/25/26 at 5:38 p.m., CNA Z weighed Resident #7 with the surveyor present, and her weight was 142.5. This is a weight loss from weight of 144.4 taken earlier in the month. 2.Record review of Resident #56's face sheet, dated 02/25/26, indicated she was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets), depression (sadness), hypertension (high blood pressure), and UTI (an infection in your urinary system). Record review of Resident 56's quarterly MDS assessment, dated 01/08/26, indicated Resident #56 was understood and was understood by others. The MDS assessment indicated he had a BIMS score of 10 indicating moderate cognitive impairment. The MDS indicated she required assistance with her ADL's. The MDS did not indicate if she had a weight loss or gain. Record review of Resident #56's comprehensive care plan, dated 01/14/26, indicated Resident #56 had unplanned/unexpected weight loss related to poor food intake. The intervention was for staff to give supplements as ordered and alert nurse/ dietitian if not consuming on a routine basis. Record review of Resident #56's physician orders dated 02/23/25 indicated regular diet, mechanical soft texture, Health shakes with all meals and peanut butter and jelly with lunch and dinner. Record review of Resident #56's weights indicated she had a 11.60 percent weight loss in 6 months and 7.83 percent in 3 months. Her weight on 09/25 was 178.6,10/25 was 178.0, 11/25 was 178.6, 12/25 was 168.6, 01/26 was 163.0 and on 02/26 was 155.4. During an observation and interview on 02/23/26 at 12:25 p.m., Resident #56 was in her room eating lunch. Her tray card read health shakes. Resident #56 did not have a health shake on her tray. Resident #56 said some days she had health shakes and some days she did not. She said she could (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not remember how often she did not have health shakes. During an observation on 02/25/26 at 5:38 p.m., CNA Z weighed Resident #56 with the surveyor present, and her weight was 151.1. This is a weight loss from 155.4 earlier in the month. 3. Record review of Resident #12's face sheet, dated 02/27/26, reflected Resident #12 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of Resident #12's quarterly MDS assessment, 12/07/25, reflected Resident #12 usually made herself understood and usually understood others. Resident #12 BIMS score was 00, which reflected her cognition was severely impaired. Resident #12 has not had a weight loss of 5% or more in the last month or 10% or more in the last 6 months. Record review of Resident #12's comprehensive care plan, revised on 02/13/26, reflected Resident #12 has potential nutritional problems related to protein calorie malnutrition. The care plan interventions included: divided plate for all meals, provide adaptive equipment as ordered and serve supplement as ordered. The care plan did not address the severe weight loss of 10.42% over 3 months. Record review of Resident #12's order summary report, dated 02/27/26, reflected an active physician's order for regular diet, puree texture, thin liquids consistency, divided plate, assistance with all meals, health shake all meals, magic cup lunch/dinner with a start date 12/21/25. Record review of Resident 12's weight summary report, dated 02/25/26, reflected a 10.42% weight loss in 3 months. Resident #12 weighed 138.2 on 12/9/25 and 131.1 on 02/08/26. Resident #12 weighed 123.89 on 02/25/26, which revealed further weight loss. 4. Record review of Resident #64's face sheet, dated 02/27/26, reflected Resident #64 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included cerebral infarction (stroke). Record review of Resident #64's quarterly MDS assessment, dated 12/24/25, reflected Resident #64 usually made himself understood and sometimes understood others. Resident #64 had a BIMS score of 04, which reflected his cognition was severely impaired. Resident #64 has not had a weight loss of 5% or more in the last month or 10% or more in the last 6 months. Record review of Resident #64's comprehensive care plan, revised on 02/13/26, reflected Resident #64 had a potential nutritional problem related to weakness. The care plan interventions included provide and serve supplements as ordered. The care plan did not address the severe weight loss of 13.01% over 6 months. Record review of Resident #64's order summary report, dated 02/27/26, reflected an active physician's order for NAS diet, regular texture, thin liquids consistency, health shake at lunch and dinner with a start date 04/21/25. Record review of Resident #64's weight summary report, dated 02/25/26, reflected a 13.01% weight loss in 6 months. Resident #64 weighed 166 on 9/2/25 and 148.2 on 02/08/26. Resident #64 weighed 144.4 on 02/25/26 which revealed further weight loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Record review of Resident #72's face sheet, dated 02/27/26, reflected Resident #72 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included metabolic encephalopathy (the brain has trouble working because of a chemical, or metabolic, problem in the body). Record review of Resident #72's quarterly MDS assessment, dated 02/03/26, reflected Resident #12 made herself understood and understood others. Resident #72 BIMS score was 2, which reflected her cognition was severely impaired. Resident #72 has not had a weight loss of 5% or more in the last month or 10% or more in the last 6 months. Record review of Resident #72's undated comprehensive care plan reflected Resident #72 had a potential nutritional problem. The care plan interventions included: provide and diet and supplement as ordered. Record review of Resident #72's order summary report, dated 02/27/26, reflected an active physician's order for NAS diet mechanical soft texture, thin liquids consistency, shake BID with a start date 02/09/25. Record review of Resident #72's weight summary report, dated 02/25/26, reflected a severe weight loss of 19.78% over 3 months. Resident #72 weighed 109.2 on 12/4/25 and 94.8 on 02/08/26. Resident #72 weighed 87.6 on 02/25/26. During an interview on 02/25/26 at 1:24 p.m., [NAME] AA stated she was the aide for 02/22/26 and there were no health shakes available. [NAME] AA stated to her knowledge four boxes came in on 02/17/26. [NAME] AA stated [NAME] W was responsible for ordering the health shakes. [NAME] AA stated it was important to ensure residents had their health shakes to prevent weight loss. During an interview on 02/25/26 at 1:34 p.m., Dietary Aide BB stated he was the aide on 02/20/26 and none of the residents received a health shake because it was less than half of box left. Dietary Aide BB stated no residents received a health shake on 02/21/26. Dietary Aide BB stated he did not report this to anyone. Dietary Aide BB stated this has been an issue in the past. Dietary Aide BB stated normally they just wait on the next truck to come in. Dietary Aide BB stated this failure could potentially cause weight loss. During an interview on 02/25/26 at 1:45 p.m., Dietary Aide CC stated there were no health shakes provided to residents on 02/21/26 and 02/22/26. Dietary Aide CC stated she did not report to anyone. Dietary Aide CC stated at least once a month they run out of health shakes. Dietary Aide CC stated this failure could potentially cause weight loss. During an interview on 02/25/26 at 1:52 p.m., Dietary Aide DD stated there were no health shakes provided to residents on 02/21/26 and 02/22/26. Dietary Aide DD, she did not report this to anyone. Dietary Aide DD stated at least once a month they run out of health shakes. Dietary Aide DD stated this failure could potentially cause weight loss. During an interview on 02/25/26 at 3:06 p.m., CNA R said the kitchen does run out of health shakes at times, she said the nurses were aware when they did. She said the kitchen staff would say they were waiting on the truck to deliver them. She said on 02-23-26 that it was not the first time the kitchen did not have health shakes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/25/26 at 3:45 p.m., LVN A said the kitchen had been short on health shakes in the past but on 02/23/26 was the first time she was aware that they completely ran out. She said if residents were not receiving their health shakes the potential could be weight loss. During an interview on 02/25/26 at 3:56 p.m., RN V said there had been times when the kitchen did not have health shakes. He said the kitchen staff would say that the truck would be delivering later that day. He said if the residents were not receiving their health shakes it could potentially lead to weight loss. During a phone interview on 02/25/26 at 5:48 p.m., the facility's dietitian said she heard something about health shakes on 02/24/26. At first, she heard they had some and then from other staff she heard they did not. She said prior to 02/24/26, she was not aware of any health shake issues. She said if they had any issues in the past, they would notify her, and she would direct them on what to substitute. She said she was not notified on 02/23/26. She said [NAME] W had been trained on how to order supplies. She said it was important for residents to receive their health shakes because it was an order, it would help provide more calories for intake and for better overall health of the resident. During a phone interview on 02/25/26 5:58 p.m., the facility's physician assistant said health shakes were ordered normally for the weight loss or extra nutritional. He said someone at the facility would usually let him know if they did not have medication or supplements, but he was not aware on 02/23/26 when the facility did not have health shakes. He said he expected staff to notify him if they did not have something for the residents. He said health shakes were ordered for extra nutrition so therefore the residents needed it. During a phone interview on 02/27/26 at 3:06p.m., the facility's dietitian said she came to the facility 2-3 times a month. She said she was aware of weight loss because she pulled the weight exception report each time and was able to see which resident triggered for weight loss. She said she and the previous DON would review the triggers and came up with a plan for each resident. She said when she visited, she would usually see the dietary manager or the resident and sometimes both when she reviewed the weights to see if she could figure out what had changed and why. She said she expected the dietary cooks to use the correct scoop size when serving. She said the cook should have the guided menu open in front of them to ensure they were using the correct scoop size. She said she expected the cooks to follow the menu, follow the doctor's orders, and use the correct scoop size. She said failure to use the correct scoop size, follow the menu or doctor's orders could potentially cause weight loss. During an interview on 02/27/26 at 3:25 p.m., ADON O said it should be a 2-way system for ensuring the residents receive what was on their tray ticket. She said the dietary staff were supposed to read the tray cards and place the health shake on the tray and then the nurses were supposed to check the trays to ensure what was on their tray ticket matched what was on the tray. She said it was important for the staff to read the tickets and ensure the residents were receiving the correct diets. She said she was aware that the kitchen had run out of health shakes on 02/23/26 and had heard about the kitchen being out of health shakes in the past periodically. She said health shakes were given for weight loss, hydration and extra calories. She said she was not aware of what portion size should be used for each meal. She said the cooks were responsible for knowing what scoop size to use. She said if the residents were not receiving health shakes consistently or not receiving enough food at meal services it could lead to weight loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/26 at 4:11 p.m., the Administrator said that when staff were serving the trays, they were responsible for ensuring the resident had the correct diet and all supplements that were ordered. He said the dietary manager was responsible for the kitchen and ensured they were ordering enough health shakes and supplies for the kitchen. He said the dietary manager was responsible for ensuring the cook served with the correct scoop sizes. He said it was important for residents to receive the correct diet/supplement to prevent weight loss. Record review of the facility's policy titled, Tray Card, undated, indicated, Policy: A tray card will be issued for each resident. Procedure: 1. Upon receipt of a diet communication slip from nursing containing a new or changed diet order, the Nutrition Services staff will prepare a tray card for the residents. 2. Tray cards should list the resident's preferred name, room number, diet order, location of meal service, food allergies, intolerances and preferences. 3. If permanent tray cards are used, they will be checked before each meal for accuracy. Record review of the facility's policy titled, Hydration, undated, indicated, Policy: It is the policy that this facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Purpose: To ensure that the resident receives sufficient amount of fluids based on individual needs to prevent dehydration. Procedure: 1. The nursing staff will encourage each resident to consume all fluids provided on their meal trays. Record review of the facility's policy titled, Nutrition, revised on 04/2012, indicated, Policy: It is the policy of this facility to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

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	675808	A. Building B. Wing	02/27/2026

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the meals served met the nutritional needs of residents for 1 of 1 meal (the lunch meal) and 1 of 1 resident (Resident #40) reviewed for nutritional adequacy. 1. The facility did not ensure 4 oz of glazed ham was given to residents who received a regular diet on 02/23/26. 2. The facility did not ensure the #12 scoop was used for the mechanical soft glazed ham on 02/23/26. 3. The facility did not ensure two #8 scoops were used for the pureed glazed ham on 02/23/26. These failures could put residents at risk of a decrease in resident choices, diminished interest in meals, and weight loss. Findings include: Record review of Resident #40's face sheet, dated 02/27/26, reflected Resident #40 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of Resident #40's annual MDS assessment, dated 01/16/26, reflected Resident #40 made herself understood, and understood others. Resident #40's BIMS score was 2, which reflected her cognition was severely impaired. Resident #40 required supervision/touching assistance with eating. Resident #40 required a therapeutic diet. Record review of Resident #40's, undated, comprehensive care plan, reflected Resident #40 had a potential nutritional problem related to disease process, impaired cognition, dysphagia (difficulty swallowing), and malnutrition risk. The care plan interventions included diet as ordered by the physician, provide and serve diet as ordered. Record review of an in-service form titled Using correct scoop, Ladle/Spoodles, Portion Size, dated 02/23/26, reflected [NAME] W's signature. Record review of Resident #40's physician order summary report, dated 02/27/26, reflected an active physician's order for NAS regular diet texture, thin liquids consistency, assistance with meals; divided plate with a start date 11/07/24. Record review of the, undated, extended week three menu reflected 4 oz of glazed ham for the regular diet, (2) 8 scoops for the pureed and the green (16) scoop for the mechanical soft. During an observation and interview on 12/23/26 at 12:25 p.m., LVN T was reviewing Resident #40's lunch meal tray and was getting ready to serve Resident #40 her tray when the state surveyor observed one sliced of glazed ham on the tray. The state surveyor asked LVN T if she could take the tray back to the kitchen to ensure one slice of ham was the correct serving size. [NAME] W weighed the ham, and it was 2 oz. The expected menu book was closed prior to [NAME] W reviewing it. [NAME] W stated it should be 4 oz. [NAME] W was preparing the mechanical soft using #16 scoop size for the glazed ham. [NAME] W was preparing the pureed using (1) 8 scoop size for the glazed ham. After reviewing the extended menu [NAME] W stated #12 scoop size should be used for the mechanical soft and (2) 8 scoop size should be used for pureed. [NAME] W stated the hall trays and half of the dining room had already been served with the improper scoop size. During an interview on 02/25/26 at 11:15 a.m., Dietary Manager X stated she was from a sister facility, and she came to assist the staff since they did not have a dietary manager at that time. Dietary Manager X stated [NAME] W should have used #12 scoops for the mechanical soft ham and (2) 8 scoops for the pureed diet. Dietary Manager X stated [NAME] W should have weighed the ham to ensure it was equal to 4 oz before serving the residents. Dietary Manager stated today was her third visit to the facility. Dietary Manager X stated this failure could potentially cause weight loss. During a telephone interview on 02/25/26 at 11:35 a.m., [NAME] W stated she was responsible for ensuring the correct portions sizes were served for meal serving. [NAME] W stated she knew the correct servicing size for all three diets but was nervous because the state surveyor was in the building. [NAME] W stated she was trained by the previous Dietary Manager who had been gone for about three weeks. [NAME] W stated she reviewed the extended menu prior to preparing the trays. [NAME] W stated this failure could potentially put residents at risk for malnutrition or weight loss/gain. During a telephone interview on 02/26/26 at 4:08 p.m., the Dietician stated she expected [NAME] W to follow the (continued on next page)

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	675808	A. Building B. Wing	02/27/2026

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	extension menu which was a spreadsheet that showed each texture portion size for each meal. The Dietitian stated [NAME] W should have the extension menu opened as she prepared the trays. The Dietician stated she monitored monthly by in-service. The Dietician stated the last in-service was done in February. The Dietitian stated she has not seen any issues in the past with [NAME] W. The Dietician stated it was important that menus were followed to provide the correct portion size to give accurate nutrients to each resident. During an interview on 02/26/26 at 2:50 p.m., ADON O stated she was unaware [NAME] W was not preparing all three textures the correct serving size until 02/23/26. ADON O stated the Dietary Manager and Dietitian were responsible for monitoring and overseeing the kitchen. ADON O stated it was important that menus were followed to prevent weight loss. During an interview on 02/27/26 at 4:34 p.m., the Administrator stated he was not aware of the incorrect portion size until 02/23/26. The Administrator stated he expected the dietary staff to follow the recipe and meal ticket. The Administrator stated in the absence of the Dietary Manager the resource Dietary Manager from a sister facility would be monitoring and overseeing the kitchen. The Administrator stated he had not observed a problem with meal service. The Administrator stated he did not have knowledge about the various sizes that were needed for meals. The Administrator stated it was important that menus were followed to prevent weight loss. Record review of the facility's undated policy titled Standardized Portions, reflected . Standard portions will be used for all food items to ensure adequate nutrients hare provided and to avoid waste.Procedure: c. Portion sizes are written on the menu to ensure equal portions are served to provide adequate nutrition. Follow portion sizes to be served as directed by the menu.

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	675808	A. Building B. Wing	02/27/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to ensure each resident received and the facility provided food that was palatable, attractive, and at a safe and appetizing temperature for 8 of 8 confidential residents, and 1 of 1 meal reviewed for palatability, attractiveness, and appetizing. The dietary staff failed to provide food that was palatable and at an appetizing temperature for 8 confidential residents. This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss.Record review of a Resident Council Meeting Form, dated 2/19/2026, indicated the group council voiced their food being cold. The form failed to address how the grievances would be managed. Record review of the food temperature log, dated 2/24/2024, indicated the Regular meat's temperature at the time of serving was 137 degrees Fahrenheit, the cooked vegetables were 176, savory rice was 155 degrees Fahrenheit, and the egg roll was 153 degrees Fahrenheit. During a confidential group interview at an undisclosed date at an undisclosed time revealed 8 of 8 residents said the food trays served on the halls were cold. During an observation on 2/04/2026 at 12:09 p.m., the tray cart with the test tray left the kitchen preparation area. The tray cart was reviewed by nurses and left the dining room and went directly to the hall. The trays were passed starting from 12:11 p.m. and ending when the test tray arrived in the work room at 12:27 p.m. During a test tray interview with the Registered Dietitian and State Surveyors on 2/24/2026 at 12:30 p.m., the Registered Dietitian stated the following regarding the regular food diet for lunch served on 2/24/2026: orange chicken tasted like orange chicken but was warm; rice was sticky and not hot, egg roll was good but soggy and not hot, and vegetable California blend was bland and warm. Overall, the registered dietitian was impressed that the food was warm. The State Surveyors tasted each item on the test tray and stated the orange chicken was warm, the rice was good but cold, vegetables were bland and cold, and the egg roll was good but soggy text. During an interview on 2/27/2026 at 2:31 p.m., [NAME] AA stated the residents made complaints about the food being cold. [NAME] AA stated the hall trays were taking an extended time to be passed which caused the food to be cold. [NAME] AA stated the residents were at risk of weight loss if they did not eat. [NAME] AA stated the food should be eatable and hot. During an interview on 2/27/2026 at 2:15 p.m., ADON O said she expected the meals to be served at the standard required temperatures. ADON O said the food served at a palatable temperature would prevent a decrease in intake and prevent weight loss. ADON O said the Dietary Manager was responsible for ensuring palatability. ADON O stated she was not aware of any food complaints or that the food was being served cold. During an interview on 2/27/2026 at 2:39 p.m., the RNC said she expected the meals to be palatable regarding temperature and taste. The RNC said palatability ensured enjoyable meals. The RNC said nursing and the dietary department was responsible for ensuring meals were palatable. During an interview on 02/27/2026 at 2:46 p.m., the Administrator said he expected the dietary staff to provide food that was hot and tasted good. The administrator stated the residents were at risk of weight loss and low quality of life. The administrator claimed responsibility for ensuring he had the staff to provide good food. The administrator said he was unaware of the food being served cold and had not received any food complaints. Record review of the, undated, Food and Drink policy revealed each resident must receive and the facility must provide: (1)food prepared in accordance with established professional food preparation practices and by methods that conserve nutritive value, flavor and appearance;2)adequate amounts of food and drink that is palatable, attractive, and at a safe appetizing temperature;3)food prepared in a form designed to meet individual needs;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare	250 W British Flying School Blvd Terrell, TX 75160

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident received and the facility provided food prepared in a form designed to meet individual needs for 3 of 6 residents (Resident's #85, #7 and #56) reviewed for food and drinks. 1.The facility failed to ensure Resident #85 was not given cornbread on 02/23/26, as ordered by the physician. 2.The facility failed to ensure Resident #7 and Resident #56, received their health shake on 02/23/26. These failures could place residents at risk for choking, weight loss, and unmet nutritional needs. Findings Include: 1.Record review of Resident #85's face sheet, dated 02/27/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #85 had diagnoses which included Chronic Obstructive Pulmonary Disease also known as COPD (a chronic lung disease that causes inflammation and narrowing of the airways, leading to airflow obstruction), anxiety (a feeling of fear, dread, and uneasiness), dysphagia (difficulty swallowing) and high blood pressure. Record review of Resident #85's admission MDS assessment, dated 01/24/26, indicated Resident #85 was usually understood and was rarely understood by others. She was severely impaired with daily decision making. Resident #85 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and for eating. The MDS during the 7-day look-back period indicated Resident #85 held food in her mouth/cheeks or residual food in her mouth after meals. Record review of Resident #85?s physician orders, dated 01/26/26, indicated No Added Salt diet, mechanical soft texture, divided plate with no bread per speech therapy (sandwiches, rolls, cornbread, or tortillas). Record review of Resident #85?s care plan, revised date of 02/05/26, indicated she had potential for nutritional problems related to poor awareness and impaired cognition. The intervention was for staff to serve diet as ordered. During an observation and attempted interview on 02/23/26 at 1:09 p.m., Resident #85 was in the main dining room eating. Her tray ticket indicated no corn bread. Resident #85 had corn bread on her plate and had eaten about 2 bites. Resident #85 just laughed when asked about the cornbread. During an observation and interview on 02/23/2026 at 1:10 p.m., LVN T looked and verified Resident #85 had corn bread on her tray. LVN T read the ticket written which indicated no bread. She said she checked the tray before staff passed it to Resident #85 and it was an oversite for missing the corn bread being on the tray. She said since her ticket read no bread then it placed Resident #85 at risk of choking. 2. Record review of Resident #7's face sheet, dated 02/26/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #7 had diagnoses which included dementia (loss of memory), Dysphagia (problem swallowing), and depression (sadness). Record review of Resident #7's significant change MDS assessment, dated 12/27/25, indicated Resident #7 was rarely understood and was rarely understood by others. Resident #7's BIMS score was 02, which indicated she was severely impaired. Resident #7 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and for eating. The MDS during the 7-day look-back period did not indicate Resident #7 had weight loss. Record review of Resident #7?s care plan, revised date of 02/13/26, indicated Resident #7 had nutritional problems due to risk of aspiration, malnutrition, depression, acid reflux, and oropharyngeal dysphagia (difficulty swallowing). The intervention was for staff to provide and serve diet and supplements as ordered. Record review of Resident #7?s physician orders, dated 02/23/25, indicated No Added Salt, puree diet texture, Health shakes with all meals and magic cup for nutrition. During an observation and attempted interview on 02/23/26 at 12:15 p.m., Resident #7 was in the main dining room eating lunch. Her tray card read health shake with meals. Resident #7 did not have a health shake on her tray. Resident #7 did not answer when asked about her health shake. During an observation and interview on 02/23/26 at 12:20 p.m., LVN T said she realized Resident #7 did not have her health shake. She said she asked the kitchen staff about the health shakes and they told her they were out. 3. Record review of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare	250 W British Flying School Blvd Terrell, TX 75160

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #56's face sheet, dated 02/25/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #56 had diagnoses which included malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets), depression (sadness), hypertension (high blood pressure), and UTI (an infection in your urinary system). Record review of Resident 56's quarterly MDS assessment, dated 01/08/26, indicated Resident #56 was understood and was understood by others. He had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #56 required assistance with her ADL's. The MDS did not indicate if she had a weight loss or gain. Record review of Resident #56's comprehensive care plan, dated 01/14/26, indicated Resident #56 had unplanned/unexpected weight loss related to poor food intake. The intervention was for staff to give supplements as ordered and alert nurse/ dietitian if not consuming on a routine basis. Record review of Resident #56?s physician orders, dated 02/23/25, indicated regular diet, mechanical soft texture, Health shakes with all meals and peanut butter and jelly with lunch and dinner. During an observation and interview on 02/23/26 at 12:25 p.m. revealed Resident #56 was in her room eating lunch. Her tray card read health shakes. Resident #56 did not have a health shake on her tray. Resident #56 said some days she had health shakes but could not remember the dates or the last time she did not have the health shake. During an interview on 02/23/26 at 1:26 p.m., [NAME] W said she was responsible for checking the tray ticket against what she served prior to the tray leaving the kitchen. She said she did not realize she put cornbread on Resident #85 tray. She said failure to read the tray ticket correctly could cause a resident to get something they should not have and cause an allergic reaction or for Resident #85 choking. She said she followed what the previous dietary manger was ordering for health shakes. She said she was not aware they were out of health shakes until the lunch meal today (02/23/26). She said she thought she was ordering enough. She said it was important the residents received their health shakes to prevent weight loss. During an interview on 02/24/26 at 11:30 a.m., Dietary Aide Y said they did not have health shakes for the 02/23/26 lunch. She said they had run out during breakfast. She said she informed [NAME] W they were out. During an interview on 02/25/26 at 3:06 p.m., CNA R said the kitchen ran out of health shakes at times, she said the nurses were aware when they did. She said the kitchen staff would say they were waiting on the truck to deliver them. She said on 02/23/26 it was not the first time the kitchen did not have health shakes. During an interview on 02/27/26 at 3:25 p.m., ADON O said she expected the diet order to be followed. ADON O said the Dietary Manager was responsible for monitoring diet orders and having health shakes. She said the nurses should be checking the trays before they were served to ensure the diet was correct and the tray ticket matched the tray. ADON O said the risk of receiving cornbread for Resident #85 could have been difficulty swallowing and/or choking. She said the risk of not receiving the health shakes could lead to weight loss. During an interview on 02/27/26 at 4:11 p.m., the Administrator said when staff were serving the trays, they were responsible for ensuring the resident had the correct diet and all supplements that were ordered. He said the dietary manager was responsible for the kitchen and ensured they were ordering enough health shakes and supplies for the kitchen. He said it was important for residents to receive the correct diet/supplement to prevent choking or weight loss. Record review of the facility's, undated, policy titled, Tray Card, indicated, Policy: A tray card will be issued for each resident. Procedure: #1. Upon receipt of a diet communication slip from nursing containing a new or changed diet order, the Nutrition Services staff will prepare a tray card for the residents. 2. Tray cards should list the resident's preferred name, room number, diet order, location of meal service, food allergies, intolerances, and preferences. 3. If permanent tray cards are used, they will be checked before each meal for accuracy. Record review of the facility's policy titled, Nutrition, revised on 04/2012, indicated, Policy: It is the policy of this facility to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

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	675808	A. Building B. Wing	02/27/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements.The facility failed to ensure the sanitation bucket was checked for chlorine level and logged according to manufacture guidelines.The facility failed to ensure the three-compartment sink was checked for chlorine level and logged according to manufacture guidelines.The facility failed to ensure the high heat dishwasher was logged daily to ensure it was functioning according to facility policy.The facility failed to ensure employees in the kitchen wore hair nets according to facility policy.The facility failed to ensure employees in the kitchen wore beard guards according to facility policy. These failures could place residents at risk of foodborne illness, and food contamination.During initial tour observation on 2/23/2026 at 11:09 a.m. - 3:26 p.m., the following was identified: the sanitation bucket was not checked for chlorine level and was not logged according to manufacture guidelines. The three compartment sink sanitization level was at 0ppm and then was remade and rechecked at 100ppm.The log for the high heat dishwasher for February 2026 was not tracked with temperature and chemical. The sanitization bucket level was at 0ppm and no log had been created. [NAME] AA was observed walking in the kitchen did not have hair restraint on with short blonde hair approximately five inches in length. [NAME] AA entered the kitchen for she scheduled shift through the dining room entrance without a hair restraint on. Dietary Aid EE in the kitchen did not have a beard guard on with a beard approximately one inch in thick dark black hair hanging from the chin, along the jaw line, and had shorter hair over the lip while washing dishes. During observation, Dietary Aid EE was observed checking the three-compartment sink and was asked to check the sanitation bucket. No long could be observed for the sanitation bucket. During observation Dietary Aid EE ran the high heat dish washer but was unable to show how to properly document the temperature and the chlorine level of the dishwasher. During observation, the dishwasher was within expected range of 120 degrees and 200ppm for chlorine. Record review of a Quality Assurance Monitor 1 Kitchen/Food Service observation with an attachment, dated 8/1/2025, indicated the Dietician found the log was not complete for the sanitation bucket and the cleaning solution was not being changed every 4 hours. Record review of a Quality Assurance Monitor 1 Kitchen/Food Service observation with an attachment, dated 10/7/2025, indicated the Dietician found the log was completed for the sanitation bucket days in advance. During an interview on 2/23/2026 at 4:20 p.m., Dietary Aid EE stated he had forgotten to put on a beard guard. Dietary Aid EE stated residents were at risk for hair getting in food. Dietary Aid EE stated all staff in the kitchen were responsible for wearing a beard guard. Dietary Aid EE stated the kitchen staff were responsible for the sanitization bucket, 3 compartment sink, and logging the temperature and chlorine level of the dishwasher. Dietary Aid EE stated the sanitation bucket was used to clean surfaces and cutting boards and it should have been at 200ppm. Dietary Aid EE stated the three-compartment sink should have been checked and remade to 200ppm chlorine level. Dietary Aid EE stated he was unaware what to do in the situation that the three compartment sink was out of range. Dietary Aid EE was able to demonstrate how to test the three-compartment sink but did not document the out-of-range finding. Dietary Aid EE stated he was unaware when the sanitation bucket had been tested, changed, and remade and was unaware of tracking the sanitation bucket. During an interview on 2/25/2026 at 9:53 a.m., the sister facility Dietary Manager X said she was unaware of the sanitation bucket not being logged. Dietary Manager X said they should be tracking the bucket, three compartment sink, and the dishwasher to ensure everything was being cleaned. Dietary Manager X said the staff inside the kitchen were supposed to wear a hairnet and beard guards at all times. Dietary Manager X said kitchen sanitation was important, so residents did not get sick. Dietary Manager X said kitchen sanitation monitoring was her responsibility when she entered the facility after state survey (continued on next page)

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	675808	A. Building B. Wing	02/27/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intervention. During an interview on 2/27/2026 at 2:23 p.m., [NAME] AA state she should had been wearing a hair net when she entered the kitchen on 2/23/2026 at the noon mealtime. [NAME] AA stated logging the dishwasher temperature was to ensure functioning of the dishwasher. [NAME] AA stated the three compartment sink and sanitizer bucket were supposed to be tested with test trips and be within manufacturer's guidelines or remade. [NAME] AA stated the sanitizer level was to prevent food born illness or illness from too high of chemical level. During an interview on 2/27/2026 at 2:33 p.m., the RNC said she expected the kitchen to follow the FDA guidelines to clean to prevent food borne illness from cross contamination. The RNC said the Dietary Manager was responsible for the dietary department. During an interview on 2/27/2026 at 3:05 p.m., the Administrator said the Dietary Manager was responsible for ensuring the sanitation bucket, three compartment sink and dishwasher were being tested and followed manufacturer guidelines and hairnets, and beard guards were to be worn to prevent food prevent borne illness and hair in the food. Record review of an, undated, Safety and Sanitation Policy revealed food & nutrition services employees shall perform job responsibilities in a safe and sanitary manner. Record review of FDA guidelines accessed at https://www.fda.gov/media/164194/download?attachment on 3/04/2026 indicated:Chapter 4. Equipment, Utensils, and Linens Multiuse 4-101.11Characteristics. Multiuse equipment is subject to deterioration because of its nature, i.e., intended use over an extended period of time. Certain materials allow harmful chemicals to be transferred to the food being prepared which could lead to foodborne illness. In addition, some materials can affect the taste of the food being prepared. Surfaces that are unable to be routinely cleaned and sanitized because of the materials used could harbor foodborne pathogens. Deterioration of the surfaces of equipment such as pitting may inhibit adequate cleaning of the surfaces of equipment, so that food prepared on or in the equipment becomes contaminated. Inability to effectively wash, rinse and sanitize the surfaces of food equipment may lead to the buildup of pathogenic organisms transmissible through food. Studies regarding the rigor required to remove biofilms from smooth surfaces highlight the need for materials of optimal quality in multiuse equipment. Cleanability 4-202.11Food-Contact Surfaces. The purpose of the requirements for multiuse food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning. Food contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts. The requirement for easy disassembly recognizes the reluctance of food employees to disassemble and clean equipment if the task is difficult or requires the use of special, complicated tools. 4-603.16 Rinsing Procedures. Manual warewashing must include:Washing with detergent,Rinsing with clean water to remove detergent and debris, and Sanitizing at the correct concentration and contact time. Failure to properly rinse may reduce sanitizer effectiveness and allow chemical or microbial contamination to remain on food contact surfaces. Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the SANITIZING solution shall be accurately determined by using a test kit or other device. Hair Restraints Consumers are particularly sensitive to food contaminated by hair. Hair can be both a direct and indirect vehicle of contamination. Food employees may contaminate their hands when they touch their hair. A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair Record review of the facility's, undated, Hair Restraints Policy revealed food employees shall wear hair restraints such as hats, hair covering or nets, beard restraints, and clothing that covers body hair. That are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.

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	675808	A. Building B. Wing	02/27/2026

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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** Based on observation, interview, and record review 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 4 of 6 residents (Residents #40, # 100, #56, and #31) reviewed for infection control. 1.The facility did not ensure EBP was put in place for Resident #40. 2.The facility did not ensure CNA B cleaned Resident #100 peri-anal area before placing a clean brief underneath her. 3.The facility failed to ensure CNA M thoroughly cleaned the peri area, changed gloves, and used hand hygiene before going from dirty to clean while providing incontinent care to Resident #56. 4.The facility failed to ensure CNA R did not wear dirty PPE into resident #31's room on 02/24/26. These failures could place any resident at the facility at risk for cross-contamination and the spread of infection.Findings include: 1. Record review of Resident #40's face sheet, dated 02/27/26, reflected Resident #40 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of Resident #40's annual assessment, dated 01/16/26, reflected Resident #40 made herself understood, and understood others. Resident #40's BIMS score was 2, which reflected her cognition was severely impaired. Resident #40 had an open lesion other than ulcers, rashes or cuts. Record review of Resident #40's, undated, comprehensive care plan, reflected Resident #40 had an actual impairment to skin integrity. The care plan interventions included administer treatments as ordered. Record review of Resident #40's physician order summary report, dated 02/27/26, reflected an active physician's order to apply vitamin A&D ointment BID and PRN every day to the left upper face, with a start date 02/26/26. The physician order summary report did not address EBP. During an observation on 02/23/26 at 2:06 p.m., revealed no enhanced barrier precautions in place outside of her room including the signage to alert staff and others of the precautions needed with the care needs of Resident #40. During an interview on 02/24/26 at 4:08 p.m., LVN A stated she provided wound care to Resident #40 on 02/23/26 and 02/24/26. LVN A stated she was told by ADON O she did not have to wear PPE while providing wound care to Resident #40. LVN A stated she thought Resident #40 should be on EBP because her wound was opened. LVN A stated it was important to ensure infection control practices were followed to prevent the spread of infection. During an interview on 02/27/26 at 2:50 p.m., ADON O stated when a resident was on EBP there was a blue dot on the name plate outside the door. ADON O stated she thought Resident #40 did not have to be on EBP because her wound did not require dressing. After stating the wound was opened, ADON O stated she should have been on EBP which meant the nurse required a gown and gloves when providing wound care. ADON O stated ADON LL was responsible for monitoring and overseeing infection control, but she was currently out due to illness. ADON O stated it was important to ensure infection control practices because you did not want to introduce any more risk for infection. During an interview on 02/27/26 at 4:34 p.m., the Administrator stated chronic open wounds required (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EBP. The Administrator stated in the absence of the DON, the ADONs were responsible for ensuring Resident #40 was on EBP. The Administrator stated it was important to ensure infection control practices to minimize the potential transfer of germs and colonized MDROs. 2. Record review of Resident #100's face sheet, dated 02/27/26, reflected Resident #100 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included non-traumatic intracranial hemorrhage (a life threatening, sudden bleeding into the brain) and need for assistance with personal care. Record review of Resident #100's quarterly MDS assessment, dated 12/30/25, reflected the resident made herself understood and understood others. Resident #100 had a BIMS score of 6, which reflected her cognition was severely impaired. Resident #100 was dependent with toileting. Record review of Resident #100's, undated, comprehensive care plan reflected Resident #100 had actual bowel/bladder incontinence related to dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), activity intolerance, confusion, history of UTI (burning with urination), and impaired mobility. The care plan interventions included check as required for incontinence, wash, rinse and dry perineum. During an observation on 02/24/26 at 11:10 a.m., CNA B and CNA M provided incontinent care to Resident #100. CNA B and CNA M performed hand hygiene and put on gloves. CNA B and CNA M transferred Resident #100 from the shower chair to the bed using the Hoyer lift. CNA B rolled Resident #100 to her right side and wiped her buttocks with peri wash and a washcloth. CNA B was about to place a clean brief under Resident #100 until the state surveyor intervened and told her to wipe her buttocks again. CNA B grabbed a wipe and sprayed peri-wash on it and wiped her buttocks twice using two different wipes. There was stool observed on both wipes. CNA B continued peri care. During an interview on 02/24/26 at 4:26 p.m., CNA B stated she should have wiped Resident #100's peri-anal area until she was cleaned. CNA B stated she would have continued peri-care if the state surveyor did not intervene because she thought Resident #100 was cleaned. CNA B stated she was checked off for incontinent care. CNA B stated it was important to ensure the resident was cleaned prior to placing a clean brief under her to prevent UTI or skin breakdown. During an interview on 02/27/26 at 2:50 p.m., ADON O stated CNA B should have wiped Resident #100's peri-anal area until she did not see any stool. ADON O stated she monitored by skill check offs and if there was an area of concern, verbal in-service would be conducted, and she would have the staff repeat the skill on a random day. ADON O stated she had not had any issues with CNA B providing incontinent care. ADON O stated it was important to ensure the resident was cleaned prior to placing a clean brief under her to prevent skin breakdown and for self-esteem appearance. During an interview on 02/27/26 at 4:34 p.m., the Administrator stated CNA B should have completely cleaned Resident #100 peri-anal area and ensured there was no evidence of stool. The Administrator stated in the absence of the DON, the ADONs were responsible for monitoring and overseeing for compliance. The Administrator stated it was important to ensure the resident was cleaned prior to placing a clean brief under her to prevent skin breakdown. Record review of peri care competency checkoff reflected CNA B had completed her training for peri-care on 12/08/25. (continued on next page)

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	675808	A. Building B. Wing	02/27/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #56's face sheet, dated 02/25/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #56 had diagnoses which included malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets), depression (sadness), hypertension (high blood pressure), and UTI (an infection in your urinary system). Record review of Resident 56's quarterly MDS assessment, dated 01/08/26, indicated Resident #56 was understood and was understood by others. Resident #56 had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #56 required assistance with her ADL's which included toileting. Resident #56 was incontinent of bowel and bladder. Record review of Resident #56's comprehensive care plan, dated 04/22/23, indicated Resident #56 had an ADL Self Care Performance Deficit related to muscle weakness, unsteady gait, dementia, malnutrition, shortness of breath at times and muscle wasting. The intervention was for staff to help with ADLs. During an observation on 02/23/26 at 2:01 p.m., CNA M was providing incontinent care to Resident #56. CNA M explained what she was going to do and pulled the curtain. She wiped her genital area, then turned her on her left side while touching her shoulder and side with the same dirty gloves on. She proceeded to wipe her buttocks and only wiped the center of her buttock which had a smear of stool. She then grabbed a clean brief without performing hand hygiene or applying new gloves. CNA M applied the resident's brief, adjusted her clothes, pulled up her covers, and touched Resident #56's phone with the same dirty gloves in which she had provided peri care. She then gathered her equipment, removed her gloves, and exited. CNA M did hand hygiene in the hallway. During an interview on 02/23/26 at 3:44 p.m., CNA M said she was supposed to do hand hygiene before applying new gloves, and in between dirty to clean. She said she did not wipe or do hand hygiene correctly which could lead to cross contamination. 4. During an observation and interview on 02/23/26 at 4:04 p.m., CNA R exited Resident #31's room who was on EBP for wounds wearing a gown and gloves. CNA R took off her gloves in the hallway and did hand hygiene but did not remove her gown. CNA R entered Resident #31's room to answer her call light and walked to her bed and talked with her. As CNA R was exiting Resident #31's room, she saw the state surveyor and said, Oh my goodness, I forgot to take off my gown. CNA R said she forgot to take off her PPE (gown and gloves) when leaving Resident #31's room and before entering Resident #31's room. She said she was supposed to take off the gown and gloves before leaving the room, but she was in a hurry and forgot. She said she knew it was an infection control issue. During an interview on 02/26/26 at 10:55 a.m., LVN A said she expected the CNAs to perform incontinent care the proper way. She said she expected them to do hand hygiene from dirty to clean and change their gloves. She said failure to change gloves and perform hand hygiene could cause infection control issues. During an interview on 02/27/26 at 3:15 p.m., ADON O said she expected incontinent care to be done correctly. The ADON said she expected the CNAs to wipe front to back, perform hand hygiene before and after providing incontinent care, change their gloves when going from dirty to clean, and in between glove changes. She said they did skill checkoffs yearly and as needed. She said the administration nurses were responsible for training the CNAs. ADON O said staff should not be in the hallway with gowns or gloves on. She said staff should take off their PPE (gown and gloves) before (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	exiting the room and hand hygiene. ADON O said not performing incontinent care correctly or hand hygiene or removing PPE (gown and gloves) correctly could lead to infection control issues. During an interview on 02/27/26 at 4:11 p.m., the Administrator said he expected staff to perform incontinent care and hand hygiene properly. He said he was not sure how often they did skill checkoffs. He said staff should remove PPE (gown and gloves) before exiting a resident's room. He said they should not wear PPE (gown and gloves) in the hallway. He said the DON was the overseer of infection control. He said if staff were not removing PPE properly, performing hand hygiene or incontinent care correctly it could lead to infection control issues. Record review of the facility's policy titled, Hand Hygiene, revised 10/2022, indicated Policy: It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. Purpose: Hand hygiene is one of the most effective measures to prevent the spread of infection. Studies show that effective hand decontamination can significantly reduce the rate of healthcare associated infection. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors. Record review of the facility's policy titled, Incontinence, dated 05/2023, indicated Policy: A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Purpose: 1.Each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible. Intervention: provide incontinence care. Record review of the facility's policy titled, IPCP Standard and Transmission-Based Precautions, reviewed 10/2022 reflected, .It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. 3. Enhanced Barrier Precautions: expand the use of PPE and refer to the use of gown and globes during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing them indirectly transferred to residents or from resident-to-resident (e.g., residents with wounds.) .

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	675808	A. Building B. Wing	02/27/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a safe, clean, and comfortable environment for residents, staff and the public for 3 of 3 residents (Residents #17, 61, and 52) reviewed for environment . The facility failed to ensure adequate lighting along the exterior pathway leading to the designated smoking area. This failure place residents at risk of falls. Findings include: During an observation and interview on 2/25/26 at 4:13 PM, Residents #17, #52 and #61 and one staff member, maintenance man E, took part in the scheduled smoke time. Residents #17, #52 and #61 self-propelled via a wheelchair approximately 45 yards from the building to the designated smoking area. Resident #61said the pathway had been dark since January, 2026. Maintenance man E stated it was dark on the pathway outside at night. Maintenance man E stated he brought residents outside at night when designated staff were not available to do so. Maintenance man E said the big light in the gazebo smoking area was good, but the pathway was dark. Maintenance man E said there were solar lamps, but they were old and did not work well. Maintenance man E said he did not tell anyone that it was dark. Maintenance man E said it was important to have a well-lit pathway for the safety of the residents getting to and from the building and gazebo. Interview on 2/25/26 at 6:30 PM with CNA D, who worked on Hall 200 and was designated to take residents out for the 7:00 PM smoke time, stated she took the resident's out and the pathway was dark. CNA D stated there was a definite need for more lighting. CNA D stated she told the ADON at the end of December 2025. During an interview on 2/25/26 at 11:55 AM, Head of Maintenance F stated he was never told the path to the gazebo from the building was too dark at night. Head of Maintenance F pointed out the three solar lights placed along the sidewalk. Head of Maintenance F said the lights were approximately a year old and did not work as good as they did. Head of Maintenance F stated they were damaged by the lawn [NAME]. Head of Maintenance F stated he took residents out to smoke when designated staff were not available, including smoking times at night. Head of Maintenance F stated it was important for the pathway to have good lighting for the residents' safety. During an interview on 2/27/25 at 9:21 AM, ADON N stated residents complained about the poor lighting in mid-January (2026). ADON N stated she told maintenance and administration, and that was when the solar lights were placed along the pathway. ADON N stated there were no more complaints made since then. ADON N stated a well-lit pathway was important for the safety of the residents. In an interview on 2/27/26 at 9:35 AM, the facility administrator stated he was not aware of any issues with poor lighting along the pathway to the smoking area. The Administrator stated the maintenance man was responsible for ensuring a safe environment. The Administrator stated his expectation was for maintenance to promptly remedy any issues. The Administrator stated it was important to have proper lighting along the pathway for the safety of the residents. Record review of the facility's policy and procedure, Safe and Homelike Environment, dated 11/2022, indicated the facility will provide and maintain adequate and comfortable lighting levels in all areas. Safe and Homelike Environment policy defines Adequate lighting as levels of illumination suitable to tasks the resident chooses to perform or the facility staff must perform.

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	675808	A. Building B. Wing	02/27/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the residents have the right to be informed of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers, for 1 of 24 residents (Resident #40) reviewed for consent for antipsychotic medications. The facility did not ensure Resident #40 was prescribed and administered Paxil (antidepressant) without prior consent. This failure could place residents at risk for receiving unnecessary psychotropic medications without informed consent.Findings included: Record review of Resident #40's face sheet, dated 02/27/26, reflected Resident #40 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included major depressive disorder (feeling of sadness and loss of interest). Record review of Resident #40's annual assessment, dated 01/16/26, reflected Resident #40 made herself understood, and understood others. Resident #40's BIMS score was 2, which reflected her cognition was severely impaired. Resident #40 did not have any little interest or pleasure in doing things or feeling down, depressed or hopeless during the 14-day look-back period. Resident #40 received an antidepressant medication during the look-back period. Record review of Resident #40's undated comprehensive care plan, reflected Resident #40 was taking an antidepressant medication related to depression. The care plan interventions included was to give antidepressant medication ordered by the physician and monitor/document side effects and effectiveness. Record review of Resident #40's physician order summary report, dated 02/27/26, reflected an active physician's order for Paroxetine (Paxil) HCl 10 mg; 1 tablet by mouth every day for depression with a start date 04/16/24. Record review of Resident #40's psychoactive medication therapy informed consent form dated 01/11/23 reflected Resident #40's representative did not give the consent for the use of the medication Paroxetine. Record review of the CMA Administered Record dated 02/01/26-01/28/26 reflected Resident #40 received Paroxetine HCl 10 mg: 1 tablet by mouth one time a day for depression for the month of February. During an attempted interview on 02/23/26 at 2:06 p.m., with Resident #40, reflected she was non-interview able. During an interview on 02/27/26 at 8:40 a.m., Clinical Resource GG stated per the consent Resident #40 should not have received the medication. Clinical Resource GG stated nursing would have been responsible for obtaining the consent and if the representative declined consent the nurse should have notified the provider. Clinical Resource GG stated it was important the consent was followed to prevent a resident rights issue. During an interview on 02/27/26 at 8:46 a.m., LVN A stated she was unaware the prior representative had consented Resident #40 not to receive the medication until state surveyor intervention. LVN A stated she did not review the consent because the medication has been given since 2024. LVN A stated this failure was a resident rights issue. An attempted telephone interview on 02/27/26 at 11:52 a.m., with LVN HH, one of the nurses that signed the consent, was unsuccessful. During an interview on 02/27/26 at 2:50 p.m., ADON O stated her and LVN HH obtained the consent from the prior representative. ADON O stated she could not remember who spoke to the representative about the medication. ADON O stated she did not know if it was overlooked about the representative not giving consent. ADON O stated either her or LVN HH should have notified the physician and let him/her know the representative did not consent to the medication and followed through with the physician to get the order discontinued. ADON O stated there was no oversight for monitoring consents. ADON O stated this failure was a medication error, unnecessary medication and resident right issue. During an interview on 02/27/26 at 4:34 p.m., the Administrator stated the medication should never have been given against the representative wishes. The Administrator stated the nurse should have notified the physician to inform them the representative has requested the medication not to be given. The Administrator stated the order should have been discontinued and put on the 24-hr. report and discussed during shift change. The Administrator stated there was a gap in the process and it will be addressed. The Administrator stated this failure was a (continued on next page)

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	675808	A. Building B. Wing	02/27/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident right issue. Record review of the facility's policy titled Chemical Restraints and Psychotropic Medication Management last reviewed on 04/2025, indicated, it is the policy of this facility to ensure that residents are free from chemical restraints. purpose: to ensure residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated and that residents only remain on psychotropic medications when a gradual odes reduction. 8 (f). Informed consent was obtained prior to medication use.

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	675808	A. Building B. Wing	02/27/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident status for 2 of 6 residents (Resident # 38 and Resident # 9) reviewed for MDS assessment accuracy. 1.The facility failed to code Resident #38's hospice accurately. 2.The facility failed to code Resident #9's hospice accurately This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: 1.Record review of Resident #38's face sheet, dated 02/26/26 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included, dementia (the loss of cognitive functioning — thinking, remembering, and reasoning), hypertension (high blood pressure), and syncope and collapse (is a temporary loss of consciousness and collapse caused by a sudden, temporary drop in blood flow to the brain, lasting typically less than two minutes). Record review of Resident 38's quarterly MDS assessment, dated 12/12/25, indicated Resident #38 usually understood and was usually understood by others. Resident #38 BIMs score was 08 indicating he was moderately cognitively impaired. The MDS indicated Resident #38 required maximum assistance with his ADLs and independent with eating The MDS indicated on section J1400 prognosis: (Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months) was answered as 0 indicating no. Record review of Resident #38's care plan dated 10/31/25 indicated Resident #38 had a terminal prognosis and was on hospice service. The intervention was to work cooperatively with the hospice team to ensure the residents' spiritual, emotional, intellectual, physical, and social needs were met. Record review of Resident #38's physician orders dated 10/31/25 indicated an order for {name} hospice. 2. Record review of Resident #9's face sheet, dated 02/27/26, reflected Resident #9 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of Resident #9's quarterly MDS assessment, dated 12/02/25, reflected Resident #9 usually made himself understood and usually understood others. The assessment did not address Resident #9's BIMS score but reflected he had long term and short-term memory problems. The assessment reflected Resident #9 did not have a life expectancy of less than 6 months and received hospice services. Record review of Resident #9's undated comprehensive care plan, reflected Resident #9 had a terminal prognosis and has elected hospice services with a dx of Alzheimer's disease. The care plan interventions included encourage resident to express feelings, listen with non-judgmental acceptance, compassion and work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Record review of the order summary report dated 02/27/26 reflected Resident #9 had an order to admit to hospice with an order date 08/07/25. During an interview and record review on 02/26/26 at 4:26 p.m., MDS Coordinator L stated she was (continued on next page)

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	675808	A. Building B. Wing	02/27/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for the completing of the MDS assessments. After reviewing Resident #38 and #9's MDS assessments, she stated it should have been coded yes, they have a life expectancy of less than 6 months. MDS Coordinator L stated both residents were on hospice services. MDS Coordinator L stated it was an oversight and didn't have a specific reason on why it was not coded. MDS Coordinator L stated it was important to code the MDS assessment correctly for accuracy. During an interview on 02/27/26 at 10:44 a.m., the MDS Resource stated Resident #38 and #9's assessment should be coded yes they have a life expectancy of less than 6 months. The MDS Resource stated she monitored by random audits every 2-3 months. The MDS Resource stated she just took this facility in January 2026. The MDS Resource stated it was important to code the MDS assessment correctly because it reflected their care. During an interview on 02/27/26 at 2:50 p.m., ADON O stated she expected the MDS assessment to be coded correctly to ensure the resident care was reflected. ADON O stated the MDS Coordinators were responsible for the completing of the MDS assessments. During an interview on 02/27/26 at 4:34 p.m., the Administrator stated he expected the MDS to be coded correctly. The Administrator stated the MDS Coordinator was responsible for completing the assessment. The Administrator stated it was important to code the MDS accurately to ensure the residents care was reflected. Record review of the facility's policy titled, Resident Assessment and Associated Processes, revised 12/23, indicated, Policy: It is the policy of this facility that resident's will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessments of each resident, and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified. Procedure: Comprehensive Assessment: includes the completion of the MDS (Minimum Data Set) as well as the CAA (Care Area Assessment) process, followed by development and/or review of the comprehensive care plan. Comprehensive MDS assessments include Admission, Annual, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment. An accurate Comprehensive Assessment will be made of the resident's needs, strengths, goals, life history, and preferences, using the RAI (Resident Assessment Instrument).

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish based on the comprehensive assessment and consistent with the resident's needs and choices for 1 of 2 resident (Resident #100) reviewed for activities of daily living. The facility failed to provide communication assistance to effectively communicate with staff for Resident #100. This failure could place residents at risk for decline and diminishing quality of life.Findings included:Record review of Resident #100's face sheet, dated 02/27/26, reflected Resident #100 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included non-traumatic intracranial hemorrhage (a life threatening, sudden bleeding into the brain). Record review of Resident #100's quarterly MDS assessment, dated 12/30/25, reflected Resident #100 preferred language was Spanish and she needed/wanted an interpreter to communicate with a doctor or health care staff. Resident #100 made herself understood and understood others. Resident #100 had a BIMS score of 6, which reflected her cognition was severely impaired. Resident #100 could repeat 3 words after first attempt. Record review of Resident #100's undated comprehensive care plan, reflected Resident #100 was at risk for communication problem related to hearing deficit and Spanish speaking (understands simple words in English). The care plan interventions included: anticipate, meet needs, provide translator as necessary to communicate with the resident and use of adaptive communication equipment (communication clip board with pictures). Record review of the facility's undated document titled, Nonverbal reflected there was no residents that required communication devices and speak in non-dominant language. During an interview and observation on 02/23/26 at 1:36 p.m., Resident #100 was lying in bed. The surveyor began talking to Resident #100 in English and asked if her needs were being met. Resident #100 replied with a smile. There was no communication board observed in her room. During an interview and observation on 02/24/26 at 9:30 a.m., Resident #100 was lying in bed. There was no communication board observed in room.During a telephone interview on 02/24/26 at 10:13 a.m., Resident #100's family member stated Resident #100 preferred language was Spanish. Resident #100's family member stated she should have a communication board in her room. Resident #100's stated this has been an issue in the past with staff/physicians not communicating effectively. During an observation on 02/24/26 at 11:10 a.m., CNA B verbally asked Resident #100 in English was she ok when she rolled her from her side to her back while providing incontinent care. Resident #100 did not respond to CNA B question. During an observation on 02/25/26 at 8:58 a.m., Resident #100 was lying in bed. There was no communication board observed in room.During an interview on 02/26/26 at 10:21 a.m., CNA C stated when she provided care to Resident #100 using hand gestures to communicate. CNA C stated it was not as effective as it could be with a translator, whiteboard or an app on the phone. CNA C stated she was unaware Resident #100 was supposed to have a communication board. CNA C stated it was important to ensure effective communication to provide the best care and to make Resident #100 understand her rights. During an interview on 02/26/26 at 10:32 a.m., LVN A stated Resident #100 understood simple words in English. LVN A stated she was bilingual and had no issues with communicating with Resident #100. LVN A stated she was not aware Resident #100 was supposed to have a communication board. LVN A stated a communication board would be effective for staff that only spoke English to meet Resident #100 needs. LVN A stated it was important to effectively communicate with Resident #100 to ensure her wants/needs were met and if there was a problem she could communicate with staff. During an interview on 02/26/26 at 11:26 a.m., LVN A came and told the state surveyor the communication board was over her bed in the room she was in prior. During a telephone interview on 02/26/26 at 12:12 p.m., CNA B stated Resident #100 understood very little English, but you must repeat and talk slow. CNA B stated she was (continued on next page)

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	675808	A. Building B. Wing	02/27/2026

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unaware of Resident #100 having a communication board, but she knew a translator was available if needed. CNA B stated a communication board would be more effective to ensure Resident #100's needs were being met. During an interview and record review on 02/27/26 at 2:50 p.m., ADON O stated she was not aware of Resident #100 having a communication board until state surveyor intervention. After reviewing Resident #100's care plan, ADON O stated she should have a communication clip board. ADON O stated to her knowledge, no one had complained to her about not being able to effectively communicate with Resident #100. ADON O stated she has only had basic conversations with Resident #100 and she answered appropriately. ADON O stated the conversations were not as depth as the staff that provided care to her. ADON O stated the only resources she knew the facility had to help staff communicate with Resident #100 was translator and staff that spoke fluent Spanish. In absence of the DON, she was responsible for monitoring and ensuring residents had needed equipment by random rounds. ADON O stated it was important to ensure Resident #100 was able to communicate effectively to make sure her needs were met. During an interview on 02/26/26 at 4:34 p.m., the Administrator stated he was unaware of Resident #100 communication board until state surveyor intervention. The Administrator stated that he and Resident #100 have had minimal conversations and she was able to express her needs. The Administrator stated if the communication board was available, it would help Resident #100 better to facilitate her needs. The Administrator stated it was important to ensure Resident #100 was able to communicate effectively to make sure her needs were met. Record review of facility's policy titled Resident Rights and Responsibilities, revised 12/2023 reflected. it is the policy of this facility to inform the resident both orally and in writing of their rights as a resident as well as the rules and regulations governing the resident's conduct and responsibilities during their stay in the facility. 4. The facility will inform the resident of their rights and responsibilities in a language that is both clear and understandable to the resident.Should the resident's knowledge of English be inadequate for understanding such rights and responsibilities, their rights and responsibilities will be explained in the language that is familiar to the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living, received the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 1 of 24 (Residents #43) residents reviewed for ADL care. The facility did not ensure Resident #43's fingernails were trimmed and free from a black colored substance routinely. These failures could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem.Findings included: Record review of Resident #43's face sheet, dated 02/27/26, reflected Resident #43 was a [AGE] year-old female, admitted to the facility on [DATE] which diagnosis which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #43's quarterly MDS assessment, dated 12/02/25, reflected Resident #43 made herself understood and understood others. Resident #43's had a BIMS score of 12, which reflected her cognition was moderately impaired. Resident #43's was depended with personal hygiene. Record review of Resident #43's undated comprehensive care plan reflected Resident #43 had an ADL Self Care Performance Deficit related to muscle weakness and unsteady gait. The care plan interventions included encourage to discuss feelings about self-care deficit. During an observation and interview on 02/23/26 at 1:24 p.m., Resident #43 was lying in bed when the state surveyor noted fingernails on both hands were jagged and appeared to be approximately 0.25-0.50 cm long with a thick line of black substance under them. Resident #40 stated she would like them cut and clean. Resident #43 stated it made her feel dirty. During an observation on 02/24/26 at 9:16 a.m., Resident #43 was lying in bed when the state surveyor noted fingernails on both hands were jagged and appeared to be approximately 0.25-0.50 cm long with a thick line of black substance under them. During an interview on 02/24/26 at 4:26 p.m., CNA B stated she was responsible for cleaning Resident #43's nails. CNA B stated the charge nurse had trimmed her nails because she was diabetic. CNA B stated nail care should be done at least three times a week and PRN. CNA B stated it was important for the residents to have their nails cleaned and trimmed to prevent the spread of infection. During an interview on 02/26/26 at 10:32 a.m., LVN A stated CNAs were responsible for cleaning Resident #43's nails but she was responsible for clipping her nails because she was a diabetic. LVN A stated Resident #43's nails should not be jagged or too long because that could interfere with her ADLs. LVN A stated usually Resident #43 would tell her when she wanted her nails trimmed. LVN A stated the charge nurses were responsible for monitoring by observations during rounds or reviewing shower sheets daily. LVN A stated it was important to ensure residents' nails were cleaned and trimmed to prevent spread of infection. During an interview on 02/27/26 at 2:50 p.m., ADON O stated nails should be cleaned and trimmed as needed and on their shower's days. ADON O stated the CNAs were responsible for cleaning and the nurses were responsible for trimming. ADON O stated the nurses should be ensuing the nails done by following up with the CNA, reviewing the shower sheets and spot checks for compliance. ADON O stated she monitored by random spot checks. ADON O stated she had not noticed any issues in the past. ADON O stated this issue was an infection, self-esteem and socialization issue. During an interview on 02/26/26 at 4:34 p.m., the Administrator stated he expected nails to be cleaned and trimmed on their shower days and as needed. The Administrator stated the ADONs were responsible for monitoring and overseeing. The Administrator stated this was an infection control issue. Record review of facility's policy titled Nail Care, revised 05/2007 reflected. It is the policy of this facility to promote cleanliness, safety, and neat appearance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare	250 W British Flying School Blvd Terrell, TX 75160

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 2 (Resident #3) residents reviewed for quality of care. The facility failed to ensure LVN T did Resident #3's left inferior lower lateral buttock and left proximal posterior thigh wound treatment as ordered on 02/23/26 and 02/24/26. This failure could result in residents with wounds not having their treatments performed as ordered, wounds becoming infected, and decreased wound healing. Findings Included: Record review of Resident #3's face sheet, dated 02/27/26, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included pressure ulcer to sacral area (a localized injury to the skin and underlying tissue over the tailbone, caused by unrelieved pressure, friction, or shear, often resulting from prolonged immobility), diabetes(is a chronic condition that happens when you have persistently high blood sugar levels), high blood pressure, and dementia(diseases that affect memory, thinking, and the ability to perform daily activities). Record review of Resident #3's quarterly MDS assessment, dated 01/26/25, indicated Resident #3 understood and was understood by others. Resident #3's BIMS score was 14, which meant she was cognitively intact. The MDS indicated Resident #3 required help with toileting, bed mobility, dressing, transfers, and personal hygiene, and was independent with eating. The MDS indicated Resident #3 had an open area that required treatment. Record review of Resident #3's care plan dated 02/20/26 indicated Resident #3 had a pressure ulcer of the left inferior lower lateral buttock and to the left proximal posterior thigh, both non pressure related to incontinence and immobility. The interventions was for staff to administer treatments as ordered and monitor for effectiveness. Record review of Resident #3's physician's orders dated 02/20/26 indicated non pressure of the left inferior lower lateral buttock, clean with normal saline, pat dry, apply anasept collagen sheets and cover with gauze island border dressing daily and as needed. Record review of Resident #3's physician's orders dated 02/20/26, indicated, non-pressure wound of the left proximal posterior thigh, clean with normal saline, pat dry, apply anasept collagen sheets and cover with gauze island border dressing daily and as needed. Record review of Resident #3's Treatment Administration Record dated 02/24/26 indicated on 02/23/26 and 02/24/26 LVN T completed the following treatments:* non-pressure wound of the of the left inferior lower lateral buttock, clean with normal saline, pat dry, apply anasept collagen sheets and cover with gauze island border dressing daily and as needed. * non-pressure wound of the left proximal posterior thigh, clean with normal saline, pat dry, apply anasept collagen sheets and cover with gauze island border dressing daily and as needed. Record review of the wound care note dated 2/19/26 indicated Resident #3 had a non-pressure wound of the left inferior lower lateral buttock, measuring 1.1 x 0.9 x 0.2 cm. Record review of the wound care note dated 02/26/26 indicated Resident #3 had a non-pressure wound of the left inferior lower lateral buttock, measuring 0.7 x 0.7 x 0.1 cm. Record review of the wound care note dated 2/19/26 indicated Resident #3 had a non-pressure wound of the left proximal posterior thigh measuring 2.4 x 6.1 x 0.1 cm(centimeters). Record review of the wound care note dated 02/26/26 indicated Resident #3 had a non-pressure wound of the left proximal posterior thigh measuring 1.9 x 4.1 x 0.1cm. During an interview on 02/24/26 at 10:42 a.m., LVN T said Resident #3's wound treatment was at night. During an observation and interview on 02/24/26 at 9:25 p.m., Resident #3 was in bed. LVN H was on duty and said Resident #3's dressing change was done on day shift. LVN H and the state surveyor went to look at Resident #3's buttock and saw a dressing dated 02/22/26 by RN V. LVN H said she would change the dressing. LVN H said failure to do treatments as ordered could lead to infection or decline in wounds. Resident #3 said the nurses usually did her treatment, but she knew it had not been done today. During an interview and observation on 02/25/26 at 4:30 p.m., RN V verified his initial on the dressing for Resident #3 and said he changed it on Sunday (02/22/26) and he was off on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monday (02/23/26)and Tuesday (02/24/26). RN V removed Resident #3's dressing and area to left thigh and left buttock appeared to be clean without any signs or symptoms of infection. During an interview on 02/25/26 at 4:55 p.m., LVN T said Resident #3's treatment was due on day shift. She said when the state surveyor asked her on Tuesday (02/24/26) at 10:42 am, she either misspoke or did not understand what the state surveyor was asking. She said she did not do Resident #3's dressing change on 2/23/26 because when Resident #3 returned from dialysis it was late and she was about to pass supper trays. She said she guessed she marked that she had done her treatment in error on the treatment administration records. She said on Tuesday (02/24/26) she had received in report that LVN H had done Resident #3's treatment about 6am therefore she did not see a reason to turn around and do her treatment again, so she marked it as being completed on the treatment administration records. She said failure to do Resident #3's treatment could slow the healing process or cause infection. During an interview on 02/27/26 at 3:25 p.m., ADON O said she expected the nurses to do treatments as ordered. She said she was the overseer of wounds. She said she looked at all wounds every Thursday with the wound care physician and as needed. She said she also monitored it by looking at the order summary report on their internal system and it would show if anything was not completed on the prior day. She said she did not recall seeing any treatments not done for Resident #3. She said the importance of following the wound care physician's orders was for wound healing and prevention of infection. During an interview on 02/26/26 at 4:11 p.m., the Administrator said the charge nurses were responsible for the wound treatments. He said they had a wound care physician who made rounds weekly. He said ADON O was the overseer of wounds. He said he was not sure what could happen if the residents did not have their treatment done for 2 days. He said it could affect the skin. Record review of the facility's policy titled Wound Care and Treatment Guidelines, undated, indicated, Policy: It is the policy of this facility to provide excellent wound care to promote healing. Procedures: #1. An assessment should be done on all wounds requiring treatment. This should include measurement and a description.9. The dressing should be labeled with the nurse's initials, date, and time.11. There must be a specific order for the treatment.12. Documentation of the treatment should be done immediately after the treatment.13. The care

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	675808	A. Building B. Wing	02/27/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 2 of 24 residents (Residents #100 and #56) reviewed for incontinent care. 1. The facility did not ensure CNA B cleaned Resident #100 peri-anal area before placing a clean brief underneath her. 2. The facility failed to ensure CNA M thoroughly cleaned the peri area, changed gloves, and used hand hygiene before going from dirty to clean while providing incontinent care to Resident #56. These failures could place residents at risk for skin breakdown, urinary tract infections and a decreased quality of life. Findings included: 1. Record review of Resident #100's face sheet, dated 02/27/26, reflected Resident #100 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included non-traumatic intracranial hemorrhage (a life threatening, sudden bleeding into the brain) and need for assistance with personal care. Record review of Resident #100's quarterly MDS assessment, dated 12/30/25, reflected made herself understood and understood others. Resident #100 had a BIMS score of 6, which reflected her cognition was severely impaired. Resident #100 was dependent with toileting. Record review of Resident #100's undated comprehensive care plan, reflected Resident #100 had actual bowel/bladder incontinence related to dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), activity intolerance, confusion, history of UTI, and impaired mobility. The care plan interventions included check as required for incontinence, wash, rinse and dry perineum. During an observation on 02/24/26 at 11:10 a.m., CNA B and CNA M provided incontinent care to Resident #100. CNA B and CNA M performed hand hygiene and put on gloves. CNA B and CNA M transferred Resident #100 from the shower chair to the bed using the Hoyer lift. CNA B rolled Resident #100 to her right side and wiped her buttocks with peri wash and a washcloth. CNA B was about to place a clean brief under Resident #100 until the state surveyor intervened and told her to wipe her buttocks again. CNA B grabbed a wipe and sprayed peri-wash on it and wiped her buttocks twice using two different wipes. There was stool observed on both wipes. CNA B continued peri care. During an interview on 02/24/26 at 4:26 p.m., CNA B stated she should have wiped Resident #100's peri-anal area until she was cleaned. CNA B stated she would have continued peri-care if the state surveyor did not intervene because she thought Resident #100 was cleaned. CNA B stated she had been checked off for incontinent care. CNA B stated it was important to ensure the resident was cleaned prior to placing a clean brief under her to prevent UTI or skin breakdown. During an interview on 02/27/26 at 2:50 p.m., ADON O stated CNA B should have wiped Resident #100's peri-anal area until she did not see any stool. ADON O stated she monitored by skill check offs and if there was an area of concern, verbal in-service would be conducted, and she would have the staff repeat the skill on a random day. ADON O stated she has not had any issues with CNA B providing incontinent care. ADON O stated it was important to ensure the resident was cleaned prior to placing a clean brief under her to prevent skin breakdown and for self-esteem appearance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675808	A. Building B. Wing	02/27/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/26 at 4:34 p.m., the Administrator stated CNA B should have completely clean Resident #100 peri-anal area and ensure there was no evidence of stool. The Administrator stated that in absence of the DON, the ADONs were responsible for monitoring and overseeing for compliance. The Administrator stated it was important to ensure the resident was cleaned prior to placing a clean brief under her to prevent skin breakdown. Record review of peri care competency checkoff reflected CNA B had completed her training for peri-care on 12/08/25. 2. Record review of Resident #56's face sheet, dated 02/25/26, indicated she was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets), depression (sadness), hypertension (high blood pressure), and UTI (.an infection in your urinary system). Record review of Resident 56's quarterly MDS assessment, dated 01/08/26, indicated Resident #56 was understood and was understood by others. The MDS assessment indicated he had a BIMS score of 10 indicating moderate cognitive impairment. The MDS indicated she required assistance with her ADL's including toileting. The MDS indicated she was incontinent of bowel and bladder. Record review of Resident #56's comprehensive care plan, dated 04/22/23, indicated Resident #56 had ADL Self Care Performance Deficit related to muscle weakness, unsteady gait, dementia, malnutrition, shortness of breath at times and muscle wasting. The intervention was for staff to help with ADLs. Record review of Resident #56's comprehensive care plan, dated 04/22/23, indicated Resident #56 had potential for bladder incontinence related to overactive bladder. The intervention was for staff to check as required for incontinence. Wash, rinse and dry perineum, and monitor/document for signs or symptoms of UTI (pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns). Record review of Resident #56's lab report dated 12/22/25 indicated she had a UTI with Pseudomonas aeruginosa (can cause infections in the blood, lungs (pneumonia), urinary tract, or other parts of the body). Record review of Resident #56's physician orders dated 12/22/25 indicated, Meropenem Solution Reconstituted 1 gram X 7days for UTI. During an observation on 02/23/26 at 2:01 p.m., CNA M was providing incontinent care to Resident #56. CNA M explained what she was going to do and pulled the curtain. She wiped her genital area, then turned her on her left side while touching her shoulder and side with the same dirty gloves on. She proceeded to wipe her buttocks and only wiped the center of her buttock which had a smear of bowel. She then grabbed a clen brief without hand hygiene or applying new gloves. CNA M applied her brief, adjusted her clothes, pulled up her covers, and touched Resident #56's phone with the same dirty gloves. She then gathered her equipment, removed her gloves, and exited. CNA M did hand hygiene in the hallway. During an interview on 02/23/26 at 3:44 p.m., CNA M said she was supposed to hand hygiene before (continued on next page)

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	675808	A. Building B. Wing	02/27/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	applying new gloves, and in between dirty to clean. She said she did not wipe or do hand hygiene correctly which could lead to cross contamination. During an interview on 02/27/26 at 3:15 p.m., ADON O said she expected incontinent care to be done correctly. ADON O said she expected the CNAs to wipe front to back, perform hand hygiene before and after providing incontinent care, change their gloves when going from dirty to clean, and in between glove changes. She said they did skill checkoffs yearly and as needed. She said the administration nurses were responsible for training the CNAs. ADON O said not performing incontinent care correctly or hand hygiene could lead to infection issues. During an interview on 02/27/26 at 4:11 p.m., the Administrator said he expected staff to perform incontinent care and hand hygiene properly. He said he was not sure how often they did skill checkoffs. He said the DON was the overseer of infection control. He said if staff were not performing hand hygiene or incontinent care correctly it could lead to infection. Record review of the facility's policy titled, Hand Hygiene, revised 10/2022, indicated, Policy: It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. Purpose: Hand hygiene is one of the most effective measures to prevent the spread of infection. Studies show that effective hand decontamination can significantly reduce the rate of healthcare associated infection. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors. Record review of the facility's policy titled, Incontinence, dated 05/2023, indicated, Policy: A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Purpose:1. Each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible. Intervention: provide incontinence car

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	675808	A. Building B. Wing	02/27/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and to dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 2 (Resident #6) residents reviewed for enteral nutrition. The facility failed to follow physician orders for Resident #6's enteral feeding tube to be administered at 74 ml/hr. This failure could place residents at risk for nutritional deficit.Findings included: Record review of Resident #6 face sheet, dated 02/27/26, reflected Resident #6 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included gastrostomy (device that deliver nutrition, fluids and medication directly to the stomach). Record review of Resident #6's quarterly MDS assessment, dated 12/26/25, reflected Resident #6 rarely/never made himself understood, and rarely/never understood others. The assessment did not address Resident #6's BIMS score but reflected he had long-term and short-term memory problems. Resident #6 had a feeding tube that he received 51% total calories through the feeding tube. Record review of Resident #6's, undated, comprehensive care plan reflected Resident #6 required tube feeding (Jevity 1.5 at 75 ml/hr) related to swallowing problem. The care plan interventions included check for tube placement and gastric contents/residual volume per facility protocol. Record review of Resident #6's physician order summary report, dated 02/27/26, reflected an active physician order for Jevity (nutrition supplement) 1.5 at 74 ml/hr times 20 hours with a start date 02/24/26. During an observation on 02/24/26 at 9:10 a.m., Resident #6 was lying in bed. The feeding tube machine reflected Jevity 1.5 at a continuous rate of 67 ml/hr. During an observation and interview on 02/24/26 at 9:25 a.m., LVN T was standing at the nursing station when the state surveyor asked her to come and confirm the rate for Resident #6's feeding. LVN T went into the room with the state surveyor and stated the rate was at 67 ml/hr. LVN T stated she would need to review his chart first to see if that was correct. After reviewing the chart, LVN T stated the rate should be 74 ml/hr. LVN T stated LVN P received a new order on 02/24/26 to change the rate from 67 ml/hr to 74 ml/hr. LVN T stated staff were made aware if there was an order change by receiving verbal report and review of the 24-hour report. LVN T stated it was important to ensure the resident's feeding was administered according to physician orders to prevent weight loss. During a telephone interview on 02/26/26 at 8:51 a.m., LVN P stated the charge nurses were responsible for verifying each order, every shift, every time the resident's feeding was administered. LVN P stated she received a new order on 02/24/26 from the 24-hour report and changed the order in PCC but forgot to change the settings on the machine. LVN P stated it was important for the residents to receive the correct rate to ensure the residents received the correct nutrition and hydration. During an interview on 02/27/26 at 2:50 p.m., ADON O stated she expected the nurses to follow the physician order. ADON O stated this was her first time hearing of this incident occurred. ADON O stated there was not an oversight to monitor for compliance related to tube feeding and ensuring the correct rate. ADON O stated it was important to ensure the residents received the correct rate because that was their only source of nutrition and to prevent weight loss. During an interview on 02/27/26 at 4:34 p.m., the Administrator stated she expected the nurses to ensure the correct rate was set per the physician order. The Administrator stated the charge nurses were responsible for ensuring the feeding machine was set at the correct rate but in absence of the DON, the ADONs were responsible for monitoring and overseeing feeding tubes. The Administrator stated it was important to ensure the residents receive the correct rate to received the correct amount of nutrition. Record review of the facility's policy titled Enteral Nutrition, revised 05/2007, reflected .it is the policy of this facility to provide enteral nutrition to those residents that cannot or will not take necessary nutrients by mouth due to physical disorders of disease and have a functioning gastrointestinal tract.

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	675808	A. Building B. Wing	02/27/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 5 residents (Residents #85) reviewed for respiratory care. 1. The facility failed to ensure Resident #85's oxygen was set at 2 liters per nasal cannula as ordered on 02/25/26. 2. The facility failed to ensure the suction equipment was maintained in working order on 1 of 1 crash carts. These failures could place residents at risk of developing respiratory complications, managing airway emergencies and a decreased quality of care. Findings include: 1. Record review of Resident #85's face sheet, dated 02/27/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #85 had diagnoses which included Chronic Obstructive Pulmonary Disease also known as COPD (a chronic lung disease that causes inflammation and narrowing of the airways, leading to airflow obstruction), anxiety (a feeling of fear, dread, and uneasiness), dysphagia (difficulty swallowing) and high blood pressure. Record review of Resident #85's admission MDS assessment, dated 01/24/26, indicated Resident #85 usually understood and was rarely understood by others. Resident #85's was severely impaired with daily decision making Resident #85 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and for eating. The MDS during the 7-day look-back period indicated Resident #85 was receiving oxygen. Record review of Resident #85's physician orders, dated 01/26/26, indicated oxygen at 2 liters per minute via nasal cannula continuously for diagnosis of COPD. Record review of Resident #85's care plan, revised date of 02/23/26, indicated she required oxygen for COPD. The intervention was for staff to apply oxygen as ordered. During an observation and attempted interview on 02/24/26 at 9:27 p.m., revealed Resident #85 was in her bed with no oxygen connected to her oxygen concentrator or portable tank. No distress noted. Resident #85 did not answer when asked if she wore oxygen. During an observation and interview on 02/24/26 at 9:31 p.m., revealed CNA Q came into the room to answer Resident #85's call light. CNA B said Resident #85 wore oxygen but could not say why it was not on. During an observation on 02/24/26 at 10:12 p.m., revealed Resident #85 was in bed with oxygen applied at 2 liters. No distress noted or signs of hypoxia noted. During an interview on 02/24/26 at 9:40 p.m., RN G said he was Resident #85's nurse. He said Resident #85 had an order for oxygen at 2 liters continuously. He said he was responsible for ensuring she had on her oxygen as ordered. He said he was aware Resident #85 did not have her oxygen on, but he could not be in two places at once. He said he was in the middle of giving two other residents breathing treatment and when he finished, he would connect Resident #85 to her oxygen. He said failure to apply oxygen even for 20-30 minutes could lead to hypoxia[TF4] (a critical condition where (continued on next page)

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	675808	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare	250 W British Flying School Blvd Terrell, TX 75160

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tissues are deprived of adequate oxygen, leading to symptoms like confusion, rapid breathing, headache, and cyanosis [bluish skin[TF5]]). During an interview on 02/27/26 at 3:25 p.m., ADON O said the nurses were responsible for ensuring oxygen was on as ordered. She said the aides should let the nurse know before they assisted a resident in bed to allow the nurse to assess the resident and apply the oxygen. She said if the resident was on a portable tank, then the aides were to leave the resident on the tank until the nurse could assess and place on the concentrator. She said failure to apply oxygen as ordered could lead to low oxygen levels which could cause respiratory distress. During an interview on 02/27/26 at 4:11 p.m., the Administrator said if a resident had an order for oxygen, it should be applied. He said the nurses were responsible for ensuring the oxygen was set at the ordered rate, and nurse managers were the overseers. He said failure to apply oxygen could lead to low oxygen saturation. 2. During an observation on 2/27/26 at 8:05 a.m., revealed the suction machine on the crash cart located at the central nurse's station did not work when plugged in and turned on. An attempted telephone interview on 2/27/26 at 8:35 a.m. with the night nurse, LVN Q, who signed off checking the crash cart on 2/27/26 was unsuccessful. In an interview on 2/27/26 at 8:05 a.m., ADON O stated night shift was responsible for checking the crash cart each shift and ensuring all medications, supplies, and equipment were current, accounted for, and working. ADON O stated she occasionally checked the cart behind the night nurses to ensure it was done properly. ADON O stated it was important to ensure all equipment on the crash cart worked so that in the event of an emergency, there were no delays with care and optimal care was provided. During an interview with the facility administrator on 2/27/26 at 5:35 p.m., the administrator stated the ADONs were responsible for cart audits. The administrator stated the nurses maintained the cart and went over the check list daily. The administrator said he expected nursing leadership to monitor that process. The administrator stated equipment on the crash cart should work. The administrator stated it was important to deliver timely care in an emergency. Record review of the Crash Cart policy and procedure, dated 10/2013, revealed All equipment will be checked to ensure it is in working order. Record review of the facility's policy titled Oxygen Administration, revised date of March 2019, indicated, Policy: It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained. Purpose: The purpose of the oxygen therapy is to provide sufficient oxygen to the blood stream and tissues.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1 of 1 crash carts (central nurse's station) reviewed for drugs and biologicals. The facility failed to ensure expired medical supplies were not available for resident use on the crash cart. This failure could place residents at risk of reduced germ-killing efficacy, skin irritation, contamination risks, and non-sterile cleaning. Findings include: During an observation on 2/27/26 at 8:05 a.m., the crash cart located at the central nurse's station, revealed there were 86 individual alcohol wipes labeled with an expiration date of 10/3/2024 located in the third from the top drawer of the crash cart. An attempted telephone interview on 2/27/26 at 8:35 a.m. with the night nurse, LVN Q, who signed off checking the crash cart on 2/27/26 was unsuccessful. In an interview on 2/27/26 at 8:05 a.m., ADON O stated night shift was responsible for checking the crash cart each shift and ensuring all medications and supplies were current and accounted for. ADON O stated she occasionally checked the cart behind the night nurses to ensure it was done properly. The ADON O stated it was important to ensure all supplies, medications, and equipment on the crash cart worked so in the event of an emergency, there were no delays with care and optimal care was provided. During an interview with the facility administrator on 2/27/26 at 5:35 p.m., the administrator stated the ADONs and pharmacy technician completed cart audits. The administrator stated the nurses should maintain the cart and go over the check list daily. The administrator said he expected nursing leadership to monitor that process. The administrator stated expired medications or supplies that were not good were not effective. Record review of Medication Access and Storage policy, dated 5/2007 indicated: Procedures: Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exists.

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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. Based on observation, interview and record review the facility failed to ensure mediations were secured in a locked medication carts to prevent unauthorized access in 2 of 7 medication carts (300 Hall nurse medication cart and 400 Hall nurse medication cart) reviewed for medication storage. The facility failed to ensure the medication carts were locked and not available for unauthorized access. This failure could place residents at risk for unauthorized access to medications, medical errors, harm to cognitively impaired residents, medication tampering, controlled substance diversion, and regulatory non-compliance.Findings include: During an observation on 2/24/26 at 9:31 p.m., revealed the 300 Hall nurse medication cart was unlocked near the nurse's station with no nurse present. In an observation on 2/24/26 at 9:44 p.m., revealed the 400 Hall nurse medication cart was unlocked near the nurse's station with no nurse present. During an interview on 2/24/26 at 9:36 p.m., LVN H stated she left in a rush to assist a resident. LVN H stated she left the 300 Hall nurse medication cart unlocked. LVN H stated it was important to keep the medication cart locked for resident safety and to prevent drug diversion. In an interview on 2/24/26 at 9:47 p.m., RN G stated he thought he locked the 400 Hall nurse medication cart before walking away. RN G stated he went to check on a resident. RN G stated it was important to ensure the medication carts were locked for the residents' safety and to prevent drug diversion. In an interview on 2/27/26 at 3:57 p.m., ADON O stated whoever was using the cart was responsible for keeping it locked, and if they were away from it, it should be locked. ADON O stated it was important to keep the medication carts locked to prevent residents from getting into the cart, and for resident safety. In an interview on 2/27/26 at 5:35 p.m., the facility administrator said he expected the cart to always be locked when not in use, and when the nurse stepped away. It was important to keep the carts locked due to the various things that were in the carts such as medications. It is for the residents' safety. Record review of the facility's Medication Access and Storage policy, dated 5/2007, reflected medication rooms, carts and medication supplies are locked or attended by persons with authorized access.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to collaborate with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services, and communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family for 1 of 1 resident (Resident #9) reviewed for hospice services. The facility did not ensure Resident #9's hospice records were a part of their records in the facility. This deficient practice could place residents at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings include:Record review of Resident #9's face sheet, dated 02/27/26, reflected Resident #9 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions).Record review of Resident #9's quarterly MDS assessment, dated 12/02/25, reflected Resident #9 usually made herself understood and usually understood others. The assessment did not address Resident #9's BIMS score but reflected he had long term and short-term memory problems. The assessment reflected Resident #14 did not have a life expectancy of less than 6 months and received hospice services. Record review of the order summary report, dated 02/27/26, reflected Resident #9 had an order to admit to hospice with an order date 08/07/25. Record review of Resident #9's, undated, comprehensive care plan, reflected Resident #9 had a terminal prognosis and elected hospice services with a dx of Alzheimer's disease. The care plan interventions included encourage resident to express feelings, listen with non-judgmental acceptance, compassion and work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Record review of Resident #9's hospice binder, accessed on 02/26/26 at 8:15 a.m. reflected no updated POC since the last IDT meeting on 02/17/26 and Clopidogrel bisulfate (Plavix) an antiplatelet medication on the medication list. During an attempted interview on 02/09/26 at 2:08 with Resident #9, revealed he was non-interview able. During an interview on 02/26/26 at 9:16 a.m., the RN Case Manager stated Resident #9 was admitted to hospice on 03/22/24 for Alzheimer's. The RN Case Manager stated the last visit was 02/24/26. The RN Case Manager stated she was responsible for bringing the IDT meeting notes on 02/24/26 but she did not stop by the office on 02/23/26. The RN Case Manager stated she should be reconciling medications every visit. The RN Case Manager stated the process for coordinating with the facility was in person. The RN Case Manager stated it was important to ensure the binder was updated so the facility and hospice were on the same page. During an interview on 02/26/26 at 10:32 a.m., LVN A stated she coordinated with hospice weekly. LVN A stated she was unaware the medication list was not updated, and the binder did not include the updated POC. LVN A stated once a month a printed updated medication list was given to the hospice nurse. LVN A stated she did not review the medication list because everything she should document regarding Plavix was in PCC such as monitoring for bleeding or medication contraindicated with Plavix. LVN A stated it was important to ensure recent hospice documentation was in the facility to keep communication between the facility and hospice for continuation of care. During an interview on 02/27/26 at 2:50 p.m., ADON O stated she was unaware Resident #9's hospice binder was not updated. ADON O stated her and the other ADON were responsible for ensuring the hospice book was updated with all required information. ADON O stated there was not a system in place at this time to monitor hospice binders. ADON O stated the hospice binder should include the updated POC and medication list. ADON O stated it was important to ensure recent hospice documentation was in the facility to keep communication between the facility and hospice for continuation of care. During an interview on 02/27/26 at 4:34 p.m., the Administrator stated he (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected the hospice binder to be updated. The Administrator stated in absence of the DON, the ADONs were responsible for ensuring the information was updated. The Administrator stated it was important to ensure recent hospice documentation was in the facility for continuation of care. Record review of the facility's policy titled End of Life Care: Hospice, revised on 12/2019, reflected, .through continuing interdisciplinary assessment, individualized plans will be developed and implemented to address the resident's physical. and practical needs.4. Collaboration with hospice will include processes for orienting staff to facility policies and procedures which may include. documentation and record keeping requirements.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish an infection prevention and control program (IPCP that included, at a minimum, an antibiotic stewardship by ensuring the propriate that included antibiotic use protocols and a system to monitor antibiotic use for 1 of 5 residents (Resident #50) reviewed for antibiotic stewardship program. The facility failed to ensure Resident #50 obtained appropriate lab work and diagnoses to support the use of prescribed antibiotics. This failure could place residents at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections. Findings include: Record review of Resident #50's face sheet dated 2/27/26 indicated an admission date of 9/10/25, reflected an 88 -year- old female who was admitted to the facility with a diagnoses which included unspecified dementia (deterioration of memory, language, and other thinking abilities with behaviors) and chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #50's annual MDS, dated [DATE], reflected Resident #50 was understood/ able to express ideas and wants, and had the ability to understand others. Resident #50 had a BIMS score of 7. The assessment addressed Resident 50's current antibiotic use and had a pressure ulcer/ injury. Record review of Resident #50's care plan, reviewed 2/24/26, reflected Resident #50 was on antibiotic therapy related to abscess to right buttocks. Care plan interventions included, administer medication as ordered, observe for possible side effects every shift, and use enhanced barrier precautions. Resident 50's care plan also indicated potential for pressure ulcer development related to immobility, incontinence of bowel and bladder. The care plan interventions included administer medications as ordered. Monitor and document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Assess, record, monitor wound healing. Report improvements and declines to the medical doctor weekly head to toe skin assessment. Record review of wound evaluation completed by wound care physician, dated 9/18/2025, reflected prescription recommendation of Doxycycline 100 mg by mouth twice daily for 10 days. Start 9/18/25 - stop 9/28/25. The wound evaluation form did not contain an order for a wound culture prior to administration of the antibiotic. Focused wound exam notes describe the wound as unstageable with intact skin, 17 centimeters x 11 centimeters x Not measurable centimeters (Length x Width x Depth), no exudate, skin intact with purple/ maroon discoloration, no pain, no sign of infection. Record review of a progress note, dated 9/18/25, completed by ADON N reflected Resident #50 was seen by the wound doctor. Right medial buttock abscess was observed with no drainage or warmth. Fluid filled area. New order per MD for Doxycycline 100 mg 1 capsule two times a day x 10 days. Record review of the medication administration records,dated 9/1/25 - 9/30/25, reflected Resident #50 received Doxycycline on 9/18/25, 9/19/25, 9/20/25, 9/21/25, 9/22/25, 9/23/25, 9/24/25, 9/25/25, 9/26/25, 9/27/25, 9/28/25, 9/29/25, and 9/30/25. Record review of the Order Summary Report for Resident #50 reflected Doxycycline 100 mg by mouth twice a day for 10 days completed on 10/1/25. During an interview with the Wound Doctor on 2/27/26 at 5:30 PM, the wound doctor stated she would expect there to be a documented reason for the order. Signs or symptoms such as light green to pseudomonas (bacteria) color drainage. Wound doctor stated she would review her records and contact this surveyor with more information. Wound doctor did not contact surveyor prior to exit of facility. During an interview with ADON O on 2/27/26 at 5:15 PM, ADON O stated she did not contact the doctor about obtaining cultures with the new order for antibiotics. ADON O stated she did not reach out unless there was a decline. ADON O stated she did what the doctor ordered, and prescribing antibiotics was at the doctor's discretion. ADON O stated cultures were not mandated. ADON O stated getting cultures was important to ensure the proper antibiotic was treating the proper infections. During an interview with the Facility Administrator on 2/27/26 at 5:35 pm, the administrator stated the facility used the McGeer Criteria for Infection Surveillance Tool. The Administrator stated the (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADONs were responsible for infection prevention and monitoring. The administrator stated nurses should talk to physicians and explain antibiotic stewardship and the McGreer's tool. The administrator stated if the wound doctor did not want to follow that criteria, then the administrator expected the wound doctor to document why. The administrator stated proper antibiotic stewardship was important to prevent overuse or inappropriate use of antibiotics and to avoid having multi-drug-resistant organisms. Record review of the facility's policy titled Antibiotic Stewardship dated 1/2022, indicated the facility implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall infection prevention and control program which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. Nursing home ASP activities should, at a minimum, include these basic elements: leadership, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting date, education for clinicians, nursing staff, residents and families about antibiotic resistance and opportunities for improvement.