STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676089	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winnie L Nursing & Rehabilitation	2104 N Karnes Cameron, TX 76520

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews the facility failed to ensure that licensed nurses have the specific competencies, and skill sets necessary to care for residents' needs for 1 (LVN A) of 3 staff reviewed for nursing competency assessments after a fall for Resident # 1.The facility failed to ensure LVN A assessed Resident #1 for injuries after a fall. This failure could potentially affect the residents by placing them at risk for injuries. Findings include: Record review of Resident #1's face sheet, dated 09/19/2025, revealed Resident #1 was an [AGE] year-old-female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: Alzheimer's disease (a progressive brain disorder that destroys memory and thinking skills, leading to the inability to perform the simplest daily tasks), other specified bone density and structure, unspecified site (a bone disorder that changes the bone's density or structure but without a specific location or site being identified) and, secondary hypertension (high blood pressure that is caused by another medical condition). Record review of Resident #1's Quarterly MDS Assessment, dated 09/04/2025, reflected Resident #1 was rarely/never understood. She had poor short- and long-term memory recall. She had disorganized thinking (rambling and irrelevant conversation). Resident #1 required partial/moderate assistance with transfers (helper does more than half the effort). Resident #1 had a history of falls. Record review of Resident #1's Comprehensive Care Plan reflected (problem initiated on 11/16/2022) Resident #1 was at risk for falls related to unaware of safety, lack of coordination (difficulty controlling one's movements to be smooth, balanced, and purposeful). Record review of the facility's in-service on fall protocol on 06/23/2025 given by the Administrator reflected LVN A attended the in-service meeting, and the fall policy was reviewed during the in-service. Observation and interview on 09/19/2025 at 10:15 AM Resident #1 was propelling herself in the common area of the facility leading into the dining room. She did not respond to any questions about her recent fall. Resident #1 made eye contact and continued to propel herself in the common area. Interview on 09/19/2025 at 9:40 AM LVN A stated she was informed on 08/27/2025 by CNA B Resident #1 was on the floor in Resident #1's room. LVN A stated she entered Resident #1's room and observed Resident #1 on the floor beside her wheelchair. She stated Resident #1 had some blood from a cut on Resident #1's head. LVN A stated she instructed CNA B to transfer Resident #1 from the floor to the bed. She stated she assessed Resident #1 from head to toe and completed vital signs after Resident #1 was in bed. LVN A stated she was expected to complete head to toe assessment and vital signs prior to transferring Resident#1 from the floor to the bed. She stated she forgot to assess Resident #1 prior to moving her from the floor. LVN A stated it was the protocol for residents not to be moved from the floor or anywhere after a fall until the resident is assessed head to toe and staff obtain vital signs. She stated a resident may have a broken bone or some other type of injury and nurses were expected to do complete assessments before moving a resident. LVN A stated she did not follow the proper protocol. She stated she had watched videos and received in person training on what the nurses were expected to do when assessing a resident after the fall. LVN A stated she had been instructed not to move a resident until after gathering information such as vital signs and complete head to toe assessment. LVN A stated the last time she was in-service was in June or July of 2025. She stated she was unsure what may happen to a resident after a fall if they were transferred prior to completing assessments. She stated she was having a stressful day the day Resident #1 fell. Interview on 09/19/2025 at 10:20 AM CNA B stated LVN A did not complete vital signs or head to toe assessment on Resident #1 until after Resident #1 was transferred from the floor to the bed. CNA B stated she had been in-serviced on fall protocol, and she learned to follow the nurses' directions. Interview on 09/19/2025 at 1:30 PM the Director of Nurses stated anytime a resident is found on the floor after a fall the nurse's best practice was not to move the resident until a head-to-toe assessment is completed and vital signs are obtained by the nurse. She stated the head-to-toe assessment includes but not limited to check for injuries of the skin, any pain near bone areas, movement of extremities, any abnormal position of extremity and any change of condition. She stated the following vital signs were expected to be obtained prior to moving resident after a fall: blood pressure (a number representing the pressure when the heart beats and when the heart rests between beats), respiratory rate (the number of breaths a person takes per minute), heart rate (the speed at which the heart beats, and O2 stats (percentage of oxygen in the blood). She stated LVN A was expected not to give directions to CNA B to move Resident #1 from the floor to the bed. She stated LVN A did not follow proper fall protocol. She stated she did not recall the last in-service given on fall