STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676219	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windcrest Health & Rehabilitation	6050 Hospital Dr Abilene, TX 79606

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation and interviews, the facility failed to provide a resident group with private space and prevent staff to attend without the invitation of the group for 1 of 1 group council meeting observed. The facility failed to prevent LVN E from entering a resident council meeting while in progress. This failure placed residents that could participate in a resident council at risk of not having the right to voice their concerns without staff being present or overhearing their concerns and conduct resident council meetings without interference. Findings included: During an observation and interview on 05/12/2026 at 2:05 PM, LVN E entered the resident council meeting. LVN E was informed a resident council meeting was in session and facility staff could not be present during the meeting. LVN E did not leave when requested to do so. LVN E stated she needed to take Resident #18's Blood Pressure and give her medication, before she left and stated she would do it really quick. During an interview on 05/14/2026 at 10:00 a.m., the AD stated resident council should have been private. She stated staff should have only entered the meeting when they were invited. She stated she did attend the meetings because the residents want her to facilitate the meetings. She stated nursing staff should have known there was a meeting in progress by the activity calendar, and did not have to block off the entrance or post signs to inform them of resident council meeting in progress. She stated all staff knew not to go into the resident council meetings. She stated staff should have left when being informed that a resident council meeting was in progress. She stated she did not feel the resident population in the facility would have any negative effect from staff coming into the private setting because of their cognitive status and that was one of the reasons she took notes and made grievances for them. She stated the residents were informed the resident council meetings were private and a reasonable person would not want staff to come in unless invited. During an interview on 05/14/2026 at 10:12 a.m., SW J stated the activities director facilitated resident council meetings. She stated she had never been told that staff had come to those meetings uninvited. She stated it was a resident right to have private resident council meetings, and a reasonable person would not want staff to interrupt the meeting uninvited. Review of the facility policy titled : Resident Council Meetings dated 04/20/2020 stated in part: The group may appoint a resident to take notes/maintain meeting minutes or may elect that the Activity Director/designated liaison to take notes/maintain minutes. Meeting minutes may include, but are not limited to:a. Names of the residents in attendance.b. Follow up from previous meetings.c. Issues discussed.d. Recommendations from the group to facility staff.c. Names of staff members, speakers, and other guests present in the meeting (as invited by thegroup to attend).

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

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	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 person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 8 of 21 (Resident #4, Resident #5, Resident #7, Resident #9, Resident #21, Resident #24, Resident #44, and Resident #81) residents reviewed for comprehensive person-centered care plans. The facility failed to develop a comprehensive care plan that included the need to reside on a secure unit for Resident #4, Resident #5, Resident #7, Resident #9, Resident #21, Resident #24, Resident #44, and Resident #81. This deficient practice could place residents in the facility at risk of not being provided the necessary care or services to meet their needs and deficits.The findings include: Record review of Resident #4's face sheet, dated 05/12/2026, revealed a [AGE] year-old male initially admitted [DATE] and most recent admission date of 04/14/2026. Resident #4 was admitted with medical diagnoses of Sepsis (the body's extreme, life-threatening response to an infection), unspecified organism, Type II diabetes (body cannot use insulin correctly and sugar builds up in the blood), Unspecified Dementia (decline in mental ability sever enough to interfere with daily life affecting m, communication, and reasoning), and Essential (primary) hypertension (high blood pressure). Record review of Resident #4's Quarterly MDS, 04/17/2026, revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score a BIMS score of 15, which indicated an intact cognition. Section E0900 - Wandering - Presence and Frequency was coded 0, which indicated Resident #4 did not exhibit this behavior. Record review of Resident #4's physician's orders, dated 04/14/2026, revealed Resident #4 had an order to admit to a secure unit for specialized dementia care. Diagnosis: Dementia. Record review of Resident #4's Comprehensive Care Plan, dated 03/19/2026, revealed there was no focus, goal, or interventions in the area of the need for Resident #4 to reside on the secure unit in the facility. Record review of Resident #5's face sheet, dated 05/14/2026, revealed a [AGE] year-old female who was admitted [DATE] with medical diagnoses of Dementia (decline in mental ability sever enough to interfere with daily life affecting m, communication, and reasoning), Major depressive disorder (mood disorder with persistent feelings of intense sadness, hopelessness, and loss of interest) and Essential (primary) hypertension (high blood pressure). Record review of Resident #5's admission MDS, dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score a BIMS score of 06, which indicated severe cognitive impairment. Section E0900 - Wandering - Presence and Frequency was coded 0, which indicated Resident #5 did not exhibit this behavior. Record review of Resident #5's physician's orders, dated 05/13/2026, revealed Resident #5 did not have an order to admit to a secure unit. Record review of Resident #5's Comprehensive Care Plan, dated 05/12/2026, revealed there was no focus, goal, or interventions in the area of the need for Resident #5 to reside on the secure unit in the facility. Review of Resident #7's face sheet dated 05/14/2026, revealed a [AGE] year-old female initially admitted on [DATE] and most recent admission on [DATE]. Resident #7 was admitted with medical diagnoses of Parkinsonism (a group of neurological conditions characterized by slow movement, muscle stiffness, balance issues and tremors), Dementia (decline in mental ability sever enough to interfere with daily life affecting m, communication, and reasoning), Bipolar disorder (mental health condition characterized by extreme shifts in mood, energy, and activity levels), Alzheimer's disease with late onset, major depressive disorder, and anxiety. Review of Resident #7 Quarterly MDS dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score a BIMS score of 15, which indicated intact cognition response. Section E0900 - (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wandering - Presence and Frequency was coded 0, which indicated Resident #7 did not exhibit this behavior. Record review of Resident #7's physician's orders, dated 05/14/2026, revealed Resident #7 did not have an order to admit to a secure unit. Review of Resident #7's Comprehensive Care plan reviewed/revised 01/29/2026 revealed there was no focus, goal, or interventions in the area of the need for Resident #7 to reside on the secure unit in the facility. Review of Resident #9's face sheet dated 05/14/2026, revealed a [AGE] year-old female admitted on [DATE] with medical diagnoses of Major depressive disorder (mood disorder characterized by pervasive low mood and loss of interest), Dementia (decline in mental ability sever enough to interfere with daily life), and anxiety. Review of Resident #9 Quarterly MDS dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score a BIMS score of 5, which indicated severe cognitive impairment. Section E0900 - Wandering - Presence and Frequency was coded 0, which indicated Resident #9 did not exhibit this behavior. Record review of Resident #9's physician's orders, dated 05/14/2026, revealed Resident #9 did not have an order to admit to a secure unit. Review of Resident #9's Comprehensive Care plan reviewed/revised 04/20/2026 revealed there was no focus, goal, or interventions in the area of the need for Resident #9 to reside on the secure unit in the facility. Record review of Resident #21's face sheet, dated 05/13/2026, revealed a [AGE] year-old female admitted on [DATE] with diagnoses of Alzheimer's disease with late onset, Dementia (decline in mental ability sever enough to interfere with daily life affecting m, communication, and reasoning), and Cognitive communication deficit (when a person has difficulty with verbal and nonverbal communication due to cognitive processes). Review of Resident #21 Annual MDS dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score a BIMS score of 03, which indicated severe cognitive impairment. Section E0900 - Wandering - Presence and Frequency was coded 0, which indicated Resident #21 did not exhibit this behavior. Record review of Resident #21's physician's orders, dated 05/13/2026, revealed Resident #21 did not have an order to admit to a secure unit. Record review of Resident #21's Comprehensive Care Plan, dated 04/28/2026, revealed there was no focus, goal, or interventions in the area of the need for Resident #21 to reside on the secure unit in the facility. Review of Resident #24's face sheet dated 05/14/2026, revealed a [AGE] year-old female admitted on [DATE] with diagnoses of Type II Diabetes (body cannot use insulin correctly and sugar builds up in the blood) and Major depressive disorder (mood disorder characterized by pervasive low mood and loss of interest). Resident #24's diagnoses revealed there was no diagnosis of Alzheimer's disease or other related dementia. Review of Resident #24 admission MDS dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed a BIMS score of 15, which indicated moderate cognitive impairment. Section E0900 - Wandering - Presence and Frequency was coded 0, which indicated Resident #24 did not exhibit this behavior. Record review of Resident #24's physician's orders, dated 05/14/2026, revealed Resident #24 did not have an order to admit to a secure unit. Review revealed #24 did not have diagnoses of Dementia. Review of Resident #24's Comprehensive Care plan reviewed/revised 02/10/2026, revealed there was no focus, goal, or interventions in the area of the need for Resident #24 to reside on the secure unit in the facility. Review of Resident #44's face sheet dated 05/14/2026, revealed a [AGE] year-old female initially admitted on [DATE] and most recent admission on [DATE]. Resident #44 was admitted with medical diagnoses including dementia (decline in mental ability sever enough to interfere with daily life affecting memory, communication, and reasoning). Review of Resident #44 admission MDS dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed a BIMS score of 12, which indicated moderate cognitive impairment. Section E0900 - Wandering - Presence and Frequency was coded 0, which indicated Resident #44 did not exhibit this behavior. Record review of Resident #44's physician's orders, dated 05/14/2026, revealed Resident #44 did not have an order to admit to a secure unit. Review of Resident #44's Comprehensive Care plan reviewed/revised 05/11/2026, revealed there was no focus, goal, or interventions in the area of the need for Resident #44 to reside on the secure unit in the facility. Record review of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #81's face sheet, dated 05/14/2026, revealed an [AGE] year-old male initially admitted [DATE] and most recent admission date on 01/06/2022. Resident #81 was admitted with medical diagnoses of Chronic obstructive pulmonary disease (lung disease that restricts airflow), Psychotic disorder with delusions (mental disorder characterized by a disconnect with reality), and Unspecified dementia (decline in mental ability sever enough to interfere with daily life affecting memory, communication, and reasoning). Record review of Resident #81's Quarterly MDS assessment, dated 05/05/2026, revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score a BIMS score of 06, which indicated severe cognitive impairment. Section E0900 - Wandering - Presence and Frequency was coded 0, which indicated Resident #81 did not exhibit this behavior. Record review of Resident #81's physician's orders, dated 04/14/2026, revealed Resident #81 had an order to admit to a secure unit for specialized dementia care. Diagnosis: Unspecified Dementia. Record review of Resident #81's Comprehensive Care plan, dated 09/05/2025, revealed there was no focus, goal, or interventions in the area of the need for Resident #81 to reside on the secure unit in the facility. During an observation on 05/12/2026 at 9:43 a.m., Resident #24 was observed in a room of the 400 hall Alzheimer's secure care unit where he lived. During an observation on 05/12/2026 at 11:18 a.m., Resident #7 was sitting on a couch in the lobby of the 100 hall Alzheimer's secure care unit. During an observation on 05/12/2026 at 11:30 a.m., Resident #9 was standing at the nurse's station of the 100 hall Alzheimer's secure care unit. Resident #9 did not have a walker beside her and ambulated without one. During an observation on 05/12/2026 at 2:14 p.m., Resident #4 was observed in his room on the 200 hall Alzheimer's secure unit. During an observation on 05/12/2026 at 3:14 p.m., Resident #21 was observed as she came out of her room on the 200 hall Alzheimer's secure unit. During an interview on 05/14/2026 at 9:03 a.m., the DON said the MDS Coordinator was responsible for ensuring the MDS assessment was accurate. The DON said the MDS Coordinator was on vacation at the time. The DON said she signed off on the MDS assessments which meant she looked at it and the assessments was accurate. The DON stated the MDS assessment should be accurate and if a resident did not need a walker then it should not be triggered. The DON said if the MDS assessment was not accurate, the care plan could not match the residents' needs. The DON said the care plans were updated after the MDS assessment was completed. During a follow-up interview on 05/12/2026 at 4:32 p.m., the DON said all residents' care plan should be updated with current care needs such as residing in the secure unit. The DON said both she and the ADON were responsible for updating the care plans along with the MDS Coordinator. The DON said the MDS Coordinator was on vacation and not available in the facility at that time. The DON said the IDT including herself monitored the care plans to ensure plans were accurate and she had overlooked that the need for the secure unit was in the plans and reviewed by the IDT. During an interview on 05/14/2026 at 4:34 p.m., the Regional Clinical Nurse said the care plans should be updated with care needs for secure unit if residents resided on the secure unit. The Regional Clinical Nurse said the social workers were responsible for the secure unit section of the care plan, but any IDT member could update the care plan. The Regional Clinical Nurse said the DON and ADON were ultimately responsible for monitoring that care plans were updated to include when a resident resided on the secure unit. The Regional Clinical Nurse denied any negative impacts had occurred. During an interview on 05/14/2026 at 4:40 p.m., the Social Worker K said she would add items to the care plan for residents' cognitive status or preference for discharge but would never update the care plan with secure intervention unless the resident was exit seeking. The Social Worker K stated she did not know who was responsible for monitoring the care plans including the need for the secure unit. During an interview on 05/14/2026 at 4:49 p.m., the Administrator said she expected for residents who resided on the secure units to have care plan updates for the secure unit. The Administrator said the nurse managers were responsible for updating the care plans. The Administrator said the failure may have occurred during the transfer process, but the nurse managers should have monitored prior to the resident entering the unit. The Administrator said she did not feel any negative impact had occurred and that it was an oversite by the nurse (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	managers. The Medical Director (MD) of the facility was traveling by plane and unavailable to interview in person or by phone. Correspondence by text was initiated on 05/14/2026 at 5:44 p.m. The Medical Director responded on 05/15/2026 at 9:18 p.m., and 05/16/2026 at 8:15 a.m., with the following response in regard to the question if he felt admission into the secure unit should be care planned, 3) yes, I believe each admission should be care planned. Record review of the facility's policy, Comprehensive Care Plans dated 09/04/2021, revealed it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure orders were provided for the resident's immediate care and needs for 4 (Resident #7, Resident #9, Resident #24, and Resident #44) of 16 residents reviewed for care supervised by a physician. The facility failed to ensure a physician order was put into place/received to admit Resident #7, Resident #9, Resident #24, and Resident #44 to an Alzheimer's certified secure care unit. The facility failed to obtain a diagnosis to admit Resident #24 to an Alzheimer's certified secure care unit. These failures could affect residents by not having their medical care supervised by a physician.The findings included the following: Review of Resident #7's electronic face sheet dated 05/14/2026, revealed a [AGE] year-old female initially admitted on [DATE] and most recent admission on [DATE]. Resident #7 was admitted with medical diagnoses of Parkinsonism (a group of neurological conditions characterized by slow movement, muscle stiffness, balance issues and tremors), dementia (impaired memory, thinking, and behavior), Bipolar disorder, Alzheimer's disease with late onset, major depressive disorder, and anxiety. Review of Resident #7's Quarterly MDS dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed she had a BIMS score of 15 out of 15, indicating intact cognition. Review of Resident #7's physician's orders dated 05/14/2026 revealed no order to admit Resident #7 to a secure care unit. Review of Resident #7's Comprehensive Care plan reviewed/revised 01/29/2026 revealed no focus, goal or interventions related to a secure care unit were addressed. During an observation on 05/12/2026 at 11:01 a.m., Resident #7's first and last name was posted by a door in the Alzheimer's certified 100 hall room. During an observation on 05/12/2026 at 11:18 a.m., Resident #7 was sitting on a couch in the lobby of the 100 hall Alzheimer's secure care unit. Review of Resident #9's electronic face sheet dated 05/14/2026, revealed a [AGE] year-old female admitted on [DATE] with medical diagnoses of major depressive disorder, dementia, and anxiety. Review of Resident #9's Quarterly MDS dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed she had a BIMS score of 5 out of 15, indicating severe cognitive impairment. Review of Resident #9's physician's orders dated 05/14/2026 revealed no order to admit Resident #9 to a secure care unit. Review of Resident #9's Comprehensive Care Plan reviewed/revised 04/20/2026 revealed no focus, goal or interventions related to a secure care unit were addressed. During an observation on 05/12/2026 at 11:08 a.m., Resident #9's first and last name was posted by a door in the Alzheimer's certified 100 hall room. During an observation on 05/12/2026 at 11:30 a.m., Resident #9 was standing at the nurse's station of the 100 hall Alzheimer's secure care unit. Review of Resident #24's electronic face sheet dated 05/14/2026, revealed a [AGE] year-old female admitted on [DATE]. Resident #24's diagnoses revealed no Alzheimer's disease or other related dementia had been diagnosed. Review of Resident #24's admission MDS dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed she had a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Section I - Active Diagnoses, subsection I4200 Alzheimer's disease, 0 - Not checked (No) was entered. Subsection I4800 Non-Alzheimer's Dementia, 0 - Not checked (No) was entered. Review of Resident #24's physician's orders dated 05/14/2026 revealed no order to admit Resident #24 to a secure care unit. Review of Resident #24's Comprehensive Care Plan reviewed/revised 02/10/2026 revealed no focus, goal or interventions related to a secure care unit were addressed. During an observation on 05/12/2026 at 9:43 a.m., Resident #24 was observed in a room of the 400 hall Alzheimer's secure care unit. She stated she had been at the facility for about a month. Review of Resident #44's electronic face sheet dated 05/14/2026, revealed a [AGE] year-old female initially admitted on [DATE] and most recent admission on [DATE]. Resident #44 was admitted with medical diagnoses including dementia. Review of Resident #44's admission MDS dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed she had a BIMS score of 12 out of 15, indicating moderate cognitive impairment. Review of Resident (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#44's physician's orders dated 05/14/2026 revealed no order to admit Resident #44 to a secure care unit. Review of Resident #44's Comprehensive Care plan reviewed/revised 05/11/2026 revealed no focus, goal or interventions related to a secure care unit were addressed. During an observation on 05/12/2026 at 3:36 p.m., Resident #44 was in a room of the 400 hall Alzheimer's secure care unit. She was talking to her family member who stated Resident #44 had been at the facility for about one week. During an interview on 05/14/2026 at 4:10 p.m. LVN A stated she had worked in the rehabilitation unit and the secure Alzheimer's (secure care) unit. LVN A stated she was not responsible for putting in physician orders for residents to be placed in the secure unit. LVN A stated she was unsure who was responsible for obtaining those orders and putting them into the computer system. During an interview on 05/14/2026 at 4:30 p.m., the ADON stated she was responsible for putting the physician order into the electronic computer system when a resident was admitted , readmitted , or transferred onto the Alzheimer's secure unit. She stated she would have to reactivate the orders and the computer system would not carry over the order which was usually the may reside on secure unit order. She stated she did not always notice the order did not get carried over. During an interview on 05/14/2026 at 4:32 p.m., the DON stated all residents who reside on the secure units should have had a physician order and diagnoses qualifying them to be placed in the Alzheimer's unit. She stated the admission nurses were responsible to obtain orders when a resident was admitted . The DON stated she and the ADON were responsible to monitor that the orders were in the medical record. She stated the physician orders were reviewed. She stated Resident #7 had an order to reside in the secure unit until she went to the hospital in November 2024, but that order was not put back into the system after she was readmitted . She stated Resident #9's physician order to reside on the secure unit had never been put into the system. She stated Resident #24's physician order to reside on the secure unit had never been put into the system. She stated she had reached out to the physician today and had gotten a diagnosis today that would qualify Resident #24 to reside on secure unit. The DON stated the diagnosis, and order should have been obtained prior to admitting into the secure unit. She stated Resident #44's physician order to reside on the secure unit had never been put into the system. During an interview on 05/14/2026 at 4:34 p.m., the RCN stated residents who resided on the secure unit should have had physician's order to reside on those units. She stated residents should have a documented diagnosis that would qualify them for the Alzheimer's secure unit. She stated the DON and ADMN were ultimately responsible for monitoring the orders were updated when a resident resided on the secure care unit. She stated not having correct diagnoses or physician's order for secure care unit could cause psychosocial unrest if a resident was admitted and did not need to be on the unit. During an interview on 05/14/2026 at 4:49 p.m., the ADMN stated she expected for residents who reside on the secure care units to have a physician order and a diagnosis qualifying them for the secure unit. She stated the nurse managers were responsible for putting in the physician orders with appropriate diagnosis. She stated the failure may have occurred during the transfer process from the hospital or from the skilled nursing unit. She stated the nurse managers should have been monitoring that those things were obtained prior to the resident entering the unit. She stated she did not feel any negative impact had occurred and that it was an oversight by the nurse managers. During a telephone interview on 05/15/2026 at 8:15 a.m., the MD stated his expectation would be for residents admitted to the secure units to have physician orders and a medical diagnosis of dementia prior to being placed on those units. He stated there are certain instances that could arise for a resident to be placed on the secure unit without a diagnosis of dementia but those residents would need to be evaluated case by case and it would need to be care planned. Record review of facility document titled, Alzheimer's Disclosure Statement for Nursing Facilities, dated 05/13/2026, reflected Alzheimer's disease or other dementia were acceptable pre-admission diagnoses for admission to specialized units. Further review reflected Physician's orders were part of the admission process for new residents. Record review of facility's policy titled, Clinical Practice Guideline, dated 05/14/2026, reflected Prior to admission to any designated memory (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care unit, a physician or other licensed independent practitioner, acting within their scope of practice, shall provide an order for admission to the unit based on the resident's cognitive status, behavioral presentation, safety needs, functional abilities, and overall clinical condition. The interdisciplinary team shall review the resident's clinical needs to ensure placement in the most appropriate unit environment. Documentation supporting the need for placement shall be maintained in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676219	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windcrest Health & Rehabilitation	6050 Hospital Dr Abilene, TX 79606

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility must not use any individual working in the facility as a nurse aide for more than four months on a full-time basis unless that individual has completed a training and competency evaluation program for 1 of 8 (NA C) non-certified nurse aides reviewed. The facility failed to ensure full-time NA C was certified within four months of the date of hire.This failure placed residents at risk of receiving inappropriate care from an individual whose skill level was not known. Findings included:Record review of the facility's employee files reflected NA C was hired on 10/29/2025 as a full-time nurse aide.During an interview on 05/14/2026 at 11:43 a.m., the DON stated NA C had been working as a full-time nurse aide in the facility and was taken off of the schedule today. During a telephone interview on 05/14/2026 at 1:29 p.m., NA C stated she started working on the floor providing resident care on 11/3/25, she stated she had already taken the online course to start her NA certification prior to being hired. She stated she was told by LVN D, the facility would help with the written test and skills test cost and scheduling for the NA certification. She stated she completed the written test and passed at the end of March 2026 but could not give a specific date. She stated she was then scheduled for the skills test on 4/21/26 and did not pass, she stated she was scheduled for another skills test on 5/26/26.During an interview on 05/14/2026 at 1:50 p.m., LVN D stated she did participate in the hiring and scheduling of staff among other duties. She stated NA C had worked as an NA at another facility prior to working at this facility. She stated she could not remember if she had been told about the NAs needing to be certified by 4 months of being full-time. She stated she does help facilitate the testing for NA certification and had signed NA C up to be tested. She stated NA C failed the skills checkoff and was scheduled to take it again. She stated the facility does allow the NAs to perform direct care on residents at the facility after the facility had done their own skills checkoff. She stated the NAs could perform showers, incontinent care, feeding assistance and other direct care independently but could not operate the mechanical lift transfer. She stated she had issues with scheduling the clinical test for certification of NAs and recently the facility in town was booked up until June for the clinical test. She stated she did not have any concerns with NA performing care with residents. She stated NA C was allowed to continue to perform resident care after failing the clinical test for certification until today.During an interview on 05/14/2026 at 1:58 p.m., the DON stated LVN D was responsible for making sure NAs were certified. She stated she was responsible for monitoring the NAs were certified. She did not provide an explanation for why NA C was allowed to continue to work full-time after 4 months of not being certified. She stated the facility did help pay for and help schedule the certification testing. She stated she did not have any concerns with NA performing direct care tasks. She stated she would provide the skills checkoff the NA had completed before she was allowed to perform resident care independently. She stated they were allowed to provide direct resident care except they could not utilize the mechanical lift for transfers. During an interview on 05/14/2026 at 2:28 p.m., the ADMN stated her expectation was for the NAs to go through a clinical class, have all of their hours and take the CNA test within 180 days of working full-time. She stated if the clinical test was failed, then her expectation would be to have them moved to hospitality aid until they could pass the exam. The ADMN stated she and the DON had just found out that NA C was allowed to continue to provide resident care after failing her clinical exam today. She stated LVN D had been aware and she did not know why it was not conveyed to the DON or herself. She stated LVN D had been told multiple times that NAs had to be certified within the four-month time frame. The ADMN stated she thought the failure came down to not keeping track and monitoring LVN D. She stated if a NA was not competent, it could lead to resident injury or adverse incidents. Record review of the facility's policy titled, Nursing Services and Sufficient Staff, dated 04/10/2022, reflected The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents' needs, as identified through resident assessments, and described in the plan of care.Record review of the facility's Certified Nurse Aide Nursing Assistant - Job Description, reviewed on 05/14/2026, reflected Must be a Certified Nursing Aide in good standing with the State or must within four (4) months of employment have completed state required training and a competency evaluation program.

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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 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure kitchen staff properly secured hair in hair nets when handling and serving food. These failures could place residents who received food from the kitchen at risk of cross contamination and food borne illness.The findings include: During an observation on 05/12/2026 at 9:35 a.m., the Dietary Manager was observed in the kitchen with a thin hair net on covered by a gray headband with approximately one (1) inch of hair exposed above her neck where the hair net had moved up and exposed the hair. During an observation on 05/12/2026 at 9:36 a.m., the Lead [NAME] was observed wearing a thin hair net with approximately two (2) inches of hair that hung out of the hair net and down by both her temples and 1/2 inch was exposed above her forehead where the hair net had moved up and exposed the hair. During an observation on 05/12/2026 at 9:55 a.m., Observed [NAME] F as she placed dinner rolls on a baking sheet and placed the pan in the oven. [NAME] F was observed with exposed hair not covered by her hair net. Observed her hair was exposed on the back of her neck, approximately 1/2 inch across and one (1) inch in length by both temples in front of her ears. During an observation on 05/12/2026 at 10:03 a.m., [NAME] G was observed standing by the cooking station, as he stacked cups and picked up silverware to roll into napkins. [NAME] G was observed wearing a thin hair net with 1/2 inch strings of hair exposed on his left temple and behind his left ear and on his right temple. During an observation on 05/12/2026 at 10:15 a.m., Observed [NAME] H as she stack small bowls and placed them on a tray. [NAME] H was observed wearing a thin hair net with strings, approximately two (2) inches in length down the back of her neck and in front of her ears. During an observation on 05/13/2026 at 9:25 a.m., [NAME] I was observed wearing a thin hair net with approximately three (3) inches of hair above her neck exposed. During an observation on 05/13/2026 at 9:31 a.m., [NAME] F was observed standing at the stove as she stirred a large pan of ground met. [NAME] F opened the oven and removed a large pan and placed it on the top of the stove. During an observation on 05/13/2026 at 9:33 a.m., [NAME] I was observed at the ice machine as she scooped ice out and filled cups and placed on a tray. [NAME] I leaned over the ice machine as she scooped the ice. During an interview on 05/13/2026 at 9:41 a.m., the Lead [NAME] said she had been trained in food handling and was aware that her hair net should cover all her hair. Lead [NAME] said that not wearing the hair net properly could cause hair to get into the food and no one wanted hair in their food. The Lead [NAME] said she was aware she should have all her hair covered. The Lead [NAME] said hair in the food could cause cross-contamination or illness. During an interview on 05/13/2026 at 9:46 a.m., the Dietary Manager said an employee's hair not covered while cooking or serving food was an infection control issue and could contaminate the food. During an interview on 05/13/2026 at 10:01 a.m., [NAME] F said she was aware that her hair should be covered while working in the kitchen and serving food. [NAME] F said she had her food handling certificate. [NAME] F said the purpose of wearing a hair net was to prevent hair from falling into the food. [NAME] F said if she found hair in her food she would return the food because it could cause bacteria and make her sick. During an interview on 05/13/2026 at 10:20 a.m., [NAME] I said she had been trained in food handling and was aware that her hair had to be covered. [NAME] I said the hair net provided by the facility would not stay on and cover her hair properly. [NAME] I said the net would ride up and exposed her hair. [NAME] I said the hair net prevented hair from falling into the food which could cause cross contamination and make others sick. During an interview on 05/13/2026 at 10:26 a.m., [NAME] H said she knew she was required to wear a hair net while in the kitchen and cover all her hair. [NAME] H spoke through interpretation as she did not speak English. [NAME] F translated. [NAME] H said would cover her hair to prevent hair from falling in the food. During a follow-up interview on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/14/2026 at 2:01 p.m., the Dietary Manager said she was not aware that hair exposed from the hair nets was an issue. The Dietary Manager said exposed hair could make the food unappetizing, contaminate the food, and cause food-borne illnesses. The Dietary Manager said the residents in the facility deserved to be served food of the highest quality. During an interview on 05/14/2026 at 2:13 p.m., the Administrator said she was not aware the kitchen employees were not wearing their hair nets appropriately until she was notified by the Dietary Manager. The Administrator said hair exposed and the hair nets that did not properly fit was an issue. The Administrator said hair could drop into the food and anyone who ate out of the kitchen would be exposed to cross-contamination. The Administrator said this was unsanitary and an infection control issue. Record review of the facility's policy, Food & Nutrition Services Policy & Procedure Manual Personal Hygiene dated 11/14/2017, revealed dietary employees will maintain proper food practices through proper personal hygiene. 11. Dietary employees shall wear hair covering, beard restraints, and clothing that covers body hair.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to treat residents with respect, dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 10 residents (Resident #18), observed in the confidential group interview. The facility failed to prevent LVN E from taking Resident #18's blood pressure and administering medication during a resident council meeting on 5/14/26., in front of 9 other residents. This failure could result in a diminished quality of life and a loss of self-esteem for the residents. The findings included: Record review of Resident #18's electronic Face Sheet dated 05/14/2026 revealed the resident was a 93 -year-old female admitted to the FacilityFfacility on 05/31/2024 with the following diagnoses: Dementia (a loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), dysphagia (difficulty swallowing), lack of coordination, and cognitive communication disorder a disorder that involves difficulty with speaking, listening, reading, writing, or social interaction, caused by a disruption in thinking processes. Record review of Resident #18's quarterly Minimum Data Set MDS assessment dated [DATE] documented, in part: Resident had a BIMS of 15 which indicated she was cognitively intact. During an observation and interview on 05/12/2026 at 2:05 PM, LVN E entered the resident council meeting. LVN E had a medication cup and blood pressure cup in her hands. The LVN E was informed a resident council meeting was being held and she could not be present during the meeting. LVN E stated that she needed to do this really quick and proceeded to take Resident #18's blood pressure and gave Resident #18 her medication in front of the 10 residents that were attending the meeting. During an interview on 5/12/26 at 2:05 p.m , Resident #18 stated LVN E was just trying to do her job and receiving her medication in a public setting did not happen very often. During an interview on 05/14/2026 at 10:00 a.m., the AD stated resident council should have been private. She stated staff should have only entered the meeting when they were invited. She stated she does attend the meetings because the residents want her to facilitate the meetings. She stated nursing staff would know there was a meeting in progress by the activity calendar and she did not have to block off the entrance or post signs to inform them of resident council meeting in progress. She stated all staff know not to go into the resident council meetings. She stated staff should have left when being informed that a resident council meeting was in progress. She stated she did not feel the resident population in the facility would have any negative effect from staff coming into the private setting because of their cognitive status and that was one of the reasons she took notes and made grievances for them. She stated the residents were informed the resident council meetings were private and a reasonable person would not want staff to come in unless invited. During an interview on 05/14/2026 at 10:12 a.m., the SW J stated it was a resident right to have private resident council meetings, and a reasonable person would not want staff to interrupt the meeting uninvited. The SW J stated residents had the right to having their vitals and medications administered in private. The SW J stated a reasonable person would have wanted for their vitals and medications given in a private location. Review of the Policy titled Resident Rights dated revised last revised 11/05/2024 stated in part: Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes accommodations, medical treatment, writing and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

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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 observation, interview, and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #9) of 21 residents whose assessments were reviewed for accuracy. The facility failed to ensure Resident #9's MDS assessment accurately reflected the use of a walker. This failure placed the residents at risk for unmet care needs.Findings included:Record review of Resident #9's electronic face sheet dated 05/14/2026 reflected a [AGE] year-old female who was admitted on [DATE] with diagnoses that included dementia (changes in the brain that affect memory, thinking, and behavior) and osteoarthritis (joint condition where the cushioning cartilage in your joints gradually wears away, causing pain, stiffness, and difficulty moving).Record review of Resident #9's quarterly MDS dated [DATE] reflected Resident #9 had a BIMS of 05 meaning severe cognitive impairment. Further review reflected she used a walker as a mobility device.Record review of Resident #9's comprehensive care plan, reviewed on 05/14/2026, reflected Resident #9 was independent with ambulation using a walker.Record review of Resident #9's physical therapy note dated 02/20/2026 reflected Resident #9 was able to perform a standing activity using no ambulatory aid (walker). Record review of Resident #9's physical therapy note dated 03/18/2026 reflected Resident #9 was able to perform gait training using no ambulatory aid (walker).Record review of Resident #9's physical therapy certification period of 03/13/2026 - 05/11/2026 documentation reflected that due to cognitive status and patient having poor safety education memory, two-wheel walker has recently presented as a safety hazard due to patient leaving it in unsafe areas and not using if for mobility purposes. During observation on 05/12/2026 at 11:30 a.m., Resident #9 was standing by the nurses' station for hall 100 without a walker. During an attempted telephone interview on 05/12/2026 at 3:16 p.m., Resident #9's RR did not answer telephone or return call after voicemail left.During an interview on 05/14/2026 at 9:03 a.m., the DON stated the MDS nurse was responsible for making sure the MDS assessments were accurate. She stated the MDS nurse was on vacation at this time and not available for interview. She stated she signed off on the MDS which meant she verified the MDS assessment had been completed. She stated the MDS should be accurate. She stated if the resident did not need a walker, then it should not have been checked on the MDS assessment. She stated not having an accurate MDS could make the care plan not match the residents needs. She stated the CNAs looked at the Kardex so that they knew what the resident's care needs were. She stated the care plans were updated after the MDS assessment had been completed.During an interview on 05/14/2026 at 2:32 p.m., the ADMN stated she expected the MDS assessment to be filled in accurately by the MDS nurse. She stated the DON should monitor that those assessments were accurate and completed. During an observation on 05/14/2026 at 4:10 p.m., Resident #9 was standing in a doorway on 100 hall without a walker. Resident #9 was looking out into the lobby area and was not holding onto anything to help her stand.During an interview on 05/14/2026 at 4:10 p.m., LVN A stated she worked on the 100 hall unit and was familiar with Resident #9. She stated Resident #9 did not utilize a walker for mobility at this time. She could not remember if Resident #9 ever used a walker but stated she may have when she first came to the facility.During an interview on 05/14/2026 at 4:21 p.m., CNA B stated she was familiar with Resident #9. She stated she thought Resident #9 used to use a walker but that was over a month or two ago. She stated currently Resident #9 did not need to use a walker for ambulation. Record review of facility policy titled, Resident Assessment - RAI, dated 10/24/2022, reflected This facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences using the resident assessment instrument (RAI) specified by CMS.The assessment will include at least the following:.h. Physical functioning and structural problems.The assessment process will include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.