STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676125	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Atrium	1814 Atrium Place Harlingen, TX 78550

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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 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 interviews and record reviews the facility failed to develop a comprehensive care plan for each resident, consistent with the resident's rights, that includes measurable short-term and long-term objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. If a child is admitted to the facility, the comprehensive care plan must be based on the child's individual needs. 1.The facility failed to develop and implement a comprehensive person-centered care plan to address Resident#1's refusal of medication. 2.The facility failed to ensure a care plan was developed and implemented to address Resident #4 getting out from bed without assistance. This failure could place residents at risk for their mental and psychosocial needs not being met. The findings include: 1.Record review of Resident #1's face sheet, dated 10/27/25, revealed a [AGE] year-old male and was initially admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Muscle Weakness, unspecified sequelae of cerebral infraction (long-term complications or after-effects of a stroke that cannot be specifically identified or classified), muscle wasting and atrophy (the shrinking of muscle tissue due to lack of use, age, or diseases that damage the nerves controlling muscles), and gastroesophageal reflux disease (a digestive condition where stomach acid flows back into the esophagus, causing irritation and various symptoms). Record review of Resident#1's Quarterly MDS assessment, dated 9/16/25, revealed Resident#1:-had moderate cognitive impairment;-was able to make self understood;-was usually able to understand others; Record review of Resident #1's Comprehensive care plans revealed no focus, goals or interventions/tasks related to Resident #1's behavioral issues, refusing medications (protonix). During an interview on 10/29/25 at 12:28 a.m., LVN G said Resident #1 refused his protonix medication. LVN G said when Resident #1 refused his medication she would let the physician know about the refusal. LVN G said she was sure the refusal of the medication was already care planned. LVN G said the negative outcome for refused medications not being on the care plan was the nurses would not give the care for the GERD . During an interview on 10/29/25 at 11:30 a.m., the MDS nurse said Resident #1's behaviors were not on the care plan. He stated he did not know they were supposed to be on the care plan. During an interview on 10/29/25 at 3:35 p.m., the DON said Resident #1 refused medications. The DON said the MDS nurse and all nurses were responsible for updating the care plan. The DON said when a resident refused medications, it should have been care planned. The DON said the negative outcome would be not following the plan of care. 2.Record review of Resident #4's face sheet, dated 10/29/25, revealed a [AGE] year-old female and was initially admitted to the facility on [DATE]. Resident #4 had diagnoses which included: Muscle Weakness, Unspecified Dementia, unspecified severity (a diagnosis used in medical coding when a person has symptoms of dementia, but there is not enough information to identify the specific type of dementia) and muscle wasting and atrophy (the shrinking of muscle tissue due to lack of use, age, or diseases that damage the nerves controlling muscles). Record review of Resident #4's Quarterly MDS assessment, dated 8/8/25, revealed Resident #4:-had severe cognitive impairment;-was not able to make self understood;-was not able to understand others. Record review of Resident #4's Progress Notes, dated 9/08/25, revealed: Nurse was alerted by aide that resident had fallen. Nurse went to assess resident. Resident was on the floor in the shower room lying on her front left side. Nurse called for assistance from staff to assist. Resident was rolled to her side. Pressure was applied to laceration on resident's forehead. Vital signs obtained. Resident was assessed by NP and EMS was called. Patient was sent to Emergency department. Record review of Resident #4's Comprehensive care plans revealed no focus, goals or interventions/tasks related to Resident #4's behavioral issues (tried to get out of bed without assistance). During an interview on 10/29/25 at 3:10 p.m., CNA E said Resident #4 tried to get out of bed without assistance, she did not press the call light for assistance. During an interview on 10/29/25 at 3:20 p.m., CNA F said Resident #4 tried to get out of bed without assistance, she did not press the call light for assistance. During an interview on 10/29/25 at 11:08 a.m., LVN D said Resident #4 had fallen twice with her. LVN D said Resident #4 tried to get out of bed without assistance and Resident #4 was not able to voice her needs or use the call light. During an interview on 10/29/25 at 11:30 a.m., the MDS nurse said Resident #4's behaviors were not on the care plan. The MDS nurse said he did not know the behaviors were supposed to be care planned . During an interview on 10/29/25 at 3:35 p.m., the DON said Resident #4 had some falls and the resident tried to get out of bed without assistance. The DON said nurses were responsible for

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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 and interview, the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles reviewed for medications stored in 1 of medication 9 carts (300 hall medication cart) reviewed for storage. The facility failed to ensure the nurses medication cart for 300 hall was secured by a lock when it was left unattended by LVN A. This failure could place residents at risk of injury to other residents if medication left unsecured were consumed.Findings include: During an observation on 10/27/2025 at 03:28 PM revealed the 300 Hall nurse's medication cart was left unlocked and unattended against the nurse's station. LVN A approached the nurses' medication cart and noticed it was unlocked and secured the cart by locking it. There was no one around the medication cart. During an interview on 10/27/2025 at 03:30 PM with LVN A revealed she was responsible for the nurse's medication cart that was left unlocked. She stated he was expected to lock the nurse's medication cart when she walked away from it. She stated if it was left unlocked then a resident could open a drawer and take anything that was not for them or medications could get stolen. She stated she forgot to lock the cart. During an interview on 10/27/2025 at 04:18 PM with the DON revealed numerous staff, which included her and the ADON, were responsible for ensuring medications carts were locked. The DON stated her expectation of staff when they walked away from the medication cart was to lock it. The DON stated the negative outcome for leaving the cart unlocked was a resident or visitor could grab the medication from the cart, and it could harm them. She stated she provided in-services to the staff, and she visually monitored daily. Record review of the facility's, undated, policy Medication Administration: revealed .The purpose of the mobile medication system is to ensure appropriate control and surveillance of resident assigned medications. The medication cart is locked at all times when not in use. Do not leave the medication cart unlocked or unattended in the resident care areas.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, in accordance with accepted professional standards and practices the facility failed to maintain medical records on each resident that were complete and accurately documented for 2 of 3 residents (Resident #2 and Resident #3) reviewed for clinical records.1. The facility failed to ensure documentation was completed on the Individual Narcotic Record for Resident #2 by ADON and LVN B on 10/12/2025 and 10/20/25.2. The facility failed to ensure documentation was completed on the Medication Administration Record for Resident #3 by LVN C on 10/0/25These failures could place residents at risk for errors by staff when reading information in the clinical record that was inaccurate or incomplete. Findings include:1. Record review of Resident #2's admission Record, dated 10/29/25, reflected an [AGE] year old female with a Principle Diagnosis of Megaloblastic Anemias (a type of anemia where the bone marrow makes abnormally large, immature red blood cells that do not work and live as long as normal red blood cells), and a diagnosis of Generalized Anxiety Disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness).Record review of Resident # 2's Quarterly MDS Assessment, dated 8/27/2025 and signed as completed on 9/02/25 by the MDS Nurse, reflected assessment observation end date of 8/27/2025. Resident # 2 had a BIMS score of 00, which indicated severe cognitive impairment.Record review of Resident # 2's Order Summary Report for the month of 10/01/25-10/31/25, reflected: -the order Lorazepam Oral Concentration 2 MG/ML Give 0.5 ML by mouth three times a day for anxiety related to Generalized Anxiety Disorder, start date 5/08/2025.Record review of Resident # 2's Medication Administration Record for the month of 10/01/25-10/31/2025 reflected medication Lorazepam 2 MG/ML Give 0.5 ML by mouth three times a day for anxiety related to Generalized Anxiety was initialed as given three times a day at, 8:00 AM, 4:00 PM, and 8:00 PM.Record review of Resident # 2's Individual Narcotic Record for Lorazepam, RX Instructions give 0.5 ML PO under tongue TID, Amount Received: 30 ML. reflected the medication had not been signed as given on 10/12/25 at 8:00 AM and 4:00 PM by ADON and on 10/20/2025 at 8:00 AM and 4:00 PM by LVN B.In an observation on 10/29/2025 at 10:52 AM of Resident # 2's bottle of Lorazepam revealed the amount in bottle of 12 ML and the amount remaining documented on the Individual Narcotic Record revealed an amount remaining of 6.5 ML.In an interview on 10/29/2025 at 10:50 AM, LVN B said the process for administering Lorazepam was I review the order first, I check the amount, check the label, verify the dose, and administer. I sign off on the narcotic sheet and document on the MAR. If the narcotic sheet is not signed, the count would be off and cause confusion for the oncoming shift. There can be miscommunication with the care plan regarding the resident. It can be communicated as a missed dose and communicated to the provider, and it can alter any new orders or care plan. She said she has been employed for 2 months, and her last in-service on medication administration and documentation was upon hire In an interview on 10/29/25 at 11:00 AM, the ADON said she checks the medication rights of administration, administers the meds, sign narcotic record and sign the MARS after the meds are given. She said if the narcotic sheet was not signed, there could be a discrepancy in the narcotic count and the resident could receive a double dose of the Lorazepam, which resulted in an increased effect of sedation. She said the last in-service she received was on 10/1/25 regarding medication administration.2. Record review of Resident # 3's admission Record, dated 10/29/2025, reflected a [AGE] year old female with Principle Diagnoses which included of Unspecified Fracture of Shaft of Humerus, Right Arm, initial Encounter for Closed Fracture, Striking Against Unspecified Object with Subsequent Fall, Initial Encounter, Diabetes Mellitus Type 2 (a chronic condition where the body cannot regulate blood sugar levels properly), and Other Cervical Disc Displacement, High Cervical Region (when a soft cushion between the neck bones {vertebrae} bulges or ruptures out of place) .Record review of Resident # 3's Quarterly MDS Assessment, dated 9/18/2025 and signed as completed on 9/24/25 by the MDS Nurse, reflected assessment observation end date of 9/18/2025. Resident # 2 had a BIMS score of 13, which indicated cognitively intact cognition.Record review of Resident # 3's Order Summary Report for the month of 10/01/25-10/31/25, reflected: -the order Hydromorphone HCl Oral Liquid 1 MG/ML Give 4 ML by mouth every 4 hours as needed for pain. start date 8/22/2025.Record review of Resident # 3's Medication Administration Record for the month of 10/01/25-10/31/2025 reflected medication Hydromorphone HCl Oral Liquid 1 MG/ML Give 4 ML by mouth every 4 hours as needed for pain, reflected the medication had not been initialed as given on 10/09/2025 at 10:28 AM by LVN CRecord review of Resident # 3's Individual Narcotic Record for Hydromorphone, RX