

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675956	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/18/2024
NAME OF PROVIDER OR SUPPLIER  Windsor Nursing and Rehabilitation Center of Duval		STREET ADDRESS, CITY, STATE, ZIP CODE  5301 W Duval Rd Austin, TX 78727	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065</b></p> <p>Based on interviews and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials for 1 (Resident #1) of 6 residents reviewed for abuse, in that:</p> <p>The facility failed to report Resident #1's abuse allegation to the State Agency. On 04/15/24, Resident #1 informed staff that he was hit by Resident #2 in the dining room during meal service.</p> <p>This deficient practice could place residents at risk of abuse and revictimization.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's Admission Record, dated 05/18/24, revealed he was a [AGE] year-old male who was admitted to the facility on [DATE], readmitted on [DATE], and had an RP and POA. Resident #1 had the following diagnoses: unspecified dementia, other lack of coordination, unsteadiness on feet, unspecified anxiety disorder, need for assistance with personal care, and bipolar disorder.</p> <p>Record review of Resident #1's Quarterly MDS Assessment, dated 03/30/24, revealed he had an 11 BIMS, which indicated he was moderately impaired with decision making. Resident #1 required supervision or touching assistance with eating. Resident #1 also took antidepressant medication in the last 7 days or since admission/entry/reentry.</p> <p>Record review of Resident #1's Care Plan, dated 04/05/24, revealed he had the potential to be physically aggressive with staff, impaired cognitive function, and an ADL self-care performance deficit related to his dementia.</p> <p>Record review of Resident #1's Progress Notes revealed the following:</p> <p>-ADON created a nurse note on 04/15/24 at 4:35 p.m. that stated,</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[4:05 p.m.] I was called to the dining area for assistance. Prior to getting to dining room another resident [Resident #2] standing in hallway so I assisted him to his room. I then went to dining room when it was reported that [Resident 1] was hit by [Resident #2]. [Resident #1] is alert and oriented x2. [Resident #1] is upset stating he was just assaulted by [Resident #2]. [Resident #1] bleeding from skin tears to right forearm and Right upper arm. Says he (Resident #1) was hit in face and head. no bleeding or discoloration noted to face/head. [4:07 p.m.] [ADM] notified and [TX Nurse] notified, dressing applied to skin tears on arm. Vitals were 179/83-93-20 98% on room air. Hall nurse present to perform head to toe skin assessment post resident to resident incident.</p> <p>-LVN A created a nurse note on 04/15/24 at 11:46 p.m. that stated,</p> <p>Nurse assistance was called to the dining room. When ADON arrived, she assisted a resident (Resident #2) back to his room. Upon returning to the dining room, she was then informed by [Resident #1] that he was hit by another resident (Resident #2). The other resident being the person that was assisted back to his room by the ADON. [Resident #1] Right forearm and bicep were bleeding. No discoloration face, no bruising, bleeding or deformities to head were observed or palpated. [Resident #1] is alert and oriented x 2. [Resident #1] states that he was struck in the face/head by another resident (Resident #2). [Resident #1] states his right arm was grabbed by the other resident (Resident #2). He (Resident #1) states the other resident (Resident #2) dug his nails into him. [Resident #1] complained of pain 5/10 to arm. PRN Tramadol administered. Head to toe assessment completed. Active ROM intact. Pain assessment completed. Skin evaluation completed. Neurological check initiated and ongoing. Treatment nurse evaluation and treatment initiated and completed. [ADM], [NP] and [RP] notified. Staff continues with attempts to assist [Resident #1]. [Resident #1] has refused all attempts of care with verbally abusing staff using speech against staff ethnicity and gender. It is to be noted that resident accepted pain medication and the snacks offered.</p> <p>Record review of Resident #1's Weekly Skin Evaluation, dated 04/15/24 at 11:21 p.m., revealed he had abnormal skin areas, was a new wound since last skin assessment, and located on the right forearm and right upper arm.</p> <p>Record review of Resident #1's Pain Evaluation, dated 04/15/24 at 4:38 p.m., revealed he complained of pain in the last five days, interventions were effective, had pain to his right forearm and right upper arm, pain was 5/10, staff administered Tramadol 50 milligrams one tab administered at 4:21 p.m., pain began on 04/15/24, and was acute due to skin tear.</p> <p>2.Record review of Resident #2's Admission Record, dated 05/18/24, revealed he was a [AGE] year-old male who was admitted to the facility on [DATE], readmitted [DATE], and had an RP and POA. Resident #2 had the following diagnoses: unspecified dementia, personal history of traumatic brain injury, generalized muscle weakness, other lack of coordination, unsteadiness on feet, delusional disorders, mood disorder, major depressive disorder, violent behavior, adjustment disorder, and low vision in one unspecified eye.</p> <p>Record review of Resident #2's Quarterly MDS Assessment, dated 04/01/24, revealed no BIMS score indicated. Resident #2 required partial/moderate assistance with eating. Resident #2 also took antipsychotic, antianxiety, and hypnotic medications in the last 7 days or since admission/entry/reentry. Resident #2 also had inattention and disorganized thinking and no physical or verbal behaviors toward others exhibited at the time of the assessment.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's BIMS Assessment, dated 03/29/24, revealed he could not have a BIMS conducted, staff had to assess Resident #2 for mental status, Resident #2 had short- and long-term memory problems and severely impaired with his daily decision making.</p> <p>Record review of Resident #2's Care Plan, dated 04/02/24, revealed he was confused and demonstrated poor adjustment with roommate, verbally and physically aggressive, had potential to be physically aggressive (aggressive, agitated, anxious, chasing everybody, shouting, yelling, trying to hit staff/residents, biting staff, combative), and had potential to be verbally aggressive with staff and other residents related to dementia with behaviors.</p> <p>Record review of Resident #2's Progress Notes revealed there were no notes related to Resident #1's alleged incident on 04/15/24.</p> <p>Record review of Resident #2's progress noted created by LVN B on 04/16/24 at 4:03 p.m. that stated,</p> <p>Res (Resident #2) on follow-up for agitation/aggression towards another resident (Resident #1) during the 2-10 p.m. shift. Res (Resident #2) is calm and in bed resting with eyes closed. no signs or symptoms of pain or discomfort.</p> <p>Record review of Resident #2's Physician's Progress Note, dated 04/22/24, revealed he was seen at bedside, awake, confused (Baseline), vitals were stable, aggressive behaviors intermittently per staff, recently had altercation with another resident, psychological services following, and continued to be monitored.</p> <p>An observation of Resident #2 and interview on 05/18/24 at 9:52 a.m. revealed he was standing in the doorway of his room. An attempt to interview Resident #2 was made, but Resident #2's responses were not understandable and Resident #2 could not concentrate when asked several different questions pertaining to Resident #1's allegation.</p> <p>During an interview on 05/18/24 at 10:19 a.m., Resident #3 revealed he witnessed Resident #2 hit Resident #1 in the dining room. Resident #3 could not recall what day Residents #1's and #2's incident happened. Resident #3 did not know if Resident #1's incident was reported to the ADM. Resident #3 stated the ADM was the abuse and neglect coordinator.</p> <p>During an observation and interview of Resident #1 on 05/18/24 at 10:26 a.m., Resident #1 had a circular purple bruise on his right bicep that was the size of a ping pong ball. Resident #1 also had several small scabs on his right forearm. Resident #1 revealed on 04/15/24, he was sitting in the dining room and waiting to eat his dinner. Resident #1 stated Resident #2 walked behind him, blasted his head, pulled his arm to where he believed Resident #2 was trying to pull him out his wheelchair. Resident #1 also stated there were no staff around when Resident #2 hit him. Resident #1 stated he was bleeding all over his arm at the time of the incident (04/15/24). Resident #1 also stated Residents #3, #4, and #5 witnessed the incident and told Resident #2 to back up. Resident #1 stated Resident #2 walked away after Residents #3, #4, and #5 said to back up. Resident #1 also stated he spoke with the ADM about the incident and told the ADM that he wanted to notify the police and State Agency. Resident #1 explained the ADM told him that he would help him tomorrow (04/16/24) and never followed-up with him on 04/16/24. Resident #1 stated the ADM was the abuse and neglect coordinator.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/18/24 at 10:59 a.m., Resident #5 revealed he observed Resident #2 attack Resident #1. Resident #5 explained he was sitting at a dinner table with Resident #1, #3, and #4. Resident #5 went on to explain that Resident #2 snuck behind Resident #1 and tried to pull Resident #1 out of his wheelchair. Resident #5 explained a female staff member, who he could not remember the name of, pulled Resident #2 off of Resident #1. Resident #5 did not know who the abuse and neglect coordinator was. Resident #5 stated he did not report Resident #1's and #2's incident.</p> <p>During an interview on 05/18/24 at 11:11 a.m., Resident #4 revealed he was not there when Resident #2 hit Resident #1. Resident #4 stated Resident #1 called the ADM about the alleged incident. Resident #4 did not know who the abuse and neglect coordinator was.</p> <p>During an interview on 05/18/24 at 1:28 p.m., the ADM revealed he recalled an incident involving Residents #1 and #2. The ADM explained Resident #1 was upset because of a quarrel between himself and Resident #2. The ADM stated there were other residents in the dining area at the time of Residents #1 and #2 incident. The ADM also stated he spoke and followed-up with Resident #1, who told him that he was no longer upset with the incident and to let it go. The ADM stated Resident #1 never followed-up wanting other action to be done about Resident #2's incident.</p> <p>An attempt to contact ADON was made on 05/18/24 at 3:43 p.m. A voicemail and call back number was left. ADON did not return the call.</p> <p>During an interview on 05/18/24 at 3:48 p.m., LVN A revealed Resident #1 told her that Resident #2 hit him. LVN A stated she did not see anything happen when she arrived in the dining area. LVN A also stated she did not observe Resident #1 hit Resident #2 because she was not in the dining area at the time of Resident #1's alleged incident. LVN A stated she remembered Resident #1 having a skin tear on 04/15/24, but she could not recall if Resident #1's skin tear was fresh or happened prior to his alleged incident. LVN A also stated the bleeding she observed on Resident #1's arm was described, As if he (Resident #1) cut his hand underneath a table. LVN A stated she notified the ADM about Resident #1's allegation.</p> <p>Record review of the facility's Resident Council Meeting Notes, dated 05/09/24, revealed the ADM, Assistant ADM, and DON reviewed abuse reporting procedures with the attendees.</p> <p>Record review of the facility's In-Service Training Reports, from 04/01/24 through 05/18/24, revealed staff were trained on the following:</p> <ul style="list-style-type: none"> <li>-Abuse/Reporting Procedures 03/18/24 and 05/08/24</li> <li>-Documentation of Incidents 04/16/24</li> <li>-Responding to Complaints 04/19/24</li> <li>-Resident Rights 04/22/24, 04/23/24, 04/24/24, 04/29/24, and 04/30/24</li> <li>-Documentation 05/06/24</li> </ul> <p>Record review of the facility's Reporting Abuse to State Agencies and Other Entities Policy and Procedure, dated November 2016, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Policy Statement: All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law.</p> <p>Policy Interpretation and Implementation:</p> <ol style="list-style-type: none"> <li>1. Should a suspected violation or substantiated incident of neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident:               <ol style="list-style-type: none"> <li>a. The State licensing/certification agency responsible for surveying/licensing the facility.</li> </ol> </li> <li>3. Should a suspected crime resulting in serious bodily injury, the employee shall report the suspicion immediately, but not later than 2 hours after forming the suspicion.</li> </ol>