STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675956	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Duval	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917 Based on interview and record review, the facility failed to keep residents free from abuse for 1 (Resident # 1) of 9 residents reviewed for abuse. The facility failed to ensure Resident # 1 was not physically assaulted by Hospitality Aide A. The noncompliance was identified as PNC. The IJ began on 08/02/2024 and ended on 08/06/2024. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of physical harm, mental anguish, or emotional distress. The findings included: Record review of Resident # 1's admission face sheet dated 9/9/24, revealed Resident # 1 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of schizoaffective disorder bipolar type (A rare mental health condition that combines symptoms of schizophrenia and bipolar disorder), profound intellectual disabilities, epilepsy (Seizure disorder) , age-related physical debility, muscle wasting and atrophy, lack of coordination, adjustment disorder with mixed anxiety and depressed mood, hyperlipidemia (High levels of fat particles in the blood), history of sudden cardiac arrest, chronic pain syndrome, disturbance of salivary secretion, hypothyroidism (Overactive thyroid), type 2 diabetes, hypertensive heart disease without heart failure, atrial fibrillation (An irregular often rapid heart rate), depression, anxiety disorder, elevated white blood cell count, and bipolar disorder current episode hypomanic (A disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Record review of Resident #1's quarterly MDS assessment dated [DATE], revealed Resident # 1 had unclear speech but was usually understood by staff. The MDS revealed Resident # 1 understood others. The MDS revealed Resident # 1 did not have a BIMS score recorded. The MDS reflected Resident # 1 had no behaviors or refusal of care. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's care plan, initiated on 12/29/21 and revised on 7/25/22, revealed Resident # 1 had, an ADL self-care performance deficit related to impaired balance, limited mobility with bilateral extremity contractures. Interventions included Resident # 1 requires extensive to total assistance by 1-2 staff with bathing/showering, bed mobility, toileting, and transfers. Resident # 1 is noncompliant with medical regiment and resistive to care related to adjustment to nursing home. Interventions stated to allow the resident to make decisions about treatment regimen, to provide a sense of control. It also stated to give a clear explanation of all care activities prior to an as they occur during each contact, to provide consistency in care to promote comfort with ADLs, and to maintain consistency in timing of ADLs, caregivers, and routine, as much as possible. Record review of witness statement dated 8/2/24 revealed Scheduler CNA A reflected Scheduler CNA A was at the nurse station when she heard a slapping noise and a resident crying. Scheduler CNA A went to go check where the crying was coming from. Scheduler CNA A found Resident # 1 in room [ROOM NUMBER] A crying and Hospitality Aide A coming from the closet gathering clothes for Resident #1. Scheduler CNA A asked Hospitality Aide A why Resident # 1 was crying. Hospitality Aide A said she did not know. Scheduler CNA A went to check Resident # 1 and found a red mark on Resident #1 right thigh. Hospitality Aide A stated that Resident # 1 hit her very hard. Scheduler CNA A told Hospitality Aide A to remove themselves from Resident # 1's room. Scheduler CNA A told Hospitality Aide A that they could no longer provide care to Resident # 1. Scheduler CNA A made sure Resident # 1 was safe and called the abuse coordinator and reported the incident to him and the charge nurse also. Record review of Resident #1's nursing progress note dated 8/2/24 at 8:17 am revealed staff member reported to charge nurse Resident # 1's increased agitation during incontinence care early that morning; likely the result of being awakened to provide care. Resisting nursing care following an incontinence episode Resident # 1 experienced. The Charge nurse completed observation, skin, and pain assessments of Resident # 1. Her demeanor was evaluated as well. Around 7 am, further assessment was completed by the DON of the incident that occurred during charge nurse shift. Primary physician notified of incident. RP unable to be reached for notification purposes of incident. Resident # 1 in bed excited at her usual demeanor without sign of distress. Record review of Resident #1's nursing progress note dated 8/2/24 at 8:32 am revealed Resident # 1 still declined to be assisted this morning despite encouragement by 2 nursing staff. The staff will revisit her to prevent the occurrence of what happened earlier in the day. Record review of Resident #1's weekly nursing skin evaluation dated 8/2/24 revealed Resident # 1 had resolving dermatitis. No skin tears, bruises, pressure ulcers, or non-pressure wounds. Record review of Resident #1's pain evaluation dated 8/2/24 at 8:36 am revealed no complaint of pain in last 5 days, normal breathing, no negative vocalization, relaxed body language, smiling facial expression, no need to console, pain score of a 2 out of 10. Record review of photo evidence from the Administrator of Resident # 1 revealed Resident # 1 had a red imprint of an entire handprint on her upper right outer thigh. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 9/9/24 at 12:20 pm of Resident # 1 revealed Resident # 1 was in bed. Resident # 1's bed was in lowest position up against the wall with fall mat on floor next to the bed. Resident # 1 shook her head yes when asked if she was ok and shook her head no when asked if she needed anything. Resident # 1 shook her head no when asked if she had any concerns. Resident # 1 appeared clean and well groomed. Resident # 1's room appeared neat, clean, and homelike. An interview on 9/9/24 at 2:00 pm with the DON reflected that he said he had been called by the Administrator to inform him of the incident. DON said when he arrived at the facility he completed a pain evaluation and skin evaluation on Resident # 1. DON said he then performed a counseling with Hospitality Aide A and placed them on suspension pending investigation. An interview on 9/9/24 at 2:50 pm with the Administrator reflected he said, about the incident involving Resident # 1 and Hospitality Aide A, that he received a phone call from Scheduler CNA A about the incident. Administrator said Scheduler CNA A explained the series of events to him and told him that she had also gave the charge nurse the details of the incident. The Administrator said Hospitality Aide A never admitted to him of slapping Resident # 1 on the thigh. The Administrator said the DON arrived at the facility shortly after the incident occurred and went and completed a skin and pain assessment of Resident # 1. An interview was attempted on 9/9/24 at 4:45 pm with Scheduler CNA A. The call was not answered; voicemail left. An interview on 9/9/24 at 5:11 pm with Administrator reflected he said it was their expectation of the staff to report all suspected abuse to him since he was the abuse coordinator. The administrator further said it was his and the DON's responsibility to educate the staff on ANE, watch for techniques for staff to practice prohibiting ANE, and to watch staff for burnout and exhaustion. The administrator said a negative impact of resident abuse would be a sense of hopelessness for the resident and that the resident could become scared to rely on staff to take care of them. Record review of Hospitality Aide A personnel file reflected a hire date of 3/5/24. Employee counseling/ suspension report dated 8/2/24. Employee termination record dated 8/6/24. No record of training was in the employee personnel file. Record review of in-service logs reflected the following Abuse, Neglect, and Exploitation training was completed: undated with 16 staff signatures of attendance, 8/3/24 with 59 staff signatures of attendance, 8/5/24 with 9 staff signatures of attendance, and 9/3/24 with 7 staff signatures of attendance. Record review of Resident behavior training completed 8/1/24 with 11 staff signatures of attendance, 8/3/24 with 60 staff signatures of attendance, and 8/5/24 with 9 staff signatures of attendance. Record review of Resident resisting care training completed 8/2/24 with 24 staff signatures of attendance. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of facility's Abuse, Neglect, and Exploitation policy dated 8/15/22 reflected under policy heading It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Under heading Policy Explanation and Compliance Guidelines 3. The facility will provide ongoing oversight and supervision of staff to assure that its policies are implemented as written. Under heading Employee Training A. New employees will be educated on abuse, neglect, exploitation, and misappropriation of resident property during initial orientation. B. Existing staff will receive annual education through planned in-services as needed. Under heading Prevention of Abuse, Neglect, and Exploitation B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation , and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of individual residents care needs and behavioral symptoms. D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. The noncompliance was identified as PNC. The IJ began on 08/02/2024 and ended on 08/06/2024. The facility had corrected the noncompliance before the survey began.