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	06/27/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review 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, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures for two of eight residents (Resident #1 and Resident #2) reviewed for abuse and neglect . The facility failed to report to Health and Human Services alleged abuse that occurred when Resident #1 threw a cold coffee at Resident #2 and Resident #2 hit Resident #1 which resulted in Resident #1 sustaining a bruise beneath her right eye, a scratch on her right arm, anger and pain . This failure could place residents at risk of abuse, neglect, pain, and diminished quality of life. Findings include: 1. Record review of Resident #1's face sheet, dated 06/27/25, reflected a [AGE] year-old female with an original admission date of 07/29/2021 and readmission [DATE]. Resident #1 had diagnoses which included Parkinson's Disease (a progressive neurological [anything related to the nervous system, which includes the brain, spinal cord, and nerves] disorder that primarily affects movement, causing symptoms like tremors, stiffness, and difficulty with balance and coordination) without dyskinesia, without mention of fluctuations (diagnosis of Parkinson's disease where the individual does not experience dyskinesia [involuntary, jerky movements] and there is no indication or mention of the motor fluctuations), schizoaffective disorder, depressive type (a mental health condition characterized by symptoms of both schizophrenia [a chronic brain disorder that significantly affects how a person thinks, feel and behaves]), mood disorder, specifically major depressive disorder (a serious mental illness characterized by persistent feelings of sadness, loss of interest in activities, and significant changes in mood and behavior that interfere with daily life),bipolar disorder (a mental illness characterized by extreme shifts in mood, energy, and activity levels, ranging from periods of elevated mood to periods of depression), current episode manic severe with psychotic features (indicates a serious manifestation of bipolar disorder, involving extreme mood swings, elevated energy levels, and potentially delusional or hallucinatory experiences.) Record review of Resident #1's MDS , dated 04/17/25, reflected a BIMS score of 15, which indicated no cognitive impairment. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan, revised dated 08/26/21, reflected Resident #1 was identified as having PASRR positive status related to a severe mental illness: schizoaffective disorder, depressive type. 2. Record review of Resident #2's face sheet dated 06/27/25, reflected a [AGE] year-old male original admission date of 03/06/2021 with diagnoses of unspecified dementia (a general term for a decline in mental ability severe enough to interfere with daily life), unspecified severity, with other behavioral disturbance (exhibits symptoms of dementia where the severity is not specified and also experiences behavioral disturbances beyond agitation and atherosclerotic heart disease of native coronary artery without angina pectoris (the coronary arteries (blood vessels supplying the heart) are narrowed due to atherosclerosis (plaque buildup) but the patient does not experience chest pain). Record review of Resident #2's MDS , dated 05/27/25, reflected a BIMS score of 7, which indicated severe cognitive impairment. Record review of Resident #2's care plan, revised dated 12/10/21, reflected Resident #2 was physically aggressive with staff at times related to dementia. Record review of Resident #1's nursing progress notes by RN A, dated 06/23/2025, reflected staff notified RN A that Resident #1 had a physical altercation with Resident #2 in the smoking area, Resident #2 punched Resident #1 in the face and Resident #1 threw coffee on Resident #2 (coffee was cold). Resident #1 stated, I requested him to move from the way, the other resident got agitated and punched in my face which made me upset that's why I threw coffee on him. Action taken - staff immediately separated the two residents and ensured their safety and residents assessed for immediate medical or psychological needs, skin evaluation completed, bruise noted to below left eye and left cheek and scratch to left arm. Pain assessment done, PRN Tylenol administered, assessed coffee cup, coffee noted cold., neuro checks initiated and were in progress, administrator, NP made aware, called POA to notify, unable to reach and left a message, resident is own RP, observed closely for any change in behaviors, response: Resident #1 alert and responded verbally, she was resting in bed with no s/s of distress/discomfort noted at this time. Record review of nursing progress notes, by LVN A, dated 06/23/25, reflected Resident #2 was assessed from head to toe three different times, no burn noted during assessment. Resident #2 did not sustain any burn in any area of his body, and he denied any pain or discomfort, will continue monitoring . Observation on 06/27/25 at 12:27 PM of Resident #1 revealed swollen a crescent shaped bruise approximately 1 inch wide and 1.5 inches in length approximately .5 inches below Resident #1's left eye and 5 red indentions scattered in a line approximately 4 inches long about 6 inches below the residents left elbow and about 4 inches above the wrist. Interview on 06/27/25 at 12:27 PM with Resident #1 revealed, she remembered the incident and said she was mad when it happened and was mad now and her face still hurt but her arm no longer hurt. Interview on 06/27/25 at 5:10 PM with Resident #2 revealed he remembered the incident with Resident #1, but he was no longer upset with Resident #1, and everything was good . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/27/25 at 1:41 PM with RN A revealed she did not witness the altercation between Resident #1 and Resident #2. She assessed Resident #1 after the AD/BOM and HRC reported the incident to her. Her understanding was Resident #1 poured coffee on Resident #2, and Resident #2 punched Resident #1 in the face, but the coffee poured on Resident #2 was not hot. RN A said at the time of her assessment or Resident #1, Resident #1 had a bruise below the left eye and a scratch to her left arm. She said she would consider the bruise to Resident #1's face, an injury because it was in the area of the brain . She said she considered the altercation a resident-to-resident altercation and a form of abuse. She said she was trained in ANE, and the administrator was the abuse and neglect coordinator, and all incidents of abuse and neglect should be reported to the administrator. RN A said she did not find any changes to Resident #1's mental status or vital signs when she conducted her assessment and Resident #1 was at her normal baseline. RN A said she called the NP, and the NP told her to monitor Resident #1 and report if Resident #1 had any change of condition, and Resident #1 did not have a change in condition. Interview on 06/27/25 at 2:04 PM with LVN B revealed she assessed Resident #2 after his altercation with Resident #1. She said she did not witness the altercation between the two residents, but it was reported to her by the AD/BOM who told LVN B Resident #1 poured coffee on Resident #2. LVN B assessed him for burns. She said she assessed him three separate times by the end of her shift and found no injury. She said she was trained in ANE when she was hired at the facility. She said because the residents engaged in a physical altercation, it was abuse and the incident was reported to the administrator directly after it occurred. She felt Resident #1 received minor injury in the altercation and because there was injury to her face, they started neuro checks, because the neuro checks would reveal if there was a major injury. Interview on 06/27/25 at 2:14 PM with the AD/BOM revealed she heard yelling from her office and went outside. She said a resident was yelling at Resident #2 because he was mad Resident #2 hit Resident #1. The AD/BOM said she separated both residents and asked what happened. They reported to her they were lined up waiting to smoke and Resident #2 was standing in front of Resident #1. Resident #1 wanted to get in front of Resident #2. Resident #1 asked to get in front of Resident #2 and Resident #2 told her No so Resident #1 threw coffee on Resident #2. When Resident #1 threw the coffee at him, Resident #2 hit Resident #1. The AD/BOM said neither resident was scared, and Resident #1 wanted to get her cigarettes so she could smoke. She stated she was trained in the different types of abuse when she was hired. She stated when one resident hit another resident it was a form of abuse and staff were to report it to the Administrator regardless of the level of injury. She said residents cussing or yelling at each other was a form of abuse. She said the Administrator was the ANE coordinator and the incident was reported to the Administrator. Interview on 06/27/25 at 4:27 PM with the Administrator revealed he did not report the incident between Resident #1 and Resident #2 to the state survey agency because a lot of their cases were unique. When he spoke with Resident #1 about the incident, she said she was not in pain or hurting. Resident #1 she initiated the contact with Resident #2, and she understood he was a man who had difficulty controlling his impulses. He said he did not report the incident because it did not require first aide. He said when he spoke with Resident #1 about it, she repeatedly said she just wanted to go out and smoke her cigarettes. He said Resident #1 was not crying or upset about the incident when he spoke with her, and he did not feel like she was abused or neglected. The Administrator said the facility followed the Long-Term Care Regulation Provider Letter to guide them for reporting incidents to HHSC. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Long-Term Care Regulation Provider Letter Title Abuse, Neglect Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility Must Report to the Health and Human Services Commission reflected: Type of Incident to Report Abuse (with or without serious bodily injury) When to report: Immediately, but not later than two hours after the incident occurs or is suspected