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	04/15/2026

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to allow one of one (Resident #1) resident reviewed, or the resident representative to obtain a copy of the resident's medical records upon verbal or written request to the facility. The facility failed to provide medical records for Resident #1 to his RP / family representative within two working days of a request on 03/31/2026. This failure placed residents in the facility at risk by causing a negative health impact due to not having continuity of care. and the right to review their health care.Findings included: A record review of Resident #1's face sheet date 04/07/2026 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included atherosclerosis of native arteries of extremities (a disease involving the buildup of fats, cholesterol, and other substances (plaque) in artery walls, which narrows pathways and restricts blood flow), Severe Protein-Calorie Malnutrition (is a life-threatening, critical lack of nutrients, appearing as marasmus (wasting), kwashiorkor (edema), or a mix of both), Gastrostomy Status (the presence of a surgically created opening (stoma) in the stomach, often using gastrostomy tube (G-tube or PEG tube) for long-term enteral feeding, hydration, or medication deliver), Type 2 Diabetes Mellitus with unspecified complication (patient has a chronic blood sugar management disorder but does not have associated diabetic retinopathy, kidney damage (nephropathy), nerve damage (neuropathy), or major vascular issues), Parkinson's Disease without Dyskinesia (a progressive, incurable neurological disorder caused by the loss of dopamine-producing neurons in the brain, leading to movement issues like tremors, stiffness, and slow movement.), Dementia (a decline in mental ability-such as memory, reasoning, and communication-severe enough to interfere with daily life). Face sheet also reflected Resident #1 had a designated RP, same person that requested medical records. A record review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score of 04 indicating severe cognitive impairment. A record review of Resident #1's care plan initiated 02/28/2026 reflected Resident #1 had an ADL self-care performance deficit related to dementia, impaired cognitive function/dementia or impaired thought processes r/t CVA. A record review of Resident #1's RP's request for medical records reflected Resident #1's RP filled out the form on 03/31/2026requesting the following (History and Physical, Medication Administration Records, Chest X-ray Report, Discharge Summary, Transfer Summary, Laboratory Date, PT, OT, ST, any and all record). The medical record request form stated, The patient named above is currently seeking/receiving medical and nursing care in our nursing facility. For optimal continuing care, we require release of the following medical information from the Resident's hospital records. A record review of Medical Record staff communication to the facility's corporate office regarding Resident #1's RP's request for medical records, reflected the Medical Records staff did not reach out to the corporate office until 04/06/2026, six days after the request was made and three days after Resident #1 was discharged from the facility. During an interview on 04/15/2026 at 10:10 am, the Medical Record staff stated Resident #1's RP requested medical records, and she submitted the request form to the corporate office. The Medical Record staff stated that once the request form was filled out by the resident or RP, the form was given to the Administrator to review and then she attached the face (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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	sheet and the POA document and sent the document to the corporate office. The Medical Record staff stated sometimes the corporate office would call to request additional documents or tell her which documents to print and give to the resident or the RP. The Medical Record staff stated she submitted the request form from Resident #1's RP to the corporate office on 04/06/2026 because she was still within her 7-day window time frame. The Medical Record staff stated the delay was on her; she was busy. The Medical Record staff stated Resident #1's RP wanted the medical records before Resident #1 was discharged or on the day of discharge. The Medical Records staff stated up to the time of this interview, on 04/15/2026, Resident #1's family had not gotten the medical records as requested because the corporate office did not give her [MR] the go ahead. During an interview on 04/15/2026 at 10:58 am, LVN A stated Resident #1's RP had asked her for medical records request form sometimes at the end of March 2026, but she could not remember the exact date. LVN A stated she collected the medical records request form from the Medical Record staff and gave it to Resident #1's RP. LVN A stated Resident #1's PR had to fill out the request form, and she gave it to the Medical Record staff herself. During an interview on 04/15/2026 at 12:28 pm, the Administrator stated the process for requesting a medical record by residents /RP was to complete a written request form, he verified the request form to understand what the resident or family was requesting. The Administrator stated the Medical Records staff would then send the request to the corporate office for the legal team to review, after revision, communication was sent out to the Medical Records staff to send the records to the resident/ RP. The Administrator stated he spoke with Resident #1's RP the day after she submitted the medical records request and the RP stated she needed a paper copy of the records for a family in the medical field to review. The Administrator stated he offered Resident #1's RP the ability to sit with a staff member and review Resident #1's medication list on the computer, and she refused. The Administrator stated that in order for a medical record to be released to a Resident or their RP, the form had to be sent to the legal department. The Administrator stated the facility usually responded to the resident or the RP within 24 hours and up to 3 days or more for the resident or RP to receive the requested documents depending on the volume of the documents. The Administrator stated Resident #1's RP's request was denied because the RP was not the POA. Attempts to contact Resident #1's RP were made via phone and email on 04/15/2026 at 09:16 am and 9:19 am respectively. There was no response, the call was directed straight to voice mail, and no way to leave a voice message. During a phone interview on 04/17/2026 at 09:56 am, Resident #1's RP stated she spoke with the Administrator regarding wanting medical records and the Administrator stated he had to get with legal before giving the records. Resident #1's RP stated the Administrator did not tell her that she needed to fill out a medical record request form. Resident #1's RP stated, a week later she found out from a nurse that she had to fill out a medical record request form and give it to the Medical Records staff to be able to get the records. Resident #1's RP stated she wanted the medical records for the resident before or on the day of discharge for Resident #1 to use for following up with his PCP. Resident #1's RP stated Resident #1 was discharged from the facility on 4/03/2026 and as of 04/17/2026, she had not gotten the requested medical records. Review of facility's policy titled Release of Medical and [NAME] Records Policy effective February 22, 2016, reflected: In order to ensure compliance with this policy, all requests for medical and billing records must be cleared through the Legal Department prior to the release of any information.The procedure for medical and billing records requests is as follows:A fully completed medical or billing records release authorization form must be submitted either by the Resident, if a Resident is able to complete such a form, or by the appropriate Authorized Party.The medical records release authorization form should be emailed or scanned to the Legal Department listed in the corporate email directory.The Legal Department will authorize the request or respond to what additional documentation may be necessary for the request to proceed. Medical and/or billing records should not be released under any circumstances until such release is authorized by the legal Department.