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	05/22/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity, including the right to be free from unnecessary drugs used in excessive dose including duplicated drug therapy, excessive duration, without adequate monitoring, and without adequate indications for it for 1 of 5 residents (Resident #14) reviewed for pharmacy services and unnecessary drugs. The facility did not prevent Resident #14 from receiving 13 doses of unnecessary psychotropic drug, Ativan 1ml/mg, discontinued on [DATE]. This failure could place residents at risk for overdosing, delayed healing, and other adverse consequences. Findings included: Record review of Resident #14's face sheet, dated [DATE], indicated an [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnoses included: dementia (an umbrella term for a loss of cognitive functions including memory, reasoning, and language that is severe enough to interfere with daily life and independent functioning) and chronic atrial fibrillation. (a continuous, long-lasting irregular heart rhythm). Record review of Resident #14's quarterly MDS assessment, dated [DATE], indicated Resident #14's BIMS score of 6 indicating severe cognitive impairment and received antidepressant medications. Record review of Resident #14's comprehensive care plan, revised [DATE], indicated Resident #14 uses anti-anxiety medications related to adjustment issues and dementia with behavioral disturbances with interventions: administer anti-anxiety medications as ordered by physician. Observation of controlled medication log for Resident #14's Ativan 1ml/mg on [DATE] at 9:12 a.m., revealed this medication was administered to Resident #14 on the following dates: -[DATE] at 2:00 p.m., [DATE] at 10:00, [DATE] at 1:10 p.m., [DATE] at 6:00 p.m., [DATE] at 10:50 p.m., [DATE] at 8:20 a.m., [DATE] at 9:00 a.m., [DATE] at 9:00 a.m., 2/2526 at 9:00 p.m., [DATE] at 9:00 a.m., [DATE] at 9:40 a.m., [DATE] at 4 p.m., and [DATE] at 7 p.m. with 13 doses were administered to Resident #14 without active physician order for this medication. During an observation and attempted interview of Resident #14 on [DATE] at 1:15 p.m., Resident #14 was observed lying in bed. She could not comprehensibly respond to questions regarding medication administration or her condition. Record review of Resident #14's order summary report indicated an order for Ativan oral tablet 0.5 mg (Lorazepam). Give 0.5 mg by mouth every 8 hours needed for anxiety related to unspecified dementia and psychotic disturbance, mood disturbance. with order day [DATE] an no active order listed for topical Ativan (1ml/mg) apply every 8 hours as needed with a start date of [DATE] and discontinued date of [DATE]. During an interview with PNP on [DATE] at 8:15 a.m., she stated Resident #14 did not have an active order for medication Ativan 1ml/mg topical form. She stated that this resident did not require the topical form any longer due to reduced agitation and being able to take oral form of this medication. She stated that topical form of this medication was discontinued on [DATE] and new order of Ativan oral tablet 0.5 mg to take every 8 hours as needed for anxiety was started last year and she renewed it on monthly basis. She stated that if nursing staff contacted her regarding the topical form needed for this resident, she could order it for Resident #14, but she was not contacted and per her assessment of Resident #14, she did not require topical form any longer. She stated that larger dose of topical Ativan (1ml/mg) is normal as it (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	absorbed through skin and not gastrointestinal system, so it is normal practice to order larger dose or the same medication for topical versus oral medication. She stated that she did not see any harm in administering on as needed basis this topical medication to Resident #14, but it should not be administered to Resident #14 without physician order and needed to be removed from the medication cart to avoid the confusion. During an interview with Pharm on [DATE] at 9:03 a.m., he stated that he was a pharmacist for this facility and Resident #14 did not have a current order for Ativan 1ml/mg topical form. He stated that it started on [DATE] and they did not receive a discontinuation order, but the order of topical Ativan for Resident #14 expired and they did not refill this order for Resident #14. He stated that Resident #14 has an active order for oral Ativan 0.5 mg every 8 hours as needed. He stated that if residents received both medications at the same time could potentially cause oversedation and harmful effect would depend on multiple factors. He stated that topical form of any medication was less effective and it was common practice to proscribe larger dose of topical than oral for effectiveness. During an interview on [DATE] at 4:05 p.m. with DON, he stated that he worked at the facility for 12 years and had medication administration in service on the annual basis and provides in services to his nursing staff on monthly basis through in person and computer modules. He stated that nursing staff received education on medication error, 10 steps of medication administration: wrong med, time, route, pt, rational for medication administration. He stated that they started the investigation and in services. He stated that he started interviewing nursing staff on different shifts and those who worked with the cart the night prior. He denied any history of suspicious behavior from staff regarding medications or any history of narcotic discrepancies. DON stated there was no harm or impact on the residents regarding the incorrect counts. He stated that ADON and himself were doing the random cart audit and MARs. He stated that each nurse or med aids were responsible for their medication carts and counting controlled medication at shift change. He stated that any medication change should be identified during medication administration through and a red sticker identifying medication order change should be placed on medication package. He stated that when medication error was identified the following steps should be taken: the computer form of medication error submitted by ADM, nurse responsible for that cart should complete the reports, DON initiate investigation in order to assess and determine the problem and consequences to residents, and notify family, physician and following with additional training to nursing staff. He stated that they have strong support from outside sources: 6 nurses, 2 physicians support and pharmacist reviewed medication and medication administration on a regular basis. He stated if PRN medication was not administered correctly for Resident #14 and it did not affect their health status but still could be considered a medication error. During an interview on [DATE] at 4:21 p.m. with ADM, she was not trained in medication administration and storage as she was not being medically licensed. She stated that DON, ADON, charge nurses and medication aides were responsible for counting controlled medications at shift change and monitor for medications' discrepancies especially with controlled medication to prevent drug diversion. She stated that DON randomly audits of med carts and MARs. She stated if discrepancy is noted, nurse of med aide was responsible to notify ADON, DON or herself. She stated that if not monitored and properly counted, it would potentially harmfully affect residents. He stated that administered controlled medications should be signed immediately in controlled book, computer, and medical chart of each resident. He stated that in-services on problem with controlled medication counting were addressed, nurse practitioner and other health professionals including medical director were notified, It is important to document controlled medication administration immediately as incomplete information is not our goals which could cause confusion and administration of medication to resident an incorrect dose. The in-service on Medication errors was received from DON regarding Resident #14 and Resident 91's medication and addressed immediately, the self-reported to state on Resident #14's controlled medication discrepancy was submitted, and in-services/investigation was initiated. Record review of an in-service Discontinued Medications, dated [DATE], revealed: when medications are discontinued by physician order. The medications (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	marked appropriately and destroyed.If a physician discontinues a medication, the medication container is placed in a location marked for discontinued medications as soon as possible signed and completed by RN A and LVN.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish a system of accurate reconciliation and determine that drug records were in order, and that an account of all controlled drugs were maintained and periodically reconciled for 3 of 11 medication carts (Medication Cart #1, Medication Cart #2, and Medication Cart #3) in the facility effecting 5 of 11 residents (Resident #91, Resident #201, Resident #122, Resident #14, and Resident #73) reviewed for pharmacy services.The facility failed to ensure:1. RN A accurately reconciled Resident #91's narcotic medication log on medication cart #1 when he administered Resident #91's Lorazepam 0.5 mg (controlled medication used for anxiety). 2.MA E accurately reconciled Resident #122's narcotic medication log on Medication Cart #2 when she administered one tablet of Hydrocodone-Acetaminophen 10-325 mg.3. MA E administered Resident #201's 1 tablet of Hydrocodone-Acetaminophen 5-325 MG after signing the controlled medication log. 4.LVN F accurately reconciled Resident #73's narcotic medication log which revealed the controlled medication discrepancy for Resident #73's Lorazepam 1 mg (controlled medication used for agitation) with lesser amount of pills in the blister pack than on the controlled medication log and lesser amount of medication in the one out of 16 syringes for Resident #14's Lorazepam 1 mg/ml gel in each syringe. These failures could place residents at risk for loss of prescribed medications, potential for not receiving their prescribed medications, and risk of drug diversion. Findings included:Record review of Resident #91's face sheet, dated 05/21/2026, reflected [AGE] year-old female, originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included: schizoaffective disorder, bipolar type (a chronic mental health condition combining schizophrenia symptoms like delusions or hallucinations with severe mood swings of mania and depression), epilepsy (a chronic neurological disorder characterized by recurring, unprovoked seizures, which occur when abnormal electrical activity in the brain causes temporary surges), anxiety, and depression disorder.Record review of Resident #91's annual MDS assessment, dated 12/02/2025, reflected unassigned Resident #91's BIMS score with severely impaired cognitive skills for daily decision making. The MDS assessment indicated Resident #91 received scheduled antipsychotic and antianxiety medications.Attempted to interview Resident #91 and not able to receive any comprehensive response due to her cognitive impairment. Record review of Resident #91's comprehensive care plan, revised on 01/13/2025, reflected Resident 91 had anti-anxiety medications related to anxiety disorder with intervention to administer antianxiety medication as ordered by physician. Record review of Resident #91's order summary report indicated she had an order for Ativan Oral Tablet 1 MG (Lorazepam) Give 1 tablet by mouth three times a day related to schizoaffective disorder, bipolar type with an order start date of 04/21/2026 and Ativan Oral tablet 1 MG (Lorazepam) give 1mg for anxiety irritability related to schizoaffective disorder, bipolar type for 30 days as needed with start date of 4/20/2026 and stop date of 05/20/2026.Record review of Resident #91's medication administration record for 05/21/2026 indicated Resident #91 received scheduled Ativan Oral Tablet 1 MG (Lorazepam) at 8 a.m. when medication was not documented in controlled medication administration record. 1. During medication cart #1's reconciliation with RN A on 05/21/2026 at 08:56 a.m., Resident #91's narcotic medication log showed a discrepancy in the count with a blister pack of Resident #91's Lorazepam 0.5 mg. The blister pack had 2 tablets less than what was documented on the controlled medication log, there was no red sticker indicating dosage directions change observed on blister pack and controlled medication log with 35 tablets in the blister pack and 37 tablets in the controlled log. During an interview on 05/21/2026 at 8:48 a.m., RN A stated he administered the two tablets of Ativan (Lorazepam) to Resident #91 but failed to document the administration on Resident #91's narcotic record. RN A stated he was responsible for documenting the administration of controlled medication on the resident's narcotic record immediately when a narcotic (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication was administered. He stated that he forgot to sign for Resident #91's controlled medications log since he was very busy all morning. RN A stated that not documenting the narcotic medication could cause a discrepancy or a medication error, since the next nurse would not know the resident had already received the narcotic medication. RN A stated he received training on medication administration and proper documentation of controlled medication administration in the last two months.2. Record review of Resident #201's face sheet, dated 05/21/2026, indicated a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnoses included: poly osteoarthritis (osteoarthritis affecting five or more joints simultaneously), anxiety disorder, major depressive disorder (a serious mood disorder), and pain in right shoulder.Record review of Resident #201's annual MDS assessment indicate Resident #201 had a BIMS score of 10, which indicated moderate cognitive impairment. The MDS assessment indicated Resident #201 was treated for pain in right shoulder with pain medication.Record review of Resident #201's comprehensive care plan, dated 01/26/2021, indicated Resident #201 had potential for pain related to Diabetic neuropathy (nerve damage caused by long-term high blood sugar and fat levels in people with diabetes), poly osteoarthritis, muscle spasms pain. The care plan interventions included Administer analgesia as per orders. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Record review of Resident #201's order summary report indicated Resident #201 had an order for Hydrocodone-Acetaminophen oral tablet 5-325 mg give 1 tablet by mouth three times a day for Arthritis with a start date of 08/28/2025.Record review of Resident #201's medication administration record, dated 05/21/2026, indicated Resident #201 did not receive 1 tablet of Hydrocodone -APAP 10-325 mg take on 05/21/2026.Record review of Resident #122's face sheet, dated 05/21/2026, indicated a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnoses included: chronic pain syndrome (a condition where persistent pain lasts beyond the expected healing time [typically 3 to 6 months]), bilateral primary osteoarthritis (degenerative joint disease with no single identifiable cause, primarily driven by aging, genetics, and lifelong joint wear) of first carpometacarpal joints (connect the carpal bones [wrist] to the metacarpal bones [hand]), and general anxiety disorder.Record review of Resident #122's quarterly MDS assessment, dated 03/27/2026, indicate Resident #122 had a BIMS score of 14, which indicated intact cognition. The MDS assessment indicated Resident #122 was treated with scheduled pain medication regiment for chronic pain syndrome.Record review of Resident #122's comprehensive care plan, dated 03/27/2026, indicated Resident #122 had chronic pain. The care plan interventions included anticipating the resident's need for pain relief and respond immediately to any complaint of pain through scheduled pain medication. Record review of Resident #122's order summary report indicated an order for Hydrocodone-Acetaminophen oral tablets 10-325 mg; give 1 tablet by mouth three times a day for pain with a start date of 09/12/2025.During medication cart #2's reconciliation on 05/21/2026 at 09:56 a.m., Resident #201's narcotic medication log showed a discrepancy of count with a blister pack of Resident #201's Hydrocodone -APAP 5-325 mg, there was 1 tablet more in the blister pack than on the controlled medication log count with 43 tablets in the log and 44 tablets in the blister pack. Resident #122's log had one tablet less of Hydrocodone -APAP 5-325 mg in the blister pack than documented on the controlled medication log with 39 tablets in the blister pack and 40 in the controlled log. During an interview with MA E on 05/21/2026 at 10:05 a.m., she stated she had been in-serviced on medication administration annually and periodically throughout the year. She stated that she was supposed to document controlled medication post administration immediately and not before administration. She stated that not documenting the medication administration or documenting and not administering medication could cause confusion and residents could receive more medication or not receive medication due to these medication errors. She stated that she was usually more attentive to details.During an interview with RN B on 05/21/2026 10:04 a.m., she stated that she worked with Resident #201. She stated that she received in-services regularly -annually and monthly - on different issues including medication administration and controlled medication reconciliation. She (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that when nurses or med aides give controlled medication, they should sign immediately on computer and controlled medication log. She stated that not signing administered medication or signing but not giving medication can lead to med error and diversion. If discrepancy is discovered, per policy they should let the ADM and DON know immediately. She stated that if ordered medication was not administered that could lead to increase in pain or worsening of medical conditions. She stated that administering medication and not signing the controlled log could be considered to be the med error.3. Record review of Resident #14's face sheet, dated 05/21/2026, indicated an [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnoses included: dementia (an umbrella term for a loss of cognitive functions including memory, reasoning, and language that is severe enough to interfere with daily life and independent functioning) and chronic atrial fibrillation. (a continuous, long-lasting irregular heart rhythm).Record review of Resident #14's quarterly MDS assessment, dated 04/23/2026, indicated Resident #14's BIMS score of 6 indicating severe cognitive impairment and received antidepressant medications.Record review of Resident #14's comprehensive care plan, revised 10/03/2025, indicated Resident #14 uses anti-anxiety medications related to adjustment issues and dementia with behavioral disturbances with interventions: administer anti-anxiety medications as ordered by physician. Record review of Resident #73's face sheet dated from 05/21/2026 indicated a [AGE] year-old male who was admitted on [DATE] with diagnoses included: dementia with agitation (distressing behavioral syndrome marked by restlessness, pacing, emotional distress, or aggression). Record review of Resident #73's quarterly MDS assessment, dated 03/11/2026, indicated Resident #73's severely impaired cognitive skills for daily decision making and unassigned BIMS score with administration of antianxiety medication. Record review of Resident #73's comprehensive care plan, revised 03/14/2024, indicated Resident #73 had physical and verbal aggressive behavior related to dementia, poor impulse control with interventions: administer medications as ordered. Record review of Resident #73's order summary report indicated Resident #73 had an order for Ativan oral tablet 1 mg (Lorazepam) Give 1 mg by mouth every 8 hours as needed for anxiety/agitation for 14 days with a start date of 05/21/2026.During medication cart #3's reconciliation on 05/21/2026 at 10:21 a.m., the discrepancy in the count of controlled medication lorazepam 1 mg tablet for Resident #73 with discrepancy in count between blister pack with one tablet less than documented on the controlled medication log and discrepancy in lorazepam 1 mg/ml gel with approximately 0.25 mg/ml left in the syringe which is 1/4 of prefilled dose observed in other syringes for Resident #14 with no documentation indicating the discrepancy in the log. The number of syringes was equal to the number in the count on the log, but each syringe should consist of 1 mg/ml medication in gel form.During an interview on 05/21/2026 at 12:28 a.m., LVN F stated she did not administer lorazepam 1mg/ml to Resident #14, and she counted the controlled medications at the beginning of her shift today, 05/21/2026 at 6:00 a.m., with a night nurse. LVN F stated that she had training on controlled medication storage and administration in the last 3-4 months. She stated that she was responsible for medications on her cart including counting the controlled medications at each shift change to make sure the count was correct. She stated that she was counting the syringes with lorazepam for Resident #14 by the tips of syringes without looking at the content of medication inside the syringes, so she overlooked that one of the syringes was 2/3 empty. She stated if she did not follow the proper medication storage and controlled medication counting policy, it could lead to medication errors and drug diversion. LVN F stated that when a medication discrepancy is found, the DON should be notified immediately. She took the medication to the DON. She stated that she was supposed to document controlled medication administration in the controlled log immediately after administration and she got busy and forgot to do it. During an interview on 05/21/2026 at 4:05 p.m., the DON stated that he worked at the facility for 12 years and had medication administration in service on an annual basis and provides in services to his nursing staff on monthly basis through in person and computer modules. He stated that nursing staff received education on medication error, 10 steps of medication administration: wrong med, time, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	route, pt, rational for medication administration. He stated that they started the investigation and in services. He stated that he started interviewing nursing staff on different shifts and those who worked with the cart the night prior. He denied any history of suspicious behavior from staff regarding medications or any history of narcotic discrepancies. The DON stated there was no harm or impact on the residents regarding the incorrect counts. He stated that the ADON and himself were doing the random cart audit and MARs. He stated that each nurse or med aides were responsible for their medication carts and counting controlled medication at shift change. He stated that any medication change should be identified during medication administration through and a red sticker identifying medication order change should be placed on medication package. He stated that when medication error was identified the following steps should be taken: the computer form of medication error submitted by ADM, nurse responsible for that cart should complete the reports, DON initiate investigation in order to assess and determine the problem and consequences to residents, and notify family, physician and following with additional training to nursing staff. He stated that they have a strong support from outside sources: 6 nurses, 2 physicians support and pharmacist reviewed medication and medication administration on a regular basis. He stated if PRN medication was not administered correctly for Resident #14 and Resident #91, it did not affect their health status but still could be considered a medication error. During an interview on 05/21/2026 at 4:21 p.m., the ADM said she was not trained in medication administration and storage as she was not medically licensed. She stated that the DON, ADON, charge nurses and medication aides were responsible for counting controlled medications at shift change and monitor for medications' discrepancies especially with controlled medication to prevent drug diversion. She stated that the DON randomly audits the med carts and MARs. She stated if a discrepancy is noted, nurse of med aide was responsible to notify the ADON, DON, or herself. She stated that if not monitored and properly counted, it would potentially harmfully affect residents. Controlled meds should be signed immediately in controlled medication book and computer, medical chart of each resident. The ADM said in services on problem with controlled medication counting was addressed, the nurse practitioner and other health professionals including medical director was notified, it is important to document controlled medication administration immediately as incomplete information was not our intended goal that could cause the confusion and administration of medication to resident incorrect dose. Inservice on Med errors received from DON regarding Resident #14's medication and addressed immediately, self-reported to state, in-services and investigation initiated.Record review of an in-services for last 12 months, May 2025-May 2026, revealed an in-service on passing medications: using the 5 rights during medication pass: 3-right dose and 5-right route. Match the MAR (medication administration record) to the drug label. completed and signed by RN A, MA E and LVN. Record review of the facility's Medication Administration policy, dated 10/01/2019, revealed Medications are administered as prescribed in accordance with good nursing principles and practices.10 Rights of Medication Administration - Whenever you are preparing to give someone medication, it is important to understand the 10 rights of medication administration. Safety should be the first thing on your mind with medications. There is always a risk of giving the wrong pill, the wrong dose, or the wrong person's medication. If this happens, harm to the person can occur and some reactions can be deadly.It is important for everyone to know the safety rules for medications.3. Right Dosage. This is one of the most important in the 10 rights of medication administration. Check the doctor's order/MAR against the medication on hand. Calculate the dosage yourself to make sure it is right. Pay attention to the dosage of the actual medication versus the required dosage the patient is to take. 6. Right Documentation - Nurses need to document medications as they are given. Any medication documentation needs to be initiated. E. Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label. If the label and MAR are different and the container is not flagged, indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's order are checked for the correct dosage schedule.2. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administration: B. Medications are administered in accordance with written orders of the prescriber.4. Documentation: The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given.Record review of the facility's Training - Education Charge Nurses and Medication Aides, dated 05/21/1026, revealed Prevention of Medication errors 2. You are responsible for adhering to the facility policy and procedure on medication administration. Follow the 10 Rights of medication Administration. Right dose: in case of dosage change, apply the change in direction sticker. Right documentation: document immediately after administration, NEVER BEFORE NOR LATER.Record review of Documentation of Controlled Medication policy, dated 10/01/2019, revealed the controlled substance record refers to the document(s) utilized to track controlled substances on a shift-to-shift basis from the point of receipt through destruction/discharge. These documents may also be referred to as a controlled substances book or proof of use sheetProcedure: 1. The Director of Nursing Services is responsible for the Controlled Substances Record. It is recommended that the Controlled Substances Record be examined weekly by the Director of Nursing or designee for any tampering, irregularities, or incompleteness. 8. The licensed nurse of medical aide on the shift reporting to duty counts all medications with licensed nurse or medical aide going off duty. The nurse coming on duty should be overseeing both the controlled substances record and each scaled unit dose card. Each card should be checked back and front for tampering and quality control. If there is a discrepancy in the count, do not sign the record. Report the discrepancy to the supervisor of DON. 9. The last signature in the controlled substances record is responsible for the count.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of significant medication errors and failed to report drug errors to the resident's physician in a timely manner and record them in the resident's record for 1 of 5 residents (Resident #91) reviewed for drug administration. The facility failed to ensure that RN A administered a correct dose of Lorazepam 0.5 mg (controlled medication used for anxiety) to Resident #91 for a week without obtaining a correct dose of medication according to the physician order. This failure could place residents at risk for overdosing, delayed healing, and other adverse consequences. Findings included: Record review of Resident #91's face sheet, dated 05/21/2026, reflected [AGE] year-old female, originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included: schizoaffective disorder, bipolar type (a chronic mental health condition combining schizophrenia symptoms like delusions or hallucinations with severe mood swings of mania and depression), epilepsy (a chronic neurological disorder characterized by recurring, unprovoked seizures, which occur when abnormal electrical activity in the brain causes temporary surges), anxiety, and depression disorder. Record review of Resident #91's annual MDS assessment, dated 12/02/2025, reflected unassigned Resident #91's BIMS score with severely impaired cognitive skills for daily decision making. The MDS assessment indicated Resident #91 received scheduled antipsychotic and antianxiety medications. Record review of Resident #91's comprehensive care plan, revised on 01/13/2025, reflected Resident 91 had anti-anxiety medications related to anxiety disorder with intervention to administer antianxiety medication as ordered by physician. Record review of Resident #91's order summary report indicated she had an order for Ativan Oral Tablet 1 MG (Lorazepam) Give 1 tablet by mouth three times a day related to schizoaffective disorder, bipolar type with an order start date of 04/21/2026 and Ativan Oral tablet 1 MG (Lorazepam) give 1mg for anxiety irritability related to schizoaffective disorder, bipolar type for 30 days as needed with start date of 4/20/2026 and stop date of 05/20/2026. Record review of Resident #91's controlled medication revealed administration of wrong dose of Ativan oral tablets of 0.5 mg instead of 1mg as ordered on following dates: -4/24/2026 at 3 p.m., 5/5/2026 at 9:00 a.m. and 8 p.m., 5/6/2026 at 9 a.m., 5/11/2026 at 9 a.m., 5/14/2026 at 9:00 a.m., 5/15/2026 at 9 a.m., 5/16/2026 at 9:00 a.m. and 5:00 p.m., 5/17/2026 at 11 a.m., which was documented on MAR which totaled to 10 doses of this medication administered to Resident #91. During an observation and attempted interview of Resident #91 on 05/21/2026 at 12:35 p.m., Resident #91 was observed trying to get out of bed. She could not comprehensibly respond to questions regarding medication administration or her condition. During an interview on 05/21/2026 at 8:54 a.m., RN A stated that he worked at this facility for 4 years on 100 hall and took care of 31 residents including Resident #91. He stated that he administered Ativan oral tablet 0.5 mg (Lorazepam) 2 tablet on 05/21/2026 at 7:40 a.m. from the blister pack that included as needed medications and not from the blister pack that contained 1mg of Ativan for Resident #91. He stated that he was not sure when this medication dosage was changed. He stated that he administered a dose of 0.5 mg Ativan instead of 1mg from this blister pack which was indicated by his signatures on the controlled log for Resident #91. He stated that when medication dose changed, nurses were responsible for placing a red sticker of medication change on the blister pack and controlled log to avoid the confusion. He stated that administering wrong dose to Resident #91 could be considered a medication error and not treating the health conditions Resident #91 had. During an interview with PNP on 05/21/2026 2:38 p.m., she stated she saw Resident #91 every other week. She stated that Resident #91 could not communicate and had behaviors like crawling on floor, she puts as needed order of 1 mg oral Ativan every 8 hours as needed with start day on 04/20/2026 and stop day on 05/20/2026. She stated that if nurses gave medication on 05/21/2026, it was a med error, due to giving med without order, she stated that giving incorrect dose of 0.5 mg of Ativan for Resident #91 could be not providing Resident #91 with needed treatment and (continued on next page)

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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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	affect the results of treatment. PNP stated that she put her own orders in the system, but nurses ask her for as needed orders and they did not ask her for new order for Ativan 1mg for Resident #91, that's why she did not put an order in the system. She stated that she will put a new PRN order right now. She stated that overall nurses at this facility were doing good job communicating residents' needs and administering medications according to physicians' orders. She was not aware of med errors at this facility prior to this incident. During interview with ADON on 05/21/2026 1:15 p.m., he stated not administering correct doze could be considered a medication error. ADON stated that he had in-service on medication administration and controlled medication reconciliation on regular basis - annually. He stated that nursing staff (CMAs and charge nurses) are supposed to count controlled meds at beginning and end of their shift. He stated that ff discrepancy in controlled medication count was found, nursing staff was supposed to notify DON, ADONs and ADM immediately to start investigation. He stated that he was not aware of discrepancies for Resident #91 and Resident #14until notified by state. ADON stated that charge nurses and CMAs were responsible for following 5 rights of medication, including correct doze of medication, according to the physician order on MAR. She stated that if correct doze of medication was not available in the facility, charge nurses or CMAs were responsible to notify ADON or DON and they would contact physician to change the order. During an interview on 05/21/2026 at 12:11 p.m., the DON, he stated that regarding the narcotic discrepancies that was found the day prior was submitted to the state for intake. The DON stated that they started the investigation and in services. He stated that interviews with the residents stated that they all received their medications. He denied any history of suspicious behavior from staff regarding medications or any history of narcotic discrepancies. The DON stated there was no harm or impact on the residents regarding the incorrect counts. He stated that ADON and himself were doing the random cart audit and MARs. The DON stated that each nurse or med aids were responsible for their medication carts and counting controlled medication at shift change and following physician orders and if physician orders changed, place a change order red sticker on blister pack to alert regarding the change. DON stated that he had training on medication storage and controlled medication annually and staff get that training through computer modules annually. During an interview on 05/21/2026 at 2:21 p.m. with ADM, he was trained proper medication administration and storage policy. He stated that he was aware of need for signing for controlled medication administration immediately and not signing until medication was administered to residents. ADM stated that DON, ADON, charge nurses and medication aides were responsible for counting controlled medications at shift change and monitor for medication discrepancies especially with controlled medication to prevent drug diversion. He stated that DON randomly audits of med carts and MARs with assistance from pharmacy consultants and he tries to assist them as much as he could due to lack of medical training. He stated if discrepancy is noted, nurse of med aide was responsible to notify ADON, DON or himself. He stated that if not monitored and properly counted, it would potentially harmfully affect residents. During an interview with Psych NP on 05/21/2026 2:38 p.m., she stated she saw Resident #91 every other week, she cannot communicate and has behaviors, crawling on floor, she puts PRN 1mg Ativan q8hrs and the stop day was yesterday. She stated that if nurses gave medication today, it was a med error, due to giving med without order, she stated that under medicating this resident would be not providing her with needed treatment and affect the results of treatment. She puts her own orders in the system, but nurses ask her for PRN and they did not ask her for new PRN order for Resident #91, that's why she did not put an order. She stated that she would put a new PRN order right now. She stated that overall nurses were doing good job communicating residents' needs at this facility and administering medications according to her orders. She was not aware of med errors at this facility prior to this incident. During an interview on 05/21/2026 at 4:05 p.m. with DON, he stated that he worked at the facility for 12 years and had medication administration in service on the annual basis and provides in services to his nursing staff on monthly basis through in person and computer modules. He stated that nursing staff received (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	education on medication error, 10 steps of medication administration: wrong med, time, route, pt, rational for medication administration. He stated that they started the investigation and in services. He stated that he started interviewing nursing staff on different shifts and those who worked with the cart the night prior. He denied any history of suspicious behavior from staff regarding medications or any history of narcotic discrepancies. DON stated there was no harm or impact on the residents regarding the incorrect counts. He stated that ADON and himself were doing the random cart audit and MARs. He stated that each nurse or med aids were responsible for their medication carts and counting controlled medication at shift change. He stated that any medication change should be identified during medication administration through and a red sticker identifying medication order change should be placed on medication package. He stated that when medication error was identified the following steps should be taken: the computer form of medication error submitted by ADM, nurse responsible for that cart should complete the reports, DON initiate investigation in order to assess and determine the problem and consequences to residents, and notify family, physician and following with additional training to nursing staff. He stated that they have a strong support from outside sources: 6 nurses, 2 physicians support and pharmacist reviewed medication and medication administration on a regular basis. He stated if PRN medication was not administered correctly for Resident #14 and Resident #91, it did not affect their health status but still could be considered a medication error. During an interview on 05/21/2026 at 4:21 p.m. with ADM, she was not trained in medication administration and storage as she was not being medically licensed. She stated that DON, ADON, charge nurses and medication aides were responsible for counting controlled medications at shift change and monitor for medications' discrepancies especially with controlled medication to prevent drug diversion. She stated that DON randomly audits of med carts and MARs. She stated if discrepancy is noted, nurse of med aide was responsible to notify ADON, DON or herself. She stated that if not monitored and properly counted, it would potentially harmfully affect residents. He stated that administered controlled medications should be signed immediately in controlled book, computer, and medical chart of each resident. He stated that in-services on problem with controlled medication counting were addressed, nurse practitioner and other health professionals including medical director were notified, It is important to document controlled medication administration immediately as incomplete information is not our goals which could cause confusion and administration of medication to resident an incorrect dose. The in-service on Medication errors was received from DON regarding Resident #14 and Resident 91's medication and addressed immediately, the self-reported to state on Resident #14's controlled medication discrepancy was submitted, and in-services/investigation was initiated. Record review of an in-service Pharmacy recommendations, dated 02/03/2026, revealed 4.When passing medications, you should do your 3 checks! While doing so you will notice any deviance in directions. Place a directions change sticker until new blister arrives signed and completed by LVN.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen reviewed for food and nutrition services.1)The facility failed to effectively reseal all food items in the walk-in refrigerator and dry pantry to prevent contamination or spoilage on 05/19/2026.2)The facility failed to label and date all food items located in the reach-in refrigerator, walk-in refrigerator, walk-in freezer, and kitchen shelves on 05/19/2026 and 05/20/2026.3)The facility failed to dispose of expired foods items located in the walk-in refrigerator and dry pantry.4)The facility failed to ensure proper hair restraints were worn by kitchen staff and individuals entering the kitchen. These failures could place residents at risk of cross contamination, loss of nutritional value, and foodborne illness.Findings included:During the initial tour of the kitchen on 05/19/2026 at 09:11 a.m. the following was observed:The reach-in refrigerator contained one tray of cups of liquid, possible juice, that were not labeled nor dated. The dry pantry revealed a pack of hamburger buns, a plastic bag containing several slices of bread, and a plastic bag containing an open bag of flour tortillas, all of which were not properly sealed, nor labeled or dated. Also on the shelf were three bags of corn tortillas with a best by date of 04/27/2026. A tray under the counter contained 10 small containers of dried cereal, none labeled or dated.The walk in refrigerator contained multiple expired and improperly stored items, including: A salad mix dated 05/18/2026 that was open and exposed to air Two trays of sandwiches dated 05/15/2026 with several not sealed Lettuce leaves in a plastic bag dated 05/06/2026 with black spoilage Cilantro in a plastic bag dated 05/07/2026 An unlabeled and undated coleslaw mix in a plastic bag An open gallon of milk with a best by date of 05/17/2026 An unopened heavy cream with a use by date of 05/14/2026The walk-in freezer revealed a previously opened, unlabeled plastic bag of unidentified frozen meat. During an observation on 05/19/2026 at 9:26 a.m. revealed [NAME] A wore a beard cover that did not cover his mustache.During an interview and observation on 05/19/2026 at 9:36 a.m., the DA stated she was trained last month on labeling, storage, and dating food. She said the milk, heavy cream, cilantro, and lettuce were expired and should have been discarded. She stated it was everyone's responsibility to label, store, and date food and did not know why expired food remained. She was observed discarding expired food and unsealed sandwiches.During an interview on 05/19/2026 at 9:45 a.m., [NAME] A stated he was trained last week on labeling, storing, and dating food and that all food should have receive, open, and use by dates. He stated all food should be sealed to avoid cross contamination and spoilage, which could make residents sick. He did not know why expired food remained in the walk-in refrigerator or pantry because it was everyone's responsibility to check.During an observation on 05/19/2026 at 12:09 p.m., revealed [NAME] B wore a hairnet that did not fully cover her hair around the forehead and neck.During an interview and observation on 05/19/2026 at 12:15 p.m., the RD stated she trained staff last week on labeling, dating, and storing food. She stated expired food should be discarded immediately and that all staff entering the kitchen must wear hairnets and beard guards covering all visible hair. She stated [NAME] A should have covered his mustache and provided [NAME] B with a second hairnet. The RD discarded the corn tortillas, bread, and flour tortillas in the dry pantry room. During an interview on 05/19/2026 at 12:36 p.m., [NAME] B stated she had been trained in kitchen hygiene and that hairnets must cover all hair to prevent contamination and choking hazards. She stated she normally wore a cap under her hairnet but overslept and did not have it. She stated she had been trained to label, date, and store food and did not know why expired food had not been discarded.During an observation on 05/20/2026 at 1:51 p.m., revealed the lunch test tray contained fresh apples with a best by date of 05/19/2026. Finished lunch trays on the 600 hall also contained empty apple packs with the same date.During a follow up observation in the kitchen on 05/20/2026 at 2:03 p.m., the reach-in refrigerator revealed meat and cheese sandwiches and peanut (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	butter and jelly sandwiches in plastic bags that were not labeled or dated.During an interview on 05/21/2026 at 9:31 a.m., the DM stated he trained staff last week on labeling, dating, and storing food. He stated food must be sealed and dated to prevent bacteria growth and spoilage. He stated he conducted daily walk throughs but did not see the expired food. He stated everyone entering the kitchen must wear hairnets and beard guards. The DM stated he went by the used by date and the Best Buy date and if it's past that he would throw out the items. The DM stated serving expired food could potentially lead to a foodborne illness and serving food beyond the Best Buy date would not be as fresh.During an interview on 05/21/2026 at 10:00 a.m., [NAME] A stated he had been trained on hair restraints and had not covered his mustache before being corrected by the RD because it was trimmed and kept short. The potential negative outcome of hair getting in food was cross contamination, and the risk of choking on hair.During an observation in the kitchen on 05/21/2026 at 10:03 a.m., the milk delivery driver entered the kitchen several times while wearing a hoodie, with a visible beard and goatee, and no hairnet.During an interview on 05/21/2026 at 10:30 a.m. the ADM stated his expectation was for anyone entering the kitchen to wear proper hairnets and beard guards, including the milk delivery man, because it was not sanitary and hair could fall in the food. During an interview on 05/21/2026 at 1:45 p.m. the DON stated labeling, dating, and storing food were necessary to avoid serving spoiled food, which could cause intestinal problems and foodborne illness.During an interview on 05/21/2026 at 2:25 p.m., the ADM stated he previously identified concerns with food storage and labeling and had provided training. He stated unsealed food might have been due to the type of bags used and that he brought new bags to correct the issue.Reviews of the facility RD monthly quality monitor reports dated 03/10/2026 and 04/22/2026 reflected that all food items were not covered, labeled, and dated. Monthly quality monitor report dated 05/04/2026 reflected that all food items were not covered, labeled, and dated and food was not expired or spoiled. Review of the kitchen's in-service training dated 03/31/2026 titled Kitchen In Service: Labeling, Storage, Sanitation & Tray line Accuracy reflected: Every product in storage must have all required dates: Received By Date - When checking deliveries, pick up each item to verify the date. Open Date - Anything opened or decanted must be labeled right away. Use By Date - All cooked items must have a clear use by date based on policy.If it's missing a date, it cannot be used.Review of the kitchen in-service training dated 05/04/2026 titled In Service: Strengths & Critical Corrections During Survey Window revealed: PurposeTo reinforce safe food handling, sanitation, pest control, and regulatory compliance practices. While the kitchen is doing many things well, several areas must be tightened immediately to avoid F812, F880, F371, F925, and F942 citations.Several storage issues were observed that must be corrected. Tortillas open/unsealed. Chili dated 4/22 still present-expiredAction:Discard expired items.Review of the kitchen in-service training dated 05/19/2026 titled In Service: Labeling, Dating, Sealing, Handwashing & Glove Use revealed:1. Labeling & Dating Expectations - KNOW TODAY'S DATE AND REFERENCE FOOD STORAGE GUIDELINES ATTACHED FOR ACCURATE USE BY DATEA. Received By Dates All items must have a received by date. Manufacturer expiration date must remain visible and must be followed.B. Items Removed From Original PackagingMust be labeled with: Item name Date opened or prepped Manufacturer expiration date if unopened Use by date if opened (per facility guidelines) or manufacturer's expiration date (which ever comes first) Items must be discarded when quality deteriorates, even if not expired.C. Leftovers Must be labeled with item name, date prepared, and use by date(72hrs per facility policy)2. Sealing RequirementsAll food items in dry storage, refrigerators, and freezers must be properly sealed.Acceptable sealing: Bags folded and fully closed Bags or containers covered with saran wrap Ziplock bags fully zipped, If zip cannot close ˆ wrap with saran wrap Containers must have tight fitting lidsUnacceptable: Open bread bags Unsealed lettuce bags Containers without lids Loosely folded bags.6. Hair Nets & [NAME] NetsHair Nets Must cover all hair. Staff may need to: oAdjust hairstyleoWear two hair netsoProvide their own bonnet that fully contains hairBeard Nets Must cover the entire beard/mustache, tuck in additional netting to reduce excess netting that may obstruct (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vision7. Surveyor Findings (Corrective Focus Areas)These items were found during survey and must not recur:Expired or Poor Quality Items Expired corn tortillas mixed with non expired items Expired milk Lettuce dated 5/6 still in use with visible deterioration (discard after 5 days from open) Prepped mixed lettuce unsealed and undated Bread items unsealed and undated Whipped cream/heavy cream expired per manufacturer date Unlabeled/undated bagged item in fridge (appeared to be meat)Labeling/Sealing Failures Items without dates (focus expiration dates) Items without labels Items not sealed properly Items stored in bags that were folded but not securedPPE Failures [NAME] nets not covering full beard/mustache Hair nets not covering all hair.Review of the facility policy titled Employee Sanitation date approved 10/01/2018 reflected, Policy: The Nutrition & Foodservice employees of the facility will practice good sanitation practices in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness.Procedure: 3. Employee Cleanliness Requirementsb. Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces.Review of the facility policy titled Food Storage date approved 10/01/2018 reflected: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines.Procedure: 1.Dry Storage roomsd. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. 2. Refrigeratorsd. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage.e. Use all leftovers within 72 hours. Discard items that are over 72 hours old.3. Freezerse. Store frozen foods in moisture-proof wrap or containers that are labeled and dated.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs for 1 of 6 residents (Resident #179) reviewed for accommodation of needs.The facility failed to ensure Resident #179's call light had been placed within reach.This failure had the potential to place dependent residents at risk for injuries and unmet needs.Findings included:Record review of Resident #179's undated admission record reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included diabetes mellitus, muscle wasting, age-related physical disabilities, and cerebrovascular accident (stroke) with paralysis of the left side.Record review of Resident #179's care plan, initiated on 03/05/2022 and revised on 10/19/2022, reflected she was at a high risk for falls related to cerebrovascular accident (stroke) with left-sided paralysis, impaired balance, and impaired coordination. Interventions included, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.Record review of Resident #179's Annual MDS dated [DATE] reflected a BIMS score of 14, indicating she was cognitively intact. The MDS further reflected Resident #179 required substantial/maximal assistance with personal hygiene, upper body dressing, and lower body dressing.During an observation on 05/19/2026 at 10:22 a.m., Resident #179 was sitting upright in her wheelchair with her bedside table positioned in front of her, the call light was located on the bed behind her and out of reach. Resident #179 stated she could not reach the call light and stated she would eventually get help because she could holler if needed.During an observation on 05/19/2026 at 10:50 a.m., Resident #179's remained up in her wheelchair and the call light remained clipped to the bed and out of reach.In an interview and observation on 05/19/2026 at 10:51 a.m., MA D stated Resident #179 could not reach the call light when it was on the far side of the bed. MA D stated the call light was supposed to be attached to the resident's wheelchair and she was not sure why it was out of reach. MA D further stated all staff were responsible for ensuring call lights remained within residents' reach and staff monitored this through rounds and resident observation. MA D stated Resident #179 would not have been able to call for assistance without access to the call light. MA D moved the call light and attached it to Resident #179's wheelchair.In an interview on 05/22/2026 at 12:04 p.m., the DON stated call lights should have remained within reach of all residents. The DON stated all staff were responsible for monitoring and ensuring call lights were accessible. The DON stated staff had been trained through in-services and return demonstrations. The DON further stated the risk to Resident #179 was her needs may not have been met if she was unable to use her call light to request assistance.In an interview on 05/22/2026 at 1:34 p.m., the ADM stated call lights were expected to remain within residents' reach at all times. The ADM stated all staff were responsible for ensuring residents' call lights were accessible. The ADM stated staff had been trained through in-services conducted by the DON and compliance had been monitored through rounds conducted throughout the building. The ADM further stated the potential negative outcomes to Resident #179 for not having the call light within reach could have included falls and unmet needs due to the resident being unable to call for assistance.Record review of the facility policy titled Call Lights: Accessibility and Timely Response, dated 10/13/2022, reflected, Staff will ensure the call light is within reach of resident and secured as needed.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to secure confidential and personal medical records for 1 (Resident #40) of 9 residents reviewed for privacy and confidentiality of records.The facility failed to protect Resident #40's PII on 03/27/2026 when the AMD emailed a PEME request form to an RP of another facility resident. This failure placed residents' PII at risk of exposure to unauthorized parties through electronic communication. Findings included:Review of Resident #40's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE]. Resident #40 had the following diagnoses: high blood pressure (the force of blood against the artery walls is consistently too high), non-Alzheimer's dementia (a decline in memory, thinking, and other cognitive abilities that interfere with daily life, not caused by Alzheimer's disease), anxiety (feelings of discomfort, distress, or apprehension often in response to real or perceived threats), lack of coordination, altered mental status, and restlessness and agitation. Resident #40 required supervision or touching assistance with all ADLs. Resident #40 had a BIMS score of 08, indicating moderately impaired cognition. Review of Resident #40's comprehensive care plan dated 05/05/2026 reflected, she was dependent on staff for meeting emotional, intellectual, physical, and social needs. She needed assistance and reminders to activities. Review of Resident #40's progress notes dated 03/21/2026-04/21/2026 revealed no progress note by any staff indicated Resident #40's PII had been shared with an unauthorized party. Review of Resident #40's signed (by the RP) admission agreement revealed: Resident Rights. As a resident of Facility, Resident is entitled to various rights that Facility encourages Resident to exercise. A Statement of Rights is available on the Texas Secretary of State website and is attached hereto. The Facility Manual and Forms to be Completed Upon admission outline additional rights of Resident, including: Rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)In an observation and attempted interview on 05/19/2026 at 10:35 AM, Resident #40 was ambulating on her own in the hallway appropriately dressed and in good spirits. Resident #40 was unable to be interviewed due to her cognitive impairments. In a confidential interview on 05/20/2026 at 1:04 PM, it was revealed that Resident #40's PII information had been shared with this interviewee via electronic communication by the facility's AMD. The interviewee stated that the email came from the facility where their FM lived, so they thought it was intended for them, and the body of the email only said, LET ME KNOW IF I DID IT RIGHT so the only way for the interviewee to know what the email was about, was to open the document that was attached, where Resident #40's PII was located. The interviewee volunteered to forward the electronic communication to the state surveyor at this time. Review of a forwarded email from the confidential interviewee revealed an email dated 3/27/20226 at 4:06 PM from the facility AMD, with a document attached to the email, titled PEME Request Form' that included Resident #40's full name, DOB, and SS#, and information about Resident #40's personal income. A typed notice at the bottom of the email reflected, Notice: This e-mail, including any attachments, is the property of [corporate] or its affiliates and is intended for the sole use of the intended recipient(s). It may contain information that is privileged and/or confidential. Any unauthorized review, retention, use, disclosure, or distribution is prohibited. If you are not the intended recipient, please notify the sender regarding the error in a separate email and delete this message. The views expressed in this e-mail do not necessarily represent the views of [corporate] or its affiliates.In an interview on 05/20/2026 at 2:54 PM, Resident #40's RP, he stated that he believed the resident was on Medicaid, and that he could not recall a time where anyone from the facility reached out the him about Resident #40's PII being accidentally shared with anyone, and that if it was, that was concerning to him. In an interview on 05/20/2026 at 2:00 PM with the ADM, he stated they did not have a HIPAA policy, but that they followed HIPAA guidance. In an interview on 05/22/2026 at 11:53 AM with the AMD, she stated that the PEME form was to send to corporate for a (continued on next page)

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	675956	A. Building B. Wing	05/22/2026

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	current resident to reapply for Medicaid. The form was used when the facility would try to get the residents covered for another month by Medicaid. She stated there were 3 residents in the facility that required the use of that form recently. She verified Resident #40 as being one of those 3. She stated that it was brought to her attention by the confidential interviewee that she had emailed Resident #40's form to that person by mistake. She stated she also made a call to the RP of Resident #40 and notified them of the mistake. She stated that she would normally ensure HIPPA compliance by double checking the email she was sending something to. She stated she could get in big trouble if she did not maintain HIPAA compliance, and that risks to residents included things getting out that should not get out. In a follow-up interview on 05/22/2026 at 1:49 PM with the ADM, he stated that usually when emails went outside of the [facility] network, the email would show the compliance snippet at the bottom of the email notifying the recipient to disregard the email if it was not intended for them. He stated his AMD had not previously reported this mistake to him. He stated that they could try to recall messages, but that he has not seen the facility utilizing encrypted emails. He stated that staff were trained in privacy and confidentiality during their initial onboarding. Review of the manual provided by the facility titled United Stated Department of Health & Human Services Summary of the HIPAA Privacy Rule dated 05/03 (no year written) revealed: Individually identifiable health information is information, including demographic data, that relates to: the individual's past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual,and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #29) of 9 residents reviewed for accidents and hazards.The facility failed to ensure Resident #29 did not keep smoking materials in his room. This failure could place residents at risk of a fire, burning themselves, or ingesting unknown substances.Findings included:Review of Resident #29's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male who admitted to the facility on [DATE]. Resident #29 had the following diagnoses: high blood pressure (the force of blood against the artery walls is consistently too high), seizure disorder (recurrent, unprovoked seizures caused by abnormal electrical activity in the brain), bipolar disorder (mental health condition characterized by significant mood swings), schizophrenia (chronic mental health condition that manifests in young adulthood, impairing daily function and quality of life, including hallucinations, delusions, disorganized thinking), lack of coordination, and allergic eczema (an allergic reaction to a substance that comes into direct contact with the skin). Resident #29 had a BIMS score of 12, indicating moderately impaired cognition. Review of Resident #29's comprehensive care plan dated 05/13/2026 reflected, Resident #29 had been identified as having PASRR positive status related to a severe mental illness: Schizoaffective Disorder, Bipolar type. He was a smoker of e-cigarettes and would not smoke without supervision. He was to be instructed about smoking risks and hazards and on the facility smoking policy. Staff were to notify the charge nurse immediately if it was suspected the resident had violated facility smoking policy. He required supervision while smoking . Review of Resident #29's smoking/tobacco acknowledgement dated 02/25/25 revealed The facility respects the resident's right to smoke. All tobacco products will be kept by the facility staff. This includes, but is not limited to, smoking tobacco, chewing tobacco, matches, lighters, and all other types of smoking paraphernalia. Under no circumstances will smoking materials (cigarettes, lighters, etc.) be allowed to be kept in the residents' room or on their person. The facility will designate a specific outdoor location and time for smoking. Smoking will be permitted only in the designated area. All residents will be allowed to smoke, with supervision, in the designated areas and times. Smoking inside the facility is expressly prohibited and will result in discharge. Resident #29's signature was observed on the acknowledgement. In an observation and interview on 05/19/2026 at 10:36 AM, Resident #29 was observed standing at his dresser, facing the doorway of his room, blowing a puff of smoke out of his mouth and then quickly putting something in the top drawer of his dresser. The surveyor asked Resident #29 what he was blowing out of his mouth and he stated it was nothing. The surveyor asked Resident #29 if staff had informed him of the facility's smoking policy, and Resident #29 shook his head ?yes', and that the staff said it was okay for him to vape in his room. There was no oxygen tanks or concentrators observed in the room. In an observation and interview on 05/19/2026 at 10:45 AM, the AD stated she facilitated smoking and smoke breaks at the facility. She stated that they had a list of residents who vaped, and that residents were not permitted to keep vapes in their rooms, due to safety and because there was posted smoking times. She stated that Resident #29's vape should be in the secured smoking box. She stated Resident #29 would sign himself out on pass, and when he came back to the facility, the receptionist would ask the resident if he had any vapes, cigarettes, or lighters on him and they would obtain the items and secure them. She stated that she was not sure if they had previously confiscated vapes from Resident #29. The SW approached at this time, and the surveyor advised the staff of their observation, to which the facility staff went outside and brought Resident #29 to his room. Resident #29 retrieved a vape from his top dresser drawer and handed it to the SW. The SW was overheard informing Resident #29 of the facility's smoking rules and informed the resident she would put the vape in his smoking box.In an interview on 05/22/2026 at 12:30 PM, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA T stated she had been driving the facility van for 6 months, and that Resident #29 frequently went on outings in the facility van. She stated that she gave all residents the whole rundown, meaning that any over the counter items, cigarettes, cigars, vapes, needed to be turned into herself, the receptionist, or the AD upon arrival back to the facility. She stated she told all riders the rules before leaving and upon return to the facility. She stated she was not aware of Resident #29 having not turned in vapes before. She stated that if residents brought those items into the facility and did not turn them in, it could be hazardous to oxygen, it could start fires, residents could potentially choke, or their blood pressure could go up. She stated that this was the first occurrence she had heard about a resident bringing something back into their room that was considered prohibited. In an interview on 05/22/2026 at 12:40 PM, the DON stated that residents were not permitted to keep smoking materials in their rooms and that they turned in those items to a staff member to be secured. He stated the facility encouraged residents to turn those items into staff so they could use them during designated smoking times. He stated that because they cannot search a resident, they remind them to turn prohibited items into staff so they could access those items during the allotted time. If family members brought in cigarettes or lighters, the staff also encouraged them to turn those items into a designated facility staff member. When staff discovered these items in a resident's possession, staff would encourage the resident again to turn the items in. The DON stated that this was the first occurrence for Resident #29 in a long time. He stated that risks to residents, if smoking materials were kept on their person or in their rooms, was that if they had something flammable, they could burn themselves or ingest something that staff did not know what the contents were. In an interview on 05/22/2026 at 1:32 PM, the ADM stated that residents were not permitted to keep smoking materials in their rooms and if residents were found with those items, they were asked to hand them over to facility staff. He stated that to ensure residents turned in those items when brought back from outings, the front desk receptionist was to ask the residents upon coming back into the facility if they obtained those items, and to turn them in for proper storing. He stated the van drivers should also be notifying residents upon reentry. He stated that his expectation was for residents to turn those items into staff. He stated that risks to residents, if smoking materials were kept on their person or in their rooms could be items catching on fire and it could be hazardous to themselves or others. Review of the facility policy titled Resident Smoking dated 10/24/22 reflected, It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. 1.Smoking is prohibited in all areas except the designated smoking area. A Designated Smoking Area sign will be prominently posted. 7.Electronic cigarettes (e-cigarettes/vape/vapor pen) can catch on fire and/or explode if not handled and stored safely. Safety measures for the use of electronic cigarettes by residents will include, but are not limited to:a.Use of e-cigarettes in designated smoking areas only.10.All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan.12.If a resident or family does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional safety measures13.Smoking materials of residents smoking will be maintained by nursing staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 14 residents (Resident #162 and Resident #179) reviewed for infection control.1. CNA C failed to wash or sanitize her hands when going from a dirty surface to a clean surface while performing incontinent care for Resident #179.2.The facility failed on 05/19/2026 to use the CDC recommendations regarding contact isolation for chicken pox for Resident #162.These deficient practices had the potential to place residents at risk for cross contamination and the spread of infection.Findings included:Review of Resident #162's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE] with the following diagnoses: non-traumatic brain dysfunction (brain-related problems that occur without and external physical injury), heart failure, arthritis (inflamed or damaged joints), non-Alzheimer's dementia (a decline in memory, thinking, and other cognitive abilities that interfere with daily life, not caused by Alzheimer's disease), and restlessness and agitation. Resident #162 had a BIMS of 00, indicating severe cognitive impairment. Review of Resident #162's comprehensive care plan dated 05/20/2026 reflected Resident #162 was receiving hospice care, she had declined recommended pneumococcal and flu vaccines, which may have increased her risk for preventable communicable respiratory illness and complications. Her care plan indicated she had active chickenpox and was at risk for infection transmission, skin breakdown, discomfort itching, and complications related to viral illness. She was to be administered anti-viral medication as ordered, maintain contact isolation as ordered, obtain labs as ordered by the provider. She was on antibiotic therapy acyclovir r/t suspected chickenpox infection. Review of Resident #162's progress notes dated 05/18/2026 revealed the first documentation of suspected diagnoses, 2:00PM: Upon assessment; noted Itchy rashes of fluid/pus filled blister on abdomen, chest and under the bilateral breast, Possible chicken pox. Resident will be contact precaution until further order.Review of progress note dated 05/18/2026 at 6:45 PM reflected Resident #162, Received Stat BMP results. Notified NP and received orders Acyclovir Oral Tablet 800 MG (Acyclovir) Give 1 tablet by mouth every 8 hours for possible chicken pox for 7 Days.Review of Resident #162's progress note dated 05/18/2026 at 9:33 PM reflected, Resident continues on f/u for suspected chicken pox and remains in contact precautions.Review of a provider communication log for daily rounds dated 05/22/2026 revealed Resident #162 had infectious abscess on her chest/abdomen, identified as pustules, small abscess, the doctor advised the facility to discontinue isolation, ordered Bactrim twice a day, and if there was drainage, to get a culture and sensitivity. In an observation on 05/19/2026 at 10:31 AM, Resident #162's room revealed a closed door with a blue cloth cubby hanging on the door containing different sized gloves, and yellow gowns. A sign on the door said Contact Precautions Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. A stop sign with a Do Not Enter Isolation See Nurse Before Entering was taped to the wall next to the door. Review of the CDC websites www.cdc.gov transmission-based precautions recommendations for chicken pox revealed, Use Airborne Precautions for patients known or suspected to be infected with pathogens transmitted by the airborne route (e.g., tuberculosis, measles, chickenpox, disseminated herpes zoster). Use personal protective equipment (PPE) appropriately, including a fit-tested NIOSH-approved N95 or higher-level respirator for healthcare personnel.Record review of Resident #179's undated admission record reflected she had been a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included diabetes mellitus, muscle wasting, age-related physical disabilities, and paralysis of the left side.Record review of Resident #179's care plan, initiated on 03/05/2022 and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised on 03/07/2022, reflected Resident #179 had bowel and bladder incontinence related to cerebrovascular accident (stroke). Interventions included: Clean peri-area with each incontinence episode. Check frequently and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes.Record review of Resident #179's Annual MDS dated [DATE] reflected a BIMS score of 14, indicating she had been cognitively intact. The MDS further reflected Resident #179 had required substantial/maximal assistance with personal hygiene, upper body dressing, and lower body dressing.In an observation on 05/20/2026 at 11:50 a.m. of peri-care CNA C washed her hands with soap and water prior to the start of care, unfastened the brief, and cleansed Resident #179's perineal area from front to back using one pass with a clean cloth for each pass. CNA C then turned Resident #179 and cleansed the buttocks using the same method. CNA C changed gloves but did not cleanse her hands with alcohol-based hand sanitizer or wash her hands prior to donning a new pair of gloves. CNA C completed care to the back and placed a new clean brief under the resident.In an interview on 05/20/2026 at 1:27 p.m., CNA C stated she had been trained to cleanse her hands after removing gloves and had been instructed to use soap and water or an alcohol-based hand sanitizer. CNA C stated she had just forgot. CNA C further stated the negative effects of failing to wash hands and change gloves when moving from a dirty surface to a clean surface could have resulted in cross contamination leading to infection.The state surveyor notified the IP (DON) on 05/21/2026 at 11:35 a.m., of the current CDC guidelines related to airborne precautions for suspected chickenpox.In an interview on 05/21/2026 at 12:11 PM with the NP, she stated she saw Resident #162 on 5/20/2026 she stated that the resident does not have a lot of spots, but she had a blister like rash to her right breast, right abdomen, and it spread to the left abdomen. She stated the resident had dementia and could not give an accurate history. She reiterated the resident was on hospice. She stated she did not think she could do a test on chicken pox, she stated usually they had to start the antibiotic early for it to be effective. She assumed the facility had started Resident #162 on precautions. She stated that the facility should be using contact and airborne precautions and specified that masks should be worn in this resident's room. In an interview on 05/22/2026 at 9:44 AM, the ADM stated that they had a skin doctor in the building at this time and the doctor ruled out chicken pox, discontinued all orders and isolation precautions and was diagnosed with a bacterial skin infection.In an interview on 05/22/2026 at 12:00 p.m., the DON stated staff should have washed or sanitized their hands when going from dirty surfaces to clean surfaces in between glove changes. The DON stated staff had been trained in handwashing, infection control, and incontinent care through in-services and return demonstrations. The DON further stated failure to wash or sanitize hands when moving from a dirty surface to a clean surface could have caused the spread of infection.In an interview on 05/22/2026 at 12:48 PM, the DON stated that he looked at the CDC and it said if it was confirmed chicken pox they were to use airborne precautions. He stated that they had 2 situations at play, they notified the NP of the situation, and she ordered the facility to place the resident on contact isolation pending her arrival. When the NP came to review the patient, they asked her where they were going with the diagnosis. He stated that he was thinking of droplet vs airborne precautions, and he asked the NP to confirm with the doctor. The NP told them the doctor would be there Friday, and she ordered an antiviral pending the arrival of the doctor. He stated if they suspected chicken pox, they should have followed the proper precautions. He stated his chief nursing officer advised him he should have sent the resident to the hospital to confirm the diagnosis rather than waiting on a doctor to come to the facility. He stated that if he would have had an outbreak, they would have had to report it to the city public health department. The resident was diagnosed with impetiginous dermatitis and was put on droplet precautions 05/22/2026. In an interview on 05/22/2026 at 1:34 PM, the ADM stated staff had been expected to wash their hands and follow facility guidelines for infection control. The ADM stated staff had been educated on infection control and handwashing through in-services and visual checkoffs. The ADM further stated failure to wash hands when needed could have led to the spread of infection.In a follow up interview on 05/22/2026 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 1:40 PM, the ADM stated that he brought the precautions up to the NP, and the ADM stated he would contact the doctor to confirm Resident #162's diagnosis. He told the NP that he wanted to do PCR testing, but the NP said she was not aware of a test for it. He stated that in short, it did not make sense to him that the NP stated it was needing to be treated as chickenpox. He stated the MD stated it would not be chickenpox either, but general wound care came here on 5/22/2026, and if they did not feel it was chickenpox they would follow the right protocol. He stated that the MD was not the resident's doctor so he could not give the diagnosis. He stated that if they did not follow the proper CDC recommendations it could have been spread to other residents and/or staff. Review of the facility's Infection Prevention and Control Program policy dated 5/13/2023 reflected, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases.5.Isolation Protocol (Transmission-Based Precautions):a.A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines.b.Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances.Record review of the facility's Hand Hygiene policy, dated 10/24/2022, reflected the following: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.