STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676206	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Arbor View	218 Baltic Edinburg, TX 78539

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47573 Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 1 of 3 residents (Resident #1) reviewed for nutritional status. The facility failed to initiate timely interventions to prevent weight loss when Resident #1 experienced significant weight loss of -6.95% (13 pounds) between the dates of 01/10/25 and 02/06/25. This failure could place residents who are dependent on staff for their nutrition and hydration at risk for nutritional deficit, weight loss, skin breakdown, and overall decline in quality of life. The findings included: Record review of Resident #1's face sheet dated 02/04/25 reflected a [AGE] year-old male with an original admitted [DATE] and last admitted [DATE]. His diagnoses included: Parkinsonism (tremors, slow movements, rigidity, postural instability), type 2 diabetes, hypertension, major depressive disorder, dementia, unspecified protein-calorie malnutrition, dysphagia (difficulty swallowing), and muscle wasting and atrophy. Record review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 8 (moderate cognitive impairment). Resident #1 required partial/moderate assistance (helper does less than half the effort) for eating. Record review of Resident #1's care plan dated 02/04/25 reflected Problem: Resident #1 had an ADL self-care performance deficit related to dementia. Date initiated: 04/27/24. Intervention: Resident #1 required partial/moderate assistance for eating. Date initiated: 10/31/24. Problem: Resident #1 had a nutritional problem or potential nutritional problem related to diet restrictions - regular diet, mechanical soft texture, regular liquids consistency. Date initiated: 05/13/24. Interventions: Monitor/document/report PRN any signs/symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Monitor/record/report to MD PRN signs/symptoms of malnutrition: emaciation, muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Provide, serve diet as ordered. Monitor intake and record every meal. RD to evaluate and make diet change recommendations PRN. Date initiated: 04/27/24. Care plan did not reflect significant weight lost. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's updated care plan dated 02/06/25 reflected additional interventions for nutritional problem: Med pass three times a day for weight stability, give 120 ml. Date initiated: 02/05/25. New Problem: Resident #1 had unplanned/unexpected weight loss related to poor food intake. MDS: -5.0% change over 30 day(s) [comparison weight 01/10/25, 187 lbs., -10.2% , -19 lbs.] MDS: -10.0% change over 180 day(s) [comparison weight 08/3/24, 189 lbs., -11.1% , -21 lbs.] -5.0% change [comparison weight 01/10/25, 187.0 lbs., -10.2% , -19.0 lbs.] -7.5% change [comparison weight 12/06/24, 186.0 lbs., -9.7% , -18. 0 lbs.] -10.0% change [comparison weight 11/01/24, 189.0 lbs., -11.1% , -21.0 lbs.] Date initiated: 02/05/25. Interventions: Alert dietician if consumption is poor for more than 48 hours. Give the resident supplements as ordered. Alert nurse/ dietitian if not consuming on a routine basis. If weight decline persists, contact physician and dietician immediately. Labs as ordered. Report results to physician and ensure dietician is aware. Monitor and evaluate any weight loss. Determine percentage lost and place interventions for weight loss per dietician/physician. Monitor and record food intake at each meal. Offer substitutes as requested or indicated. RP signed resident refusal of treatment/medication/diet. Weigh every month and PRN. Date initiated: 02/05/25. Record review of Resident #1's weight record reflected the following weights: 187 lbs. on 01/10/25 (readmission weight from hospitalization), 187 lbs. on 01/17/25, 180 lbs. on 01/24/25, no weight entered on 01/31/25, 168 lbs. on 02/04/25, and 174 lbs. on 02/06/25. Record review of Resident #1's order dated 02/03/25 reflected Med Pass 2.0 three times a day for weight stability, give 120 ml. No new order for a house shake noted. Record review of Resident #1's change in condition communication form dated 02/04/25 reflected Resident #1 weighed for monthly weight. Resident #1 noted with 168.0 lbs. for February weight. Family present when Resident #1 was weighed. NP was notified of weight loss. New order for Med Pass 2.0 120ml TID for weight stability and dietician consult. Resident #1 continued on speech therapy services. Resident #1 was encouraged to go to dining room for meals. Completed by ADON P. Record review of Resident #1's RD assessment dated [DATE] reflected initial consult. Indicated [AGE] year old male presented with diagnosis of Parkinsonism and dementia. Present for assistance with ADLs due to tremors and therapy. Tolerated diet order well. Noted with good appetite and oral intakes to meals and snacks. Recommendation: Liberalize regular (mechanical soft) diet. Recommendation: large protein portions with lunch due to low protein labs. Goal: weight stability +/-5%, oral intakes remain >50% all meals and maintain skin integrity. Will monitor as needed. Completed by RD L. Record review of Resident #1's RD assessment dated [DATE] reflected consult related to new significant weight loss. Communication with ADON, verbal recommendation to continue new order for Med Pass 2.0 supplement to aid with weight stability. Food preferences continue to include milk with all meals, large protein portions with meals. Therapy following. Stable labs for hydration status. Improving albumin level. Recent poor oral intake. Likely unavoidable dietary/weight decline may be attributed to recent acute infection, pain, advanced age with dementia and chronic inflammatory diagnosis/condition. Goal: weight +-2%, oral intake>50%, and good skin integrity. Completed by RD L. Record review of Resident #1's progress notes: On 02/05/25 at 1:50 PM - (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 ate poorly for lunch, offered second choice chicken nuggets, but refused. Asked if he is craving something else but he said no he is ok not hungry. Called daughter to notified of resident refusing lunch and offered other options but he continued to refuse, daughter asked if he is on a supplement resident is on Med pass TID. Documented by LVN E. On 02/05/25 at 6:36 PM - Resident #1 with dietary recommendation. Recommendation to promote weight stability. MD agrees. Continue Med Pass 2.0 120ml TID, weekly weights x 4 weeks, update food preferences. Will continue to observe. Documented by ADON P. On 02/06/25 at 8:27 AM - Resident #1's meal preferences and recommendations have been updated on dining details. Visited with him this morning. He stated he likes coffee, milk, and a variety of juices, oatmeal. He does not really like a lot of vegetables. He chooses to eat in room, if not eating 1st choice is offered 2nd choice, and always on hand menu items. He had no other specific meal preferences at this time. Will be monitoring meal intake, and weights to ensure proper nutrition. RD recommendations in place. Documented by DM I. On 02/06/25 at 9:24 AM - RD visit this morning during breakfast. Resident #1 consumed about 50% of meal, consumed 50% of large protein portion. Trial of fortified cereal provided this morning, accepted about 50%. Recently refused lunch and decreased intake for dinner. Resident #1 able to eat independently. Speech therapist at bedside providing assistance. Noted with snacks in room, per nursing, resident has family support to provide outside foods. DM updated food preferences this morning. Anticipated weight stability as infectious process resolves. Recommendations: continue plan of care at this. Will continue weekly weights for 4 weeks to monitor. Goal: weight +-2%, oral intake >50%, good skin integrity. RD to continue monitoring. Documented by RD L. On 02/06/25 at 10:13 AM - Resident #1 re-weighed in wheelchair. New weight 174.0 lbs. Patient continues on Med Pass 2.0 120ml TID. Resident with diagnosis of Unspecified Protein-Calorie Malnutrition. Documented by ADON P. Interview and Observation of Resident #1 on 02/05/25 at 11:00 AM revealed Resident #1 was eating candy and cookies in his room. Observation of snacks in Resident #1's room. Resident #1 said he liked his snacks. Interview and Observation of Resident #1 on 02/05/25 at 12:40 PM revealed Resident #1 was not eating. Resident #1 said he did not want to eat as he was not hungry. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA B on 02/05/25 at 1:30 PM revealed CNA B said if a resident did not want to eat, she offered the second option. CNA B said if the resident still refused, she notified the nurse that the resident did not want to eat. CNA B said she worked with Resident #1 today, 02/05/25, and he did not want to eat lunch. CNA B said she told LVN E that Resident #1 did not eat and LVN E offered Resident #1 something else, but he still refused. CNA B said the nurses usually informed them when a resident was losing too much weight or asked about their eating habits. CNA B said she had not been informed that Resident #1 had lost a lot of weight. Interview with LVN E on 02/05/25 at 2:20 PM revealed LVN E said if a resident did not want to eat, she offered them second options, alternatives, and tried to convince them. LVN E said if it was a reoccurring issue, she would also inform the doctor to see if the doctor wanted to order maybe a supplement or an appetite stimulant. LVN E said the facility may have also implemented other interventions such as therapy or a swallow study. LVN E said today, 02/05/25, the staff informed her that Resident #1 did not eat lunch. LVN E said she offered Resident #1 the second option or if there was something else, he wanted, but he still refused. LVN E said some day last week, FM 1 asked about Resident #1's weight because he appeared thinner. LVN E said she was not sure if any interventions had been implemented for Resident #1 last week. LVN E said RA P was responsible for weighing the residents. Interview with FM 1 on 02/05/25 at 3:00 PM revealed FM 1 said the facility called her today, 02/05/25, and informed her that Resident #1 had lost 17 lbs. in the last 3 weeks. FM 1 said she had told the facility that Resident #1 had not been eating. FM 1 said she made the staff weigh Resident #1 yesterday, 02/04/25, and he weighed 168 lbs . FM 1 said Resident #1 was started on a supplement yesterday, 02/04/25. Interview with DM I on 02/0/25 at 3:40 PM revealed DM I said whenever there was a resident with weight loss, the nurses informed her or it flagged in the system. DM I said the dietitian came twice a month and the dietitian's technician was also here twice a month so they were here 4 times a month. DM I said if there was a resident with significant weight loss, the dietitian assessed and gave recommendations. DM I said she had not been informed recently that Resident #1 had significant weight loss. DM I said Resident #1 refused to eat at times, but they offered him second options or preferred foods. Interview with CNA C on 02/05/25 at 4:20 PM revealed CNA C said if a resident refused to eat, she informed the nurse. CNA C said she worked with Resident #1 yesterday, 02/04/25, and he threw the dinner plate as he refused to eat. CNA C said if a resident was losing weight, the nurse would inform them, so they ensured to report to the nurse if they were eating or not eating. CNA C said she had not been informed that Resident #1 lost a lot of weight nor had been asked about his eating habits. Interview with LVN F on 02/05/25 at 4:45 PM revealed LVN F said Resident #1 was ordered the Med Pass (protein supplement) to help with weight loss, but she was not sure when it was ordered or when the weight loss was noted. LVN F said RA P was responsible for weighing the residents and RA P reported the information to the ADON/DON. LVN F said ADON/DON would have implemented interventions for weight loss. Interview and Observation of Resident #1 on 02/05/25 at 5:30 PM revealed Resident #1 ate about half of the food. Resident #1 said the chicken was good. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 02/05/25 at 5:40 PM revealed the DON said RA P weighed the residents then gave the DON the information to input in the system. The DON said she had not been informed that Resident #1 had lost a lot of weight. The DON said she was not sure when was the last time the dietitian saw him. Interview with ADON P on 02/05/25 at 6:00 PM revealed ADON P said the dietitian had not seen resident since he came back from the hospital on 01/09/25. Interview with the NP on 02/06/25 at 9:15 AM revealed who said the MD ordered the Med Pass (supplement) for weight loss, but he did not recall when. The NP said Resident #1 had been hospitalized in January 2025 and some weight loss would be normal. The NP said especially because of his age and diagnosis of Parkinson's. The NP said he could not remember when the dietitian reached out to him, but they did reach out to him. The NP said Resident #1's albumin level (protein in blood that regulates fluids/nutrients) was a little low but it had improved, and it was at a stable level for his age and condition. The NP said Resident #1 would likely continue to lose weight, but they tried to prolong it as much as they could. Interview with RD L on 02/06/25 at 9:40 AM revealed RD L said she had last assessed Resident #1 on 05/09/24 because he had not triggered for weight loss. RD L said she was notified yesterday, 02/05/25, at around 6:00 PM that Resident #1 needed a consult as there was significant weight loss identified. RD L said on 02/04/25, Resident #1 weighed 168 lbs. which was a big difference. RD L said 168 lbs. compared to 187 lbs. on 01/10/25 when Resident #1 was readmitted from the hospital was a difference of 19 lbs. RD L said as she followed the >5% trigger in 30 days, that was more than 5%, it was 10.2% which was severe weight loss. RD L said from 01/17/25 to 01/24/25, Resident #1 lost 7 lbs. RD L said she was not notified of that change. RD L said if Resident #1 lost 7 lbs. in one week, they did not necessarily need to report to her if the facility implemented interventions. RD L said when Resident #1 was readmitted from the hospital, he was supposed to be weighed weekly for 4 weeks. RD L said they usually monitored for 4 weeks to capture that window and reestablish their baseline when the resident returned from the hospital. RD L said Resident #1 was weighed on 01/10/25 after he was readmitted on [DATE]. RD L said Resident #1 weighed 187 lbs. on 01/10/25, 187 lbs. on 01/17/25, 180 lbs. on 1/24/25, and then on 01/31/25 there was no weight entered. RD L said they could have weighed Resident #1 within the week of 01/31/25 but there was nothing documented. RD L said Resident #1 weighed 168 lbs. on 02/04/25 and based on his overall clinical status or his anthropometrics (height/weight/BMI), Resident #1 had a healthy weight for his BMI and for his age. RD L said Resident #1 was overweight before when he was around 190 lbs. and now was at a healthy weight based on his BMI. Interview and Observation of Resident #1 on 02/06/25 at 10:13 AM revealed RA P weighed Resident #1 on his wheelchair. The scale read 213.6 lbs. with the wheelchair. RA P informed that the wheelchair weighed 40 lbs. Resident #1's weight was 173.6 lbs. and they rounded to the higher lb. if it is more than 0.5 so his weight was 174 lbs. Weight loss % from 01/10/25-02/06/25 from 187 lbs. to 174 lbs. was -6.95%. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RA P on 02/06/25 at 10:20 AM revealed RA P said she was in charge of completing the weights for all the residents. RA P said the wheelchairs were all different so she weighed the wheelchair alone first for each resident. RA P said she weighed the residents at around the same time and tried to keep everything consistent. RA P said she weighed Resident #1's wheelchair on its own and it weighed 40 lbs. RA P said she weighed Resident #1 on 02/04/25 because FM 1 requested him to be weighed around lunch time. RA P said FM 1 thought Resident #1 was skinnier. RA P said she weighed Resident #1 on 02/04/25 and he weighed 168 lbs. standing on his own. RA P said when a resident returned from the hospital, the resident was weighed for 4 weeks, weekly. RA P said the 4 weekly weights were completed for Resident #1 after he was readmitted on [DATE] from the hospital. RA P said she gave the weights to the ADON or the DON. RA P said the ADON/DON inputted the information into the system. RA P said she weighed Resident #1 on 01/31/25 but she did not remember how much he weighed. RA P said she gave those numbers to the ADON/DON. RA P said if the resident lost a lot of weight, that would be determined by the ADON/DON. Interview with ADON P on 02/06/25 at 10:35 AM revealed ADON P was asked for the weight for Resident #1 on 01/31/25. ADON P said she only entered the monthly weights, and the DON would have entered weekly weights. Interview with the DON on 02/06/25 at 10:45 AM revealed the DON was asked for the weight for Resident #1 on 01/31/25. The DON said RA P wrote the weights on a paper, gave the DON the paper, the DON inputted the weights in the system, and shredded the paper. The DON said she would look for the weight for Resident #1 for the week of 01/31/25. Interview with ADON P on 02/06/25 at 11:10 AM revealed ADON P said when they identified weight loss for Resident #1, they notified the NP on 02/04/25 and the RD yesterday, 02/05/25. ADON P said RD L recommended to continue the Med Pass, update his food preferences, large protein portions, and weigh him weekly 4 more weeks to monitor his weight. ADON P said those interventions were implemented today, 02/06/25. ADON P said from 01/17/25-01/24/25, Resident #1 had lost 7 lbs. and normally that did not trigger for them to implement interventions such as reaching out to the MD, dietitian, and obtaining additional supplements, medications, orders, etc. ADON P said for the month it automatically triggered because it was more than 5%. ADON P said Resident #1's care plan indicated to monitor/notify MD for more than 3 lbs. in one week. ADON P said if it says that on the care plan, then they should have followed that, but they did not notify the MD for the 7 lbs. weight loss that week. ADON P said it was important to follow the care plan because that was what was structured for Resident #1. Observation of Resident #1 on 02/06/25 at 12:35 PM revealed Resident #1 eating lunch (ground beef with potatoes). Meal ticket indicated large protein portions. Resident #1 ate well on his own. Resident #1 was also observed by RD L. Interview with the DON on 02/06/25 at 1:10 PM revealed the DON said she did not find the weight for Resident #1 for 01/31/25 or that week. The DON said RA P gave her the paper with the weights and RA P did not keep records of the weights. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 02/06/25 at 2:00 PM revealed when Resident #1 came back from the hospital, he was supposed to be weighed 4 times, weekly. The DON said Resident #1 was weighed on 01/10/25 at 187 lbs., on 01/17/25 at 187 lbs., on 01/24/25 at 180 lbs., and weighed on 01/31/25 but she was not aware of what his weight was. The DON said for 01/31/25, she just did not input the weight and did not know how that happened. The DON said when the resident returned from the hospital, they would take the 4 weekly weights to monitor the weight for any fluctuations or changes. The DON said from 01/17/25-01/24/25, Resident #1 lost 7 lbs. but the system did not flag for significant weight loss. The DON said Resident #1's care plan indicated to notify the MD for weight loss of 3 lbs. in 1 week. The DON said if the care plan says indicated that then they would still need to follow it even if it did not trigger in the system. The DON said if the staff did not follow the care plan, that could place the resident at risk of harm. The DON said when Resident #1 had 7 lbs. weight loss noted on 01/24/25, it did not flag for the >5% so there were no interventions implemented. The DON said the MD was not called, the NP was not called, and the dietitian did not see him until today, 02/06/25. The DON said if weight loss was not being monitored properly that could negatively affect the resident. The DON said the negative outcome could be weight loss. The DON said Resident #1 had diagnoses that could lead to weight loss eventually, but tried to prevent weight loss as much as they could. The DON said there was no negative outcome to Resident #1. Interview with ADM on 02/06/25 at 2:40 PM revealed the ADM said if an intervention was on the care plan, then it should be followed. The ADM said she did not know when the care plan was done for Resident #1 or that it indicated to notify the MD for weight loss of 3 lbs. in 1 week. The ADM said it was important to monitor for weight loss to prevent malnutrition and ensure the resident was medically stable. The ADM said although there were diagnosis or conditions that would cause the resident to continue to lose weight, they still had to monitor, address it, and try to prevent further weight loss. Record review of Weight Monitoring Policy (not dated) reflected the following: Policy: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. 4. Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. 5. A weight monitoring schedule will be developed upon admission for all residents: a. Weights should be recorded at the time obtained. Mathematical rounding should be utilized. b. Newly admitted residents - monitor weight weekly for 4 weeks. 7. Documentation: g. The interdisciplinary plan of care communicates care instructions to staff.