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	09/11/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure all alleged violations including abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (which included to the State Survey Agency) in accordance with State law through established procedures for 1 of 4 residents (Resident #1) reviewed for reporting alleged allegation of abuse. The facility failed to report, within 2 hours, when Resident #1 was diagnosed with a nondisplaced proximal fibular fracture on 01/30/25. This failure could place residents at risk for undetected abuse, neglect and/or decline in feelings of safety and well-being. The finding included: Record review of Resident #1's admission sheet dated 09/11/25 reflected a [AGE] year-old female with an admit date of 04/06/21 and an original admission date of 06/12/18. Her relevant diagnoses included vascular dementia (brain damage caused by multiple strokes), edema (swelling that occurs when fluid builds up in the body's tissue), muscle wasting and atrophy (decrease in size and wasting of muscle tissue), lack of coordination, osteoporosis (a condition in which bones become weak and brittle), and weakness. Record review of Resident #1's quarterly MDS assessment dated [DATE], reflected a BIMS score of 15, which indicated her cognition was intact. Record review of Resident #1's quarterly care plan dated 08/28/25, reflected:Problem:[Resident #1] has a nondisplaced proximal fibular fracture (dated initiated/revised 01/31/25).Goal: will not develop complications or permanent loss of mobility related to fracture (dated initiated/revised 01/31/25).Interventions/Tasks in part included: set up appointments with orthopedic, support injured area with pillows and immobilize part as appropriate, and weigh bearing as tolerated. Record review on 09/08/25 of Resident #1's change in condition completed by the DON dated (late entry) 01/26/2025 4:30 pm which reflected: SN informed by CNA that resident was assisted to restroom and when standing resident up, resident stated her knees gave out and resident was assisted to floor with CNA. Resident did not hit her head. SN performed head to toe assessment, no abnormalities noted. Resident states no pain upon assessment. Resident was transferred by mechanical lift on to chair then back to bed. Resident stated that she did not fall and stated that her knees gave out. Resident complains of no pain. Head to toe assessment performed, resident able to perform active range of motion to upper extremities. Resident able to perform active range of motion to lower extremities. Record review on 09/08/25 of Resident #1's late entry progress note dated 01/30/25 at 4:38 pm, reflected: NP came to round on patients. N.O. for an x-ray of the right leg and ankle due to pain. Record review on 09/08/25 of Resident #1's late entry progress note dated 01/30/25 at 5:54 pm, authored by NP reflected: complaining of some leg pain mainly to the lower part of her knee as per patient she states that she hit herself in the restroom few days ago. She states that she did not let any of the nursing staff know. Record review on 09/08/25 of Resident #1's x-ray results dated 01/30/25 at 9:50 pm, reflected Resident #1 had a nondisplaced proximal fibular fracture (still broken bones but the pieces didn't move far enough to be out of alignment during the break). Record review on 09/08/25 of Resident #1's progress note dated 01/31/25 at 5:16 am, reflected: Received report from 2-10 nurse regarding patients pending Xray of right leg and ankle due to pain. Results were reviewed and N/O from PA to do repeat of x-ray to the right leg and ankle were ordered and carried out. Record review on 09/08/25 of Resident #1's x-ray results dated 01/31/25 at 1:39 pm, reflected Resident #1 had an age-determinate fracture (not sure how long ago the fracture occurred) of her right tibia/fibula . Record review on 09/08/25 of TULIP (HHSC online incident reporting application) reflected a self-report from the facility's Administrator on 01/31/25 at 4:20 am, more than 24 hours after Resident #1's diagnosis of a nondisplaced proximal fibular fracture. The allegation was injury of unknown origin. In an interview on 09/04/25 at 3:25 pm, Resident #1 said she did not remember the exact date but said she had an incident while she was being assisted from the toilet to her wheelchair. She said there were 2 CNAs assisting in the transfer, when of all of a sudden she felt her knees giving out. She said she advised the CNAs to sit on the floor because she was not going to make it to the wheelchair. She said one of the CNAs stayed with her and the other went to call the nurse. Resident #1 said between the nurse and both CNAs, she was transferred back to bed in a mechanical lift. Resident #1 said she did not have any pain at that time and refused medication. She said the following day, she started having pain and was given pain

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 3 residents (Resident 21) reviewed for accidents and supervision, in that:The facility failed to ensure Resident #2 received adequate supervision to prevent him from exiting the facility undetected on 06/06/25. The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 06/06/25 and ended on 06/07/2025. The facility corrected the non-compliance before the investigation began. Past Non-Compliance form sent to Administrator on 09/11/25 at 11:49 am.This failure could place the residents at risk for injury or death. The findings included: Record review of Resident #2's admission sheet dated 09/09/25 reflected a [AGE] year-old male with an admission date of 05/26/25 and a discharge date of 06/07/25. His relevant diagnoses included diabetes (too much sugar in the blood), hypertension (a condition in which the force of the blood against the artery walls is too high), abnormalities of gait and mobility (a change in walking pattern), and lack of coordination (impaired balance or coordination). Record review of Resident #2's 5-day Medicare MDS assessment dated [DATE], reflected a BIMS score of 6, which indicated his cognition was severely impaired. MDS further indicated, Resident #2 had not exhibited wandering behaviors. Record review of Resident #2's initial care plan dated 05/29/25, reflected:Problem: [Resident #2] is an elopement risk/wanderer r/t disorientated to place, impaired safety awareness resident wanders aimlessly (date initiated 06/06/25 and cancelled on 06/10/25).Interventions: in place included complete wandering evaluation tool, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books (date initiated 06/06/25 and cancelled on 06/10/25). Record review of Resident #2's wandering evaluation dated 05/25/25, reflected he was not a wandering risk. Record review of Resident #2's progress notes dated 06/06/25 at 9:20 pm, authored by LVN F, reflected Upon interviewing [Resident #2] he stated that he exited through the east exit door pushing the bar and door opening. Record review of Resident #2's progress notes dated 06/06/25 at 11:13 pm, authored by LVN F, reflected a change of condition Patient was found outside of facility across the street from facility in the sidewalk. Record review of Resident #2's progress notes dated 06/06/25 at 11:15 pm, authored by LVN F, reflected At 9 pm cna's moved resident to RM [ROOM NUMBER] from 407 due to plumbing issues. At 9:30 pm Med Aide F saw resident in his room. 9:40pm nurse went to check on patient and he was not in room nor in restroom. Activated code pink at 9:45pm. At 9:50pm resident was found across the street on sidewalk and was brought back to facility via wheelchair. At 9:55pm head to toe assessment was performed no noted injuries, patient denies falling while not at facility, denies pain or discomfort. Resident shows no signs of distress or discomfort, resident in good spirits. Notified family. Notified NP and ordered a cbc, cmp, and a ua to be collected . In an interview on 09/10/25 at 2:24 pm, CNA U said the last time she saw Resident #2 on 06/06/25 was around 8:00 pm. She said around 9:30 pm, she and CNA B went to his room to check on him and they discovered he was not in his room. She said she immediately notified LVN A (Charge Nurse), who activated code pink. She said at that time all staff started looking for him. She said by the time she checked her assigned hall/rooms; she was told Resident #2 had been found outside. She said she immediately went outside to see if staff needed help. She said by that time, Resident #2 was being escorted by LVN A and CNA B and were already in the facility's parking lot. She said she noticed Resident #2 was not wearing shoes, only socks. She said the weather was not too hot and not too cold. She said once Resident #2 was back in his room, she gave him water. CNA U said Resident #2 was confused and kept saying he was going home. She said at no point did she hear the door alarm go off. She said when the maintenance director was checking the door alarms after the incident (that same night), they were working. CNA U said the facility had provided in-services on the topics of elopement and responding to door alarms. CNA U said the facility also had monthly elopement drills. CNA U said Resident #2 was placed on a 1:1 for supervision immediately after he was found. CNA U said Resident #2 had not displayed any exit seeking behaviors since he was admitted . An interview on 09/10/2025 at 2:37 pm, CNA B said on 06/06/25, she last saw Resident #2 at about 8:00 pm. Resident #2 when she and CNA U had gone to his room to do their final round around 9:40 pm she noticed Resident #2 was not in his room. She said she checked down his hall and enclosed patio near his room, but he was not found. CNA B said she immediately notified LVN A (Charge Nurse) who activated code pink via the intercom. She said LVN A named the resident, what he was wearing and had his picture

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) of 3 residents by 1 of 1 nurse (LVN E) reviewed for accuracy and completeness of clinical records.The facility failed to ensure LVN E correctly completed Resident #1's assessment on 01/26/25 after her knees gave out and resident was assisted to the floor. This failure could place residents at risk for not receiving nursing services by adequately trained nurses and could result in a decline in health. The findings included:Record review of Resident #1's admission sheet dated 09/11/25 reflected a [AGE] year-old female with an admit date of 04/06/21 and an original admission date of 06/12/18. Her relevant diagnoses included vascular dementia (brain damage caused by multiple strokes), edema (swelling that occurs when fluid builds up in the body's tissue), muscle wasting and atrophy (decrease in size and wasting of muscle tissue), lack of coordination, osteoporosis (a condition in which bones become weak and brittle), and weakness.Record review of Resident #1's quarterly MDS assessment dated [DATE], reflected a BIMS score of 15, which indicated her cognition was intact.Record review of Resident #1's quarterly care plan dated 08/28/25, reflected:Problem:[Resident #1] has a nondisplaced proximal fibular fracture (dated initiated/revised 01/31/25).Goal: will not develop complications or permanent loss of mobility related to fracture (dated initiated/revised 01/31/25).Interventions/Tasks in part included: set up appointments with orthopedic, support injured area with pillows and immobilize part as appropriate, and weigh bearing as tolerated.Record review on 09/04/25 of Resident #1's change in condition completed by the DON dated (late entry) 01/26/2025 4:30 pm which reflected: SN informed by CNA that resident was assisted to restroom and when standing resident up, resident stated her knees gave out and resident was assisted to floor with CNA. Resident did not hit her head. SN performed head to toe assessment, no abnormalities noted. Resident states no pain upon assessment. Resident was transferred by Hoyer lift on to chair then back to bed. Resident stated that she did not fall and stated that her knees gave out. Resident complains of no pain. Head to toe assessment performed, resident able to perform active range of motion to upper extremities. Resident able to perform active range of motion to lower extremities.In an interview on 09/04/25 at 3:25 pm, Resident #1 said she did not remember the exact date but said she had an accident while she was being assisted from the toilet to her wheelchair. She said there were 2 CNAs assisting in the transfer, when of all of a sudden she felt her knees giving out. She said she told the CNAs to sit on the floor because she was not going to make it to the wheelchair. She said one of the CNAs stayed with her and the other went to call the nurse. Resident #1 said between the nurse and both CNAs, she was transferred back to bed in a Hoyer lift. Resident #1 said she did not have any pain at that time and refused medication. She said the following day, she started having pain and was given pain medication and it helped. Resident #1 said days later her doctor visited her and she told him about the incident in the restroom and that she was still experiencing pain to her right lower leg. She said her pain started the day after the incident in the restroom but was controlled with pain medication.An interview on 09/04/25 at 4:08 pm, CNA C said she and CNA D took Resident #1 to the restroom and while assisting her from the toilet to the wheelchair (using a gait belt) she said they both felt Resident #1 was going limb, and her knees were giving out. She said at the same time Resident #1 told them her knees were giving out and to sit her on the floor. CNA C said at that point Resident #1 and both of them decided to assist the resident in sitting her on the floor. She said one of the CNAs stayed with her and the other one went to call LVN E. She said when LVN E arrived, she had done a head-to-toe assessment and Resident #1 was transferred back to bed in a Hoyer lift. She said Resident #1 did not have any discolorations, bleeding, or injuries. CNA C said Resident #1 did not complain of pain when she was assessed by LVN E or when she was placed back in bed. CNA C said at no time dis Resident #1 hit her legs or head while she was being assisted to the floor.An interview on 09/04/25 at 4:20 pm, CNA D said she and CNA C took Resident #1 to the restroom and while assisting her from the toilet to the wheelchair (using a gait belt) Resident #1 told them that her knees were giving out. She said Resident #1 told them to sit her on the floor. She said Resident #1 was sat on the floor and was assessed by LVN E. CNA D said between the three of them, Resident #1 was transferred back to bed in a Hoyer lift. She said Resident #1 had not sustained any injuries while she was being assisted to the floor, and she denied having any pain. CNA D said at no time dis Resident #1 hit her legs or head while she was being assisted to the floor.An interview on 09/4/25 at 4:35 pm, LVN E she had