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	12/02/2025

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 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)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 reviews, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for accuracy of records. The facility failed to ensure LVN B documented on Resident #1's electronic medical record that her foley catheter was re-inserted on 11/24/25. This failure could place residents at risk of not receiving appropriate care through inadequate documentation resulting in deterioration in condition, exacerbation of disease process, overmedication, and increased risk of harm or injury. The Findings included:Record review of Resident #1's admission sheet dated 12/02/25 reflected a [AGE] year-old female with an admit date of 10/26/25 and initial admission date of 09/28/25. Her relevant diagnoses included sepsis (a life-threatening medical emergency where the body's overwhelming response to an infection damages its own tissues and organs), vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect blood vessels in the brain). Record review of Resident #1's 5-Day MDS assessment dated [DATE] reflected a BIMS score of 4, which indicated her cognition was severely impaired. Record review of Resident #1's initial care plan dated 10/28/25 reflected a problem of [Resident #1] is at risk for falls r/t gait/balance problems (date initiated/revised 10/07/25). Interventions included to 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 request for assistance, provide resident with mobility device: WC, walker, cane.(date initiated 10/04/25)Record review of Resident #1's progress notes dated 11/24/25 at 2:37 pm, authored by RN A reflected I heard a scream come from the patient's room when I walked into the patient's room patient was sitting down on the floor and foley had been pulled out, patient was unable to tell us what happened, assessed patient and took vitals, skin was intact, patient was able to move both upper and lower extremities without difficulty, patient was able to walk to bed had no complaint of pain, notified md patient just ordered for us to monitor patient, notified rp and don. In a telephone interview on 12/02/25 at 3:43 pm, RN A said that on 11/24/25, between 2:00 pm and 2:45 pm, while she was giving report to the incoming nurse (LVN B) they heard a scream coming from Resident #1's room. She said they both immediately made their way to Resident #1's room and found her in a sitting position on the floor. She said Resident #1 had both legs extended and her foley had been pulled out. She said a head-to-toe assessment was completed, and no injuries were noted. RN A said she asked Resident #1 how she fell but she was not able to say what happened. RN A said Resident #1 was transferred back to bed and where she was assessed for trauma or bleeding at the site where the foley catheter had been pulled out and no trauma or bleeding was observed. RN A said since it was towards the end of her shift, LVN B agreed to re-insert the foley catheter. She said she notified Resident #1's NP but no new orders were given. RN A said she initiated the neurological checks on Resident #1. RN A said Resident #1's foley had been re-inserted by the time she returned the next day. RN A said the facility's protocol for whenever a foley catheter was re-inserted was for the nurse who re-inserted the foley needed to create a progress note which indicated foley was re-inserted, if the resident felt discomfort or not, and flow. She was not able to say what the negative outcome was to Resident #1 was for not having her electronic medical record indicate her foley was re-inserted. An attempted telephone interview on 12/02/25 at 3:50 and 4:15 pm, LVN B did not answer, voice message was left. In an interview and observation on 12/2/25 at 4:13 pm, ADON D, she was observed as she reviewed Resident #1's electronic medical record and said that on 11/24/25, Resident #1 was found on the floor by RN A and LVN B and observed her foley catheter had been pulled out. She said Resident #1 had been assessed by RN A and no injuries were noted. ADON D said she could not find a note on Resident #1's electronic medical record that indicated who had re-inserted her foley catheter but was confident it had been re-inserted. She said because the insertion or re-insertion of a foley catheter was considered a sterile procedure the nurse who completed the procedure should make a note in the resident's electronic medical record that indicated the time, the size of the gauge size, and if the resident had tolerated the procedure. ADON D there was no negative outcome to Resident #1 for not having the re-insertion of her foley catheter documented on her electronic medical record. An interview on 12/02/25 at 4:46 pm, the DON said whenever a foley catheter was re-inserted the nurse who completed the procedure needed to document that it was re-inserted. She said note did not require anything else. The DON said there were no negative outcome to Resident #1 not having the re-insertion of her foley catheter documented in her electronic medical record