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	12/11/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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

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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: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 (Resident #1) of 4 residents reviewed for accuracy of records, in that:LVN A failed to document a change of condition form on Resident #1's electronic medical record for a fall on 11/25/25.This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care.The findings included:Record review of Resident #1's face sheet dated 12/10/25 reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes (high levels of sugar in blood), end stage renal disease (kidney failure), dependence on renal dialysis (treatments to manage kidney function), heart failure, peripheral vascular disease (disorder of the blood vessels that affects circulation outside of the heart/brain), hypertension (high blood pressure), anxiety disorder, and chronic obstructive pulmonary disease (progressive lung disease). Resident #1 was discharged to the hospital on [DATE]. Record review of Resident #1's care plan dated 12/10/25 reflected [Resident #1] was at risk for falls related to history of falls, decreased mobility, and generalized weakness. Date initiated: 05/11/22. Record review of the facility's sign in sheet dated 11/25/25 reflected LVN A worked on 11/25/25 from 6 AM-2 PM. Record review of Resident #1's electronic medical record on 12/11/25 reflected no change of condition form documented for Resident #1's fall on 11/25/25. On 12/10/25 at 1:05 PM, in an interview with LVN A, he said he worked on 11/25/25 with Resident #1 when Resident #1 had a fall at around 7:20-7:25 AM. LVN A said he followed the protocol for the fall, assessed Resident #1, assisted him up, initiated neuro checks, notified the MD, the RP, and the DON. LVN A said for a fall, he was trained to document a change of condition form, pain evaluation, fall risk evaluation, skin assessment, and neuro checks. LVN A verified he was supposed to document a change of condition form for each fall. LVN A said he had been in-serviced on documentation and told to ensure he documented all forms for any incident. LVN A said he thought he documented the change of condition form for Resident #1's fall on 11/25/25, but maybe he forgot. On 12/11/25 at 12:00 PM, in an interview with the DON, she said staff were trained on the fall protocol and documentation. The DON said for a fall, staff were supposed to document a change of condition form, pain evaluation, fall risk evaluation, skin assessment, and neuro checks. The DON said there was no negative outcome for Resident #1 if LVN A did not document a change of condition form as the fall protocol was followed. The DON said staff were supposed to document all forms to show what care the resident received and so that other staff were aware.Record review of the facility's Documentation in Medical Record policy dated 10/24/22 reflected:Policy: Each residents medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation. Policy explanation and compliance guidelines: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.