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	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Arbor View	218 Baltic Ave 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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **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 receive written notice, including the reason for the change, before the resident's room or roommate in the facility was changed for for 1 of 3 residents (Resident #3) reviewed for resident rights. The facility failed to ensure Resident #1 received written notice prior to a room change on 03/04/26 and 04/07/26. This failure could place residents at risk for a decreased quality of life being in a new environment.The findings were:Record review of Resident #3's admission record, dated 06/05/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her relevant diagnoses included diabetes (a chronic condition where your body either cannot produce enough insulin or effectively se the insulin I t makes, causing blood sure (glucose) levels to rise), acute kidney failure (rapid loss of your kidney's ability to filter waster products from your blood), dementia (term for a decline in mental ability severe enough to interfere with daily life) and had an AR.Record review of Resident #3's quarterly MDS assessment, dated 05/28/26, reflected a BIMS score of 11, which indicated her cognition was moderately intact. Resident #3 was admitted as a short term resident.Record review of Resident #3's census record, dated 06/05/26, reflected the following room changes:01/21/26 Resident was admitted to room [ROOM NUMBER]-A03/04/26, Resident #3 was transferred to room [ROOM NUMBER]-B04/07/26, Resident #3 was transferred to room [ROOM NUMBER]-BDuring an interview on 06/05/26 at 8:30 a.m., Resident #3's FM said when Resident #3 was initially admitted to the facility, she was admitted to the short term unit but later became long term. The FM said Resident #3 was transferred multiple times without her consent or receiving a written notice. The FM said after the first transfer on 03/04/26, the facility informed her the room change was necessary because Resident #3 went from short term to long term. The FM said she thought the second time, Resident #3 was transferred was because she (FM) had complained to administration Resident #3 and her roommate were not compatible. The FM did not have dates of when she spoke to administration. The FM said she would have wanted to be informed of the room change to ensure Resident #3 was compatible with her roommate prior to being moved. The FM said Resident #3 was happy with her most recent room and roommate.During an observation and interview on 06/05/26 at 9:00 a.m., Resident #3 was observed lying in bed watching television. She said she was happy in her room and liked her roommate. Resident #3 said she had not received written notification of her room changes.During an interview and observation on 06/05/26 at 10:59 a.m., the SW said the DON was responsible for room changes. She said the DON would ensure both residents were compatible with each other and if approved, she would be responsible to notify the residents and their FMs of room changes. She said the manner in which she would notify the resident's FM of a room change was by phone and would then ensure the room change was documented in the resident's electronic medical record. The SW said she remembered on 03/04/26, Resident #3 transitioned from short term to long term and was transferred to room [ROOM NUMBER]-B. She said she remembered calling Resident #3's FM on that day and agreed to the room change. The SW said on 04/07/26, Resident #3 was moved to room [ROOM NUMBER]-B because her FM was not happy with the (continued on next page)

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	roommate. The SW was observed as she reviewed Resident #3's electronic medical record and said she had not found any documentation of the room change on 03/04/26 and 04/07/26.During an interview on 06/05/26 at 11:22 a.m., the DON said Resident #3 had an FM. She was observed as she reviewed Resident #3's medical electronic record and said she had not seen any documentation regarding room changes for Resident #3. She said she was responsible for all room changes. She said any room change was discussed with the IDT team to ensure both residents were compatible with each other. The DON said a resident's FM was notified by telephone or in person prior to the room change. The DON said the facility's protocol regarding room changes was the resident's FM needed to be notified by phone prior to the room change.During an interview on 06/05/26 at 2:45 p.m., the Administrator said the DON was responsible for all room changes. She said once the DON approved the room change, the facility's SW would ensure the resident and their FM were notified by telephone or in person. She said written notification was not necessary. The Administrator said she had reviewed Resident #3's electronic record and grievance logs and had not found any documentation regarding her room changes. The Administrator said there were no negative outcomes to Resident #3 being transferred to different rooms without notifying her FM. Record review of the facility's undated, Room Change, Transfer, and Discharge policy reflected: Room change.The resident and responsible party will be notified prior to a transfer and will have an opportunity to provide input on roommate selection and location.except in an emergency, the facility must notify the resident and either the responsible party, family member, or legal representative at leave 5 days before relocation of resident to another room within the facility. Facility must prepare a written notice that states the reason for the relocation, the effective date of the relocation, and the room to which the resident is being relocated.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 any significant medication errors for 1 of 4 residents (Resident #1) reviewed for medication errors. The facility failed to ensure MA A did not administer Resident #1's blood pressure altering medication on 05/23/26 when his blood pressure was not within the required parameters per the physician's order.This failure could place residents at an increased risk for complications, exacerbation of symptoms and disease process, and potential hospitalization.Findings included: Record review of Resident #1's admission record review, dated 06/04/26, reflected an [AGE] year-old-male with and admission date of 05/22/26. His relevant diagnoses included hypertension (a condition where the force of blood pushing against your artery walls is consistently high), atrial fibrillation (irregular heartbeat), cardiomyopathy (a progressive disease of the heart muscle), and chronic kidney disease (long term condition where your kidneys are damaged and lose their ability to filter waste and excess fluid from your blood). Record review of Resident #1's 5-day Medicare MDS assessment, dated 05/26/26, reflected a BIMS score of 13, which indicated his cognition was cognitively intact. Record review on 06/04/26 of Resident #1's care plan, dated 05/27/26, reflected:Problem: [Resident #1] has hypertension (HTN) r/t CHF, lifestyle choices. Date initiated and revised 05/25/26. His interventions included to give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (a sudden drop in blood pressure that occurs when you stand up after sitting or lying down) and increased heart rate (Tachycardia) and effectiveness. Date initiated 05/25/26. Record review on 06/04/26 of Resident #1's physician order summary, dated 06/04/26, reflected an order for Metoprolol Succinate ER Oral tablet extended-release 24-hour 50 MG (Metoprolol Succinate), give 1 tablet by mouth two times a day for hypertension, hold if SBP is under 110, or if DBP is under 60, or if pulse is under 60, start date of 05/22/26. Record review on 06/04/26 of Resident #1's May 2026 MAR reflected on 05/23/26 at 9:00 a.m., Metoprolol Succinate ER Oral tablet extended-release 24 hour 50 MG (Metoprolol Succinate) give 1 tablet by mouth two times a day for hypertension, hold if SBP is under 110, or if DBP is under 60, or if pulse is under 60 was administered when vital signs were 90/60, pulse 80, by LVN C. An attemped telephone interview on 06/04/26, LVN C did not answer.During an interview and observation on 06/04/26 at 12:47 p.m., The ADON said Resident #1 had a diagnosis of hypertension and was being treated with medication. The ADON was observed as she reviewed Resident #1's electronic medical record and said Resident #1's high blood pressure medication was being treated with Metoprolol Succinate ER Oral tablet extended-release 24-hour 50 MG (Metoprolol Succinate), give 1 tablet by mouth two times a day for hypertension, hold if SBP is under 110, or if DPB is under 60, or if pulse is under 60. The ADON said Resident #1's high blood pressure medication had parameters that needed to be followed to determine if the medication would be administered. The ADON said on 05/23/26 at 9:00 a.m., Resident #1 was administered his high blood pressure medication Metoprolol even though his blood pressure was not within the required parameters. The ADON said each morning, she and the facility's DON reviewed the previous day's medication orders and medication administration records to ensure medications were administered correctly and all required vital signs were documented. The ADON said she must have overlooked LVN C's medication error when she reviewed Resident #1's medication administration record for accuracy. The ADON said nursing staff were regularly in-serviced on the topic of medication administration. She said a negative outcome to Resident #1 being administered his blood pressure medication when his blood pressure was not within the required parameters could be his blood pressure could drop further. During an interview on 06/04/26 at 2:00 p.m., the MD said he treated Resident #1 since his admission to the facility. He said Resident #1 had a diagnosis of hypertension and was being treated with medication. He said he visited Resident #1 on 05/23/26 sometime before noon and had noticed his blood pressure had been low when he was administered his blood pressure medication. He said he (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately ordered a nurse to recheck Resident #1's blood pressure to ensure it was within the normal range. The MD said Resident #1's blood pressure was within normal range when it was rechecked, therefore; there were no negative outcomes to Resident #1 being administered blood pressure medication when his blood pressure was not within the required parameters. During an interview on 06/04/26 at 4:00 p.m., the DON said Resident #1 had a diagnosis of hypertension which was being treated with medication. She was observed as she reviewed Resident #1's electronic medical record and said on 05/23/26, at 9:00 a.m., Resident #1 was administered his high blood pressure medication, Metoprolol when his blood pressure reading was 90/60 by LVN C. The [NAME] said Resident #1's Metoprolol order had parameters to hold if SBP was under 110, or if SBP is under 60, or if pulse was under 60. The DON said, LVN C should not have administered Resident #1 Metoprolol medication on 05/23/26, at 9:00 a.m., because it was not within the ordered parameters. The DON said the facility's ADONs and herself reviewed all residents' orders and medication administration record to ensure medications were administered according to their orders and medications that required vitals to be checked were entered. The DON said nursing staff were regularly in-serviced on the topics of medication administration. The DON said a negative outcome to Resident #1 being administered Metoprolol when his blood pressure was not within the required parameter could be his blood pressure could drop further. The DON said the facility did not have a medication administration policy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for medical records. The facility failed to ensure MA A documented Resident #1's blood pressure on the MAR when the resident's blood pressure altering medication was not administered because it was outside the parameters for administration on 05/29/26. This failure could place residents at risk for errors in care and treatment. Findings included: Record review of Resident #1's admission record review, dated 06/04/26, reflected an [AGE] year-old-male with and admission date of 05/22/26. His relevant diagnoses included hypertension (a condition where the force of blood pushing against your artery walls is consistently high), atrial fibrillation (irregular heartbeat), cardiomyopathy (a progressive disease of the heart muscle), and chronic kidney disease (long term condition where your kidneys are damaged and lose their ability to filter waste and excess fluid from your blood). Record review of Resident #1's 5-day Medicare MDS assessment, dated 05/26/26, reflected a BIMS score of 13, which indicated his cognition was cognitively intact. Record review of Resident #1's care plan, dated 06/07/26, reflected:Problem: [Resident #1] has hypertension (HTN) r/t CHF, lifestyle choices. Date initiated and revised 05/25/26. His interventions included give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (a sudden drop in blood pressure that occurs when you stand up after sitting or lying down) and increased heart rate (Tachycardia) and effectiveness. Date initiated 05/25/26. Record review of Resident #1's physician order summary, dated 06/04/26, reflected an order for Metoprolol Succinate ER Oral tablet extended-release 24 hour 50 MG (Metoprolol Succinate) give 1 tablet by mouth two times a day for hypertension, hold if SBP is under 110, or if DPB is under 60, or if pulse is under 60, start date 05/22/26. Record review of Resident #1's May 2026 MAR reflected on 05/29/26 at 9:00 a.m., Metoprolol Succinate ER Oral tablet extended-release 24 hour 50 MG (Metoprolol Succinate) give 1 tablet by mouth two times a day for hypertension, hold if SBP is under 110, or if DPB is under 60, or if pulse is under 60 was not administered due to vitals being outside the required parameters but no vital readings were entered by MA A. During an interview on 06/04/26 at 11:58 a.m., MA A said her responsibilities as a Med Aide were to administer oral medications to residents. She said some blood pressure medications had parameters that needed to be met before the medication could be administered. She was observed as she reviewed Resident #1's electronic medical record and said both had a diagnoses of high blood pressure which was being treated with medication. MA said the blood pressure medications Resident #1 were ordered had parameters that needed to be followed. MA said before she administered a blood pressure medication to Resident #1, she ensured she checked their vitals and entered them on their medication administration record before she administered their medication. She said she was not sure why Resident #1's electronic medication record did not show his vitals on 05/29/26 and pulse on 06/01/26. She said, I remembered entering their vitals. MA A said she was regularly in-serviced on the topic of medication administration by the facility's ADON and DON. MA A said a negative outcome for the resident could be staff would not know the blood pressure readings.During an interview and observation on 06/04/26 at 12:47 p.m., The ADON said Resident #1 had a diagnosis of hypertension and was being treated with medication. The ADON was observed as she reviewed Resident #1's electronic medical record and said Resident #1's high blood pressure medication was being treated with Metoprolol Succinate ER Oral tablet extended release 24-hour 50 MG (Metoprolol Succinate), give 1 tablet by mouth two times a day for hypertension, hold if SBP is under 110, or if DPB is under 60, or if pulse is under 60. The ADON said Resident #1's high blood pressure medication had parameters that needed to be followed to determine if the medication would be administered. The ADON said on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/29/26 at 9:00 a.m., Resident #1 had not been administered his blood pressure medication. She said she knew because, MA A had documented a code 4 which she meant his vitals were not within the required parameters for that day/time. She said she was not sure why MA A had not documented his vitals. She said MA's and nursing staff must document vital signs prior to medication administration. She said a negative outcome to Resident #1 for having his blood pressure sign documented could be that nursing staff would miss a low or high reading. The ADON said each morning, she and the facility's DON reviewed the previous day's medication orders and medication administration records to ensure medications were administered correctly and all required vital signs had been documented. The ADON said she must have overlooked LVN C's medication error when she reviewed Resident #1's medication administration record for accuracy. She said a negative outcome to Resident #1 not having his medical record accurately documented would be staff would not know his vitals. During an interview on 06/04/26 at 4:00 a.m., the DON said Resident #1 had a diagnosis of hypertension which was being treated with medication. She was observed as she reviewed Resident #1's electronic medical record and said on 05/29/26, at 9:00 a.m., Resident #1 had not been administered his blood pressure medication, Metoprolol because a code 4 was documented on his medication administration record. She said code 4 indicated his vitals were not within the required parameters and was held. The DON said MA's and nursing staff were required to document a resident's vital signs before administering blood pressure medication. The DON said a negative outcome to Resident #1 could be that nursing staff could miss a resident's low or high vital signs if not documented. The DON said the facility did not have a medication administration policy. Record review of the facility's Documentation in Medical Record policy, dated 10/24/22 reflected: Policy:Each resident's 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 inter disciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2.Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.