STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676206	A. BUILDING _____ B. WING _____	**07/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0557 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide reasonable accommodation of individual needs and preferences, for one Resident (R#1) of five residents reviewed for accommodations of needs. The facility moved or blocked R#1's video camera on more than one occasion while providing care to R#1. This failure could place residents at risk for not receiving necessary care and services. The findings were: Record review of R#1's Admission Record, dated 06/15/20, revealed R#1 was 91-years-old and was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]., [MEDICAL CONDITIONS] infraction, and pressure ulcer of sacral region stage 2. Record review of R#1's Comprehensive Minimum Data Set (MDS) assessment, dated 05/13/20, revealed R#1: -had no speech; -was rarely/never understood by others; -was rarely/never able to understand others; -had severe cognitive impairment; -was totally dependent on staff with eating; and -required extensive assistance from staff with bed mobility, transfers, dressing, toilet use, and personal hygiene. Record review of R#1's facility document titled, Request for Authorized Electronic Monitoring, dated 05/07/20, revealed R#1's RP requested electronic monitoring to be set up in R#1's room. The agreement specified the following: If the monitoring device is a video surveillance camera, the camera should always be unobstructed. In an interview on 07/15/20 at 12:39 p.m., LVN B said he recalled one occasion that he was in the nurse's station and received a call from R#1's RP asking why R#1's camera had been moved. LVN B said he went into the room and saw LVN A, the treatment nurse, was in R#1's room finishing a wound care treatment. LVN B said he asked LVN A to put the camera back when done. LVN B said he explained to the family the reason the camera was moved, and the RP seemed to be satisfied with the explanation. LVN B said there should be no reason R#1's camera should be moved when staff was providing care to R#1. In an interview on 07/15/20 at 12:59 p.m., LVN A said R#1 had video surveillance in her room. LVN A said the camera was placed on a bedside table and, at times, was on a chair. LVN A said on at least 2-3 occasions she recalled moving the camera because she needed the bedside table and/or the chair to put her wound care supplies on while conducting wound care on R#1. LVN A said the camera would be placed on a nearby dresser, but LVN A said the cord was not long enough for the camera to be set up on the dresser so at times it would not be facing R#1 during wound care. LVN A said one of the other nurses had told her the family had called and asked why the camera was moved. LVN A said she moved the camera back once she was done with the wound care. LVN A said she only moved the camera because she needed the piece of furniture to put her supplies on. In an interview on 07/27/20 at 9:20 a.m., The DON said he was not aware of R#1's camera being moved on more than one occasion to where R#1 was out of view during care. The DON said he recalled LVN B telling him R#1's RP had called upset that the camera was moved, but as far as he knew, the camera was moved back and that was the end of the problem. The DON said he did not know where the camera was placed in the room because he did not go into R#1's room when R#1 had the camera. DON said the camera should be placed in an area where it was not in the way of the staff conducting care and where the view was not obstructed during care. In an interview on 07/27/20 at 9:35 a.m., the Administrator said R#1's family requested electronic monitoring for R#1. The Administrator said R#1's family brought the camera to the facility and the Administrator himself installed the camera in R#1's room. The Administrator said the camera was placed on a bedside table at the time and to set it up he only had to plug it in and point the camera towards the resident. The Administrator said there were plenty of bedside tables in the facility that were not being used due to low census. The Administrator said there should be no reason for the camera to be moved from where it was placed. The Administrator said he was not aware the camera was being moved while wound care was being conducted on R#1. The Administrator said the agreement stated the camera was to always be unobstructed. Record review of the facility's, Resident Admission Agreement, revealed: Rights and obligations of the resident. Resident Rights. As a resident of Facility, resident is entitled to various rights that facility encourages resident to exercise. A statement of rights is available on the Texas Secretary of State website and is attached here to. The facility manual and forms to be completed upon admission outline additional right of resident, including: Right to authorized electronic monitoring .

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

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.