

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455575	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER Windsor Nursing and Rehabilitation Center of Morga		STREET ADDRESS, CITY, STATE, ZIP CODE 2322 Morgan Ave Corpus Christi, TX 78405	

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)
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to manage the personal funds deposited by residents for 1 (Resident #4) of 5 residents reviewed for residents' rights. The facility failed to ensure Resident #4 had access to his personal funds upon request in a timely manner on 04/03/2026. This failure could place residents whose funds were managed by the facility without access to their funds deposited within the facility. The findings included: Record review of Resident #4's face sheet dated 04/10/2026 revealed a [AGE] year-old male who was originally admitted to the facility on [DATE] with a readmission on [DATE]. Resident #4's admitting diagnosis was Transient Cerebral Ischemic Attack (a mini stroke which occurred when there was a temporary interruption of blood flow to the brain). Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14, which indicated intact cognition. Record review of Resident #4's care plan, initiated 08/13/2024, revealed Resident #4 was independent with meeting emotional, intellectual, physical, and social needs. Record review of Resident #4's Resident Statement, dated 04/13/2026, revealed Resident #4 had a balance of \$1,250.37 in his personal trust fund through the facility. In an interview on 04/13/2026 at 10:00 AM, Resident #4 stated he could not recall the exact date, but there was a Friday when he had requested to get some of his money, but they (the facility) would not give it to him. He stated he was supposed to have gotten \$75.00 per month, but sometimes they did not give it to him when he wanted it. In an interview on 04/13/2026 at 10:50 AM, the BOM stated when a resident's check came through, their board and room were paid, and the rest got deposited into a resident trust fund account. She stated Medicaid applied money toward the resident's room and board plus \$75.00 for spending on what they wanted and/or needed. She stated Resident #4 was under the assumption his entire check was supposed to be given to him, even though they have explained to him it did not work this way. The BOM stated when a resident wants to withdrawal money from their account, they fill out a form, and the money was then pulled from the petty cash box. If there was not enough money in the petty cash box, the Administrator would cash a check and replenish the box. The BOM stated they tried to always make sure they had the money on-site, and there was always someone there during business hours to honor the request, and the longest she thought Resident #4 ever had to wait for his money was maybe 2 hours. In an interview on 04/13/2026 at 2:30 PM, the ABOM stated Resident #4 came to the business office on the evening of Friday April 3rd, maybe around 3:00 or 4:00 PM, asking for his money, and he was told the BOM was gone for the day, and she would not be back until Monday. The ABOM stated she had a key and access to the petty cash, but she had forgotten her key at home on this day, so Resident #4 did not get any money this day. The ABOM stated Resident #4 was angry, yelling and cussing because he expected to get his money as soon as he requested it. The Administrator was already gone at this time as well on this day, and she could not remember if she had notified the administrator or not. Resident #4 did not end up getting his money until the following Monday on 04/06/2026. The ABOM stated they have always tried to get the residents their money the same day it was requested, unless it was an amount over \$100. In an interview on 04/13/2026 at 3:00 PM, the Administrator stated they did not have a specific policy regarding keeping and giving residents their funds, but they have a procedure they followed. She also stated there was always (continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 455575	If continuation sheet Page 1 of 9

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>someone there with a key during business hours (Monday - Friday 8:00 AM - 5:00 PM) to give residents access to their funds, and if a resident requests a reasonable amount of money it should be given as soon as possible. The Administrator also stated there was no one there on the weekends to give residents access to their funds if requested, but this was why they gave them out on Fridays. Record review of the facility's Resident Trust Fund Procedures, revised 01/13/2026, revealed Additional Review Items Required: Witnesses: Be aware of resident needs and status. Record Retention: B. Resident Trust Fund transactions should be recorded daily, as they happen. C. Resident Petty Cash: Petty cash box should be reconciled daily. Record review of the facility's updated Personal Funds and Resident Trust Fund policy revealed Residents have the right to select how personal funds will be handled.</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**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 be free from abuse and neglect for of 5 residents (Resident #2) reviewed for abuse, neglect, and exploitation. The facility failed to protect Resident #2 from physical abuse when Resident #1 hit Resident #2 multiple times in the head and fell to the floor with him on 03/29/2026. These failures could place residents at risk for physical and/or psychological harm or injury. The findings included: 1. Record review of Resident #1's face sheet, dated 04/09/2026, revealed a [AGE] year-old male with an admission date of 06/28/2024. Resident #1's diagnoses included Unspecified Dementia (a group of symptoms affecting memory, thinking and social abilities) and a history of Transient Ischemic Attack with Cerebral Infarction (a blockage or disruption of blood flow to the brain). Record review of Resident #1's Quarterly MDS assessment, dated 02/27/2026, revealed a BIMS score of 03, which indicated severely impaired cognition. Resident #1's MDS also revealed Resident #1 exhibited verbal behaviors toward others, as well as he utilized a cane as a mobility device. Record review of Resident #1's care plan, initiated 03/30/2026, revealed Resident #1 had the potential to be physically aggressive toward other residents. Interventions included Resident #1's behaviors were de-escalated by redirection and intervening, as well as monitor, document, and report, as needed, any signs or symptoms of Resident #1 posing a danger to himself or others. Record review of an activities progress note, dated 11/26/2025, revealed Resident #1 was being very demanding and making rude comments toward another resident. Record review of a nursing progress note, dated 12/12/2025, revealed Resident #1 was upset with his girlfriend and stated, where the hell have you been and fuck you. Record review of a nursing progress note, dated 01/04/2026, revealed Resident #1 yelled at his girlfriend's neighbor for going around in a brief. Record review of a progress note, written by the SW, dated 01/05/2026, revealed Resident #1 was educated about other patients' rights after he made a gesture and tried to hit another resident with his cane after he became upset. Record review of Resident #1's progress note, written by the SW, dated 03/29/2026, revealed Resident #1 hit another resident in the face. Record review of Resident #1's progress note, written by the SW, dated 03/30/2026, revealed Resident #1 made another attempt to engage in physical contact with Resident #2, but nursing staff intervened and prevented resident-to-resident contact. The SW noted Resident #2 was in the elevator on his way to his floor when Resident #1 tried to engage with him. Record review of Resident #1's change of condition assessment, dated 10/06/2025, revealed Resident #1 was angry with his roommate and was yelling at his roommate. Record review of the facility's incident reports revealed Resident #1 and Resident #2 had a resident-to-resident incident on 03/29/2026. 2. Record review of Resident #2's face sheet, dated 04/10/2026, revealed a [AGE] year-old male with an admission date of 03/13/2026. Resident #2's diagnoses included Alzheimer's Disease (a progressive disorder which was the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes) and Cognitive Communication Deficit (difficulties in communication which arise from impaired cognitive processes, such as attention, memory, organization, and executive functioning). Record review of Resident #2's admission MDS assessment, dated 03/19/2026, revealed a BIMS score of 07, which indicated severely impaired cognition. Resident #2's MDS also revealed no physical or verbal behaviors directed toward others. Record review of Resident #2's care plan, initiated 03/29/2026, revealed Resident #2 was involved in a physical altercation with another resident. Interventions included assessing for feelings of fear, anxiety, and/or behavioral changes after the incident; assessing Resident #2 for injuries; encourage Resident #2 to report any concerns immediately without hesitation. Another care plan, initiated 04/02/2026, revealed Resident #2 had an actual fall from his wheelchair during the physical altercation on 03/29/2026 and had an acute left distal clavicular fracture (a fracture which typically (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>occurred after a direct blow to the shoulder, such as a fall) with clavicular superior displacement (a condition in which the clavicle, or collarbone, was displaced) to left shoulder. Interventions included Resident #2 was to follow-up with an orthopedist, medicate for pain as needed, and a physical therapy consult for strength and mobility. Record review of the Provider Investigation Report, dated 04/02/2026, revealed the description of the allegation included Resident #2 was sitting in his wheelchair talking to the receptionist at the front desk when Resident #1 got up from across the lobby and walked toward Resident #2 while using foul language. The receptionist told Resident #1 to stop and ran to the phone to call for assistance. Resident #1 was punching Resident #2, and they both fell to the floor. Investigation summary revealed Resident #1 became upset and agitated when Resident #2 was talking to a female resident. Resident #2 was sent to the emergency room for an evaluation where he was noted to have sustained an ear injury. On 04/01/2026 Resident #2 complained of pain to the left shoulder, and an x-ray revealed an acute left distal clavicular fracture with clavicular superior displacement. The Provider Investigation Report concluded the facility unsubstantiated the incident as both residents have no prior history of this type of behavior. In an observation on 04/10/2026 at 9:55 AM, the chair Resident #1 was sitting in prior to walking over and punching Resident #2 on 03/29/2026 was approximately 25 feet away from where Resident #2 was sitting. In an interview on 04/09/2026 at 11:16 AM, the Receptionist stated Resident #2 was sitting at the front desk by the front door talking to her, and just looking around, when Resident #1 started cursing from across the room at him. She stated Resident #1 thought Resident #2 was looking at his girlfriend. She stated Resident #1 continued to curse at Resident #2 while he crossed the room, and then he began to punch Resident #2 in the side and back of his head. The Receptionist tried telling him to stop as he was crossing the room and started to hit Resident #2, but Resident #1 was not listening to her, so she ran to call for help. She stated Resident #2 was in his wheelchair when the altercation was occurring, and he cursed back and Resident #2 wrapped his arms around Resident #1, and they both fell to the floor while still punching each other. She stated the nurse, as well as another resident came and assisted with getting the residents separated, and she had not noted any obvious injuries to either resident after the altercation. In an interview on 04/09/2026 at 1:50 PM, the SW stated she was called up to the facility after the altercation between Resident #1 and Resident #2. The SW stated Resident #1 recalled and admitted to the altercation, but stated he was defending himself. She stated Resident #1 had never really exhibited physical aggression previously other than an instance when he got agitated and threatened to hit another resident with his cane. She stated she had previously educated Resident #1 over his, as well as other, resident's rights. In an interview on 04/10/2026 at 10:27 AM, LVN-A stated Resident #2 did not have any injuries from the altercation on 03/29/2026. She stated she did a complete head-to-toe assessment on Resident #2 after the altercation, and he was doing okay but had some redness and slight swelling to his head and was complaining of right ear pain, which was one of the areas he had been hit. LVN-A stated they sent Resident #2 to the ER to just be assessed, and he was monitored for approximately 2 hours, and he refused treatment, so the ER sent him back with no new orders. LVN-A stated Resident #2's redness had subsided before she left at the end of her shift, and she hadn't noticed any other issues or injuries with Resident #2. In an interview on 04/13/2026 at 9:13 AM, the RNC stated it was only approximately 15 feet from where Resident #1 was to Resident #2 prior to the altercation on 03/29/2026. The RNC stated the receptionist told Resident #1 to stop the altercation, and she ran to call for assistance. She stated the receptionist was the only one monitoring the residents on the first-floor lobby area during the time of the incident as there was no requirement for there to be any other staff in the lobby area to monitor the residents. In an interview on 04/13/2026 at 9:15 AM, the Administrator stated she had never seen Resident #1 get physically aggressive with anyone in the past. She stated he had always been pleasant and polite. She stated Resident #1 had some issues with depression and anxiety, but never with any physical aggression she knew of. The Administrator stated Resident #1 was very fast, even though he utilized a cane, he was very fast and hit Resident 2 before the Receptionist could stop him. (continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Administrator stated the receptionist told him to stop and ran to call for assistance. She stated Resident #2 did not have any serious injuries, and the staff were in-serviced over abuse and neglect, as well as resident-to-resident altercations after the incident. Record review of the facility's Abuse, Neglect, and Exploitation policy, dated 07/11/2025, revealed It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Record review of the facility's Resident Smoking policy, dated 10/24/2022, revealed 6. Residents who smoke with be further assessed, using the Smoking Safety Screen to determine safety with smoking. 14. The IDT, with guidance from the physician, will help to support the resident's right to make an informed decision regarding smoking by: d. Developing a safe smoking plan.		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframes to meet the residents' medical, nursing, and psychosocial needs for 1 (Resident #1) of 5 residents reviewed for person-centered care plans: The facility failed to recognize, develop, and implement a care plan and care plan interventions with measurable timeframes and objectives to address Resident #1's aggressive behaviors prior to his physical aggression incident on 03/29/2026. These failures could affect residents by placing them at risk of not being provided with the necessary care and services to address their needs. The findings included: Record review of Resident #1's face sheet, dated 04/09/2026, revealed a [AGE] year-old male with an admission date of 06/28/2024. Resident #1's diagnoses included Unspecified Dementia (a group of symptoms affecting memory, thinking and social abilities), and a history of Transient Ischemic Attack with Cerebral Infarction (a blockage or disruption of blood flow to the brain). Record review of Resident #1's Quarterly MDS assessment, dated 02/27/2026, revealed a BIMS score of 03, which indicated severely impaired cognition. Resident #1's MDS also revealed Resident #1 exhibited verbal behaviors toward others, as well as he utilized a cane as a mobility device. Record review of Resident #1's care plan, initiated 03/30/2026, revealed Resident #1 had the potential to be physically aggressive toward other residents. Interventions included Resident #1's behaviors were de-escalated by redirection and intervening, as well as monitor, document, and report as needed any signs or symptoms of Resident #1 posing a danger to himself or others. There were no other care plans prior to the physical aggression on 03/30/2026 which addressed Resident #1's verbally or physically aggressive behavior. Record review of Resident #1's progress note, written by the SW, dated 03/29/2026, revealed Resident #1 hit another resident in the face. Another progress note, written by the SW, dated 03/30/2026, revealed Resident #1 made another attempt to engage in physical contact with another resident, but nursing staff were able to intervene and prevented resident-to-resident contact. The SW noted a resident was in the elevator on his way to his floor when Resident #1 tried to engage with him. An activities progress note, dated 11/26/2025, revealed Resident #1 being very demanding and making rude comments toward another resident. A nursing progress note, dated 12/12/2025, revealed Resident #1 was upset with his girlfriend and stated, where the hell have you been and fuck you. A nursing progress note dated 01/04/2026 revealed Resident #1 yelled at his girlfriend's neighbor for going around in a brief. A progress note written by the SW, dated 01/05/2026, revealed Resident #1 was educated about other patient's rights after he made a gesture to try to hit another resident with his cane after becoming upset. Record review of Resident #1's change of condition assessment, dated 10/06/2025, revealed Resident #1 was angry with his roommate and was yelling at his roommate. Record review of the facility's incident reports revealed Resident #1 had a resident-to-resident incident on 03/29/2026. In an interview on 04/09/2026 at 11:16 AM, the Receptionist stated a resident was sitting at the front desk by the front door talking to her just looking around when Resident #1 started cursing from across the room at him. She stated Resident #1 thought the resident was looking at his girlfriend. She stated Resident #1 continued to curse at the resident while he crossed the room, and then he began to punch the other resident on the side and back of his head. The Receptionist tried telling him to stop as he was crossing the room and started to hit the other resident, but Resident #1 was not listening to her, so she ran to call for help. In an interview on 04/09/2026 at 1:50 PM, the SW stated she was called up to the facility after the altercation between Resident #1 and another resident. The SW stated Resident #1 recalled and admitted to the altercation, but stated he was defending himself. She stated Resident #1 had never really exhibited physical aggression previously other than an instance when he got agitated and (continued on next page)</p>		

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F 0656 Level of Harm - Actual harm Residents Affected - Few	threatened to hit another resident with his cane, and once when he became angry with a roommate over the television. She stated he had been verbally aggressive in the past, and she had previously educated him over his as well as other residents' rights. The SW stated if Resident #1 was having verbal aggression toward others, it should have been care planned. She also stated typically nursing would have care planned this. In an interview on 04/13/2026 at 9:15 AM, the Administrator stated she had never seen Resident #1 get physically aggressive with anyone in the past. She stated he had always been pleasant and polite to her. She stated Resident #1 had some issues with depression and anxiety, and had gotten upset before, but never had physical aggression which she knew of. In an interview on 04/14/2026 at 9:37 AM, the MDS nurse stated if Resident #1 had any type of physical or verbal aggression previously, it should have been care planned, and anyone on the IDT could have added it, but typically the SW added behavior care plans. The MDS nurse stated interventions would have included trying to determine what the triggers were or what set the resident off and attended to any needs they would have been having at the time. Record review of the facility's Comprehensive Care Plans policy, implemented 10/24/2022, revealed It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' environment remains as free of accidents and hazards as possible for 1 of 5 residents (Resident #3) reviewed for abuse, neglect, and exploitation. The facility failed to protect Resident #3 from neglect when the AA failed to apply her smoking apron, and Resident #3 received a cigarette burn on 03/19/2026. These failures could place residents at risk for physical and/or psychological harm or injury. The findings included: Record review of Resident #3's face sheet, dated 04/10/2026, revealed a [AGE] year-old female with an original admission date of 02/15/2024, and a current admission date of 06/11/2024. Resident #3's diagnoses included Type 2 Diabetes (a chronic condition which affects how your body metabolizes sugar [glucose], leading to high blood sugar levels and various health complications) and Dementia with other behavioral disturbances (a condition which affected memory, thinking, and the ability to perform daily activities, as well as could include symptoms such as agitation, aggression, delusions, and/or hallucinations). Record review of Resident #3's Quarterly MDS assessment, dated 03/04/2026, revealed a BIMS score of 09, which indicated moderately impaired cognition. Resident #3's MDS also revealed disorganized thinking which comes and goes and changes in severity. Record review of Resident #3's care plan, initiated 03/20/2026, revealed Resident #3 sustained a burn to her left thigh while smoking. Interventions included educate resident on safe smoking practices. Resident #3 also had a care plan, initiated 02/16/2025 and revised 03/20/2026, to use a smoking apron. Interventions included Resident #3 required a smoking apron while smoking, and Resident #3 required supervision while smoking. Record review of Resident #3's progress note, dated 03/19/2026, revealed Resident #3 had a partial thickness burn (a second degree burn which damages the outer and underlying layers of the skin) to the left front thigh, with an intact, fluid-filled blister with redness around the wound. In an interview on 04/10/2026 at 10:44 AM, the AA stated Resident #3 could be very impatient when wanting to smoke. The AA stated she was the one who gave and lit Resident #3's cigarette for her without first applying her apron. She stated not all the smokers wear aprons, but most typically do. The AA stated she never saw Resident #3 drop the cigarette, but Resident #3 stated she had dropped it, so the AA picked the cigarette up out of Resident #3's lap and handed it back to her. While putting Resident #3's smoking apron on, Resident #3 stated the area was still burning. The AA stated she saw the ember and knocked it off Resident #3's lap, but she had not noticed a hole in Resident #3's clothing. The AA stated Resident #3 continued to smoke, and after Resident #3 went back to her floor, the CNA performing peri-care noticed the burn on Resident #3, which was in the same location the ember had fallen. The AA stated the smoking aprons were used to prevent situations such as dropping cigarettes or embers and burning residents' clothing or skin. The AA stated she should have placed the apron on prior to lighting Resident #3's cigarette, and she received a counseling and a suspension for the incident. In an interview on 04/10/2026 at 11:48 AM, CNA-B stated she was putting Resident #3 to bed and got ready to change her when she noticed the burn to Resident #3's upper left thigh area. CNA-B stated the burn looked like a fresh burn with a blister and white-grey color to it. CNA-B reported the burn to the charge nurse. She stated after the incident, the staff were in-serviced over smoking safety and using smoking aprons, as well as abuse and neglect. Record review of the facility's Abuse, Neglect, and Exploitation policy, dated 07/11/2025, revealed It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Record review of the facility's Resident Smoking policy, dated 10/24/2022, revealed 6. Residents who smoke will be further assessed, using the (continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Smoking Safety Screen to determine safety with smoking. 14. The IDT, with guidance from the physician, will help to support the resident's right to make an informed decision regarding smoking by: d. Developing a safe smoking plan.		