STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676321	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Corpu	3030 Fig St Corpus Christi, TX 78404

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on observation, interview, and record review, the facility failed to review and revise the care plans for 1 of 5 residents (Resident #1) whose care plans were reviewed, in that: The facility failed to ensure Resident #1's care plans accurately reflected current mobility and activity level and status. These failures could place residents at risk of receiving inadequate individualized care and services. Findings included: Record review of Resident #1's face sheet revealed an [AGE] year-old female with an original admitted [DATE] and current admitted [DATE]. Record review of quarterly MDS dated [DATE] revealed Resident #1 had a BIMS of 08, which suggests moderate cognitive impairment. The MDS also revealed that resident had functional impairment on one side of lower extremity, utilized a wheelchair for mobility, and was dependent with dressing, hygiene, and toileting. Record review of Resident #1's Care Plan revealed resident enjoyed attending group activities, and she ambulated independently via wheelchair, but may needed assistance at times, initiated 7/17/23 and no revision. It also revealed Resident #1 had an activities of daily living self-care performance deficit related to impaired mobility and Dementia; limited physical mobility related to weakness and disease processes; high risk for fall related to impaired mobility and Dementia. In an observation on 1/27/25 at 1:10 PM, 2:00 PM, and 3:00 PM, Resident #1 was not in her bed because she was at dialysis. In an observation on 1/28/25 at 8:40 AM and 10:15 AM, Resident #1 was observed to be lying in her bed. She raised her head to acknowledge surveyor but did not turn or rotate her body. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA-A on 1/27/25 at 1:20 PM, she stated Resident #1 did not fall frequently that she knew of because she was bed bound. CNA-A stated the resident was trying to get up by herself, and she was not supposed to, and that was how she fell previously in July 2024, and since that fall the resident had declined physically and mentally, and she stays in bed all the time, except when she had to go to dialysis. CNA-A stated that when she went to change the resident, she found her on the floor on her side by the bed. She stated Resident #1 was cognitive enough to push the light when she needed something prior to the fall, but she had declined a lot, and she was more confused since that fall. CNA-A stated she immediately called the nurse to check Resident #1 when she found her on the floor. She stated staff were in-serviced over falls at monthly meetings and every time there was an incident, as well as their annual in-services. She also stated abuse and neglect was in-services monthly and in between as needed. CNA-A stated Resident #1 never complained about abuse or neglect to her, but if she had seen or heard about it, she would have reported it to her charge nurse and the Administrator, who was the abuse and neglect coordinator. In an interview with CNA-B on 1/27/25 at 1:30 PM, he stated he had worked on Hall 4 for a while and knew Resident #1 fairly well but did not work with her often because she preferred to have female staff to take care of her. He stated Resident #1 did not ambulate, nor did she use her wheelchair for mobility since declining after the fall in July 2024. He also stated that Resident #1 was no longer able to roll or turn herself in bed to assist with any of her care. CNA-B stated Resident #1 had not been able to move much or reposition herself in bed for many months now. In an interview with LVN-C on 1/27/25 at 2:10 PM, she stated that Resident #1 did not fall a lot. Resident #1 used to get in her chair and go to the bathroom before she started to decline quite a bit. The decline seemed to happen after the big fall with hip fracture in July 2024 from her trying to transfer herself to get ready for dialysis. She stated that Resident #1 no longer got herself up, transferred herself, or assisted with rolling or repositioning in bed. Resident #1 had gotten a lot weaker, and she only gets up for dialysis, and at times therapy, if it was ordered, but she mostly did not get up anymore. She stated that Resident #1 can tell you if she wanted to get out of bed or if she was in pain. She knows how to use her call light. LVN-C stated that care plans were updated by the MDS nurse and the social worker typically. She stated that Resident #1 had not had any further falls since the major fall that caused the hip fracture in July 2024. In an interview with the ADON on 1/27/25 at 2:30 PM, she stated that Resident did not fall a lot. She had declined so much that she only gets out of bed to go to dialysis. The fall occurred when resident was trying to get or transfer out of bed to get ready for dialysis, but she was confused because she did not have dialysis that day. She no longer tries to transfer self or get out of bed except dialysis days, and she was typically transferred by staff to wheelchair or stretcher. She stated the MDS nurse was the one who updated the care plan, but she can see that the care plan needs to be updated and personalized as it still says Resident #1 was ambulatory with her wheelchair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the MDS Nurse on 1/27/25 at 2:55 PM, she stated she realized Resident #1's care plan still showed ambulatory with wheelchair and limited mobility, but she was changing it to impaired mobility, as well as removing the activities care plan stating that Resident #1 attends group activities and ambulates independently via wheelchair. She stated the Activities Director updated the activities care plans, and the care plans were done at minimum with the MDS assessment and with acute changes. She stated that Resident #1 had declined so much that her dialysis sessions were decreased to twice a week and less time. She stated Resident #1 no longer likes to get out of bed other than having go to dialysis. She was still able to verbalize wants and needs and could answer questions depending on the complexity of questions. She stated Resident #1 had been refusing dialysis recently, and she was more tired and wanted to be left alone. MDS Nurse did not remember the exact situation but remembered Resident #1's fall in July 2024. She stated she did not fall frequently and had not fallen since then. The MDS Nurse stated she will get with the Activities Director right now to have her update and change the care plan, so it did not reflect that Resident #1 was still mobile with wheelchair as she was only transferred from bed to stretcher/chair for dialysis now. In an interview with the Activities Director on 1/27/25 at 3:12 PM, she stated she reviewed and updated the activity care plans quarterly and with any changes. She stated Resident #1 had a fall a while back and a recent hospital stay, and her care plan needed to be updated to accurately reflect these things. She also stated that the care plan should have been updated in November, but the activities portion had not been revised since July 2024 due to Resident #1 being in and out of the hospital. The Activities Director stated that there was a corporate person who used to look over the care plans to check that they were complete and accurate, and to see if anything was missed, but right now there was no system in place to show the care plans were being checked or updated as needed. She stated Resident #1 no longer gets up to activities, and she was going to update this in the care plan, even though it was already updated in her assessment. In an interview with the Administrator on 1/27/25 at 3:19 PM, he stated vaguely remembered Resident #1's fall from July 2024, and typically with a fall, the CNA will alert the nurse to assess resident for pain and the physical condition. They were in-serviced on falls at least monthly as well, and if there was an incident. Administrator stated the care plans were covered in QAPI meetings, and he had noticed there was a deficit with them. The MDS nurse and Interdisciplinary team updated the care plans driven by the care management nurse. As a plan of correction, the Administrator stated they were care planning individuals who were triggering more on metrics, such as the residents who had the most needs. The Interdisciplinary Team reports whether or not the care plans were updated, including the activities portion, and we have recognized that care planning needs to be brought up to speed, and more person centered. The Administrator stated that the Director of Nursing was much more versed in this process as a former MDS coordinator with experience looking at the quality of the care plan and given the fact that Resident #1 had a fall recently, as well as a hospital stay, her care plan should have been reviewed more thoroughly and updated.