

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER Windsor Nursing and Rehabilitation Center of Corpu		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse for one (Resident #1) of 5 residents reviewed for abuse. The facility failed to protect Resident #1 from Resident #2's sexual abuse on 11/21/25 in the dining room during dinner service at around 4:45 PM. This failure could lead to residents developing or exacerbating anxiety, depression, and feelings of embarrassment. The findings included: Record review of Resident #1's face sheet, dated 11/26/25, reflected a [AGE] year-old male with an original admission date of 01/11/22 and a current admission date of 05/03/25. Resident #1's pertinent diagnosis included Cerebral Infarction (a type of ischemic stroke where a blood clot blocks an artery in the brain, leading to the death of brain tissue). Record review of Resident #1's Quarterly MDS assessment, dated 10/17/25, reflected a BIMS score of 1 which indicated severe impairment. Record review of Resident #1's comprehensive care plan, dated 11/26/25, reflected the focus [Resident #1] is at risk for emotional distress r/t sexual incident involving another resident initiated on 11/21/25 and revised on 11/25/25. Interventions listed for this focus included Monitor [Resident #1] for any distress for 3 days initiated on 11/21/25, Psych services to follow up and Staff to ensure [Resident #1] and other resident maintain their distance both initiated on 11/25/25. Record review of Resident #2's face sheet, dated 11/26/25, reflected a [AGE] year-old female with an original admission date of 08/24/24 and a current admission date of 11/15/25. Resident #2's pertinent diagnosis included Alzheimer's Disease (progressive neurological disorder that is the most common cause of dementia, slowly destroying the ability to remember, think, and carry out daily tasks). Record review of Resident #2's Quarterly MDS assessment, dated 08/29/25, reflected a BIMS score of 6 which indicated severe impairment. Record review of Resident #2's comprehensive care plan, dated 11/26/25, reflected the focus [Resident #2] had an incident of inappropriate behavior involving another resident and sexual touching initiated on 11/21/25 and revised on 11/25/25. Interventions listed for the focus included closely monitor resident and ensure she is not sitting next to [Resident #1], Monitor for inappropriate behaviors q shift indefinitely, Monitor for triggers such as overstimulation, confusion, or loneliness and Place [Resident #2] on a 1:1 until 11/24/2025. In an interview with the SSD on 11/25/25 at 2:19 PM, the SSD stated at around 4:45 PM on 11/21/25 she was in the dining room speaking with residents. The SSD stated she made eye contact with Resident #1 from across the room and he gave her a strange look, like he was surprised. The SSD stated she saw Resident #2 sitting next to Resident #1. The SSD stated she bent down to see under the table and saw Resident #2's hand moving around on top of Resident #1's genital area over his pants. The SSD stated Resident #2 did not appear to be grabbing or rubbing with her hand motion. The SSD stated it did not look like Resident #2 was trying to give any sexual gratification to Resident #1. The SSD stated she immediately went over and moved Resident #2 to a different table in the dining room. The SSD stated it took about 10-15 seconds from when she first looked under the table to when she had reached Resident #2 and moved her away from Resident #1. The SSD stated she told Resident #2 that what she was doing was inappropriate, but Resident #2 appeared confused and did not understand what she was doing. The SSD stated she informed the ADM about the incident once the two residents were separated. The SSD stated she had followed up with both residents since the incident and neither had any sign or symptoms of distress related to the incident. The SSD stated she was not aware of any past allegations of sexual abuse for either resident. The SSD stated it was important to protect residents from any type of abuse to ensure that they were not harmed. The SSD stated she was not sure if the physical contact was consensual. The SSD stated after reviewing everything she did not think this incident was sexual abuse. An interview was attempted with Resident #1 on 11/25/25 at 3:51 PM but he was not interviewable. In an interview with Resident #2 on 11/25/25 at 4:09 PM, Resident #2 stated she did not have any problems with any residents at the facility. Resident #2 stated she had never touched another resident inappropriately. Resident #2 stated she would never hurt another person at the facility. Resident #2 stated she mostly kept to herself. In an interview with SW on 11/26/25 at 9:06 AM, SW stated she worked for a local psychiatric services company contracted with the facility. SW stated she started working with Resident #1 and Resident #2 on 10/15/25. SW stated when she first met with Resident #1 he was reserved. Resident #1 stated he has opened up more to her over the past month. SW stated Resident #1 got defensive when she asked him about the sexual abuse incident. SW stated his demeanor changed when she asked him about the incident, indicating he might have remembered the incident. SW stated she asked Resident #1 if he wanted to talk about the</p>		