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	06/10/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents.The facility failed to ensure Resident #1 was secured in bed during a linen change and fell out of bed onto the floor on 05/29/26.This failure could place residents at risk for injury from falling and decreased quality of life.Findings Included:Record review of Resident #1's face sheet indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with an original admission date of 02/25/26. Diagnoses included terminal cirrhosis of the liver (a chronic liver disease characterized by formation of permanent scar tissue (fibrosis) that damages the liver and interferes with its functioning; it can lead to liver failure), A-fib (an irregular, often rapid heartbeat caused by a glitch in the heart's electrical system that can cause a fluttering feeling in the chest and increase the risk of blood clots and stroke) with a pacemaker, Diabetes, high cholesterol, low potassium, depression, thyroid disease, heart failure, and muscle wasting.Record review of Resident #1's quarterly MDS assessment, dated 05/09/26, revealed Resident # 1 had a BIMS score of 10, indicating she had moderate cognitive impairment. The MDS indicated Resident #1 required supervision with eating, oral, and personal hygiene, and upper body dressing. She required substantial assistance with toileting, bathing, and lower body dressing. She was dependent for footwear, transfers, rolling side to side, sitting to lying, and sit-to-stand. She was always incontinent of bladder and bowel. Her active diagnoses were medically complex conditions. She was on hospice. She was discharged to a local hospital on [DATE], did not return, and was unavailable for an interview.Record review of Resident #1's care plan dated 05/07/26, Goal: The resident has an ADL self-care performance deficit r/t disease process Date Initiated: 05/07/2026. Intervention: May utilize halo grab bars x2 to aid in repositioning and mobility. Date Initiated: 05/06/2026. Bed mobility: The resident is totally dependent on (2) staff for repositioning and turning in bed as necessary. Date Initiated: 05/29/2026. Goal: at risk for falls r/t impaired mobility. Date Initiated: 05/27/2026. Intervention: Concave/scoop mattress in place Date Initiated: 05/30/2026. Goal: Resident #1 has had an actual fall Date Initiated: 05/29/2026. Intervention: 5/29/2026- Resident had a witnessed fall from bed during care. Resident appears to have turned too far during care and fell from the bed. Neuro checks initiated and VS (vital signs) WNL (within normal limits) for baseline. Unable to assess ROM (range of motion) due to resident position, ROM not checked due to risk for further injury. 911 called and she was sent out to ED (emergency department) for further evaluation. Concave/scoop mattress placed for fall prevention. RP (patient representative) /MD (medical director) aware. Date Initiated: 05/29/2026. Record review of physician progress notes dated 05/07/26 revealed .Resident #1 admitted for skilled nursing care, rehabilitation, medication management, monitoring of cirrhosis/hepatic encephalopathy, weakness, fall risk, and chronic medical conditions. Plan: Fall with generalized weakness and debility: continue PT/OT evaluation and treatment; continue fall precautions.Record review of the facility's provider investigation report dated 06/05/26 revealed an incident date of 05/26/26 at 11:45 am. During perineal care and a bed change, the resident fell out of bed and landed on her right (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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Comparison x-rays ordered and resulted in no definite radiographic evidence of the acute fracture or dislocation of ribs, stable, and chronic fracture of the right 7th, 8th, and 9th ribs healed with mild deformity unchanged. Hospital x-rays determined no acute injury. The investigation findings were unfounded. Record review of LVN B progress notes dated 05/26/26 at 4:34 pm revealed called by CNA B that resident was on floor. When entering room resident was on right side between bed and wall. Right side of face on floor, right arm behind resident with body on top of it. Left arm bent hold onto the floor. Resident #1 with no brief on. Bed at mid position. Resident alert and oriented x3. Resident #1 said she fell from the bed. 911 called immediately due to resident complaining of pain to head, right shoulder, and hip. Vitals taken WNL (within normal limits). Ambulance arrived. EMTs (emergency medical technician) moved resident to sitting position and cleansed right elbow due to open area. Resident alert and oriented x3. 2 EMTs lifted the resident to stretcher with one EMT grabbing legs and the other hugging from behind . In an interview with the ADM on 06/09/26 at 10:00 am, he said Resident #1's fall was tragic and unfortunate in that no one could have determined that would happen. He said she was not cognitively impaired and was in the facility for a short term stay and then transition to hospice. He said Resident #1 had loose stools frequently resulting in getting complete bed changes. He said he spoke with Resident #1 after the incident and she told him how it happened, how she turned herself. He said she told him she was a little sore on her right arm. He said she only had one halo (circular bed rail), but it was on the opposite of the bed from where she was turning. He said the fall may have been prevented with another halo on the bed. He said at one point her bed was against the wall on the side without a halo and did not know when or who moved the bed away from the wall.In an interview with LVN A on 06/09/2026 at 12:06 pm, she said she was not working the day Resident #1 fell out of bed on 05/26/26. She said she heard the resident rolled out of bed when the CNA B was changing her and got sent to the hospital per protocol. She said x-rays were done that night and she got the report around 10 pm. She said the report said there were fractures on her right-side ribs. She said she called the DON, the doctor, and Resident #1's family member. She said she checked on Resident #1 before she made the calls, and the resident was ok. She said Resident #1 continued to complain of generalized pain over the next few days. Normally, she complained of pain to the left shoulder and Resident #1's family told her she always had that pain. She said Resident #1 was weak in general and confused, depending on her ammonia level. LVN A said Resident #1 could not get out of bed or dress herself. She said Resident #1 could feed herself and brush her teeth. She said Resident #1 had 1 halo on the right side. She said the family, physician, resident or team member could request them. She said no one requested a second rail until after the fall. LVN A said a physician order, updated care plan, and a consent was required for a halo. She said she never looked at Resident #1's care plan. She said she only looked at the Kardex the CNAs used (there was only 1 Kardex) to know which resident had or needed what. In an interview with CNA B on 06/09/2026 at 12:30 pm, she said she worked at the facility for about 6 months. She said she went to change Resident #1 by herself. She said she had worked with the resident several times before. She said the resident had diarrhea often, so the bed had to be changed completely. She said she always turned Resident #1 to her same side (left side). She said she asked the resident to turn to her left side on 05/29/26 and she did. She said Resident #1 kept rolling and ended up on the floor. She said there was no halo on that side of the bed. She said there was no fall mat either. She said normally, Resident #1 would turn on her own. She said she did (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not have to help her turn, that she did it on her own. She said she immediately got the nurse when she realized Resident #1 fell and the nurse called 911 right away. She said when she was putting the new sheets on the bed, she looked up to see her fall. She said Resident #1 did not make any sounds when she fell but she heard a loud thud. CNA B said, It happened so fast, there was no time to try to stop her fall. She said if there was a halo on that side of the bed, it (the fall) probably would not have happened. She said she and the ADM spoke with the resident after she returned from the hospital [maybe a few days later] she said she had to show the ADM how it happened. She said the ADM asked Resident #1 if she had a weak arm and she said ?no'. In an interview with CNA C on 06/10/2026 at 10:10 am, she said she worked at the facility for about 2 years. She said she worked with Resident #1 frequently. She said she provided peri care & linen changes. She said when Resident #1 first got to the facility, she was able to help turn. She said by the time Resident #1 was discharged , she had been declining and was much weaker and had to have help to turn. She said, Occasionally she would go over too far, and I would have to guide her back toward me. She said Resident #1 never fell. She said Resident #1's bed had one halo on the right side. She said she was not sure if she was supposed to have two of them (halos). She said Resident #1 never asked her but asked other (unknown) CNAs for another one. She said Resident #1 would hold onto the side of the bed and the headboard when she was turned to her left. She said the resident had a weaker right side. She said she could not say for sure, but the second halo might have prevented her from falling off the bed. She said there were no fall mats on either side of Resident #1's bed.In an interview with CNA D on 06/10/2026 at 11:10 am, he said he worked at the facility for about 2 1/2 years. He said he worked with Resident #1 frequently. He said Resident #1 was able to turn on her own. He said he had to keep his hand on her hip to keep her from going too far over. He said he was concerned about that because there was no rail on that side of the bed. He said, Before, the left side of the bed was against the wall and there was a halo on the right side. He said he did not know why or who moved the bed. He said he went in to help CNA B move Resident #1 up in bed before the incident occurred. He said CNA B told him what happened- that she just rolled over too much, and she did not know that was going to happen. He said he told her she should keep a hand on their hip and he was not sure why there was not a second rail. He said he had not asked anyone why there was not a second rail or a matt in there. He said the second rail probably would have kept Resident #1 from falling out of the bed. He said there were no fall mats on either side of Resident #1's bed.In an interview with the DON on 06/10/2026 at 12:02 pm, she said having a second halo could have prevented Resident #1's fall. She said they had some residents with no halos at all. She said the way they (the facility) determined who needed halos and who did not was dependent upon mentation, preference, needs and their ability to use it. She said Resident #1 had the ability and her mentation was good. She said, to her knowledge Resident #1 did not ask for a second halo. She said there should be an order, in the care plan, and a consent for the halos because they could be considered a type of restraint or danger of entrapment. She said Resident #1 had orders for halos dated 05/29/26. She said care plan initiation dated 05/06/26 read, utilize halos x2 for pt mobility, but the ?date created' was 06/01/26. She said Resident #1 had a consent for the halos. She said Resident #1 had a fall on 05/30/26 but did not have an injury. She said Resident #1 was not a fall risk and that was her only fall. She said she was sure if there were fall mats on either side of Resident #1's bed.In an interview with the ADON on 06/10/2026 at 12:40 pm, she said she recalled hearing about Resident #1's fall. She said CNA B was changing her and while she was changing the sheet, Resident #1 overturned and fell off the bed. She said there was no injury except a skin tear on her elbow. She said the halos were not designed to prevent a fall, and she could not speak to that because she did not know what her position Resident #1 was in bed when she fell. She said she did some of the in-house training for the nurse aide training program and said CNA B had repositioning, mechanical lift, and transfers training. The ADON said fall risk assessments were done on every resident upon admission. She said she could not remember if Resident #1 was a fall risk, but she probably was. She said Resident #1 was really with it meaning (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had sense and her cognition was good. She said she was not sure if there were fall mats on either side of Resident #1's bed. Record review of CNA B's employee file revealed a one-on-one in-service for proper procedure to provide resident care dated 05/26/26 at 1:00 pm: Reeducated employee on proper procedure for providing care for residents. Always be mindful of resident safety while providing care. When care is completed place bed in lowest position and call light within reach. When a fall occurs report to nurse immediately for further evaluation. Record review of in-services:05/29/26-Abuse/Neglect and fall prevention, teamwork, safe handling of residents. 06/02/26-Abuse/neglect related to falls 06/03/26- medications administration. 06/04/26-Proper transfer techniques (safety, gait belt use, environmental factors), special needs, giving instruction, bed locks, wheelchair locks, mechanical lift is always a 2-person job.Record review of facility discharges revealed Resident #1 was discharged to an acute care hospital on [DATE] for respiratory distress and did not return.Record review of the facility fall risk evaluations for Resident #1 revealed on 05/26/26 High Risk 11.0. On 05/06/2026 admission Low Risk 0.0 Original admission on [DATE] admission Low Risk 5.0.Record review of the facility pre-restraint assessment/screening dated 05/29/26 revealed under Type of restraint currently used (including side rails, Wanderguard, Dutch door), ?Halo x2' was handwritten in the blank. Under Reason for restraint use, the boxes checked were ?recent fall (within 90 days), ?postural/positioning', 'balance problem', and ?weakness'.Record review of the facility physical restraint consent dated 05/29/26 had Resident #1's family member's signature via phone consent. Record review of the facility policy dated 08/15/22 titled, Fall Prevention Program revealed under policy; Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Under definitions, a fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force .Record review of the facility policy dated 07/11/25 titled, Abuse, Neglect, and Exploitation under neglect, means failure of the facility, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.