STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676391	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Calallen	4162 Wildcat Dr Corpus Christi, TX 78410

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48633 Based on observation, interview and record review the facility failed to ensure that drugs and biologicals were stored in locked compartments for 1 of 9 medication carts observed for compliance. One medication cart in the 600 hall was left unlocked and unattended by LVN C. This failure could place residents at risk of access and ingestion of non-narcotic medications. Findings were: Observation on 6/27/2024, at 1:41 p.m., one medication cart was unlocked (the button to lock the cart was out and a drawer opened when tugged on) on hall 600 without a supervised staff in view of the cart. The cart was unlocked for 2 minutes until LVN C exited a room and returned to the cart. During an interview on 6/27/2024 at 1:41 p.m., LVN C verbalized the unlocked cart was her cart. She verbalized she thought she locked the cart before entering a room to give medication to a resident. The cart had a variety of medications in it, but the narcotics were in a locked drawer. LVN C stated it was proper process to lock the carts when the cart was not in view or when not being utilized. She also states a resident could have accessed the medications in the drawers that were accessible (all non-narcotics). During an interview on 6/27/2024 at 1:47 p.m., the Assistant Director of Nursing (ADON) stated it is the expectation of the facility for all staff passing medications to follow the policy and lock the medication carts. The ADON stated all carts are to be within the line of sight of the staff member utilizing the cart or locked. The locked carts prevent residents from obtaining access to improper medication. During an interview on 7/1/2024 at 12:27 p.m., the Administrator stated LVN C has been 1:1 counseled and we have conducted a staff in-service regarding leaving medication carts unlocked. It is the policy of the facility to keep all medication carts locked. A review of the medication cart policy dated 10/01/2019 reveals Do not leave the medication cart unlocked or unattended in the resident care areas and The cart must remain in your line of sight when it is not locked.

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