

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Windsor Calallen		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157</p> <p>Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care for 1 (Resident #2) of 5 residents reviewed for care plans.</p> <p>The facility failed to develop a baseline care plan, or a comprehensive care plan in place of a baseline care plan, in place of a baseline care plan, for Resident #2 during the 20 days Resident #2 was at the facility.</p> <p>This failure could place residents at risk of not receiving effective person- centered care to achieve their highest practicable level of physical, mental, and psychosocial well-being.</p> <p>The findings included:</p> <p>Record review of Resident #2's Admission Record reflected a female who was admitted to the facility on [DATE] and discharged on [DATE]. Her diagnoses included aftercare following joint replacement surgery, left femur fracture (the long bone at the top of the leg) anemia, type 2 diabetes (adult onset condition in which the body has trouble controlling blood sugar), unspecified protein-calorie malnutrition (a state of inadequate intake of food as a source of protein, calories, and other essential nutrients), hyperlipidemia (high cholesterol), depression, hypertension (high blood pressure), paroxysmal atrial fibrillation (an irregular, often fast heartbeat that is not constant), age related osteoporosis (decreased bone marrow density), unspecified fall, and a need for assistance with personal care.</p> <p>Record review of Resident #2's admission MDS dated [DATE] reflected a BIMS score of 13 which indicated that Resident #2 was cognitively intact.</p> <p>Record review of Resident #2's September 2024 MAR reflected an order for Lovenox (an anticoagulant/ blood thinner) Injection Solution 40mg. Inject 40mg subcutaneously (the fatty layer under the skin) every 24 hours for DVT prophylaxis s/p left hip repair for 14 days until finished with a start date of 09/06/24 and an order for Tramadol HCl Oral Tablet 50mg. Give 1 tablet orally every 6 hours as needed for pain- moderate with a start date of 09/06/24.</p> <p>(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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Windsor Calallen		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's medical record in PCC reflected there was no baseline or comprehensive care plan.</p> <p>Record review of Resident #2 's Nursing- Initial Baseline/Advanced Care Plan-V4 effective 09/06/24 at 8:46pm and signed by ADON A reflected the following information:</p> <p>Section 1 Part C1 Vision and Hearing: Resident#2 wore glasses, however none of the boxes for Vision Care Planning were marked.</p> <p>Section 1 Part D1 ADLs: Resident #2 required assistance with ADLs, however none of the boxes for Functional Status Care Planning were marked.</p> <p>Section 1 Part G Safety and Skin Risks: G1: Resident #2 was at risk for falls however none of the boxes for Fall Risk Care Planning were marked. G2: Resident #2 had a moderate risk for developing pressure injuries, G2b: Resident #2 had potential/ actual impaired skin integrity, however none of the boxes for Potential/ Actual impaired skin integrity Care Planning were marked. 2d: Resident #2 had pressure ulcers however none of the Pressure Ulcer Care Planning boxes were marked.</p> <p>Section 2 Part C2: Medications ordered: Resident #2 had pain medications ordered however none of the boxes for Pain Care Planning were checked. Resident #2 was also on an anticoagulant however the Anticoagulant box was not checked therefore the Anticoagulant Care Planning area did not populate on the form.</p> <p>Section 2 Part C 4d: Resident #2 had upper and lower dentures, however the box for dentures was not checked.</p> <p>In an interview on 02/19/25 at 3:57pm, CMN C stated a baseline care plan was done on admission by the admitting nurse on the initial baseline/advanced care plan form. It would automatically populate to the care plan when the admitting nurse marked the boxes in the care planning area for the pertinent items. CMN C stated the IDT would meet Monday through Friday in the morning and check the initial admission forms for the admissions that came in the previous day or over the weekend. CMN C stated either ADON A or the DON would look over and sign the Initial Baseline/ Advanced Care Plan form that was filled out by the admitting nurse. CMN C stated she oversaw the long-term resident's care plans and CMN D oversaw the short-term resident ' s care plans. CMN C stated the SW made sure residents' code status was correct or updated, the DON or ADON B would update infection control issues, and CMN C would update things like wounds and falls after the morning meeting. CMN C stated it was important to have things care planned so everyone was on the same page and knew what was going on with the resident. CMN C stated if things were not care planned, the staff may not provide the proper care for the resident; for example, if the resident was supposed to be transferred with a Hoyer lift (a mechanical lift that used a sling to help safely transfer someone) but it was not care planned and the CNAs attempted to transfer someone without it, it could have led to injury to the resident or to staff. CMN C stated overall she did the care plans, but each of the department heads had to go in and sign their own parts. CMN C stated if there were changes to the care plan, she would go in and update the whole care plan for the department heads to sign. CMN C stated they did audits every so often, but not on any specific schedule.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Windsor Calallen		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/19/25 at 5:14pm, LVN E stated when a resident was admitted they would do a care plan form that had the questions that pertained to baseline care planning. LVN E stated if a question was checked yes, it would generate the focus, goals, and intervention boxes. LVN E stated the nurse would then check the boxes that pertained to that resident. LVN E stated she had always checked the boxes that applied so she did not know what would happen if the focus, goals, and interventions were not marked. LVN E stated it was important things were care planned so the residents got proper care and everyone knew what was going on with them. LVN E also stated that they could all check the care plan to see what needed to be done with the resident.</p> <p>In an interview on 02/20/25 at 8:06am, CMN D stated baseline care plans were done by the admitting nurse upon admission, and the facility had 48 hours to complete it. CMN D stated the IDT reviewed the baseline care plan information then she went in and added to it with the MDS information and completed the comprehensive care plan. CMN D stated her job was to review the resident's normal activities and ascertain what the resident's risks were going to be. CMN D stated her expectation was the admitting nurse did a thorough assessment so that any risk factors could be identified, and care planned accordingly. CMN D stated if the admission care plan was not done thoroughly it could cause a delay in resident care because not everyone was aware of the needs of the resident.</p> <p>In an interview on 02/20/25 at 9:09am, ADON A stated a baseline care plan was developed upon admission when the resident came in with a form that was filled out during the admission process, the next day the IDT looked at it to ensure all of the resident's care needs were reflected in it. ADON A stated it then got signed off by an RN. ADON A stated it was very important it was filled out accurately and completely because it was personalized to each resident and dealt with goals and interventions needed. ADON A stated if it was not done correctly, it could delay or prevent the resident from reaching their highest practicable level of physical, mental, and psychosocial well-being. ADON A stated the Initial Baseline/Advanced Care Plan form had to have an RN sign off on it if an LVN did it initially. ADON A stated she was not sure why Resident #2 's Initial Baseline/Advanced Care Plan form was not filled out completely when Resident #2 was admitted . ADON A stated every weekday morning the IDT looked over the new admissions from the previous day or the weekend and had a checklist to ensure all the needed information was there. ADON A stated as new staff came in, in services were done on care plans and they typically did an in service or at least discussed care plans weekly. ADON A stated new nurses would shadow the more experienced nurses to learn how to do the admission/ assessment paperwork.</p> <p>In an interview on 02/20/25 at 10:25am, ADON B stated baseline care plans were developed by the admission nurse when the resident arrived and the admitting nurse checked off the focus, goals and intervention for each of the care areas that applied to the resident and those items were then incorporated into the baseline care plan. ADON B stated the following day the DON or one of the ADONs opened up the baseline care plan, made sure it was complete with goals and interventions, then either CMN C or CMN D went over it and added what was in the MDS. ADON B stated CMNs C and D were the ones who were ultimately responsible for making sure care plans were done and accurate. ADON B stated it was important to have a care plan to coordinate the residents' care so they could reach their goals. ADON B stated if a care plan was not done or not accurate things would be missed and some interventions would not be put into place to ensure the residents were safe and they would reach their goals. ADON B stated a care plan was a way for the entire team to see what needs and preferences the resident had so that everyone was on the same page. ADON B stated CMN C usually did in-services on care plans once a month. ADON B stated he did not recall the last in-service, but he thought CMN C started one on 02/19/25 after she talked with the state surveyor.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Windsor Calallen		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A baseline care plan policy was requested from CMN C on 02/19/25 at 4:30 pm. A baseline care plan policy was not received prior to exit. The facility provided only the Comprehensive Care Plans policy.</p> <p>Record review of the facility's Comprehensive Care Plans policy dated 10/24/22 reflected:</p> <p>Policy: 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 includes 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.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care.</p> <p>4. The comprehensive care plan will be prepared by an interdisciplinary team .</p> <p>5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly assessment.</p> <p>6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident ' s needs as identified in the resident ' s comprehensive assessment. The objectives will be utilized to monitor the resident ' s progress. Alternative interventions will be documented, as noted.</p> <p>8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Windsor Calallen		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038</p> <p>Based on observation, interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices for one (Resident #1) of two residents reviewed for quality of care.</p> <p>The facility failed to ensure the Wound Care Nurse followed doctor's orders (pat dry wound) during wound care for Resident #1.</p> <p>This failure could place residents at risk for not receiving the appropriate care and treatment.</p> <p>The findings include:</p> <p>Record review of Resident #1's face sheet, dated 02/12/25, reflected a [AGE] year-old-female with an original admitted [DATE]. Resident #1 had diagnoses which included Dementia (loss of cognitive functioning that interferes with a person's daily life and activities), end stage renal (kidney) failure, and unspecified open wound of right breast.</p> <p>Record review of Resident #1's physician orders, dated 01/14/25, reflected:</p> <p>Cleanse nonhealing surgical wound to the right breast with anasept (skin wound cleanser that fights bacteria) and 4x4 gauze (allows fluids from wound to be absorbed into the fibers), pat dry with 4x4 gauze, apply blue bacteriostatic foam (type of wound dressing that prevents the growth of bacteria) apply bordered dry dressing daily and as needed if soiled/dislodged. Monitor site for redness, warmth, increased drainage, increased pain, and notify doctor as needed.</p> <p>Record review of Resident #1's care plan initially, dated 02/29/24, stated reflected Resident #1 had a non-healing surgical wound to the right breast. Interventions included administer medications as ordered to address medical diagnosis/conditions. Monitor for effectiveness and adverse side effects .</p> <p>Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIM score of 9 (Moderate cognitive impairment).</p> <p>During an observation of wound care on 2/11/25 at 2:08 PM, the Wound Care nurse performed wound care on Resident #1 by cleansing the wound with anasept as ordered. The Wound Care nurse then applied the blue bacteriostatic foam without pat drying the wound and applied a bordered dry dressing.</p> <p>In an interview on 02/11/25 at 2:28 PM, the Wound Care nurse stated Resident #1's wound should have been patted dry as ordered to ensure the skin had an enact dry surface before applying the bordered foam. The Wound Care nurse stated the wound could retain moisture by not pat drying which could have increased the chance of infection. The Wound Care nurse stated she usually pat dried the wound but forgot. The Wound Care nurse stated the last in-service on infection control was approximately a month or two ago.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Windsor Calallen		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/11/25 at 3:31 PM, the DON stated the wound care nurse should have followed the doctor's orders as written and pat dried the wound. The DON stated the wound could stay wet with moisture making the wound more prone to infection. The DON stated the last infection control in-service was in the last 30 days but was going to in-service staff on infection control and following physician orders immediately.</p> <p>Record review of the facility's in-service on infection control and following physician orders ,dated 02/12/25, reflected it was for all staff .</p> <p>Record review of the facility's Medication Administration policy, dated 10/01/19, reflected:</p> <p>Procedure</p> <p>2. Administration</p> <p>B. Medications are administered in accordance with written orders of the prescriber .</p>