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	04/09/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on observation, interview and record review the facility failed to develop and implement a person-centered comprehensive care plan to include measureable objectives and timeframes to attain or maintain the resident's highest practical physical, mental and psychosocial well-being for 1 of 5 residents (Resident #8) reviewed for comprehensive care plans in that: The facility failed to revise or update Resident #8's care plan to reflect the habitual losing or misplacing of items and accusing others of theft. This failure could affect the resident by placing him at risk for not receiving appropriate interventions to meet his current needs. The findings included: Record review of Resident #8 ' s face sheet dated 04/09/25 revealed an [AGE] year-old male with an original admitted [DATE], and a current admitted [DATE]. Diagnoses for Resident #8 revealed Dementia (a decline in cognitive function) and Anxiety (feelings of worry, fear, and apprehension). Record review of Resident #8 ' s Quarterly MDS assessment dated [DATE] revealed a BIMS score of 10, which indicated moderately impaired cognition. Record review of Resident #8 ' s care plan initiated 03/15/23 revealed no care plan for misplacing items, losing items, and/or accusing others of theft of items. In an interview with CNA-D on 4/8/25 at 2:56 PM, she stated the CNAs used the care plans to know what the residents ' needs were and how to meet them, but they were not the ones who updated them. She stated she thought the nurses did that. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #8 on 04/09/25 at 10:35 AM, he stated that he had 40 dollars in his wallet on his bed and 60 dollars in an envelope in his drawer. He stated that when he realized it was missing on 03/08/25, he reported it. He stated he was not exactly sure what happened to the money, and he initially stated he thought the nurse took it but then stated he had been suspicious of the CNA who worked his hall and the CNA who worked the other hall. He stated they were mother and daughter, and he thought they were in on it together. Resident #8 also stated he had property that went missing previously, and he usually found it, but he never found this missing money. Resident #8 stated he locked everything up now and kept the keys on him. In an observation on 04/09/25 at 10:35 AM, Resident #8 was showing how he wore the keys to his locked compartment around his neck so as to not lose them. Resident #8 was then observed unlocking the locked compartment on his dresser and leaving his keys in the locked compartment. Resident #8 started to go back to bed, but this surveyor reminded Resident #8 that he forgot his keys in the locked compartment. In an interview with the SW on 04/09/25 at 10:40 AM, she stated she spoke with Resident #8 after his money went missing. She stated he had accused two of the CNAs of taking his money, although he had no proof. She stated Resident #8 had property that went missing in the past, and accused others of stealing it, then found it. She stated this was a behavior that should have been care planned so the nurses and other staff were aware of the behavior and knew what interventions to take. She stated care plans were updated and revised by the IDT. In an interview with the MDS nurse on 04/09/25 at 11:20 AM, she stated if a resident frequently lost or misplaced items, and accused others of stealing them, it should have definitely been care planned so that the proper goals and interventions could have been set for this resident. She stated the SW should have updated Resident #8 ' s care plan with this information, but she would work on getting it updated right now. In an interview with ADON-A on 04/09/25 at 11:25 AM, she stated if a resident frequently lost items, misplaced items, and accused others of stealing them, it should have been noted in their care plan so that nurses and other staff knew the appropriate interventions to take, and this should have been updated in the care plan by either the SW or the MDS nurse, but either way, it should have been care planned. In an interview with ADON-B on 04/09/25 at 11:30 AM, he stated Resident #8 should have had a care plan regarding lost and/or misplaced items and accusing others of stealing items. He stated this should have been done by the MDS nurse, the SW, the DON or one of the ADONs. He stated the care plans needed to be personalized so the nurses and staff knew the appropriate precautions and interventions to use. Record review of the Comprehensive Care Plan policy, implemented 10/24/22, revealed 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. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, for one Resident (Resident #1) of five residents reviewed for infection control practices, in that: The facility failed to ensure CNA C performed hand hygiene after removing gloves during incontinent care. This failure could place residents that require assistance with personal care at risk for healthcare associated cross-contamination and infections. The findings included: Record review of Resident #1's face sheet dated 04/09/25 reflected an [AGE] year-old-female with an original admitted [DATE]. Diagnosis included dementia (general decline in cognitive abilities that affects a persons ability to perform everyday activities). Record review of Resident #1's annual MDS dated [DATE] reflected a BIMS score of 00 (severe cognitive impairment). During an observation of incontinent care on 04/09/25 at 10:10am, CNA C was performing peri care on Resident #1, she removed her gloves, did not wash, or sanitize hands, before putting new gloves on. In an interview on 04/09/25 at 10:26 am CNA C stated she did not wash/sanitize hands between glove change. CNA C stated she was nervous and just forgot. CNA C stated she should have washed or sanitized her hands between glove change to stop the spread of infection. CNA C stated in-service on infection control and hand washing is done frequently and was done last week (verified through record review). In an interview on 04/09/25 at 10:31am the DON stated CNA C should have washed and sanitized hands between glove changes to prevent cross contamination. The DON stated by not washing/sanitizing hands during glove changes could put the resident at risk for infection. In an interview on 04/09/25 at 10:38am ADON A stated CNA C should have washed or sanitized hands between glove changes to prevent the risk of resident infection. The ADON A stated staff are in-serviced weekly on hand washing and sanitizing hands. Record review of the facility's Hand Hygiene policy dated 10/24/22 stated: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of antiseptic hand run, also known as alcohol-based hand run (ABHR). 6. Additional consideration: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.