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	08/08/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews the facility failed to ensure that drugs and biologicals for Resident #1 were received and counted appropriately for 1 of 4 residents. A narcotic medication for Resident #1 was not received and counted appropriately by RN A when Resident #1 admitted to the facility. The narcotic count for medication Oxycodone-Acetaminophen Oral Tablet 10-325 MG was short by 15 pills.This failure could result in being in pain.Findings included: Record review of Resident #1’s face sheet dated August 5, 2025, revealed Resident #1 admitted on [DATE]. Resident #1 had medical diagnoses of Cirrhosis of the liver (chronic liver damage), Other Psychoactive substance abuse, Hypertension (High Blood Pressure), Hepatitis C, and Repeated falls. Review of Resident #1’s admission MDS assessment dated [DATE], revealed Resident #1 had a BIMS (Brief Interview Mental Status) score of 05 which indicates severe cognition impairment. Record review of Resident #1’s care plan, undated, revealed Resident #1 had chronic pain due to liver cirrhosis. Record review of Resident #1’s physician orders dated August 5, 2025, included Oxycodone-Acetaminophen Oral Tablet 10-325 MG by mouth every 4 hours as needed for Pain with a start date of July 10, 2025. During an interview on August 5, 2025, at 1:35p.m., LVN A verbalized she was giving report to the oncoming nurse on July 10, 2025, and they (she and the oncoming shift nurse) were waiting on narcotics from the hospice nurse for Resident #1. LVN A stated “RN A told me she would count the narcotics when they arrived”. I had already signed in some other medications Resident #1 brought from home. LVN A stated she was going off shift and RN A was coming on shift when the narcotics arrived, but I never opened or saw the narcotics. LVN A stated she did not think this resident was abused or neglected due to Resident #1 never being without medication. LVN A stated we (the facility staff) changed the way we receive medication, and we have to ensure we count the medication with whomever drops off the medication and we have them sign our paperwork also. It has always been the policy to have 2 staff members sign for narcotic medication. During an attempt to reach Resident #1 on August 8, 2025, this investigator was hung up on two times. This occurred at 2:00p.m and 2:05p.m. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on August 8, 2025, at 2:30p.m., LVN B verbalized he counted the narcotic medication cart when he came on shift on July 11, 2025. LVN B stated the off-going shift nurse had Resident #1's medication in pill bottles and when he counted the narcotics named Oxycodone-Acetaminophen Oral Tablet 10-325 MG the count was off by 15 pills. LVN B stated he notified the ADON and DON that the narcotic count was off. LVN B stated the DON and ADON took the medication and recounted the medication and started an investigation. LVN B stated he was not sure what happened after they started investigating the missing medication. During an interview on August 8 ,2025 at 2:40p.m., RN A stated she did receive the Oxycodone-Acetaminophen Oral Tablet 10-325 MG from the hospice nurse, and she did lock them up but did not count them. RN A stated she took report from the off going staff member (LVN A) started her shift. RN A stated she received a pill bottle from the hospice nurse and took the count listed on the bottle as the amount of narcotics in the bottle (the count was 60). RN A stated she knew she should have counted them, but she did not count the medication. RN A stated she did not know how to answer the question of if its abuse or neglect for Resident #1. RN A stated Resident #1 was never without her medication and was never in pain. RN A stated she did not follow proper policy and protocol. During an interview on August 8, 2025, at 3:00p.m., the Director of Nursing (DON) stated she was notified by LVN B that the narcotic medication labeled Oxycodone-Acetaminophen Oral Tablet 10-325 MG count was off by 15 pills for Resident #1. The DON stated she immediately took the bottle of medication and tried to find the missing pills. The DON stated she notified the Administration and started an investigation. The DON verbalized the investigation included interviewing staff, calling hospice, placing staff on suspension, doing in-services on narcotic medication, reviewing Resident #1's entire clinical record, reviewing narcotic logs, and providing support to leadership during the process of investigating. During an interview on August 8, 2025, at 3:15p.m., the Administrator stated he was made aware the narcotic medication labeled Oxycodone-Acetaminophen Oral Tablet 10-325 MG was missing the morning of July 11, 2025, by the DON. The Administrator stated I called the person who delivered the medication, the pharmacy, and the DON for Hospice. The Administrator stated we (staff involved in the investigation) found out that this medication was left at the Hospice office for over 24 hours. The Administrator stated his facility staff nurse (RN A) trusted the pharmacy count and she did not count the actual medications. The Administrator stated policy and procedure was not followed. The Administrator stated the staff were placed on suspension and we have updated our policy and process for receiving medication. The Administrator stated we have also updated staff on the policy and now we request blister packs from all our pharmacies and Hospice companies. The Administrator stated I do not think this resident was abused or neglected and the resident was never in pain because she was never out of medication. A review of the facility policy named “Medication Policy, subsection Receiving Controlled Substances” dated October 1, 2019, revealed “At the time of delivery, the licensed nurse will verify the controlled substances received in the presence of the driver. The information on the manifest delivery log is correlated and both copies are signed indicating delivery and receipt of the individual controlled substances has been accomplished”.