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	06/24/2026

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide or obtain laboratory services to meet the needs of its residents for of 1 of 5 residents (Resident #1) reviewed for laboratory services. The facility failed to ensure Resident #1's Keppra (a medication used to treat seizures) level was drawn every three months to ensure Resident #1 was at a therapeutic level. This failure could place residents at risk of not receiving needed laboratory services and not having medications managed at a therapeutic level. The findings included:Record review of Resident #1's face sheet, dated 06/22/2026, revealed a [AGE] year-old male who was originally admitted to the facility on [DATE] with a readmission on [DATE]. Pertinent diagnoses included Epilepsy, not intractable, without status Epilepticus (a form of epilepsy [seizure disorder] where seizures were controlled with medication and did not involve prolonged or continuous seizures).Record review of Resident #1's Annual MDS assessment, dated 04/16/2026, revealed Resident #1 had a BIMS score of 00, which indicated severely impaired cognition. Further review of the MDS assessment also revealed Resident #1 had a seizure disorder or epilepsy. Record review of Resident #1's comprehensive care plan, revised 10/13/2021, revealed Resident #1 had a seizure disorder. Interventions included: give seizure medications as ordered by the doctor; monitor labs and report any sub therapeutic or toxic results to the doctor. Record review of Resident #1's physician order summary dated 05/25/2026 revealed a laboratory order for a Keppra level every 3 months. Order date was 11/10/2023. Record review of Resident #1's active physician order summary dated 06/22/2026 revealed an order to discontinue all routine labs; please call Hospice services with any questions or concerns, changes in condition, fall or absent vitals. Order date was 06/10/2026. Record review of Resident #1's physician orders revealed Resident #1 had been on Keppra since 2021, with the most recent change or revision to the order on 06/04/2026, Levetiracetam (Keppra) 500MG / 5ML, give 5ML by mouth four times a day related to Epilepsy.Record review of Resident #1's lab results revealed the last Keppra level was drawn on 12/20/2025.In an interview on 06/22/2026 at 4:13 PM, Resident #1 did not recall when the last time he had a seizure was, as well as was confused about what medications he took. Resident #1 was only concerned with getting more food and snacks. In an interview on 06/23/2026 at 1:15 PM, ADON-B stated Resident #1 had been admitted to hospice this month, which was why all his lab work had been discontinued. She stated she was not sure how often labs were supposed to be drawn to monitor epilepsy medications or what the therapeutic ranges were supposed to be for the medications Resident #1 was on. ADON-B stated since Resident #1's last Keppra level was checked on 12/20/2026, he should have had lab work checked again sometime in March 2026 and June 2026. ADON-B stated if his Keppra levels were not in a therapeutic range it could have contributed to him having seizures, and the labs should have been drawn every three months as ordered. ADON-B stated Resident #1 had not had any seizures recently that she was aware of. In an in interview on 06/23/2026 at 1:56 PM, ADON-A stated Resident #1's last Keppra level was in December 2025, so the next one should have been in March 2026. ADON-A stated everyone was different, so he was not sure if Resident #1 needed to be in the therapeutic range for his Epilepsy medication to work, but being at a subtherapeutic level could have possibly caused Resident #1 to have a seizure. In an interview on (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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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/24/2026 at 10:05 AM, the DON stated Resident #1's labs should have been checked to ensure his Epilepsy medication was at a therapeutic level because if the medication was not at a therapeutic level, it could have possibly contributed to Resident #1 having seizures. The DON stated Resident #1 had not had any seizures since the seizure like activity when he was transported to the hospital in May 2025. The DON stated she had already called Resident #1's Hospice company and got an order to restart labs to assess the therapeutic levels of Resident #1's Epilepsy medication since all of his routine labs had been discontinued after being admitted to hospice this month. Record review of the facility's Laboratory Services and Reporting policy, implemented 04/08/2024, revealed Policy: The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. Policy Explanation and Compliance Guidelines: 1. The facility must provide or obtain laboratory services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation, and sanitation.The facility failed to ensure all kitchen staff wore hair and beard covers while assisting in the kitchen during lunch on 06/24/2026. This failure could place residents at risk for food contamination and food borne illness. The findings included: In an observation of the dining room and kitchen on 06/24/2026 at 12:27 PM, the DM was observed in the kitchen talking to and assisting another kitchen staff who was preparing and setting up lunch trays for residents. The DM had hair on his head and a beard, but he did not have a hairnet or beard cover on to prevent hair or facial hair from falling into residents' dishes or food. In an interview on 06/24/2026 at 1:34 PM, the DM he knew he was supposed to wear hairnets and beard covers while in the kitchen. The DM stated he had just gone out the back entrance to do something and was coming back in the back door, and there were no hairnets or beard covers at the back entrance where he usually kept them, so he was walking through the kitchen to grab one from the front entrance. The DM stated if a hair or beard cover was not worn while in the kitchen, hair could have fallen into the resident's food and caused cross contamination.In an interview 06/24/2026 at 2:13 PM the Administrator stated the DM and kitchen staff knew they were supposed to wear hair and beard covers while in the kitchen, even if the staff were just walking from one entrance of the kitchen to the other entrance. Loose hairs could fall into the residents' food or dishes if hair covers were not worn. He stated he had already started an in-service today (06/24/2026) regarding covering hair and facial hair while in the kitchen.Record review of the facility's Employee Sanitation Policy, dated 10/01/2018, revealed Policy: The Nutrition and Foodservice employees of the facility will practice good sanitation practices in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness. Procedure: 3. B. Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces.References: FDA Food Code 2022 Ch. 2-102.20 Food Protection Manager Certification 2-103 Duties 2-103.11 Person in Charge. The PERSON IN CHARGE shall ensure that: 2-4 Hygienic Practices 2Ch. 3-305 Preventing contamination from the premises 3-305.11 Food Storage (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination (2) Where it is not exposed to splash, dust, or other contamination.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained and accurately documented for 1 of 5 residents (Resident #1) reviewed for accuracy of records. The facility failed to ensure Resident #1's bowel and bladder documentation was charted in PCC (the electronic record and charting system) for the dates of 06/20/2026 and 06/21/2026.This failure could place residents at risk for improper care due to inaccurate or incomplete assessments and records.The findings included:Record review of Resident #1's face sheet, dated 06/22/2026, revealed a [AGE] year-old male who was originally admitted to the facility on [DATE] with a readmission on [DATE]. Pertinent diagnoses included Chronic Kidney Disease Stage 2 (also called chronic kidney failure, involves a gradual loss of kidney function).Record review of Resident #1's Annual MDS assessment, dated 04/16/2026, revealed Resident #1 had a BIMS score of 00, which indicated severely impaired cognition. Further review of the MDS assessment also revealed Resident #1 was always incontinent of both bladder and bowel, and he required substantial or maximal assistance with toileting hygiene.Record review of Resident #1's comprehensive care plan for ADL self-care performance deficit related to confusion, revised 10/22/2021. Interventions, revised 04/23/2026, revealed Functional Performance: Toileting Hygiene: Resident #1 required dependent assistance for toileting hygiene. Record review of Resident #1's bladder elimination documentation from 06/09/2026 - 06/22/2026 revealed the dates of 06/20/2026 and 06/21/2026 were missing from the documentation. Record review of Resident #1's bowel elimination documentation from 06/09/2026 - 06/22/2026 revealed the dates of 06/20/2026 and 06/21/2026 were missing from the documentation.In an in interview on 06/23/2026 at 1:56 PM, ADON-A stated the CNAs were supposed to document the residents' bowel movements and incontinent episodes on the care task in PCC. After checking in PCC, ADON-A stated the documentation for the 20th and 21st of this month (June) were not there, but they should have been. He stated the charge nurses were ultimately responsible for following up to make sure the CNAs were documenting the care tasks performed on their shift.In an interview on 06/23/2026 at 2:47 PM, LVN-D stated she worked Saturday and Sunday (06/20/2026 and 06/21/2026) as a charge nurse and a medication aide on the 400 hall. She stated the CNAs documented the bowel and bladder notes in PCC. LVN-D stated it was ultimately the charge nurse's responsibility to check to make sure it was document. LVN-D stated she was busy helping the CNAs and passing medications, so she had not had time or a chance to check if the CNAs completed their charting, but the charting should have been completed so the residents' bowel patterns were known. In an interview on 06/23/2025 at 4:33 PM, CNA-C stated she had worked the previous weekend. She stated she documented bowel movement and incontinent briefs in the bowel and bladder section of PCC, and if there were any urinary symptoms, she reported the symptoms to the nurse. She was unsure why they were not documented for the previous weekend.Record review of the facility's Documentation in Medical Record policy, implemented 10/24/2022, revealed Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.