

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 05/07/2025
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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to a PASRR evaluation was completed on newly admitted residents prior to admission or after admission for 1 of 5 residents (Resident #83) reviewed for Preadmission Screening and Resident Review screenings.</p> <p>The facility failed to ensure Resident #83's PASRR L1 screening dated 08/26/21 accurately reflected his diagnoses of mental illness.</p> <p>There was no evidence that Resident #83 was referred to a Level 2 PASRR Screening and Evaluation.</p> <p>This failure could affect residents by placing them at risk for not receiving needed treatments and services.</p> <p>Findings included:</p> <p>Record review of Resident #83's face sheet revealed a [AGE] year-old male with an admission, original and initial date of 08/27/21. His principal diagnosis was stroke and secondary diagnoses were alcohol abuse and kidney failure. Diagnoses included major depressive disorder, recurrent, moderate dated 06/07/22, and anxiety disorder dated 06/07/22 and 12/08/21. Post-Traumatic Stress Disorder, Chronic dated 09/15/21, mood (affective) disorder dated 04/21/25, dementia, unspecified severity, with agitation dated 01/24/23, dementia dated 04/25/23, insomnia, altered mental status, and restlessness and agitation dated 04/21/25.</p> <p>Record review of Resident #83's admission MDS report dated 08/30/21 revealed a BIMS score of 06 indicating severe cognitive impairment. Section D: Mood indicated he had little interest or pleasure in doing things, felt tired or had no energy nearly every day. He felt down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much half or more of the days. He had a poor appetite for several days. He was on a mechanically altered diet. He was not steady and only able to stabilize with staff assistance. He required staff assistance with toileting, dressing, footwear, showering and positioning, personal hygiene, and set-up with oral hygiene and eating. He could sit in a wheelchair. He was frequently incontinent of bladder and bowel.</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
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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #83's quarterly MDS report dated 04/22/25 revealed a BIMS score of 00 indicating severe cognitive impairment. His cognitive skills were severely impaired for daily decision making. His inattention was continuous. He had physical and/or verbal behavioral symptoms directed toward others every 1-3 days. He was dependent on staff for all ADL's. He was on a mechanically altered diet. He was always incontinent of bladder and bowel. His active diagnoses were stroke, mood (affective) disorder, insomnia, altered mental status, restlessness and agitation, encounter for palliative care, cognitive communication deficit, insomnia, and alcohol abuse. He was taking antianxiety, antidepressant, and hypnotic medications. He was receiving hospice care.</p> <p>Record review of Resident #83's PL1 from a local hospital dated 08/26/21 was negative for MI (mental illness), ID (intellectual disability), and DD (developmental disability). There were no other PL1 screenings for Resident #83.</p> <p>Record review of Resident #83's Care Plan dated 08/29/21 revealed he has an ADL self-care performance deficit r/t Confusion,</p> <p>Dementia Date Initiated: 09/02/21 Revision on: 09/02/21. He had a behavior problem of abusive language, threatening behavior, rejection of care, and will push staff related to PTSD, dementia, yelling, screaming, pushing, and grabbing Date Initiated: 05/09/22</p> <p>Revision on: 08/08/22. He had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's, Dementia</p> <p>Date Initiated: 06/07/22 Revision on: 06/07/22. He had a history of actual falls and was at a high risk for further falls. Confusion, poor safety awareness, Deconditioning, anxiety, use of psychoactive medications. Will pull his floor mat onto his bed. Date Initiated: 09/02/21 Revision on: 05/05/25. He used anti-anxiety medications r/t anxiety disorder and mood disorder. Date Initiated: 10/22/21</p> <p>Revision on: 03/12/25. He used antidepressant medication r/t Depression, Insomnia Date Initiated: 10/22/21 Revision on: 04/28/25. He had a terminal prognosis r/t cerebral infarction (stroke) Date Initiated: 10/31/22 Revision on: 10/31/22.</p> <p>Record review of Resident #83's Care Plan dated 04/16/25 revealed the revision date for a history of actual falls and was at a high risk for further falls. Confusion, poor safety awareness, deconditioning, anxiety, use of psychoactive medications. Will pull his floor mat onto his bed. Date Initiated: 09/02/21 Revision on: 03/12/25. He was on sedative/hypnotic therapy r/t Insomnia Date Initiated: 09/02/21 Revision on: 09/26/22.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #83's Form 1012 (Mental Illness/Dementia Resident Review) dated 02/02/23 revealed Yes, the individual has a primary diagnosis of dementia as defined above. The physician signs and dates the form attesting to the dementia diagnosis. Complete Sections D and E of the form. File the form in the resident's medical record. The Form 1012 Indicated the PL1 was dated 08/26/21. Section C. of the Form 1012 indicated Resident #83 had a Mood Disorder (Major Depression) The Form 1012 did not indicate Resident #83 had an anxiety disorder or any other disorder (such as PTSD). Section C instructed If all the responses are No, physician signs and dates the form. A new PL 1 is not needed at this time. Complete Sections D and E. If any of the responses are YES, the nursing facility needs to complete a new PL 1 and Sections D and E of the form. A full PASRR Evaluation will be conducted after the nursing facility submits the new positive PL 1. Section D of Resident #83's Form 1012 had The PL 1 remains negative and no new PL 1 needs to be completed. The nursing facility files the completed form in the resident's chart selected, but not A new positive PL 1 was submitted on _____ according to the instructions in Section C with DLN Driver's License Number). Resident #83's Form 1012 was signed by the MDS nurse on 02/02/23.</p> <p>Record review of Resident #83's Psychiatric Subsequent assessment dated [DATE] indicated he had diagnoses of: Primary Treating Diagnosis: Generalized anxiety disorder. Secondary Treating Diagnosis: Insomnia due to other mental disorder. Tertiary Treating Diagnosis: Major depressive disorder, recurrent, moderate. Reason for Referral: Anxiety, Agitation, Alcohol or Substance Abuse, Previous Mental Health Diagnosis: fidgety, pacing, intruding roommates' space, Other: PTSD.</p> <p>In an interview with the MDS on 05/06/25 at 5:28 PM, she said Resident #83's PASRR L1 dated 08/26/21 was negative and the person who worked at the facility before her, quit, so she had been catching things up, and that was why Resident #83's Form 1012 dated 02/02/23 had taken 2 years to send. She said she checked the Form 1012 Section C yes for Mood Disorder (Major Depression) and signed the form. She said she missed the part of the instructions where the Form 1012 stated, If any of the responses are yes, the nursing facility needs to complete a new PL1 and sections D and E of the form. A full PASRR Evaluation will be conducted after the nursing facility submits the new positive PL1. She said she misread Section D of the Form 1012 and filled in the circle that stated, The PL1 remains negative and so no new PL1 needs to be completed. The nursing facility files the completed form in the resident's chart. She said her signature was on the Form 1012 and said she would submit another PL1 now. She said Resident #83 had declined since his admission. Policy for PASRR was requested at this time.</p> <p>In an interview with the ADM on 05/07/25 at 8:55 AM, he said the facility did not have a policy on PASRR.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 1 of 5 residents (Resident #50) reviewed for nutritional status.</p> <p>The facility failed to recognize, evaluate, and address timely interventions such as continued weekly weights to identify and prevent weight loss when Resident #1 experienced significant weight loss of 21% (47 pounds) between the dates of 03/10/25 and 05/07/25.</p> <p>This failure could place residents at risk for improper care, weight loss, malnutrition, and overall health decline.</p> <p>Findings included:</p> <p>Record review of Resident #50's face sheet revealed an [AGE] year-old male with an admission date of 03/06/25. Diagnoses included Type 2 Diabetes Mellitus (a disease that affects how the body uses blood sugar), Congestive Heart Failure (a condition affecting the heart's ability to pump blood well), Pressure Ulcers, Chronic Kidney Disease (a condition affecting the kidney's ability to filter waste from the blood), and Muscle Wasting and Atrophy (a decrease in size or wasting away of a body part or tissue).</p> <p>Record review of Resident #50's care plan initiated 05/06/25 revealed he had potential nutritional problems due to decreased mobility, and multiple areas of impaired skin integrity. Interventions included monitor, record, and report to provider signs and symptoms of malnutrition, emaciation, muscle wasting, and significant weight loss (3lb in 1 week, greater than 5% in 1 month, greater than 7.5% in 3 months, and/or greater than 10% in 6 months).</p> <p>Record review of physician orders initiated 03/07/25 revealed an order to weigh weekly x 4 weeks, then monthly and PRN. There were also multiple orders for wound care. A physician order dated 04/30/25 revealed an order for liquid protein and an order for a nutritional supplement. A regular diet order dated 03/06/25 revealed an order for fortified foods with all meals, and large portions with breakfast and dinner.</p> <p>Record review of Resident #50's weight summary revealed on 05/07/25 a weight of 174.2lbs; on 05/02/25 a weight of 179.6lbs; on 04/02/25 a weight of 196.2lbs; on 03/27/25 a weight of 194.6lbs; on 03/20/25 a weight of 196.6lbs; on 03/13/25 a weight of 204.6lbs; on 03/10/25 a weight of 221lbs for a total weight loss of 47 lbs. Resident #50's current BMI was 27.3.</p> <p>Record review of Resident #50's progress note dated 04/16/25 revealed Resident #50 had refused to be weighed. No other weight refusals or weight attempts noted between 04/02/25 and 05/02/25. No progress notes noting the physician was notified of weight loss or weight refusals.</p> <p>Record review of in-service dated 05/06/25 revealed an in-service regarding nursing staff obtaining weights on admission, as well as obtaining weekly weights when the RA is unavailable.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview and observation on 05/06/25 at 8:45 AM Resident #50 was observed lying in bed with a wound vac sitting below the bed attached to his lumbar or sacral area. Resident #50 stated he had many wounds the nurses had been working on to get better. He stated he was losing weight because his appetite was not as good as it used to be, and he did not eat as much as he used to. He also stated the food there was not great either.</p> <p>In an observation on 05/07/25 at 9:00 AM, the RA was observed weighing Resident #50 via the mechanical lift.</p> <p>In an observation on 05/06/25 at 2:56 PM, Resident #50's wounds appeared to be progressing and healing.</p> <p>In an interview with ADON-A on 05/06/25 05:42 PM she stated the RA typically weighed the residents weekly on the same day each week. She also stated the RA was also a CNA, so she would get pulled to work the floor frequently. She also stated she was unsure why Resident #50 was not getting weighed weekly. She stated when a resident had as much weight loss as Resident #50 had, weekly weights should have been continued. She stated they were aware they needed to continue to monitor his weight due to his weight loss, and they had attempted it, but it was why there was a refusal in the progress notes dated for 04/16/25. ADON-A stated although the RA was the one who took the weights, only nurses entered weights into the electronic charts, and it was typically the DON who entered the weights. She stated the RA had been falling behind on obtaining weights because they had been scheduling her to work on the floor as a CNA. She also stated if weights were not being taken, the TAR should have flagged that the weights were not being completed, and this was something her and ADON-B, as well as the DON were alerted about. She stated they all dropped the ball on continuing his weights and reporting his weights to the provider.</p> <p>In an interview with the RD on 05/06/25 at 5:51 PM she stated she was flagged regarding Resident #50's weight loss, and it was why he was on interventions for weight loss and wounds such as Med Pass (started 04/07/25), Mirtazipine (started 05/03/25), Critical Care Liquid Protein (started 04/30/25), Juven (started 04/30/25), high protein snacks three times a day (started 04/07/25), fortified diet with large portions (started 03/06/25). She stated she was unsure of the reasons he continued to have weight loss. She stated she was only alerted when the residents' weights were entered, and they triggered for weight loss. She stated she ran weight variance reports monthly to determine which residents had weight loss or weight gain and what interventions needed to be put into place. She stated she did not always look at the orders to determine who was a daily, weekly, or monthly weight, and she was not sure if she was supposed to look at the orders or know that information. She stated she was not sure if it was in her job description to check orders, but she would find out.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with ADON-B on 05/07/25 at 8:50 AM he stated Resident #50 had lost over 40 lbs. He stated excessive weight loss could lead to dehydration, malnutrition, loss of muscle mass, and possible death. ADON-B stated the RA did the weekly weights then took them to the DON, and the DON input the weights and checked for weight loss. He also stated weights that had not been completed would flag red in the TAR when they had not been done, and this would alert the ADONS. If the weight obtained showed a large weight loss or weight gain, the RA would usually get a reweigh; also, if the weight was not obtained because the RA was busy working the floor or gone that day, either the LVN would obtain the weight, or the RA would obtain at a later time. Resident #50's orders were for weekly weights x 4 weeks, then monthly and PRN. He stated if the resident continued to have weight loss the order should have been continued for weekly weights, and although Resident #50's order showed monthly and prn, the RA knew to continue weighing him weekly due to his weight loss. He was currently being weighed monthly. ADON-B stated Resident #50 refused weights sometimes, and this was care planned. After checking Resident #50's chart, ADON-B stated he could not find a progress note or anything else showing the physician had been contacted regarding Resident #50's weight refusals or weight loss. He stated they usually discussed the residents who needed weights and the residents with weight loss in the morning meetings, but somehow, they had missed or overlooked Resident #50's weight loss, the need for a new weight order, and the need for continued weekly weights. He stated either the ADONs or the DON should have put in an order to continue weekly weights, and by not doing that it placed the resident at risk for malnutrition and poor wound healing.</p> <p>In an interview with the RA on 05/07/25 at 9:20 AM she stated she had a list of weekly weights that came from the DON and the RD that were obtained from the residents' orders, and Resident #50 was on her weekly weight list, and he was weighed via mechanical lift. She stated she was the one who did the admission and weekly weights when she was able, but if she was pulled to work the floor, and unable to obtain the weights, the DON would get a nurse or someone else to get the weights. She notified the DON with any 5lb weight gain or loss, and she would typically have to reweigh them within 24 hours. She stated Resident #50 was a refusal on 4/16, but she should have attempted again that evening or the next day; she also stated Resident #50 was supposed to be weighed on 04/09/25 and 04/23/25, but she was working the floor those days, so the DON was supposed to get someone else to weigh him. She stated she did not know Resident #50 had a weight loss until 05/06/25 because the DON was the one who input and reviewed the weights. She stated she did get the 04/29/25 weight, but she was unsure why the DON entered the 04/29/25 weight on 05/02/25. She stated Resident #50's current weight for today (05/07/25) was 174.2 lbs. She also stated if a resident continued to lose weight it could prevent them from getting better, and they would probably get sicker.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON on 05/07/25 at 10:35 AM she stated the RD should be reviewing the residents' orders for weight orders. She stated on 04/16/25 Resident #50 declined to be weighed, but it should have been attempted again at a later time. The DON stated Resident #50 was care planned for weight refusals. She stated he was not currently on weekly weights, but if his weight continued to decline, he would be placed on weekly weights. Then she stated considering the amount of weight loss he had there should have been weekly weights ordered. The DON stated the RA obtained the weights and reported them to her, and if she was pulled to work the floor she would stay late to get weights, or the floor nurses would obtain their own, and if the weights were not obtained for residents on weekly weights, there would be an alert on the dashboard (the electronic monitoring system) for the ADONs. According to the DON, the alerts for the missed weights and concerns for weight loss were discussed in their morning stand-up meetings. She stated the RA was pretty good about going back and getting weights that had been missed. She stated in-services and communication notes were done yesterday (05/06/25) regarding the need for nurses to obtain their own weights when the RA was unable to obtain them. She stated she did not get alerts that the weights were not being done, but she did in-service if there was an alert on the dashboard that weights were not getting done, she needed to be notified so someone else could get the weight. The DON stated if a resident had a large amount of weight loss it could potentially lead to malnutrition, dehydration, organ failure, and even death, but none of these issues had happened, and no red flags were noted for Resident #50 by the nursing or therapy teams. She stated there were no signs of excessive weight loss of Resident #50 such as lethargy, dehydration, or clothing fitting differently. She stated she had access to the dashboard where unobtained weights would alert, but she had not been reviewing the dashboard for any alerts. She thought the ADONs may have opened the alerts and reviewed and cleared them.</p> <p>In an interview with the primary care provider on 05/07/25 at 12:05 PM he stated the skilled patients were not at the facility for long term needs, they were only there for a short-term skilled need, so he was not concerned with their weight loss. He also stated most of the skilled patients were okay to lose some weight and probably needed to lose some weight, and Resident #50's weight was acceptable and not a concern. He stated he did not have an expectation for the nurses to call him with weight loss regarding the skilled patients, only the long-term patients. The provider stated he was busy trying to drive and unable to answer any more questions.</p> <p>In an interview with the Wound Care Nurse on 05/07/25 at 2:10 PM, she stated the Resident #50's wounds were healing and looked better. She also stated Resident #50 was being seen and followed by a wound care physician and service that tracked the progress of his wounds.</p> <p>In an interview with the RD on 05/07/25 at 2:50 PM she stated she had spoken with her supervisor and found out it was not in her job description to review residents' orders, and she was not required to look at the orders to determine who was on daily, weekly, or monthly weights. She stated she typically came to the facility weekly unless she was out on vacation or PTO. She also stated she printed weight variance reports weekly, not monthly as previously stated.</p> <p>Record review of the facility's Weight Monitoring policy (no implementation or revision date) revealed Weight can be a useful indicator of nutrition status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. 5. A weight monitoring schedule will be developed upon admission for all residents: C. Residents with significant weight loss - monitor weight weekly. D. If clinically indicated - monitor weight daily.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly label and include the expiration date for 2 of 4 medication carts (Hall #3 med-cart and Hall #5 med-cart) reviewed for storage and 1 of 1 medication room (med-room [ROOM NUMBER]) reviewed for labeling and storage.</p> <p>The facility failed to properly label from hall #3 med-cart a bottle of saline nasal spray that had been opened and used. The bottle was approximately half full.</p> <p>The facility failed to dispose of the medication from hall #3 med-cart Morphine (a narcotic pain medication) 30 MG tablets belonging to Resident #17 that expired on 04/11/24.</p> <p>The facility failed to dispose of the medication from hall #3 med-cart Pravastatin (a drug used to lower cholesterol) 20 MG tablets belonging to Resident #44 that expired on 04/08/2025.</p> <p>The facility failed to dispose of the medication from hall #5 med-cart a tube of Hydrocortisone Cream that expired in April of 2025.</p> <p>The facility failed to dispose of a large bin of single use Tuberculin Safety Syringes from med-room [ROOM NUMBER].</p> <p>These deficient practices could place residents at risk of receiving medications or supplies that were both expired and possibly cross-contaminated.</p> <p>The findings included:</p> <p>Record review of Resident #17' s face sheet dated 05/07/25 revealed an [AGE] year-old female with an initial admission date of 08/04/16, and a current admission date of 12/19/24. Diagnoses included Chronic Pain Syndrome.</p> <p>Record review of Resident #17' s care plan initiated 04/03/18 and revised 02/20/19 revealed a care plan for risk for pain with interventions to include give medications for pain as ordered.</p> <p>Record review of Resident #17's physician orders dated 01/02/25 revealed an order for Morphine Sulfate 30 MG.</p> <p>Record review of Resident #44' s face sheet dated 05/07/25 revealed a [AGE] year-old female with an original admission date of 08/27/21, and a current admission date of 07/12/22. Diagnoses included Hyperlipidemia (abnormally high levels of lipids or fats in the blood).</p> <p>Record review of Resident #44's physician orders dated 07/10/23 revealed an order for Pravastatin Sodium 20mg for Hyperlipidemia.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 05/06/25 at 9:37 AM of the Hall #3 med-cart revealed Hall #3 med-cart had an open, unlabeled bottle of saline nasal spray, approximately half full. The med-cart from hall #3 also had expired meds to include 10 tablets of Morphine (belonging to Resident #17) that had expired 04/11/25, 60 tablets of Pravastatin (belonging to Resident #44) that had expired 04/08/25, and 30 tablets of Pravastatin (belonging to Resident #44) that had expired 10/20/24.</p> <p>During an observation on 05/06/25 at 9:57 AM of med-room [ROOM NUMBER] revealed a large bin with approximately 50 single use Tuberculin Safety Syringes that expired 11/30/24.</p> <p>During an observation on 05/06/25 at 4:55 PM of Hall #5 med-cart revealed an approximately half full, open tube of Hydrocortisone Cream that expired in April of 2025.</p> <p>In an interview with MA-F on 05/06/25 at 9:42 AM, she stated did not realize the medications were expired, and the ADONs and the DON typically checked the med-carts every week or so for expired medication, but the floor nurses knew they were supposed to routinely check their carts for expired medications as well. She stated the reason the DON checked the carts every two weeks was because the med-aides were not allowed to take expired narcotics from the med-carts. So, if a med-aide noticed an expired narcotic on the med-cart they would let the DON know it was there so she could have removed it. She stated administering expired medications could cause a resident to become sick or could be ineffective in treating the resident since most medications lose their efficacy after expiring.</p> <p>In an interview with LVN E on 05/06/25 at 11:00 AM, she stated the ADONs or the DON would typically check the med-carts and medication room every couple of weeks for expired medication or supplies. She also stated central supply usually checked the medication room for expired supplies when they stock items, but she was unsure of how often. She stated those syringes (expired Tuberculin syringes) never got used, so the bin stayed full, and that was probably why no one ever noticed they were expired.</p> <p>In an interview with RN-D on 05/06/25 at 4:55 PM he stated the ADONs or the DON routinely checked the medication room and med-carts for expired medications and supplies. He stated he thought they had just checked his cart today, but they must have missed the expired Hydrocortisone Cream. He stated using expired medications could be ineffective at treating whatever the medication was intended for, and it could even possibly cause harm.</p> <p>In an interview with ADON-B on 05/07/25 at 8:50 AM he stated both the ADONs and the DON routinely checked for expired medications and supplies in the medication room and on the med-carts. They were typically checked every week or so. He stated using expired medications could be ineffective at treating the residents' symptoms as well as could even possibly cause harm.</p> <p>Record review of Medication Policies revised 10/01/19 revealed all drugs and biologicals in the facility are labeled in accordance with all Federal and State regulations. 6. Resident specific over the counter products that are not labeled by the pharmacy are to be labeled with the name of the resident and room number at minimum. Nursing may apply such a label when the over-the-counter product is procured from an alternative vendor.</p> <p>Record review of Medication Policies revised 10/01/19 revealed 1. Unused, unwanted, and non-returnable medications should be moved from their storage area and secured until destroyed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Windsor Calallen		STREET ADDRESS, CITY, STATE, ZIP CODE 4162 Wildcat Dr Corpus Christi, TX 78410	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Medication Policies revised 10/01/19 revealed Drugs which have been dispensed for individual residents are not to be used beyond the expiration date indicate by the manufacturer or pharmacy. The facility is to strictly adhere to the expiration dating.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, 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 sanitation in that:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure all food was labeled, dated, and not expired in refrigerators #1 and #2. 2. The facility failed to ensure all food was labeled, dated, and not expired in freezers #1 and #2. 3. The facility failed to ensure all refrigerators and freezers had internal thermometers. 4. The facility failed to ensure the chest-type milk refrigerator was clean and sanitized. 5. The facility failed to ensure rotted tomatoes were not stored with fresh tomatoes. 6. The facility failed to ensure dry goods were dated, labeled, sealed, and not expired. 7. The facility failed to ensure the meat slicer and roasting pans were clean and sanitized. 8. The facility failed to ensure the steamer oven was clean and sanitized. 9. The facility failed to ensure the dumpster side doors remained closed at all times. 10. The facility failed to ensure personal items were not kept on a prep table. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11.</p> <p>The facility failed to ensure a spatula was not chipped.</p> <p>These failures could place residents at risk of foodborne illnesses.</p> <p>Findings included:</p> <p>Observation and initial tour of the kitchen on 05/05/25 beginning at 10:00 AM revealed 1, half-full 4-quart container of what appeared to be sliced cheese, and 1, half full 4-quart container of what appeared to be shredded cheese with the lids ajar, unlabeled, and undated in refrigerator #1. There were 2, 4-quart containers of what appeared to be sliced meat unlabeled and undated in refrigerator #1. There were 3 pre-made plates of salad and 3 pre-made bowls of salad unlabeled and undated in refrigerator #1. There was a 1-quart container of an unknown substance unlabeled and undated in refrigerator #1. There was a cut onion loosely wrapped in plastic, not sealed, unlabeled and undated in refrigerator #1. There were 2, 1-gallon containers with manufacturer labels of Dijon mustard on one and Cole slaw dressing on the other that had crusty substances around the lids and black furry dots and clumps on the outsides of the containers in refrigerator #1-both containers expired on 07/2024. There were 2 trays of beverages that were unlabeled and undated; 1 tray had 15 beverage cups filled with some red and some brown liquids in them, the other tray had 17 beverage cups with various liquids in them; some with a thick white substance appearing to be milk, some with a red substance, and others with a brown substance in refrigerator #1. There was an unknown substance wrapped in foil that was unlabeled and undated in refrigerator #1.</p> <p>There was a tray with 20 small cups of a thick yellow substance, unlabeled, undated and approximately half of them had lids ajar in refrigerator #2. There were 5 slices of pie and 7 small cups of what appeared to be cut fruit unlabeled and undated in refrigerator #2. There were 7, 4-quart containers partially full of various substances that had no use-by dates; 1 was labeled cranberry sauce and 1 was labeled tomato sauce. The other 5 containers were unlabeled and undated. There was a 2-pound opened bag of cheese that was not sealed in refrigerator #2. There were 2, 1-gallon jugs of an unknown dark brown liquid that were unlabeled and undated in refrigerator #2. There was a 1-gallon bag labeled pureed egg that was undated. There was a 4-quart container of a yellow substance that was unlabeled and undated in refrigerator #2. There was a mostly empty 25-pound container with a manufacturer label of hard cooked peeled eggs and the lid ajar. It was undated. There was a take-out container with hand-written sausage and egg that was undated in refrigerator #2. There were two bowls of an unknown substance that were unlabeled and undated in refrigerator #2. There was no internal thermometer in refrigerator #2.</p> <p>There was a removable black substance on the entire gasket of the lid to the chest-type milk refrigerator and ice accumulation on all four of the inside walls. There was condensation dripping from the top of the chest-type milk refrigerator where the lid met the chest. The bottom of the chest-type milk refrigerator was dirty and a reddish-brown substance on places of the metal floor and metal grate above the floor of the chest-type milk refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was a large, partial bag of French fries with frost on them and on the inside of the bag, open to air, unlabeled and undated in freezer #1. There was a 29.7-pound box of frozen biscuits open to air, unlabeled and undated in freezer #1. There was 3, 2-gallon bags of what appeared to be English muffins, unlabeled and undated in freezer #1. There were 17 large beverage glasses on a tray filled with what appeared to be ice. The ice in the glasses had frost on them. The tray nor the glasses were labeled or dated in freezer #1.</p> <p>There was a 10.5-pound box with a manufacturer label of Salisbury steak that was open to air and the steaks inside were shriveled in freezer #2. There was no internal thermometer in freezer #2.</p> <p>There was a large, mostly empty box of fresh tomatoes that had what appeared to be rotten tomatoes open and dripping onto fresh tomatoes in the kitchen.</p> <p>There was an opened 28-ounce box with a manufacturer label of instant breakfast cereal that was undated and not sealed properly, leaving it open to air in the dry storage area.</p> <p>The covered meat slicer had food debris on the blade, the cutting platform, and the slider platform. The plastic cover on the meat slicer was dusty. There was a rubber spatula that had missing chunks of it around the edges and crevices worn into both sides. There were dirty roasting pans on the shelf of the steamer table.</p> <p>The oven-type steamer had a thick, yellow-white substance caked on the bottom and all four sides. The substance was flaking and floating in the water of the oven-type steamer.</p> <p>The dumpster side doors were open or partially open on all days of the survey from 05/05/25-05/07/25.</p> <p>Return observation of the kitchen on 05/06/25 at 04:21 p.m. revealed the steam oven still had a flaking yellow-white substance on the sides and bottom with floating debris in the water.</p> <p>Return observation of the kitchen on 05/07/25 at 11:30 a.m. revealed the steam oven still had a flaking yellow-white substance on the sides and bottom with floating debris in the water.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the FSS on 05/05/25 at 10:30 a.m. during the initial tour, she stated she did not know what the used-by dates were for any of the unlabeled and undated containers in Refrigerator #1, Refrigerator #2, Freezer #1, or Freezer #2. She said she did not know why the labels on the food containers only had the received dates on them. She said she received shipments and labeled food and containers with the received dates only. She said she and whoever placed food in the refrigerators and freezers was responsible for writing the correct dates and their initials on labels, including use-by dates. She said using undated food could cause the residents to get sick because of staff would not know how old the food was and because of cross-contamination. She said staff should know to make sure lids were tight on the containers in the refrigerators, but it was her responsibility to make sure the lids were tight on the containers. The FSS said the black furry dots and clumps on the outsides of the 1-gallon containers in Refrigerator #2 was mold. She said she was unaware of the mold and the expiration dates on the 1-gallon containers. She said she was responsible for checking the refrigerators and freezers for cleanliness. She said the open boxes of food in the freezers were probably freezer burned. She said she did not know who left them open or why. She said they would have to dispose of all the ruined food. The FSS stated the steam oven was cleaned weekly. The FSS said she was not aware rotten tomatoes were in the same box as fresh tomatoes. She said rotten tomatoes could attract gnats, ants, and roaches and could cross contaminate the good tomatoes. She said the entire box should be discarded. The FSS stated the contents of the unsealed container of instant breakfast cereal in the dry storage room could be contaminated by things in the air, moisture, or insects. She said the container of instant breakfast cereal could also taste funny and make residents not want to eat it or make them sick. She said she did not know why some of the refrigerators and freezers had more than one internal thermometer and others did not have any and she would have to speak to the kitchen staff about it. She said all the refrigerators and freezers had to have internal thermometers because there was no way to compare the digital reading on the exterior with an internal thermometer for accuracy. She said temperatures inside the refrigerators and freezers were important to make sure they were working properly and keeping foods the kitchen served from being bad. The FSS said the chest-type milk refrigerator had mold all around the gasket and did not know that it could affect the seal. She said she did not know how long it had been since the milk refrigerator had been cleaned and it was not on the cleaning schedule. She said she did not know if a bad seal could cause ice build-up on the inside walls of the chest-type milk refrigerator. She said the meat slicer was cleaned after each use. She said the meat slicer did not look like it had been cleaned. She said they did not use it very often, so she did not know when it was cleaned last or who used it last. She said the bits of meat on the meat slicer could be growing bacteria and could cause some real problems with residents getting sick from it. The FSS said she had not noticed the dirty roasting pans on the shelf below the steam table because they did not use them very often. She said they should be clean and were not on the cleaning schedule. The FSS said the chipped spatula should be thrown out because the pieces probably got in the food and could be bad for the residents. The FSS said the doors on the dumpsters were supposed to be closed unless it was being used. She said the kitchen was not the only department that used them. She said if they were already open, no one would bother to close them. She said open doors on the dumpsters could attract rodents. The FSS said she did not know who put their personal items on a prep table in the kitchen. She said the kitchen staff had a designated area for their things. She said she would have in-services about everything. Training, cleaning schedules, and kitchen policies requested at this time. Cleaning schedules were not received.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the COOK on 05/05/25 at 11:30 a.m., he said everything in the refrigerators and freezers and storage room should be labeled, dated, initialed, and have the use-by date on them. He said everyone was responsible, including himself. He said they (kitchen staff) all knew what was in there and when it was put in there. He said nothing when asked about the mold on the 1-gallon containers. He said there was a cleaning schedule and the meat slicer, and roasting pans were not on the schedule. He said he had not used the meat slicer because they usually got pre-cut meat. He said he did not know who used it last. He said personal items were not allowed in the kitchen. He said he did not know who or why someone would do that. He said personal items on the prep table caused cross contamination and could make residents sick if whoever it was did not wash their hands before touching items the residents would be touching.</p> <p>In an interview with the RD on 05/06/25 at 11:30 a.m., she said the kitchen followed a cleaning schedule. She said she monitored hand washing and service when she was at the facility every 2 weeks or so and as needed. She said she was always available to kitchen staff to answer any questions. She said she did not check labeling of food in the refrigerators or freezers. She said the FSS conducted in-services.</p> <p>Record review of In-services: 02/07/25-Deep Cleans of all areas, 03/21/25-Report any AC issue on electronic reporting system, 04/08/25-Coffee Temp.</p> <p>Record review of the facility policy, Food Storage revised 06/01/19: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal, and US Food Codes and HACCP (Hazard Analysis Critical Control Point) guidelines. Procedure: 1. Dry storage rooms d. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. c. Use all leftovers within 72 hours. Discard items that are over 72 hours old. 2. Refrigerators: d. Date, label and tightly seal all refrigerated foods using clean, covered containers .e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. h. Place a thermometer inside refrigerators near the door .Check the temperature of all refrigerators using the internal thermometer to make sure the temperature stays at 41F or below. 3. Freezers: e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated. h. Place a thermometer inside freezers near the door .Check the temperature of all freezers using the internal thermometer to make sure the temperature stays at 0F or below.</p> <p>Record review of the facility policy, General Kitchen Sanitation dated 10/01/18: Policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All nutrition and food service employees will maintain clean, sanitary kitchen facilities in accordance with the state and US food Codes in order to minimize the risk of infection and food-borne illness. Procedure: 6. Clean non-food-contact surfaces of equipment at intervals as necessary to keep them free of dust, dirt, and food particles and otherwise in a clean and sanitary condition.</p> <p>Record review of the facility policy, Steamers dated 10/01/18: Policy: The facility will maintain steamers in a clean and sanitary manner to minimize the risk of food hazards. The steamers will be cleaned after each use.</p> <p>Record review of the facility policy, Meat Slicer dated 10/01/18: Policy: The facility will maintain the meat slicer in a sanitary manner to minimize the risk of food hazards. The meat slicer will be cleaned after each use.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases. The facility failed to handle, store, process, and transport all linens to prevent the spread of infection for 2 of 2 (Bin #1 and Bin #2) laundry bins reviewed for infection control.</p> <p>The facility failed to ensure LA H and LA I properly washed and stored wet linen according to facility procedures.</p> <p>The facility failed to ensure LA H and LA I dried wet linen and resident clothing after washing them.</p> <p>These failures could place residents at risk for cross contamination and infection.</p> <p>The findings include:</p> <p>During an observation of the laundry facility on 05/06/25 at 04:35 PM, two bins, one with wet white linen and one with wet resident clothing were observed in the dryer area.</p> <p>In an interview on 05/06/25 at 04:45 PM, the HS stated the two LA ' s had left for the day and must have left the wet linen and wet resident clothing in the bins without drying them. When asked if this was normal practice, the HS stated staff would normally rewash them in the morning if they did not have time to dry them the previous day. The HS stated she had only been employed at the facility for six months and this was how they always did it. When asked if she spoke to the laundry aides about leaving wet resident clothing and wet linen overnight, the HS stated she did not know they were leaving wet clothing and linen, and this was the first time she had seen this. The HS stated after the LA ' s had left for the day, she would walk by and see the bins through the window, but she would not go into the laundry room to check if there was clothing or linen in them. The HS stated resident clothing, and linen should not be left wet because the linen and clothing could get mildew or mold. The HS stated the linen and resident clothing should have been dried before the LA ' s left for the day.</p> <p>In an interview on 05/07/25 at 10:12 AM, LA H stated it was not normal practice but yesterday (05/06/25) she did not have enough time to dry and fold the linen and resident clothing and decided she would leave the wet linen and clothing to be dried the next day. LA H stated she was the last one to leave yesterday and for her it was not a problem to leave the linen and resident clothing wet. LA H stated the HS in-serviced her on why it was not good to leave the clothes wet and she would no longer do that. LA H stated it was not the first time she has left the clothes wet and had done it about 3 to 4 times before and the next day she would just dry them but would not rewash them.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/07/25 at 10:23 AM, LA I stated she left the facility at 2:30 PM yesterday (05/06/25) before her coworker (LA H) and was not the last one to leave for the day. LA I stated the linen and resident clothing should not have stayed wet overnight because they could become smelly and get mildew. LA I stated she was the first to arrive the morning of 05/07/25, and had seen the wet linen and wet resident clothing in the bins and did not rewash them at first but dried them. LA I stated later, when the HS in-serviced her on the proper drying procedures, she rewashd all the linen and resident clothing that was left overnight.</p> <p>In an interview on 05/07/25 at 01:06 PM, ADON A stated she was not aware of the issue and the LA ' s should not have left wet linen or wet resident clothing overnight due to the possibility of getting mildew. ADON A stated the resident clothing could become smelly, which could be a dignity issue for residents. ADON A stated she was going to in-service all staff on infection control and speak with the HS.</p> <p>Record review of facility's Laundry Process not dated reflected:</p> <p>Drying</p> <p>Linens should be moved from washer to dryer as quickly as possible</p> <p>Record review of facility's General Personal Clothing Policies not dated reflected:</p> <p>4. Washing</p> <p>Once a load of personal clothing is washed it should be dried immediately. Wet clothes left to sit will mildew. If it is just not possible to process wet clothing immediately, store the wet linen in bin with a plastic, airtight cover.</p>		