

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/22/2026
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.			
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to provide a safe environment for residents in 1 of 6 hallways (300 Hall) with 1 of 3(IT room) locked non-residential rooms left unlocked. 1.The facility failed to ensure the safety of the residents in the 300 hall by not closing the door to the IT room, which contained hazardous items. These failures have the potential to result in an injury to residents. The findings included:The findings included: In the initial facility observation on 07/20/26 at 9:48 AM the 300 Hall revealed the door to the IT room left unlocked with no one in the hallway to monitor. The IT room contained a large wall panel with many wires for cable for the television, floor polishing equipment, a cart, 2 vacuums and a high voltage power loss relay box with no staff with and could be a hazardous for a with a resident with a cognitive mental condition and becoming locked in with others knowing for some time. The items can also result in the resident possibly tripping over items on floor, become entangled in the wire causing a fall, becoming electrocuted causing serious harm with hospitalization and death. In an interview on 07/20/2026 at 10:06 PM with the maintenance man he stated he and the floor tech guy have a key and his responsibility to make sure the door shut. The maintenance man stated it may have been the floor tech who may have entered and left the door open. The maintenance man stated he does a monthly check on all the doors to all in the facility to make sure they are all in working condition and non-residential rooms can be locked. The maintenance man stated the if a resident with mental cognitive condition could walk in could fall, become entangled pulling wires and may get electrocuted and can result in death. The maintenance man stated they will be changing the lock with a key pad and only he and the floor tech will have the key. In an interview on 07/14/26 at 4:53 pm, the Adm stated the only two people who had keys to the IT room was the maintenance man and floor tech. The Administrator stated he did not know who left the door open but it is to be locked every time they leave the room they change the doorknob to one that unlocked with a keypad. The Administrator stated the maintenance man will continue to make checks on the conditions of locks monthly, and the staff will be in serviced on make sure all non-resident doors are locked after use. The Administrator stated they had no policy or procedure on the maintenance or functions of the doors in the facility, but did have one on physical environment of the facility. Record review of the facility's Physical Environment dated 01/2023 stated Environmental issues the community is designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.		

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 (Resident #6) of 5 residents reviewed for respiratory care. The facility failed to ensure Resident #6's oxygen was administered at the correct setting of 4 liters per minute on 07/20/2026 as ordered by the physician. This deficient practice could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident #6's face sheet, dated 07/20/2026, revealed a [AGE] year-old male with an admission date of 06/10/2026. Pertinent diagnoses included Dysphagia, Oropharyngeal Phase (difficulty with swallowing) Aphasia (a disorder which affected an individual's ability to communicate effectively), Hemiplegia (severe or complete paralysis on one side of the body), and Hemiparesis (mild to moderate weakness on one side of the body). Record review of Resident #6's Quarterly MDS assessment, dated 07/17/2026 (this was the current, unsubmitted MDS), revealed a BIMS score of 10, which indicated moderately impaired cognition. Record review of Resident #6's active physician order summary, reviewed 07/20/2026, revealed an order, started 06/10/2026, for Oxygen at 4 liters per minute via nasal cannula every shift for hypoxia (a condition in which the body did not receive enough oxygen). An observation on 07/20/2026 at 10:06 AM revealed Resident #6's oxygen concentrator (a medical device used to deliver oxygen to an individual) was set at 2 liters per minute. In an interview on 07/22/2026 at 8:45 AM, RN-A stated he was the charge nurse for this hall, and it was the charge nurse's responsibility to set and adjust the oxygen concentrator settings for residents. He stated the order should have been verified, then the setting on the concentrator verified to match the order. He stated nurses assessed the settings on the concentrators when they did patient rounds at the beginning of the shift and during the shift. RN-A was not sure what Resident #6's oxygen orders were off the top of his head, and he was not sure how Resident #6's concentrator ended up on 2 liters. He stated oxygen was used for patients with respiratory issues, and if they were not getting enough oxygen, it could cause or increase respiratory issues. In an interview on 07/22/2026 at 9:47 AM, the ADON stated the floor nurses set and adjusted the oxygen settings on the concentrator based on the physician's orders. She stated Resident #6 had an order for 4 liters per minute continuous oxygen, and she was not sure why his oxygen was set at 2 liters per minute. The ADON stated the nurses should have been checking the concentrators for accuracy when they do their patient rounds. She stated if Resident #6 was not getting enough oxygen, his oxygen saturation could drop, and he could have become confused and had respiratory issues. An Oxygen Administration Policy was requested from both the Administrator and the DON on 07/22/2026 at 11:03 AM, but the Administrator stated they did not have a policy for Oxygen Administration.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from any significant medication errors for 1 of 8 residents (Resident #49) reviewed for medication errors. The facility failed to administer Resident #49's metoprolol tartrate (medication that lowers blood pressure) when Resident #1's blood pressure was inside the physician's parameters on 07/17/26 and 07/20/26. These failures could place residents at risk for complications such as increased blood pressure, exacerbation of symptoms, and potential hospitalization. The findings included: Record review of Resident #49's face sheet dated 07/22/26 revealed a [AGE] year-old male with an admission date of 04/15/26. Resident #49's pertinent diagnosis included Essential Primary Hypertension (high blood pressure with no identifiable secondary medical cause). Record review of Resident #49's admission MDS assessment dated [DATE] revealed a BIMS score of 4 indicating severe cognitive impairment. Record review of Resident #49's Comprehensive Care Plan dated 07/22/26 revealed the focus [Resident #49] has hypertension (high blood pressure initiated on 04/16/26. An intervention listed for this focus included Give anti hypertensive medications as ordered initiated on 04/16/26. Record review of Resident #49's order summary dated 07/22/26 revealed an active order for metoprolol tartrate 25 MG give 1 tablet by mouth two times a day related to Essential Primary Hypertension Hold for SBP less than 100 or DBP less than 60. Record review of Resident #49's MAR for July 2026 revealed metoprolol tartrate was held at the following dates with associated blood pressures: 07/17/26 - 103/64 by RN B 07/20/26 - 101/66 by RN B During an interview on 07/22/26 at 11:21 AM, the DON stated based on the July 2026 MAR for Resident #49 it appeared the metoprolol was held when it should have been administered on 07/17/26 and 07/20/26. The DON stated not giving blood pressure medications when they were indicated could cause blood pressure to become elevated leading to dizziness, sweating, or headaches. The DON stated if the blood pressure and heart rate were within physician parameters then it should be administered. During an interview on 07/22/26 at 2:18 PM, RN B stated she always checked the blood pressure and pulse of a resident as needed before administering medications. RN B stated she saw that Resident #49's blood pressure was just above the threshold of the physician's parameters on 07/17/26 and 07/20/26 and used her nursing judgement to hold the metoprolol. RN B stated she did not contact the doctor before holding the medication on either day, but she should have. RN B stated it was important to follow physician's orders when administering blood pressure medications to prevent hypertension (high blood pressure) symptoms like headaches, blurred vision, or chest pain. Record review of the facility policy Medication Administration effective 10/01/19 revealed the following policy: .2. Administration.B. Medications are administered in accordance with written orders of the prescriber		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles for medications stored in 1 of 5 medication carts (400-Hall Nurse Cart) reviewed for storage. The facility failed to ensure the Lispro Insulin pen (short acting insulin used to lower blood glucose) for Resident #97 in the 400-Hall Nurse Cart was labeled with the date it was opened. This failure could place residents at risk of receiving expired medications and not receiving the therapeutic benefit of the medication from staff. The findings included: Record review of Resident #97's face sheet dated 07/21/26 revealed a [AGE] year-old male with an admission date of 07/09/26. Resident #97's pertinent diagnosis included Type 2 Diabetes (chronic condition where your body resists insulin or doesn't make enough of it, causing blood sugar levels to spike). Record review of Resident #97's admission MDS assessment dated [DATE] revealed a BIMS score 3 indicating severe cognitive impairment. Further review revealed Resident #97 was taking hypoglycemic medication during the assessment. Record review of Resident #97's Comprehensive Care Plan dated 07/21/26 revealed the focus [Resident #97] has altered endocrine status DIABETES initiated on 07/09/26. Interventions listed for the focus included monitoring for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) and to report any significant changes to the Medical Director. Record review of Resident #97's order summary revealed an active order for Insulin Lispro Inject as per sliding scale: 70 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; greater than 400 = 10 units and notify [Medical Director], subcutaneously (layer situated just beneath the skin and above the muscle) before meals and at bedtime initiated on 07/10/26. During an observation of the 400-Hall Nurse Cart on 07/21/26 at 3:50 PM, an open Insulin Lispro Pen was found in the top drawer. The label on the pen indicated the pen was for Resident #97 with no open date documented. During an interview on 07/21/26 at 4:12 PM, RN A stated he was currently in charge on the 400-Hall Nurse Cart. RN A stated he administered the insulin to Resident #97 earlier in the day using the undated insulin pen. RN A stated he was supposed to check the expiration date on medications before administering them, but he forgot to when he administered the insulin to Resident #97 in the morning. RN A stated insulin pens expired around a month after opening them. RN A stated the resident had only been in the facility for approximately a week and a half, so the pen was not expired. RN A stated it was important to check the expiration dates on medications before administering them to ensure a resident was not administered an expired medication. RN A stated an expired medication would not be as effective and may not have the desired therapeutic effect on residents. During an interview on 07/22/26 at 11:21 AM, the DON stated insulin pens should have the open date and new expiration date written on the pen or label so it was readily visible once they were opened. The DON stated it was important to have the dates visible so residents were not administered expired insulin. The DON stated she saw the Insulin Lispro pen for Resident #97 and it did not have either the open date or new expiration date written on it. The DON stated Resident #97 was admitted to the facility on [DATE] so the pen was not expired yet. The DON stated insulin pens were usually good for around a month once they were opened. The DON stated expired medications may not have the desired therapeutic effect on residents when administered. Record review of the facility policy titled Expiration Dating and Expired Medications dated 10/01/19 (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the following: .5. For multi-dose vials of injectable drugs:Date and initialed when openedThe expiration date for multi dose injectable vials is the manufacturer's printed date, unless otherwise indicated by the manufacturer.8. It is the responsibility of all nurses who administer medications to monitor the expiration dates of the medications. Expired medications will not be administered in the Facility.		

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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 wear hair restrains correctly, ensure food preparation and service area was clean and storage of food in accordance with professional standards for food service safety for 1 of 1-refrigerator (1 of 1 facility refrigerator) and 1 of 1 freezer (1 of 1 resident freezer reviewed for storage, preparation and sanitation. The facility failed to ensure food items in the refrigerators were sealed correctly preventing exposure to air and cross contamination The facility failed to ensure items in the freezers were sealed correctly preventing exposure to air and cross contamination. The facility failed to ensure steam table wells were clean and free from debris to ensure proper working condition. The facility failed to ensure kitchen staff were wearing hair restraints properly while in the kitchen to prevent cross contamination.Observations during the initial tour of the kitchen on 07/20/26 at 8:30 AM revealed kitchen manager not wearing beard restrains correctly covering his mustache and some of his beard. Observation of the facility refrigerator revealed a container of ham not sealed correctly, and a box of packaged boiled eggs with one package open with two eggs out of opened package possibly coming contaminated. Observation of facility freezer revealed bag of cooked fried chicken unsealed exposed to air possibly coming contaminated. Observation of Hot table revealed the hot steam wells with a grey scaly substance at the bottom of each hot steam well. In second observation and interview on 07/21/26 at 11:16 AM of kitchen revealed cook not wearing beard restrain properly over mustache and beard. The cook stated it was important that all facial hair be in a hair restraint so that the food being cooked could not become contaminated. The cook stated the resident could become sick possibly hospitalized if contaminated food is eaten. The cook stated all food is to be properly sealed and labeled when stored in freezer or refrigerator. The cook stated if residents were to have eaten the contaminated food they could become sick and possibly hospitalized . The cook stated the last in-service on proper storage of food was a week ago. The cook stated the last in service on proper hygiene was about 2 months ago. In an interview 07/21/26 at 11:24 AM with DA C she stated all food should be sealed correctly to prevent cross contamination of all food stored in the refrigerator. DA C stated she did not know why the food items were not sealed corrected only that they must have been missed when the refrigerator or freezer was checked for expired or unsealed food items. All the kitchen staff is responsible for ensuring all food is stored properly. DA C stated the last in service on proper storage of food was about 1 week ago.In an interview 07/21/26 at 11:31 AM with DA D she stated the refrigerator and freezer should be checked everyday and the ham and eggs must have been missed or just used for breakfast. DA D stated the last person who used the food item and put them back in should be making sure the items are closed completely. DA D stated it is important for food to be closed correctly so it is not exposed to air and become cross contaminated. DA stated the if a resident was to eat contaminated food they could get sick and end up in the hospital. DA D stated the last in service for proper storage of food was about a week ago. In an interview on 07/21/2026 at 11:42 AM with the Dietary Manager he stated any items that are stored in the refrigerator and freezer must be sealed completely closed to prevent cross contamination of the food item. The DM stated that food that is exposed to air can make residents ill, be hospitalized , and even death if resident is already compromised. The DM stated he does do random inspections of both freezer and refrigerator everyday to ensure so food items are open. The DM stated the ham and eggs must have just been used and not properly inspected before being placed inside the refrigerator and have been thrown away. The DM stated in the freezer the chicken must have not been sealed correctly since placed (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there because they had not been used and have been thrown away. The DM stated all employee are responsible for the items that a be labeled and sealed correctly before food is storage either freezer, refrigerator, and dry goods pantry in the kitchen. Any items that are found open or in an unsealed container and over 3 days old are thrown away immediately so that they are not used to feed the residents. The DM stated the last in-service he held with kitchen staff was in about a week ago but will have another to reenforce the proper sealing of food items. The DM stated all hair restraints need to be worn properly overall facial hair to prevent cross contamination and will do an in-service with all staff. In record review the of the Food Storage policy and procedure stated 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 guidelines. Dry stored. To ensure freshness, store opened and bulk items in tightly covered containers. All containers, must be labeled and dated. Refrigerators Date, label, and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. Freezer. Store frozen foods in moisture-proof containers that are labeled and dated. In record review of Employee Sanitation dated 10/01/2018 it stated 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. 3 b. Hairnets, hairbands, caps beard coverings or other effective hair restraints must be worn to keep hair form food and food-contact surfaces.		

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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** Based on observation, interview, and record review, the facility failed to 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 and infections for 1 of 5 residents (Resident #11) reviewed for infection control practices. The facility failed to ensure LVN-E performed proper and adequate tracheostomy care and hand hygiene for Resident #11 on 07/21/2026. The facility failed to ensure RN-B performed adequate hand hygiene during a medication pass on 07/21/2026 and tracheostomy care on 07/21/2026. The facility failed to ensure Resident #11 had one accurate physician order for EBP. These failures could place residents at risk for cross-contamination and infection due to inadequate care and hygiene being used. The findings included: Record review of Resident #11's face sheet, dated 07/22/2026, revealed a [AGE] year-old female with an original admission date of 04/17/2020, and a current admission date of 05/12/2026. Pertinent diagnoses included Cerebral Palsy (a group of conditions which affect movement, balance, and posture) and Chronic Respiratory Failure (a long-term condition in which the lungs cannot supply enough oxygen). Record review of Resident #11's active physician order summary, reviewed 07/22/2026, revealed an order with a start date of 07/14/2026 to change disposable 6 MM uncuffed inner cannula (a tracheostomy [an incision to access the windpipe] tube which was inserted into the trachea [the windpipe, a tube which allows air to pass to the lungs] to assist with breathing) for copious secretions, one time a day, and as needed. There was another order, with a start date of 07/10/2026, for EBP: Use gown and gloves for high contact resident care activities for those known to be colonized or infected with a CDC targeted MDRO as well as those with increased risk of MDR (residents with wounds or indwelling medical devices), every shift. Resident #11's physician order summary had a second order for EBP: Use gown and gloves for high contact resident care activities for those known to be colonized or infected with a CDC targeted MDRO as well as those with increased risk of MDR (residents with wounds or indwelling medical devices) one time a day. Record review of Resident #11's Quarterly MDS assessment, dated 06/10/2026, revealed no BIMS score as Resident #11 was rarely or never understood. The Annual MDS assessment revealed Resident #11 received respiratory care to include suctioning and tracheostomy care. Record review of Resident #11's care plan initiated 10/04/2024 and revised 04/25/2025, revealed a focus for Enhanced Barrier Precautions due to trach. Interventions included gown and gloves for high contact resident care activities (dressing, bathing, showering, personal hygiene, changing linens, assisting with toileting, incontinent care, medical device care, wound care). An observation of Resident #11's trach care on 07/21/2026 at 3:20 PM revealed LVN-E performed hand hygiene and continued to get out supplies for trach care; Surveyor did not observe bedside table to be sanitized as LVN-E stated she had previously disinfected the table she was using for her sterile field, so it did not need to be disinfected again. RN-B, who assisted with trach care, was observed to perform hand hygiene improperly by turning on the water, applying soap to her hands, without wetting her hands, she began scrubbing for approximately 3 seconds, then applied water to hands, scrubbed for approximately 3 more seconds, then applied more water, scrubbed for 3 more seconds, then rinsed and dried hands. LVN-E placed her stethoscope around her neck with her hair falling over it, then took stethoscope off her neck and assessed Resident #11's respiratory status. Resident #11 was observed to be forcefully coughing up thick, green sputum (a material coughed up and expelled from the airways) throughout the respiratory assessment and trach care. LVN-E placed the stethoscope back around her neck against and under (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her hair and over her gown. After assessing Resident #11's respiratory status, LVN-E performed hand hygiene with ABHS and continued to prep for trach care. LVN-E was observed touching the trash-can to move it closer to her, then proceeding with set-up and donning (to put on) sterile gloves. After starting trach care, LVN-E's gown became untied and fell very loosely down below her chest while her hair was loosely falling over her shoulders and over her gown throughout trach care. LVN-E's scrub top was exposed for the majority of the trach care, while she both leaned over the sterile field and leaned over Resident #11 to perform care. At no point during the actual trach care (after initial gathering of supplies, respiratory assessment, and hand hygiene with ABHS) did LVN-E stop to put her hair up, fix or re-apply her gown, or perform hand hygiene again, and during trach care, LVN-E was not noted to clean the trach and neck area 3-4 inches out from trach, in a circular motion from inner to outer. She was noted to wipe each side of the trach area. RN-B was observed to stop Resident #11's feeding pump prior to trach care and hold Resident #11's trach - oxygen mask which supplied oxygen to the trach. RN-B did not perform hand hygiene and apply new, clean gloves when she assisted LVN-E with applying the new, clean trach collar after trach care. LVN-E was also noted to touch and adjust Resident #11's oxygen concentrator before applying the new, clean trach collar. An observation of med-pass on 07/21/2026 at 5:33 PM revealed RN-B performed inadequate hand hygiene. After applying hand sanitizer, RN-B only rubbed hands together for approximately 3-4 seconds. In an interview on 07/22/2026 at 8:18 AM, LVN-E stated she should not have touched something dirty like the trash-can or oxygen concentrator then moved back to a clean or sterile area without performing hand hygiene and donning clean or sterile gloves. She stated hand hygiene should be performed when going from any dirty to clean area. LVN-E stated she probably should not have placed her stethoscope around her neck and hair both before and after assessing Resident #11's respiratory status. LVN-E stated she should have put her hair up so it was not hanging over her clean gown, her sterile field, or the resident when performing care, and she should have stopped trach care and re-applied her gown or donned a new gown, performed hand hygiene again, and donned new sterile gloves after her gown fell down. LVN-E stated not performing proper or adequate hand hygiene, not wearing appropriate PPE, and not performing adequate trach care could have caused cross contamination and infection. In an interview on 07/22/2026 at 9:47 AM, the ADON, who was also the ICP, stated RN-B had improperly performed hand hygiene, and the proper hand hygiene process with soap and water consisted of turning the water on, wetting hands, applying soap, rubbing hands and applying friction for 20 seconds, blotting hands dry, then using a paper-towel to turn the water off. The ADON also stated LVN-E should have stopped trach care, put her hair up so it did not hang over her shoulders, gown, sterile field, or the resident, pulled her gown up and re-tied it, then re-sanitized her hands, donned new gloves, and continued trach care. She also stated hand hygiene should be performed, and clean gloves donned anytime the nurses or staff went from a dirty area to a clean area. In an interview on 07/22/2026 at 2:18 PM, RN-B stated prior to assisting with trach care she should have performed adequate hand hygiene and should have wet her hands first prior to applying soap, then scrubbed her hands for 20 seconds before rinsing them. She also stated she should have rubbed hands for approximately 20 seconds with ABHS, and 3-4 seconds was not long enough to perform hand hygiene with ABHS. She stated not performing hand hygiene properly could cause cross contamination and infection. Record review of the facility's Tracheostomy Care Competency Assessment, no date available, revealed 4. Perform hand hygiene and put on gloves and other PPE. 8. Remove resident's tracheostomy dressing. then discard dressing; 10. Remove and discard gloves; 11. Perform hand hygiene; 12a. Open tracheostomy kit using aseptic technique; 12b. [NAME] sterile gloves; 12c. Setup sterile field; 12d. Empty contents onto sterile field; 12e. Pour sterile solution into basins. 12k. Reinsert (continued on next page)		

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 07/22/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inner cannula into the tracheostomy tube and lock into place. 13. Using dominant hand, use a sterile cotton-tipped applicator and/or sterile gauze pad to clean the stoma-site. 14. Using dominant hand, moisten a sterile gauze pad with the sterile solution. Squeeze out the excess liquid. Then clean trach/neck area 3-4 inches around in circular motion from inner to outer, clean face plate, outer cannula and pat dry thoroughly with additional sterile gauze; 16. Instruct assistant to don clean gloves and hold tracheostomy tube in place to prevent expulsion during tie replacement. Record review of the facility's Enhanced Barrier Precautions policy, dated 11/24/25, revealed Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Policy Explanation and Compliance Guidelines: 3. Implementation of Enhanced Barrier Precautions: b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4. High-contact resident care activities include: A. Dressing; B. Bathing, C. Transferring; D. Providing hygiene; E. Changing linens; F. Changing briefs. G. Device care or use. H. Wound care. Record review of the CDC: Long-Term Care Facilities (LTCFs): Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 04/02/2024, revealed EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: A. Wounds or indwelling medical devices, regardless of MDRO colonization status; B. Infection or colonization with an MDRO. Enhanced Barrier Precautions: Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices. https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html?CDC_AAref_Val=https://www.cdc.go		