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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Calallen	4162 Wildcat Dr Corpus Christi, TX 78410

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 48118 Based on observation, interview, and record review the facility failed to ensure residents have the right to personal privacy and confidentiality of his or her personal and medical records for 1 (Residents # 27) of 6 residents for personal privacy and confidentiality in that: On 03/04/2024, MA A did not lock the nurse's station computer that contained sensitive resident information such as medication administered, name, room numbers, and advance directives for Resident # 27. This failure could place residents at risk for having their personal and medical information exposed. Findings included: An observation on 03/04/24 at 10:18 AM revealed a medication cart at the nurse's station with the computer on and unlocked. On the screen was Resident #27's personal information including name, date of birth, medication administered, and code status. Observed MA A walking in from the front door of the facility, around the nurse's station, stopped at the medication cart with the opened computer, used ABHR, and walked into the nurse's station to another computer. In an interview and observation on 03/04/24 at 10:24 AM with MA A, MA A walked down # three hall and identified the unlocked computer. MA A stated the computer was to be locked after every use. MA A stated locking the computer after each use was taught during orientation. MA A stated there was no paper or online training available for HIPAA documentation. MA A stated DON oversaw the medication cart containing the computer. MA A stated a negative outcome was it released HIPAA information. In an interview on 03/04/24 at 10:28 AM, MA A stated she forgot to close the computer after working on it. Indicated she has been trained on locking the computer since back in nursing classes and training. MA A stated she did learn the procedure at the facility, and she just completed another in-service on HIPAA information. MA A stated a negative outcome could be patient information could be stolen, used, or transferred to someone it doesn't belong to. No policy related to HIPAA privacy and documentation was provided by the facility prior to exit .

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on observation interview and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 4 of 10 residents (Resident #24, Resident #58, Resident #55, and Resident #68), staff, and the public; in that: 1.)The facility failed to ensure bathroom sinks hot water temperatures were below 110 degrees Fahrenheit in occupied rooms for Resident #24 and Resident #58 on 3/4/24 through 3/6/24. 2.)The facility failed to ensure bathroom sinks hot water temperatures were below 110 degrees Fahrenheit in occupied rooms for Resident #55 and Resident #68 on 3/4/24 through 3/6/24. This failure could affect residents by placing them at risk for diminished quality of life due to the lack of a well-kept environment and water temperatures over 110 degrees Fahrenheit, placing residents at risk of being in an unsafe environment and at risk for burn injuries. Findings Included: 1.) Observation on 03/04/24 at 4:45pm with the Maintenance Director and using the maintenance director's digital thermometer revealed the sink hot water temperature on 3/4/24 at 4:07 PM were: Resident #24 bathroom was 112 degrees Fahrenheit. Resident #58-bathroom sink was 117 degrees Fahrenheit. In an interview on 03/05/24 at 02:37 PM with Resident #24 stated she does not have a problem adjusting the water temp in the restroom sink and has never been burned with hot water. In an interview on 3/5/24 at 11:44 AM PM with Resident #58 stated she does not use the water in the bathroom and requires total assistance for ADL's (activities of daily living), so it was of no concern to her. 2.) Observation on 03/04/24 at 4:45pm with the Maintenance Director and using the maintenance director's digital thermometer revealed the sink hot water temperature were: room [ROOM NUMBER]-bathroom sink was 116 degrees Fahrenheit. room [ROOM NUMBER]-bathroom sink was 115 degrees Fahrenheit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/04/24 at 4:45pm the Maintenance Director at time of observation stated he did rounds every day in the morning. The Maintenance Director stated he checks two rooms in each hall every day and the last time he checked them was this morning (3/4/24). The Maintenance Director stated that he documented the temperature readings in the logbook. The Maintenance Director stated the temperature should be at 100-110 degrees Fahrenheit, but no higher than 115 degrees Fahrenheit. The Maintenance Director stated he has only been working at the facility for about 4-5 months and the previous Maintenance Director trained him for about 2 weeks. Record Review of the Logbook documentation dated 03/04/24 revealed room [ROOM NUMBER] was 110 degrees F and room [ROOM NUMBER] was 102 degrees F. Further review of Logbook for month of February and March revealed minimal variation of temperature between 110 to 112 degrees F. Record review of Resident #55's electronic face sheet dated 03/05/2024 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnosis included Hyperlipidemia (high cholesterol), Essential Hypertension (high blood pressure), Mixed Receptive Expressive Language Disorder (problems with speaking), Dysphagia (difficulty swallowing), and Unsteadiness on feet. Record review of Resident #55's quarterly MDS assessment, dated 02/16/2024 revealed a BIMS score of 03, indicating Resident #55 was severely cognitive impaired. In an interview on 03/05/24 at 2:18 pm with Resident #55, he was coming out of the restroom in his wheelchair. His speech was not clear. Surveyor A asked if he had any problems adjusting the temperature of the water in the sink, he shook his head no. Surveyor A asked if he had ever gotten burned, he shook his head no and motioned with his finger no. Record review of Resident #68's electronic face sheet dated 03/05/24 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis included Anxiety Disorder, Gastroesophageal Reflux Disease, Dementia, Major Depression, Post Traumatic Stress Disorder, Chronic Obstructive Pulmonary Disease (a chronic lung disease that causes air flow limitation). Record review of Resident #68's quarterly MDS assessment, dated 01/19/24 revealed a BIMS score of 09, indicating Resident #55 was moderately cognitive impaired. In an interview on 03/06/24 at 10:11am with Resident #68, stated she has not had any issues with the sink water temperature and has never been burned. Call light within reach. In an interview on 03/06/24 at 9:50am with the Administrator, stated that the procedure for checking the water temperature was that the maintenance director does sample tests every day. He documents the readings in the log. She ensures the water temperatures are getting checked by using the TELS system (a platform designed to help maintenance teams' efficiency). This system will show her things that have been done daily and or monthly. She monitors this on her end and their corporate team does as well. This system was accessible through an application on their mobile phone and in the computer. The administrator stated that the hot water temperature, max should be 110 degrees F. She stated if the hot water was too hot, then there was a potential that it could cause injury to the resident. Staff in the showers will test water to make sure it was an appropriate temperature prior to getting into the shower. She stated Maintenance director was trained by the regional maintenance director. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's incident and accidents logs dated 12/2023, 01/2024, and 02/2024 did not reveal any injuries to residents due to hot water. Review of the facility's Grievance logs dated 12/2023, 01/2024, and 02/2024 did not reveal any complaints of water temperature being too hot. Review of the facility's Instructions Direct Supply TELS provided the following information: 1. Ensure patient room water temperatures are between 100 degrees and 110 degrees Fahrenheit. Record results in the water temperature log.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on observation, record review and interview the facility failed to develop and implement written policies and procedures that Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for one resident (Resident#70) of four residents reviewed for abuse, neglect, and exploitation. The facility failed to conduct an investigation of Resident#70 injury of unknown origin. Resident #70 sustained a skin tear approximately 5.5cm X 0.1 cm to his left wrist. These deficient practices could place residents at risk for abuse, neglect, and not having their needs met. Findings Included: Record review of Resident #70's electronic face sheet dated 03/05/2024 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnosis included Anxiety Disorder, Dementia, Chronic Obstructive Pulmonary Disease (a chronic lung disease that causes air flow limitation), Osteoarthritis (degenerative joint disease), Essential Hypertension (high blood pressure), Hyperlipidemia (high cholesterol), Hypothyroidism (underactive thyroid gland), and Unsteadiness on feet. Record review of Resident #70's quarterly MDS assessment, dated 12/22/2023 revealed a BIMS score of 08, indicating Resident #70 was moderately cognitive impaired. Record Review of Nursing Noted dated 02/17/2024 at 7:04pm, Created by: LVN D Resident#70 with skin tear to left hand/wrist area measuring 5.5cm X 0.1cm. Resident stated that skin tear was caused during peri care in the middle of the night. Resident #70, reached out for the assist bar rail while trying to turn onto his right side and struck his hand against it causing the skin tear several nights ago. Resident #70 with no complaints of pain at this time, skin tear continues healing with dressing clean and dry and in place with daily care. Will continue to monitor. Called LVN D via phone on 03/05/24 at 03:47pm, no answer. Surveyor A not able to leave voicemail due to box being full. Called LVN D via phone on 03/06/24 at 09:27am, no answer. Surveyor A not able to leave voicemail due to box being full. Interview on 03/04/24 at 02:55pm with Resident#70 stated he has not been mistreated by any staff. Resident#70 stated he feels safe at this facility. Call light was answered in a timely manner. Surveyor A asked what happened on his left wrist. He stated that two CNAs changed his brief, and he thinks they might have accidently cut him with their fingernail when they turned him over. He does not remember who the two CNAs were. Resident was observed in his room, lying in bed. Resident was well dressed and appeared with good personal hygiene. Resident had a small dressing on his left wrist. Resident was not in distress. Call light within reach. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/05/24 at 04:05pm, during Resident #70 perineal care. Observed Resident #70 logrolled self and would hold on to the side bed rails throughout care. When he turned to the right side, he would hold on to the side bed rail with his left hand. Then when he turned to the left side, he would hold on to the side rail with his right hand. Observed neither CNA grab his arms for any reason. Resident #70 lifted buttocks up and CNA C placed brief down. Interview on 03/06/24 at 9:30am CNA G, stated she worked with Resident#70 the night of 02/17/24. She stated if he needs to change, he does assist. CNA G stated he usually turns himself in bed when doing perineal care. Resident #70 lifts his bottom to pull pants down. She stated Resident #70 did not let her know if he did get a skin tear. She did not see it and Resident #70 is pretty good at telling her. Resident #70 had a long sleeve flannel shirt that night. She stated she did not see or verbalize anything. She cannot remember who else would have assisted her since Resident #70 is usually really good to assist. She stated Resident #70 was good at voicing his needs. CNA G stated if she were to notice a skin tear on a resident, she was to notify nurse in charge right away. Then they would have her complete and sign an incident report. She stated she has not signed an incident report for Resident #70. She stated the abuse coordinator was the Administrator. She has not witnessed any abuse. She stated the in-service for abuse, neglect and exploitation was done last week around Thursday or Friday. Interview on 03/05/24 at 03:15pm with RN E, stated process if a resident had a skin tear is as followed: He would go in and assess resident, if they need a dressing then he would put one right there in then. He would then notify doctor, RP, and wound care nurse. RN E would then do a skin assessment. He would do an incident report and they would try to investigate. RN E stated they are to notify RP of any skin tears or any new injury. He stated if a resident falls, there is another protocol for that. He stated Resident #70 does not like when you go in there. Resident #70 will use call light when he needs something. RN E stated he monitors CNAs by being in the hall and looking at the dashboard in the computer. RN E stated in service for abuse, neglect was last week. Interview on 03/06/24 at 10:25am with LVN F, stated he works with Resident #70. He stated process if a resident had a skin tear is as followed: He would go assess and see how the resident is doing. He would ask them if they have any pain. He would talk to him and try to find out what happened. LVN F would then notify doctor and family member. He would document in his chart with a note that way that resident could be monitored. He would also put order in for wound care treatment. LVN F stated that an incident report is done on all skin tears, he documents everything. He has not witnessed any abuse. Resident #70 is vocal and is able to tell you what happened. He stated his last in service for abuse, neglect, and exploitation, was done maybe about a month ago. Interview on 03/06/24 at 10:38am with ADON A, stated the process for a skin tear is to stop it from bleeding, apply pressure, cleanse, and apply a dressing. Stated then to notify the RP and the doctor. ADON A stated that an incident report is done at all times with skin tears. In service for abuse, neglect, and exploitation was done last week. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/24 at 11:05am with DON, stated the skin tear procedure is that it would be investigated. She stated the nurse attend to the resident and document incident. The DON stated the nurse will also get measurements, put in the treatment orders that is required. Stated depending on what type of skin tear it is it will be in the incident/accident log. The DON stated that she is not sure why LVN D did not do an incident report. She stated that there was no investigation was done since he did not do an incident report on that skin tear. She stated there is no documentation that he notified RP or doctor. The DON stated they are to reach out to RP and medical doctor for any changes like skin tears or new medications. She stated that LVN D was supposed to complete an incident report as well. Incident report is done to continue to follow up and make sure the resident is okay and does not have a decline. Proper notification is required. Making sure they are doing investigation, and looking into how he is turning. Interview on 03/06/24 at 02:35pm with the Administrator, stated that the process of when a resident acquires a skin tear is as follows: skin tear is identified by staff or resident themselves. Staff reports it to the nurse. The nurse then does an assessment and communicates with doctor. RP or family are notified. She stated they have stand by treatment to pat dry and apply dressing. Staff is to continue to monitor skin tear. She stated they have a way to review incidents in the facilities electronic health records system. She reviews it and identify any significant injuries that were not reported. The DON stated she does not know why there was no incident report done for Resident #70 skin tear. She stated she was not aware of incident. Record review of the facility's Incidents and Accidents Policy and Procedure dated 08/15/22 revealed Policy: It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. An Incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. This can involve a visitor, vendor, or staff member. Policy Explanation: The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented, and corrective actions are taken to prevent recurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement to avoid further occurrences. Alert administration of occurrences that could result in reporting requirements. Meeting regulatory requirements for analysis and reporting of incidents and accidents. Compliance Guidelines: 1.Incident/accident reports are part of the facility's performance improvement process and are confidential quality assurance information. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Licensed staff will utilize PCC Risk Management to report incidents/accidents and assist with completion of any investigative information to identify root causes. 4. The following incidents/accidents require an incident/accident report but are not limited to: Self-inflicted injuries, unobserved injuries

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, for one resident (Resident #18) of 16 residents reviewed for quality of care, in that: The facility did not implement the use of Prevalon Boots (heel protectors that help reduce the risk of bedsores by keeping the heel floated, relieving pressure) for Resident #18, as ordered by her physician to maintain skin integrity on 3/5/24. This deficient practice could affect residents receiving preventative skin care at risk for pressure ulcer development or a deterioration of a current pressure ulcer. The findings included: Record review of Resident #18's Face Sheet dated 03/05/2024 reflected a [AGE] year-old female with an original admitted [DATE] and a readmitted [DATE]. Diagnoses included Dementia (decline in cognitive abilities that impacts a person's ability to perform everyday activities), heart failure, muscle wasting and atrophy (wasting away of tissue or an organ), neuropathy (damage or disease affecting the nerves), acute respiratory failure, and hypertension (high blood pressure). Record review of Resident #18's physician orders stated; Order Summary: 11/13/23 Prevalon Boots to bilateral feet to promote skin integrity, every shift. Record Review of Resident #18's Care Plan dated 5/17/22 stated; Skin Integrity: The resident is at risk for impaired skin integrity related to bladder incontinence, bowel incontinence. Resident #18 had an order for Prevalon Boots. Administer medications as ordered to address medical diagnosis / conditions. Monitor for effectiveness and adverse side effects. C.N.A's (certified nurse aide) to monitor skin daily during care and report any signs of skin breakdown to licensed nurse. Conduct skin inspections / examinations weekly and as needed. Document findings. Educate and reinforce on risk factors associated with resident or family. Encourage and/or assist with frequent position changes while in bed and out of bed if applicable. Record Review of Resident #18 MDS dated [DATE] reflected under the Skin and Ulcer/Injury Treatments, pressure reducing device for bed was selected for Resident #18. In an interview/observation on 03/05/24 at 09:43 AM Resident #18 was not wearing Prevalon Boots to bilateral feet to promote skin integrity as ordered. Resident #18 stated she thought she was supposed to be wearing the boots, but no one has come to put them on. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/05/24 at 03:26 PM Resident #18 was not wearing Prevalon Boots. In an interview on 03/05/24 at 03:30 PM, LVN C stated Resident #18 was not wearing the Prevalon Boots as ordered but Resident #18 was ordered to be wearing them to promote skin integrity and to take pressure off her heels. LVN C stated nurses are in charge of making sure Resident #18 was wearing her boots and if Resident #18 refused, it should have been documented in nurses notes and be care planned. LVN C stated it was important to follow physician order's as it was person centered and prescribed for that resident by a doctor. LVN C asked Resident #18 if she would like to wear the Prevalon Boots and Resident #18 stated yes. LVN C proceeded to apply Prevalon Boots. In an interview 03/06/24 at 09:49 AM the DON stated Resident #18 should be wearing the Prevalon Boots as ordered to prevent skin breakdown and promote skin integrity. The DON stated following doctor's orders was important because it is person centered. The DON state the charge nurses are in charge of making sure Resident #18 was wearing Prevalon Boots as ordered and DON should oversee doctor's orders are being implemented. The DON stated there was no specific policy for following doctor's orders.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure he accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident on one of four medication carts (hall 100 nurse's cart) reviewed for pharmacy services. 1. The facility failed to account for 2 of Resident #81's 0.5mg Lorazepam (medication to treat anxiety) tablets. 2. RN A and RN B failed to accurately document Resident #81's 0.5mg Lorazepam drug count on 03/04/24. This failure could place residents at risk for drug diversion and delay in medication administration. Findings included: Record review of Resident #81's face sheet revealed a [AGE] year-old female admitted on [DATE]. Her diagnoses included mixed receptive-expressive language disorder (difficulty understanding words/sentences and difficulty speaking), need for assistance with personal care, dementia- mild- with agitation (organic brain disease causing loss of intellectual functioning, memory impairment, and often personality change), Alzheimer's disease (generalized brain degeneration causing mental deterioration), and other symptoms and signs involving cognitive functions and awareness. Record review of Resident #81's quarterly MDS dated [DATE] revealed a BIMS score of 00 indicating severe cognitive impairment. Observation of 100 hall nurse's medication cart on 03/04/24 at 10:35 AM revealed a discrepancy with a narcotic (Lorazepam) for 1 of 4 residents reviewed. Resident #81 was prescribed Lorazepam 0.5mg PO every 4 hours as needed for anxiety. The medication card showed that there should have been 58 tablets, however there were 2 tablets missing (blister pockets 51 and 41). The backs of blister pockets 51 and 41 were intact, however the bottom of the card was not securely sealed (the sticky substance that held the 2 parts of the card together was not sealed leaving an opening at the bottom left side of the card). Blister pockets 51 and 41 are on the bottom left side of the card. RN A inspected the narcotic drawer and there were no loose tablets of any kind. Record review of the Individual Narcotic Record on 03/04/24 at 10:40 AM for Resident #81's Lorazepam 0.5mg tablets indicated that the last dose of this medication was given on 11/2/23 at 09:00 PM by RN C and documented that there were 58 tablets left. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview of RN A on 03/04/24 at 10:42 AM, RN A stated that she did not notice any missing tablets during the morning shift change narcotic count done on 03/04/24 at approximately 06:00 AM with RN B. RN A stated that the procedure for checking narcotics was to look at the card to make sure the tablets are all there and to look at the back of the card to see if it had been tampered with. RN A stated that if she found that there were missing medications, she would notify the DON or the ADON. In an interview with DON on 03/04/24 at 11:47 AM, DON stated the procedure for verifying the narcotic count is for 2 nurses to look at the card and make sure the card matches the count. DON stated, if the count is not correct, they should call me. I will try to figure it out. Check to see if there's a missing medication not signed out, check to see if it was accidentally popped out, and check the bottom of the drawer. If it's not there, I would call Regional. When asked about why narcotic counts are important, DON stated it was to make sure that the residents are getting their medications. DON stated if there was a discrepancy, they would go through the MARs (Medication Administration Records), interview staff, and ask the doctor about drug labs for the resident. DON stated if there was an indication of diversion, she would call Regional and see about drug tests for staff that were in charge of that cart for the last 24 - 72 hours. DON stated that she had already contacted Regional in reference to this situation. Record review on 3/4/24 at 2:00PM of the facility Medication Policy, Reporting Controlled Substance Theft, Breakage, or Other Loss dated 10/01/19 revealed: Policy The following procedures are designed to serve as guidelines for the facility when any type of medication diversion or tampering has occurred. Procedure If drug diversion is suspected by a Licensed Nurse, it is his/her responsibility to report this to the Director of Nursing. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with DON on 3/5/24 at 3:12 PM, DON stated that she would have to find out because as far as she knew, they did not have a system for drug diversions. DON stated she called their pharmacy and they did not have any paperwork for that. DON stated that the only thing they had was their medication error form that they would fill out but that she didn't know where that goes after it was uploaded to the resident's profile. DON stated, I guess we have a tracking system for that. DON stated that when she was out doing observations of the shift change count, she would focus on making sure the nurses were taking the actual card out and checking for all of the pills, not just pulling it up to see what the last number was because the bottom of the card couldn't really be seen since the pills that were missing were on the bottom of a card. DON stated she would also make sure that the nurses were looking at the back of the blister pack and if they saw a medication that looked like it was about to pop out, the nurse would get another nurse so they could pop it out and destroy it so that it didn't end up missing or at the bottom of the drawer. When asked what she would do if she suspected drug diversion, the DON stated she would contact the regional nurse, the pharmacist, and the police. DON stated the decision to call the police would be made if they believe that the residents were in any danger or weren't getting their medications or if the nurse that had that cart showed any signs or symptoms of drug use. DON stated that she would need to verify with ADMIN if the police were called for this incident or if it was just reported to state because ADMIN would be the one reporting it. DON stated that they had been doing audits and found a couple more today that came from the pharmacy and from Hospice that were coming unglued at the bottom of the blister pack card. DON stated that she and the ADONs went through all the carts and notified the pharmacy consultant also. DON stated that a narrative would be done to add to the state report. In an interview with ADMIN on 3/5/24 at 1600, she stated that the police had been notified on 3/4/24. The police department assigned Event #2403005261 to this incident. Record Review on 3/6/24 at 08:30 AM of RN A's Facility RN/LVN Orientation Skills Checklist indicated that RN A had been checked off as performing the following skills/duties in facility on 7/10/23 and signed off by preceptor ADON-B. PHARMACY: -Storage- Carts, Refrigerator, and Med room -Receipt of meds -Narcotic count Record Review on 3/6/24 at 08:30 AM of RN B's Facility RN/LVN Orientation Skills Checklist indicated that RN B had been checked off as performing the following skills/duties in facility on 1/8/24 and signed off by preceptor ADON-B. PHARMACY: -Storage- Carts, Refrigerator, and Med room -Receipt of meds -Narcotic count

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on interview and record review, the facility failed to ensure the drug regimen of 1 out of 1 resident (Resident #4) was reviewed at least once a month by a licensed pharmacist, in that: Resident #4 was missing monthly medication reviews documented for the months of January 2024 and February 2024. This deficient practice could place resident at risk from harm related to unnecessary medications or dosages, could place them at risk for adverse consequences related to medication therapy, and impact residents' ability to achieve or maintain their highest practicable level of physical, mental, and psychosocial well-being. The findings included: A record review of Resident #4's face sheet dated 03/06/2024 reflected an [AGE] year-old female admitted on [DATE] with diagnoses of Cerebral Infarction (a stroke), Dementia, Atherosclerotic Heart Disease (thickening or hardening of the arteries), Anxiety, Hyperglycemia (high blood sugar), Anemia, Type 2 Diabetes Mellitus, Insomnia, Hyperlipemia (high cholesterol), Depression, Essential Hypertension (high blood pressure). A record review of Resident #4's quarterly MDS assessment dated [DATE] reflected a BIMS score of 04, which indicated severely impaired cognition. A record review of Resident #4's order dated 09/08/2023 revealed an active order for Prozac 40 mg daily give 1 capsule by mouth one time a day for Depression. A record review of Resident #4's order dated 09/01/2023 revealed an active order for Temazepam 15 mg daily give 1 capsule by mouth at bedtime for insomnia. A record review of Resident #4's order dated 09/08/2023 revealed an active order for Xanax 0.25mg daily give 1 tablet by mouth three times a day for Anxiety. In an interview on 03/06/24 at 02:12 PM with DON, surveyor A asked to provide copy of Medication Regimen Review for Resident #4, DON stated she would have to go through her emails to check for it. DON did not provide surveyor A with the document prior to exit. A record review of the facility's policy titled Psychotropic Medication dated 8/15/2022 reflected the following: Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Explanation and Compliance Guidelines: 3. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team.

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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** 48118 Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments for one hall (Hall 300) of eight medication carts. On 03/05/2024, The facility failed to keep one medication cart locked on Hall 300 . These failures placed 24 residents on Hall 300 at risk of drug diversions or misuse of medications. Findings included: Observation on 03/05/24 at 3:25 PM revealed medication cart 1 was unlocked and unattended on Hall 300 near room [ROOM NUMBER]. Investigator noticed the drawers on medication cart 1 were slightly ajar. All the drawers of medication Cart 1 could be opened, and the medication was easily accessible. The cart was unattended for about 30 seconds until 3:26 PM when they were closed by LVN A. Interview with LVN A on 03/05/24 at 3:26 PM revealed staff were to secure medications and not leave medication carts unlocked and unattended. LVN A reported that she was the one that left it unlocked, but the locking mechanism on medication cart 1 is faulty and that sometimes the lock does not get pushed in all the way. She added that maintenance had been notified of the issue one and a half months ago, but it had not been fixed yet. This surveyor asked LVN A what some potential consequences of an unlocked cart are, and she responded that some residents may grab and use medication that were not theirs or steal others resulting in harm to residents. Interview with DON on 03/06/24 at 9:37 AM revealed that medication carts should be locked when the nurse or medication aide is away from the cart. DON was unaware of any issues or maintenance requests relating to the locking mechanism of medication cart 1. Interview with MD on 03/06/24 at 2:27 PM showed that he was unaware of any active maintenance work orders relating to the locking mechanism of medication cart 1. Record review showed the policy Medication Carts and Supplies for Administering Meds dated 10/01/19. Under the Procedure heading for medication carts, points 2 and 3 state The medication cart is locked at all times when not in use and Do not leave the medication cart unlocked or unattended in the resident care areas respectively. Record review showed that on 03/04/24 there was an in-service training for all LVN's, RN's and CNA's about proper policies for locking medication carts. LVN A's signature was located on the attendance sign-in sheet as a participant for this in-service training.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 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 and 1 of 1 nutrition room reviewed for sanitation in that: 1. The facility failed to ensure juice dispenser guns were sanitary 2. The facility failed to ensure equipment was clean and sanitized 3. The facility failed to ensure dishwasher temperatures were at a safe temperature to sanitize dishes 4. The facility failed to ensure chemical logs were accurate and at safe sanitation levels 5. The facility failed to ensure dry goods were dated, labeled, sealed, and not expired 6. The facility failed to ensure spices were not left open to air 7. The facility failed to ensure items in the nutrition room refrigerator were not expired 8. The facility failed to ensure the kitchen was following their policies 9. The facility failed to implement an approved cleaning schedule These failures could place residents at risk of foodborne illnesses. Findings included: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and initial tour of the kitchen on [DATE] at 10:30 a.m. revealed the juice gun nozzles and hoses were coated with a thick, reddish, sticky substance. There was a slimy looking substance in the holster for the juice guns. The insides of the steam table wells were crusted with a whitish yellow substance that was flaking from the sides and bottoms, with floating debris in the water. The Steamer well was crusted with a whitish yellow substance that was flaking from the sides and bottoms, with floating debris in the water. The shelf directly above the steam table had a removable reddish substance the length of it. The can opener had a white substance around the blade. There was a removable yellow substance on the ice machine chute. The dishwasher log dated [DATE] (no other dishwasher logs were provided) had dish washer temps marked as 110 F on [DATE], 110 F on [DATE], 120 F (scratched out) on [DATE], and 123 F on [DATE] for breakfast service, and 120 F for all other services from [DATE]-[DATE]. The 3-compartment sink sanitizer test strip logs dated Jan. 2024, Feb. 2024, and [DATE] had 200 ppm on every entry. The dry storage area revealed a partial 1-gallon container labeled Fortified Dry Milk with a use-by date of [DATE]. There were 5, 5 lb. boxes of dry pancake mix with a use-by date of [DATE]. There was an unopened partial 50 lb. bag of dry oatmeal open to air. There was 1 open and unsealed 16 oz. box of brown sugar, and 1 opened and unsealed 16 oz. box of powdered sugar. There were 4, partially filled 1-gallon containers of dry cereals that had no use-by dates, no initials, nor were the contents identified on the labels. There were 4 of 12, 18 oz. containers of spices that were open to air. There were 2 unopened cases of bread with use-by dates of [DATE]. The Nutrition room revealed 1 liter of tube feed with expiration date of [DATE]. Return observation of the kitchen on [DATE] at 04:21 p.m. revealed the steam table wells still had a flaking yellow-white substance on the sides and bottoms with floating debris in the water, in all 4 wells. Return observation of the kitchen on [DATE] at 11:33 a.m. revealed the steam table wells still had a flaking yellow-white substance on the sides and bottoms with floating debris in the water, in all 4 wells. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DM on [DATE] at 10:30 a.m. during the initial tour stated the can opener had not been cleaned but was supposed to have been cleaned after every service. The DM pointed at a cleaning schedule posted on a window inside the kitchen. There were no initials and no spaces for initials. The DM stated the juice guns and hoses were not supposed to look like that. The DM stated the steam table wells were supposed to be cleaned weekly and de-limed every Wednesday. The DM identified the removable reddish substance the length of the shelf directly above the steam table as rust and grease and wiped his thumb on it. The DM stated the substance could drop off into the food and cause cross-contamination or make the residents sick. The DM stated he did not know what the removable yellow substance was on the ice machine chute and did not know how the substance got there. The DM stated the temperature of the dishwasher should be at least 120 F, and he had not been notified by staff the temperatures were less than that. The DM stated the temperatures needed to be hot enough to kill germs to keep bacteria from forming because it could make the residents sick or very sick. The dish washer chemical strips were all marked 50 ppm on the [DATE] log. The DM tested a chemical strip in the dishwasher and the result was 200 ppm. The DM stated, the minimum the chemical test strips should be was 50 ppm. The DM tested a chemical test strip in the 3-compartment sink that showed 400 ppm. The DM stated too many chemicals could be hard to rinse off and stick to the dishes. The DM stated chemical residue could make the residents sick. The DM stated it was his fault for not teaching the kitchen staff to write down the exact numbers because he only told them about the ppm for the 3-compartment sink had to be at least 200 ppm, and the dish washer minimum was 50 ppm. The DM stated he did not have any other past logs for the dishwasher. The DM stated the contents of the containers in the dry storage room were various dry cereals. The DM stated the (expired) bread was in use for service. The DM stated all foods should be labeled with the contents, opened date, use-by dates, and initials. The DM stated he did not know why the labels were not correct. The DM stated he did not check items for labels. Interview with the DON and ADM on [DATE] at 03:49 p.m. stated the nutrition room was stocked by central supply and maintained by central supply. Interview with CS on [DATE] at 03:53 p.m. stated the nutrition room was stocked by central supply and maintained by central supply, and he was responsible for the nutrition room. The CS stated he checked the nutrition room at least daily. Interview with the DM on [DATE] at 11: 35 AM stated the steam table wells were still dirty and he put in an order with maintenance. The DM stated the steam wells were supposed to be cleaned weekly and de-limed every Wednesday. The DM stated he had been working on them for several days. The DM stated the steam wells did not look like they had been cleaned according to his cleaning schedule. The DM stated it was not maintenance's responsibility to clean the steam table wells. Record review of the facility policy, Food Storage revised [DATE]: 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 an HACCP 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy, General Kitchen Sanitation dated [DATE]: 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. Record review of the facility policy, Cleaning Schedules dated [DATE]: Policy: The facility will maintain a cleaning schedule prepared by the Nutrition and Foodservice Manager and followed by employees as assigned in order to ensure that the kitchen is free of hazards. Procedure: 1.Sample forms for daily cleaning, weekly cleaning, and monthly cleaning follow this policy. 3. The cleaning list will be posted weekly and initialed off and dated by each employee upon completion of the task. The Nutrition and foodservice Manager or designee will verify that the tasks were completed as assigned. Record review of In-services: [DATE]-Temperature Logging, [DATE]-Dietician and Activities Department, [DATE]-Shelf Life, Dish Room References: TAC 228.111 (p) Warewashing equipment (three-compartment-sink) determining chemical sanitizer concentration: concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. Figure: 25 TAC 228.111(n)(1) Sanitizer Concentration range: ,d+[DATE] ppm, when the minimum temperature is 150 degrees Fahrenheit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038 Based on observation, record review, and interview, 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 two of six Residents (Resident #89, and Resident #70) that were reviewed for infection control and transmission-based precautions policies and practices, in that: 1.) The facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling Legionella (bacteria that grows and multiplies in moist areas that can cause respiratory illness) through a program that identifies areas in the water system where Legionella bacteria can grow and spread. 2.) Resident #89's ventilator mask and oxygen nasal cannula tubing were left unbagged for 2 days when not in use. 3.) The CNA C did not remove the dirty barrier linen underneath Resident#70's buttocks and placed the clean brief on top of the dirty linen while performing perineal care. These failures could place residents at risk for infection through cross contamination of pathogens and infectious diseases and affects residents on oxygen therapy that could result in respiratory infections. The findings included: 1.) During an interview with the Maintenance Director on 03/06/24 at 09:35 AM stated he did not know what Legionella was and did not know if there was a water flow chart or a log of Legionella testing. The Maintenance Director stated he was recently hired by the facility and was still learning the job functions and unsure where he would find that information. In an interview on 03/06/24 at 09:45 AM, the DON/ Infection Control Preventionist stated she did not know if testing was being done and stated the Maintenance Director was a new employee and unsure if he had a flow chart or if testing for Legionella was being conducted. In an interview on 03/06/24 09:58 AM, the Administrator stated Corporate was revising a new plan for Legionella testing and planned to roll out the new testing by the end of the month. The Administrator stated she was unsure if current testing was being conducted. The Administrator stated, the facility did not have a policy or procedure for Legionella testing and stated she thought Legionella testing was only conducted if there was a concern. The Administrator stated the facility currently did not have any measures in place to monitor for Legionella. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Record review of Resident #89's electronic face sheet dated 03/04/2024 reflected she was originally admitted to the facility on [DATE]. Her diagnoses included: diabetes mellitus (a disease of inadequate control of blood levels of glucose), atherosclerotic heart disease (a common condition that develops when plaque builds up inside the arteries), obstructive sleep apnea (when the throat muscles relax and block the airway), Alzheimer's disease (a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment) and heart failure (occurs when the heart muscle doesn't pump blood as well as it should). Record review of Resident #89's quarterly MDS assessment of 01/22/2024 reflected she scored a 10/15 on her BIMS which signified she was moderate cognitive impairment. She required moderate assistance with her ADL's. She was coded to have an active diagnosis of congestive heart failure (CHF) (a long-term condition that happens when the heart cannot pump blood well enough to give a body a normal supply, blood and fluid can collect in the lungs and legs). Record review of Resident #89's comprehensive care plan revised date 02/03/2024 reflected Focus, altered respiratory status r/t DX of CHF, and acute/chronic respiratory failure, use of oxygen PRN and ventilator machine at NOC. Record review of Resident #89's Active Orders as of: 02/20/2024 .Change O2 tubing, humidifier water, and bag to place tubing in weekly . 07/26/2023. May apply O2 via Nasal Cannula PRN SOB/hypoxia (a state in which oxygen is not available in sufficient amounts at the tissue level to maintain homeostasis): Titrate O2 2-5LPM to keep SPO2 equal or greater than 90%. Write liters per min of O2 as needed for SOB/Hypoxia Active 07/26/2023. Record review of Resident #89's MAR for February 2024 reflected she was being checked for edema each shift and her compression stockings were applied in the AM and taken off in the PM. On 03/04/2024 at 10:13am, upon observation of residents it was discovered that Resident #89 (R #89) was asleep in her room and her nasal canula was on the floor the right side of her bed. The oxygen machine was not on. On 03/04/2024 at 4:14pm, the resident was awake, and her nasal cannula was still on the floor on the right side of her bed and it was not bagged. Upon interview with the resident, she stated that she hardly uses her oxygen, and it is only when he needs it. The investigator asked R #89 when the last time was, she used the oxygen machine and she stated that it has been about two months. Observation on 03/05/2024 at 10:00 AM of Resident #89 revealed she was sitting in her room in her bed. Her ventilator mask was unbagged, and his oxygen nasal cannula was hanging over the concentrator and was unbagged. On 03/04/2024 at 4:30pm, interview with C.N.A. A stated that the resident does not use her oxygen every day and does not know why it is on the floor. C.N.A. A stated that she does not work every day and does not know when the last time R #89 used her oxygen but can check. The investigator asked C.N.A. A if the nasal canula should be on the ground when not in use. C.N.A. A stated that it should be in a bag. Investigator asked C.N.A. A what the harm to the nasal canula is being on the floor, C.N.A. A stated that it is not clean on the floor and that it will have germs the next time that R #89 needs it again. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/06/2024 at 1:38pm, interview with LVN B. LVN B is the Licensed Vocational Nurse and the Guardian Angel Advocate for R #89. The Guardian Angel is a resident advocate for the facility. LVN B was not aware of the oxygen tank being inside R #89's room. She stated that she had not noticed it behind the curtain. LVN B stated that R #89 has not utilized her oxygen for a month and a half. The investigator asked LVN B when the oxygen is not in use where does the nasal canula belong. LVN B replied that it should be in a bag until it is used again. The investigator asked LVN B how often she visits with R # 89 and she stated she sees all of her residents daily. The investigator asked her how she didn't see the oxygen machine behind the curtain or the nasal canula on the ground if she had already visited with R # 89 and LVN B stated that she may have just missed it. The investigator asked LVN B what could happen if a nasal canula is left on the floor and LVN B stated that it could lead to contamination. Interview on 03/06/2024 at 2:10 PM with the DON, she stated Resident #89's oxygen tubing and ventilator mask needed to be bagged when not in use to prevent cross contamination. Record review of the facility titled Cleaning and Disinfecting Equipment (undated) stated: Resident care-equipment, including reusable items and durable medical equipment will be cleaned and disinfected. 3.) Record review of Resident #70's electronic face sheet dated 03/05/2024 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnosis included Anxiety Disorder, Dementia, Chronic Obstructive Pulmonary Disease (a chronic lung disease that causes air flow limitation), Osteoarthritis (degenerative joint disease), Essential Hypertension (high blood pressure), Hyperlipidemia (high cholesterol), Hypothyroidism (underactive thyroid gland), and Unsteadiness on feet. Record review of Resident #70's quarterly MDS assessment, dated 12/22/2023 revealed a BIMS score of 08, indicating Resident #70 was moderately cognitive impaired. Resident #70's urinary incontinence is always incontinent, and bowels are frequent incontinent. Record review of Resident #70's comprehensive person-centered care plan, date revised on 02/14/2023 and reflected Focus Resident #70 has bowel and bladder incontinence related to Dementia. Intervention Resident #70 clean peri-area with each incontinence episode . Observation of Resident #70 on 03/05/24 at 4:05 PM revealed CNA C kept the dirty barrier linen underneath resident's buttocks and placed the clean brief on top of it. After CNA was done fastening the clean brief, she then removed the dirty barrier linen from underneath the resident. Interview on 03/05/24 at 4:20 PM with CNA C, stated she forgot to remove the dirty barrier linen from underneath the residents' buttocks, and she put down the clean brief on top of it. She stated that it was important to remove dirty linen and keep it from touching the clean brief to prevent infection. CNA C stated in service on infection control was done about 2 weeks ago. (continued on next page)

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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Calallen	4162 Wildcat Dr Corpus Christi, TX 78410

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/6/24 at 1:50pm with ADON A, stated she conducts the yearly skill check offs on the CNAs and as needed. She stated the CNAs should be rolling the dirty draw sheet in when they are putting a clean sheet along with the clean brief. ADON A stated that it is important to keep dirty surface does not touch clean surface. She stated this is done to prevent infection control. ADON A stated the negative outcome could be cross contamination or cellulitis. She stated you don't know if the dirty linen got wet and they want to keep skin integrity. In service for perineal care and infection control was done last month. Record review of CNA C, Validation Skills Checklist: Pericare Male dated 05/01/23 revealed she performed pericare male procedure in accordance with the facility's standard of practice. Record review of the facility's Perineal Care Policy and procedure dated 10/24/22 revealed Policy: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Perineal care refers to the care of the external genitalia and the anal area. 48118 48278