STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455557	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Palms Nursing & Rehabilitation	5607 Everhart Rd Corpus Christi, TX 78411

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on interview and record review, the facility failed to ensure the residents had the right to be free from abuse for one (Resident #1) of fifteen residents reviewed for abuse. The facility failed to protect Resident #1 from being verbally abused by SA on April 29th 2024. The non-compliance for Resident #1 was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 04/29/2024 and ended on 04/29/2024. The facility corrected the non-compliance before the investigation began. This failure placed all residents at the facility at risk of severe psychosocial harm by being forced to interact with an employee that verbally abuses residents. The findings included: Record review of Resident #1's face sheet reflected a [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included depression unspecified (patient is primarily depressive but does not meet the full criteria for any specific depressive disorder) and type 2 diabetes mellitus. Record review of Resident #1's quarterly MDS assessment section C, cognitive patterns, dated 05/29/2024 reflected a BIMS score of 15 (cognition intact). Record Review of Resident #5's face sheet reflected a [AGE] year-old male with an admitted [DATE]. Pertinent diagnoses included depression unspecified, generalized anxiety disorder, and alcohol-induced persisting dementia (damage to the brain caused by regularly drinking alcohol over many years resulting in memory loss and difficulty thinking things through). Record review of Resident #5's quarterly MDS assessment section C, cognitive patterns, dated 06/06/2024 reflected a BIMS score of 13 (cognition intact). Record review of Resident #6's face sheet reflected a [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included vascular dementia (general term for problems with reasoning, planning, judgement, memory and other thought processes), anxiety disorder, unspecified depression, and bipolar disorder (mental illness causing unusual shifts in a person's mood, energy, activity levels, and concentration). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #6's MDS assessment section C, cognitive patterns, dated 06/10/2024 reflected a BIMS score of 13 (cognition intact). Record review of the provider investigation report dated 05/01/2024 revealed that on 04/29/2024 The alleged perpetrator (SA) was in the patio washing the concrete area. This is when the alleged victim (Resident #1) started confronting the alleged perpetrator about washing the concrete during smoke break. According to witness' the alleged perpetrator became upset with the alleged victim and cussed at her. Once the facility was advised of the incident at about 2:15 PM., the Administrator suspended the alleged victim pending the outcome of the investigation. The provider investigation report found the results of the investigation to be inconclusive. Record review of the provider investigation report dated 05/01/2024 revealed a signed statement from Resident #1 stating I went outside to have a cigarette after lunch. SA was wetting down the patio (smoke area) with the water hose, I asked why he was doing that, he said they asked him to. So I went inside to find his boss (HR) to tell her he was not passing cigarettes because he was cleaning the patio. She asked why I was telling her. I said because you are his boss and I went outside to where he was then pouring liquid soap. Then HR came out and asked if he was giving cigarettes out, he said in a few minutes, but he was on the first part of the patio. At this point I told him his head was a little big with his job, and I was tired of him being so controlling. He said fuck you, I said what did you say to me? He said it a little louder. I am not defending my behavior, but I did not deserve that. I went and to SSD, then administrator and my witnesses came forward and corroborated my complaint. The DON came and talked to me, and again before she left for the night. Record review of the provider investigation report dated 05/01/2024 revealed a signed statement from Resident #7 stating I heard SA, the smoke monitor, tell Resident #1 'Fuck you.' 4/29/24 Record review of the provider investigation report dated 05/01/2024 revealed a signed statement from FT stating On April 29th I was outside SA was scrubbing the patio and Resident #1 came outside and asked for a cigarette. He told her she had to wait she questioned why they had to wait and his reply was after she asked what did you say and he said 'fuck you.' Record review of 1:1 in-service titled, Abuse Prevention, Abuse & Neglect Facility Policy, specifically verbal abuse was conducted by the Administrator with the SA on 04/28/24 and signed in ink by both. In an interview with SM on 08/06/2024 at 10:41 AM, SM stated that the patio was open to residents that wish to smoke from 7 AM to 7 PM. SM stated there was a lunch break from 12 PM to 1 PM where the patio was closed for smoking. SM stated that he was familiar with SA and he had heard from residents that SA would frequently yell and cuss at all of them. SM stated he was not familiar with any specific incident involving Resident #1, and that he had not started working yet at the facility on 04/29/2024. In an interview with Resident #5 on 08/06/2024 at 1:07 AM, Resident #5 stated that SA would cuss and yell at all the residents in the smoking area. Resident #5 stated that he was aware of the incident involving Resident #1 when SA said Fuck you to her on 04/29/2024, but could not elaborate further on other incidents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with Resident #6 on 08/06/2024 at 2:49 PM, Resident #6 stated that SA told one of the ladies in the smoking area to Fuck off. Resident #6 stated that she was not there at the time of the incident, but that she heard it from everyone that goes out to the patio to smoke. In an interview with Resident #1 on 08/07/2024 at 9:50 AM, Resident #1 stated that SA said fuck you to her. Resident #1 stated that a lot of other residents were out there and heard it as well. Resident #1 stated that she immediately reported the incident to the Administrator. Resident #1 stated that SA was suspended, but that he came back to work as a maintenance person and that she had seen him walking around the building. In an interview with HR on 08/07/2024 at 11:09 AM, HR stated that the last day SA worked was on 07/10/2024. HR stated that SA was not fired after the verbal abuse incident. HR stated the reason SA no longer works at the facility was because he stopped showing up for work after 07/10/2024. In an interview with the Administrator on 08/07/2024 at 11:33 AM, the Administrator stated that, during the initial incident on 04/29/2024, Resident #1 was upset because SA was washing the patio and not handing out cigarettes. The Administrator stated that SA allegedly told Resident #1 to fuck off when she told him to stop cleaning the patio. The Administrator stated they reported the incident to Texas Department of Health and Human Services for verbal abuse and suspended SA. The Administrator stated that SA was suspended for a few days before returning to work, but he could not remember exactly how long the suspension lasted. In a follow-up interview with Resident #1 on 08/08/2024 at 9:41 AM, Resident #1 stated that when the incident first occurred, she felt embarrassed and anxious because she did not like being talked to that way in front of other residents. Resident #1 stated that after the incident, when she saw SA working in the facility, she felt fearful that he might confront her because she made him change job roles at the facility. Resident #1 stated that there was one incident once SA returned to work at the facility where he was painting other resident's doors outside her room in the 300 hall. Resident #1 stated that a lot of her fear and anxiety returned when she saw him so close to her room. Resident #1 stated that she felt like the facility did not care to protect her from him, or future aggressors if a similar event happened again. In a follow-up interview with the Administrator on 08/08/2024 at 10:53 AM, the Administrator stated that the findings of the provider investigation were inconclusive because SA never admitted to saying fuck you. The Administrator refused to answer if he had reasonable suspicion on whether SA said fuck you to Resident #1. The Administrator stated that verbal abuse of this nature does not reach the threshold of needing to call the police. The Administrator stated that the resident never voiced any concerns about SA still working at the facility. The Administrator stated that this incident did not violate Resident #1's rights because she could have waited a few minutes for her cigarette. The Administrator stated that he did not know if SSD did wellness checks on Resident #1 after the incident. In an interview with the SSD on 08/08/2024 at 1:20 PM, the SSD stated approximately two weeks after SA was suspended where Resident #1 saw SA painting the doors near Resident #1's room. SSD stated that Resident #1 was upset at that time, but SSD calmed Resident #1 down and let Resident #1 know that SA would finish his work soon. SSD stated that was the only incident she was aware of involving Resident #1 and SA after the incident on 04/29/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON on 08/08/2024 at 1:25 PM, the DON stated that she talked with Resident #1 a few weeks after the incident and Resident #1 expressed concerns about SA still working in the facility. The DON stated that she reported this to the Administrator and SSD. Record review of the Time Card Report for SA revealed that on the day of the incident, 04/29/2024, SA clocked out at 2:44 PM. The Time Card report revealed that on the day after the incident, 04/30/2024, SA worked from 7:01 AM to 7:16 PM with a break from 11:57 AM to 12:37 PM. Record Review of the facility's undated policy titled Abuse Prevention defined Verbal Abuse as The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Following that, in the section titled PROCEDURE: STEPS TO PREVENT, DETECT AND REPORT: SCREENING: #3 stated It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment. Record review of the facility's policy titled Statement of Resident Rights dated 07/20/2015 stated under the DIGNITIY AND RESPECT section You have the right to: Be free from abuse, neglect, and exploitation. Be treated with dignity, courtesy, consideration, and respect. Record review of the facility's abuse and neglect in-service dated 08/08/2024, 08/09/2024 reflected all staff in attendance. Record review of the facility's customer service, resident rights, respecting resident wishes in-service dated 08/10/2024 reflect all staff in attendance. Record review of the facility's Abuse Prevention policy and procedure undated. Record review of the facility's resident safe surveys, including Resident #1, dated 08/09/2024 were reviewed and reflected residents felt safe in the facility environment. 50039

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety 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** 44748 Based on record review and interview the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation for 1 of 5 residents (Resident #1) reviewed for neglect and abuse. The facility failed to report verbal abuse by the SA to local law enforcement in accordance with state law on 04/29/24 The non-compliance for Resident #1 was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 04/29/2024 and ended on 04/29/2024. The facility corrected the non-compliance before the investigation began. This failure could place residents at risk of continued victimization, abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life. Findings included: Record review of the undated facility Abuse, Neglect, and Exploitation policy stated the facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Definitions: b). Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. Procedure: A. Steps to prevent, detect, and report: Screening: Suspected or substantiated cases of resident abuse, neglect, misappropriation of property, or mistreatment shall be thoroughly investigated, documented, and reported to the physician, families, and or representative, and as required by state guidelines. In addition, the facility will follow Section 1150B of the Social Security act's time limits for reporting a reasonable crime (immediately but no later than 2 hours if serious bodily injury and 24 hours for all others) In addition to reporting to the state agency, a reasonable suspicion of crime or allegation of abuse, neglect, or misappropriation of resident property is to be reported to at least one law enforcement agency. Record review of the facility policy reference to Section 1150B of the Social Security Act: Guidance for Reporting Suspicion of a Crime. Section 1150B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), requires specific individuals in applicable long-term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility to State Survey Agencies and Law Enforcement. Record review of Resident #1's face sheet revealed a [AGE] year-old female with diagnoses including diabetes, neuropathy, rheumatoid arthritis, heart disease, chronic skin infections, anxiety, left below the knee amputation. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's MDS Quarterly dated 05/28/24 revealed Resident #1 had a BIMS Score of 15 indicating no cognitive impairment and needed little to no assistance with all ADLs. Record review of the provider's investigation dated 05/01/24 described on 04/28/24, the smoking attendant became upset with Resident #1 and cursed at her twice telling her Fuck You each time during a smoking break. There was a total of 4 residents who attested to, witnessed, and confirmed the incident. The provider investigation included Penal Code Title 9 Ch. 42 Sec. 42.01 Disorderly conduct (a) a person commits an offense if he intentionally or knowingly: (1) uses abusive, indecent, profane, or vulgar language in a public place, and the language by its very utterance tends to incite an immediate breach of the peace (a-1) (d) An offense under this section is a class C misdemeanor. There was no Case # and local law enforcement were not contacted. There was a signed 1:1 Teachable Moment dated 04/29/24 between the ADM and the SA. The employee was suspended initially and in-serviced on the importance of respecting the residents. The details revealed the employ was in the smoking area and cussed at one of the residents. The SA was not available for interview. Record review of 1:1 in-service titled, Abuse Prevention, Abuse & Neglect Facility Policy, specifically verbal abuse reflected the in-service was conducted by the ADM with the SA on 04/28/24 and signed in ink by both. Record review of the SA's time sheets dated 03/21/24-07/10/24 documented he was sent home on 04/29/24 at 2:44 pm. He returned to work on 04/30/24 from 7:01 am-7:16 pm. The record showed he worked Tuesdays, Thursdays, and Saturdays regularly and occasionally on a Monday or Friday. The SA was never suspended for his verbal abuse, he was only sent home early as reflected on his time sheets In an interview with Resident #1 on 08/07/2024 at 9:48 am she stated the SA specifically said, fuck you and she asked him, what did you say to me? and he said it again, louder. Resident #1 stated this happened on the smoking patio and lots of other people were out there. She stated she reported it immediately to the SW who sent her to the ADM, and she told him about the incident. She stated, First the SW and DON told her they fired him (the SA), then suspended him, but then he was back. Resident #1 stated, Since then, he (SA) either quit or got fired probably 3-4 weeks ago. She said did not speak to him, nor him to her when he came back. She stated she saw him around 3-4 times, and became very anxious each time. She said seeing him would ruin her day. She said she did not know what she was afraid of but felt unprotected. She said she spoke with the SW and asked the ADM why the SA was still around. She said she asked to see the report he (the ADM) sent because he had gone back & forth with her about when & if he called the state. Resident #1 stated the ADM told her if she kept causing trouble, she could find herself on the street. She stated HR had joined their conversation and told her, The state had more to worry about than her. She stated the ADM was not joking with her and had raised his voice to her. In an interview with HR on 08/07/2024 at 11:09 am she stated she (Resident #1) came to me about the smoke guy (SA) and said, who the F was I to let this MF clean the patio when we trying to smoke. HR stated she had never had any situations with the SA, that he was a good guy. HR stated the SA just stopped coming to work on July 10, 2024, and that was the day she terminated him. She stated she tried to call him, but he never answered her calls. HR stated the SA came to pick up his check and he told her his truck broke, and that was that. She stated the ADM had to tell Resident #1 she could not speak that way to them. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the ADM on 08/07/2024 at 11:34 am he stated he was not at the facility during the first encounter Resident #1 had with HR because he was at lunch. He stated Resident #1 wanted to speak to him in his office and she said she told the SA he should not be doing that (washing the smoking patio) right then and that he (the SA) cursed at her. The ADM stated he suspended the SA immediately then reported it to the state for verbal abuse. The ADM stated the SA was allowed to return after his suspension and was moved to a different role (light maintenance and painting) so he would not have any contact with Resident #1. The ADM stated the SA ended up leaving/quitting. In an interview with Resident #1 on 08/08/24 at 9:41 am, she stated that she felt embarrassed and anxious because she did not like being talked to by the SA in such a negative way in front of other residents. She stated that she felt fear and anxiety seeing him (the SA) around the facility after the incident. The resident stated that when they did not get rid of him right away, she felt like the facility did not care to protect her. In an interview the ADM on 08/08/24 at 10:53 am, he stated, The findings were inconclusive because the man (SA) never admitted to saying fuck you to the resident. He said signing the 1:1 was not an admission of guilt, it only meant he received the 1:1 training. The ADM repeated that the SA never admitted to it. He said a teachable moment (the 1:1 training) was just a record of a verbal reprimand. The ADM said there was no policy that stated what the punishment was for abusing a resident. The ADM said his conclusion of his investigation was inconclusive. He stated the allegation met the definition of verbal abuse, but his findings were inconclusive. The ADM refused to answer whether the incident had reasonable suspicion of a crime (verbal abuse) if the smoking attendant said fuck you to the resident. The ADM stated, In my opinion verbal abuse does not reach the threshold of needing to call the police (meaning he did not notify local law enforcement). If you want to get me for not following my policy, then that is fine. The ADM stated he did not know if the social worker did wellness checks on Resident #1 after the incident. In an interview with the DON on 08/08/24 at 1:25 pm, she stated she talked with Resident #1 a few weeks after the incident, and she was concerned about the SA still working in the facility. She stated, I eased her concerns and said he would not bother her. I reported this to the administrator and the social services director. She stated she did not know if the ADM or SW spoke to Resident #1. In an interview with the ADM on 8/9/24 at 4:00 PM, he stated, The SA was suspended for 3 or 4 days, then he had some days off behind it, making it seem longer. The ADM had no comment regarding the SA's timesheets. Record review of the facility's abuse and neglect in-service dated 08/08/2024, 08/09/2024 reflected all staff in attendance. Record review of the facility's customer service, resident rights, respecting resident wishes in-service dated 08/10/2024 reflect all staff in attendance. Record review of the facility's Abuse Prevention policy and procedure undated. Record review of the facility's resident safe surveys, including Resident #1, dated 08/09/2024 were reviewed and reflected residents felt safe in the facility environment.

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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** 47371 Based on observation, interview and record review, the facility failed to securely store all drugs and biologicals in locked compartments under proper temperature control, and permit only authorized personnel to have access to keys in that: An unknown nurse left Resident #2's discontinued medication in a clear bin, affixed to the ADON's office door, which left it easily accessible to all mobile residents and visitors. These deficient practices could affect residents with medications and could result in missing or misuse of drugs by unauthorized personnel. The findings included: Record review of Resident#2's Face Sheet dated 07/29/2024 revealed, Resident #2 was admitted on [DATE], and was a [AGE] year-old female with diagnoses of dementia (cognitive impairment), cellulitis (tissue inflammation infection), history of urinary problems, and acute cystitis without hematuria (inflammation of the bladder without blood in urine). Record review of Resident #2's MAR dated July 2024, revealed Resident #2 for a URI (Upper Respiratory Infection) received 2 Azithromycin Z-pack (an antibiotic) 250mg tablets on 07/26/2024, followed by 1X250mg tablet daily for 4 days. Record review of Resident #2's physician order dated 07/26/2024 revealed, Azithromycin 250mg tablets. Take (2) tablets by mouth today (now, 7/26/24), then 1 tablet daily for 4 days. During an observation on 08/02/2024 at 12:36PM, on the 2500 Hall, on a door labeled Assistant Director of Nurses was a clear bin with initially, unknown red colored medications. Upon further inspection there was a label with Resident #2's name on the top of the blister pack followed by date 07/26/24, name of the medication Azithromycin 250MG tablet, with instructions that stated take (2) tablets by mouth today (now) then 1 tablet daily for 4 days. During a brief interview on 08/03/2024 at 12:38PM the administrator was walking down the 2500 Hallway, and was directed to observe a clear bin, filled with one medication, attached to the ADON's office door. The administer was questioned why the initially unknown medication, was placed in a clear bin, attached to the ADON's door. The administrator responded by asking the same question to the ADONs, ADON A and ADON B. Both ADONs responded that the blister pack in question was supposed to be empty, but upon their further inspection they stated the medication had been completed but the remaining medication was not supposed to be left on the door for easy resident access. Both ADONs stated any blister pack that has medications is supposed to be in a locked box. All three staff members quickly removed items from the clear bin. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/03/2024 at 12:46PM ADON A stated an unknown nurse placed Resident #2's medication filled blister pack in the clear box attached to the ADON's door. ADON A stated the expectation of the facility is for nurses to put empty blister packs on the ADON's door, and then the ADONs will pick up those empty cartridges and discard appropriately. ADON A stated any medication blister packs that are not empty must be kept within the locked narcotic box, which will be retrieved by the ADONs/DON the following day to be properly destroyed. ADON A stated she did not know how long the medication was within her clear bin, nor did she know that the medication was in the box prior to being notified. ADON A stated medications should not be left unattended nor accessible to residents. ADON A stated the medications in question should not have been left on the ADON's door but should have been secured/locked within the narcotic box. ADON A stated somebody could have accessed those unattended medications and consumed them. ADON A stated there are many mobile residents on the second floor. ADON A stated some of the mobile residents have cognitive impairments and could have consumed the medication without fully understanding what they were consuming. ADON A stated both floor/levels of the facility, have residents with dementia and cognitively impaired residents. ADON A stated if a resident consumed any non-prescribed medication a resident could potentially develop an adverse respiratory reaction which could lead to stricture of breathing, or anaphylactic shock, which could affect residents negatively. ADON A stated additional adverse reactions would include rashes, nausea, and vomiting. ADON A stated in conjunction with ADON B and the DON, she facilitated a discontinue blister pack in-service on 08/2/24. During an interview on 08/03/2024 at 2:02PM ADON B stated she could never figure out who left the medication in the clear bin attached to the ADON's office door. ADON B stated the expected process for medications remaining in the blister packs is for them to be kept within the secured/locked narcotic box, followed by either the ADONs or DON retrieval and proper destruction and disposal. ADON B stated the medication in question, should never have been left in the clear bin accessible to all residents. ADON B stated there is a lot of foot traffic on the second floor/level including cognitively impaired residents. ADON B stated potentially a resident could have consumed the non-prescribed medication and could have ended up having an anaphylactic reaction, which could have led to hospitalization , or worse, death. ADON B stated the clear bin has been removed from the door. ADON B stated in conjunction with ADON A, both began a medication storage in-service on 08/03/2024 and are 90% completed. ADON B stated on 08/02/2024, she began in-services regarding antibiotics that need to be disposed, are left in the narcotic box. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455557	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Palms Nursing & Rehabilitation	5607 Everhart Rd Corpus Christi, TX 78411

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/05/2024 at 5:00PM DON stated the medications that were observed on 08/02/2024 should not have been placed in the attached clear bin located on the ADON's office door. The DON stated keeping medications unattended is not allowed and is unacceptable. The DON stated in a collaborative effort with the ADONs, she checks the narcotic boxes daily for any medication that is needing to be destroyed and disposed of. The DON stated medications are supposed to be kept within a locked box or medication room but should never be accessible to residents. The DON stated once she was aware of the easily accessible medication issue, she advocated for the immediate removal of the clear bin. The DON stated it really bothered her. The DON stated if a person consumes non-prescribed medications the residents could potentially experience an allergic reaction with adverse symptoms like vomiting, headaches, and dizziness, which would necessitate immediate life-saving interventions. The DON stated it could also affect the respiratory system like shortness of breath, stricture of airway, or cessation of breathing. The DON stated the facility is very busy and has a lot of foot traffic daily, including resident movement. The DON stated she has been employed with the facility for roughly 3 months. The DON stated this situation should not have occurred. The DON stated the ADONs are currently in-servicing all clinical staff regarding medication storage and medication disposal procedures. Record review of Discontinued Blister Packs (Narcotics/Antibiotics) in-service dated 08/02/2024 documented, all nurses please put all discontinued empty narcotics blister packs and sheets inside the container at the nurses' station. ADON's will pick them up every morning. Do not put antibiotics in there if they still have pills left. Leave in narcotic box and we will get them out when we come in. Only empty blister packs in the container. Do not put on Manager's doors anymore. Record review of the facility's Medication-discontinued medication/destruction of drugs policy effective date 01/2008 and revision date 11/2013 documented, 1. When a medication has passed its expiration date or is otherwise deteriorated, or has been discontinued, or for a resident no longer a resident at the home, it should be removed from the medication cart as soon as possible and accounted for and kept under lock and key in the medication room.

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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** 47371 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection for one (Resident #3) of five residents reviewed for infection control, in that: 1. CNA A did not perform hand hygiene during Resident #3's perineal care. 2. CNA A did not perform under foreskin cleansing care of Resident #3's penile area. These failures could place residents at risk for contamination and infection. The findings included: Record review of Resident #3's Face Sheet dated 07/22/2024, originally admitted on [DATE] and readmitted on [DATE], documented a [AGE] year-old male with the following diagnoses of: dementia (cognitive impairment), Acute upper respiratory Failure (serious condition that causes fluid to build up in lungs), and personal history of urinary tract infections. Record review of Resident #3's Face Sheet dated 07/22/2024, originally admitted on [DATE] and readmitted on [DATE], documented a [AGE] year-old male with the following diagnoses: dementia (cognitive impairment), Acute upper respiratory Failure (serious condition that causes fluid to build up in lungs), and personal history of urinary tract infections. Record review of Resident #3's Quarterly MDS assessment dated [DATE], documented a Brief Interview for Mental Status score of 3/15 which means severe cognitive impairment, as well as dependent of staff assistance for all activities of daily living. Record review of Resident #3's Care Plan, start date 10/29/2022, revealed Resident #3 has uninhibited (without restraint) bowel and bladder and is dependent on staff for monitoring and management of incontinent episodes and care needs. He has history of nocturia (urinating at night) and UTI and is at risk for UTI. Potential for constipation. Diagnoses : BPH without lower Urinary Tract symptoms. Interventions: check on resident at routine intervals to assess needs and offer assist with toileting task. Resident is dependent X1 staff for toileting tasks, incontinent care. Ensure clothes and linen are clean, and dry, change PRN. Provide incontinent care promptly when found wet or soiled. Monitor for S/S of UTI. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/03/2024 at 11:21AM the DON was conducting her own observation concurrently. CNA A knocked, walked into the room, performed hand hygiene for 42 seconds, and applied clean gloves. CNA A then lifted Resident #3's gown, removed Resident #3's brief (no hand hygiene observed after touching two separate surfaces). CNA A removed contaminated gloves and applied a new set of clean gloves (no hand hygiene performed amidst the glove change), followed by retrieving wipes, cleaned the outer penile area but did not clean under Resident #3's penile foreskin. CNA A proceeded to remove contaminated gloves, applied new gloves (no hand hygiene observed), and turned Resident #3 onto his right side. CNA A then cleaned gluteal area with clean wipes (no hand hygiene performed when Resident #3 was turned). During the observation, while CNA A was performing perineal care to Resident #3, no observable form of hand hygiene was performed during care, and additionally, there was no observed cleansing of under foreskin care. During an interview on 08/03/2024 at 11:36AM CNA A stated she worked weekends and has been with the facility for 6 weeks. CNA A stated she was still acclimating to the facility. CNA A stated she typically follows the facility's guidelines regarding perineal care, which includes utilizing ABHR during perineal care. CNA A stated she was instructed, upon hire, during her new hire orientation competency, to utilize ABHR during each glove change and when moving from a clean area to dirty area. CNA A stated she typically will retract the penile foreskin to cleanse the area but did not complete during Resident #3's care, for the reason that she did not want to hurt Resident #3. CNA A proceeded to state she would usually retract the penile foreskin to mitigate bacteria buildup that potentially may cause infection. CNA A stated she did possess ABHR but it remained in her pocket as she did not want to retrieve from her pocket with her contaminated gloves, and stated she usually will use ABHR with each glove change. CNA A stated ABHR is used to minimize microorganisms from causing infections. CNA A stated by not performing hand hygiene and thorough penile care Resident #3 could have been exposed to microorganisms including fungi, which could cause UTIs. Additionally, CNA A stated by not retracting Resident #3's foreskin, there potentially could be a skin breakdown. However, reiterated this was an isolated event, and normally performs thorough perineal cleansing. During an interview on 08/03/2024 at 12:33PM and on 08/05/2024 at 5:00PM collaboratively ADON A and DON stated CNA A should have pulled back the foreskin to clean the penile area thoroughly as it is a measure of preventing infection. ADON A stated CNA A only does weekends however that is not an excuse. Both ADON A and DON stated after CNA A touched potential contaminated surfaces, CNA A should have completed hand hygiene, as well as when turning Resident #3, and when cleaning from clean to dirty, CNA A should have changed gloves and applied ABHR. ADON A stated CNA A was given a competency checkoff prior to being allowed to work independently. ADON A stated there was a check off for perineal care. Both stated by not performing hand hygiene nor thorough penile care, Resident #3 could have contracted an infection, respiratory issues (including pneumonia), or UTIs. Both stated UTIs can affect the elderly population negatively. Both stated they have commenced a hand hygiene in-service on 08/03/2024 once the issue was recognized. The DON stated while concurrently conducting her observation on 08/03/2024 at 11:21am, she stated she witnessed CNA A did not retract Resident #3's foreskin but did not verbalize any instruction to CNA A due to not wanting to make CNA A nervous. The DON stated she would have also inquired about CNA A not using her ABHR during Resident #3's perineal care but did not due to not wanting to make CNA A nervous. Record review of the facility's Infection Control policy dated 11/28/2022 documented Employees are required to use appropriate handwashing after each direct resident contact when handwashing is indicated by accepted professional practice. Require staff follow hand hygiene practices consistent with accepted standards of practice. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's competency skills check off dated 07/03/2024 documented CNA A had completed incontinent care checkoff. Record review of the facility's Incontinent perineal care checkoff form undated, for male: 1. Retract foreskin of the uncircumcised penis .7. Instruct and assist resident to turn on their side.8. Discard soiled gloves, sanitize hands and apply clean gloves; additionally, discard diaper and used supplies, remove gloves and apply clean gloves, apply clean brief, make resident comfortable. Record review of the federal government's agency CDC Guidelines, entitled Clinical Safety: Hand Hygiene for Healthcare Workers, dated 02/27/2024 revealed, know when to clean your hands, immediately before touching a patient. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient, or patient's surroundings. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal.