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	04/17/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure the safe and orderly discharge for one (Resident #1) of four residents. Based on interviews and record review, the facility failed to ensure the safe and orderly discharge for one (Resident #1) of four residents. The facility (Facility A) failed to plan a coordinated discharge and returned Resident #1 back to the discharging facility (Facility B) on the same day. This failure placed Resident #1 in the hospital due to the original discharging facility not accepting the resident. Findings included: Record review of Resident #1's Face sheet dated 4/10/2025 indicated Resident #1 was a [AGE] year old who was admitted with diagnosis of Autistic Disorder (a neurodevelopmental disorder characterized by repetitive, restricted, and inflexible patterns of behavior, interests, and activities, as well as difficulties in social interaction and social communication), Epilepsy (a brain disorder characterized by recurrent seizures, which are episodes of abnormal electrical activity in the brain), Dysphasia (difficulty with swallowing foods or liquids), and Cognitive Communication Deficit Disorder (a type of communication impairment where difficulties arise due to problems with cognitive processes, rather than speech or language production itself). A quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS (Brief Interview for Mental Status) of 99 which indicated severe cognitive impairment and also indicated the resident could not complete the interview. The section GG (Functional Abilities) indicated Resident #1 independently walked and transferred himself but needed assistance with toileting and showering himself. Record review of Resident #1's care plan, undated, revealed, Resident #1 had behavior problems. The care plan indicated Resident #1 was sexually inappropriate with female staff and continually tries to reach for female staff as they passed by the resident. (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #1's progress note dated 3/19/2025 indicated Resident #1 had an increase in dosage of his medication. The progress note indicated the medication Provera was increased from 10 mg to 15 mg by mouth 1 time per day for the diagnosis of Paraphilia (an intense or recurring sexual arousal from atypical situations). During an interview on 4/12/2025 at 3:51 p.m., the DON stated Resident #1 was admitted to Facility A on 4/11/2025. The DON stated upon admission Resident #1 did not have any of his medications, he did not have any paperwork to include a medication list, the resident was soiled and brought no personal clothing items with him upon admission. The DON stated after setting the resident up in his room Resident #1 started trying to sexually grope the female staff. The DON stated the facility in which the resident was discharged from did not communicate Resident #1's behavior issues of sexual inappropriateness (this diagnosis was not in the list on the face sheet). The DON stated this was when Facility A became unable to care for the resident or to meet the needs of the resident. The DON stated she was informed Administrator A called the facility where Resident #1 was discharged and made them aware Facility A would be returning the resident to their facility (Facility B). The DON was informed that the Administrator at Facility B was not going to readmit Resident #1, but after contacting the local Ombudsman, Facility A was told Facility B would have to readmit Resident #1. During an interview on 4/12/2025 at 4:03 p.m., Administrator A at Facility A stated after finding out Resident #1 was sexually deviant and grabbed private parts of the staff he contacted the local Ombudsman. Administrator A stated he was informed Facility A could return Resident #1 back to the facility he originated. Administrator A stated the Ombudsman informed him the admitting facility had three to five days to make this transfer back to the other facility due to Facility B not communicating the behaviors of Resident #1 and the condition the resident was in when admitting to Facility A (no medications, no medication list, and no clothing). Administrator A stated he called the other facility and made them aware they would be transporting Resident #1 back to their facility. Administrator A stated staff at Facility B informed him they would not be accepting Resident #1 back at their facility and they would call the police. Administrator A informed the staff at Facility B they lied to Facility A and put their staff in danger and informed Facility B Resident #1 was already in route to Facility B. During an interview on 4/17/2025 at 12:38p.m., LVN A stated Resident #1 was admitted to Facility A on 4/11/2025 during her shift. LVN A stated she was calling for report from Facility B when Resident #1 arrived at the facility with no medications, no medication list, no personal items, and was soiled. LVN A stated, Resident #1 reached out and grabbed my bottom while bent over the medication cart and Resident #1 was also making sexual gestures towards other people in the area. During a review of email correspondence on 4/15/2025, the local Ombudsman stated, I do not represent the facility but the resident. The Ombudsman also communicated that he (Administrator A) should have consulted with his legal team regarding the discharge of Resident #1. During an interview on 4/16/2025 at 1pm, Resident #1's family member stated she was aware the discharge occurred on Friday (4/11/25), but the discharge was very rushed from Facility B to Facility A. She also stated the discharge from Facility A to Facility B was rushed as it occurred the same day, which caused her family member to be placed in the hospital because he had nowhere to go. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/25 at 2:40p.m., Administrator B from Facility B stated, Facility A did transfer Resident #1 back to the facility, but due to informing Administrator A that Resident #1 would not be readmitted to the facility, the police and Adult Protective Services (APS) were contacted. Administrator B stated APS instructed Facility B to take the resident to the hospital due to not having placement for Resident #1. Record review of facility's Transfer and Discharge policy dated 3/2012 stated, written notice will be given to Resident/Responsible Party for all planned discharges and transfers. Exceptions to the 30-day requirement apply when the transfer or discharge is effected because: the residents welfare and needs cannot be met in the facility, resident no longer needs services provided by the facility, the resident is endangering the safety of other persons in the facility, the resident is endangering the health of other individuals in the facility, the resident fails to pay for goods and services provided by the facility after reasonable and appropriate notices have been provided, the facility ceases to participate in the program that pays for the resident's care, or a resident has not resided in the facility for 30 days. The facility's Transfer and Discharge policy also included verbiage stating, documentation of the reason for transfer or discharge and the necessity for the resident's welfare and the needs that cannot be met in the facility, and the service available to meet the needs will be documented in the resident's medical record. And in exceptional cases a notice must be provided to the resident, the resident's representative if appropriate, and the Long-Term Care Ombudsman as soon as practicable before the transfer or discharge.