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	06/26/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents were treated in a respectful manner that maintained or enhanced each resident's dignity for 1 (Resident #3) of 6 residents reviewed for dignity. The facility failed to treat Resident #3 with dignity and respect during a post-fall assessment by RN D in Resident #3's room on 05/16/25. RN D asked Resident #3 in a stern tone What is wrong with you and Do you want to break something while Resident #3 was still on the floor post-fall. This failure could place residents who require assistance from nurses at risk of feeling disrespected. Findings included: Record review of Resident #3's face sheet dated 06/19/25 revealed a [AGE] year-old female with an initial admission date of 04/18/25 and a discharge date of 06/19/25. Pertinent diagnosis included Depression. Record review of Resident #3's Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 13 (cognition intact). Record review of Resident #3's comprehensive care plan reviewed with no related information. During an observation of a surveillance video at 8:30 AM on 06/25/25 from Resident #3's room with a timestamp dated 05/16/25, RN D was observed speaking loudly at Resident #3 while she was on the floor next to her bed after an apparent unwitnessed fall. RN D was heard on the video stating What is wrong with you? and Do you want to break something? while Resident #3 lay on the floor next to her bed. In an interview with ADON-A at 5:38 PM on 06/25/25, ADON-A stated it was important to treat a resident with respect and dignity so they feel like the facility can be their home. ADON A stated Resident #3 was not treated with dignity, respect, consideration, or courtesy after her fall on 05/16/25. ADON-A stated it was important to always treat residents with patience and kindness, otherwise they could experience emotional harm. (continued on next page)

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

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	06/26/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADM at 4:51 PM on 06/26/25, the ADM stated it was important to treat the residents the same way you would want to be treated. The ADM stated the residents have the rights to be treated with dignity and respect. The ADM stated berating a resident after a fall was not treating them with consideration or courtesy. The ADM stated he was not aware of the video until it was brought to his attention by this state surveyor. The ADM stated RN D was fired not long after the incident in the video for her behavior, mannerisms, and lack of tact. The ADM stated residents could experience mental anguish leading to physical symptoms if they were not treated properly. In an interview with the DON at 5:06 PM on 06/26/25, the DON stated it was important to always treat residents with respect, dignity, consideration, and courtesy. The DON stated nurses should treat others as they would like to be treated. The DON stated a resident could get depressed and experience mental anguish if they were treated inappropriately by staff. Record review of the Facility admission Packet last updated 07/20/15 stated You have the right to be treated with dignity, courtesy, consideration, and respect.

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	06/26/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have evidence that all alleged violations were thoroughly investigated and measures were taken to prevent further potential abuse, neglect, exploitation or mistreatment in accordance with State law, and if the alleged violation was verified appropriate, corrective action must have been taken for 1 (Resident #1) of 5 residents reviewed for abuse, neglect, and/or misappropriation. The facility failed to do a thorough investigation to include interviewing the victim (Resident #1) in the incident, the victim ' s RP, as well as other residents which may have been involved in the incident. This failure placed residents at risk of not having their allegations investigated thoroughly or timely. The findings included: Record review of Resident #1 ' s face sheet dated 11/29/2024 revealed a [AGE] year-old female with an admission date of 07/16/2024. Diagnoses included End Stage Renal Disease (last stage of kidney failure), Anxiety, Type 2 Diabetes (chronic condition which occurs when the body cannot use insulin effectively), and Depression. Record Review of Resident #1's annual MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 15, which revealed intact cognition. Record Review of the PIR completed on 11/21/2024 revealed an incorrect narcotic count of Resident #1 ' s Clonazepam 0.125 MG (a medication used to treat seizure disorders and panic disorder) on 11/21/2024 at 8:30 AM. The controlled medication count revealed 11 missing tablets. Incorrect count was identified when oncoming LVN-B counted with off-going LVN-A. Both LVN-A and LVN-B were interviewed and denied taking the pills. ADON-A recounted and determined 11 tablets were missing. According to the PIR, both LVN-A and LVN-B stated the count was correct the previous night when oncoming LVN-A counted with off-going LVN B. Both nurses were suspended pending investigation, with LVN-B ultimately being fired for other reasons. Record review of Resident #1 ' s physician orders revised 02/05/2025 revealed Clonazepam 0.125 MG, give 1 tablet twice per day. In an observation on 06/25/2025 at 6:25 AM revealed off-going LVN-A and on-coming MA-F counted controlled medications whereas MA-F would actually count the medications, but LVN-A just looked to verify the count on the controlled medication sheet was correct. LVN-A was not actually watching MA-F count the medications, and MA-F was not actually looking at the sheet to verify it was correct. (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	06/26/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with ADON-A on 06/24/2025 at 2:25 PM she stated she was informed of the drug discrepancy on the morning 0f 11/21/2024 and recounted the medications herself. She stated there were 11 missing Clonazepam when she counted, and they were never recovered. She stated in house drug screens were completed, and both nurses were suspended pending investigation results with LVN-B ultimately being fired for other issues. She stated both nurses were interviewed at the time of the investigation, but no one else was interviewed at that time. She stated neither Resident #1 nor her RP was notified interviewed for this investigation. In an interview with the Administrator on 06/24/2025 at 3:16 PM he stated the count was wrong with 11 controlled medications missing on the morning of 11/21/2024, so an investigation was started. He stated the nurses involved were drug tested and suspended pending investigation. He also stated the nurses were interviewed, but no one else was interviewed at the time of the investigation because he did not see any need to involve anyone else. In an interview with LVN-A on 06/24/2025 at 4:23 PM she stated she was the off-going nurse the morning the controlled medication count was off. She stated she was interviewed, a drug screen was done, and she was suspended pending investigation. In an interview with Resident #1 on 06/24/25 at 4:50 PM she stated she remembered when her medication went missing in November of 2024 because she heard the nurses talking about it, but she stated she was never interviewed or questioned about the missing medication or if she had received or missed any of her medication. She denied ever missing any doses of her medication or any increased anxiety. In an interview with LVN-A on 6/25/25 at 6:35 AM stated she was usually here until 7:00 AM, but sometimes the nurses or medication aides came in early, so they went ahead and counted early. LVN-A stated if she was the one off-going she looked at the count sheet to make sure it was correct, and the one who was on-coming actually counted the controlled medication, and they did not typically double check if the other was correct or telling the truth. LVN-A stated she had never been told to do the count any other way, but she saw how not verifying the count was correct could be a cause for concern because medications could be missing or stolen if the count was not correct. She also stated she gave the medication during her shift, she did not technically perform a count after the medication was given but waited until the end of her shift to count. She denied taking any of the controlled medications. In an interview with the DON on 06/25/2025 at 9:00 AM she stated on the morning of 11/21/2024 she, along with the ADONs, did a re-count of the controlled substances and found Resident #1 ' s Clonazepam 0.125 MG was missing 11 tablets. She stated both LVN-A and LVN-B were interviewed, drug tested and suspended pending investigation. She stated no residents or RPs were contacted or interviewed for this investigation. (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	06/26/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with ADON-A on 06/26/2025 at 4:55 PM she stated the facility could have and should have done more with the investigation of the missing controlled medications. She stated no resident or RP interviews were done until yesterday (06/25/2025). She stated they interviewed Resident #1 as well as other residents with high BIMS scores to determine if they were getting their medications as ordered and scheduled, and all residents stated they were. She also stated they did not notify Resident #1 ' s RP until two days ago (06/24/2025). She stated they should have interviewed Resident #1 when the controlled medication went missing, as well as interviewed residents which were on the same type of medication as the one that went missing. Record review of Resident Rights, date unknown, revealed (c) the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, and misappropriation of resident ' s property. (3) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. Record review of the facility ' s How to Conduct an Investigation policy, dated 04/2012, revealed 6. Interview all potential witnesses. Statements will be taken in anticipation of litigation. 8. Identify who the alleged victim is, who witnessed the incident, who may have information related to the incident.

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	06/26/2025

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 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** Based on observations, interviews, and record reviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (Resident #3) of 6 residents reviewed for quality of care. The facility failed to enforce the post-fall assessment policy leading to Resident #3 being moved after a fall prior to checking her vital signs and neurological status on 05/21/25. The failure could affect residents currently residing in the facility, resulting in not receiving needed care to maintain optimal health and placing them at risk for injury or deterioration in their condition. The findings included: Record review of Resident #3's face sheet dated 06/25/25 revealed a [AGE] year-old female with an initial admission date of 04/18/25 and a discharge date of 06/19/25. Pertinent diagnosis included Depression and Muscle Wasting and Atrophy, Record review of Resident #3's Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 13 (cognition intact). Record review of Resident #3's comprehensive care plan dated 05/12/25 revealed the resident posed a risk for potential injuries from falls. Interventions listed to prevent injuries from falls were to place articles I need within my reach, remind/encourage me to use call light for assistance, Provide me with a low bed. Keep the bed in low position whenever I'm in bed, Place fall mats on floor at my bedside, and Refer me to therapy so they can re-screen me. During an observation of a surveillance video at 8:45 AM on 06/25/25 from Resident #3's room with a timestamp dated 05/21/25, Resident #3 was observed falling in her room with no staff around. LVN E was observed on video entering the room and briefly checking on the resident for 45 seconds before supervising her movement from the floor too her bed. LVN E was observed not performing vital signs checks or neurological status checks on Resident #3 before moving her into her bed. In an interview with ADON-A at 5:38 PM on 06/25/25, ADON-A stated when a resident had an unwitnessed fall, it was important to follow the proper post-fall procedure to ensure the resident was not harmed further. ADON-A stated the resident's vitals (blood pressure, oxygen saturation, temperature, and pulse) and neurological status should be checked prior to moving the resident. The ADON-A stated LVN E did not assess Resident #3's vitals or neurological status before moving Resident #3 back to her bed after her fall on 05/21/25. ADON-A stated the facility policy was not followed in this instance. (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	06/26/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN E at 6:31 PM on 06/25/25, LVN E stated when responding to an unwitnessed fall of a resident, she would check their vital signs, ask them questions, check for trauma, check their range of motion, look for bleeding. LVN E stated she would determine if the resident was safe to move after performing her examination. LVN E stated she did not check the vital signs or neurological status of Resident #3 before moving her into her bed. LVN C stated Resident #3 was not on her hall the evening 05/21/25, so she was helping the other nurse because she was busy. LVN E stated she should have checked Resident #3's vital signs and neurological status before moving Resident #3 to her bed. LVN E stated it was important to check a resident's vitals and neurological status before moving them because they could be harmed further if they were moved prematurely. In an interview with the DON at 5:06 PM on 06/26/25, the DON stated when a resident had an unwitnessed fall, the nurse responding to the incident should perform a physical assessment on the resident before determining it was safe to move them. The DON stated a physical assessment included checking the resident's vital signs and neurological status. The DON stated it was important to check on the resident before moving them because they may be harmed further when moving them prematurely. Record review of the facility policy titled Falls - Evaluation and Prevention last revised 09/2014 revealed the following: .Evaluate the resident promptly in order to identify and treat injuries. The resident should not be moved until the licensed nurse has evaluated their condition, unless absolutely necessary. The evaluation should include vital signs and neurological status.

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	06/26/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #1) of 5 residents reviewed for pharmacy services. The facility failed to ensure LVN-A's medication cart on hall 300 contained an accurate count and record for Resident #1's Clonazepam 0.125 MG (a medication used to treat seizure disorders and panic disorder). This failure could place residents at risk for drug diversion and/or a delay in medication administration, as well as risk of not having allegations investigated throughly or timely. Findings included: Record review of Resident #1's face sheet dated 11/29/2024 revealed a [AGE] year-old female with an admission date of 07/16/2024. Diagnoses included End Stage Renal Disease (last stage of kidney failure), Anxiety, Type 2 Diabetes (chronic condition which occurs when the body cannot use insulin effectively), and Depression. Record Review of Resident #1's annual MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 15, which revealed intact cognition. Record Review of the PIR completed on 11/21/2024 revealed an incorrect narcotic count of Resident #1's Clonazepam 0.125 MG on 11/21/2024 at 8:30 AM. The controlled medication count revealed 11 missing tablets. The incorrect count was identified when oncoming LVN-B counted with off-going LVN-A. Both LVN-A and LVN-B were interviewed and denied taking the pills. ADON-A recounted and determined 11 tablets were missing. According to the PIR, both LVN-A and LVN-B stated the count was correct the previous night when oncoming LVN-A counted with off-going LVN B. Both nurses were suspended pending investigation, with LVN-B ultimately being fired for other reasons. Record review of Resident #1's physician orders revealed a revised active order for Clonazepam 0.125 MG revised on 02/05/2025. Record review of Resident #1's Individual Drug Administration Record revealed the Clonazepam 0.125 MG count at 9:00 PM on 11/20/2024 was 29, and on 11/21/2024 at 10:15 AM the count was 18. In an observation on 06/25/2025 at 6:25 AM revealed off-going LVN-A and on-coming MA-F counting controlled medications whereas MA-F would actually count the medications, but LVN-A just looked to verify the count on the controlled medication sheet was correct. LVN-A was not actually watching MA-F count the medications, and MA-F was not actually looking at the sheet to verify it was correct. (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	06/26/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with ADON-A on 06/24/2025 at 2:25 PM she stated she was informed of the drug discrepancy on the morning 0f 11/21/2024 and recounted the medications herself. She stated there were 11 missing Clonazepam when she counted, and they were never recovered. She stated in house drug screens were completed and both nurses were suspended pending investigation results with LVN-B ultimately being fired for other issues. She stated both nurses were interviewed at the time of the investigation, but no one else was interviewed at that time. She stated neither Resident #1 nor her RP were interviewed for this investigation. She denied anyone alleging abuse, neglect or misappropriation at that time. In an interview with the Administrator on 06/24/2025 at 3:16 PM he stated on the morning of 11/21/2024 the count was wrong with 11 controlled medications missing, so an investigation was started. He stated the nurses involved were drug tested and suspended pending investigation. He stated the nurses were interviewed, but no one else was interviewed at the time of the investigation because he did not see any need to involve anyone else in the investigation. He denied anyone alleging abuse, neglect or misappropriation at that time. In an interview with LVN-A on 06/24/2025 at 4:23 PM she stated she was the off-going nurse the morning the controlled medication count was off, but she stated the count was correct when she had come on shift the night before on 11/20/2024 and counted with LVN-B. She stated she was interviewed, a drug screen was done, and she was suspended pending investigation. Interview with Resident #1 on 06/24/25 at 4:50 PM she stated she remembered when her medication went missing in November of 2024 because she heard the nurses talking about it, but she stated she was never interviewed or questioned about the missing medication or if she had received or missed any of her medications. She denied ever missing any doses of her medication or any increased anxiety. In an interview LVN-A on 6/25/25 at 6:35 AM she stated she was usually here until 7:00 AM, but sometimes the nurses or medication aides came in early, so they went ahead and counted early. LVN-A stated if she was the one off-going she looked at the count sheet to make sure it was correct, and the one who was on-coming actually counted the controlled medication, and they did not typically double check the other was correct or telling the truth. LVN-A stated she had never been told to do the count any other way, but she saw how not verifying the count was correct could be a cause for concern because medications could be missing or stolen if the count was not correct. She also stated if she gave the medication during her shift, she did not technically perform a count after the medication was given but waited until the end of her shift to count. She denied taking any of the controlled medications. In an interview with LVN-B on 6/25/25 at 8:30 AM she stated she was the on-coming nurse on 11/21/2024 and counted around 7am. She stated she was the one who noticed the controlled medications were missing. LVN-B stated she was drug tested by the DON, and as far as she knew they were both fired because of the missing medication. She refused to accept the keys to the medication cart because the count was incorrect. In an interview with the DON on 06/25/2025 and 9:00 AM she stated on the morning of 11/21/2024 she, along with the ADONs, did a re-count of the controlled medications and found Resident #1's Clonazepam 0. 125 MG was missing 11 tablets. She stated both LVN-A and LVN-B were interviewed, drug tested and suspended pending investigation. She stated no residents or RPs were contacted or interviewed for this investigation. She denied anyone alleging abuse, neglect or misappropriation at that time. (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	06/26/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with ADON-A on 06/26/2025 at 4:55 PM she stated the facility could have and should have done more with the investigation of the missing controlled medications. She stated no resident or RP interviews were done until yesterday (06/25/2025) when they interviewed Resident #1 as well as other residents with high BIMS scores to determine if they were getting their medications as ordered and scheduled, and all residents stated they were. She also stated they did not notify Resident #1's RP until two days ago (06/24/2025). She stated they should have interviewed Resident #1 and her RP when the controlled medication went missing, as well as interviewed residents who were on the same type of medication as the one that went missing. She denied anyone alleging abuse, neglect or misappropriation at that time. Record review of the facility's Administering Medications policy, date unknown, revealed 13. During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide. Record review of the facility's Medication Storage policy, date unknown, revealed 7. Compartments (including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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	06/26/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure medical records were kept in accordance with professional standards and practices and were complete and accurately documented for 5 of 5 residents (Resident #1, Resident #2, Resident #5, Resident #6, and Resident #7) reviewed for accuracy of records. The facility failed to ensure Resident #1, Resident #2, Resident #5, Resident #6, and Resident #7 had documented Quarterly Elopement Assessments since January 2025. This failure could place residents at risk for improper care due to inaccurate or incomplete assessments and records. Findings included: Record review of Quarterly Assessments for sampled residents (Resident #1, Resident #2, Resident #5, Resident #6, and Resident #7) revealed no quarterly assessments had been completed since 01/16/2025. In an interview with ADON-A on 06/26/2025 at 10:00 AM she stated the Quarterly Elopement Assessments were typically completed either by the charge nurse or one of the ADONs. She stated the previous MDS nurse would create a calendar for when the Quarterly Elopement Assessments were due on each resident, but the previous MDS nurse was fired. She stated the new MDS nurse started in January 2025 and refused to create the calendar for the nurses because it was not her job. She stated the charge nurses and ADONs did not have time to create this calendar, so it was never created, and the elopement assessments were never completed. ADON-A also stated they were looking to hire a new MDS nurse and had discussed this situation with the quarterly assessment calendar and incomplete elopement assessments with the Administrator, so he was aware of the situation. She stated she realized this puts the residents at risk for elopement if they were not being evaluated and assessed properly. In an interview with the MDS nurse on 06/26/2025 at 2:50 PM she stated she started working at the facility in January 2025. She stated she had not created the calendar for the Quarterly Elopement Assessments for the nurses because it was not her job. She stated the nurses on the floor were the ones who did the assessments, so they should be creating their own calendars for the assessments since it was considered a nursing task. She stated the residents were probably not being assessed any longer for elopement since the nurses were not keeping up with when the quarterly assessments were due. In an interview with the DON on 06/26/2025 at 2:54 PM she stated the MDS nurse no longer created the Quarterly Elopement Assessment calendar. She stated nursing was supposed to be doing this since it was a nursing task, but she also stated she found out today nursing had not been doing this, so these assessments had not been completed. The DON stated this placed the residents at risk for elopement and inaccurate or inadequate care or treatment. Facility policy regarding Quarterly Elopement Assessments or Elopement Assessments requested on 06/26/2025 at 12:05 PM. Per the Administrator, the facility did not have a specific policy regarding Quarterly Elopement Assessments.