| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455557 | A. Building<br>B. Wing | 07/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Palms Nursing & Rehabilitation | 5607 Everhart Rd<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(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 |
|---|---|---|
| | | |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on interviews and record review, the facility failed to report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures by one staff member (the SW) of five staff members reviewed for reporting of abuse allegations. The facility failed to ensure the SW reported all suspected abuse or mistreatment when a handful of residents informed her RN F and RN G were being mean to them approximately between March and April of 2025. This failure could place residents at risk for physical, mental, and psychosocial harm. The findings include: In an anonymous interview, it was stated, night nurses RN F and RN G would yell at residents to go to bed and would yell at the residents to hurry up. RN F would yell at the residents saying, the call light is not a toy'. RN F made the residents feel scared to ask for help or use the call light. RN F would tell residents If I am investigated by HHS, they will believe me and not you because you have dementia. LVN E and SW were told about the mistreatment by RN F and RN G but unsure of what came about the complaint. RN F and RN G no longer work at the facility and the residents feel safe. Residents felt like nothing was being done when they made complaints about the mistreatment by RN F and RN G. In an anonymous interview, it was stated, RN G would poke residents when she would go in to give them medicine, yelling at residents to get up and would make them feel beneath her. RN F would yell at residents stating, I am tired of cleaning up your shit and both RN F and RN G would make the residents feel like they were alone and could not ask for help, especially since it was nighttime and no administration was around. In an interview on 07/29/25 at 9:10am, LVN E stated the residents would complain to her about their medicine being administered late but never expressed to her they were being mistreated or yelled at by any staff member, including RN F and RN G. LVN E stated she would have reported any suspected abuse to the ADM. In an interview on 07/29/25 at 3:29pm, the SW stated a resident (who was no longer at the facility) informed her that they (night nurses, SW did not get names of who) were rude to them and would not give them their medicine. The SW stated she thought she reported it to the DON and was not sure what happened after that. The SW stated she did not follow up on the grievance and was not sure if anything was investigated. The SW stated the allegation was reported to her several months ago but could not recall when. The SW stated she would hear from a handful of residents that the night nurses were mean to them. The SW stated when the residents informed her of this, they told her not to say anything. The SW stated she did not ask why they felt they should not report anything and did not think it was abuse even though the residents used the word mean. The SW stated she never asked what the residents meant by mean and left it at that. The SW stated she did not write up grievances because the residents told her not to. The SW stated she was aware of what verbal abuse was and that all suspected abuse should be reported to the abuse coordinator. The SW stated in-service on ANE was held every month and the SW was the one who conducted the monthly in-service. The SW stated all suspected abuse should be reported and could not give a reason why she did not report the allegations of the night nurses being mean to the residents other than the resident did not want me to. In an interview on 07/30/25, the DON stated the SW should have reported any and all suspected mistreatment or possible abuse. The DON stated resident safety was important to the facility and any allegations of abuse were taken seriously and needed to be investigated. The DON stated if suspected abuse was not reported, it could cause the residents to become fearful or allow the alleged perpetrator/s to continue or escalate the abuse. In an interview on 7/30/25 at 11:10 am, ADON B if a resident went to her and stated that a nurse was being mean or mistreating them, she would ask the resident for details, remove the nurse from the area and go tell the DON and ADM. ADON B stated a staff member yelling at a resident or cursing at a resident was verbal abuse and should be reported to the DON and ADM immediately. In an interview on 07/30/25 at 11:54pm, the ADM stated the SW should have reported any suspected abuse and the facility takes all allegations of abuse or neglect seriously. The ADM stated he was going to in-service the SW on ANE as well as all staff. The ADM stated the facility staff, including administration, conduct Angel Rounds every morning and residents have not expressed they were being mistreated by any staff. Record review of the facility's Abuse Investigation and Reporting policy not dated reflected: 'Policy Statement All reports of resident abuse, neglect |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure residents were free from accident hazards and received adequate supervision and assistance devices to prevent accidents for one (Resident #2) of three residents reviewed for accidents. 1. The facility failed to ensure Resident #2 did not fall out of his bed on 07/08/25 due to CNA C performing incontinent care alone instead of with a second person. This failure could place residents at risk for physical, mental, and psychosocial harm.The findings included: Record review of Resident #2's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] and discharged on 07/18/25. His diagnoses included cerebral infarction (stroke), hemiplegia and hemiparesis affecting right dominant side (paralysis and weakness on one side of the body), aphasia (an impairment in the ability to read, write, and speak), lack of coordination, seizures (abnormal brain activity which affects muscle control, behavior, and awareness), and history of falling. Record review of Resident #2's admission MDS dated [DATE] reflected a BIMS score of 4 which indicated severe mental impairment. Resident #2's admission MDS also reflected he required the assistance of two or more helpers with eating, oral hygiene, toileting hygiene, showering/bathing himself, dressing, and personal hygiene. Resident #2 required substantial/maximal assistance (helper did more than half the effort) to roll left and right in bed. Resident #2's admission MDS reflected he was always incontinent of bowel and bladder, and he weighed 178 pounds. Record review of Resident #2's care plan dated 07/09/25 reflected a potential for falls due to history of falls, CVA with residual right dominant hemiplegia, reduced range of motion to left leg, impaired cognitive functioning/ safety awareness/ problem solving, and seizure disorder. Interventions included provide adequate staff assistance and support for tasks. Record review of the facility's investigation report dated 07/11/25 reflected CNA C stated she rolled Resident #2 from his left side to his right side while providing incontinent care and the resident made a jerking move, slipped off the bed, and landed on his stomach/side on the floor. CNA C then contacted other staff to assist to get resident back to bed after he was assessed for injuries by the nurse. Resident #2 did not have any complaints or visible injuries; however, his RP wanted him sent to the emergency room to be evaluated. While in the emergency room, multiple radiological exams were completed, and it was determined Resident #2 sustained no injuries from the fall. CNA C was suspended pending the outcome of the investigation and was subsequently terminated after the investigation findings determined the allegation of resident neglect was confirmed. Record review of CNA C's employee file reflected a General Employee Orientation dated 01/08/25 which included the following: Nursing Department (ADON)Incidents and accidents Fall precautionsWelcome (Administrator)ExpectationsCompliance and communicationAll the above were dated 01/08/25 and were checked off by the respective instructor for that area.There were no previous disciplinary actions documented in CNA C's employee file. An attempt was made to contact CNA C on 07/29/25, however the phone number listed in her employee file was disconnected. There were no other phone numbers or means of contact available. In an interview on 07/29/25 at 11:12 am, CNA D stated Resident #2 was paralyzed on his right side, but he would scoot in the bed, roll over and throw his left leg off the bed. It was in the ADL book that he was a two person assist all the time because he was paralyzed on one side, and he was heavy. CNA D stated Resident #2 had fallen several times that she was aware of. CNA D stated she was not working on that hall the day he fell off the bed with CNA C. CNA D further stated, If they were a two person assist, I would not do it on my own, I would wait until I had help. CNA D stated if she did not wait until she had help, the resident could fall of the bed and get hurt. CNA D stated she had assisted with incontinent care for Resident #2 before and he would move around while being cleaned and rolled from side to side. CNA D stated, I always tell the new CNAs that everyone is a two person assist because it was standard practice in places where I worked in the past and it was just better and safer for residents. In an interview on 07 /29/25 at 4:18 pm ADON A stated the CNA care plan was how the CNAs knew if a resident was a one or two person assist with things like incontinent care and repositioning. The CNA care plans for each resident were in the front of the ADL book at the nurse's station. ADON A stated if a resident was supposed to be a two person assist with incontinent care and the CNA did not follow that, they could get disciplined which included teachable moments and/or a verbal warning. ADON A stated if a resident fell it could cause serious injuries such as fractures, bleeds, hospitalization, and even death if they were on blood thinners and hit their head. ADON A stated they called the administrator first if someone fell, then the DON, the RP and the physician |