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	10/18/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents had the right to be free from abuse for 1 of 5 residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 was free from verbal abuse when CNA-A yelled at and ridiculed Resident #1 on 10/16/2025 as he was requesting assistance. These failures could place residents at risk of physical, mental and emotional decline, psychosocial harm, as well as result in isolation and withdrawal.Findings included: Record review of Resident #1's face sheet, dated 10/16/2025, revealed an [AGE] year-old male first admitted to the facility on [DATE], and a readmission date of 11/18/2024. Pertinent diagnoses included vascular dementia (a type of dementia caused by brain damage from impaired blood flow), major depressive disorder (a persistent feeling of sadness and loss of interest), and generalized anxiety disorder (nagging feelings of worry or anxiety). Record review of Resident #1's Quarterly MDS Assessment, dated 08/31/2025, revealed a brief interview for mental status was not completed. The MDS also revealed Resident #1 had a short-term and long-term memory problem, and cognitive skills for daily decision making were severely impaired. The MDS also revealed Resident #1 was dependent in bathing, dressing, and toileting. Record review of Resident #1's care plan, dated 05/01/2023, revealed Resident #1 required assistance for ADLs and mobility tasks due to generalized weakness, poor endurance, activity intolerance, and impaired balance. The care plan also indicated Resident #1 was status post CVA (stroke) with Vascular Dementia and Cognitive Communication Deficits (difficulties which arise from impaired cognitive functions such as attention, memory, reasoning, and problem-solving), as well as Aphasia (a communication disorder which results from damage to the areas of the brain responsible for language). Record review of Form 3613-A, Provider Investigation Report, dated 10/16/2025, revealed an allegation of abuse was confirmed when CNA-A yelled at Resident #1. Resident #1 was moved from CNA-A's area, and CNA-A was suspended and subsequently terminated. The RP, physician, MD, HHSC, PD, the DON, and the RDO were notified. A head-to-toe assessment of Resident #1 was conducted, with no injuries found. The PIR also indicated Resident #1 was interviewable with capacity to make informed decisions. The witness statement made by the Administrator in the PIR, dated 10/16/2025, revealed the Administrator was advised that CNA-A was shouting down the hallway toward Resident #1. The tone of his voice could be construed as verbal abuse. The SW spoke to Resident #1, and no emotional distress was discovered. Resident and staff interviews were conducted. No one advised of witnessing abuse or neglect. In an observation on 10/16/2025 at 11:23 AM, this surveyor observed CNA-A walk past the nurse's station heading toward and down the 200 hall, while yelling down the hall at Resident #1 you can do it yourself. If you want something you need to learn how to do it yourself. I am not going to help you. Resident #1 was observed to be holding his coffee cup and looking at staff behind CNA-A and at the nurses' station while CNA-A continued to raise his voice with him. CNA-A began stating again Do not look at them, they are not going to help you. You have to learn to do things yourself. RN-B was observed walking up to CNA-A and telling him You need to tone it down. State is in the building and standing right over there, to which CNA-A looked up toward the nurses' station and replied I don't care. It's called tough love. In an interview on 10/16/2025 at 11:40 AM, the DON stated CNA-A could be loud when he spoke to the residents, but she had never heard him scream or yell or speak down to them. She stated if she had ever heard CNA-A act this way in the past, she would have started an investigation for abuse and probably terminated him. The DON stated CNA-A was suspended immediately for this incident, and he was not answering his phone, as she had attempted to contact him to discuss suspension and termination with him. In an interview on 10/16/2025 at 11:55 AM, the SW stated raising your voice and speaking down to the residents was considered verbal abuse. She stated she had never had any reports or grievances from residents regarding CNA-A, but he could be very loud at times. The SW stated when CNA-A first started working here, he used a lot of curse words around the residents, and he was really loud. He had to be told to tone it down multiple times, and he had toned it down a lot. In an interview on 10/16/2025 at 12:04 PM, Resident #1 shook his head up and down (yes) when asked if the language and tone CNA-A used with him made him feel sad and embarrassed. He was observed to be shaking his head yes and saying Si [meaning yes in the spanish language]. He was also observed to be looking down and his eyes watering while answering the questions. In an interview on 10/16/2025 at 12:15 PM, the Administrator stated he had never heard CNA-A yell at the residents before, but the bottom line was this was verbal abuse, which was why he walked out of his office

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, and/or mistreatment were reported immediately, but not later than 2 hours after the allegation was made if the allegation involved abuse or resulted in serious bodily injury, or no later than 24 hours if the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including the State) in accordance with state law for 1 of 5 residents (Resident #2) reviewed for abuse and neglect. The facility failed to ensure all alleged possible violations or allegations involving abuse for Resident #2 were reported to the proper entities immediately or as required by law on 10/08/2025. This failure could place residents at an increased risk for abuse or further potential for abuse due to unreported allegations of abuse and neglect.Record review of Resident #2's face sheet, dated 10/14/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Pertinent diagnoses included dementia (a condition which affects memory, thinking, and the ability to perform daily activities), cognitive communication deficit (difficulties in communication which arise from impaired cognitive processes, such as attention, memory, organization, and executive functioning), bipolar (a mental health condition characterized by extreme mood swings which include emotional highs and lows), alcohol induced persisting dementia (a condition in which years of excessive alcohol use damages the brain, leading to cognitive deficits), depression (a mood disorder which causes a persistent feeling of sadness and loss of interest and could interfere with daily living). Record review of Resident #2's quarterly MDS assessment, dated 07/25/2025, revealed a BIMS score of 04, which indicated severely impaired cognition. In section C0300, Temporal Orientation (to include year, month, and day) Resident #2 missed the current year by greater than 5 years, or no answer. Resident #2 missed the current month by greater than one month, or no answer, and Resident #2 was not able to determine what the correct day of the week was. Record review of Resident #2's most recent nurse's note, dated 10/13/2025 at 6:00 PM, revealed the nurse was following up on Resident #2 after a room change. Resident #2 was redirected to his room multiple times. This nurse's note did not give any details as to why Resident #2 was moved to a different room, when he was moved to a different room, or if Resident #2 or his RP were made aware of the room change and/or why. Prior to this note, there were no other nurse's notes since 08/21/2025. Record review of Resident #2's care plan dated 06/30/2023, and revised 06/11/2025, revealed Resident #2 had impaired cognitive function related to Schizophrenia, Bipolar, and Alcohol Induced Persisting Dementia, to include impaired short-term memory, impaired long-term memory, and moderately impaired decision-making abilities. The care plan also revealed Resident #2 was unable to retain information and continuously asks the same questions multiple times and becomes agitated easily. Record review of Resident #3's face sheet, dated 10/15/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #3's quarterly MDS assessment, dated 09/03/2025, revealed a BIMS score of 13, which indicated intact cognition. Record review of Resident #3's care plan, dated 06/06/2025, revealed Resident #3 had impaired cognitive functioning further impacted by mental illness and Schizophrenia. Resident #3 had impaired short-term and long-term memory, impaired decision making, impaired problem solving, and he was forgetful and often confused. Resident #3 exhibits disorganized thinking and a history of medication noncompliance secondary to inability to understand consequences and adverse effects suffered by noncompliance. Record review of Resident #4's face sheet, dated 10/14/2025, revealed a [AGE] year-old male with an admission date of 08/23/2025. Record review of Resident #4's quarterly MDS assessment, dated 08/27/2025, revealed a BIMS score of 15, which indicated intact cognition. Record review of a statement dated 10/08/2025 and written by CNA-G revealed she saw Resident #4 sitting outside of his bedroom around 9:30 PM. Resident #4 was upset and told her he did not want to go into his room because they were in there making noises, and he did not want to be part of this. CNA-G then went back to his room and saw Resident #2 standing in the dark, against the wall, with his hands over his private area. CNA-G then went and reported back to the nurse. CNA-G stated she had not heard any noises or seen the men engaging in any activities. She only saw both men in the room in the dark. Record review of a statement dated 10/08/2025 and written by RN-H revealed she came back from her break and was informed Resident #4 did not want to go into his room. RN-H read the statement CNA-G had already written (regarding finding the 2 residents alone in the bedroom in the dark with one holding his private area), and she called the DON to come to the facility. The DON and the Administrator both came to

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed in response to allegations of abuse, neglect, exploitation, or mistreatment have evidence that all alleged violations were thoroughly investigated and prevented further potential abuse, neglect, exploitation or mistreatment while the investigation was in progress for 1 (Resident #2) of 5 residents reviewed for abuse, neglect, and/or misappropriation. The facility failed to do a thorough investigation to include having the CNA and/or charge nurse perform a thorough assessment of the situation and the environment of the residents identified in the abuse allegation the night of 10/08/2025. The facility also failed to have the charge nurse assess the residents identified in the allegation the night of 10/08/2025. This failure could place residents at risk of not having their allegations investigated thoroughly or timely, as well as the potential for abuse to continue.The findings included: Record review of Resident #2's face sheet, dated 10/14/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Pertinent diagnoses included dementia (a condition which affects memory, thinking, and the ability to perform daily activities), cognitive communication deficit (difficulties in communication which arise from impaired cognitive processes, such as attention, memory, organization, and executive functioning), bipolar (a mental health condition characterized by extreme mood swings which include emotional highs and lows), alcohol induced persisting dementia (a condition in which years of excessive alcohol use damages the brain, leading to cognitive deficits), depression (a mood disorder which causes a persistent feeling of sadness and loss of interest and could interfere with daily living). Record review of Resident #2's quarterly MDS assessment, dated 07/25/2025, revealed a BIMS score of 04, which indicated severely impaired cognition. Record review of Resident #2's most recent nurse's note, dated 10/13/2025 at 6:00 PM, revealed the nurse was following up on Resident #2 after a room change. Resident #2 was redirected to his room multiple times. This nurse's note did not give any details as to why Resident #2 was moved to a different room, when he was moved to a different room, or if Resident #2 or his RP were made aware of the room change and/or why. Prior to this note, there were no other nurse's notes since 08/21/2025. Record review of Resident #2's most recent skin assessment dated [DATE] did not indicate any skin issues or concerns. Prior to this date, the last skin assessment for Resident #2 was done 10/02/2025. Record review of Resident #2's care plan dated 06/30/2023, and revised 06/11/2025, revealed Resident #2 had impaired cognitive function related to Schizophrenia, Bipolar, and Alcohol Induced Persisting Dementia, to include impaired short-term memory, impaired long-term memory, and moderately impaired decision-making abilities. The care plan also revealed Resident #2 was unable to retain information and continuously asks the same questions multiple times and becomes agitated easily. Record review of Resident #3's face sheet, dated 10/15/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #3's quarterly MDS assessment, dated 09/03/2025, revealed a BIMS score of 13, which indicated intact cognition. Record review of Resident #3's care plan, dated 06/06/2025, revealed Resident #3 had impaired cognitive functioning further impacted by mental illness and Schizophrenia. Resident #3 had impaired short-term and long-term memory, impaired decision making, impaired problem solving, and he was forgetful and often confused. Resident #3 exhibits disorganized thinking and a history of medication noncompliance secondary to inability to understand consequences and adverse effects suffered by noncompliance. Record review of Resident #4's face sheet, dated 10/14/2025, revealed a [AGE] year-old male with an admission date of 08/23/2025. Record review of Resident #4's quarterly MDS assessment, dated 08/27/2025, revealed a BIMS score of 15, which indicated intact cognition. Record review of a statement dated 10/08/2025 and written by CNA-G revealed she saw Resident #4 sitting outside of his bedroom around 9:30 PM. Resident #4 was upset and told her he did not want to go into his room because they were in there making noises, and he did not want to be part of this. CNA-G then went back to his room and saw Resident #2 standing in the dark, against the wall, with his hands over his private area. CNA-G then went and reported back to the nurse. CNA-G stated she had not heard any noises or seen the men engaging in any activities. She only saw both men in the room in the dark. Record review of a statement dated 10/08/2025 and written by RN-H revealed she came back from her break and was informed Resident #4 did not want to go into his room. RN-H read the statement CNA-G had already written (regarding finding the 2 residents alone in the bedroom in the dark with one holding his private area), and she called the DON to come to the facility. The DON and the Administrator both came to the facility. RN-H took Resident #4 downstairs to the Administrator's office. RN-H's written