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	12/03/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	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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F 0600 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 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 #4) reviewed for abuse, neglect, and exploitation. The facility failed to protect Resident #4's right to be free from verbal abuse when CNA-C made an insulting and ridiculing comment toward Resident #4 on 10/25/2025. This failure could place residents at risk for psychological harm or injury.The findings included: Record review of Resident #4's face sheet, dated 12/03/2025, revealed a [AGE] year-old female with an original admission date of 10/28/2013, and a current admission date of 02/05/2025. Resident #4's diagnoses included Neuromuscular Dysfunction of the Bladder (commonly referred to as neurogenic bladder, occurred when nerve damage impaired bladder control), Obstructive Uropathy (a condition characterized by a blockage in the urinary system which impeded normal urine flow, potentially leading to kidney damage and other complications), Metabolic Encephalopathy (a brain dysfunction leading to symptoms like confusion, memory loss, and altered consciousness), and Diabetes Mellitus (a chronic disorder characterized by high blood sugar levels due to insufficient insulin [a crucial hormone that regulates blood sugar levels and plays a vital role in energy metabolism] production or ineffective use of insulin by the body). Record review of Resident #4's Quarterly MDS assessment, dated 11/25/2025, revealed a BIMS score of 15, which indicated intact cognition. Record review of Resident #4's care plan, initiated 04/11/2016, and revised 10/04/2025, revealed Resident #4 required assistance with all ADLs and mobility tasks. Interventions included 1. Resident #4 was bedbound and 2. Assist Resident #4 to turn and reposition every 2 hours and as needed. Resident #4's care plan, initiated 04/11/2014, and revised 10/04/2025, revealed Resident #4 was dependent on an indwelling Foley catheter due to Neuromuscular Dysfunction of the Bladder, Urinary Retention (a condition in which the bladder did not empty completely, leading to difficulty in urination), and Obstructive Uropathy. Interventions included 1. Check Resident #4 at routine intervals to assess needs and offer assistance with toileting, and 2. Resident #4 was dependent for toileting tasks. Resident #4 was also care planned on 04/11/2016, and revised 10/04/2025, for behavioral symptoms of making false allegation and threats toward staff, with interventions to include when Resident became inappropriate, disruptive, accusatory, or threatening, provide for basic needs, assess for pain, hunger, toileting needs, and temperature needs (too hot or too cold). Record review of Resident #4's progress note, dated 10/26/2025, revealed Resident #4 made an allegation of verbal abuse from a CNA, and family, the Administrator, the DON, and the Nurse Practitioner were made aware of the incident, and the incident was reported to state. Record review of Resident #4's active physician orders, started 12/13/2023, revealed an order for transportation to appointments may be set up via stretcher due to morbid obesity, Foley catheter, and Resident #4 was unable to stand or bear weight for transfers to the bed or wheelchair due to Paraplegia (a form of paralysis which specifically affects the legs and lower part of the body, often resulting from a problem with the nervous system). In an interview on 12/02/2025 at 10:35 AM, Resident #4 stated she did not feel like it was an appropriate thing for CNA-C make the statement we know what you like. She found it offensive, and she did not feel like it was meant like she knew what type of care she wanted or liked, but they felt like she wanted them to keep wiping or touching her private area. She stated she told CNA-C that it was inappropriate and uncalled for to talk to her like that, and she would provide the video of CNA-C during the incident on 10/25/2025. Observation of a video footage, dated 10/25/2025 9:43 PM, provided by Resident #4, CNA-C was cleaning Resident #4 while the MA assisted with handing her supplies, and CNA-C stated, Is it clean now? Resident #4 responded with yes, thank you. CNA-C stated Good. Yeah, we know what you like. Resident #4 responded Excuse me, that's not called for. CNA-C proceeded to raise her voice and stated No. No. No, it's not. You got us scrubbing down here when I already told you that I had already cleaned you, and I did. I had already cleaned you like 3 or 4 times already. That don't make any sense. In an interview on 12/02/2025 at 11:02 AM, the SW stated she thought she had spoken to the resident after the verbal abuse incident, but she could not recall for sure, and she did not think she had written a note regarding the incident. She stated the incident had occurred over the weekend, so she did not find out about it until the following Monday, and she usually went and spoke with residents after incidents or allegations, but she could not remember if she had spoken to Resident #4 in regard this incident. The SW also stated she was not sure if what CNA-C stated was considered verbal abuse because she had not known the context in which it was used or the surrounding conversation in which it happened. She stated she saw the video of the

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 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 the comprehensive care plan was developed and implemented within a timely manner for each resident, consistent with resident rights, to include measurable objectives and timeframes to meet resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment for 1 of 5 residents (Resident #3) reviewed for care plans. The facility failed to develop or implement Resident #3's comprehensive care plan when, after searching for over 3 hours, they were unable to find Resident #3's comprehensive care plan in her chart, on the electronic medical system, or in medical records. This failure could place residents at risk of receiving inadequate care and services.The findings included: Record review of Resident #3's face sheet dated 09/17/2025 revealed an [AGE] year-old female with an admission date of 12/18/2024. Pertinent diagnoses included Unspecified Dementia (a condition which affects memory, thinking, and the ability to perform daily activities), Cerebral Infarction (a type of stroke which occurs when a blood clot blocks a brain artery, leading to a loss of blood flow to a specific area of the brain), Aphasia (a communication disorder which affects a person's ability to process and formulate language, and it could impact various aspects of communication, including speaking, understanding, reading, and writing), and Atrioventricular (AV) block (a condition characterized by the partial or complete block of electrical impulses from the atria (upper chambers) to the ventricles (lower chambers) of the heart. Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed no BIMS as the BIMS interview was not conducted due to Resident #3 was rarely or never understood. C0700 and C0800 revealed Resident #3 had short-term and long-term memory problems. C1000 revealed severely impaired decision-making skills. C1310 revealed Resident #3 continuously had difficulty with focusing attention. GG0130 revealed Resident #3 was dependent with oral hygiene, toileting, showering, and personal hygiene. There was no care plan to be reviewed in the electronic chart or the paper chart. In an interview on 12/02/2025 at 4:45 PM, the SW stated she kept a list of quarterly care plan meetings due, and she was the one who sent out the notifications for the care plan meetings. The SW stated she was not sure whose responsibility it was to update the care plan information since they no longer had an MDS nurse, and she was not sure if Resident #3's care plan was ever completed. In an interview on 12/02/2025 at 4:55 PM, ADON-A stated the MDS nurse was the one who updated the care plans, but since they did not currently have an MDS nurse, the regional MDS nurses had been coming to help with care plans. ADON-A stated she was not sure how may care plans had been updated so far, but she knew they had been working on them. In an interview on 12/03/2025 at 4:14 PM, the DON stated care plan meeting should be held quarterly and with significant changes to update any changes or needs the resident may have had. She also stated the ADONs, and the Nurse Managers were the ones who should be updating the care plans since they did not currently have an MDS nurse. The DON stated she was not sure what happened to Resident #3's care plan. In an interview on 12/03/2025 at 4:35 PM, ADON-A stated care plan meetings were held quarterly and with significant changes, or at least they were supposed to be. The SW kept up with who needed the care plan meetings, and she sent out the notifications for the meetings. ADON-A stated after three hours searching for Resident #3's care plan, they were not able to find one. She was not sure if a care plan meeting was ever held or a comprehensive care plan was ever completed for Resident #3. She stated residents were supposed to have care plans to help staff identify the type of individualized care the residents needed. Record review of the facility's Care Plans, Comprehensive Person-Centered Policy, no date indicated, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 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 the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments, and the change of condition assessments to reflect the current conditions for 2 of 5 residents (Resident #1 and Resident #2) whose care plans were reviewed for timing and revision. The facility failed to ensure Resident #1's care plan was revised after a significant change to accurately reflect current diagnoses and needs. The facility failed to ensure Resident #2's care plan had been reviewed or revised since 2024. These failures could place residents at risk of receiving inadequate, individualized care and services. The findings included: Record review of Resident #1's face sheet dated 12/02/2025 revealed a [AGE] year-old male admitted to the facility on [DATE]. Pertinent diagnoses included Unspecified Dementia (a group of thinking and social symptoms which interfere with daily functioning) and Chronic Obstructive Pulmonary Disease (COPD, an ongoing lung condition caused by damage to the lungs). Record review of Resident #1's significant change MDS assessment dated [DATE] revealed a BIMS score of 11, which indicated moderately impaired cognition. The MDS assessment section J1400 revealed Resident #1 did not have a condition or chronic disease which resulted in a life expectancy of less than 6 months. The MDS assessment section N0415 revealed Resident #1 was not on an Opioid. The MDS assessment section O0110 revealed Resident #1 was placed on hospice care. Section Z0500 of the MDS assessment revealed it was signed as complete on 11/07/2025. Record review of Resident #1's active physician orders started 10/15/2025 revealed multiple orders for Morphine (an opioid, narcotic medication used to treat pain) for mild, moderate, or severe pain. There was another order dated for 10/15/2025 to admit Resident #1 to nursing home care under hospice routine care. Record review of Resident #1's comprehensive care plan, initiated 05/01/2025 and revised 07/03/2025, revealed the care plan had not been reviewed or revised since 07/03/2025. There was no care plan regarding Resident #1's hospice transition, and no care plan regarding Resident #1's morphine. Record review of an email dated 12/02/2025 at 4:35 PM, revealed the Administrator stated we (the facility) did our best to have care plan meetings, and the SW contacts hospice to attend, but they did not always comply. Record review of Resident #2's face sheet dated 12/03/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged [DATE]. Pertinent diagnoses included Unspecified Dementia (a group of thinking and social symptoms which interfere with daily functioning) and Type 2 Diabetes (a chronic condition which affects how your body metabolizes sugar (glucose), leading to high blood sugar levels and various health complications). Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 09, which indicated moderately impaired cognition. The MDS assessment also revealed Resident #2 had lower extremity functional limitations. The quarterly MDS also revealed Resident #2 had active diagnoses of Coronary Artery Disease (CAD, a common type of heart disease which affects the main blood vessels which supply blood to the heart, called the coronary arteries), Hypertension (high blood pressure happens when the force of the blood pushing against the artery walls was consistently too high, and the heart had to work harder to pump blood), Unspecified Dementia (a group of thinking and social symptoms which interfere with daily functioning), Anxiety (intense, excessive and persistent worry and fear about everyday situations), and Depression (a mood disorder which causes a persistent feeling of sadness and loss of interest). The MDS was signed as completed by the DON on 09/11/2025. Record review of Resident #2's physician orders, started 03/02/2025, revealed an order for Amlodipine (a Hypertension medication). Record review of Resident #2's comprehensive care plan, revealed the care plan had not been reviewed, revised, or edited since 10/04/2024. The most recent MDS revealed a diagnosis of Hypertension, and the most recent physician orders revealed a hypertension, or high blood pressure, medication, but there was no care plan noted for the Hypertension or the medication. In an interview on 12/02/2025 at 4:45 PM, the SW stated she kept a list of quarterly care plan meetings which were due, and she was the one who sent out the notifications for the care plan meetings. The SW also stated she showed Resident #1 had a quarterly care plan meeting in September 2025 and a change of condition care plan meeting in October 2025, but she could not find the care conference meeting forms, and she was not sure whose responsibility it was to update the care plan information since they no longer had an MDS nurse. After stating she had Resident #1 on the care plan meeting lists for September 2025 and October 2025, SW then stated she could only find Resident #1 on the lists for care plan meetings for April 2025 and