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	12/23/2025

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 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)

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 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 interviews, and record review the facility failed to develop and implement a person-centered comprehensive care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for one (Resident #1) of six residents reviewed. The facility did not develop a measurable and individualized care plan to address Resident #1's falls. This failure could place residents at risk for unmet medical, nursing, mental, and psychosocial needs and preferences. Record review of face sheet dated 12/18/2025 revealed Resident #1 was last admitted on [DATE]. Resident #1's Face sheet also revealed admission and Primary Diagnosis as Unspecified Dementia (a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, language, judgement and behavior). Record review of the MDS Assessment Summary dated 11/02/2025 revealed Resident #1 had a Brief Interview for Mental Status score of 00 which indicated severe mental impairment. The MDS also revealed Resident #1 had disorganized thinking and requires assistance for activities of daily living to include assistance of supervision for dressing and clothing changes, partial assistance with showers, and assistance with set up for personal hygiene tasks. Record review of care plan, undated, revealed Resident #1 was mobile using a wheelchair and walker. The care plan also revealed Resident #1 was independent for transfers tasks. The care plan also indicated Resident #1 was a fall risk due to her history of falls, impaired cognition, safety awareness, unsteady gait requiring use of walker, and other indicators with interventions of keeping the bed in low position, keeping the call light in reach, keeping the floor clean, dry, and clutter free, to intervene with resident to minimize or reduce fall occurrences (did not indicate how to minimize or reduce fall occurrences), monitor for complaints of dizziness, drowsiness, weakness, and not feeling well, monitor medication effectiveness, provide adequate staff assistance and support for tasks, and should fall occur, nurse to assess resident and notify the doctor and resident representative. The care plan did not include a measurable objective or individualized way to prevent Resident #1 from falling. Record review of Incident Report dated 12/13/2025 indicated Resident #1 had a witnessed fall from her wheelchair with a history of 2 other falls in the last 3 months. The report indicated Resident #1 cannot verbalize coherently and was assessed immediately by RN C. The report indicated Resident #1 was attempting to pick up a blanket from the floor and fell forward out of her wheelchair. The report indicated Resident #1 had two hematomas (a collection or pool of blood that forms outside of blood vessels appearing as a localized lump or bruise where blood has leaked and clotted in tissues or body spaces) to her forehead and the doctor ordered to send Resident #1 to the emergency room for further evaluation. On 12/19/2025 at 10:00 a.m., observation of Resident #1 as she pushed a wheelchair down the hallway with RN C monitoring the hallway. Resident #1 was unable to answer questions when asked. Resident #1 In an interview on 12/18/2025 at 12:20 p.m., MA B stated Resident #1 does fall due to wanting to get out of her wheelchair and not having personal safety awareness. MA B stated the staff redirect Resident #1 the best they can and try to keep her active. MA B stated Resident #1 may have future falls because the facility does not want to restrain her. MA B stated she does not think Resident #1 is abused but also stated she is not sure what else the facility can do to help her not fall. In an interview on 12/19/2025 at 10:15 a.m., the DON indicated Resident #1 does have some minor instances of balance loss and stated her care plan does not reflect specific interventions needed to prevent falls for Resident #1. The DON stated the facility cannot provide 1:1 care for this resident and has spoken with Resident #1's representative and they have not been able to find a good intervention or solution. The DON stated she has recommended Resident #1 may be a good candidate for a different facility, but the family did not agree. In an interview on 12/19/2025 at 11:05 a.m., the Administrator stated he is aware that Resident #1 is a fall risk and has had multiple falls. The Administrator stated Resident #1's family blocks them from transferring the resident to a different facility with a locked unit. The Administrator stated she may need to be transferred out of the facility and will discuss this with the DON. In an interview on 12/22/2025 at 11:00 a.m. Case Manager A of Resident #1's hospice provider stated she has spoken with the facility staff and with the resident's family member regarding Resident #1's falls. Case Manager A stated the facility has been trying different interventions, but it has been difficult due to Resident #1 most likely needing a locked memory care and being unable to find a place that is a good fit for her. Case Manager A also stated Resident #1 is [AGE] years old and susceptible to falls, but they did not want her to be restrained using medication and they want to ensure the Resident is safe. Case Manager A stated she did not think Resident #1 was abused or neglected