

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455557	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER The Palms Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969</p> <p>Based on interviews and record reviews, the facility failed to send a copy of the notice of transfer or discharge, and the reasons for the transfer or discharge in writing to the resident, resident representative, or the Office of the State Long-Term Care Ombudsman for two (Residents #37 and #81) of three residents reviewed for transfer and discharge.</p> <p>The facility failed to send the notice of transfer or discharge in writing to Residents #37 and #81, their RP or the Ombudsman when Resident #37 transferred to emergency roiaognom on [DATE], and Resident #81 was transferred to the hospital on 6/28/2024.</p> <p>This failure could affect residents by placing them at risk of being discharged and not having access to available advocacy services, discharge/transfer options, and the appeal processes.</p> <p>Findings included:</p> <p>1. Record review of Resident #37's face sheet revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included Type 2 Diabetes (disease in which the body has trouble controlling blood sugar and using it for energy), Hypoxemia (low level of oxygen in the blood), Seasonal Allergies, Pneumonitis (general inflammation of lung tissue), Hematemesis (vomiting blood), Gastroesophageal Reflux (acid reflux and heartburn), Fusion of Spine, Cyst of Left Kidney.</p> <p>Interview with Resident #37 on 08/26/24 at 09:54 AM, he stated he was in the hospital recently.</p> <p>Record review on 08/28/24 at 09:42 AM of physician's orders dated 08/13/2024 revealed Resident #37 was sent to the emergency room for low saturation and shortness of breath, and he was diagnosed with Covid-19 and Hypoxia. Record Review also revealed Resident #37 returned to facility same day with new orders.</p> <p>Record review on 8/28/24 revealed Resident #37s care plans to maintain infection control practices and Covid 19 testing per facility policies.</p> <p>Interview with second floor ADON on 8/28/24 at 10:15 AM, the ADON stated that RP for Resident #37 was contacted via phone to let them know Resident #37 was being transferred to the emergency room . The ADON stated that they only notify resident or RP verbally or by phone, but not in writing.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 455557	If continuation sheet Page 1 of 29

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #81's face sheet revealed he was an [AGE] year-old-male admitted to the facility on [DATE]. Diagnoses include Fracture of Right Femur, Aftercare of Joint Replacement, Presence of Artificial Hip Joint, Protein Calorie Malnutrition, Gastroesophageal Reflux Disease.</p> <p>Record review on 8/28/24 of Resident #81's MDS revealed adequate hearing, clear speech, makes self understood, comprehends others, and a BIMS score of 11.</p> <p>Interview with Resident #81 on 08/26/24 at 11:08 AM, he stated he broke his hip in June 2024 after falling while trying to get a towel out of the closet and got dizzy. and he was admitted to the hospital on 06/28/24.</p> <p>Interview with second floor ADON on 08/28/24 at 10:15 AM, she stated Resident #81 was admitted to the hospital on 06/28/24 and returned to facility on 07/02/24 back to same room. ADON is unsure if the ombudsman was ever notified. ADON stated that RP was contacted via phone to let them know Resident #81 was being transferred to ER. ADON states that they only notify residents or RPs verbally or by phone, but not in writing.</p> <p>Record review on 08/29/24 at 09:07 AM of the Transfer or Discharge Policy revealed that when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider.</p> <p>Interview with the Administrator on 08/29/2024 at 09:05 AM, he stated that the social worker handles all the transfer and discharge notices.</p> <p>Interview with the Social Worker on 08/29/2024 at 09:12 AM, she stated that she only handled transfers and discharges that were not medical related, such as AMA (Against Medical Advice) and discharges or transfers to another facility. She stated she did not notify the resident or RP in writing, but called them to inform them, and she would also usually send the Ombudsman an email.</p> <p>Interview with the State Ombudsmen on 08/29/2024 at 09:27 AM, she stated the facility should be notifying her of transfers and discharges, and that she had not gotten anything lately.</p> <p>Record review on 08/29/2024 of the facility's policy titled Discharge or Transfer Policy revised 01/01/2022 revealed when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969</p> <p>Based on interviews and record reviews the facility failed to refer for a PASRR level II screening who had newly evident or possible serious mental disorder, intellectual disability, or a related condition for review upon a significant change in condition for 1 of 3 residents (Resident #37) reviewed for PASRR.</p> <p>The facility failed to refer Resident #37 for a PASRR level II review after resident received diagnoses of Anxiety, Bipolar with Severe Psychotic Features, Adjustment Disorder, Suicidal Ideations, Depression, Personality Disorder, Mood Disorder.</p> <p>This deficient practice could affect residents who received new mental illness diagnoses by not receiving additional evaluations and needed services.</p> <p>The findings included:</p> <p>Record review of Resident #37's Face Sheet revealed an admitted [DATE] with a readmitted [DATE]. Diagnoses included Insomnia, Anxiety, Bipolar with Severe Psychotic Features, Adjustment Disorder, Suicidal Ideations, Depression, Personality Disorder, Mood Disorder.</p> <p>Review of Resident #37's PASRR evaluation dated 9/1/23 revealed the mental illness assessment, Section C, showed no evidence or indicator this individual had a primary diagnosis of dementia, a mental illness or intellectual disability.</p> <p>Record review of Resident #37's physician orders revealed the resident was ordered antianxiety and antipsychotic medication and a Senior Psych Care Consult on 02/09/24.</p> <p>Interview on 8/27/24 at 03:57 PM with the MDS coordinator, she stated that if resident already had a PASRR screening, then a new one is not completed. MDS coordinator also stated that she only completes the 1012 follow-up form if the individual had a diagnosis of dementia or if there is an evaluation done while resident is admitted to a psychiatric hospital. She stated that she was not aware that the PASRR needed to be completed or updated for change of status or new mental health diagnoses or she would have completed one for him.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the MDS coordinator and the DON on 08/29/24 at 10:15 a.m., the DON stated the nurse managers followed up and updated the orders and care plans, as well as the MDS, DON and the ADON. The DON stated the system to ensure the PASRR was being done and correct was those that were already done, she and the nurse managers would be checking for accuracy, and they were now helping. She said she had not put anything in place in the 3 months she had been employed at the facility. She stated they needed to make an improvement to their system to make sure the data of the patient is accurate. She said the MDS and care plans were used for the aides and nurses to know what the focus on the resident was. She said they needed to improve documentation and focus on the needs of the patients. She said she would be involved in this training. She said she reviewed care plans only when there was a concern, and she had not reviewed all of them. She said she saw a failure in care planning and PASRR, and they needed to improve that. The MDS nurse said all the nurses were responsible for checking for mental illness correctness, and it's a hit or miss because they come from home, hospital, etc.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748</p> <p>Based on record review and interview the facility failed to perform preadmission screening for individuals with a mental disorder and individuals with intellectual disability prior to admission for 1 of 3 residents (Resident #39) reviewed for preadmission screenings.</p> <p>The facility failed to perform a PASRR for Resident #39 before or after she was admitted on [DATE] with readmission on 01/29/19.</p> <p>This failure could place residents at risk of receiving inadequate care.</p> <p>Findings included:</p> <p>Record review of Resident #39's admission record revealed an [AGE] year-old female with an original admitted on 08/13/18 and a readmission on 01/29/19. Diagnoses included Alzheimer's, dementia with psychotic disturbance, mood disorder due to known physiological condition, psychotic disorder with delusions due to known physiological condition, anxiety disorder, major depressive disorder, recurrent.</p> <p>Record review of Resident #39's care plan dated 08/02/24 revealed pg. 10 identified a problem dated 10/31/22 of potential for Staff report that she appeared to have little interest in doing things, appeared tired and had poor appetite. Potential for increased mood symptoms due to Mood Disorder, Psychotic Disorder, Anxiety, Depression, end stage disease process / Alzheimer's Disease. Edited: 08/28/2024.</p> <p>Record review of Resident #39's L1 dated 04/28/20 was negative for MI or IDD.</p> <p>In an interview with the MDS nurse on 08/27/24 at 1:41 PM stated she did not know how she missed Resident #39's PASRR L1 that was negative on 04/28/20 and she should have sent a 1012. She said she missed it because Resident #39's PASRR was done way before she started working at the facility as MDS. She said she started working at the facility in 2019. She stated, The new forms automatically grey out once the question for dementia was answered 'yes', even if they (residents) had qualifying diagnoses. She said Resident #39 had diagnoses of Mood disorder, Psychotic disorder, and Major depressive disorder, recurrent. She said a level 2 should be done with those diagnoses, regardless of a diagnosis of dementia. She stated, The resident would not qualify unless she had a psychiatric evaluation at a mental hospital.</p> <p>In an interview with the MDS coordinator on 08/27/24 at 3:57 PM, she stated that if a resident already had PASRR, then a new one was not completed. She said she only completed the 1012 form if the individual had a diagnosis of dementia or there was an evaluation done while the resident was admitted to a psychiatric hospital. She stated that she was not aware that the form needed to be completed for change of status or new mental health diagnoses.</p> <p>Interview with the MDS nurse on 08/28/24 at 2:25 p.m., revealed she did not have or send a 1012 for Resident #39.</p> <p>(continued on next page)</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the MDS coordinator and the DON on 08/29/24 at 10:15 a.m., the DON stated the nurse managers followed up and updated the orders and care plans, as well as the MDS, DON and & the ADON. etc. The DON stated the system to ensure the PASRR was being done and correct was those that were already done, she and the nurse managers would be checking for accuracy, and they were now helping. She said she had not put anything in place in the 3 months she had been employed at the facility. She stated they needed to make an improvement to their system, to make sure the data of the patient is accurate. She said the MDS and care plans were used for the aids and nurses to know what the focus on the resident was. She said they needed to improve documentation and focus on the needs of the patients. She said she would be involved in this training. She said she reviewed care plans only when there was a concern and she had not reviewed all of them. She said she saw a failure in care planning and PASRR and they needed to improve that. The MDS nurse said all the nurses were responsible for checking for mental illness correctness-it's a hit & miss because they come from home, hospital, etc.</p> <p>Reference: CFR S483.20(k)(2), and the resident remains in the facility longer than 30 days, the facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038</p> <p>49157</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, for 3 residents (Resident #8, Resident #34, and Resident #48) of 18 residents whose care plans were reviewed, in that:</p> <p>1) Resident #8's comprehensive care plan was not reviewed or revised to include Resident #8's current code status of Full code, instead of Do Not Resuscitate.</p> <p>2) Resident #34's comprehensive care plan was not reviewed or revised to discontinue Resident #34's use of insulin.</p> <p>3) Resident #48's comprehensive care plan was not reviewed or revised to discontinue Resident #48's wounds or wound vac (medical device that helps wounds heal by applying negative pressure to the wound site). Resident #48's care plan was also not revised to include that Resident #48 changes out his own urinary catheter monthly.</p> <p>These failures could place residents at risk for inadequate care and services.</p> <p>The findings included:</p> <p>1.) Resident #8</p> <p>Record review of Resident #8's face sheet dated 8/27/24 reflected a [AGE] year-old female with an original admitted [DATE]. Diagnoses included dementia (general decline in cognitive abilities that affects a person's ability to perform everyday activities) and bipolar disorder (mental disorder with periods of depression and periods of abnormally elevated mood).</p> <p>Record review of Resident #8's care plan dated 8/7/24 reflected no code status.</p> <p>In an interview on 08/27/24 at 01:18 PM, the SW stated she, the DON, ADON, MDS and Activities work on care plan meetings. The SW stated the MDS Coordinator was the main person to work on care plans. The SW stated she could not find the code status in Resident #8's chart, but the code status should be care planned. The SW stated the code status should be care planned so staff could know what the code status was and the goals and what the interventions were. The SW stated she was not sure who audits care plans once they are done by the MDS Coordinator</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 08/27/24 at 01:39 PM, the MDS Coordinator stated Resident #8's code status should be care planned. The MDS Coordinator stated the code status should be care planned so nursing staff could know what interventions to take in case of emergency. The MDS Coordinator stated the ADON and the DON audit care plans quarterly and as needed. The MDS Coordinator stated the code status was not in Resident #8's care plan. The MDS stated once upon a time Resident #8 had a code status of do not resuscitate and that code status was discontinued and changed to full code and the change in code status did not get entered in as it was overlooked. The MDS Coordinator stated the nursing staff do not look at the care plans to find the code status, but all code status should be care planned. The MDS Coordinator stated she was going to update Resident #8's care plan immediately to reflect the current code status.</p> <p>In an interview on 08/27/24 at 02:07 PM, the DON stated a resident's code status should be care planned. The DON stated resident code status was care planned so nursing staff could know what interventions to take for Resident #8. The DON stated she thought Resident #8 had a code status of do not resuscitate but could not remember because there were so many residents. The DON stated she was not sure who audited care plans, but she had not audited care plans before and does not know who should be. The DON stated the code status was not in the chart but should be. The DON stated she had been at the facility for about 3 months and has not audited any care plans but thinks she should be auditing care plans to ensure accuracy. The DON stated moving forward she was going to be auditing care plans. The DON stated she assists in care plan meetings and helps with more acute changes. The DON stated when there are changes with a resident, in morning meetings it is discussed and addressed. The DON stated once a change is identified, the care plan is updated by either the SW or MDS Coordinator.</p> <p>2.) Resident #34</p> <p>Record review of Resident #34's face sheet revealed a [AGE] year-old female with an original admitted [DATE]. Diagnoses included Type II Diabetes Mellitus (high blood sugar) with chronic kidney disease, dementia (general decline in cognitive abilities that affects a person's ability to perform everyday activities), and left side paralysis (inability to move the left arm or leg) due to cerebral infarction (disrupted blood flow to the brain).</p> <p>Record review of Resident #34's admission MDS dated [DATE] revealed a BIMS score of 5 which indicated severe cognitive impairment.</p> <p>Record review of Resident #34's Care Plan on 8/28/24 revealed a Problem of Resident receives insulin R/T diabetes mellitus with diabetic CKD (chronic kidney disease) Problem start date: 6/8/23. Edited: 8/2/24. Goal: Resident will not have any episodes of hyperglycemia (high blood sugar)/hypoglycemia (low blood sugar) throughout next review date. Long Term Goal Target Date: 8/31/24. Edited: 8/2/24. Approach: Administer insulin as ordered per md order. Approach start date: 6/8/23. Created: 6/8/23.</p> <p>Record review of Resident #34's Active Orders on 8/28/24 revealed no active order for any type of insulin.</p> <p>3.) Resident #48</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #48's face sheet revealed a [AGE] year-old male resident originally admitted on [DATE]. Diagnoses included acute pulmonary edema (fluid build-up in the lungs), vascular dementia (brain damage caused by multiple strokes), paraplegia (paralysis of the lower extremities) due to a gunshot wound, neuromuscular dysfunction of the bladder, urinary retention, urinary tract infection, and pressure ulcers of the sacral region and right buttock.</p> <p>Record review of Resident #48's quarterly MDS dated [DATE] revealed a BIMS score of 14 which indicated resident was cognitively intact.</p> <p>Record review of Resident #48's Care Plan on 8/28/24 revealed a problem of: I am at risk of impaired skin integrity r/t incontinence of bowel and bladder and decreased mobility r/t paraplegia. Admit with multiple pressure ulcers. Stage 4 pressure ulcer with wound vac. Problem start date 6/30/20. Edited: 8/2/24. Goal: My skin integrity will improve over the next review date. Long term goal target date: 8/31/24. Edited: 8/2/24. Approach: Treatment as ordered for all wounds. Wound vac as ordered. Approach start date: 6/30/20. Edited: 7/13/20. The Care Plan also revealed a problem of: Resident at risk for UTI r/t indwelling catheter use DX Neurogenic bladder. Problem start date: 6/30/20. Edited: 8/2/24. Goal: I will be free from infection r/t catheter use through the next review date. There was no approach for foley change by licensed staff or the resident himself.</p> <p>In an interview on 8/27/24 2:47 p.m., CNA F stated, Resident #48 prefers to change his foley out himself. Sometimes we offer him help but he says he wants to do it himself.</p> <p>In an interview on 8/27/24 at 2:49 p.m., CNA G stated, I believe it is the nurse's job to change Resident #48's foley catheter out. All he does is empty the drainage bag. CNA G stated she did not really know anything about the foley because it is a nurse job.</p> <p>In an interview on 8/27/24 at 2:51 p.m., LVN E stated, The night nurse told me that she had taught Resident #48 how to change it and she was in there with him. He likes to be independent. LVN E stated that she would sometimes get the urinary catheter supplies during the day because they could be difficult to find at night.</p> <p>In an interview on 8/27/24 at 3:15 p.m., the MDS stated she did not know anything about Resident #48 changing his own urinary catheter and that, that would be a nurse manager thing. The MDS stated it was important to be care planned, so that everyone would know that he does it himself, although he probably shouldn't be doing it himself. The MDS stated she did not know that he was non-compliant with care. The MDS stated that Resident #48 changing out his own urinary catheter should have been discussed in morning meetings. The MDS stated the ADON should have let her know about it in morning meeting and there should have been an order in the chart. The MDS stated, It is the nurse's job to tell the nurse manager, and the nurse manager should bring it up in morning meeting so that everyone is on the same page. The MDS stated It should have been on the 24 hour report also.</p> <p>In an interview on 8/28/24 at 10:48 a.m., RN A stated that Resident #48 liked to do a lot of things for himself, and that staff would provide the supplies for him. RN A stated she was not sure if he changed out his own urinary catheter. RN A stated that Resident #48 had asked her for supplies, but that he had never let her change the catheter. RN A stated Resident #48 frequently cussed out staff and would not let them do any care for him. RN A stated she did not know if anyone had taught him how to change his foley.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 8/28/24 at 11:00 a.m., ADON H stated, Resident #48 is a young guy and very private- he is embarrassed for us to do his foley care/change. ADON H stated that one of the night nurses showed Resident #48 how to insert his foley and had him do a return demonstration after she taught him. ADON H stated it had been a while since the night shift nurse told her about Resident #48 being taught how to change his own urinary catheter. ADON H stated, I think the doctor is aware that he changes his own foley. There is not an order or care plan in reference to him changing his own foley. ADON H stated the night nurse should have gotten the order when she taught him how to change the catheter or that she (ADON H) should have gotten the order when she learned of the situation. ADON H stated It was important that there was an order so the doctor was aware that Resident #48 was doing his own foley changes. ADON H stated it was also important to have an order and for it to be care planned so that if anything went wrong, the doctor knew that Resident #48 changed his own foley. ADON H stated it was also important to have an order and a care plan so that staff was aware that Resident #48 changed his own foley. When asked how long Resident #48 has been changing his own urinary catheter, ADON H stated, It's been about a year- not too long, that he's been changing his own foley. ADON H stated there had to be an order for the resident to change his own urinary catheter and the resident had to be trained to do it so that he did not cause any urethral trauma or infection. ADON H stated, We're going to contact the physician now and get it care planned.</p> <p>In an interview on 8/28/24 at 12:48 p.m., the MD stated that he did not know that Resident #48 was doing his own foley changes. The MD asked how long the resident had been doing it and was told the staff said he had been doing it for about a year. When asked about his thoughts on it, the MD stated, I guess it is ok. When it was clarified to the MD that Resident #48 was changing out his entire urinary catheter, which was a sterile procedure, and the MD was asked if he was still okay with that, the MD asked, what if I say no? The MD was advised that he would have to discuss the situation with the resident and the nursing staff. The MD asked if there was a male nurse that could change the catheter if Resident #48 did not want a female to change it and was told that he would have to ask the facility about staffing. When the MD was told that one of the night nurses had taught Resident #48 how to change his catheter and that Resident #48 did it on his own, the MD replied, Well, I guess it's okay this time, but I will talk to him and the staff the next time I come in.</p> <p>In an interview on 8/28/24 at 12:59 p.m., Resident #48 was asked what the process was for changing out his foley. Resident #48 stated, I deflate the balloon, remove the old foley, clean my penis with the iodine swabs, then put together the catheter with the drainage tube, put the lubricant on, insert it, use the wipe to clean off the lubricant and iodine, then inflate the balloon. Resident #48 stated he used the gloves that come in the kit. Resident #48 stated he put them on before he took the old foley out and took them off before he filled the balloon. When asked if he changed gloves after he took the old catheter out and put the new catheter in, Resident #48 stated he did not change gloves. Resident #48 stated he did not think that he had been treated for any urinary tract infections over the past year. Resident #48 stated that there was a nurse in the room when he changed the foley in case he had any issues.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 8/28/24 at 1:06 p.m., the DON stated she had just found out the day before that Resident #48 was changing his own foley. The DON stated, My expectation would be notified right away if the resident is insistent on changing his own foley. The DON stated there were concerns because he could do it wrong and cause urethral trauma or he could cause an infection if he broke sterility. The DON stated the doctor should have been notified, but she was not sure how long the MD had been there. When asked if he should have been notified when he took over, the DON stated, Oh, of course. The DON stated it should have been care planned because it was important for everyone know what was going on with the care of the resident. The DON stated, When we hire the nurses, we tell them to make sure and look at the care plans. When asked whether the nurses looked at the paper or electronic care plans the DON stated they looked at the paper ones. When asked about Resident #48's wounds and wound vac that were on his care plan, the DON stated that he no longer had a stage 4 or a wound vac. The DON asked if that was the latest care plan and was informed that it appeared to be. The DON stated, No, that shouldn't be on there- it should be updated. The DON stated care plans should be updated with any changes but was not sure if it was supposed to be every 30 days or every 60 days. The DON stated it was important that the electronic care plan matched the paper care plan because the nurses did not have access to the electronic one.</p> <p>Record review of facility's Care Plans, Comprehensive Person-Centered policy dated 2/20/22 stated:</p> <p>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.</p> <p>a. Include measurable objectives and timeframes;</p> <p>i. Reflect the resident's expressed wishes regarding care and treatment goals;</p> <p>j. Reflect treatment goals, timetables, and objectives in measurable outcomes;</p> <p>12. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who entered the facility with a urinary catheter received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #34) of 4 residents reviewed for urinary catheters in that:</p> <p>The facility failed to ensure that Resident #34 ' s urinary catheter drainage bag did not touch the floor.</p> <p>This failure could place residents who had a urinary catheter at risk for developing or worsening of a urinary tract infection.</p> <p>Findings Included:</p> <p>Record review of Resident #34 ' s face sheet revealed a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE]. Diagnoses included neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), end stage renal disease (the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), dependence on renal dialysis (a process that removes waste products and excess fluid from the blood because the kidneys cannot), dementia, and left side paralysis (inability to move the left arm or leg) due to cerebral infarction (disrupted blood flow to the brain).</p> <p>Record review of Resident #34 ' s admission MDS dated [DATE] revealed a BIMS score of 5 which indicated severe cognitive impairment. Resident #34 required extensive 2-person assistance with bed mobility, toileting, personal hygiene, and bathing.</p> <p>Record review of Resident #34 ' s physician orders dated 8/27/24 revealed an order dated 5/16/24 that read, Foley catheter 16fr/5cc to gravity drainage, change foley catheter and drainage bag every month and as needed on the 15th of the month and an order dated 5/16/24 that read, Foley catheter care every shift, twice a day.</p> <p>Record review of Resident #34 ' s care plan on 8/27/24 revealed Problem: Resident requires an indwelling urinary catheter R/T neurogenic bladder. Problem start date: 5/23/24. Edited: 8/25/24. Goal: Resident will have catheter care manage appropriately as evidenced by: not exhibiting signs of urinary tract infection or urethral trauma. Created: 8/25/24. Long term goal date: 8/31/24. Approach: Avoid obstructions in the drainage, catheter per MD order, change catheter per MD order, help resident choose new clothing that will not constrict catheter system, irrigate catheter only if obstruction is suspected, provide assistance for catheter care, provide catheter care Q shift and as needed, report signs of a UTI (urinary tract infection), store collection bag inside of a dignity pouch, use a catheter strap. All approaches had an Approach start date 5/23/24 and a created date of: 8/25/24.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 8/25/24 at 1:52pm revealed Resident #34 ' s urinary catheter drainage bag was attached to the lower right side of Resident #34 ' s bed frame. The drainage bag was touching the floor. RN A went into the room and hung the drainage bag on a higher rail so that it was not touching the floor after Resident #34 ' s family member went out into the hallway to ask RN A some questions.</p> <p>Observation on 8/26/24 at 10:16am revealed Resident #34 ' s urinary catheter drainage bag was attached to the lower right side of Resident #34 ' s bed frame. The drainage bag was touching the floor.</p> <p>In an interview on 08/27/24 at 9:22am, CNA D was able to describe appropriate urinary catheter care. CNA D stated, After foley care, the foley bag goes on the bottom rail of the bed and make sure it isn't touching the floor. CNA D stated the bag has to be off the floor to prevent infection. CNA D stated the last in-service on catheter care was about a month ago.</p> <p>In an interview on 08/27/24 at 9:41am, LVN E stated that it ' s important to make sure that the urinary drainage bag was flowing, not leaking, and lower than the bladder. LVN E also stated that it cannot stay on the bed. LVN E was not able to state that the bag could not touch the floor until she was reminded. LVN E stated if the drainage bag touched the floor or if the urine was not able to drain freely and backed up into the bladder, the resident could end up with a urinary tract infection. LVN E stated the last in-service about urinary catheters was sometime in the last few weeks.</p> <p>In an interview on 08/27/24 2:20pm, the DON stated, Whoever did the foley care, they usually had a dirty bag and a clean bag. The drainage bag was supposed to be secured to the leg to keep it from pulling. The drainage bag got hung on the bed rail with a privacy cover on it and it was not supposed to touch the floor due to potential for infections. The DON stated if the bag touched the floor or if urine did not flow freely to the drainage bag, it could cause infection or sepsis, which could lead to high fever, vomiting, bladder pain, hospitalization , or possibly death. The DON stated staff was in-serviced at least once a month and that she would do another in-service that day.</p> <p>Record review of the facility ' s Policy and Procedure for Catheters- Insertion and Care- Indwelling, Straight, Suprapubic, and External dated 01/2008 and revised 07/2016 stated in part:</p> <p>It is the policy of this home that the resident with a urinary catheter will be provided services in a safe and appropriate manner in order to minimize the risks of urinary tract complications.</p> <p>Procedure- Indwelling Catheter- Insertion:</p> <p>RN/LVN to insert catheter using the following procedure:</p> <p>6. Secure urinary drainage bag below the level of the bladder and keep off the floor.</p> <p>Record review of the facility ' s second Policy and Procedure for Catheter Care, Urinary that the facility provided stated in part:</p> <p>The purpose of this procedure is to prevent catheter- associated urinary tract infection.</p> <p>Maintaining Unobstructed Urine Flow</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.</p> <p>Infection Control</p> <p>2.b. Be sure the catheter tubing and drainage bag are kept off the floor.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46038</p> <p>Based on observation, interviews, and record review the facility failed to ensure all drugs and biologicals were safely stored in 1 of 4 medication carts (300-hall cart) reviewed for storage of medications.</p> <p>-The facility failed to ensure disinfectant wipes on the 300-hall medication cart were kept in a separate compartment away from resident's medications.</p> <p>-The facility failed to ensure staff 's personal drink items were not stored in the 300-hall medication cart with resident's medications.</p> <p>This failure could affect residents receiving medications and put them at risk for cross contamination.</p> <p>The findings included:</p> <p>During an observation on 08/28/24 at 10:46 AM, this surveyor opened the 300-hall medication cart and found disinfectant wipes in the same compartment with a variety of resident ' s liquid medications along with one open water bottle and a closed energy drink.</p> <p>In an interview on 8/28/24 at 2:30 PM, RN A stated the personal drink items were hers and they were not supposed to be in the medication cart due to cross-contamination. RN A stated she did not have an answer on why she stored the personal drink items in the medication cart as staff are reminded daily by administration not to store personal food or drink items in the medication carts. RN A was visibly upset and immediately removed the items from the medication cart. RN A stated the disinfectant wipes should not be stored with resident medications as they are considered a chemical and should be stored in a separate compartment. RN A stated she did not have an answer as to why the sanitation wipes were stored with a variety of medications and it must have been an oversight.</p> <p>In an interview on 08/28/24 at 2:34 PM the DON stated personal items should not be in the medication carts because it can cause cross-contamination. The DON stated the nursing staff are verbally reminded daily that personal items should not be in the medication carts. The DON stated the disinfectant wipes should have been in a separate drawer without medications because it is considered a chemical. The DON stated the last in-service on safely storing medications was about a week ago.</p> <p>Record review of the facility ' s Storage of Medication policy not dated stated:</p> <p>The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. Antiseptics, disinfectants, and germicides used in any aspect of resident care must have legible, distinctive labels that identify the contents and the directions for use and shall be stored in a manner separating from regular medications (including, but not limited to dividers, cards, cubicles, drawers, cabinets, boxes, etc).</p> <p>8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident 's medications shall be assigned to an individual utilizing a separation system (dividers, cards, cubicles, etc) to prevent the possibility of mixing medications of several residents.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen and 2 of 2 nutrition rooms (first floor and second floor nutrition room) reviewed for sanitation.</p> <p>The facility failed to maintain the dish room in a safe, sanitary condition.</p> <p>The facility failed to keep the dish room walls and floor clean.</p> <p>The facility failed to keep the ice machine clean and free of leaks.</p> <p>The facility failed to serve juices and milks in clean drinking glasses.</p> <p>The facility failed to keep the air intake filter above the stainless-steel refrigerator clean.</p> <p>The facility failed to keep hot dogs in the refrigerator tightly sealed.</p> <p>The facility failed to maintain 2 chest type freezers in good working order.</p> <p>The facility failed to discard a spatula with peeling edges and kept using it.</p> <p>The facility failed to discard eroded non-stick pans and kept using them.</p> <p>The facility failed to discard dented pans and kept using them.</p> <p>The facility failed to ensure kitchen staff were wearing hairnets while in the kitchen.</p> <p>The facility failed to ensure kitchen staff were washing their hands.</p> <p>The facility failed to ensure kitchen staff were not using a prep sink to wash their hands.</p> <p>The facility failed to ensure kitchen staff were educated on calibrating thermometers.</p> <p>The facility failed to ensure kitchen staff were following their cleaning schedules.</p> <p>The facility failed to ensure the grease barrel was sealed.</p> <p>The facility failed to ensure items on the first floor and second floor nutrition rooms were not expired.</p> <p>The facility failed to ensure items on the second-floor nutrition room were refrigerated.</p> <p>The facility failed to ensure items in the refrigerators and freezers were labeled and dated.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility failed to keep miscellaneous items off of a prep table.</p> <p>These failures could place residents at risk of foodborne illnesses.</p> <p>Findings included:</p> <p>Observation and Initial tour of the kitchen on [DATE] at 11:15 a.m., revealed multiple gnats flying in the dish room and there was a foul odor. The sink drain was dripping liquid onto the floor. The walls and floor were stained in a dripping pattern with a substance that ranged from brownish to white to dark grey. There was a large electrical box on the wall that had an open hole approximately 4 inches by 2 inches in the bottom corner with rusted, sharp jagged edges and high potential for injury as it was next to the dish counter. The ice machine had white/yellow/black substances around the outside, inside, and around the door hatch. The ice chute had a removable dark grey substance along the edge of it where the ice dropped. There were wet towels on the floor around the perimeter of the ice machine and a basin with a moderate amount of water in it. 12 of 20 drinking cups on the clean rack had a removable white substance on the insides. The air filter above the refrigerator was covered in a thick furry dark grey substance. There were 2 trays of 25 total drinking glasses full of juices and milks in the refrigerator that were unlabeled and undated. There was an opened bag of hot dogs in the refrigerator that were open to air, unlabeled and undated. There were 2 large chest type freezers (A and B). The inside of the top in freezer A was severely cracked and the seal had large gaps missing. The seal in freezer B was not sealing at all and there was ice where the seal should have been, and ice formed on the walls inside. There were 2 large pans on the stove, in use. One had deep and many scratches bottom of the pan and had a loose handle. The other pan was a non-stick surface type, and the entire bottom was bare and scratched. There were 6 small-size steam table holding pans with deep dents in the corners that were in use. There was a tape dispenser and a handheld lighter on a prep table. There was a large spatula with peeling edges on the pot rack. There was a gaping hole approximately 6x6 inches in the base of a wall, adjacent to the floor under the 3-compartment sink. There was what appeared to be rat droppings along the same baseboard near the hole. There was a stainless-steel prep sink that had a thick black and a scaly white substance in the corners and on the insides. [NAME] B scraped some of the black substance with her bare fingernail and stated, It looks like mold and did not wash her hands afterwards but went about the kitchen touching surfaces and handling dishes. [NAME] A did not wash his hands after entering the kitchen from the outside. [NAME] A was not wearing a hair net nor a beard cover. [NAME] A's beard was not closely trimmed. The temperatures written in the log dated [DATE] for the lunch service were reg meat 140F, purred meat 135F, spinach 135F. The hand washing sink took 3 minutes to reach a temperature of 110F. The stainless-steel prep sink next to the handwashing sink was instantly at temp.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with [NAME] B on [DATE] at 11:30 a.m. she stated, the large spatula with peeling edges was in use and the particles could come off into the food and make the residents choke. She stated the stainless-steel prep sink that was next to the hand washing sink was also used as a hand washing sink. She said the dirty drinking glasses were on the clean rack, where they would be used for service. She said the large spatula with the peeling edges was used all the time. She said the dented holding pans were used frequently. She said the scratched pan with the broken handle was used all the time, as was the eroded non-stick type pan. She said she guessed the pans should be replaced and did not know who was responsible for replacing them or taking them out of service. [NAME] B said, we clean as we go and did not mention any referral to the cleaning schedule. She said the cleaning schedule was around here somewhere. She said the ice machine had been leaking for a while and that was why there were towels on the floor. She said they wring the towels in the basin then empty the basin in the stainless-steel prep sink.</p> <p>Observation and interview with [NAME] A on [DATE] at 11:40 a.m., he stated he usually wore a hairnet and beard cover while in the kitchen. He said he was in a hurry today because he thought he was late. He stated, I just started here 3 months ago and I'm still learning. He said he used to be a dietary manager. He said he did not calibrate the thermometer prior to temping for food service. While attempting to calibrate the thermometer he used earlier, he said the temperature he was looking for to calibrate the thermometer in ice water was Negative 34 F or negative 32 F. He prepared a cup of ice water and a cup of hot water. The thermometer had a blue line indicating 32 F and the needle on the thermometer dropped 8 degrees below the blue line. He said he did not know how to adjust the thermometer. He said he guessed the temperatures he had taken earlier were too low for service. He stated the residents could get real sick from foodborne illness if the food was not held at the proper temperatures.</p> <p>An interview with DA I on [DATE] at 11:45 a.m., she stated the kitchen staff did not use the porcelain sink for hand washing because it took too long to get hot. She stated the staff used the stainless-steel prep sink next to the hand washing sink to wash their hands because it had hot water. She said the tape dispenser and handheld lighter were supposed to be on the other side of the prep table and moved them to the other side of the prep table. She said, we clean as we go and did not mention any referral to the cleaning schedule. She said she had never seen the cleaning schedule.</p> <p>Observation and interview with the FSM on [DATE] at 11:45 a.m., she stated the ice machine was cleaned weekly inside and out. She stated the ice machine did not look clean and it was leaking. She said it had been leaking several months. She said she had informed maintenance on several occasions. She said she did not say anything to anyone else about the ice [NAME] machine. She stated any utensil or dented pans and pans with non-stick finishes should be removed and replaced immediately when showing that kind of wear. She stated she did not know why the dented pans, spatula, and eroded non-stick pans were still being used. She stated the seals in the white chest type freezers needed to be replaced and she had been telling the maintenance man about it for about 3 months. She stated freezer A needed to be replaced because the lid was badly cracked. She stated the freezers were keeping temps. She said she was unaware of the hole in the baseboard by the 3-compartment sink, the state of the dish room, staff not washing their hands or not wearing hairnets. She said the gnats in the dish room had been an on-going problem. Pest control invoices were requested. Policies for hand washing, Pest control, waste and disposal, cleaning schedules, food storage, and thermometer calibration were requested. In-services/training for the last 3 months were requested.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455557	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER The Palms Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5607 Everhart Rd Corpus Christi, TX 78411	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Return visit, observation of the kitchen, and interview with [NAME] A on [DATE] at 1:10 p.m. revealed the large spatula with peeling edges was still in use and hanging on the pot rack. The grease barrel had a removable lid with a hole in the top to pour grease into and the ring that held the top closed was halfway down the barrel. [NAME] A stated he was responsible for pouring used grease into the barrel, and he just lifted the lid and poured the grease directly into the barrel. He stated the ring on the barrel had never been around the lid, at least for the past 3 months since he had been employed at the facility. He stated he knew the ring was supposed to be around the lid, but it was easier to lift the lid and pour grease directly into the barrel. [NAME] A demonstrated raising the ring and secured it around the lid without difficulty. When [NAME] A raised the ring on the barrel, there was a significant difference in the color of the barrel from where the ring was (halfway down the barrel) and the rest of the barrel. The barrel appeared to be sun-bleached because the color of the barrel under the ring was much brighter, indicating the ring had been in the same position halfway down the barrel for a long time.</p> <p>Observation of the kitchen on [DATE] at 12:24 PM revealed a female kitchen staff member had a ball cap on over a hair net. Her hair was in a bun on the top of her head that had a separate hairnet over the bun. Her hair was sticking out ~ 4 inches all around the back and sides of her neck.</p> <p>An interview with DA J on [DATE] at 12:24 PM, she stated she had worked at this facility for three years. She said her head was a strange shape and the hairnets did not fit. She said she did not know what else to do with her hair and she had been wearing the ball cap over the hairnets for as long as she had worked in the kitchen. She said she had not tried to use a different type of hairnet, such as a bonnet and this was the best she could come up with to contain her hair. She said she was aware the hair on her neck was crazy, meaning not contained by hairnet(s).</p> <p>Observation of the second-floor nutrition room on [DATE] at 10:45 AM, revealed 14, 8-ounce bottles of hand sanitizer with expiration dates of ,d+[DATE]; three of the bottles had broken seals, and two of the three bottles were partially empty. There was 1, 46-ounce container of thickened, lemon-flavored water with a handwritten open date of [DATE], and directions on the box read .after opening may be kept up to 7 days under refrigeration. There were 2, 32-ounce containers of high calorie protein drink with expiration dates of [DATE].</p> <p>Observation of the first-floor nutrition room on [DATE] at 10:55 AM, revealed 17, 1.5-ounce calorie and protein enhancer with expiration dates of [DATE]. There were 13, 32-ounce high protein chocolate nutrition drinks with expiration dates of [DATE].</p> <p>An interview and record review with the FSM on [DATE] at 9:45 a.m., she said she was not sure where the cleaning schedules were but thought they were in her office. She said the cleaning schedule tasks were all marked as having been done, but the kitchen did not reflect cleaning had been done. She said she was responsible for making sure the tasks on the cleaning schedules were done correctly and timely and would not say why the kitchen was not clean.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the MS on [DATE] at 11:00 a.m., revealed the process of him knowing what needed to be fixed was that they (kitchen staff) contacted him verbally via the FSM and she told him by phone. He said there was a handwritten maintenance log at the nurse's station, but anything related to the kitchen he considered a priority. He said there was currently a bid for the stainless-steel freezer, and the technician was there at the facility Saturday ([DATE]) because the staff was concerned about the blinking outer thermometer. He said the inner thermometer was showing correct readings and holding temps. He said there was an icicle that had formed inside the stainless-steel freezer and the pan needed to be replaced. He said the white chest type freezers were holding temperature and there was no cool air escaping. He stated, Ice forms on the inside if the staff left it (the lid) open. He asked this state surveyor if there was ice on the insides of the white chest type freezers. The MS said the seals/gaskets were checked last month by his maintenance guys, then he said he checked them himself and they were good, and the ice probably formed last week when they (kitchen staff) got a shipment from the food distributor and had it opened. The MS stated there was also a bid on a new ice machine. The MS stated the reason the grease barrel needed to be secured was because it could cause environmental hazards if it got knocked over and cause rodents and other vermin attraction. The maintenance log, pest control log and invoices, and invoice/bid for the stainless-steel refrigerator service on [DATE] as well as the bid on the ice machine were requested.</p> <p>Record review of the daily 23-item kitchen cleaning schedules, weekly 10-item kitchen cleaning schedules and monthly 7-item kitchen cleaning schedules dated from [DATE]-[DATE], [DATE]-[DATE], [DATE]-[DATE], and [DATE]-[DATE] revealed all daily, weekly, and monthly cleaning checklists were marked as having been done.</p> <p>Pertinent items on the daily kitchen checklist were: #1. All dishes, pots, pans, and utensils are cleaned and stored properly after each meal and snack. 3. All sinks are cleaned and sanitized after each use. #12. Sweep floors after meals and mop daily. #14. Food Service employees wear hair restraints. #15. Clean ice machine exterior.</p> <p>Pertinent items on the weekly kitchen checklist were: #2. Delime floor under sinks and ice machine. #5. Clean walls. #8. Polish all stainless-steel surfaces.</p> <p>Pertinent items on the monthly kitchen checklist were: #2. Clean all baseboards. #4. Clean ice machine. #6. Pest control report on-hand.</p> <p>The exceptions of items not checked as having been done were: on the daily kitchen checklist for Monday, [DATE], #7-Dishwasher is cleaned after each use, #9-Trash can is emptied and cleaned after each meal, #10-Bathroom is cleaned daily or as needed, #13-Oven spills are cleaned and ovens are turned off, #15-Clean ice machine exterior, #16-All tools cleaned, locked, and inventoried, #21-Foods thawed appropriately. Friday [DATE] and Saturday [DATE], #7-Dishwasher is cleaned after each use. The weekly kitchen cleaning checklist for [DATE]-7, 2024, [DATE]-14, and [DATE]-11, ,d+[DATE], 2024 #8 Polish all stainless-steel surfaces.</p> <p>Record review of the facility pest sighting log indicated gnats in the dish room was addressed and initialed by the MS on [DATE], [DATE] and [DATE]. Rat droppings were addressed and initialed by the MS on [DATE], [DATE], and [DATE]. The Pest control invoices were requested but not received.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility kitchen policy titled, Sanitation and Infection Control-insect and rodent control revised ,d+[DATE] revealed It is the policy of this home to prevent and control insect and rodent infestations within the dietary services department to prevent food borne illness. Under Procedure, 2. The home will maintain .properly sealed water/sewer pipes, structurally maintained walls, baseboards, etc. to prevent entrance access of insects and rodents. 3. The sanitation of the kitchen will be maintained to prevent food sources, breeding places, etc. for insects or rodents. 8. The pest control company will leave a copy of treatments made in the kitchen at the end of each service call.</p> <p>Record review of the undated facility kitchen policy titled, Choosing the Right Thermometer revealed under Bimetallic Thermometers, there are two ways to calibrate a bimetallic thermometer: the ice point method and the boiling point method. Ice point Method 1. Start with a container large enough to easily accommodate your thermometer. Fill it with ice. Add tap water to fill and stir. Allow the ice water mixture to cool for a few minutes. 2. Put the thermometer probe into the ice water. It is important to wait about 30 seconds .Be sure the temperature indicator is no longer moving. 3. Look for the nut on the underside of the thermometer, use a wrench and turn the head of the thermometer until the reading on the face of the dial reads 32 F.</p> <p>Record review of the facility kitchen policy titled, Sanitation and Infection Control-Food Storage-Refrigerated and frozen foods revised ,d+[DATE] revealed Refrigerators and freezers will be kept clean and sanitized. The procedures to maintain the proper temperatures for storing cold foods will be strictly followed to prevent food borne illness. Procedure 6. Food must be stored in a properly covered container with a date and label identifying what is in the container. 7.Do not block the fan of the refrigerator or freezer. 14. Freezers should be defrosted regularly so that they will operate more effectively .15. A. All of the following terms will be considered expiration dates for cold food products: Expires by date, Best Used By date, Use By date, Sell By date. Once the date has been reached, whether the food has only been partially used or unopened, the food product will be discarded on or by that date.</p> <p>Record review of the facility kitchen policy titled, Sanitation/Infection Control-Handwashing revised , d+[DATE] revealed Dietary employees are to wash hands to ensure sanitary work habits are established when handling or serving foods to residents. Procedure: 1. Employees are to wash hands: a. before starting work, b. between handling of dirty dishes and clean dishes, equipment/utensils, and food, c. after all work breaks, using restroom, tobacco use or eating, h. after touching objects that may be a source of contamination if the next contact with the hands is food or food contact surfaces. 2. Hand washing occurs in sinks provided for that purpose .Food preparation sinks are not to be used for hand washing.</p> <p>Record review of the facility titled, Dress Code: dated ,d+[DATE] revealed 4. Hair should be clean and, in a style, suited for food service. Hair must be fully covered with a hairnet or hair bonnet at all times within the department. We do not accept the use of baseball caps, visors, and other cloth covers in dietary. All hair coverings should be disposable. 5, Facial hair is to be closely trimmed and all facial hair is to be covered with a hair restraint.</p> <p>Record review of the facility kitchen policy titled, Sanitation and Infection Control-Waste Control and Disposal revised ,d+[DATE] revealed Policy: The dietary services department will handle and dispose of waste in a sanitary manner to prevent cross-contamination and food borne illness. Procedure: 6. All rancid or used grease/oil will be poured into the appropriate grease barrel for recycling.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility kitchen policy titled, Sanitation/Infection Control-Cleaning Schedule revised , d+[DATE] revealed Policy: The dietary services department and all equipment in the kitchen will be cleaned on a regularly scheduled basis for daily, weekly, and monthly tasks. 3. It is the responsibility of all employees to follow the cleaning schedule. 6. Items not listed, but part of your kitchen, should be added to the cleaning schedule. 7. The dietary manager is responsible for training staff on proper cleaning procedures</p> <p>Kitchen staff in-services and/or training was not received. Bids on equipment and invoices were not received.</p> <p>References: U.S. Food and Drug Administration Food Code http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ :</p> <p>FDA Food Code 2017, Ch.5, ,d+[DATE].15 Outside Receptacles. (A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. Ch. [DATE].11 Characteristics. Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be: (A) Safe; (B) Durable, corrosion- resistant, and nonabsorbent; (C) Sufficient in weight and thickness to withstand repeated warewashings; (D) finished to have a smooth, easily cleanable surface; and Euro Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition.</p> <p>Ch. ,d+[DATE].18 Nonstick Coatings, Use Limitation. Multiuse kitchenware such as frying pans, griddles, saucepans, cookie sheets, and waffle bakers that have a perfluorocarbon resin coating shall be used with nonscoring or nonscratching utensils and cleaning pads.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>44748</p> <p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 stainless-steel refrigerator, 2 of 2 chest type freezers (freezer A and freezer B), 1 of 1 refrigerator intake filter, 1 of 1 electrical box, and 1 sink drain reviewed for essential equipment in the kitchen.</p> <p>The facility failed to maintain sink drainage in the dish room of the kitchen, and there was a foul odor in the dish room.</p> <p>The facility failed to maintain an electrical box in the dish room of the kitchen.</p> <p>The facility failed to maintain the seals/gaskets on 2 chest type freezers.</p> <p>The facility failed to keep the air intake filter above the stainless-steel refrigerator clean.</p> <p>The facility failed to keep the ice machine clean and free of leaks.</p> <p>These failures could place residents at risk of foodborne illness from improper refrigeration of refrigerated and frozen foods, and potential injury to kitchen staff.</p> <p>The findings were:</p> <p>Observation and Initial tour of the kitchen on 08/25/24 at 11:15 a.m., revealed the sink drain was dripping liquid directly onto the floor, and there was a foul odor in the dish room of the kitchen. There was a large electrical box on the wall that had an open hole approximately 4 inches by 2 inches in the bottom corner with rusted, sharp jagged edges and high potential for injury as it was next to the dish counter. The ice machine had white/yellow/black substances around the outside, inside, and around the door hatch. The ice chute had a removable dark grey substance along the edge of it where the ice dropped. There were wet towels on the floor around the perimeter of the ice machine and a basin with a moderate amount of water in it.</p> <p>Observation of the dish room and interview with the FSM on 08/25/24 at 11:45 a.m., revealed she stated the ice machine was cleaned weekly inside and out. She stated the ice machine did not look clean and it was leaking. She said it had been leaking several months. She said she had informed maintenance on several occasions. She said she did not say anything to anyone else about the ice machine. She stated the seals in the white chest type freezers needed to be replaced and she had been telling the maintenance man about them for about 3 months. She stated freezer A needed to be replaced because the lid was badly cracked. She stated the freezers were keeping temps. She said she was unaware of the state of the dish room and she would let maintenance know about the dripping sink, odor, and electrical box.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the MS on 08/29/24 at 11:00 a.m., he stated he was unaware the air filter above the stainless-steel refrigerator was covered in a thick furry dark grey substance. He said there was currently a bid for the stainless-steel freezer, and the technician was there at the facility Saturday (08/24/24) because the staff was concerned about the blinking outer thermometer. He said the inner thermometer was showing correct readings and holding temps. He said there was an icicle that had formed inside the stainless-steel freezer and the pan needed to be replaced. The MS stated he was unaware of the odor, electrical box, and dripping sink in the dish room of the kitchen. He said the white chest type freezers were holding temperature and there was no cool air escaping from around the lids. He stated, Ice forms on the inside if the staff left it (the lid) open. He asked this state surveyor if there was ice on the insides of the white chest type freezers. The MS said the seals/gaskets were checked last month by his maintenance guys, then he said he checked them himself by holding his hand near the lid, and they were good, and the ice probably formed last week when they (kitchen staff) got a shipment from the food distributor and had it opened. The MS stated there was a bid on a new ice machine. He said the process of him knowing what needed to be fixed was that they (kitchen staff) contacted him verbally via the FSM and she told him by phone. He said there was a handwritten maintenance log at the nurse's station, but anything related to the kitchen he considered a priority. The maintenance log, facility policy on maintaining equipment, and invoice/bid for the stainless-steel refrigerator service on 08/24/24 as well as the bid on the ice machine were requested, but not received.</p> <p>References: U.S. Food and Drug Administration Food Code http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ :</p> <p>FDA Food Code 2022, Ch.4-16, 4-501 Equipment, 4-501.11 Good Repair and Proper Adjustment. (B) Equipment components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. 6-501.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition. (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. 5-501.110 Storing Refuse, Recyclables, and Returnables. REFUSE, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents. 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (1) Contain FOOD residue and are not in continuous use; or (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>50039</p> <p>Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for 3 of 8 halls (Halls 200, 2200, and 2400) reviewed for environment.</p> <p>1) The facility failed to keep a storage room containing mouthwash with alcohol on hall 2400 locked while not in use.</p> <p>2) The facility failed to keep the shower room on hall 200 and hall 2200 locked while not in use.</p> <p>This deficient practice could place residents at risk of not living in a safe, functional, sanitary, and comfortable environment.</p> <p>The findings included:</p> <p>During an observation on 08/25/2024 at 12:56 PM, a storage room on the 2400 hall was left unlocked while not in use. Inside the storage room was a basket containing approximately 20 unopened bottles of mouthwash containing alcohol.</p> <p>During an observation on 08/25/2024 at 1:21 PM, the shower room on the 200 hall was left unlocked while not in use. Inside the shower room was a bottle of disinfectant left out in the open.</p> <p>During an observation on 08/25/2024 at 1:36 PM, the shower room on the 2200 hall was left unlocked while not in use. Inside the shower room was a bottle of disinfectant left out in the open.</p> <p>In an interview with LVN B on 08/27/2024 at 8:45 AM, LVN B stated the storage room on hall 2400 was used to store various things for the residents to use during activities. LVN B stated there should not have been mouthwash containing alcohol in the storage room. LVN B stated they only used mouthwash without alcohol in the facility. LVN B stated that the shower rooms should have been locked when not in use. LVN B stated that if a resident went into a shower room by themselves they could get a burn from the hot water, slip and fall, or ingest the cleaner fluid.</p> <p>In an interview with RN A on 08/27/2024 at 2:05 PM, RN A stated that the shower rooms should have been locked at all times. RN A stated that a resident could have fallen in the shower if they were alone. RN A stated that the storage room on hall 2400 should have been locked. RN A stated that a resident could have drunk the mouthwash containing alcohol and injured themselves.</p> <p>In an interview with CNA C on 08/27/2024 at 2:13 PM, CNA C stated that the shower rooms should have been locked at all times. CNA C stated that a resident could have fallen down in the shower room and hurt themselves. CNA C stated that the disinfectant used in the showers should have been in the locked cabinet inside the shower room. CNA C stated that the storage room on hall 2400 should have been locked. CNA C stated that the mouthwash used in the facility did not contain alcohol. CNA C stated there should not have been mouthwash containing alcohol in any storage room in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the ADM on 08/27/2024 at 2:26 PM, the ADM stated that he believed the mouthwash containing alcohol had only been in the storage room for a few weeks at most. The ADM stated that a resident could have entered the storage room and drank the mouthwash containing alcohol and hurt themselves. The ADM stated that the shower rooms should have been locked at all times. The ADM stated that he has not seen the shower rooms unlocked before. The ADM stated that a resident could have drunk the disinfectant left out in the shower room.</p> <p>In an interview with the DON on 08/28/24 at 02:40 PM, the DON stated storage rooms should have been locked at all times and shower rooms should have been locked when not in use, so residents or other individuals would not have access to any hazardous items such as, mouthwash containing alcohol, razors, shampoos, or anything that could have been potentially harmful. The DON stated that after a resident was done receiving a bath, that staff member would have been responsible to ensure the shower room was locked. The DON stated it was a team effort to ensure that all storage and shower rooms were locked for resident safety.</p> <p>Record review of the facility policy Hazardous Areas, Devices and Equipment last updated 02/20/2020 revealed the following:</p> <p>As part of the facility's overall safety and accident prevention program, hazardous areas and objects in the resident environment will be identified and addressed by mitigation of access to environmental hazards.</p> <p>Areas identified as potential for environmental hazards will be identified and secured to restrict access of residents in environment.</p> <p>A hazard is defined as anything in the environment that has the potential to cause injury or illness.</p> <p>Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455557	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER The Palms Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>44748</p> <p>Based on observation, interview and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests in 1 of 1 kitchen reviewed for pests.</p> <p>The facility failed to maintain an effective pest control program for gnats flying in the dish room of the kitchen, and there was a foul odor in the dish room.</p> <p>The facility failed to ensure there was not a method for rodents to enter the kitchen due to a gaping hole in the baseboard.</p> <p>These failures could put residents who consumed food from the kitchen at risk for infection and/or food contamination.</p> <p>The findings included:</p> <p>Observation and initial tour of the kitchen on 08/25/24 at 11:15 a.m., revealed multiple gnats flying in the dish room and there was a foul odor in the dish room of the kitchen. There was a gaping hole approximately 6x6 inches in the base of a wall, adjacent to the floor under the 3-compartment sink. There were what appeared to be rat droppings along the same baseboard near the hole.</p> <p>An interview with the FSM on 08/25/24 at 11:45 a.m., she said she was unaware of the hole in the baseboard by the 3-compartment sink. She said the gnats in the dish room had been an on-going problem. Pest control invoices were requested.</p> <p>An interview with the ADM (and the FSM present) on 08/28/24 at 1:04 PM, the ADM revealed he was not aware of the state of the dish room. He said the facility received regular and as needed pest control. He said could not recall the last time the facility had been treated, but the MS should have the receipts.</p> <p>An interview with the MS on 08/29/24 at 11:00 a.m., revealed the process of him knowing what needed to be fixed was that they (kitchen staff) contacted him verbally via the FSM and she told him by phone. He said there was a handwritten maintenance log at the nurse's station, but anything related to the kitchen he considered a priority. He said pest control came out whenever they need them and monthly. He said the pest control company had sprayed for gnats before, but would not say how often or when the last treatment was done. The Maintenance log and pest control log/invoices were requested.</p> <p>Record review of the facility pest sighting log indicated gnats in the dish room was addressed and initialed by the MS on 01/06/24, 07/13/24 and 07/30/24. Rat droppings were addressed and initialed by the MS on 05/05/24, 07/12/24, and 08/09/24. The Pest control invoices were not received.</p> <p>The Maintenance log and pest control log/invoices were not received .</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility kitchen policy titled, Sanitation and Infection Control-insect and rodent control revised 05/2016 revealed It is the policy of this home to prevent and control insect and rodent infestations within the dietary services department to prevent food borne illness. Under Procedure, 2. The home will maintain .properly sealed water/sewer pipes, structurally maintained walls, baseboards, etc. to prevent entrance access of insects and rodents. 3. The sanitation of the kitchen will be maintained to prevent food sources, breeding places, etc. for insects or rodents. 8. The pest control company will leave a copy of treatments made in the kitchen at the end of each service call.</p>