

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/02/2025
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 (Resident #36, Resident #11, Resident #88, Resident #58) of 18 residents reviewed for care plans. The facility failed to develop and implement a comprehensive care plan for Resident #36, Resident #11, Resident #88, and Resident #58. This deficient practice could place residents at risk of not receiving services to meet their needs. The findings included: Review of Resident #36's face sheet revealed, the resident was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Dementia (group of symptoms affecting memory, thinking or language), Coronary Artery Disease (a type of heart disease that occurs when the arteries of the heart cannot deliver enough oxygen to the heart due to plaque buildup), Hypertension (high blood pressure), Hyperlipidemia (high cholesterol), Diabetes Mellitus (high blood sugars), and Depression (a persistent feeling of sadness, hopelessness, and loss of interest in activities once enjoyed). Record review of Resident #36's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 09 which indicated his cognition was moderately intact. Review of Resident # 11's face sheet revealed, the resident was a [AGE] year-old male admitted to the facility on [DATE] with an original date of 12/21/2024. The resident had diagnoses which included Alzheimer's Disease (a progressive brain disorder that affects memory, thinking, and behavior), Coronary Artery Disease (a type of heart disease that occurs when the arteries of the heart cannot deliver enough oxygen to the heart due to plaque buildup), Hypertension (high blood pressure), Hyperlipidemia (high cholesterol), Depression (a persistent feeling of sadness, hopelessness, and loss of interest in activities once enjoyed), and Muscle Wasting and Atrophy. Record review of Resident #11's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 03 which indicated his cognition was severely impaired. A record review of Resident #88 Face sheet dated 09/17/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #88's diagnoses include Quadriplegia (A Paralysis that affects the ability to voluntarily move the upper and lower body), muscle atrophy (a condition that causes a progressive loss of muscle mass, strength, and power) Anxiety Disorder(a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation) and Depression(Is a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world. Resident #88's quarterly MDS 06/23/25 revealed a BIMS score of 14 which indicates normal thinking and memory with little to no impairment. Resident #88 Functional Abilities revealed Resident #88 is dependent on staff for all ADL's. Record review of Resident #58's admission record dated 09/10/25 revealed a [AGE] year-old male with diagnoses of Cerebral Infraction (when blood flow to brain is interrupted, causing damage to brain tissue), Unspecified, Hypertensive Heart Disease without Heart Failure (prolonged high blood pressure that damages the heart muscle), Essential (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 455557	Facility ID: 455557 If continuation sheet Page 1 of 39

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Primary) Hypertension (high blood pressure), Other Lack of Coordination, Need for Assistance with Personal Care, Muscle Wasting and Atrophy, not Elsewhere Classified, Multiple sites, and Anxiety Disorder Unspecified. Record Review of Resident #58's Quarterly MDS dated [DATE] reflected a BIMS Score of 8 indicating moderate impairment. In an interview on 09/18/2025 at 10:00 a.m. MDS LVN stated that she was the one responsible for completing the comprehensive care plans. She verified that there were no care plans for Resident #36 and Resident #11. MDS LVN stated that she must have overlooked their care plans. She stated that she started working from home as of July 2025 and does not have a set schedule to come in but tries to come at least once a week. She stated that the comprehensive care plans were to be completed within 21 days from the day that they were admitted . MDS LVN stated that the negative outcome of not having a comprehensive care plan was that there would be a lack of communication between the IDT team and staff not knowing in which direction they were going to provide care. In an interview on 09/18/2025 at 10:17 a.m., the DON stated that the comprehensive care plans were to be completed within 21 days from when the resident was admitted . She stated that the MDS LVN, corporate nurses, and the nurses were responsible for completing the comprehensive care plans. She stated that it was important for the comprehensive care plan to be completed for insurance purposes, to make sure that they got everything the patient needs and to know how to address it. In an interview on 09/18/2025 at 11:06 a.m., LVN Q stated that it had been about 2 weeks since she started working. She stated that the MDS nurse was responsible for completing the comprehensive care plan. She stated that she was responsible for completing the baseline care plan upon admission if she did the admission. LVN Q stated that if she were to complete a change of condition, then she would follow up with updating the care plan. She stated that she followed the care plan that was on file for that resident. LVN Q stated that the negative outcome of not having a comprehensive care plan was that someone can get hurt due to not updating interventions. In an interview on 09/18/2025 at 5:11 p.m. MDS LVN stated there was no care plan for Resident #58. She stated she was responsible for completing them and wasn't working at this facility full time and just overlooked it. In an interview on 09/18/25 at 6:03 PM with the MDS nurse she stated there was NO care plan for Resident #88. The state surveyor asked when the resident was admitted and the MDS nurse stated 11/13/24. The state surveyor asked why there was not care plan for Resident #88 and the MDS nurse stated she was not aware that a care plan had not been developed and implemented and did know why it was developed for this resident and would bring up to the DON so a care plan could be developed and implemented as soon as possible. Record review of the facility's Care Plans, Comprehensive [NAME]-Centered Policy, not dated, revealed Policy Statement 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.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for two of six residents (Resident #66 and Resident #93) reviewed for medication errors in that: 1) The facility failed to ensure Resident #66 was administered glargine insulin appropriately within parameters on 08/19/25 and 08/25/25. 2) The facility failed to ensure Resident #93 was administered glargine insulin appropriately by administering expired insulin on 09/16/25 and 09/17/25. These failures could place residents who receive insulin at an increased risk for complications such as hypoglycemia (low blood sugar), hyperglycemia (high blood sugar) and potential hospitalization. The findings included: 1) Record review of Resident #66's face sheet dated 09/17/25 revealed an [AGE] year-old male with an admission date of 10/09/24. Pertinent diagnosis included Type 2 Diabetes (chronic disease where your body becomes resistant to insulin, leading to high blood sugar levels). Record review of Resident #66's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 5 (severe impairment). Record review of Resident #66's comprehensive care plan dated 09/17/25 revealed the problem Resident has Diabetes Mellitus initiated on 04/16/25 and revised on 07/31/25. Approaches listed for the problem included .Administer Glucose Gel / Glucagon [as needed] as ordered initiated on 04/16/25. Record review of Resident #66's order summary revealed an active order for [Glargine] U-100 Insulin solution; 100 unit/mL; [amount]: 10 units; subcutaneous Special instructions: HOLD IF BLOOD SUGAR < 100 Once A Day initiated on 07/17/25. Record review of Resident #66's MAR revealed 10 units of glargine insulin were administered at 6:30 AM in Resident #66's right arm on 08/19/25 and left arm on 08/25/25. Further review revealed Resident #66's blood glucose was measured to be 92 on 08/19/25 and 86 on 08/25/25. Both records have an unknown nurse's initials by them. In an interview with the DON at 9:30 AM on 09/18/25, the DON stated it was important to follow the doctor's orders and only administer medications when necessary. The DON stated administering medications outside of parameters, especially insulin, could lead to severe resident harm or even death. The DON stated the glargine insulin should not have been administered to Resident #66 when his glucose measured less than 100. 2) Record review of Resident #93's face sheet dated 09/17/25 revealed a [AGE] year-old male with an admission date of 04/13/21. Pertinent diagnosis included Type 2 Diabetes (chronic disease where your body becomes resistant to insulin, leading to high blood sugar levels), and long-term use of insulin. Record review of Resident #93's Quarterly MDS assessment dated [DATE] revealed a BIMS score could not be obtained due to the resident rarely being understood. Record review of Resident #93's comprehensive care plan dated 09/17/25 revealed the problem Resident has Diabetes Mellitus initiated on 10/21/22 and revised on 08/02/24. Approaches listed for the problem included .Administer routine [glargine] insulin as ordered. Administer [aspart insulin] for sliding scale as ordered. Administer [dulaglutide] as ordered initiated on 10/21/22. Record review of Resident #93's order summary revealed an active order for [Glargine] U-100 (insulin glargine) solution; 100 unit/mL; [amount]:5 UNITS; subcutaneous Once A Day initiated on 07/13/25. Record review of Resident #93's MAR revealed 5 units of glargine insulin were administered to Resident #93 at 9:00 AM on 09/16/25 and 09/17/25. During an observation of the 2300/2400 Halls medication cart at 2:00 PM on 09/17/25, this state surveyor found a glargine insulin pen with an open date of 08/18/25 and an expiration date of 09/15/25 in the top drawer. The label on the insulin pen revealed it was ordered for Resident #93. In an interview with RN F at 2:40 PM on 09/17/25, RN F stated she administered expired insulin glargine to Resident #93 on both 09/16/25 and 09/17/25. RN F stated she did not check to see if the insulin was expired before administering it to Resident #93. RN F stated insulin pens expired 28 days after opening them. RN F stated administering expired medications to residents could lead to unexpected side effects and ultimately harm the resident. In an interview with the DON at 9:30 AM on 09/18/25, the DON stated it was dangerous to administer expired medications to residents. The DON stated nurses should check (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications before administering them to ensure the medication, dose, route, expiration, and resident were all correct. The DON stated there should not have been expired insulin in the medication cart in the first place. The DON stated administering expired medications could lead to hyperglycemia or other unintended side effects. Record review of the undated facility policy titled Storage of Medications revealed the following policy: .2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Record review of the undated facility policy titled Administering Medications revealed the following policy: .3. Medications must be administered in accordance with the orders, including any required time frame 7. The individual administering the medication shall follow the three rights of medication administration: right resident; right dose; right time 9. The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 1 of 1 nutrition rooms (first floor and second floor nutrition room) reviewed for sanitation. The facility failed to ensure items in the refrigerators and freezers were labeled and dated. The facility failed to ensure items stored in the dry storage room were correctly dated and labeled. The facility failed to ensure refilled cereal in cereal dispensers were dated and label with correct date. The facility failed to ensure gloves were used at all times while making preparing uncooked foods. The facility failed to ensure applesauce and pudding sitting out in room temperature were labeled with current date and time. These failures could place residents at risk of foodborne illnesses. The findings included: Observation and Initial tour of the kitchen on 09/16/25 at 8:15 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. There was a block of cheese in the refrigerator unlabeled and undated. There was a tray of corn undated. In the dry goods storage room a bag of pasta had no label and undated. On one of the tables four cup sat at room temperature without dates, times, and legible labels. In observation on 09/17/24 at 5:10 PM for the return visit of the kitchen and interview revealed DA# N was going to make a sandwich for a resident and reached in and grabbed two slices of bread as she touched the first slice she realized she had no gloves threw away the bread and went and washed her hands again and put on gloves and started to make the sandwich. In an interview with DA O on 09/16/25 at 8:32 AM she said all kitchen staff were responsible for labeling any stored food in the refrigerator and cleaning the refrigerator and made sure that all food was labeled, had not expired and had a use by date. DA O stated the fridge was cleaned and all expired food was thrown out daily. DA O could not explain why the cheese and corn did not have a date of when they were placed in refrigerator. The dry goods storage room was cleaned out every time they received an order so at least once a week and a label with a received date and expiration date should be put on all items stored in the dry goods storage room. In an interview with the FSM on 09/16/25 at 9:43 AM stated she and the staff clean out the refrigerator daily and could not explain why the cheese had no label or date and why corn did not have a date only that it must have been done recently in error. The FSM stated she did not know why the pasta had no received by date or expiration date as all other items had a label with a date. The FSM said they could have been just used for cooking and label could have fallen off and could be the reason why the pasta had no labels with dates. The FSM stated she will do a retraining on the importance of dating food and making sure refrigerated food stored in refrigerator are dated, making sure dry food stored are all dated with received by and expiration dates, and throwing out expired foods for all forms of storage. In an interview on 09/17/25 at 5:16 PM with DA N said she was nervous because state surveyor was watching her make the sandwich a resident asked for during dinner time. DA#2 said she know not the touch any food she is going to prepare without washed and gloved hands. In an Interview on 09/17/25 at 5:30 PM with FSM she stated she would retain the staff on why and when to wash hands and put on gloves while serving and preparing food. Record review of the facility pest control receipts indicated gnats in the dish room was addressed and initialed by the MM and pest control technician on 04/22/25, 07/21/25 and 08/08/25. 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. Record review of the facility kitchen policy titled, Sanitation/Infection (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Control-Handwashing revised 06/2013 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.References: U.S. Food and Drug Administration Food Code http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ :FDA Food Code 2022 Ch. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. to (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETYFOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of infection, for 2 of 5 Residents (Resident #40 and Resident #63) that were reviewed for infection control in that: 1. The facility failed to ensure the wound dressing on Resident #40 was dated and initialed. 2. The facility failed to ensure CNA I performed proper perineal care (incontinent care) with Foley catheter for Resident #63. These deficient practices could place residents in the facility at risk for infections, healthcare associated cross contamination, and the spread of infection. Findings included: 1. Record review of Resident #40's electronic face sheet, dated 09/18/2025, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. The resident had diagnoses which included: Unspecified Dementia, Cerebral Infarction (stroke), Aphasia (a language disorder that makes it hard to understand or express language), Heart Failure, Coronary Artery Disease (a type of heart disease that occurs when the arteries of the heart cannot deliver enough oxygen to the heart due to plaque buildup), Hypertension (high blood pressure), Anxiety, Depression, and Osteoarthritis (the protective cartilage in your joints breaks down). Record review of Resident #40's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 0, indicating her cognition was severely impaired. Resident #40's skin and injury treatments marked for application of nonsurgical dressings. Record review of Resident #40's person- centered care plan, initiated date 09/16/2025 reflected resident potential for injury: skin tears/bruising related to fragile skin, restless movements, bumping arms/legs, and ecchymotic skin (bruises). Interventions included treatment to skin ears per physician orders, geri-gloves or long sleeve clothes to protect arms, assess/monitor skin every shift, and handle carefully during transfers/repositioning. Record review of Resident #40's physician order reflected, left forearm skin tear: cleanse with normal saline, pat dry with 4x4 island gauze daily Monday, Wednesday, Friday, and as needed until resolved, dated 09/16/2025. During an observation on 09/16/2025 at 12:25 p.m. revealed Resident #40 was sitting in a wheelchair by the nurses' station upstairs. She had a wound dressing on her left forearm with no date and no initials. In an interview on 09/16/2025 at 12:27 p.m. RN F, the charge nurse for Resident #40, confirmed the resident had a wound dressing on her left forearm that was not labeled. She stated that she was not the one who applied the dressing. RN F stated that the nurse who applied it was responsible for labeling the dressing with the date and the initials. She stated that it was important to label the dressing to know when it needed to be changed. RN F stated that it was important to label the dressing because it can cause infection, not knowing how long they have had it for. She stated she had done wound training upon hire, which was about a month ago, but they have a wound care nurse. In an interview on 09/16/2025 at 3:39 p.m. with the WCN, stated that she did not put the dressing on Resident #40. She stated that it was important to label the dressings because then they would not know how long they have had it for, and it can cause infection. The WCN stated that the dressing should be labeled with the date and the nurse's initials upon application. She stated she had wound training last October and got her wound certification. She stated that she does get wound skill check offs. In an interview on 09/16/2025 at 6:45 p.m. with the DON, stated that the wound dressings were to be labeled with the date and the initials of the nurse to know when it was done. She stated that it was important for the nurse to ensure that it was labeled so they knew when to change it. The DON stated that by not having the dressing labeled the site can develop an infection or it can cause the infection to get worse. She stated that she had seen Resident #40's dressing on the left forearm not labeled the morning of, 09/16/2025, but she did not have a chance to notify the wound care nurse because the state surveyors walked in shortly after and she got busy. The DON stated that the WCN was new and that they hired another treatment nurse to assist. She stated that wound care training was done annually and as needed. She stated skill check offs are done as well. 2. Record review of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #63's electronic face sheet, dated 09/18/2025, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and original date 02/20/2020. The resident had diagnoses which included: Neuromuscular Dysfunction of bladder (affects the nerves that control voluntary muscles of the bladder), Cerebral Infarction (stroke), Hemiplegia and Hemiparesis, Coronary Artery Disease (a type of heart disease that occurs when the arteries of the heart cannot deliver enough oxygen to the heart due to plaque buildup), Hypertension (high blood pressure), Anxiety, Depression, and Type 2 Diabetes Mellitus (high blood sugar). Record review of Resident #63's Quarterly MDS assessment, dated 06/26/2025 reflected a BIMS score of 11, indicating Resident #63 was moderately cognitively impaired. Resident #63 had an indwelling catheter and was always bowel incontinent. Record review of Resident #63's comprehensive person-centered care plan dated 08/18/2025 reflected Problem Resident #63 has indwelling Foley catheter due to Neuromuscular Dysfunction/Neuropathic Bladder. She is incontinent with uninhibited bowl. Interventions: Resident #63 Provide incontinent care promptly when found wet or soiled and resident is dependent for toileting tasks/incontinent care. During an observation on 09/17/2025 at 1:47 p.m. revealed CNA I cleansed Resident #63 bilateral groin folds. She then cleansed the left outer side of the labia with one swipe, disregarded wipe. She then proceeded to clean the catheter tubing. She did not clean the right outer side of the labia or both inner sides of the labia before she got to the catheter tubing. In an interview on 09/17/2025 at 2:06 p.m. CNA I, stated that she forgot to clean both outer and inner folds of the vaginal opening. She stated she got nervous, but she tried her best. CNA I stated that it was important to cleanse perineal area properly to prevent infection. She stated that in-services for infection control were done about once a month. In services for perineal care were done frequently with the most recent one done about a month ago. In an interview on 09/17/2025 at 2:10 p.m. ADON A, was present during the perineal care observation. She stated that she had seen that CNA I had not cleaned Resident #63 properly. She stated that she cleaned only one side of her labia fold. ADON A stated that Resident #63 was to be cleaned on both sides of the outer and inner labia before cleaning the foley catheter tube. She stated that CNA I was probably nervous. She stated that they have in-services for infection control and perineal care on a monthly basis. She stated that they do conduct perineal care skill check offs upon hire and annually. ADON A stated that it was important for the CNAs to do perineal care properly to prevent infection. In an interview on 09/18/2025 at 10:17 a.m. with the DON, she stated CNAs have competency checks for incontinent care done annually and as needed. She stated that the CNAs should have cleansed both sides of the inner and outer labia folds before proceeding to the foley catheter tubing. The DON stated this was important to provide proper perineal care for infection control. She stated the last in-service for infection control was done a couple days ago. Record review of the facility's skill check off record provided revealed WCN met requirements for Skin/Wound on 07/28/2025. Record review of the facility's skill check off record provided revealed CNA I met requirements for Perineal/Incontinent Care-Female on 06/11/2025. Record review of the facility's mandatory in-service dated 09/15/2025 revealed one of the topics discussed was Infection Control to include techniques for prevention and control of infections, Handwashing. Record review of the facility's Wound Care, Procedure policy, not dated, revealed Documentation: The following information should be recorded in the resident's medical record, treatment sheet or designate wound form: 1. The date and time the dressing was changed. Record review of the facility's Incontinent Care/Perineal Care with or without a Catheter policy, revised date 07/2012, revealed Policy: It is the policy of this home to provide incontinent care to residents in a manner which provides privacy, promotes dignity and ensures no cross contamination. Female:Wash clean to dirty Clean the middle outSpread labia and clean left, right, and center (clean to dirty; front to back)Pat dryWash inner thighs .Record review of the facility's Infection Prevention and Control Program Policy date revised December 2016 revealed: Policy Statement: 1.The infection prevention and control program is a facility wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. 2.The elements of the infection prevention and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	control program consist of coordination/oversight, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure each resident had a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 (Resident #5) of 5 residents reviewed for resident rights. The facility failed to provide Resident #5 with choices concerning her caregivers for personal care. LVN D did not leave the room when Resident #5 asked her multiple times to step out on 08/23/25. LVN D did not treat Resident #5 with respect and dignity on 09/05/25. This failure could place residents at risk for diminished quality of life and loss of dignity and self-worth. The findings included: Record review of Resident #5's face sheet reflected a [AGE] year-old female originally admitted to the facility on [DATE] with most recent admission on [DATE]. Her diagnoses included paraplegia (the loss of voluntary movement and sensation in both legs), anxiety disorder (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life), metabolic encephalopathy (a chemical, or metabolic, problem in the body that can cause brain dysfunctions such as confusion, memory loss, and/or personality changes), and muscle wasting and atrophy (loss of muscle mass and strength), morbid (severe) obesity due to excess calories (weight is more than 80 to 100 pounds above a person's ideal body weight) and neuropathy (damage to nerves outside of the brain and spinal cord that leads to pain, weakness, numbness or tingling in one or more parts of the body). Record review of Resident #5's quarterly MDS dated [DATE] reflected in section C- Cognitive Patterns, a BIMS score of 15 which indicated she was cognitively intact. Section GG- Functional Abilities-Interim reflected Resident #5 was dependent (helper did all the effort, resident did none of the effort, to complete the activity) with toileting hygiene, shower/bathe self, and lower body dressing. Resident #5 required substantial/maximal assistance (helper did more than half the effort) to roll left and right in bed. Section H- Bladder and Bowel reflected Resident #5 had an indwelling urinary catheter, she was always incontinent of bowel, and a bladder and/or bowel toileting program were not being used. Record review of Resident #5's care plan dated 04/11/16 reflected a problem of resident required assistance for all ADL and mobility tasks due to paraplegia, neuropathy, weakness, impaired balance, and poor endurance/ activity tolerance with start date 04/11/16. The goal was resident would be clean/ well-groomed/ appropriately dressed, would have mobility needs met, and would maintain current functional ability through review date. Approaches included resident required extensive X1 staff assistance for personal hygiene tasks, dressing, and clothing changes daily and PRN (start date 01/28/21). Resident #5's care plan also reflected a problem of resident had hx of making false allegations/threats towards staff members. Refused care from all staff at times, had preferences in staff she preferred, and stated staff refused to attend to her needs if staff she preferred were not on schedule, with start date 04/11/16 and edit date 09/30/24. The goal was resident would reduce the number of threatening remarks toward staff throughout next review. Approaches included convey an attitude of acceptance toward the resident, maintain a calm environment and approach to the resident, maintain a calm, understandable approach, repeat as necessary, set acceptable expectations and limits for resident and ensure resident that all needs have been met by staff every day, support appropriate moods/behavior, and when resident begins to become inappropriate, disruptive, accusatory, or threatening, provide for basic needs: assess for pain, hunger, toileting, too hot/cold, etc. dated 01/28/21. Resident #5's care plan further reflected a problem of resident had an electronic monitoring device in bedroom per their and family's wishes with start date 03/07/24. The goal was resident's and family's wishes were to be respected throughout next review (long term goal target date 10/31/24). In an interview on 09/16/25 at 11:12 AM and 09/18/25 at 10:00 AM, Resident #5 stated due to her childhood trauma she had a lot of issues and because of those issues, she would not allow men to change her. Resident #5 stated to her (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	knowledge, all the CNAs were told when they started working at the facility that males would not perform incontinent care for her. Resident #5 stated there were 2 new CNAs that were orienting, and to her knowledge they were both female. Resident #5 stated she found out later that one of them (CNA C) was a male but was representing himself as a female. She stated he was very good at the job he was doing, and she had no complaints other than the fact that some staff knew he was not biologically a female but allowed him to provide incontinent care for her anyway. Resident #5 stated LVN G was taken off her care several years ago and she had not seen her in approximately 5 years. Resident #5 stated, Recently something possessed her, exactly what, I don't know. [LVN G] was upset because [CNA H] was coming to a different hall to change me. Resident #5 stated LVN G came to her door 3 times to rush CNA H and the resident reported her (LVN G). Resident #5 stated she felt like LVN G was getting back at her for complaining about her. Resident #5 stated, They had found out earlier in the week that [CNA C] was a male, but [LVN G] sent him in here anyway. Resident #5 states she was told by CNA H that LVN G stopped her from changing her (Resident #5) and instead sent CNA C to change her. Resident #5 stated CNA H was off for the weekend after that and when she came back CNA H told her she was so sorry, there was nothing she could do about it, but LVN G told CNA C to go change her (Resident #5) and to never tell her that he was not a female. Resident #5 stated, It made me so mad because of all the stuff I'd been through in my childhood. Over time here, I was able to let males help a little bit like adjust my diaper or zinc oxide ointment. But when I found out that the nurse sent him, knowing he was a male, I couldn't understand how a nurse could be so evil. Resident #5 stated she has had to take control of her anxiety and her emotions and talk to her church for emotional support because of LVN G. Resident #5 stated CNA C did not mistreat her in any way, but she felt that he should have been honest with her. Resident #5 stated they did talk to CNA C then he and his sister (also a CNA) both quit. Resident #5 stated she kept a logbook and had a log entry on 08/23/25 at 1:50 AM that stated LVN D barged in her room without knocking to see what CNA H was doing. Resident #5 stated it was the second time that shift LVN D did not knock before entering her room; it had also happened at 8:50 PM. Resident #5 stated, When [LVN D] did it the first time, we had words over knocking on the door because she [LVN D] walked in without knocking to tend to my roommate. [LVN D] stated that I was not going to do to her like I did to the other nurse about knocking. That she was not going to play that game. Resident #5 stated she complained to the DON on 08/24/25 about LVN D's behavior throughout the shift and showed her the video. Resident #5 then showed the surveyor a video dated 08/24/25. In that video, CNA H was performing incontinent care for Resident #5. Resident #5 asked LVN D to step out of the room. LVN D can be heard saying, She can be in here 15 minutes. Resident #5 told LVN D to step out of the room again. LVN replied, I will when I am done speaking to her. I'm the charge nurse. Resident #5 again told LVN D to step out of the room. LVN D stated, No, she will not be in here that long. She will not be in here 45 minutes. LVN D then left the room. In the 16 second video clip, Resident #5 can be heard telling LVN D to step out of the room [ROOM NUMBER] times total. Resident #5 showed the surveyor a video dated 09/05/25 at 10:09 PM. In that video which lasted 48 seconds, Resident #5 was on her left side and LVN D was seen placing a brief under her. Resident #5 asked, Clean it? and pointed to her buttocks area. LVN D replied, No, no, no. Just wait. Scoot over there. Resident #5 stated, You better clean me with soap. LVN D answered, No. No, You just wait 'til I get over there. I was wiping off all the poop first, as she was tucking the brief under Resident #5's hip. LVN D stated, Don't talk to me like that cause I won't do it. I won't come in here. That's for sure. I'm over here making sure that you have nothing on you first. That way we get nothing on the clean diaper, while she was using peri foam to wipe Resident #5 and the video ended. Resident #5 showed the surveyor a video dated 09/05/25 at 10:10 PM. In that video which lasted 1 minute and 46 seconds, LVN D was performing incontinent care for Resident #5 who was rolled to her left side. LVN D told Resident #5, OK, come back. Resident #5 asked her, Did you get the folds? LVN D then answered rudely, Unh-uh. Yes, I did. We had the foam. Yah. I'm not gonna sit there and toalla and toalla (towel and towel in Spanish). No. I do what I. And I used the foam, (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the peri wash on you and that's all I need to do. And put cream. And cleaned in between your creases. Resident #5 rolled to her back and stated, You need to put cream down here, right here where I got the rash, and pointed to the back of her upper thigh/buttocks area. LVN D said to her, No. No ma'am. Unh-uh. No. This is. I'm already doing this. And that's all I'm gonna do. I have cream, the [name of the ointment] ointment all over the place, while wiping cream on Resident #5's inner thigh. LVN D then handed the packet to the person in the room that was helping her and told Resident #5, OK, roll this way or however you do. Resident #5 rolled to her right side and asked, Am I dirty on that side? LVN D answered, No. I told you I cleaned you with a lot of them and we used the peri foam. Resident #5 asked, OK, you put cream over here on this side? LVN D answered, No, because I did it already. Resident #5 replied, Not on that side. LVN D told her, yes, I did [Resident #5]. Resident #5 rolled onto her back and LVN D stated, Now come on. Let's get this on and I'm going to empty the catheter before I leave. Resident #5 said, Now we gotta get this [unintelligible]. Don't pull it, don't pull it. (Referring to her urinary catheter). LVN D stated, Not right now. OK then, you need to lift up because I'm fixing to walk out. The video ended at that point. In a telephone interview on 09/17/25 at 4:29 PM, CNA C stated he worked at the facility for 2 weeks. He stated he quit, and it was the worst place he had ever worked. CNA C stated the facility was aware that he was a male because his ID showed he was a male, but the night nurses did not know he was a male since he looked like a female and had breasts. CNA C stated when he started, he was just put on the floor alone with no orientation, no teaching, no nothing. CNA C stated it was probably 3 days in, they figured out he was a boy because of a conversation that they had. CNA C stated he did not know it was an issue for him to provide care for Resident #5 until another nurse who, he guessed had been there longer, yelled at him to not go in there because that resident (Resident #5) was not to have care done by males. CNA C stated after that night, he went in her room to clean up and stuff, just not provide incontinent care or anything. CNA C stated Resident #5 did not have any issues with him going in to clean her room or anything, and never told him that she knew he was a boy. CNA C stated, On my last day, I asked [Resident #5] is everything ok because she just randomly asked me who the charge nurse was for this hall and the other hall. When I went to tell the nurse about the interaction, the nurse started yelling at me and calling me stupid for going in there. She was yelling at me that males could not go in there and provide care. That night, the nurses also wouldn't let me go upstairs to get a female CNA to provide care. And they would not go in and provide care. CNA C stated his last night was 9/2/25. CNA C stated, I saw that all of the nurses were rude to her on purpose. On my first day there, they were telling me that I would not want to care for her because she was needy about the way that we change her. Basically, she gets a bed bath every time we change her. You soap her up on the front, wipe it, re-soap it, wipe it, then do the same on the back. Changing her took about an hour. CNA C stated he originally talked to the DON and the HR person. During his interview, the DON asked what shift he wanted to work (he stated overnight), how long had he been a CNA, (he stated 3 months), and how much he wanted to be paid. She then said to come in on Wednesday (08/13/25). CNA C stated, The HR lady just gave me paperwork to fill out. They copied my ID which says I'm male. CNA C stated, After the nurse yelled at me, I was crying and [CNA H] walked with me and said she was sorry, that she did not know I was a boy. [CNA H] said she would have told me about [Resident #5] not wanting a male to provide care. CNA C further stated, The nurses knew before that night that I was a guy, but it was a few days before that they told me not to provide care. 2 days before my last day, I went up to have 2 female CNAs from upstairs switch with me to provide care for Resident #5, but the nurses said to ignore [Resident #5] because she did not want my help. [Resident #5] was on the call light so I told her that I would get someone to help her. An hour later her light was still on, and I asked her if anyone had gone to help her and she said no. I told her that I had told the nurses and that's when she asked me for their names, I told her I didn't know then described them and she told me she knew who they were. So that's when I went out and told the 300 hall nurse that [Resident #5] wanted to know her name. My nurse in the 200 hall is the one who told me to ignore her. She had just put in her 2 week notice (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that day. She was saying she was quitting because they were so short staffed. The nurses never moved from the nurse's station all night. In an interview on 09/18/25 at 11:44 AM, CNA L stated she had been at the facility for three years and normally worked in Resident #5's hall. She was able to name the abuse coordinator and the types of abuse. She stated if she saw any abuse she would report it right away to the charge nurse and to the Admin. CNA L stated new CNAs oriented on which residents were continent or incontinent, what the daily routine was, and they had a sheet at the nurse's station in the ADL book that listed residents with any special needs. CNA L stated there were special instructions regarding Resident #5's care, but she did not remember specifically what the instructions were. CNA L stated the last in-service over ANE was 09/15/25 and they were every month on the 15th. CNA L stated the in-service covered types of abuse, who to report it to, resident hydration and cleaning. CNA L was not sure what constituted abuse. CNA L stated, [Resident #5] just has her ways and if she did not like you, she would not let you touch her. CNA L stated she was not allowed to take care of Resident #5 because Resident #5 said she was being too rough with her. CNA L stated, [Resident #5] has certain people that she does want to take care of her and certain ones that she doesn't, but she did not remember the names of any of them. In an interview on 09/18/25 at 12:16 PM, CNA N stated she had been at the facility for over 10 years and primarily worked in Resident #5's hall. CNA N stated there were a lot of people that Resident #5 did not like and on the day shift, the only person she liked was CNA N. CNA N stated, If [Resident #5] did not like anyone that was working, she would wait the entire shift to be changed because she would not let anyone she did not like change her. With her it was always 2 people because she was always accusatory, so in the mornings, a nurse had to go with me sometimes if [Resident #5] didn't like any of the other CNAs. CNA N stated Resident #5 did not like men to provide care for her and only 1 male CNA could check to see if she needed to be changed, but he was not allowed to provide incontinent care. CNA A stated the male CNA could be in the room, but he had to face away. CNA N stated ANE in-service was done the 15th of every month, and the last one was 09/15/25. CNA N stated they gave papers with the in-service that went into more detail about the training. In an interview on 09/18/25 at 12:28 PM, ADON A stated Resident #5 complained about LVN D a couple of weeks back. ADON A stated the CNAs took a long time with Resident #5 when care was provided because Resident #5 was very particular about the care and was also very picky about who provided care for her. ADON A stated that evening they had to get the CNA from the other side to take care of Resident #5, and LVN D went in the room and told the CNA she only had 15 minutes to do care for her (Resident #5) while CNA H was providing care. Resident #5 had told LVN D to leave the room and she left the room. LVN D got moved upstairs because she was PRN, and we needed her upstairs. LVN D got fired for that incident on 09/15/25 after we watched the video because of how she talked to Resident #5. ADON A stated in-services on abuse and neglect were done anytime there was an incident and monthly on the 15th of every month or the nearest weekday if the 15th was on a weekend. ADON A stated they went over the types of abuse and asked the staff to identify the different types of abuse. ADON A stated there were not any hand-outs that went with the abuse/neglect in-services, but staff was verbally quizzed about different scenarios, and they were to identify what type of abuse it was. In an interview on 09/18/25 at 12:51 PM, the SW stated Resident #5 had talked to her about LVN D being rude about the CNA taking too long to care for her approximately 1 1/2 to 2 weeks ago. The SW stated, I think she had talked to the DON before she talked to me. I don't know what was done about it, you'd have to ask the DON. The SW stated abuse/neglect in-services were on the agenda for the meetings that were held on the 15th of every month. The SW stated Resident #5 was tying our hands because she would not allow many of the CNAs to provide care. The SW stated there was only one specific CNA downstairs that was allowed to take care of her that she knew of. The SW asked Resident #5 if she wanted to talk to psychiatric services and the following day, Resident #5 stated she did want to talk to them. In an interview on 09/18/25 at 1:01 PM, the DON stated, [Resident #5] has gotten to the point that she doesn't want anyone to care for her. I have 2 nurses and 2 aides on (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3-11 that she won't let care for her. The same with day shift. I have asked the ombudsman for help, and she said she didn't have any suggestions. The DON stated Resident #5 took about 45 minutes to change her because she was very particular about what she wanted done and how it was done and when she wanted it done. The DON speculated maybe Resident #5 just wanted company, but they had so many residents that they could not spend an hour at a time in with Resident #5. The DON stated, [Resident #5] always threatens that she has video and will report us. The DON stated Resident #5 complained about LVN D approximately 2 weeks ago and said that LVN D was rude and unprofessional. The DON stated Resident #5 showed her the video a couple of weeks ago, and further stated, I was surprised with [LVN D] being so rude and disrespectful. The DON stated she and ADON A called LVN D into the office the next day and told her that she was unprofessional and asked her why she talked to [Resident #5] like that. The DON stated LVN D said she was tired of doing that all day and Resident #5 was very aggressive and would be on the call light all day long. The DON stated, We talked to [Resident #5] and told her that [LVN D] was not going to work that area anymore. The DON stated LVN D worked one shift after that, and she told them not to let her work anymore. The DON stated, We let her go on 09/15/25 for being disrespectful, rude, and unprofessional. You don't treat a patient like that. When asked if she thought LVN D's behavior was abuse, the DON stated, I would say that it was verbal abuse. I told the Admin about it the same day that I did the interview with [Resident #5], about 2 weeks ago. Me, the ADON and the Admin discussed it and decided it would be better to let the nurse go. The DON stated allegations of abuse were to be reported to the state within 2 hours, but this one was not reported within 2 hours because, We could not get a hold of her (LVN D). The DON stated when she talked to LVN D about it a couple of weeks ago, she (LVN D) said she was not coming back, but she did work another shift after that. The DON stated she told the ADONs not to have her come back in. Later in the interview the DON stated, It did not get reported to state because we were discussing it and listening to the video trying to decide if it was abuse or not, but we had already let her go. In an interview on 09/18/25 at 5:18 PM, the Admin stated he found out about the issue between Resident #5 and LVN D when the ombudsman told him on Monday, 09/15/25, and that he was out of the facility for part of the week between 08/24/25 and 08/30/25. The Admin stated, the SW and I went over to talk to Resident #5, and she showed me a video where LVN D is telling the CNA H that she shouldn't be taking 45 minutes to change the resident. [Resident #5] was telling [LVN D] to get out of the room and [LVN D] kept talking to the CNA instead of leaving. I decided to report it to state even though I hadn't even completed my investigation yet. When I listened to it, then I looked over the rules and regulations, I wanted to make sure that it would fall under verbal abuse. The more I looked at the video, I don't think she (LVN D) was trying to threaten her (Resident #5) or make her feel afraid, and [Resident #5] said she wasn't afraid of her, but I couldn't find anything that made me feel like it was abuse. The Admin stated that being rude and ugly toward someone did make it reportable and they let her go because they did not want her to be rude or ugly to anyone else. The Admin stated no one told him anything prior to 09/15/25. The Admin stated, For the most part, he did see the grievances. The Admin stated in the mornings he would ask the SW if there were any issues. He further stated he would ask for grievances at every morning meeting. The Admin stated he was surprised to know that there was a grievance about this issues before he heard it from the ombudsman. The Admin stated, If the DON had told me about that grievance, I would have reported it. Once I find out about abuse it's 2 hours to report, everything else is 24 hours. Once I saw the video, I reported it. The DON saw the video first and she came back and told me she was not sure if it was abuse or not, so then I went in with the SW and watched it, talked with corporate, then decided to report it. The Admin stated they had abuse/neglect in-services every month on the 15th. Record review of the facility's grievance dated 08/21/25 at 10:06 AM reflected the following: Resident Name: [Resident #5] Describe the grievance/concern: Resident complain on a CNA that whoever did peri care-had done a very good job-but she did not know weather it was a he or a she- & was very concerned [sic]. Expectation of person voicing concern: Resident voiced that she does not (continued on next page)		

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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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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	want the 2 CNA that work her hall [sic].Findings: Resident also complain on my 2 nurses that work 7P to 7A [sic].Action taken: Spoke to [LVN G] and advise her to please, do not go to her room- never again- because resident hates her. Also on the other nurse, Resident says she does not knock at her room. 8/22/25 Advice to other nurse- to please knoce at her door- this is a state regulation & she must follow up- she agreed. *Note 2 of my CNA & (1) nurse are not allowed to go to her room. Because she resident does not want them [sic].Reportable to outside agency? Nolf yes, was this reported? NoInvestigation findings reported to person voicing concerns? YesHow? In personNote: On the complain above I have an older CNA that will attend her (unreadable name) Now when [CNA H] is off, one of the CNA upstairs will help her [sic].Person Completing Inquiry: [DON] signatureDate: 08/23/25Record Review of the facility's Quality of Life-Dignity Policy dated 02/2020 reflected in part: Policy StatementEach resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.Policy Interpretation and Implementation1. Residents shall be treated with dignity and respect at all times.2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.6. Residents' private space and property shall be respected at all times.a. Staff will knock and request permission before entering residents' rooms.7. Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs.11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by:b. Promptly responding to the resident's request for toileting assistance.Record review of the facility's undated admission packet reflected in part: Statement of Resident RightsYou, the resident, do not give up rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law. It is against the law for any facility employee to threaten, coerce, intimidate, or retaliate against you for exercising your rights.If anyone hurts you, threatens to hurt you, neglects your care, takes your property, or violates your dignity, you have the right to file a complaint with the facility administrator or with the Texas Department of Aging and Disability Services by calling [PHONE NUMBER].Dignity and RespectYou have the right to:Be free from abuse, neglect, and exploitation.Be treated with dignity, courtesy, consideration, and respect and be free from discrimination based on age, race, religion, sex, nationality, disability, marital status, or source of payment.Freedom of choice:You have the right to:Make your own choices regarding personal affairs, care, benefits, and services.Participation in your care:You have the right to:Receive all care necessary to have the highest possible level of health.Participate in developing a plan of care, to refuse treatment, and to refuse to participate in experimental research.Complaints:You have the right to:Complain about care or treatment and receive a prompt response to resolve the complaint without fear of reprisal or discrimination.Your rights may be restricted only to the extent necessary to protect you or others, or to protect the rights of others, particularly those rights relating to privacy and confidentiality. These described rights are in add remedies an individual may be entitled to, according to rules under law.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from abuse, neglect, misappropriations of resident property, and exploitation for 1 (Resident #5) of 5 residents reviewed for abuse. LVN D was verbally abusive to Resident #5 on two occasions on 08/24/25 and 09/05/25. This failure could place residents at risk for physical, mental, and/or psychosocial harm. The findings included: Record review of Resident #5's face sheet reflected a [AGE] year-old female originally admitted to the facility on [DATE] with most recent admission on [DATE]. Her diagnoses included paraplegia (the loss of voluntary movement and sensation in both legs), anxiety disorder (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life), metabolic encephalopathy (a chemical, or metabolic, problem in the body that can cause brain dysfunctions such as confusion, memory loss, and/or personality changes), and muscle wasting and atrophy (loss of muscle mass and strength), morbid (severe) obesity due to excess calories (weight is more than 80 to 100 pounds above a person's ideal body weight) and neuropathy (damage to nerves outside of the brain and spinal cord that leads to pain, weakness, numbness or tingling in one or more parts of the body). Record review of Resident #5's quarterly MDS dated [DATE] reflected in section C- Cognitive Patterns, a BIMS score of 15 which indicated she was cognitively intact. Section GG- Functional Abilities-Interim reflected Resident #5 was dependent (helper did all the effort, resident did none of the effort, to complete the activity) with toileting hygiene, shower/bathe self, and lower body dressing. Resident #5 required substantial/maximal assistance (helper did more than half the effort) to roll left and right in bed. Section H- Bladder and Bowel reflected Resident #5 had an indwelling urinary catheter, she was always incontinent of bowel, and a bladder and/or bowel toileting program were not being used. Record review of Resident #5's care plan dated 04/11/16 reflected a problem of resident required assistance for all ADL and mobility tasks due to paraplegia, neuropathy, weakness, impaired balance, and poor endurance/ activity tolerance with start date 04/11/16. The goal was resident would be clean/ well-groomed/ appropriately dressed, would have mobility needs met, and would maintain current functional ability through review date. Approaches included resident required extensive X1 staff assistance for personal hygiene tasks, dressing, and clothing changes daily and PRN (start date 01/28/21). Resident #5's care plan also reflected a problem of resident had hx of making false allegations/threats towards staff members. Refused care from all staff at times, had preferences in staff she preferred, and stated staff refused to attend to her needs if staff she preferred were not on schedule, with start date 04/11/16 and edit date 09/30/24. The goal was resident would reduce the number of threatening remarks toward staff throughout next review. Approaches included convey an attitude of acceptance toward the resident, maintain a calm environment and approach to the resident, maintain a calm, understandable approach, repeat as necessary, set acceptable expectations and limits for resident and ensure resident that all needs have been met by staff every day, support appropriate moods/behavior, and when resident begins to become inappropriate, disruptive, accusatory, or threatening, provide for basic needs: assess for pain, hunger, toileting, too hot/cold, etc. dated 01/28/21. Resident #5's care plan further reflected a problem of resident had an electronic monitoring device in bedroom per their and family's wishes with start date 03/07/24. The goal was resident's and family's wishes were to be respected throughout next review (long term goal target date 10/31/24). Record review of the facility's grievance dated 08/24/25 reflected the following: Resident Name: [Resident #5] Describe the grievance/concern: Resident complain that [LVN D] was rude to her and mistreat her. [sic]Expectation of person voicing concern: Spoke to [Resident #5] and [LVN D] will be transferred upstairs. Findings: Nurse will not work on [Resident #5's hall]- She will be transferred upstairs. Action Taken: [blank] Reportable to outside agency: Nolf (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	yes, was this reported: [NAME] Whom: [DON]Date: [check mark]Investigation findings reported to person voicing concern: [neither yes nor no checked]How? In personNote: [Resident #5] is very selective as to who take care of her- She does not want the 2 nurses that worked here, that is [LVN G] and [LVN D] both LVN charge nurse. [sic]Person Completing Inquiry: [DON] signatureDate: 08/25/25 In an interview on 09/18/25 at 10:00 AM, Resident #5 stated she kept a logbook and had a log entry on 08/23/25 at 1:50 AM that stated LVN D barged in her room without knocking to see what CNA H was doing. Resident #5 stated it was the second time that shift LVN D did not knock before entering her room; it had also happened at 8:50 PM. Resident #5 stated, When [LVN D] did it the first time, we had words over knocking on the door because she [LVN D] walked in without knocking to tend to my roommate. [LVN D] stated that I was not going to do to her like I did to the other nurse about knocking. That she was not going to play that game. Resident #5 stated she complained to the DON on 08/24/25 about LVN D's behavior throughout the shift and showed her the video. Resident #5 then showed the surveyor a video dated 08/24/25. In that video, CNA H was performing incontinent care for Resident #5. Resident #5 asked LVN D to step out of the room. LVN D can be heard saying, She can be in here 15 minutes. Resident #5 told LVN D to step out of the room again. LVN replied, I will when I am done speaking to her. I'm the charge nurse. Resident #5 again told LVN D to step out of the room. LVN D stated in a rude tone, No, she will not be in here that long. She will not be in here 45 minutes. LVN D then left the room. In the 16 second video clip, Resident #5 was heard telling LVN D to step out of the room [ROOM NUMBER] times total. Resident #5 showed the surveyor a video dated 09/05/25 at 10:09 PM. In that video which lasted 48 seconds, Resident #5 was on her left side and LVN D was seen placing a brief under her. Resident #5 asked, Clean it? and pointed to her buttocks area. LVN D replied, No, no, no. Just wait. Scoot over there. Resident #5 stated, You better clean me with soap. LVN D answered, No. No, You just wait ?til I get over there. I was wiping off all the poop first, as she was tucking the brief under Resident #5's hip. LVN D stated, Don't talk to me like that cause I won't do it. I won't come in here. That's for sure. I'm over here making sure that you have nothing on you first. That way we get nothing on the clean diaper, while she was using peri foam to wipe Resident #5 and the video ended. Resident #5 showed the surveyor a video dated 09/05/25 at 10:10 PM. In that video which lasted 1 minute and 46 seconds, LVN D was performing incontinent care for Resident #5 who was rolled to her left side. LVN D told Resident #5, OK, come back. Resident #5 asked her, Did you get the folds? LVN D then answered rudely, Nuh-uh. Yes, I did. We had the foam. Yah. I'm not gonna sit there and toalla and toalla (towel and towel in Spanish). No. I do what I. And I used the foam, the peri wash on you and that's all I need to do. And put cream. And cleaned in between your creases. Resident #5 rolled to her back and stated, You need to put cream down here, right here where I got the rash, and pointed to the back of her upper thigh/buttocks area. LVN D said to her, No. No ma'am. Nuh-uh. No. This is. I'm already doing this. And that's all I'm gonna do. I have cream, the [name of the ointment] ointment all over the place, while wiping cream on Resident #5's inner thigh. LVN D then handed the packet to the person in the room that was helping her and told Resident #5, OK, roll this way or however you do. Resident #5 rolled to her right side and asked, Am I dirty on that side? LVN D answered, No. I told you I cleaned you with a lot of them and we used the peri foam. Resident #5 asked, OK, you put cream over here on this side? LVN D answered, No, because I did it already. Resident #5 replied, Not on that side. LVN D told her, yes, I did [Resident #5]. Resident #5 rolled onto her back and LVN D stated, Now come on. Let's get this on and I'm going to empty the catheter before I leave. Resident #5 said, Now we gotta get this [unintelligible]. Don't pull it, don't pull it. (Referring to her urinary catheter). LVN D stated, Not right now. OK then, you need to lift up because I'm fixing to walk out. The video ended at that point. n a telephone interview on 09/17/25 at 4:29 PM, CNA C stated he worked at the facility for 2 weeks. He stated he quit, and it was the worst place he had ever worked. CNA C stated when he started, he was just put on the floor alone with no orientation, no teaching, no nothing. CNA C stated it was probably 3 days in, they figured out he was a boy because of a conversation that they had. CNA C stated he had provided (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinent care for Resident #5 a few times and he did not know it was an issue for him to provide care for Resident #5 until another nurse who, he guessed had been there longer, yelled at him to not go in there because that resident (Resident #5) was not to have care done by males. CNA C stated after that night, he went in her room to clean up and stuff, just not provide incontinent care or anything. CNA C stated Resident #5 did not have any issues with him going in to clean her room or anything, and never told him that she knew he was a boy. CNA C stated, On my last day, I asked [Resident #5] is everything ok because she just randomly asked me who the charge nurse was for this hall and the other hall. When I went to tell the nurse about the interaction, the nurse started yelling at me and calling me stupid for going in there. She was yelling at me that males could not go in there and provide care. That night, the nurses also wouldn't let me go upstairs to get a female CNA to provide care. And they would not go in and provide care. CNA C stated his last night was 9/2/25. CNA C stated, I saw that all of the nurses were rude to her on purpose. On my first day there, they were telling me that I would not want to care for her because she was needy about the way that we change her. Basically, she gets a bed bath every time we change her. You soap her up on the front, wipe it, re-soap it, wipe it, then do the same on the back. Changing her took about an hour. CNA C stated he originally interviewed with the DON and then met with the HR person a couple of days later. During his interview, the DON asked what shift he wanted to work (he stated overnight), how long had he been a CNA, (he stated 3 months), and how much he wanted to be paid. She then told him to come in on Wednesday (08/13/25). CNA C stated, The HR lady just gave me paperwork to fill out. They copied my ID which says I'm male. CNA C stated, After the nurse yelled at me, I was crying and [CNA H] walked with me and said she was sorry, that she did not know I was a boy. [CNA H] said she would have told me about [Resident #5] not wanting a male to provide care. CNA C further stated, The nurses knew before that night that I was a guy, but it was a few days before that they told me not to provide care. 2 days before my last day, I went up to have 2 female CNAs from upstairs switch with me to provide care for Resident #5, but the nurses said to ignore [Resident #5] because she did not want my help. [Resident #5] was on the call light so I told her that I would get someone to help her. An hour later her light was still on, and I asked her if anyone had gone to help her and she said no. I told her that I had told the nurses and that's when she asked me for their names, I told her I didn't know then described them and she told me she knew who they were. So that's when I went out and told the 300 hall nurse that [Resident #5] wanted to know her name. My nurse in the 200 hall is the one who told me to ignore her. She had just put in her 2 week notice that day. She was saying she was quitting because they were so short staffed. The nurses never moved from the nurse's station all night. In an interview on 09/18/25 at 11:44 AM, CNA L stated she had been at the facility for three years and normally worked in Resident #5's hall. She was able to name the abuse coordinator and the types of abuse. She stated if she saw any abuse she would report it right away to the charge nurse and to the Admin. CNA L stated new CNAs oriented on which residents were continent or incontinent, what the daily routine was, and they had a sheet at the nurse's station in the ADL book that listed residents with any special needs. CNA L stated there were special instructions regarding Resident #5's care, but she did not remember specifically what the instructions were. CNA L stated the last in-service over ANE was 09/15/25 and they were every month on the 15th. CNA L stated the in-service covered types of abuse, who to report it to, resident hydration and cleaning. CNA L was not sure what constituted abuse. CNA L stated, [Resident #5] just has her ways and if she did not like you, she would not let you touch her. CNA L stated she was not allowed to take care of Resident #5 because Resident #5 said she was being too rough with her. CNA L stated, [Resident #5] has certain people that she does want to take care of her and certain ones that she doesn't, but she did not remember the names of any of them. In an interview on 09/18/25 at 12:16 PM, CNA N stated she had been at the facility for over 10 years and primarily worked in Resident #5's hall. CNA N stated there were a lot of people that Resident #5 did not like and on the day shift, the only person she liked was CNA N. CNA N stated, If [Resident #5] did not like anyone that was working, she would wait the entire shift to be (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed because she would not let anyone she did not like change her. With her it was always 2 people because she was always accusatory, so in the mornings, a nurse had to go with me sometimes if [Resident #5] didn't like any of the other CNAs. CNA N stated Resident #5 did not like men to provide care for her and only 1 male CNA could check to see if she needed to be changed, but he was not allowed to provide incontinent care. CNA A stated the male CNA could be in the room, but he had to face away. CNA N stated ANE in-service was done the 15th of every month, and the last one was 09/15/25. CNA N stated they gave papers with the in-service that went into more detail about the training. In an interview on 09/18/25 at 12:28 PM, ADON A stated Resident #5 complained about LVN D a couple of weeks back. ADON A stated the CNAs took a long time with Resident #5 when care was provided because Resident #5 was very particular about the care and was also very picky about who provided care for her. ADON A stated that evening they had to get the CNA from the other side to take care of Resident #5, and LVN D went in the room and told the CNA she only had 15 minutes to do care for her (Resident #5) while CNA H was providing care. Resident #5 had told LVN D to leave the room and she left the room. LVN D got moved upstairs because she was PRN, and we needed her upstairs. LVN D got fired for that incident on 09/15/25 after we watched the video because of how she talked to Resident #5. ADON A stated in-services on abuse and neglect were done anytime there was an incident and monthly on the 15th of every month or the nearest weekday if the 15th was on a weekend. ADON A stated they went over the types of abuse and asked the staff to identify the different types of abuse. ADON A stated there were not any hand-outs that went with the abuse/neglect in-services, but staff was verbally quizzed about different scenarios, and they were to identify what type of abuse it was. In an interview on 09/18/25 at 12:51 PM, the SW stated Resident #5 had talked to her about LVN D being rude about the CNA taking too long to care for her approximately 1 1/2 to 2 weeks ago. The SW stated, I think she had talked to the DON before she talked to me. I don't know what was done about it, you'd have to ask the DON. The SW stated abuse/neglect in-services were on the agenda for the meetings that were held on the 15th of every month. The SW stated Resident #5 was tying our hands because she would not allow many of the CNAs to provide care. The SW stated there was only one specific CNA downstairs that was allowed to take care of her that she knew of. The SW asked Resident #5 if she wanted to talk to psychiatric services and the following day, Resident #5 stated she did want to talk to them. In an interview on 09/18/25 at 1:01 PM, the DON stated, [Resident #5] has gotten to the point that she doesn't want anyone to care for her. I have 2 nurses and 2 aides on 3-11 that she won't let care for her. The same with day shift. I have asked the ombudsman for help, and she said she didn't have any suggestions. The DON stated Resident #5 took about 45 minutes to change her because she was very particular about what she wanted done and how it was done and when she wanted it done. The DON speculated maybe Resident #5 just wanted company, but they had so many residents that they could not spend an hour at a time in with Resident #5. The DON stated, [Resident #5] always threatens that she has video and will report us. The DON stated Resident #5 complained about LVN D approximately 2 weeks ago and said that LVN D was rude and unprofessional. The DON stated Resident #5 showed her the video a couple of weeks ago, and further stated, I was surprised with [LVN D] being so rude and disrespectful. The DON stated she and ADON A called LVN D into the office the next day and told her that she was unprofessional and asked her why she talked to [Resident #5] like that. The DON stated LVN D said she was tired of doing that all day and Resident #5 was very aggressive and would be on the call light all day long. The DON stated, We talked to [Resident #5] and told her that [LVN D] was not going to work that area anymore. The DON stated LVN D worked one shift after that, and she told them not to let her work anymore. The DON stated, We let her go on 09/15/25 for being disrespectful, rude, and unprofessional. You don't treat a patient like that. When asked if she thought LVN D's behavior was abuse, the DON stated, I would say that it was verbal abuse. I told the Admin about it the same day that I did the interview with [Resident #5], about 2 weeks ago. Me, the ADON and the Admin discussed it and decided it would be better to let the nurse go. The DON stated allegations of (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse were to be reported to the state within 2 hours, but this one was not reported within 2 hours because, We could not get a hold of her (LVN D). The DON stated when she talked to LVN D about it a couple of weeks ago, she (LVN D) said she was not coming back, but she did work another shift after that. The DON stated she told the ADONs not to have her come back in. Later in the interview the DON stated, It did not get reported to state because we were discussing it and listening to the video trying to decide if it was abuse or not, but we had already let her go. In an interview on 09/18/25 at 5:18 PM, the Admin stated he found out about the issue between Resident #5 and LVN D when the ombudsman told him on Monday, 09/15/25, and he was out of the facility for a few days between 08/24/25 and 08/30/25. The Admin stated, the SW and I went over to talk to Resident #5, and she showed me a video where LVN D is telling the CNA H that she shouldn't be taking 45 minutes to change the resident. [Resident #5] was telling [LVN D] to get out of the room and [LVN D] kept talking to the CNA instead of leaving. I decided to report it to state even though I hadn't even completed my investigation yet. When I listened to it, then I looked over the rules and regulations, I wanted to make sure that it would fall under verbal abuse. The more I looked at the video, I don't think she (LVN D) was trying to threaten her (Resident #5) or make her feel afraid, and [Resident #5] said she wasn't afraid of her, but I couldn't find anything that made me feel like it was abuse. The Admin stated that being rude and ugly toward someone did make it reportable and they let her go because they did not want her to be rude or ugly to anyone else. The Admin stated no one told him anything prior to 09/15/25. The Admin stated, For the most part, he did see the grievances. The Admin stated in the mornings he would ask the SW if there were any issues. He further stated he would ask for grievances at every morning meeting. The Admin stated he was surprised to know that there was a grievance about this issues before he heard it from the ombudsman. The Admin stated, If the DON had told me about that grievance, I would have reported it. Once I find out about abuse it's 2 hours to report, everything else is 24 hours. Once I saw the video, I reported it. The DON saw the video first and she came back and told me she was not sure if it was abuse or not, so then I went in with the SW and watched it, talked with corporate, then decided to report it. The Admin stated they had abuse/neglect in-services every month on the 15th. Record review of the facility's self-report dated 09/15/25 reflected in part:The facility was notified of the incident on 09/15/25 by the ombudsman.The facility's investigation summary stated, On the above date and time, the alleged victim advised that an LVN [LVD D] had spoken lo her very badly. Upon viewing the video of the incident, it showed that the LVN was telling the C.N.A., while in [Resident #5's] room, that she should not be taking 45 min. to clean her. [Resident #5] then became upset and started yelling for the LVN to get out. The LVN then staled to [Resident #5] that she was the charge nurse and that she would get out when she was finished talking to the C.N.A. Facility in-serviced staff on facility abuse and neglect policy. Responsible party, physician, police department and THHS were all notified of the incident. The facility's investigative findings were, Inconclusive. Provider Action Taken Post-Investigation: In-service staff on facility abuse and neglect. Subsequently alleged perp. was terminated.Record review of the facility's undated Abuse Prevention policy reflected: POLICY: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. b) Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. 3. It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatment shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment. Care will be monitored so that the resident's care plan is followed.CORRECTIVE ACTION:Any instances of employee disregard for the policies and procedures of this facility are cause for corrective action up to and including suspension, termination, and reporting to licensing agencies.Record review of the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 12/02/2025
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's undated Abuse Investigation and Reporting policy reflected in part: Policy StatementAll reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.Reporting:1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:a. The State licensing/certification agency responsible for surveying/licensing the facility;b. the local/State Ombudsman2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; orb. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.5. The administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 (Resident #5) of 6 residents reviewed for abuse and neglect. The DON failed to follow the facility's policy to report an allegation of verbal abuse made by Resident #5 on or about 08/24/25 to the administrator, the ombudsman, or to the Texas Health and Human Services Commission (HHSC). This failure could place the residents in the facility at risk for physical, mental, and/or psychosocial harm and lack of timely reporting of incidents. The findings included: Record review of Resident #5's face sheet reflected a [AGE] year-old female originally admitted to the facility on [DATE] with most recent admission on [DATE]. Her diagnoses included paraplegia (the loss of voluntary movement and sensation in both legs), anxiety disorder (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life), metabolic encephalopathy (a chemical, or metabolic, problem in the body that can cause brain dysfunctions such as confusion, memory loss, and/or personality changes), and muscle wasting and atrophy (loss of muscle mass and strength). Record review of Resident #5's quarterly MDS dated [DATE] reflected in section C- Cognitive Patterns, a BIMS score of 15 which indicated she was cognitively intact. Section GG- Functional Abilities-Interim reflected Resident #5 was dependent (helper did all the effort, resident did none of the effort, to complete the activity) with toileting hygiene, shower/bathe self, and lower body dressing. Resident #5 required substantial/maximal assistance (helper did more than half the effort) to roll left and right in bed. Section H- Bladder and Bowel reflected Resident #5 had an indwelling urinary catheter, she was always incontinent of bowel, and a bladder and/or bowel toileting program were not being used. Record review of the facility's grievance dated 08/24/25 reflected the following: Resident Name: [Resident #5] Describe the grievance/concern: Resident complain that [LVN D] was rude to her and mistreat her. [sic] Expectation of person voicing concern: Spoke to [Resident #5] and [LVN D] will be transferred upstairs. Findings: Nurse will not work on [Resident #5's hall]- She will be transferred upstairs. Action Taken: [blank] Reportable to outside agency: Nolf yes, was this reported: [NAME] Whom: [DON] Date: [check mark] Investigation findings reported to person voicing concern: [neither yes nor no checked] How? In person Note: [Resident #5] is very selective as to who take care of her- She does not want the 2 nurses that worked here, that is [LVN G] and [LVN D] both LVN charge nurse. [sic] Person Completing Inquiry: [DON] signature Date: 08/25/25 In an interview on 09/18/25 at 10:00 AM, Resident #5 stated she kept a logbook and had a log entry on 08/23/25 at 1:50 AM that stated LVN D barged in her room without knocking to see what CNA H was doing. Resident #5 stated it was the second time that shift LVN D did not knock before entering her room; it had also happened at 8:50 PM. Resident #5 stated, When [LVN D] did it the first time, we had words over knocking on the door because she [LVN D] walked in without knocking to tend to my roommate. [LVN D] stated that I was not going to do to her like I did to the other nurse about knocking. That she was not going to play that game. Resident #5 stated she complained to the DON on 08/24/25 about LVN D's behavior throughout the shift and showed her the video. Resident #5 then showed the surveyor a video dated 08/24/25. In that video, CNA H was performing incontinent care for Resident #5. Resident #5 can be heard telling LVN D to leave her room multiple times. LVN D stated to Resident #5 in a rude tone, No, I am not going to leave until I am done talking. I am the charge nurse. LVN D was also heard telling the CNA she was not going to take more than 15 minutes for care. In an interview on 09/18/25 at 12:28 PM, ADON A stated Resident #5 complained about LVN D a couple of weeks back. ADON A stated the CNAs took a long time with Resident #5 when care was provided because Resident #5 was very particular about the care and was also very picky about who provided care for her. ADON A stated that evening they had to get the CNA from the other side to take care of Resident #5, and LVN D went in the room and (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told the CNA she only had 15 minutes to do care for her (Resident #5) while CNA H was providing care. Resident #5 had told LVN D to leave the room and she left the room. LVN D got moved upstairs because she was PRN, and we needed her upstairs. LVN D got fired for that incident on 09/15/25 after we watched the video because of how she talked to Resident #5. ADON A stated in-services on abuse and neglect were done anytime there was an incident and monthly on the 15th of every month or the nearest weekday if the 15th was on a weekend. ADON A stated they went over the types of abuse and asked the staff to identify the different types of abuse. ADON A stated there were not any hand-outs that went with the abuse/neglect in-services, but staff was verbally quizzed about different scenarios, and they were to identify what type of abuse it was. In an interview on 09/18/25 at 12:51 PM, the SW stated Resident #5 had talked to her about LVN D being rude about the CNA taking too long to care for her approximately 1 1/2 to 2 weeks ago. The SW stated, I think she had talked to the DON before she talked to me. I don't know what was done about it, you'd have to ask the DON. The SW stated abuse/neglect in-services were on the agenda for the meetings that were held on the 15th of every month. The SW asked Resident #5 if she wanted to talk to psychiatric services and the following day, Resident #5 stated she did want to talk to them. In an interview on 09/18/25 at 1:01 PM, the DON stated Resident #5 complained about LVN D approximately 2 weeks ago and said that LVN D was rude and unprofessional. The DON stated Resident #5 showed her the video a couple of weeks ago, and further stated, I was surprised with [LVN D] being so rude and disrespectful. The DON stated she and ADON A called LVN D into the office the next day and told her that she was unprofessional and asked her why she talked to [Resident #5] like that. The DON stated LVN D said she was tired of doing that all day and Resident #5 was very aggressive and would be on the call light all day long. The DON stated, We talked to [Resident #5] and told her that [LVN D] was not going to work that area anymore. The DON stated LVN D worked one shift after that, and she told them not to let her work anymore. The DON stated, We let her go on 09/15/25 for being disrespectful, rude, and unprofessional. You don't treat a patient like that. When asked if she thought LVN D's behavior was abuse, the DON stated, I would say that it was verbal abuse. I told the Admin about it the same day that I did the interview with [Resident #5], about 2 weeks ago. Me, the ADON and the Admin discussed it and decided it would be better to let the nurse go. The DON stated allegations of abuse were to be reported to the state within 2 hours, but this one was not reported within 2 hours because, We could not get a hold of her (LVN D). The DON stated when she talked to LVN D about it a couple of weeks ago, she (LVN D) said she was not coming back, but she did work another shift after that. The DON stated she told the ADONs not to have her come back in. Later in the interview the DON stated, It did not get reported to state because we were discussing it and listening to the video trying to decide if it was abuse or not, but we had already let her go. In an interview on 09/18/25 at 5:18 PM, the Admin stated he found out about the issue between Resident #5 and LVN D when the ombudsman told him on Monday, 09/15/25. The Admin stated, the SW and I went over to talk to Resident #5, and she showed me a video where LVN D is telling the CNA H that she shouldn't be taking 45 minutes to change the resident. [Resident #5] was telling [LVN D] to get out of the room and [LVN D] kept talking to the CNA instead of leaving. I decided to report it to state even though I hadn't even completed my investigation yet. When I listened to it, then I looked over the rules and regulations, I wanted to make sure that it would fall under verbal abuse. The more I looked at the video, I don't think she (LVN D) was trying to threaten her (Resident #5) or make her feel afraid, and [Resident #5] said she wasn't afraid of her, but I couldn't find anything that made me feel like it was abuse. The Admin stated that being rude and ugly toward someone did make it reportable and they let her go because they did not want her to be rude or ugly to anyone else. The Admin stated no one told him anything prior to 09/15/25. The Admin stated, For the most part, he did see the grievances. The Admin stated in the mornings he would ask the SW if there were any issues. He further stated he would ask for grievances at every morning meeting. The Admin stated he was surprised to know that there was a grievance about this issues before he heard it from the ombudsman. The Admin stated, If the DON had (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told me about that grievance, I would have reported it. Once I find out about abuse it's 2 hours to report, everything else is 24 hours. Once I saw the video, I reported it. The DON saw the video first and she came back and told me she was not sure if it was abuse or not, so then I went in with the SW and watched it, talked with corporate, then decided to report it. The Admin stated they had abuse/neglect in-services every month on the 15th. Record review of the facility's self-report dated 09/15/25 reflected in part: The facility was notified of the incident on 09/15/25 by the ombudsman. The facility's investigation summary stated, On the above date and time, the alleged victim advised that an LVN [LVD D] had spoken to her very badly. Upon viewing the video of the incident, it showed that the LVN was telling the C.N.A., while in [Resident #5's] room, that she should not be taking 45 min. to clean her. [Resident #5] then became upset and started yelling for the LVN to get out. The LVN then stated to [Resident #5] that she was the charge nurse and that she would get out when she was finished talking to the C.N.A. Facility in-serviced staff on facility abuse and neglect policy. Responsible party, physician, police department and THHS were all notified of the incident. The facility's investigative findings were, Inconclusive. Provider Action Taken Post-Investigation: In-service staff on facility abuse and neglect. Subsequently alleged perp. was terminated. Record review of the facility's undated Abuse Prevention policy reflected: POLICY: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. b) Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. 3. It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatment shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment. Care will be monitored so that the resident's care plan is followed. CORRECTIVE ACTION: Any instances of employee disregard for the policies and procedures of this facility are cause for corrective action up to and including suspension, termination, and reporting to licensing agencies. Record review of the facility's undated Abuse Investigation and Reporting policy reflected in part: Policy Statement All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. the local/State Ombudsman 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. 5. The administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures for 1 (Resident #5) of 6 residents reviewed for reporting. The DON did not report an allegation of verbal abuse made by Resident #5 on or about 08/24/25 to the Administrator, the ombudsman, or the state licensing/certification responsible for surveying/licensing the facility per facility policy. This failure could place residents at risk for physical, mental, and/or psychosocial harm. The findings included: Record review of Resident #5's face sheet reflected a [AGE] year-old female originally admitted to the facility on [DATE] with most recent admission on [DATE]. Her diagnoses included paraplegia (the loss of voluntary movement and sensation in both legs), anxiety disorder (mental disorder characterized by excessive and persistent worry, fear, or anxiousness which significantly interferes with daily life), metabolic encephalopathy (a chemical, or metabolic, problem in the body that can cause brain dysfunctions such as confusion, memory loss, and/or personality changes), and muscle wasting and atrophy (loss of muscle mass and strength). Record review of Resident #5's quarterly MDS dated [DATE] reflected in section C- Cognitive Patterns, a BIMS score of 15 which indicated she was cognitively intact. Section GG- Functional Abilities-Interim reflected Resident #5 was dependent (helper did all the effort, resident did none of the effort, to complete the activity) with toileting hygiene, shower/bathe self, and lower body dressing. Resident #5 required substantial/maximal assistance (helper did more than half the effort) to roll left and right in bed. Section H- Bladder and Bowel reflected Resident #5 had an indwelling urinary catheter, she was always incontinent of bowel, and a bladder and/or bowel toileting program were not being used. Record review of the facility's grievance dated 08/24/25 reflected the following: Resident Name: [Resident #5] Describe the grievance/concern: Resident complain that [LVN D] was rude to her and mistreat her. [sic] Expectation of person voicing concern: Spoke to [Resident #5] and [LVN D] will be transferred upstairs. Findings: Nurse will not work on [Resident #5's hall]- She will be transferred upstairs. Action Taken: [blank] Reportable to outside agency: Nolf yes, was this reported: [NAME] Whom: [DON] Date: [check mark] Investigation findings reported to person voicing concern: [neither yes nor no checked] How? In person Note: [Resident #5] is very selective as to who take care of her- She does not want the 2 nurses that worked here, that is [LVN G] and [LVN D] both LVN charge nurse. [sic] Person Completing Inquiry: [DON] signature Date: 08/25/25 In an interview on 09/18/25 at 10:00 AM, Resident #5 stated she kept a logbook and had a log entry on 08/23/25 at 1:50 AM that stated LVN D barged in her room without knocking to see what CNA H was doing. Resident #5 stated it was the second time that shift LVN D did not knock before entering her room; it had also happened at 8:50 PM. Resident #5 stated, When [LVN D] did it the first time, we had words over knocking on the door because she [LVN D] walked in without knocking to tend to my roommate. [LVN D] stated that I was not going to do to her like I did to the other nurse about knocking. That she was not going to play that game. Resident #5 stated she complained to the DON on 08/24/25 about LVN D's behavior throughout the shift and showed her the video. Resident #5 then showed the surveyor a video dated 08/24/25. In that video, CNA H was performing incontinent care for Resident #5. Resident #5 can be heard telling LVN D to leave her room multiple times. LVN D stated to Resident #5 in a rude tone, No, I am not going to leave until I am done talking. I am the charge nurse. LVN D was also heard telling the CNA she was not going to take more than 15 minutes for care. In an interview on (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/18/25 at 12:28 PM, ADON A stated Resident #5 complained about LVN D a couple of weeks back. ADON A stated the CNAs took a long time with Resident #5 when care was provided because Resident #5 was very particular about the care and was also very picky about who provided care for her. ADON A stated that evening they had to get the CNA from the other side to take care of Resident #5, and LVN D went in the room and told the CNA she only had 15 minutes to do care for her (Resident #5) while CNA H was providing care. Resident #5 had told LVN D to leave the room and she left the room. LVN D got moved upstairs because she was PRN, and we needed her upstairs. LVN D got fired for that incident on 09/15/25 after we watched the video because of how she talked to Resident #5. ADON A stated in-services on abuse and neglect were done anytime there was an incident and monthly on the 15th of every month or the nearest weekday if the 15th was on a weekend. ADON A stated they went over the types of abuse and asked the staff to identify the different types of abuse. ADON A stated there were not any hand-outs that went with the abuse/neglect in-services, but staff was verbally quizzed about different scenarios, and they were to identify what type of abuse it was. In an interview on 09/18/25 at 12:51 PM, the SW stated Resident #5 had talked to her about LVN D being rude about the CNA taking too long to care for her approximately 1 1/2 to 2 weeks ago. The SW stated, I think she had talked to the DON before she talked to me. I don't know what was done about it, you'd have to ask the DON. The SW stated abuse/neglect in-services were on the agenda for the meetings that were held on the 15th of every month. The SW asked Resident #5 if she wanted to talk to psychiatric services and the following day, Resident #5 stated she did want to talk to them. In an interview on 09/18/25 at 1:01 PM, the DON stated, [Resident #5] has gotten to the point that she doesn't want anyone to care for her. I have 2 nurses and 2 aides on 3-11 that she won't let care for her. The same with day shift. I have asked the ombudsman for help, and she said she didn't have any suggestions. The DON stated Resident #5 took about 45 minutes to change her because she was very particular about what she wanted done and how it was done and when she wanted it done. The DON stated, [Resident #5] always threatens that she has video and will report us. The DON stated Resident #5 complained about LVN D approximately 2 weeks ago and said that LVN D was rude and unprofessional. The DON stated Resident #5 showed her the video a couple of weeks ago, and further stated, I was surprised with [LVN D] being so rude and disrespectful. The DON stated she and ADON A called LVN D into the office the next day and told her that she was unprofessional and asked her why she talked to [Resident #5] like that. The DON stated LVN D said she was tired of doing that all day and Resident #5 was very aggressive and would be on the call light all day long. The DON stated, We talked to [Resident #5] and told her that [LVN D] was not going to work that area anymore. The DON stated LVN D worked one shift after that, and she told them not to let her work anymore. The DON stated, We let her go on 09/15/25 for being disrespectful, rude, and unprofessional. You don't treat a patient like that. When asked if she thought LVN D's behavior was abuse, the DON stated, I would say that it was verbal abuse. I told the admin about it the same day that I did the interview with [Resident #5], about 2 weeks ago. Me, the ADON and the admin discussed it and decided it would be better to let the nurse go. The DON stated allegations of abuse were to be reported to the state within 2 hours, but this one was not reported within 2 hours because, We could not get a hold of her (LVN D). The DON stated when she talked to LVN D about it a couple of weeks ago, she (LVN D) said she was not coming back, but she did work another shift after that. The DON stated she told the ADONs not to have her come back in. Later in the interview the DON stated, It did not get reported to state because we were discussing it and listening to the video trying to decide if it was abuse or not, but we had already let her go. In an interview on 09/18/25 at 5:18 PM, the admin stated he found out about the issue between Resident #5 and LVN D when the ombudsman told him on Monday, 09/15/25. The Admin stated, the SW and I went over to talk to Resident #5, and she showed me a video where LVN D is telling the CNA H that she shouldn't be taking 45 minutes to change the resident. [Resident #5] was telling [LVN D] to get out of the room and [LVN D] kept talking to the CNA instead of leaving. I decided to report it to state even though I hadn't even completed my investigation yet. When I (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	listened to it, then I looked over the rules and regulations, I wanted to make sure that it would fall under verbal abuse. The more I looked at the video, I don't think she (LVN D) was trying to threaten her (Resident #5) or make her feel afraid, and [Resident #5] said she wasn't afraid of her, but I couldn't find anything that made me feel like it was abuse. The Admin stated that being rude and ugly toward someone did make it reportable and they let her go because they did not want her to be rude or ugly to anyone else. The Admin stated no one told him anything prior to 09/15/25. The Admin stated, For the most part, he did see the grievances. The Admin stated in the mornings he would ask the SW if there were any issues. He further stated he would ask for grievances at every morning meeting. The Admin stated he was surprised to know that there was a grievance about this issues before he heard it from the ombudsman. The Admin stated, If the DON had told me about that grievance, I would have reported it. Once I find out about abuse it's 2 hours to report, everything else is 24 hours. Once I saw the video, I reported it. The DON saw the video first and she came back and told me she was not sure if it was abuse or not, so then I went in with the SW and watched it, talked with corporate, then decided to report it. The Admin stated they had abuse/neglect in-services every month on the 15th. Record review of the facility's self-report dated 09/15/25 reflected in part: The facility was notified of the incident on 09/15/25 by the ombudsman. The facility's investigation summary stated, On the above date and time, the alleged victim advised that an LVN [LVD D] had spoken to her very badly. Upon viewing the video of the incident, it showed that the LVN was telling the C.N.A., while in [Resident #5's] room, that she should not be taking 45 min. to clean her. [Resident #5] then became upset and started yelling for the LVN to get out. The LVN then stated to [Resident #5] that she was the charge nurse and that she would get out when she was finished talking to the C.N.A. Facility in-serviced staff on facility abuse and neglect policy. Responsible party, physician, police department and THHS were all notified of the incident. The facility's investigative findings were, Inconclusive. Provider Action Taken Post-Investigation: In-service staff on facility abuse and neglect. Subsequently alleged perp. was terminated. Record review of the facility's undated Abuse Investigation and Reporting policy reflected in part: Policy Statement All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. the local/State Ombudsman 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. 5. The administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. Record review of the facility's undated Abuse Prevention policy reflected: POLICY: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. b) Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. 3. It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatment shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment. Care will be monitored so that the resident's (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan is followed.CORRECTIVE ACTION:Any instances of employee disregard for the policies and procedures of this facility are cause for corrective action up to and including suspension, termination, and reporting to licensing agencies.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the Pre-admission Screening and Resident Review (PASRR) program to the maximum extent practicable to avoid duplicative testing and effort for 1 of 3 residents reviewed for PASRR. (Resident #8). The facility failed to refer Resident #8 for PASRR Level II assessment when the facility had coded mental illness on his PASRR Level I assessment. This failure could place residents at risk of not receiving specialized services that would enhance their highest level of functioning. The findings included: Record review of Resident #8's Resident Face Sheet dated 09/18/25 reflected a [AGE] year-old male with a re-admission date of 09/04/24. Resident #8 had diagnoses which included Type 2 diabetes mellitus with other specified complication (body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), unspecified, Major Depressive disorder, recurrent (mental condition with repeated episodes of major depression), Post-traumatic stress disorder, unspecified (mental health condition that can develop after experiencing or witnessing a traumatic event), and Insomnia, unspecified (difficulty sleeping, staying asleep resulting in daytime tiredness & impaired functioning). Record review of Resident #8's quarterly MDS reflected a BIM score of 11 indicating moderate cognitive impairment. Record review of Resident #8's PASRR Level I Screening reflected in Section C questioning if there was evidence or an indicator that this individual had a Mental Illness to which the answer was Yes. Record review of Resident #8's medical chart reflected no evidence of Resident #8's PASRR Evaluation. Observation on 09/17/25 at 4:22 p.m. Resident #8 was observed in his room. Resident #8 had refused to speak with the Surveyor and didn't allow Surveyor to enter his room. During an interview on 09/18/25 at 4:50 p.m. MDS LVN said she wasn't able to find to find a PASRR Evaluation for Resident #8. She said she didn't know if one had been done for him. MDS LVN said she worked part time at the facility while they find someone to work fulltime. She said if resident didn't have the right assessments done they would miss out on opportunities for services like case management or programs to re-enter the community. During an interview on 09/18/25 at 6:25 p.m. the Admin said MDS oversees completing PASRR's. Record review of facility policy titled Resident Assessment Coordination of PASRR & Assessments dated 11/28/20 documented; ObjectiveTo provide the appropriate care and services needed for each resident admitted to the facility.PolicyReferring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.		

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming, and personal hygiene, for one (Resident #86) of 3 residents reviewed for activities of daily living. The facility failed to provide Resident #86 with fingernail grooming. This failure could result in decrease in resident self-esteem, embarrassment, and infections. The findings included: Record review of Resident #86's Resident Face Sheet dated 09/18/25 reflected a [AGE] year-old male with an admission date of 09/27/24. Resident #87 had diagnoses which included Dementia (decline in brain functions such as, memory, thinking, problem-solving & language) in other diseases classified elsewhere, mild, with mood disturbance, Other lack of Coordination (difficulty with voluntary movements & balance), Need for assistance with personal care, Type 2 diabetes mellitus (chronic condition where body does not produce enough insulin to regulate blood sugar levels) with diabetic neuropathy (complication of diabetes that damages the nerves, leading to various symptoms and health problems), unspecified, Essential (primary)hypertension (persistent elevated blood pressure without an identifiable underlying cause) and Depression (feeling of sadness, that affects how you think, feel & act, making daily activities difficult), unspecified. Record review of Resident #86's quarterly MDS dated [DATE] reflected a BIMS score of 11 which indicated moderate cognitive impairment. For Functional abilities resident had impairment on both sides of upper extremity (shoulder, elbow, wrist, hand), and Personal hygiene Resident was dependent (helper does all of the effort. Resident does none of the effort to complete the activity). Observation and interview on 09/17/25 at 4:12 p.m. revealed Resident #86's nails untrimmed. Nails were observed to be about 2 centimeters in length from the tip of finger, also squared off at the tip of the nail. Resident #86's stated someone had come in about 2 weeks ago and asked him if he wanted them trimmed and he said at the time he was asleep and said no. He said he wanted them trimmed but no one has trimmed them or offered to do so. He said he had requested it. In an interview on 09/17/25 at 5:02pm LVN I said Resident #86 hadn't told him he wanted his fingernails trimmed. LVN I also said he hadn't asked him either. LVN I said no one had mentioned to him about trimming his fingernails. LVN I said only nurses could trim Resident #86's fingernails because he had a diagnosis of diabetes. He said they are inserviced often in the mornings on ADL's which included grooming. LVN I said if fingernails are not trimmed as needed, the resident could scratch himself or get an infection. In an interview on 09/18/25 at 3:38 p.m. CNA O said Resident # 86 usually doesn't like to have his nails cut. She said if he had told her, she would've let the nurse know because she can't cut his nails because he is diabetic. CNA O said they have received constant in-services on grooming residents. She said the last in-service she received was last week. In an interview on 09/18/25 at 4:09 p.m. LVN P said she had offered to trim Resident #86's fingernails about 2 weeks ago but he had declined. She said she had not asked him again. She said the nurses had to do his nail care due to him being a diabetic. LVN P said if his nails aren't trimmed, he could have cut himself or gotten an infection. She said they had received an in-service on grooming about a week ago. In an interview on 09/18/25 at 4:19 p.m. the DON stated the nurses were supposed to do nail grooming for diabetic residents. She said they should have asked residents if they wanted their nails trimmed. She said if resident nails were kept untrimmed it could have caused infections. Record Review of the facility's policy titled, Quality of Life - Dignity, updated on 02/2020 documented, Policy StatementEach resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.Policy Interpretation and Implementation1. Residents shall be treated with dignity and respect at all times.2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.3. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.).		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, physicians orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 5 (Resident #47) residents reviewed for respiratory care. The facility failed to ensure Resident #47's oxygen tubing was changed and documented every night shift on Sunday as ordered. This failure could place residents at an increased risk of infection leading to a decline in health. The findings included: Record review of Resident #47's face sheet dated 09/17/25 revealed a [AGE] year-old male with an admission date of 04/05/24. Pertinent diagnoses included Chronic Obstructive Pulmonary Disease (COPD) (group of diseases that cause chronic inflammation and narrowing of the airways, making it difficult to breathe), and dependence on supplemental oxygen. Record review of Resident #47's Quarterly MDS assessment dated [DATE] revealed a BIMS of 15 (cognition intact). Further review revealed Resident #47 had not received oxygen within 14 days of the assessment. Record review of Resident #47's comprehensive care plan dated 09/17/25 revealed the problem Resident is at risk for respiratory distress [related to] chronic hypoxia (low oxygen)/COPD. Oxygen dependent initiated on 04/24/24 and revised on 08/06/24. Approaches listed for the problem included: Administer oxygen at 2-3 LPM via NC. Observe oxygen precautions revised on 08/06/24. Provide medications as ordered. Explain medication regimen, actions, and side effects revised on 08/06/24. Record review of Resident #47's order summary revealed an active order for Change updraft tubing, and humidifier bottle once a day on Sun[day] nights initiated on 04/05/24. Further review revealed an active order for Oxygen via NC at 2-5 Lpm to maintain saturation above 90% every shift initiated on 04/05/25. Record review of Resident #47's MAR revealed the last time staff documented Resident #47's oxygen tubing was changed was on 08/24/25. During an observation of Resident #47's room at 10:22 AM on 09/16/25, Resident #47 was resting in bed. Oxygen tubing attached to the oxygen concentrator was dated 4/27. In an interview with RN E at 10:24 AM on 09/16/25, RN E stated Resident #47's oxygen tubing was not dated correctly. RN E stated based on the date written on the oxygen tubing, she was unable to tell the last time it was changed. RN E stated the oxygen tubing was supposed to be changed out weekly to help prevent possible infections. In an interview with the DON at 9:30 AM on 09/18/25, the DON stated the oxygen tubing was supposed to be changed out weekly on Sundays as ordered by the physician. The DON stated the oxygen tubing should be dated whenever it was changed out. The DON stated it was important to change out the oxygen tubing weekly to help prevent infection. Record review of the undated facility policy Oxygen Administration revealed the following policy: .10. Label oxygen tubing with date and initials and change per facility standard.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and labeled in accordance with currently accepted professional principles reviewed for medications stored in 1 of 4 medication carts (2300/2400 Cart) reviewed for storage. The facility failed to ensure the medication cart for halls 2300/2400 was free from expired insulin pens. The failure could place residents in the facility at risk of receiving expired medications from staff. The findings included: Record review of Resident #93's face sheet dated 09/17/25 revealed a [AGE] year-old male with an admission date of 04/13/21. Pertinent diagnosis included Type 2 Diabetes (chronic disease where your body becomes resistant to insulin, leading to high blood sugar levels), and long-term use of insulin. Record review of Resident #93's Quarterly MDS assessment dated [DATE] revealed a BIMS score could not be obtained due to the resident rarely being understood. Record review of Resident #93's comprehensive care plan dated 09/17/25 revealed the problem Resident has Diabetes Mellitus initiated on 10/21/22 and revised on 08/02/24. Approaches listed for the problem included .Administer routine [glargine] insulin as ordered. Administer [aspart insulin] for sliding scale as ordered. Administer [dulaglutide] as ordered initiated on 10/21/22. Record review of Resident #93's order summary revealed an active order for [Glargine] U-100 (insulin glargine) solution; 100 unit/mL; [amount]:5 UNITS; subcutaneous Once A Day initiated on 07/13/25. Record review of Resident #93's MAR revealed 5 units of glargine insulin were administered to Resident #93 at 9:00 AM on 09/16/25 and 09/17/25. During an observation of the 2300/2400 Halls medication cart at 2:00 PM on 09/17/25, this state surveyor found a glargine insulin pen with an open date of 08/18/25 and an expiration date of 09/15/25 in the top drawer. The label on the insulin pen revealed it was ordered for Resident #93. In an interview with RN F at 2:40 PM on 09/17/25, RN F stated she was in charge of the medication cart for halls 2300/2400 when the expired insulin pen was found. RN F stated insulin pens expired 28 days after taking them out of the refrigerator. RN F stated she did not have a good reason for why the expired insulin pen was still in the medication cart. RN F stated it was important to not keep expired medications in the medication cart, so they did not accidentally get administered to residents. RN F stated administering expired medications to residents may harm them in unexpected ways. In an interview with the DON at 9:30 AM on 09/18/25, the DON stated expired medications should not be stored in the medication carts. The DON stated expired medications should be taken out of the carts and disposed of properly. The DON stated leaving expired medications in the medication carts may lead to a staff member inadvertently administering expired medications to a resident, potentially harming them. Record review of the undated facility policy Storage of Medications revealed the following policy: .4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 3 residents personal refrigerators reviewed for food safety (Resident #114) in that: Resident #114's personal refrigerator located in her room was observed to have 2 slices of pie that were not dated or labeled. This failure could place residents at risk for food-borne illnesses. The findings included: Record review of Resident #114's Resident Face Sheet dated 09/17/25 reflected a [AGE] year-old female with a re-admission date of 08/08/25. Resident #114 had diagnoses which included Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (Primary Admission), Essential (primary) hypertension, Schizophrenia, unspecified. Record review of Resident #114's BIMS score quarterly MDS, dated [DATE], revealed a BIMS score of 0, which indicated severe cognitive impairment. An observation on 09/16/25 at 3:40 p.m. of Resident #114's personal refrigerator revealed 2 slices of pie covered in plastic wrap and were not dated or labeled. In an interview on 09/16/25 at 3:42 p.m. the RP stated he had not brought in those pies and he didn't know when they were brought in. In an interview on 09/16/25 at 3:59 p.m. CNA R stated she doesn't check residents' refrigerators, she said the night nurses check them. She said they check them for temperature and dates. CNA R said she didn't check Resident #114's refrigerator and said she'd check it and remove any food not dated. In an interview on 09/16/25 at 3:59 p.m. LVN T said she checks residents' personal refrigerators. She said she checked the temperature but did not check the label or dates of food. She said she checks them every day on her shift. When asked why she didn't check the food dates or labels, she did not answer. Record review of the facility policy, titled Foods Brought by Family/Visitors not dated documented, Policy Statement Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 6 residents (Resident #66) reviewed for accuracy and completeness of clinical records. The facility failed to accurately document the glucagon injection (hormone produced by the pancreas that raises blood sugar levels by signaling the liver to release stored glucose) Resident #66 received at approximately 7:45 AM on 07/08/25 in the MAR. This failure could result in residents' records not accurately reflecting the administration of medications and could result in further errors due to inappropriately administering medications twice. The findings included: Record review of Resident #66's face sheet dated 09/17/25 revealed an [AGE] year-old male with an admission date of 10/09/24. Pertinent diagnosis included Type 2 Diabetes (chronic disease where your body becomes resistant to insulin, leading to high blood sugar levels). Record review of Resident #66's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 5 (severe impairment). Record review of Resident #66's comprehensive care plan dated 09/17/25 revealed the problem Resident has Diabetes Mellitus initiated on 04/16/25 and revised on 07/31/25. Approaches listed for the problem included .Administer Glucose Gel / Glucagon [as needed] as ordered initiated on 04/16/25. Record review of Resident #66's order summary revealed an active order for Glucagon (HCl) Emergency Kit [reconstituted solution]; 1 mg; [amount] 1 MG; injection Special Instructions: GIVEN FOR HYPOGLYCEMIA (low blood sugar) Every 2 Hours - [as needed] initiated on 10/15/24. Record review of nurse's progress notes revealed a note written by LVN J at 7:45 AM on 07/08/25 that stated Resident #66's blood sugar was measured at 29 and the resident received a glucagon injection. The Resident's blood sugar was measured again at 8:15 AM and it had risen to 85. Record review of Resident #66's MAR revealed the order for Glucagon HCl was never administered during the month of July 2025. A phone interview was attempted with LVN J at 4:01 PM on 09/16/25, but LVN J did not return the phone call. In an interview with RN E at 10:24 AM on 09/16/25, RN E stated anytime a medication was administered it should be documented in the MAR. RN E stated it was important to document all medication administrations so another nurse did not come after and administer the same medication again. RN E stated it was also important to document all as needed medications to notice if there were any trends or patterns so they could make adjustments as needed. In an interview with the DON at 9:30 AM on 09/18/25, the DON stated it was dangerous to administer medications and then not document them. The DON stated if it was not documented then another nurse may come afterwards and unnecessarily administer the same medication. The DON stated if a resident received double the dose of their medication it could become toxic for the resident, causing harm. Record review of the undated facility policy titled Administering Medications revealed the following policy: .16. The individual administering the medication must initial the resident's MAR on the appropriate line or EHR after giving each medication and before administering the next ones.		

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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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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 2 of 2 resident's bathroom sink (Resident # 43 and #88) and 2 of 5 resident rooms (Resident #76 and Resident #114) reviewed for the environment in that: The bathroom sinks in resident #43's and Resident #88's room were clogged. Resident #76's wall pad and floor mats were torn. Resident #76's nightstand was broken. Resident #114's bathroom sink cabinet door was missing. Resident #114's trim wall trim inside her bedroom was broken off. These failures could place residents at risk of living in an unsafe, unsanitary, and uncomfortableA record review of Resident #43's Face Sheet 09/16/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #43's diagnoses included Multiple Sclerosis(is a chronic autoimmune disease that affects the central nervous system, leading to a range of neurological symptoms due to the immune system attacking the protective myelin sheath around nerve fibers), Muscle Atrophy (The loss or thinning of muscle mass, which can significantly impact strength and physical function), Depression (Is a mood disorder characterized by a persistent feeling of sadness and a loss of interest in activities once enjoyed), and Hypotension (A condition in which the force of the blood pushing against the artery walls is too low). A record review of Resident #43's MDS ([NAME] Data Set) dated 07/31/25 revealed a BIMS (Brief Interview for Mental Status) score of 13 which indicates normal thinking and memory with little to no impairment. Resident #43 Functional Abilities revealed Resident #43's performance indicated the resident is dependent on staff for all ADL's (Activities of Daily Living). A record review of resident #43's care plan dated 09/17/25 revealed resident requires assistance for ASL and mobility tasks due to generalized weakness and poor endurance. Potential for unavoidable decline due to same. The resident has reduced range of motion to bilateral lower extremities. A record review of Resident #88's Face sheet dated 09/17/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #88's diagnoses include Quadriplegia (A Paralysis that affects the ability to voluntarily move the upper and lower body), muscle atrophy (a condition that causes a progressive loss of muscle mass, strength, and power) Anxiety Disorder(a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation) and Depression (Is a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world). Resident #88's MDS 06/23/25 revealed a BIMS score of 14 which indicates normal thinking and memory with little to no impairment. Resident #88 Functional Abilities revealed Resident #88 is dependent on staff for all ADL's. Resident #88 Revealed no care was available for this resident as a baseline care plan was never created in the time frame allowed. Record review of Resident #76's face sheet reflected a [AGE] year-old male initially admitted to the facility on [DATE] with most recent admission on [DATE]. Diagnoses included cerebral palsy (a group of conditions that affect movement and posture that is caused by damage that occurs to the developing brain, most often before birth), history of falling, seizure disorder (abnormal brain activity which affects muscle control, behavior, and awareness), unspecified intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently), and aphasia (an impairment in the ability to read, write, and speak). Record review of Resident #76's comprehensive MDS dated [DATE] reflected in section C- Cognitive Patterns: Cognitive Skills for Daily Decision Making a score of 3 which indicated that Resident #76 had severely impaired cognitive skills and never/ rarely made decisions. Section GG- Functional Abilities-Interim reflected Resident #76 was dependent (helper does all of the effort, resident does none of the effort to complete activities) for all of his ADLs. Resident #76 was not able to roll side to side in bed, sit up, or transfer without extensive staff assistance. Section H- Bladder and Bowel reflected Resident #76 was always incontinent of bladder and bowel. Record review of (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #76's care plan dated 03/05/20 reflected in part: Focus: Special Care- Resident has seizure disorder. Start date: 03/05/20. Goal: Resident will not injure himself due to seizure disorder with seizures prevented to extent possible through next review. Approaches: Concave mattress on floor with floor mat to be used as ordered and indicated. Start date: 11/23/22. Torso harness with seatbelt to be applied while up in wheelchair to assist with proper positioning and safety due to cerebral palsy and convulsions. Check every 1 hour and PRN, release and reposition resident every 2 hours for 10 minutes and PRN. Start date: 11/23/22. Focus: Falls- Potential for falls due to history of falls, weakness, impaired balance, seizure disorder, severe cognitive impairment/ safety awareness with intellectual disability/ mental retardation, cerebral palsy with spastic uncontrolled movements to all extremities and neuroleptic and psychotropic medication administration. Start date: 03/05/20. Goal: Reduce the risk for falls while preventing injury through next review date. Approaches: Concave mattress/ floor mattress to establish bed boundaries and reduce risk of rolling out of bed as ordered. Floor mat to be used as ordered. Start date: 11/23/22. Record review of Resident #114's Resident Face Sheet dated 09/17/25 reflected a [AGE] year-old female with a re-admission date of 08/08/25. Resident #114 had diagnoses which included Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (Primary Admission), Essential (primary) hypertension, Schizophrenia, unspecified. Record review of Resident #114's quarterly MDS, dated [DATE], revealed a BIMS score of 0, which indicated severe cognitive impairment. The MDS also revealed Resident #114's Mobility devices included a walker and manual wheelchair. During an observation on 09/16/25 beginning at 10:48 AM Resident #76's bed was turned so that the head of the bed was toward the room entry door. The headboard of Resident #76's bed was against the wall that connected with the bathroom and the right side of the bed was against the right side wall. There was a grey pad screwed to the right side wall that had 12 horizontal tears ranging in length from less than 1/2 inch to over 18 inches in length and 6 vertical tears ranging in length from less than 1/2 inch to over 6 inches on it. The largest vertical tear was approximately 1/2 inch wide. Resident #76 had 2 floor mats beside his bed with one long continuous rip that started in approximately the middle of the first floor mat and extended through approximately 1/3 of the second floor mat. Resident #76's 2 drawer nightstand was missing the second/ bottom drawer, and the guide tracks were visible. The front piece of the missing drawer was leaned against the front/bottom of the nightstand, on the floor, with a trashcan against it. In observation and interview on 09/16/25 beginning at 11:13 AM of Resident #43's and Resident #88's bathroom, the sink was clogged halfway with dirty water. The state surveyor asked how long the sink had been clogged both residents said since earlier that morning could not honestly give an exact time. Resident #43 stated the clogging of the sink happened at least 4 times a month and maintenance will resolve the problem within the day it occurred. During an observation on 09/16/25 beginning at 3:35 PM Resident #114's restroom was observed to be missing a cabinet door underneath the sink exposing sink pipes underneath. Also observed in Resident #114's room was trim against wall that was broken off. In an interview on 09/16/25 at 3:52 PM, CNA R said she hadn't noticed the missing cabinet in Resident #114's restroom, she also said she hadn't paid attention to the trim on the walls. She stated they were supposed to report those things to maintenance so they can fix them. In an interview on 09/18/25 at 2:24 PM, ADON A stated everyone was responsible for setting up rooms. ADON A stated she did not know of any rules for how rooms were set up, but she was aware that beds were not supposed to be against the wall because it could prevent residents from getting out of bed. ADON A stated Resident #76's bed was against the wall because he had spastic movements and could fall out of the bed. There was also a pad on the wall so that he would not hurt himself if he hit the wall and a floor mat beside the bed. ADON A stated housekeeping was responsible for changing the pad on the wall, the floor mats, and the nightstand and she did not know how long the pad, mats or nightstand had been that way. In an interview on 09/18/25 at 2:35 PM, the MM stated maintenance was responsible for changing the pad on the wall in Resident #76's room and it was changed at the end of April 2025. The MM stated the (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor mats were changed out as they needed to be, and the nightstands were replaced as they were reported. The MM stated it was the responsibility of whoever saw the issue to report it in the maintenance logbook or it was told to him directly. He stated no one has said anything about Resident #76's room lately. When shown what the pad on the wall, the floor mats, and the nightstand looked like, the MM stated he would go change them out now. The MM stated that would be the second wall pad that had been replaced. When asked if he knew of any regulations regarding how the room was set up and how beds were supposed to be arranged, the MM stated Life Safety told him beds had to be 18 inches away from the wall. Interview on 09/18/25 at 4:38 PM the Maintenance man stated resident rooms are being fixed starting with 200 hall and then the rest of the halls. The MM stated no time frame had been given but the maintenance crew was actively working on the project. The MM stated the staff was to report any issues of clogging sinks and toilets immediately. The MM stated no work order needs to be done it is a priority even if after hours. The MM stated if the problem is constantly happening after being monitored for some time a plumbing company would be called to come and service the room. The MM stated last week the plumbing company was called to a clogged toilet he could not fix themselves, but if a sink occurs the maintenance crew will try to fix the problem in house before the plumber would be called. The MM stated no residents are to try to unclog sinks or toilets themselves as all plungers are kept in the janitor's closet. In an interview on 09/18/2025 at 5:20 PM with the Administrator he stated anybody that sees the issue of plumbing should report the issue immediately. The admin stated if the plumber needs to be called if the issue cannot be resolved in house. The admin stated any plumbing issues will be taken care of As soon as possible and the maintenance man should be able to call the plumber to fix the problem without workorder or issues of cost. Record review of the facility's policy titled, Statement of resident rights, dated 07/20/20 revealed in part: Dignity and Respect: You have the right to: Live in safe, decent and clean conditions.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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. These failures could put residents who consumed food from the kitchen at risk for infection and/or food contamination. The findings included: Observation and initial tour of the kitchen on 09/16/25 at 8:15 AM, revealed multiple gnats flying in the dish room and there was a foul odor in the dish room of the kitchen. An interview with the FSM on 09/16/25 at 8:45 a.m., she said the gnats in the dish room had been an on-going problem. Pest control was called and were there about 3 weeks ago. The FMS stated all the walls and floors were washed and scrubbed with disinfectant. Pest control invoices were requested. An interview on 09/18/25 at 4:38 PM with Maintenance Man he stated the pest control comes once a month and more if needed. The MM stated if a resident complains about insects or pests it is written in the maintenance log and then facility would call pest control and usually gets responds asap. The MM stated until the pest control company arrived the dishwashing crew tried to keep the dish room cracks as dry as possible with no water left in cracks and floors were mopped and cleaned every day or when needed. The pest control company is not a local pest control company it is in San [NAME] and services areas from there to the valley and this can delay service to the facility at times when service is needed. The MM stated he has instructed the staff to clean all rooms so there are no food crumbs to contribute to the pest problem. The facility does not promote the to use anything else other than the pest control company to control insect or pest control. The MM stated the pest control company was just here last month to spray for gnats and other insects. The pest control and maintenance log invoices were requested. The MM stated the cracks in the dish room were in the process of being approved by the company as the whole floor may need to be replaced so he is waiting to hear if it will be approved for repairs. In an interview on 09/18/2025 at 5:20 PM with the Administrator stated he was aware of the problem with gnats in the dishwashing room. The Admin stated there was a Quality Assurance meeting that included the business office manager, maintenance man and Human Resource Coordinator and came up with solutions for the problem. The Admin stated the gnat problem started getting worse this week. The admin stated they were going to implement a type of program to try to fix the gnat problem. The Admin stated the pesticide company was involved along with housekeeping and the kitchen staff to combat the insect problem in the facility. The Admin stated there are some resident's hording food that may contribute to the problem. The admin stated some of the ideas were implemented already having housekeeping clean out resident rooms of hidden foods and floors kept free of crumbs. The Admin stated staff was instructed to go into resident's rooms and clean and throw away any old food very old personal food and facility food. The ADM stated staff found food shoved in drawers that make have cause gnats to in other areas. The surveyor asked the Admin if he was aware the pest control company had made recommendations on the last invoice and he stated he was not aware. The Admin stated if the pest control company makes a recommendation the facility will try to implement the solution. The Admin stated any repairs would be the responsibility of the maintenance team to fix the problem identified by the pest control company if possible. The Admin stated the MM can go and get supplies and fix any minor problem. The Admin stated not all the recommendations from the pest control company are always good idea sometimes they are more to get more service and money out of the facility. The Admin stated any recommendations or problem the facility is facing will be fixed as soon as possible if it is something minor it can be fixed. The Admin stated the MM did not mention the pest control recommendation, if he had known about the recommendations it would have been fixed. The Admin stated any problems in the facility concerning pest control needs to be fixed and the problems will be fixed. In records review on 09/18/25 of the pest control log stationed at the nurse (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	station revealed gnat sightings logged for the last 5 month by both staff and residents by the dish washing room and was resolved by the pest control company who came in and sprayed in the locations indicated in the log. In record review on 09/18/25 of the pest control receipt from January to August 2025 revealed pest control for gnats were conducted on 08/08/25; 07/21/25; 05/28/25; and 04/22/25. All of the receipts showed a recommendation regarding gnats from 03/14/24 that read Cracks and damage to floor and wall and equipment itself are being used as breeding ground for gnats. Repairs need to be made to help with issue. In 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. In record review of the Pest Control Policy undated read Purpose- To protect the health and safety of residents, personnel and the public. Policy- The facility will maintain an effective pest control program so to ensure the facility is free of pest and rodents through the use of environmental cleaning and contracted pest control services on regularly scheduled visits and as warranted if needed in between extermination services.		