

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Senior Care of Corpus Christi		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Fortune Dr Corpus Christi, TX 78405	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on observations, interviews, and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for one (Resident #1) of 5 residents reviewed for supervision. The facility failed to ensure Resident #1 received adequate supervision while Resident #1 was unaccounted for approximately 10 minutes from 9:05 PM to 9:15 PM on 12/13/24 before LVN C found Resident #1 alone in the 100-hall shower room on the floor. Resident #1 sustained an injury to his head from the fall and was taken to a local hospital where he was diagnosed with an acute on chronic intracranial subdural hematoma (occurs when a new, acute bleed happens to a pre-existing chronic subdural hematoma, often triggered by even minor trauma. A subdural hematoma is a collection of blood that accumulates between the brain and the innermost layer of the skull). The noncompliance was identified as PNC. The PNC began on 12/13/24 and ended on 12/14/24. The facility had corrected the noncompliance before the investigation began. This failure could place residents requiring supervision at risk for injury and accidents with potential for more than minimal harm. The findings included: Record review of Resident #1's face sheet dated 03/25/25 revealed a [AGE] year-old male with an original admitted [DATE] and a current admitted [DATE]. Pertinent diagnoses included abnormalities of gait and mobility and lack of coordination. Record review of Resident #1's Quarterly MDS assessment dated [DATE] section C, cognitive patterns, revealed a BIMS score of 5 (Severe Impairment). Section GG, functional abilities, revealed no attempt was made for Resident #1 to walk 10 feet due to medical conditions or safety concerns, but Resident #1 was able use his wheelchair to travel 150 feet with partial assistance (helper does less than half the effort). Section J, health conditions, revealed the resident had not had any falls since admission/entry or reentry or the prior assessment, whichever was more recent. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan dated 03/24/25 revealed the problem [Resident #1] is at risk for falls and injuries r/t Confusion, Gait/balance problems, Incontinence, and episodes of generalized weakness, poor safety awareness and forgets limitations, does not call for assistance with transfers or use call light, hx of falls initiated on 03/01/23 and revised on 12/16/24. Interventions listed for the problem included: -Orthostatic Blood Pressures [drop in blood pressure that occurs when a person stands up from a sitting or lying position] to be taken when resident gets up in AM and again before he does to bed at night initiated on 12/11/24 and revised on 12/16/24. -9/11/24 Intervention: assessment, neurological checks, encouraged to utilize call bell, medication review, RP and MD notified initiated on 09/11/24. -Anticipate and meet the resident's needs initiated on 03/01/23. -Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance initiated on 03/01/23. -Ensure that the resident is wearing appropriate footwear or non-skid socks during transfers or mobilizing in w/c initiated on 03/01/23. -The resident needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position, personal items within reach initiated on 03/01/23. -Toileting program Q 2HRS to aide in prevention of falls[.] Placed in tasks for aides to assist initiated on 12/26/24. Record review of Resident #1's order summary revealed an active order titled Toileting program Q 2HRS to aide in prevention of falls[.] Placed in tasks for aides to assist initiated on 12/19/24. Record review of the provider investigation report dated 12/20/24 revealed the following report of the incident: It was reported on 12/13/24 around 9:15 pm that [Resident #1] was observed in 100 hall shower room about 10 minutes after being seen by [LVN C] while he was making his way to his room. [Resident #1] scheduled shower on the 2-10 [PM shift] but was not getting a shower at the time. Currently being treated for UTI. Resident self propels in wheelchair and self transfers at times. Requires frequent education on call light and assistance with transferring. [Resident #1] sustained laceration to left ear, unable to determine the severity initially due to bleeding. Sent to [local hospital] ER for evaluation. [Resident #1] is there currently under observation. [Resident #1's] room is two doors down from the shower room and we believe he mistook it for the correct door. Record review of LVN C's progress note dated 12/13/24 at 9:36 PM revealed the following narrative of the incident: (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[LVN C] observed resident on the floor of 100 hall's common bathroom/shower room laying on his left side with his pants around his ankles, brief intact, no shoes and only wearing socks on. Resident's wheelchair noted beside him facing his back. Resident noted to be alone in 100 hall bathroom. [LVN C] observed blood on the floor of resident's cephalic [head] region. Upon further assessment laceration noted to left ear. Resident stated, I was trying to go to the bathroom. This nurse pulled call light located in bathroom then stood at entrance of 100 hall bathroom doorway and shouted Help for additional assistance. Immediately after [LVN D] and [LVN E] arrived at restroom to assist. [LVN E] initiated 911 call after observing resident's condition. This nurse immediately provided treatment to left ear wound while resident in supine [lying down face upward] position. Dressing noted intact to old skin tear to right and left forearm. During treatment this nurse assessed resident's mental status. Resident noted to be alert and oriented to person, place, and situation. Resident answered questions appropriately. Vitals obtained BP 142/97 HR 76 T 97.4 O2 96% on room air PAIN 0/10. Head to toe assessment completed. Patient continued to deny pain and discomfort to this nurse. EMS arrived at scene at approximately 9:30 PM and took over care. EMS transported resident to [local hospital] ER for further evaluation and treatment. MD notified. DON notified. RP notified. Record review of Resident #1's hospital discharge summary dated 12/18/24 revealed Resident #1 was diagnosed with an acute on chronic intracranial subdural hematoma while at the local hospital after his fall on 12/13/24. Record review of Resident #1's fall risk assessment dated [DATE] revealed Resident #1 was a high risk. During an observation at 8:30 AM on 03/25/25, the shower rooms on the 100, 200, and 300 halls were all locked and secured with a number combination lock. During an observation at 10:55 PM on 03/25/25, the shower rooms on the 100, 200, and 300 halls were all locked and secured with a number combination lock. During an observation of Resident #1's room at 11:00 AM on 03/25/25, Resident #1's room was free from clutter, fall mats were in position by his bedside, his bed was in the low position, and his call light was within reach of his bed. In an interview with Resident #1 at 11:07 AM on 03/25/25, Resident #1 stated he remembered falling in December, 2024. Resident #1 stated he tripped, went down, and hit his face while he was walking. Resident #1 was not able to recall any more details about the fall on 12/13/24. An interview was attempted with LVN C at 3:06 PM on 03/25/25, but LVN C could not be reached so this state surveyor left a message on her voicemail. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the ADM at 3:59 PM on 03/25/25, the ADM stated he remembered getting a call that the resident fell in the shower room and nobody knew how he got in there. The ADM stated the shower door was supposed to be locked, and that Resident #1 should not have been allowed in the room without an employee present. The ADM stated before Resident #1's fall, they used to have a lock and key mechanism on the shower doors, with the key hanging from a chain by the door. The ADM stated they did not know if Resident #1 used the key to enter the shower room or an employee left the door slightly open on accident. The ADM stated the DOM came up to the facility that evening to change the lock on the 100-hall shower door to a number combination lock. The ADM stated the locks on the shower rooms in the 200 and 300 halls were changed the following day. In an interview with LVN E at 5:50 PM on 03/25/25, LVN E stated he was working the night Resident #1 fell in the 100-hall shower room. LVN E stated both LVN C and LVN D arrived at the resident before him, so LVN C told him to go call 911. LVN E stated after he called 911, he started getting paperwork ready for EMS and waited for them by the door to direct them to Resident #1 as fast as possible. LVN E stated he did not know how Resident #1 got in the shower room, but that the shower rooms were supposed to be locked at all times. In an interview with the DON at 8:57 AM on 03/26/25, the DON stated LVN C notified her that Resident #1 fell in the shower room on the night it occurred. The DON stated she recommended Resident #1 wear a helmet to protect him from future injuries, but the family did not want him to wear it to protect his dignity. The DON stated the shower room doors were always supposed to be locked and Resident #1 was not supposed to be in a shower room without an employee present. The DON stated she did not know how Resident #1 got in the shower room. The DON stated they provided in-services for all staff on ensuring shower room doors were closed and functioning properly at all times, fall prevention, and abuse/neglect. The DON stated they changed the locks on all shower room doors to require a keypad entry instead of just a lock and key. The DON stated Resident #1 had many fall prevention tasks implemented, which included fall mats, keeping his bed in the low position, toileting program to ask him if he needs to go to the bathroom every 2 hours, medication reviews, encouraging Resident #1 to use his call light, keeping his phone and glasses on a bedside table near him, and a camera in his room for his RP to help keep an eye on him. The DON stated it was important for residents to not enter the shower rooms without staff because a resident could fall in the shower room and not be able to call for help. In an interview with the DOT at 9:18 AM on 03/26/25, the DOT stated Resident #1 has not regressed physically due to his fall on 12/13/24. The DOT stated any decline Resident #1 has had since then has been due to his natural disease processes. In an interview with the DOM at 9:33 AM on 03/26/25, the DOM stated he was notified of Resident #1's fall on 12/13/24 the night it happened. The DOM stated he came up that night and replaced the lock on the 100-hall shower door. The DOM stated he would have replaced all three shower door locks at that time, but they only had one replacement lock in the facility. The DOM stated he went out to a local department store on the morning of 12/14/24 and bought two more locks to replace the locks on the 200 and 300-hall shower doors. The DOM stated all three shower rooms had a new lock on them before the afternoon of 12/14/24. The DOM stated the old locks required a key, but the key was hung by a chain next to the door. The DOM stated he checked the shower doors daily for functionality and they never failed during the month of December, 2024. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN D at 2:14 PM on 03/26/25, LVN D stated he worked the night Resident #1 fell in the 100-hall shower room. LVN D stated he heard LVN C call for help, and by the time he got there another staff member had placed a towel on Resident #1's ear to help with the bleeding. LVN D stated he did not remember much about the incident, but that LVN C was the charge nurse at that time, and she provided most of the care that night to Resident #1. LVN D stated he did not know how Resident #1 got in the shower room and that he should not have been in there on his own. This surveyor requested a facility policy from the ADM at 4:00 PM on 03/25/25 regarding proper shower room use and keeping the doors locked, but none was provided. In interviews beginning at 11:28 AM on 03/25/25 with staff from multiple shifts, the DON, DOT, DOM, ADM, LVN D, LVN E, LVN F, LVN H, MA G, CNA I, CNA J, CNA K, CNA L, CNA M, and CNA N were able to identify the proper procedures to follow when responding to a witnessed or unwitnessed fall. All staff understood the importance of keeping the shower doors locked and secured and were familiar with proper abuse and neglect policies and procedures. Record review and verification of the corrective action implemented by the facility beginning on 12/13/24: All staff in-serviced on the following procedures: - Keeping the shower room doors closed at all times, - Ensuring shower room doors function properly, - Fall precautions, - Abuse/Neglect, Verified by observations, record review and interviews with various staff. All shower door locks replaced by 12/14/24 to provide additional security verified by interview with the DOM. Medication review conducted for Resident #1 to help prevent future falls by 12/18/24 verified by record review and interview with the DON. Ordered a soft helmet for Resident #1 to wear throughout the day verified by interview with the DON. Instituted bathroom checks every 2 hours for Resident #1 to limit him trying to perform a self-transfer verified by interviews with the DON and various CNAs. The noncompliance was identified as PNC. The PNC began on 12/13/24 and ended on 12/14/24. The facility had corrected the noncompliance before the investigation began.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50969 Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, documenting, and administering of all drugs and biologicals) to meet the needs of each resident for 3 of 5 residents (Residents #4, #2, and #3) reviewed for pharmacy services. The facility failed to ensure LVN-A signed her MAR when she administered PRN narcotics to Residents #4, #2 and #3. The facility failed to ensure LVN-A wasted her PRN narcotic medications with another licensed nurse. These failures could place residents at risk for not receiving, or receiving more than intended amount of, PRN narcotic medications. Findings included: Record review of Resident #4's face sheet dated 03/26/25 revealed a [AGE] year-old female with an admitted [DATE], and a discharge date of [DATE]. One of her diagnoses included Systemic Inflammatory Response Syndrome (an exaggerated defense response of the body to a harmful stressor, such as infection, trauma, or inflammation, and can cause intense pain). Record review of Resident #4's admission MDS assessment dated [DATE] revealed a BIMS score of 15, indicating intact cognition. Record review of Resident #4's physician orders dated 08/25/24 revealed an order for Hydrocodone-Acetaminophen (a narcotic pain medication) Oral Tablet 5-325 MG for pain. Record review of Resident #4's MAR dated September 2024 revealed no signatures for the whole month of September 2024 for Hydrocodone-Acetaminophen 5-325 MG. Record review of Resident #4's Controlled Substance Administration Record - Hydrocodone/APAP 5-325 MG dated 08/28/24 revealed the starting count was 30 tablets and the ending count was 18 tablets on 09/05/24 with 1 tablet documented as dropped with no witnessed waste on 09/04/24. Record review of Resident #2's face sheet dated 03/26/25 revealed a [AGE] year-old male with an original admitted [DATE], and a current admitted [DATE]. Resident #2 had a diagnosis of Pain Unspecified. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating intact cognition. Record review of Resident #2's physician orders started on 08/26/24 revealed an order for Hydrocodone-Acetaminophen 5-325 MG for pain. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's MAR dated September 2024 revealed only two signatures for the whole month of September 2024 for Hydrocodone-Acetaminophen 5-325 MG. Record review of Resident #2's Controlled Substance Administration Record - Hydrocodone/APAP 5-325 MG, dated 08/30/24, revealed the starting count was 30 tablets and the ending count was 8 tablets on 09/16/24 with 1 extra tablet pulled but no witnessed waste on 09/01/24. Record review of Resident #3's face sheet dated 03/25/25 revealed an [AGE] year-old male with a current admitted [DATE], and a discharge date of [DATE]. Resident #3 had a diagnosis of Gout (a type of arthritis that includes sudden attacks of severe pain). Record review of Resident #3's quarterly MDS assessment dated [DATE] revealed a BIMS score of 10, indicating moderately impaired cognition. Record review of Resident #3's physician orders started on 08/01/24 revealed an order for Hydrocodone-Acetaminophen 7.5-325 MG for pain. Record review of Resident #3's MAR dated September 2024 revealed no signatures for the whole month of September 2024 for Hydrocodone-Acetaminophen 5-325 MG. Record review of Resident #3's Controlled Substance Administration Record - Hydrocodone/APAP 7.5-325 MG, dated 08/31/24, revealed the starting count was 30 tablets and the ending count was 15 tablets on 09/16/24. Interview with LVN-A attempted, but she no longer worked for the facility, and her phone number was disconnected. Interview with Resident #4 attempted, but she is no longer living at this facility, and she refused to be interviewed by phone. In an interview with the ADON on 03/25/25 at 9:30 AM, she stated she never realized the MAR was not being signed off accordingly because with PRN medications there was really no way to tell if they were signed or any type of alert since they were PRN medications and not scheduled. She denied that there was any sort of check or audit in place during that timeframe in which they were checking the MARs against the narcotic count sheets for signatures or accuracy. She stated she and the DON were trying to be more proactive and aware and follow-up on reviewing the PRN medications at the weekly meetings. She stated this could have been an issue because residents may or may not have been getting any or the appropriate amounts of pain medication, which could ultimately not relieve their pain at all or cause the resident harm if too much pain medication was administered. In an interview with Resident #2 on 3/25/25 at 9:40 AM, he stated he remembered the nurse, and she was always nice to him. He stated he did not use much pain medication, but she was always good about bringing him his medication. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 03/25/25 at 9:50 AM, she stated she was not here during this time frame, so she was not sure if any audits were being completed to verify that the MARs were being signed appropriately and checked or verified against the narcotic count logs, or if medications were being wasted appropriately, but she stated she felt like if there were any systems in place to check, this would not have happened, and it should have been noticed or caught by someone. She stated this could have been an issue because if the MARs were not signed appropriately residents may end up getting inappropriate amounts of pain medication, which could ultimately not relieve their pain at all or cause harm if too much pain medication was administered. She stated she was trying to be more proactive and aware and follow-up on reviewing the PRN medications at the weekly meetings. She also stated she and the facility were currently putting a system into place to perform random audits of the MARs of residents with narcotics and compare to the narcotic logs, as well as compare the MARs and logs to resident interviews. In an interview with LVN-B on 3/25/25 at 1:37 PM, she stated she never paid attention to whether things were being signed off on the MARs or narcotic logs by other nurses, and she never paid attention to whether other nurses were wasting medications with or without a witness. She stated they had previously been in-serviced over documentation and passing medications so as to keep the residents safe from harm. In an interview with the pharmacy director on 3/25/25 at 3:18 PM, he stated he did an audit around September 17th or 18th 2024 and sent the report to the interim DON at the time. He stated he provided dispensing information, but no further recommendations since there were no red flags or discrepancies with the areas that were observed during their audit. He stated they did an observational reconciliation to make sure there were not any discrepancies in medication counts. He stated they did not audit to check against MARS or nursing narcotic count logs because that was not something they performed in their audits, but they basically just checked to make sure the count was correct and that nothing seemed off, so their audits would not have noticed or recognized unsigned MARS or unsigned wasted narcotic medications. In an interview with the Administrator on 3/26/25 at 2:30 PM, he stated he did not know what systems or checks were in place during the time frame between August and October to verify that MARs and narcotic logs were being checked for accuracy, but the DON and ADON had been discussing these areas in their weekly meetings in which they review from the previous Friday to the current Friday to look for any red flags with the residents who were on PRN medications. He stated that he did not understand how these things were missed before, and that could have caused harm to the residents if they had been given incorrect or inaccurate dosages of medications. He was unsure if any in-services since September of 2024 had been conducted regarding verification of signing MARS appropriately and wasting narcotics with another licensed nurse. In an interview with the DON on 3/26/25 at 2:35 PM, she stated they had been doing spot checks here and there of MARs and Narcotic logs but not performing any actual audits. She stated during the weekly meetings they review pain, pain medications, and other areas of concern. She also stated she met with the nurses each morning went over any concerns with the residents, but she did not think any in-services since September of 2024 had been conducted regarding verification of signing MARS appropriately and wasting narcotics with another licensed nurse. The DON stated after consulting with her regional nurse, and as of today, she would be putting a system check or audit into place where she would look at three residents with a BIMS of 13 or greater on each hall weekly to ensure they received their PRN pain medication, and that it was signed out appropriately on the narcotic log and MAR. (continued on next page)		

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Controlled Substance Policy, 2001 Med-Pass revised November 2022, revealed 6. Unless otherwise instructed by the director of nursing services, when a resident refuses a dose (or it was not given), or a resident receives a partial dose (or it was not given) the medication was destroyed and may not be returned to the container. 7. Waste and/or disposal of controlled medication were done in the presence of the nurse and a witness who also signs the disposition sheet. Record review of the Pharmacy Medication Administration Policy (no date listed on policy) revealed 9.4 Following resident medication administration, facility staff should appropriately document medication administration, dispose of unused medication per facility policy, discard used supplies per facility policy, and clean reusable equipment and supplies.		