

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676107	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER Corpus Christi Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2735 Airline Rd Corpus Christi, TX 78414	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48633</p> <p>Based on observation, interview and record review the facility failed to ensure that drugs and biologicals were stored in locked compartments for 2 of 8 medication carts observed for compliance.</p> <p>Two medication carts in the 100 hall were left unlocked and unattended by CMA B.</p> <p>This failure could place residents at risk of access and ingestion of non-narcotic medications. This failure had the potential to affect all 29 residents in the 100 hall.</p> <p>Findings were:</p> <p>Observation on 6/4/2024, at 10:48 a.m., two medication carts were unlocked on hall 100 without a supervised staff in view of both carts. The carts were unlocked for 4 minutes until CMA B exited a room and returned to one (later stated both carts were his carts) of the carts.</p> <p>During an interview on 6/4/2024 at 10:52 a.m., CMA B verbalized both carts that were unlocked were his carts. He verbalized he thought he locked them before entering a room to take a blood pressure on a resident. CMA B stated he was assigned to two medication carts due to a staff member calling in for the shift. CMA B states it is proper process to lock the carts when the cart is not in view or when not being utilized but due to the demand of the residents at the time, he did not lock them properly. He also states a resident could have accessed the medications in the drawers that were accessible (all non-narcotics).</p> <p>During an interview on 6/4/2024 at 2:09 p.m., the Director of Nursing (DON) stated it is the expectation of the facility for all staff passing medications to follow the policy and lock the medication carts. The DON stated the call-in staff member was supposed to be covered by LVN H not CMA B. The expectation of the On-call staff is for them to cover the entire job responsibilities of the staff member that called in and not to assign any job responsibilities to other staff member(s). All carts are to be within the line of sight of the staff member utilizing the cart or locked this prevents residents from obtaining access to improper medication.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/4/2024 at 2:46 p.m., LVN H confirmed she is the On-call staff person. LVN H stated CMA B is more familiar with the medication cart on the 100 hall and she was already behind in passing the medication on the other hall (hall 400) she was assigned due to the call in of a staff member. LVN H stated she allowed CMA B to fill in the job responsibilities of passing the medications on hall 100 so all medications would be on time and there would be no complaints from the residents.</p> <p>During an interview on 6/5/2024 at 1:30 p.m., the Administrator stated LVN H has been suspended as she was the On-call staff person, and she did not cover the call-in staff member's duties as assigned which led to another staff person being overloaded and leaving medication carts unlocked. It is the policy of the facility to keep all medication carts locked. The Administrator also stated one medication cart was not locking properly and it has been fixed at this time.</p> <p>A review of the medication cart policy dated 10/01/2019 reveals Do not leave the medication cart unlocked or unattended in the resident care areas and The cart must remain in your line of sight when it is not locked.</p>		