STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676107	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corpus Christi Nursing and Rehabilitation Center	2735 Airline Rd Corpus Christi, TX 78414

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 49157 Based on interview and record review, the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriations of resident property, and exploitation for one (Resident #1) of five residents reviewed for abuse. The facility failed to ensure that Resident #1 was free from abuse. On 04/30/24, Resident #2 intentionally pinched Resident #1 on the left arm because Resident #1 put her fingers into Resident #2's cup of ice. Resident #1 sustained bruising from the pinches. Resident #2 was transferred to another facility on 05/01/2025. This failure could place residents at risk for abuse and physical, mental, and psychosocial harm. The findings include: Record review of Resident #1's admission record reflected a [AGE] year-old female that was admitted to the facility on [DATE] with an original admitted [DATE]. Resident #1's pertinent diagnoses included Alzheimer's disease with late onset (progressive disease in which brain cells and connections degenerate and die resulting in confusion and loss of memory and thinking, as well as the ability to do simple tasks) and unspecified dementia (condition in which a person loses the ability to think, remember, learn, make decisions, and problem solve). Record review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 0 due to the inability to complete the BIMS section and a Cognitive Skills for Daily Decision Making score of 3 which indicated that Resident #1 was severely cognitively impaired. Record review of Resident #1's care plan dated 11/17/20 to 07/24/24 reflected a focus of Resident #1 was involved in a resident to resident altercation on 04/30/24 when she was pinched by roommate (Resident #2) which resulted in a discoloration to the middle, lower part and front part of her left upper arm initiated on 05/01/24. The goal of this focus was Resident #1 would remain free from injury from a resident to resident altercation throughout the next review period initiated on 05/01/24. The interventions were head to toe assessment, notified MD, monitored discoloration for 5 days, residents were immediately separated and redirected away from each other, roommate (Resident #2) was immediately moved to another room, and roommate (Resident #2) was transferred to another facility. Those interventions were initiated on 05/01/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes reflected a note dated 05/01/24 at 11:54 am by ADON A that stated, This nurse was notified by CNA that resident had bruising to her upper left extremity. Upon assessment, resident has left deltoid (front) 2cm by 2cm purplish discoloration, left medial distal deltoid cluster of 2 discoloration areas 1st one 1cm by 1cm, 2nd .7cm by .7cm (circular) discolorations also noted around those areas. Resident #1's progress notes also had an entry by the SW dated 05/01/24 at 12:03 pm that stated, Followed up with Resident #1 regarding resident to resident incident. Resident #1's cognition is severely impaired. No distress noted during assessment. Record review of Resident #1's orders reflected an order dated 05/02/24 that read, Monitor discoloration to left deltoid area, with an end date of 05/07/24. Record review of Resident #2's admission record reflected a [AGE] year-old female that was admitted to the facility on [DATE] with an original admitted [DATE]. Resident #2's pertinent diagnoses included Bipolar disorder (a disorder associated with episodes of extreme mood swings ranging from lows of sad, indifferent, or hopeless feelings to highs of elated, energized, or irritable behavior), anxiety disorder (a disorder characterized by excessive feelings of fear, worry, or anxiety that interfere with daily activities), and depression (persistent feelings of sadness and hopelessness). Record review of Resident #2's discharge MDS dated [DATE] reflected a BIMS score of 15 which indicated that Resident #2 was cognitively intact. Record review of Resident #2's orders reflected orders dated 05/01/24 that stated psychiatric services to evaluate and treat [Resident #2], monitor [Resident #2] for physical aggression towards others every shift, and Resident #2 to transfer to [another facility] with all medications and personal belongings. Record review of the facility's provider investigation report dated 05/01/24 reflected the following: Investigation: On 05/01/24 at approximately 10:00 am, as the CNA was tending to [Resident #2], getting her ready for dialysis, [Resident #2] stated, [Resident #1] pisses me off. The CNA then asked why and [Resident #2] proceeded to tell the CNA, Yesterday (04/30/24) [Resident #1] grabbed my up of ice and put her fingers in it. The CNA asked, during what shift? [Resident #2] responded, 2-10. [Resident #2] then stated, But it's ok, I got her good. I pinched her several times on her arm [referring to Resident #1], showing the CNA exactly where she pinched [Resident #1]. [Resident #1] unable to recall what happened. [Resident #2] initially out to dialysis. Resident [#2] returned from dialysis and states, It upset me that she was touching and putting her hands on my stuff, I just wasn't thinking, and I pinched her, but I don't think I did it that hard. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's progress notes reflected an entry by the SW on 05/01/24 at 4:30 pm that stated, Resident [#2] returned from dialysis. Discussion was had with resident regarding incident with roommate [Resident #1]. SW, DON, and administrator present during conversation with resident [#2]. Resident [#2] asked for male resident, fiance, to be present during conversation. Resident [#2] appears to be upset during conversation but stated she pinched roommate [Resident #1] due to roommate putting her hands in her [Resident #2's] ice. Resident [#2] also stated she did not think she pinched her that hard. Resident [#2] aware mistake was made and was apologetic. Resident [#2] stated she is okay with going to another facility and understands. Concerns about fiance transferring with her. At this time, male resident stated he is wanting a transfer to same facility. The SW also had 2 other entries dated 05/01/24 at around the same time that stated, Resident will be a 1:1 until discharged , and, DON, employee with MHID, ombudsman, and MD notified of the situation. The progress notes also reflected an entry dated 05/01/24 at 7:27 pm that stated, Resident [#2] d/c to another facility. Record review of the facility's grievance log reflected no grievances regarding this incident noted. Record review of the facility's incident and accident log from 03/2024-10/2024 reflected only the one incident on 05/01/24 that involved either Resident #1 or Resident #2. In an interview on 02/26/25 at 2:03 pm, LVN C stated Resident #2 was a younger lady and was alert and oriented and Resident #1 had dementia. LVN C stated she did not recall the specific incident between Resident #1 and Resident #2, and she had never noticed Resident #2 being physically aggressive with anyone; however, she had been verbally aggressive sometimes. LVN C stated they were in-serviced on ANE at least monthly and every time there was an incident. In an interview on 02/27/25 at 10:10 am, LVN E stated she did not remember the incident, but did remember the residents. LVN E stated Resident #2 was friendly and outgoing but did not like her stuff messed with. LVN E stated she never saw Resident #2 get violent, physical or mean. LVN E stated Resident #1 never really talked, and kept to herself because she did not comprehend things said to her and was totally dependent on staff. LVN E states she never saw Resident #1 put her hands in anything or grab things. LVN E stated she was not aware of any other resident to resident altercations with Resident #2 because Resident #2 was good about telling staff when she was upset. LVN E stated if she had ever witnessed abuse, she would have removed the resident from the situation and reported to the administrator. LVN E stated abuse/neglect in-services were at least every month and the last one was a couple of weeks ago. In an interview on 02/27/25 at 10:25 am, ADON B stated he was not directly involved in the incident between Resident #1 and Resident #2 but did remember the incident. ADON B stated he remembered they were monitoring for edema and discoloration on Resident #1's arm. ADON B stated he was not aware of any physical altercations with any other residents, but she was possessive with her food and items. ADON B stated Resident #2 definitely had no problem telling on residents to keep them out of her stuff or complaining about things that happened. ADON B stated he never observed Resident #1 stick hands or fingers into other residents' food or cups, but Resident #1 liked ice and would at times try to get into the ice bucket. ADON B stated Resident #1's dementia was so progressed that she did not know right from wrong or what she was doing. ADON B stated Resident #2 was moved to a different room on 05/01/24 when she returned from dialysis, then transferred to another facility later that evening. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/27/25 at 11:05 am, CNA H stated he had worked here for a year. CNA H stated he did not remember the incident between Resident #1 and Resident #2, but he did remember Resident #2 was very nice and friendly; he never saw her get confrontational with other residents. CNA H stated Resident #2 was alert and her cognition was intact. CNA H stated Resident #1 was nice but had her bad days and could not answer questions because of her dementia; he never saw her have any altercations with any other residents. CNA H stated Resident #1 would grab at food or drinks but did not really know what she was doing and only tried to pick up an item if it was placed within her reach. CNA H stated if he had witnessed the abuse, he would have reported it to the administrator. CNA H stated they were in-serviced at least monthly regarding abuse. Record review of the facility's investigation of this incident reflected the staff had an in-service on 05/01/24 on all forms of abuse and neglect as well as timely reporting of abuse to the administrator, DON and immediate supervisor. Record review of the facility's Abuse, Neglect, and Exploitation policy dated 08/15/22 reflected: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect exploitation, and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident and certain resident to resident altercations. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict harm or injury. Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; b. Establish policies and procedures to investigate any such allegations; c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention; and d. Establish coordination with the QAPI program. The components of the facility abuse prohibition plan are discussed herein: I. Screening: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Prospective residents will be screened to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility. III. Prevention of Abuse, Neglect, and Exploitation: D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. VI. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; F. Providing emotional support and counseling to the resident during and after the investigation, as needed; G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as the result of an incident of abuse.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50969 Based on observation, interview, and record review, the facility failed to ensure that licensed nursing staff were able to demonstrate the specific competencies and skill sets necessary to care for resident's needs. The facility failed to ensure LVN-D and LVN-E both were competent in counting their narcotics correctly, as well as competent in keeping control of the narcotic keys appropriately. On 02/26/25 prior to shift change, LVN-D failed to count her narcotics off with LVN-E prior to leaving at the end of her shift, as well as LVN-E failed to secure the narcotic key on her body or person, but left it sitting in a cabinet at the nurses station. This failure had the potential to place residents, visitors, and staff at unnecessary risks of a medication error or drug diversion, to include both the risk of missing or stolen narcotic medications, as well as the risk of missing or stolen narcotic keys. Findings included: Record review of in-service dated 10/29/24 revealed staff were in-serviced over knowing job duties, report must be given, and narcotic log must be done at every shift. Record review of in-service dated 01/15/25 revealed staff were in-serviced over policies regarding locking med-carts. Record review of controlled count sheets for February and March 2025 revealed multiple narcotics being counted on a single sheet instead of their own separate sheets, as well as multiple narcotics being marked out, subtracted, and/or re-added to the count. Observation on 02/26/25 at 3:00 PM revealed the DON, ADON-A, and ADON-B checking all the narcotic compartments of the medication carts to verify they were all locked and secured. Observation on 02/26/25 at 3:00 PM revealed the DON, ADON-A and ADON-B checking all the narcotic count sheets to verify all counts were correct. In an interview with LVN-D on 02/26/25 at 2:20 PM, she stated that she counted her medications and narcotics with herself, and left the keys with LVN-E, who held onto them until whichever nurse was going to take over that cart, then that on-coming nurse would have counted to verify that the narcotic count was correct. She stated that she was supposed to count with an oncoming nurse or whoever was taking over the med-cart and narcotic keys prior to leaving, but sometimes when there was no nurse available to count with, the nurses would just count with themselves. She also stated that if narcotic keys were left in a desk or unattended, they could get stolen, and a resident or staff could steal narcotics, which could harm them if they took them. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with ADON-B on 02/26/25 at 2:50 PM, he stated that the nurses should never be counting by themselves. They should always count with another nurse and sign off that the count was correct prior to handing off the keys or the cart, and the keys should always be on the person of the nurse who was in control of or over that med-cart. He stated that if they were not counting with the oncoming nurse, or the nurse taking over the narcotic keys and cart, the count could be incorrect, and someone would be held liable for missing narcotics. He also stated that if the keys were left in or on a desk, or in a cabinet, they could be stolen, and residents or staff could get a hold of narcotics that do not belong to them, and this could cause them harm. He initially stated he was unsure of who held the keys between off-going nurse LVN-D and on-coming nurse LVN-L, but he thought it may had been LVN-E who held onto the keys until LVN-L came onto shift. He then stated no one had control of the keys as they were left inside a binder at the nurse's station by LVN-D, and LVN-D verbally told LVN-E she was leaving them there for the on-coming nurse. ADON-B also stated he understood why it could be confusing to determine correct counts and information on the controlled count sheets when multiple counts were being done on a single sheet, and many things were being deducted then re-added. In an interview with ADON-A on 2/26/25 at 3:30 PM, she stated the oncoming should get report and count off medications with the off-going nurse, then the on-coming nurse accepts responsibility for the medication cart and narcotic keys. She stated that the nurses had been in-serviced multiple times on getting report and counting their medications. She stated that LVN-D should have counted off with LVN-L, and LVN-L then counted with myself (ADON-A) since the nurses were leaving early and/or working a split shift; then I (ADON-A) counted with LVN-C. The off-going nurses were supposed to count together at the end of a shift with the on-coming nurses, or if the cart and keys had to switch hands with another nurse during a shift, like a split shift. If the count was wrong, the oncoming nurse should not accept the count or cart because this can create a medication error or drug diversion. She also stated that if the keys were left unattended, they could be taken or stolen by a resident or other staff member who would then have had access to narcotic medications that could have caused them harm. In an interview with the DON on 02/26/25 at 3:45 PM, she stated nurses should never count by themselves, and they should always count with another nurse, as well as sign off that the count was correct prior to handing off the keys or the cart, and the keys should always be kept on the nurse who was in control of or over that medication cart. She stated that if they were not counting with the oncoming nurse, or the nurse taking over the narcotic keys and cart, the count could be incorrect, and keys or narcotics could go missing. She also stated that keys should never be left in a desk or cabinet, and if the keys were left in or on a desk, or in a cabinet, they could be stolen, and residents or staff could get a hold of narcotics that do not belong to them, and this could cause them harm. She was unsure of who held the keys between off-going nurse LVN-D and on-coming nurse LVN-L. She stated she thinks it was LVN-E who held onto the keys until LVN-L came onto shift, but she was not sure. The DON also stated she understood why it could be confusing to determine correct counts and information on the controlled count sheets when multiple counts were being done on a single sheet, and many things were being deducted then re-added. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN-E on 2/27/25 at 9:00 AM, she stated she has worked here 7 years and knew the nurses should be counting their narcotics together prior to the on-coming nurse taking control of a medication cart or narcotic keys. She stated the nurses keep the med-cart and narcotics locked for the safety of the residents and staff because if left unlocked a resident or staff could take something that was not ordered for them, and it could harm them. She also stated LVN-D left yesterday morning without counting meds with the oncoming nurse and left the keys with her (LVN-E) to give to the oncoming nurse, but the keys were left in a cabinet at the nurse's station for the next nurse to take over. She stated that if keys were left unattended someone could find them, get into the med-cart and steal medications, including narcotics. Record review of the Medication Administration Policy dated 10/01/19, under the subsection: General Guidelines: Medication Carts and Supplies for Administering Meds, revealed only a licensed nurse or certified medical aide may carry keys to the medication cart, and keys to the controlled drug section were assigned to the nurse dispensing controlled substances. Record review of the Medication Administration Policy dated 10/01/19, under subsection: General Guidelines: Documentation of Controlled Substances, revealed medications included in the Drug Enforcement Administration classification as controlled substances were subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulation. Controlled substance keys were kept on a separate key ring and were always in the possession of the licensed nurse or certified medical aide who has been designated responsible for medication administration and signed for those controlled substances in the control substances record at the change of shift.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50969 Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were secured and stored in accordance with current accepted professional principles for 2 of 4 medication carts observed for medication storage in that: The facility failed to ensure the 400 hall medication cart and the 100 hall medication cart were locked and/or secured. This failure could place the residents at risk of gaining access to unlocked medications that were not prescribed to them. Findings included: Record review of in-service dated 10/29/24 revealed staff were in-serviced over knowing job duties, report must be given, and narcotic log must be done at every shift. Record review of in-service dated 01/15/25 revealed staff were in-serviced over policies regarding locking med-carts. Observation on 02/26/25 at 8:05 AM revealed an unlocked med-cart parked at the nurse's station with no nurses or other staff around it. There were residents noted to be walking and passing by, as well as a nurse at another med-cart parked at the other side of the nurse's station. The med-cart lock was popped out, and all drawers were able to be opened. Most of the med-cart drawers were stocked full of medications. Observation on 2/26/25 at 9:08 AM revealed an unlocked med-cart parked in the 400 hall with no nurses or other staff around it. There were residents noted to be walking and passing by, as well as a nurse at another med-cart just down the hall. The cart lock was popped out, and all drawers were able to be opened. The med-cart was pushed to the DONs office, and the drawers were opened to show to both the DON and ADON of it being unlocked, and anyone having access to take anything. Most of the med-cart drawers were stocked full of medications. In an interview on 02/26/25 at 8:07 AM with Med-Aide-K, he stated it was his med-cart from the 100 Hall, and he saw that it was unlocked, but he did not leave it unlocked because he had just gotten there, and it was already unlocked when he came on shift this morning. He stated it must have been left unlocked by night shift, but he did not know specifically who. He stated it was usually locked when he comes on shift in the mornings, and it should always be locked when not in use because if left unlocked anyone could get into it and get medications out that did not belong to them, and this could cause harm. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/26/25 at 9:10 AM with ADON-A, she stated the 400 hall med-cart belonged to the Med-Aide who had not even arrived yet, so it must have been left unlocked by the night shift nurse. She stated they had not had an issue with unlocked med-carts previously, and if the carts were left unlocked a resident or anyone else could get into the cart and take the medication from it. This could cause harm or even be fatal. In an interview on 02/26/25 at 9:12 AM with the DON, she stated the second unlocked med-cart from the 400 Hall belonged to a med-aide that was not here yet, and she was unsure why it was left unlocked, but it may have been left unlocked by night shift. She stated that if a cart was left unlocked a resident or anyone else could get into it and take any of the medication, and if a resident ingested a medication that was not theirs, it could make them sick or cause harm. In an interview on 02/26/25 at 2:20 PM with LVN-C, she stated she never saw med-carts unlocked, and med-carts should never be left unlocked. If a med-cart was left unlocked a resident could get a hold of something or ingest medications that could harm them, or anyone could steal medications or something out of the med-cart. She stated that the nurses were in-serviced at least monthly regarding the med-carts, so they should have known better than to leave them unlocked. In an interview on 02/26/25 at 2:35 PM with LVN-D, she stated med-carts were supposed to be locked or other staff or residents could get into them, and things like death, sickness, or theft could happen. She stated the nurses were in-serviced at least monthly regarding med-carts. In an interview on 02/27/25 at 9:00 AM with LVN-E, she stated she had never seen a med-cart left unlocked, but if she did, she would immediately lock it because they were supposed to be kept locked when not in use. She stated the carts were kept locked for the safety of the residents and staff because if left unlocked someone could take something that was not ordered for them, and it could harm them. Record review of the Medication Administration Policy dated 10/01/19, under the subsection: General Guidelines, and Subject: Medication Carts and Supplies for Administering Meds, revealed the medication cart is locked at all times when not in use, and do not leave the medication cart unlocked or unattended in the resident care areas.