

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  04/10/2025
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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50039</p> <p>Based on interviews and record review, the facility failed to ensure residents and/or the residents' representatives the right to participate in the development and implementation of his or her person-centered plan of care for 1 (Resident #1) of 5 residents reviewed for care plans.</p> <p>The facility failed to record any documentation showing any care plan meeting involving Resident #1 or their RP occurred during her stay at the facility from her admitted on 05/29/24 through her discharge date of [DATE].</p> <p>This failure could place residents at risk for inadequate care, accidents, and injuries.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet dated 04/10/25 revealed an [AGE] year-old female with an initial admitted [DATE] and discharge date of [DATE]. Pertinent diagnoses included unspecified dementia (loss of cognitive function that interferes with daily life in which the cause was unidentified).</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 (moderate cognitive impairment).</p> <p>Record review of Resident #1's care plan was initiated on 05/29/24 with the next review date set for 03/26/25. Resident #1's comprehensive care plan had been developed with interventions made in the care plan throughout her stay at the facility.</p> <p>Record review of Resident #1's care plan history revealed no documentation that any care plan meetings occurred with the resident or RP.</p> <p>In an interview with the RP for Resident #1 on 04/07/25 at 4:20 PM, the RP stated they only had one care plan meeting during the seven months Resident #1 was at the facility. The RP stated they did not have quarterly care plan meetings.</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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON at 11:28 AM on 04/10/25, the DON stated it was standard procedure to invite resident RP's to care plan meetings. The DON stated they would hold care plan meetings even if the RP did not show up based on the status of the resident. The DON stated the RP did show up to the first care plan meeting with Resident #1, but she could not remember the exact date. The DON stated the care plan meetings with Resident #1 should have been documented, along with notes from the meetings. The DON stated care plan meetings happened quarterly, after a change of condition, within 72 hours of a transition, and as needed. The DON stated there was no documentation of any care plan meetings with Resident #1. The DON stated the CMS nurse should have recorded the meetings. The DON stated it was important to document care plan meetings so they could reference them in the future to measure changes in a resident's behavior, progression, or regression of their conditions.</p> <p>In an interview with the LMSW at 12:11 PM on 04/10/25, the LMSW stated typically the CMS Nurse documented care plan meetings. The LMSW stated the CMS Nurse would document who attended the meetings and what was discussed. The LMSW stated she was present at all care plan meetings. The LMSW stated care plan meetings occurred quarterly, with a change of condition, or as needed. The LMSW stated she did not find any documentation of care plan meetings with Resident #1. The LMSW stated she only remembered taking part in one care plan meeting with Resident #1 around September of 2024. The LMSW stated it was important to have care plan meetings to discuss concerns with the resident and RP to ensure everybody was on the same page.</p> <p>In an interview with the CMS Nurse at 12:24 PM on 04/10/25, the CMS Nurse stated she could not find any documentation related to any care plan meetings with Resident #1. The CMS Nurse stated she should have documented the details of the quarterly care plan meetings for Resident #1. The CMS nurse stated she remembered participating in a care plan meeting with Resident #1 around September of 2024. The CMS Nurse stated it was important to document the details of care plans meetings so they could look back and reference them to notice any changes in the resident.</p> <p>Record review of the facility policy titled Care Plan Revisions Upon Status Change implemented on 10/24/22 revealed the following:</p> <ul style="list-style-type: none"> <li>b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options.</li> <li>c. The team meeting discussion will be documented in the nursing progress notes.</li> </ul>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50039</p> <p>Based on interviews and record reviews, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 9 of 12 residents (Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, and Resident #10) reviewed for pharmacy services.</p> <p>1) The facility failed to ensure ADON D disposed of one tablet of Hydrocodone-APAP 10-325 mg by properly including a witness signature on the narcotic sheet when destroyed on 02/28/25 for Resident #2.</p> <p>2) The facility failed to ensure ADON D disposed of one tablet of Hydrocodone-APAP 10-325 mg by properly including a witness signature on the narcotic sheet when destroyed on 03/04/25 for Resident #3.</p> <p>3) The facility failed to ensure ADON D disposed of one tablet of Hydrocodone-APAP 10-325 mg by properly including a witness signature on the narcotic sheet when destroyed on 03/04/25 for Resident #4.</p> <p>4) The facility failed to ensure ADON D disposed of one tablet of Hydrocodone-APAP 10-325 mg by properly including a witness signature on the narcotic sheet when destroyed on 01/13/25 for Resident #5.</p> <p>5) The facility failed to ensure ADON D disposed of one tablet of Hydrocodone-APAP 10-325 mg by properly including a witness signature on the narcotic sheet when destroyed on 02/09/25 for Resident #6.</p> <p>6) The facility failed to ensure ADON D disposed of one tablet of Hydrocodone-APAP 10-325 mg by properly including a witness signature on the narcotic sheet when destroyed on 03/15/25 for Resident #7.</p> <p>7) The facility failed to ensure ADON D disposed of one tablet of Hydrocodone-APAP 5-325 mg by properly including a witness signature on the narcotic sheet when destroyed on 01/13/25 for Resident #8.</p> <p>8) The facility failed to ensure ADON D disposed of Tramadol 50 mg (pain medication) by properly including a witness signature on the narcotic sheet when destroyed on 01/13/25 for Resident #9.</p> <p>9) The facility failed to ensure ADON D disposed of Acetaminophen-Codeine 300-30 mg (pain medication) by properly including a witness signature on the narcotic sheet when destroyed on 12/18/24 for Resident #10.</p> <p>These failures could place residents at risk for or lead to drug diversion.</p> <p>Findings included:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Record review of Resident #2's face sheet dated 04/10/25 revealed a [AGE] year-old male with an initial admitted [DATE] and current admitted [DATE].</p> <p>Record review of Resident #2's order summary revealed an active order for Hydrocodone-APAP 10-325 mg initiated on 12/15/22.</p> <p>Record review of Resident #2's narcotic sheet for Hydrocodone-APAP 10-325 mg revealed 1 tablet was destroyed without a witness present on 03/04/25.</p> <p>2. Record review of Resident #3's face sheet dated 04/10/25 revealed a [AGE] year-old female with an initial admitted [DATE] and current admitted [DATE].</p> <p>Record review of Resident #3's order summary revealed an active order for Hydrocodone-APAP 10-325 mg initiated on 03/14/25.</p> <p>Record review of Resident #3's narcotic sheet for Hydrocodone-APAP 10-325 mg revealed 1 tablet was destroyed without a witness present on 03/04/25.</p> <p>3. Record review of Resident #4's face sheet dated 04/10/25 revealed an [AGE] year-old male with an admitted [DATE].</p> <p>Record review of Resident #4's order summary revealed a discontinued order for Hydrocodone-APAP 10-325 mg initiated on 02/20/25.</p> <p>Record review of Resident #4's narcotic sheet for Hydrocodone-APAP 10-325 mg revealed 1 tablet was destroyed without a witness present on 03/04/25.</p> <p>4. Record review of Resident #5's face sheet dated 04/10/25 revealed a [AGE] year-old male with an initial admitted [DATE] and current admitted [DATE].</p> <p>Record review of Resident #5's order summary revealed a discontinued order for Hydrocodone-APAP 10-325 mg initiated on 01/05/25.</p> <p>Record review of Resident #5's narcotic sheet for Hydrocodone-APAP 10-325 mg revealed 1 tablet was destroyed without a witness present on 01/13/25.</p> <p>5. Record review of Resident #6's face sheet dated 04/10/25 revealed a [AGE] year-old male with an initial admitted [DATE] and current admitted [DATE].</p> <p>Record review of Resident #6's order summary revealed an active order for Hydrocodone-APAP 10-325 mg initiated on 12/06/24.</p> <p>Record review of Resident #6's narcotic sheet for Hydrocodone-APAP 10-325 mg revealed 1 tablet was destroyed without a witness present on 02/09/25.</p> <p>6. Record review of Resident #7's face sheet dated 04/10/25 revealed a [AGE] year-old male with an initial admitted [DATE] and current admitted [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #7's order summary revealed an active order for Hydrocodone-APAP 10-325 mg initiated on 07/03/24.</p> <p>Record review of Resident #7's narcotic sheet for Hydrocodone-APAP 10-325 mg revealed 1 tablet was destroyed without a witness present on 03/15/25.</p> <p>7. Record review of Resident #8's face sheet dated 04/10/25 revealed a [AGE] year-old female with an admitted [DATE].</p> <p>Record review of Resident #8's order summary revealed an active order for Hydrocodone-APAP 5-325 mg initiated on 10/20/22.</p> <p>Record review of Resident #8's narcotic sheet for Hydrocodone-APAP 5-325 mg revealed 1 tablet was destroyed without a witness present on 01/13/25.</p> <p>8. Record review of Resident #9's face sheet dated 04/10/25 revealed a [AGE] year-old male with an admitted [DATE].</p> <p>Record review of Resident #9's order summary revealed an active order for Tramadol 50 mg initiated on 06/06/24.</p> <p>Record review of Resident #9's narcotic sheet for Tramadol 50 mg revealed 1 tablet was destroyed without a witness present on 01/13/25.</p> <p>9. Record review of Resident #10's face sheet dated 04/10/25 revealed a [AGE] year-old female with an initial admitted [DATE] and current admitted [DATE].</p> <p>Record review of Resident #10's order summary revealed a discontinued order for Acetaminophen-Codeine 300-30 mg initiated on 09/20/23.</p> <p>Record review of Resident #10's narcotic sheet for Acetaminophen-Codeine 300-30 mg revealed 1 tablet was destroyed without a witness present on 12/18/24.</p> <p>Record review of the provider investigation summary dated 03/24/25 revealed the following:</p> <p>[ADON D] admitted to disposing of the medications as per protocol but did so without a witness. He denies taking any medication for himself from the facility [ADON E] also confirmed that several times she did cosign of a disposed medication where the other ADON had signed without personally witnessing the act This incident has been reported to HHSC due to its nature and per reporting guidelines however, the facility believes the alleged incident is unconfirmed Both ADON's will be terminated for failure to follow company policy and procedures.</p> <p>In an interview with ADON E at 2:27 PM on 04/08/25, ADON E stated she never destroyed any narcotics without a witness present. ADON E stated in her review of the narcotic books, she saw a lot of signatures by ADON D destroying narcotics without an accompanying witness signature. ADON E stated she informed the DON about these incidents of not following proper procedure.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with LVN B at 3:21 PM on 04/08/25, LVN B stated she had never seen anyone destroy a controlled medication without a witness. LVN B stated she always got a witness to sign the narcotic book if she had to destroy a narcotic to ensure there were no suspicions of drug diversion.</p> <p>In an interview with ADON D at 4:54 PM on 04/08/25, ADON D stated the ADONs were given an instruction by the DON to audit the narcotics on the resident halls. ADON D stated he never destroyed any controlled medications without a witness present. ADON D stated he marked the narcotics for destruction, and then came back with a witness anytime he destroyed one.</p> <p>In an interview with LVN C at 8:47 AM on 04/09/25, LVN C stated she always got a witness to sign the narcotic sheet anytime she had to destroy a narcotic. LVN C stated she had destroyed narcotics twice since she had been at the facility since December 2024, and both times she had a witness sign the book with her.</p> <p>In an interview with LVN A at 10:12 AM on 04/09/25, LVN A stated she had never seen any nurse destroy a controlled medication without a witness. LVN A stated it was important to have a witness when a nurse destroyed a narcotic because narcotics were often abused and preventing drug diversion was important.</p> <p>In an interview with the DON at 11:38 AM on 04/09/25, the DON stated there were several medications that ADON D destroyed without a witness to sign. The DON stated she told the ADONs sometime in November or December of 2024 to go through the medication carts and find blister packs that were damaged and destroy the potentially damaged medications. The DON stated ADON D found medications with damaged blister packs but destroyed the medications without a witness. The DON stated it was important to have a witness sign off on drug destruction to ensure nobody was diverting any controlled medications.</p> <p>Record review of the facility's policy titled Documentation of Controlled Substances dated 10/01/19 revealed the following:</p> <p>When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It must be destroyed by two licensed nurses employed by the facility, and the disposal is documented in the controlled substances record on the line representing that dose. The same process applies to disposal of unused partial tablets and unused portions of single dose ampules and doses of controlled substances waster for any reason.</p>