

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  11/21/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences for one (Resident #1) of four residents reviewed for call light placement. The facility failed to ensure Resident #1's call light was within reach. This failure could place residents at risk for needs and accommodation being unmet. Record review of a face sheet dated 11/05/2025 indicated Resident #1 was a [AGE] year-old who was last admitted on [DATE] with multiple diagnoses to include Chronic Obstructive Pulmonary Disease (a long term lung condition that makes it hard to breathe), Memory Deficit, Cerebral Infarction (blood flow to part of the brain was or is blocked, leading to brain cell damage or death), Dysphagia (difficulty swallowing), Cognitive Communication Deficit, Altered Mental Status, and Vascular Dementia (a condition that causes memory, thinking, and reasoning problems due to reduced or blocked blood flow to the brain. Review of a quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS score of 13 which indicated normal cognitive function. The MDS indicated Resident #1 was able to understand others and to make her needs known verbally. The MDS also indicated Resident #1 needed supervision and/or partial assistance with toileting hygiene, showering, upper and lower body dressing and personal hygiene. Record review of Resident #1's care plan, undated revealed, Resident #1 at a high risk for falls with an intervention to ensure the resident's call light within reach of the resident to use for assistance as needed. Resident #1's care plan also revealed The resident needs prompt response to all requests for assistance. On 11/5/2025 at 2:15 pm, during an observation of Resident #1 in her room, Resident #1 was in her bed with the door open calling out into the hallway with call light on the bedside table outside of the reach of Resident #1. Resident #1 attempted to use call light but used the bed remote instead because Resident #1 could not find the call light within her reach. On 11/5/2025 at 2:20 pm, during an interview with LVN A, she stated she is unaware Resident #1 could not reach the call light, and the call light should have been left where Resident #1 could reach the call light. LVN A stated she is unsure how long Resident #1 was without her call light. LVN A stated she checked on Resident #1 after lunch and Resident #1 had her call light within her reach at that time. On 11/5/2025 at 2:40 pm, during an interview with the DON, she stated it was not acceptable for residents to not be able to reach the call light. The DON stated she had just walked down Resident #1's hall at 2:10 pm and Resident #1 was not calling out for assistance at that time. The DON stated she will be doing staff education, check offs for call light placement, and 1:1 education with staff last assisting this resident. The DON stated it is protocol for residents to have their call light in reach. The DON stated Resident #1's result of not having the call light within reach could mean her needs may not have been met. On 11/6/2025 at 1:50 pm, during an interview with CNA B, she stated she did care for Resident #1 on 11/5/2025 and did assist the resident to bed. CNA B stated the call light was placed next to Resident #1 about 1:20 pm and she wasn't aware of anyone else moving the call light. CNA B stated she was in-serviced on call light placement today by the DON. On 11/6/2025 at 2:00 pm, during a follow-up interview with the DON, she stated staff were in-serviced regarding call lights always being in reach of all residents and the call light policy, 100% rounding performed to ensure all call lights were in reach of all residents yesterday evening, and there was an audit of 40% of the rooms with call lights this morning. The DON stated all residents had their call lights within reach. Record review of facility policy titled Call Lights: Accessibility and Timely Response and dated 10/13/2022 included verbiage The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.</p>		