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 03/30/2026
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain clinical records in accordance with accepted professional standards of practice, that were complete and accurately documented, for one (Resident #1) of five residents reviewed for meal percentage logs.The facility failed to document the meal percentages in Resident #1's electronic health record on 02/28/2026, 03/17/2026, and 03/23/2026 as per the facility's Medical Record documentation Policy. This failure could jeopardize residents from receiving adequate nutrition and assessment which could compromise the residents' specific dietary needs. Record review of Resident #1's admission record dated 03/28/2026 revealed Resident #1 was initially admitted on [DATE]. Resident #1 was admitted with multiple diagnoses including Alzheimer's disease (cognition disease), dementia (memory deficit), muscle wasting and atrophy (wasting), not elsewhere classified, other lack of coordination, and need for assistance with personal care. Record review of Resident #1's Significant Change MDS dated [DATE] revealed Resident #1 had a BIMS score of 1- indicating severe cognitive impairment. Resident #1 was coded for mechanically altered diet and was not coded for weight loss or gain for the last 6 months. Resident #1 was coded for needing partial/moderate assistance with ADLs. Record review of Resident #1's care plan date initiated 03/26/2026 revealed The family of [Resident #1] requests that he does not get up for meals. [Resident #1] will maintain highest practicable level of function and nutritional intake. Monitor and document meal intake and tolerance. Report changes in condition (e.g., increased coughing, decreased intake, fatigue). Notify physician and interdisciplinary team of any concerns or decline. Record review of Resident #1's meal percentage log dated 02/28/2026, 03/17/2026, and 03/23/2026 revealed no documentation for meal percentages eaten. During an interview on 03/30/2026 at 1:28pm-2:31PM with CNA A, CNA C, and CNA F, all stated they have assisted Resident #1 to eat. While referencing date 02/28 CNA A stated she assisted Resident #1 to eat for his meals, CNA C stated she assisted Resident #1 to eat his meals on 03/17/2026, and CNA F stated she has assisted Resident #1 to eat on 03/23/2026. All three CNAs stated that due to the heaviness of the hall and the demanding needs of the residents on the 100 hallways, they had forgotten to document the meal percentages during their shift. All three CNAs verbalized the recent facility education regarding documentation and stated documenting the meal percentages were important as it could negatively impact Resident #1's well-being. All three CNAs stated they were more diligent with documenting Resident #1's meal percentages and furthermore the facility has incorporated a paper log binder on 03/26/2026, for Resident #1, that they were also to document meal percentages. All three CNAs reiterated that they did assist Resident #1 to eat on 02/28/2026, 03/17/2026, and 03/23/2026 but forgot to document the meal percentages. During an interview on 03/30/2026 at 3:08pm Dietician, stated Resident #1's current BMI 27.9 and WNL for Resident #1's age and weight range. The Dietician stated she was not concerned for Resident #1's nutritional status and was not concerned that Resident #1 was not receiving his meals. The Dietician stated there has been no compromising concern for Resident #1's weight or muscle waste, and furthermore reiterated Resident #1's nutrition was satisfactory. During an interview on 03/30/2026 at 4:26pm the DON stated, she implemented a (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
	676107	A. Building B. Wing	03/30/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	binder for Resident #1 that was specific to his meal percentages and care. The DON stated she has commenced an clinical staff in-service on 03/25/2026 regarding documentation in the electronic health record. The DON stated it was the facility's expectation to all clinical staff when providing any form of care, including meal eating assistance, to document the care in the resident's electronic health record. The DON stated since 03/25/2026 the facility has additionally incorporated at the end of every nurse's shift; the nurses were expected to review and ensure the documentation has been completed by the CNAs. Additionally, the DON stated she was also assisting as a third reviewer to ensure the documentation was completed daily. The DON stated the lack of documentation did not negatively affect Resident #1, but had the circumstances been different, Resident #1's nutritional status and well-being of could have been negatively affected. The DON stated the incident regarding Resident #1's meal percentages was an isolated to just Resident #1. Record review of the facility's Documentation in Medical Record policy date implemented 10/24/2022 revealed, B. Documentation shall be accurate, relevant and complete, containing sufficient details about the residents' care and/or responses to care.