STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455557	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Palms Nursing & Rehabilitation	5607 Everhart Rd Corpus Christi, TX 78411

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48633 Based on observations, interviews, and record review the facility failed to develop and implement a person-centered comprehensive care plan for one (Resident #1) of four residents reviewed. The facility failed to care plan Resident #1's preferences to leave the building and the actions or long-term goals to meet the needs of the resident. This failure could place residents at risk for unmet medical, nursing, mental, and psychosocial needs and preferences. Findings were: On 9/27/2024 at 1:24 p.m. review of face sheet dated 9/19/2023 revealed Resident 1 admitted on [DATE] for major depressive disorder, schizophrenia (mental disorder that affects a person's ability to think, feel, and behave clearly), and acute gastritis (inflammation of intestine lining) without bleeding. On 9/27/2024 at 1:24 p.m. review of Resident 1's Quarterly Minimum Data Set, dated dated dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 14 (Intact). On 9/27/2024 at 1:24 p.m. review of Resident 1's care plan last reviewed on 8/2/2024 did not include the residents plan or preference to leave the facility. The care plan did not indicate where the resident would go when leaving the facility. The care plan did not indicate the need for the resident to sign out and did not indicate the facility will clean the resident's room when the resident was not in the facility. On 9/27/2024 at 12:25 p.m. interview with Resident 1 revealed resident was served her breakfast tray, but Resident #1 stated she did not want what she was served or the alternatives that were offered. Resident #1 stated she would be leaving to get lunch somewhere outside of the facility. In an interview on 9/27/2024 at 12:35 p.m. RN A stated Resident 1 can sign herself out of the facility to leave the premises. Resident also showered herself. In an interview on 9/27/2024 at 1:30 p.m. the Administrator stated Resident 1 had a hoarding issue, and her room was cleaned up when she would go out on leave. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/30/2024 at 2:17 p.m. the Social Worker stated Resident 1 would come and go from the facility by signing in and out for herself. Resident 1 did have bad living conditions before living at this Nursing facility and will sometimes go to a mental health appointment by public transportation system. Resident 1 did not have to sign in and out on her care plan because We don't care plan when residents leave the facility on their own if they have the ability. In an interview on 9/30/2024 at 2:46 p.m. LVN A stated Resident 1 did leave the facility by signing in and out, but they did not have her care plan updated to reflect her leaving the facility. LVN A stated the ability of the resident to leave the premises should be care planned . In an interview on 10/10/24 at 1:35 p.m. the DON stated Resident 1 could sign herself in and out of the facility. Resident 1 sometimes would go to or to other appointments via the bus system. Resident 1's ability to sign out and into the facility was expected to be on the care plan. All activities, preferences, and goals of residents should be care planned . In an interview on 10/10/24 at 2:04 p.m. the Administrator stated, I would expect the care plans to have the resident's permissions to leave the facility and our expectations of the resident to sign in and out; care plans give the resident a plan of how to live their lives while they are here in this facility, and it gives us their expectations and freedoms of choice .

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48633 Based on observations, interviews, and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for one (R#3) of 4 residents reviewed for injuries of unknown origin. The facility failed to ensure a resident remained free from an injury of unknown origin. Resident #3 suffered a dislocated shoulder and a later identified broken elbow . This failure could place residents at risk for further accidents and injuries. Findings were: Record review on Resident #3's face sheet dated 10/02/24 revealed the resident was admitted on [DATE] with the following diagnoses: vascular dementia, primary osteoarthritis, and other specified bone density and structure, affective disorder , anxiety due to physiological condition, depression, and glaucoma. Record review of Resident #3's Minimum Data Set, dated dated dated [DATE] revealed resident had a BIMS score of 00 (resident unable to complete this part of the assessment). MDS also indicated the resident had moderately impaired vision, rarely understands others, and was completely dependent on staff for mobility. Review of Resident #3's Care Plan undated indicated the resident had a potential for unrelieved pain due to impaired cognitive/communication abilities due to dementia. Further review of the care plan also indicated the resident was not able to participate in a BIMS assessment due to impaired short term and long-term memory, problem solving, and safety awareness. This care plan also indicated Resident #3 was disoriented and had poor decision-making abilities with Dementia. The care plan indicated Resident #3 was bed bound and was dependent X2 staff for transfer tasks with the mechanical lift. Record review on October 4, 2024, at 10:00 a.m. of provider investigation revealed Resident #3 was sent to the hospital on September 29, 2024, for complaint of pain in her left arm. Record review of provider's investigation 3613 at 9:30 a.m., indicated three staff were suspended pending the internal investigation, the shoulder was dislocated, and a witness statement from LVN C indicated staff did notify the Nurse Practitioner appropriately. An in-service was completed for staff on 09/30/24, and CNA E's witness statement indicated repositioning the resident in the shower completed appropriately and with no issues or concerns . Record review of Hospital Emergency Department admission notes dated 09/29/24 revealed Resident #3 had a slight widening of the acromioclavicular articulation (possible shoulder dislocation). Further review indicated Resident #3 was not a good historian and did have a deformity and dislocation of the right upper extremity on exam. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on October 4, 2024, at 6:17 p.m., LVN B stated that when she arrived for her shift, she and RN A did an assessment on Resident #3, and they did not note any abnormality of the arm or injury. LVN B said the Nurse Practitioner was contacted and briefed on Resident #3's pain complaint and the Nurse Practitioner gave an order to administer acetaminophen and monitor the resident for effectiveness. LVN B said the acetaminophen was administered and it was effective with the pain and allowed Resident #3 to rest. LVN B said Resident #3 did say someone hurt her but could not provide specifics and this was communicated to the lead nurse. LVN B said Resident #3 had a diagnosis of dementia and history of saying she was in pain, so the Nurse Practitioner followed up and ordered a mobile x-ray later in the shift. LVN B stated the x-ray was delayed because the technologist did not come to the facility before her shift was over for the day. During an interview on 10/04/24, at 12:07 p.m., LVN C stated on 09/28/24 she we went to assess Resident #3 during her shift and the resident complained of pain. LVN C said she reviewed the shift report from the previous shift and noted that only acetaminophen was administered, and the x-ray was still pending. LVN C said when she re-assessed Resident #3, she was experiencing pain and was holding her arm in an abnormal way. LVN C said she called the NP and obtained an order to send Resident #3 to the hospital for evaluation. During an interview on October 4, 2024, at 5:12 p.m., the Nurse Practitioner, stated he was notified by a staff member (unsure which staff member and exact time of day) of Resident #3 having pain in the arm in the late afternoon on 9/28/24 and ordered PRN Tylenol and an x-ray. Later the same day or early the next day, (during sleep hours) he was notified the resident did not receive the x-ray due to a technician not being available and agreed for Resident #3 to be sent to the hospital. The Nurse Practitioner stated this injury could be from poor transferring or poor repositioning and he believed the nursing staff contacted him appropriately given they did not know the x-ray technologist would not be available. During an interview on 10/04/24, at 12:44 p.m., Resident #3 stated she was wheeled back to her room on 9/28/24 and placed in bed where someone then got on top of her and straddled her and tried to pull her up in her bed. They jerked her forward and back while trying to move her up in the bed. She yelled for them to stop and eventually they did. This wass what happened to hurt her arm. Resident #3 stated she had never seen this CNA, and this was not a usual staff member. During an interview on 10/10/24, at 1:35 p.m., the Director of Nurses (DON) stated Resident #3 had sustained a dislocated shoulder according to the emergency department. Resident #3 claimed she was injured on 9/28/24 but cannot identify the perpetrator and all staff have been questioned. The DON stated her expectations were for the nursing staff to be the eyes and ears of the physician. When the x-ray technician did not show u p the resident should have been sent to the emergency room . During an interview on 10/10/24, at 2:04 p.m., the Administrator stated an investigation had been completed, but there was no conclusive finding at this time. The Administrator confirmed all staff working on this day were facility staff and not agency staff. Resident #3 was still at the hospital with a dislocated shoulder and now a fracture of the elbow. The Administrator stated the nurses did treat the pain with medication and the resident rested for a bit. The next shift the nurse did talk with the Nurse Practitioner (NP) and got more medication and an x-ray ordered and sent the resident to the hospital per the NP orders when the x-ray technologist did not show up . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/30/24, at 9:40 a.m., CNA E stated she and CNA F did reposition Resident #3 the morning of the incident and completed the action accurately and according to policy and protocol. CNA E stated she was suspended after the incident and will not be returning to the facility due to the work being extremely stressful. During an observation on 10/04/24, at 1:50 p.m., CNA A and CNA B demonstrated transferring a resident appropriately and according to policy and protocol. During an observation on 10/31/24, at 11:05 a.m., CNA C and CNA D demonstrated transferring of a resident in a Hoyer lift appropriately and according to policy and protocol .