

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375102	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER Cimarron Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 905 Beall Road Kingfisher, OK 73750	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>47453</p> <p>Based on record review and interview, the facility failed to update and/or revise a care plan for two (#2 and #49) of fourteen sampled residents reviewed for care plans.</p> <p>The DON identified 53 residents resided in the facility.</p> <p>Findings:</p> <p>An undated Update and Maintain Care plans policy, read in part, with the most accurate resident preferences and needs available.</p> <p>1. Resident #2 had diagnoses which included recurrent urinary tract infections and multiple sclerosis.</p> <p>A Physician Order, dated 05/13/24, documented Resident #2 was placed on Macrobid (antibiotic medication) 50mg daily prophylactically for diagnosis of recurrent UTI's.</p> <p>A Care Plan, review date 01/02/25, did not document a focus problem for recurrent UTI's or being on Macrobid prophylactic.</p> <p>2. Resident #49 had diagnoses which included schizoaffective disorder (bipolar type) and dementia.</p> <p>A Physician Order, dated 06/08/24, documented the resident was placed on Seroquel (antipsychotic medication) 200mg at bedtime for diagnosis of schizoaffective disorder (bipolar type).</p> <p>A Care plan, review date 01/02/25, did not document a focus problem for use of an antipsychotic medication.</p> <p>On 02/03/25 at 8:58 a.m., MDS coordinator #1 was asked the facility policy for updating and revision of care plans. They stated they got information from floor staff regarding a resident and then they put it in the careplan. They stated they tried to update at that time. They were then asked to review the care plan for Resident #2 and then asked if the care plan had a focus problem for recurrent UTI's and Macrobid prophylactic. They stated, No.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/03/25 at 10:46 a.m., MDS coordinator #1 was asked what the steps were for adding a problem and/or focus on a care plan. They stated they looked at the admission paperwork and then placed the main problem areas on the initial care plan and then added new problems as needed. MDS Coordinator #1 was asked to review the care plan for Resident #49 and were then asked if the care plan included a problem or focus area for their antipsychotic medication use. They stated No.</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>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>35749</p> <p>Based on record review and interview, the facility failed to administer insulin per physician orders for two (#5 and #47) of six sampled residents whose medications were reviewed.</p> <p>The DON identified 10 residents received insulin.</p> <p>Findings:</p> <p>An Administering Medications policy, dated April 2010, documented medications must be administered as prescribed.</p> <p>1. Resident #5 had diagnoses which included diabetes mellitus.</p> <p>A physician's order, dated 01/11/24, documented to administer insulin aspart 100 units/ml per sliding scale, subcutaneous, before meals and at bedtime at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. It documented:</p> <ul style="list-style-type: none"> a. if BS was less than 60 call physician, b. if BS was 151 to 200 give 2 units, c. if BS was 201 to 250 give 4 units, d. if BS was 251 to 300 give 6 units, e. if BS was 301 to 350 give 8 units, f. if BS was 351 to 400 give 10 units, g. if BS was 401 to 450 give 12 units, and h. if BS was greater than 450 call physician. <p>A physician's order, dated 11/12/24, documented to administer Tresiba insulin 100 units/ml, 11 units; subcutaneous twice daily between 7:00 a.m. - 08:00 a.m. and 7:00 p.m. - 8:00 p.m.</p> <p>A December 2024 FSBS and insulin administration sheet documented the following:</p> <ul style="list-style-type: none"> a. on 12/01/24 at 8:00 p.m., FSBS was 163, 2 units of insulin was ordered to be administered. There was no insulin administered, b. on 12/05/24 at 7:50 p.m., FSBS was 161, 2 units of insulin was ordered to be administered. There was no insulin administered, <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>c. on 12/07/24 at 7:59 p.m., FSBS was 98, Tresiba 11 units was ordered to be administered. There was no insulin administered,</p> <p>d. on 12/08/24 at 4:00 p.m., FSBS was 302, 8 units of insulin was ordered to be administered. There was 6 units of insulin administered,</p> <p>e. on 12/08/24 at 8:00 p.m., FSBS was 314, 8 units of insulin was ordered to be administered. There was 4 units of insulin administered,</p> <p>f. on 12/16/24 at 8:12 p.m., FSBS was 186, 4 units of insulin was ordered to be administered. There was no insulin administered, and</p> <p>g. on 12/31/24 at 7:31 p.m., FSBS was 163, 2 units of insulin was ordered to be administered. There was no insulin administered.</p> <p>A January 2025 FSBS and insulin administration sheet documented on 01/28/25 at 8:42 p.m., FSBS was 162, and 2 units of insulin should have been administer. There was no insulin administered.</p> <p>2. Resident #47 had diagnoses which included diabetes mellitus.</p> <p>A physician's order, dated 10/24/24, documented to administer insulin aspart 100 units/ml, insulin pen, per sliding scale, subcutaneous, before meals and at bedtime at 7:00 a.m., 11:00 a.m., 4:00 p.m., 8:00 p.m. It documented:</p> <p>a. if BS was less than 60 call physician,</p> <p>b. if BS was 151 to 175 give 3 units,</p> <p>c. if BS was 176 to 200 give 4 units,</p> <p>d. if BS was 201 to 225 give 6 units,</p> <p>e. if BS was 226 to 250 give 8 units,</p> <p>f. if BS was 251 to 275 give 10 units,</p> <p>g. if BS was 276 to 300 give 12 units, and</p> <p>h. if BS was greater than 300 give 14 units.</p> <p>A December 2024 FSBS and insulin administration sheet documented the following:</p> <p>a. on 12/01/24 at 11:00 a.m., FSBS was 217, 6 units of insulin was ordered to be administered. Other Comment: 4 units where administered,</p> <p>b. on 12/08/24 at 8:00 p.m., FSBS was 177, 4 units of insulin was ordered to be administered. There were 2 units of insulin administered,</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>c. on 12/21/24 at 8:00 p.m., FSBS was 228, 6 units was ordered to be administered. There were 4 units of insulin administered,</p> <p>d. on 12/22/24 at 11:00 a.m., FSBS was 154, 3 units of insulin was ordered to be administered. There were 2 units of insulin administered,</p> <p>e. on 12/22/24 at 8:00 p.m., FSBS was 184, 4 units of insulin was ordered to be administered. There were 2 units of insulin administered,</p> <p>f. on 12/28/24 at 11:00 a.m., FSBS was 191, 4 units of insulin was ordered to be administered. There were 2 units of insulin administered,</p> <p>g. on 12/28/24 at 4:00 p.m., FSBS was 191, 4 units of insulin was ordered to be administered. There were 2 units of insulin administered, and</p> <p>h. on 12/28/24 at 8:00 p.m., FSBS was 321, 14 units of insulin was ordered to be administered. There were 8 units of insulin administered.</p> <p>A January 2025 FSBS and insulin administration sheet documented the following:</p> <p>a. on 01/03/25 at 4:00 p.m., FSBS was 286, 12 units of insulin was ordered to be administered. There were 8 units of insulin administered,</p> <p>b. on 01/05/25 at 4:00 p.m., FSBS was 261, 10 units of insulin was ordered to be administered. There were 8 units of insulin administered,</p> <p>c. on 01/18/25 at 8:00 p.m., FSBS was 209, 6 units of insulin was ordered to be administered. There were 4 units of insulin administered, and</p> <p>d. on 01/19/25 at 11:00 a.m., FSBS was 185, 4 units of insulin was ordered to be administered. There were 3 units of insulin administered.</p> <p>A February 2025 FSBS and insulin administration sheet documented the following:</p> <p>a. on 02/01/25 at 11:00 a.m., FSBS was 236, 8 units of insulin was ordered to be administered. There were 6 units of insulin administered, and</p> <p>b. on 02/02/25 at 8:00 p.m., FSBS was 227, 8 units of insulin was ordered to be administered. There were 6 units of insulin administered.</p> <p>On 02/02/25 at 9:37 a.m., LPN #2 stated Resident #47 received FSBS's before meals and at bedtime. LPN #2 stated Resident #47 was on a high sliding scale, so they sometimes used their own judgement on how much insulin they would administer.</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>On 02/04/25 at 9:18 a.m., LPN #3 was asked what the policy was for insulin administration. They stated they would check the FSBS, verify the physician's order to see how much insulin was to be administered, then go administer the insulin. LPN #3 was asked what the policy was if they felt like the insulin dosage was too high. They stated they would not give the insulin if their FSBS was not much over 150 or if they had not eaten a snack. LPN #3 stated there were times they had not administered the sliding scale insulin.</p>		