STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676087	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cimarron Place Health & Rehabilitation Center	3801 Cimarron 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47573 Based on interviews and record review the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident needs, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 (Resident #1) of 4 residents reviewed for care plans. The facility failed to develop a comprehensive person-centered care plan for Resident #1 to address her behaviors (e.g. yelling, banging on bed/table, throwing items, removing brief). The facility failed to care plan the fall mat for Resident #1. This failure could place the residents at risk of not receiving appropriate interventions and care to meet their current needs as indicated on the comprehensive care plans. The findings included: Record review of Resident #1's face sheet dated 03/06/25 reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: traumatic subdural hemorrhage (brain bleed), hemiplegia (left side paralysis), muscle wasting and atrophy, unsteadiness on feet, cognitive communication deficit, type 2 diabetes (high levels of sugar in blood), unspecified dementia, cerebral infarction (stroke), and chronic kidney disease. Record review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 7, indicating severe cognitive impairment. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) reflected no behaviors exhibited. Record review of Resident #1's care plan dated 03/06/25 reflected Resident #1 had an ADL self-care performance deficit related to cognitive deficit, weakness, and subdural hematoma. Date initiated: 02/13/25. Resident #1's care plan did not reflect behaviors (yelling, banging on bed/table, throwing items, removing brief). Resident #1 was at risk for falls related to history of falls with subdural hematoma. Date initiated: 02/13/25. Resident #1's care plan did not reflect the fall mat. Interview attempted with Resident #1 on 03/06/25 at 1:00 PM, revealed Resident #1 was discharged . (continued on next page)

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 - Few	Interview with MDS N on 03/13/25 at 11:00 AM, revealed MDS N said Resident #1 would yell out and was very vocal since she was admitted . MDS N said Resident #1 would mostly yell that she wanted to go home or would sometimes curse at others so it took a lot of redirection and reassuring. MDS N said since it was Resident #1's normal behaviors since admission, the behaviors would not need to be care planned. MDS N said if there was an increase in behaviors or change noted, then that would be care planned. MDS N said whenever they noticed an increase or change of behaviors, then at that point they would have to update the care plan as soon as possible. MDS N said the care plan was updated by the team as they discussed things every morning during their meeting and then decided what could be implemented. Interview with the DON on 03/13/25 at 3:10 PM, revealed the DON said when Resident #1 was first admitted , she would repetitively call out and said hello or I want to go home. The DON said Resident #1 also had behaviors of throwing items since admission. The DON said she recalled the hospital records indicated Resident #1 was on a 1:1 at the hospital and she speculated it was due to behaviors. The DON said Resident #1 would holler out, bang on the bed or table, and throw other items like her brief. The DON said she did not think Resident #1's behaviors had really increased during her stay but her behaviors fluctuated depending on the time of the day. The DON said Resident #1 was more vocal some days than others. The DON said Resident #1's behaviors would have been care planned. The DON said it was important for Resident #1's behaviors to be care planned so that staff were aware and knew what to do if Resident #1 exhibited behaviors. The DON said the care plan would have reflected the interventions implemented specific for Resident #1's behaviors. The DON said for Resident #1 it was a lot of redirection and distraction to address her behaviors. The DON said she was not sure why Resident #1's behaviors were not care planned. The DON said Resident #1 did not have any falls at the facility but they were aware of Resident #1's history of falls prior to admission so Resident #1 had a fall mat at her bedside and the bed low during her stay. The DON said fall mats were care planned for those residents at risk for falls as the fall mats were an intervention. The DON said Resident #1 was at risk for falls since admission. The DON said the fall mat was not care planned for Resident #1 and the DON said she did not know why not. The DON said the care plans were developed by the team. Record review of the facility's Care Plans, Comprehensive Person-Centered policy dated December 2016 reflected - Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 8.g. Incorporate identified problem areas, incorporate risk factors associated with identified problems. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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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	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** 47573 Based on interviews and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for accuracy of records, in that: The facility failed to document in Resident #1's medical record when Resident #1 was sent to the hospital on 02/25/25 for a CT scan. The facility failed to document the physician's order for the CT scan. This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care. The findings included: Record review of Resident #1's face sheet dated 03/06/25 reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: traumatic subdural hemorrhage (brain bleed), hemiplegia (left side paralysis), muscle wasting and atrophy, unsteadiness on feet, cognitive communication deficit, type 2 diabetes (high levels of sugar in blood), unspecified dementia, cerebral infarction (stroke), and chronic kidney disease. Record review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 7, indicating severe cognitive impairment. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) reflected no behaviors exhibited. Record review of Resident #1's care plan dated 03/06/25 reflected Resident #1 had an ADL self-care performance deficit related to cognitive deficit, weakness, and subdural hematoma. Date initiated: 02/13/25. Record review of Resident #1's orders for entire stay dated 03/06/25 reflected no physician's order documented for the CT scan ordered on 02/25/25. Record review of Resident #1's progress notes dated 03/06/25 reflected no progress notes documented when Resident #1 was sent to the hospital on 02/25/25 for a CT scan. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN C on 03/12/25 at 2:00 PM, revealed LVN C said on 02/25/25, the MD ordered a CT scan for Resident #1 as Resident #1 exhibited increased behaviors. LVN C said she took over Resident #1's hall (hall 200) at about 5:45 PM and had to arrange the transport for Resident #1 to be taken to the hospital for the CT scan. LVN C said in between completing tasks and documenting for 2 halls, she forgot to document a progress note in Resident #1's medical record regarding the CT scan or transport. LVN C said the previous nurse, LVN D, had not documented either as that nurse had a personal emergency and left. LVN C said she was not aware if the CT scan order was entered or documented in Resident #1's orders. LVN C said she followed directives from the DON once she took over hall 200 to arrange Resident #1's transport. LVN C said Resident #1 was transported to the hospital on 02/25/25 at around 6 PM. Interview with the DON on 03/12/25 at 6:40 PM, revealed the DON said there was no physician's order documented for the CT scan ordered for Resident #1 on 02/25/25 as it was a verbal order communicated to the hospital staff. The DON said there would be no need to document the order in the chart. The DON said the nurse called in report and gave the hospital staff the information of what was needed and the hospital staff knew what Resident #1 was sent for. The DON said there would be a progress note to show that Resident #1 was sent to hospital for the CT scan and why. Interview attempted with LVN D on 03/12/25 at 7:00 PM. LVN D did not answer. LVN D was no longer employed by the facility. Interview with the DON on 03/13/25 at 3:10 PM, revealed the DON said on 02/25/25, Resident #1 was sent out to a small hospital to get a CT scan. The DON said she was not sure at what time Resident #1 was sent out. The DON said Resident #1 was supposed to come right back so the DON would not expect there to be a progress note documented in the medical record for when Resident #1 was sent out. The DON said she had seen in the past where they documented a progress note when the resident returned from what hospital or doctor's office, what occurred and if they received any new orders. The DON said Resident #1 never returned to them so there was no progress note entered. The DON said the charting and documenting policy indicated to document changes, labs, medications, but not necessarily document a note for sending a resident to the hospital for an in/out procedure like this CT scan for Resident #1. The DON said they had a meeting with the MD and the MD requested a CT scan to check how Resident #1 was doing in comparison to before her admission at the facility because she had a brain bleed. The DON said they never documented notes in the resident's medical record based on the meetings with providers. The DON said the policy for medication and treatment orders indicated that verbal orders must be recorded immediately in the resident's chart. The DON said they had not taken the CT scan as a verbal order, but the MD had requested it and they sent Resident #1 out. The DON said she did not know that an order needed to be inputted for Resident #1 to get a CT scan that was going to be in and out, outpatient procedure. Interview with the ADM on 03/13/25 at 4:00 PM, revealed the ADM said when they sent Resident #1 out to get the CT scan on 02/25/25, the nurse should have documented that Resident #1 was going out for a scan and should have documented the order. The ADM said it was important to have such things documented so the next shift knew what was being done and so they could follow up on test results. The ADM said it was important for the resident's medical record to be complete and accurately documented to ensure there was proper continuity of care. Record review of the facility's Medication and Treatment Orders policy dated July 2016 reflected - (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and time of the order. Record review of the facility's Charting and Documentation policy dated July 2017 reflected - Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 3. Documentation in the medical record will be objective, complete, and accurate.