

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/14/2025
NAME OF PROVIDER OR SUPPLIER  Cimarron Place Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50039</p> <p>Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs, for 1 (Resident #1) of 5 residents reviewed for care plans.</p> <p>The facility failed to update Resident #1's care plan with the DNR code status after the OOH DNR order was signed by all appropriate parties on [DATE].</p> <p>This failure could place residents at risk of receiving care out of line with their wishes.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated [DATE] revealed an [AGE] year-old female with an initial admitted [DATE] and a current admitted [DATE]. Pertinent diagnosis included Unspecified Dementia (dementia without a specific diagnosis or a diagnosis that is not yet known). Resident #1 was discharged on [DATE] due to death.</p> <p>Record review of Resident #1's PPS MDS assessment dated [DATE] revealed a BIMS score of 0 (severe impairment).</p> <p>Record review of Resident #1's comprehensive care plan dated [DATE] revealed the focus [Resident #1] wishes to have CPR performed should the need arise initiated on [DATE] and cancelled on [DATE]. The goal listed for this focus included Resident, family, surrogate will have wishes respected initiated on [DATE] and cancelled on [DATE]. Interventions listed for the focus included:</p> <ul style="list-style-type: none"> <li>-Ensure chart is properly identified initiated on [DATE] and cancelled on [DATE].</li> <li>-If resident has no pulse or respirations, initiate CPR initiated on [DATE] and cancelled on [DATE].</li> </ul> <p>Record review of Resident #1's order summary revealed a discontinued order for DNR initiated on [DATE] and ended on [DATE].</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's OOH DNR order revealed the document was signed by Resident #1's RP and two non-staff witnesses on [DATE]. The document was signed by the physician on [DATE].</p> <p>In an interview with LVN A on [DATE] at 9:27 AM, LVN A stated if she did not know a resident's code status, she would check the front page of the MAR. LVN A stated a resident's code status should be listed on the care plan as well. LVN A stated it was important to keep the care plan updated so everyone on the healthcare team knew how to care for the resident. LVN A stated if the code status was incorrect on the care plan it was possible for a resident with a signed OOH DNR to receive CPR or vice versa.</p> <p>In an interview with LVN B on [DATE] at 10:06 AM, LVN B stated if she needed to know the code status of a resident, she would check the resident's MAR or the binder at the nurse's station which contained the code status for all residents at the facility. LVN B stated she did look at resident's care plans to ensure she was up to date on how to care for her residents. LVN B stated if the code status was not accurate in the care plan, it was possible a resident with an active DNR order could receive CPR or a resident with a full code order could not receive CPR.</p> <p>In an interview with the ADON on [DATE] at 11:09 AM, the ADON stated, typically, the social worker updated the code status in the care plan for residents. The ADON stated it was a team effort to ensure the care plans were accurate. The ADON stated if the care plans did not accurately reflect a resident's code status, the resident could receive CPR unnecessarily or not get CPR when they wished to receive it.</p> <p>In an interview with the DON on [DATE] at 1:30 PM, the DON stated nurses could look in PCC or the binder at the nurse's station to determine a resident's code status. The DON stated when a resident wished to go from a full code status to DNR status, they met with the social worker who started the process. The DON stated once the OOH DNR form was signed by all parties, the social worker would inform the nurses to put the new DNR order in the resident's chart. The DON stated it was a team effort to ensure the care plan was updated appropriately. The DON stated if the care plan did not accurately reflect the resident's current plan of care, a nurse could provide inappropriate care to a resident such as using improper transfer methods or not taking a resident's behavior into account.</p> <p>In an interview with the LMSW on [DATE] at 2:24 PM, the LMSW stated she had meetings with families and residents about updating their code status. The LMSW stated once the form was signed by all parties, she informed the DON and charge nurses about the update to the resident's code status. The LMSW stated she was normally the one to update the care plan with the new code status if she uploaded the OOH DNR into PCC. The LMSW stated sometimes the MDS nurse uploaded the DNR into PCC. The LMSW stated she remembered Resident #1 was a DNR but did not know why Resident #1's care plan was not updated with the correct code status. The LMSW stated if a resident's care plan was not updated in a timely manner, staff may not know the current best way to care for a resident.</p> <p>Record review of the facility policy titled Care Plans, Comprehensive Person-Centered last revised on [DATE] revealed the following:</p> <p>.8. The comprehensive, person-centered care plan will:</p> <p>.e. Include the resident's stated goals upon admission and desired outcomes;</p> <p>(continued on next page)</p>		

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