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	05/06/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 5 residents reviewed for pharmacy services.The facility failed to ensure Resident #1 received their medications as ordered.These failures could place residents at risk of medical complications and prevent them from receiving the therapeutic effects of their medications. The findings included:Record review of Resident #1's face sheet revealed an [AGE] year-old female with an admission date of 06/01/25. Diagnoses included chronic obstructive pulmonary disease, high blood pressure, heart failure, polyneuropathy (a condition where multiple nerves become damaged or malfunctioning), depression, blindness, breast cancer, blood clots, muscle wasting, and a need for assistance with personal care. Her MDS dated [DATE] revealed a BIMS score of 02, indicating severe cognitive impairment.Record review of the facility's medication administration audits dated 04/21/26 revealed medications on the 6 am - 2 pm shift were administered 5 to 7 hours late by LVN A.Record review of the medication audit of the 6:00 am - 2:00 pm shift for the 500-hall dated 04/21/26 revealed LVN A medicated residents in the 500-hall. Scheduled times for the medications were 6:00 am. Residents received their medications from 11:11 am to 1:32 pm. In an interview with Resident #1 on 05/06/26 at 10:00 am, she said she did not recall any problems with her medications on 04/21/26. In an interview with the RP for Resident #1 on 05/06/26 at 12:31 pm, she said she was watching the in-room camera footage and saw LVN A take Resident #1's blood pressure and administer medications around noon on 04/21/24. She said a couple of hours later, she saw another nurse do the same thing around 1 pm and thought it was off. She said she called the DON and was told the DON would look into it. She said she found out from (unknown) there was no checklist to prevent medications being given too close together. She said LVN A had always been good but was running late and was behind that day. She said she spoke with LVN B who checked on it and told her she was right. She said she asked LVN B for the DON's phone number and suggested they call the doctor and inform them. She said LVN B told her she made the call and that the DON spoke with the MD and was told the dose was not dangerous. She said she wanted to know why there was no communication for the oncoming nurse who was running late. She said the medication had no harm to the resident. She said she was not happy about the whole deal. She said the facility needed to have some kind of checks and balances for making sure times were followed for medications and she thanked God there was no harm. She said she did not know the name of the male PRN LVN who administered the dose, and a female who administered it too close in time. She said she started monitoring the times meds were given, and there were no problems before or after that day (04/21/26). In an interview with the DON on 05/05/26 at 1:25 pm, she said she did a thorough investigation of all residents LVN A medicated during the time and day of complaints about medication times she received from the RP of Resident #1. She said the audits revealed 6 residents received their morning medications 5 -7 hours late. She said she identified six residents who received medications 3 times a day because they had closer dosing due to the medication error. The DON provided a medication audit report she conducted (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 04/22/26 for the date of 04/21/26. She said she asked LVA A why he did not ask for help, and he told her, Everyone else had what they had going on and (he) did not want to bother them. She said there was no way the on-coming shift knew if the medication was given late because the computerized MAR turned green once it was completed/administered. She said the MAR on the computers showed medications on a white background. She said once a medication was in the timeframe of one hour until due, the background turned yellow. She said once a medication was in the timeframe of one hour past due, the background turned red and stayed red until the medication was given. She said the medical director was informed and discussed with all residents. She said the medical director said all 6 residents were ok with the late meds and the on-time/early meds given. She said she spoke with staff about TID meds to make sure of the times given and provided an in-service. She identified LVN A's name was not on the in-service, and said he was given the same packet that included the medication administration policy, medication storage, and medication carts.In a phone interview with LVN A on 05/06/26 at 1:15 pm, he said the DON spoke with him about late medicines to let them know if he was running late with meds. He said on 04/21/26 that he did not tell anyone he needed help. He said he passed meds when he got to the facility, and he had a lot of residents that day. He said the residents all had lots of questions- more than usual, needing help to the bathroom, wanting water, etc. He said he realized he was late when he got to his 2nd hall (500 Hall) because the computer was red. He said he was doing his best to get the meds to the residents. He said there were other nurses and med aides in the facility at the time. He said he had been a nurse for 13 years. He said he was giving morning medicine and that was what he was focused on. He only knew what he had to give and did not look to see what time the doses were to be given. Then he said he had passed meds at this facility before and he knew the med times because the computer showed it. He said as a nurse, meds were supposed to be scheduled BID (twice a day), Q8hrs (every 8 hours), or TID (three times a day) and have an hour before and an hour after the scheduled dosing time. He said he did not contact the doctor about giving the meds late. He said he did not let anyone know he was running late. He said he did not recall anyone asking him if he needed help because he would have taken the help. He said he was doing the morning meds that started at 6:00 am. He said he did not know what time it got to be when he started the second hall (500). He said he had been hopping around to both the 400 hall and the 500 hall passing meds. He said he did not have a routine down and could not explain it. He said he was doing the morning meds and knew the residents had not had anything overnight, so he had to get their medicines to them. He said he was asked by the DON about meds due at 6 am but given at 12 pm. He said every medicine was important and he did not know all of his medications. He said he was pushed into a situation meaning he did not know what he was doing. He said he did not look up medications he was not familiar with. He said none of the residents he medicated asked why the medication was late. He said he did not mention to the on-coming nurse, LVN B, that his medications had been given late.In an interview with LVN B on 05/06/26 at 2:30 pm, she said she was shocked when she heard from the DON that LVN A had given his medications very late. She said she had no idea, because the MAR only showed scheduled times. She said an audit had to be run in order to see actual times. She said the DON showed her the audit from 04/21/26. She said she was alerted to the med error by Resident #1's RP and immediately called the DON, and the DON called the MD. She said she received a call from the DON explaining her conversation with the MD and that there were no adverse reactions. In an interview with the MD on 05/06/26 at 3:00 pm, he said he recalled the situation on 04/21/26 and had spoken with the DON about it. He said that, with the help of the DON, he determined there were no immediate concerns and directed the DON to ensure the residents were monitored closely and to notify him of any concerns. Record review of Resident #1's progress notes dated 04/21/26, beginning at 6:18 pm, revealed the timeline of LVN B being notified of medication times by Resident #1's RP, the call to the DON, and the DON's communication with the MD. Record review of Grievances dated 02/01/26-04/30/26 revealed no identified concerns regarding medications. Record review of an in-service dated 04/22/26- Administering of Medications did not (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have LVN A's signature.Record review of the facility policy revised December 2012 titled, Administering Medications under policy statement, Medications shall be administered in a safe and timely manner, and as prescribed. 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.