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	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cimarron Place Health & Rehabilitation	3801 Cimarron Blvd 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure that one (1) residents (Resident #1) of five residents reviewed for transfer or discharge was sent to the Ombudsman to ensure a safe and effective transition of care for the resident. The facility discharged Resident #1 to the hospital for an incident on 5/19/2026 and did not allow the resident to facility The facility discharged Resident #1 on 5/19/2026 without sending notification to the Ombudsman. This failure could place discharged residents at risk of being discharged from the facility causing a disruption in their care and/or services.Findings include:Review of Resident #1's face sheet date 6/2/2026 revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses that included Dementia (A group of thinking an social symptoms that interferes with daily functioning), Anxiety (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), Dementia (A group of thinking an social symptoms that interferes with daily functioning), Depression (a group of conditions associated with the elevation or lowering of a person's mood), Chronic Ischemia (a long-term condition where progressive plaque buildup or vessel damage severely restricts blood and oxygen supple to specific tissues). Review of Resident #1's Discharge MDS assessment dated [DATE] reflected he had a BIMS of 03 suggesting he was severely cognitive impairment and the discharge MDS dated [DATE] revealed rejection of care, wandering, and physical, verbal, and other behaviors directed at others were present at discharge to a short-term general hospital without return anticipated. Review of Resident #1's closed care plan dated 2/20/2026 revealed he was an elopement risk had wandering behaviors, had impaired cognitive and function impaired thought processes related to dementia, had limited physical mobility related to weakness and required the use of rolling walker for safe mobility. Resident #1 used antidepressant medication and was at risk for side effects for depression. Interventions included to observe, document and report to physician as needed for ongoing signs and symtoms of depression unaltered by antidepressant medications like sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative moods and comments, slowed movement , agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight, appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, and needing constant reassurance. Review of Resident #1's progress notes dated 3/18/2025 at 12:15 pm revealed: Resident #1 extremely agitated coming out of room and scared the one-to-one monitoring staff member and began to walk away from Resident#1 and he followed the staff member down the hall and chased CNA B attempting to hit and push her. Resident #1 refused to return to Residents #1's room. Hospice staff was called and notified, Resident Medicated with morphine 0.5 mL which all he has ordered at this time PRN. Resident did return to his room, slammed door and can be heard barricading furniture against door. Will not allow any staff in room DON notified. In an interview on 06/02/2026 at 4:35 pm with Ombudsman she stated the family was upset with the facility for not allowing the resident to return to the facility. The Ombudsman stated on 05/19/2026 the facility called police regarding an incident with Resident #1 having slapped a staff member that resulted in (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit. The RP stated the facility would admit him as a regular patient and if he started exhibiting wandering or exit seeking behaviors they would escalate him to memory care. The RP stated the new facility notified him they no longer had a bed available for Resident #1. The RP stated at IDT meeting on 05/04/26 no discharge notification was discussed and told the RP if they appealed they were going to give the resident a 30-day notice. The RP stated on 05/11/26 they had a conference with no discussion of 30 days' notice. The RP stated there were a meeting on 05/04/26 or 05/11/26 with the facility, but there was never a discussion of discharge during meetings The RP state one of the meetings was regarding the appeal process for Medicaid not a discharge but could not remember which one. The RP stated the ombudsman stated she was told by administrator he was going to discharge the resident for nonpayment and the ombudsman stated she would appeal has discharge and administrator stated he would work with family about payment. In an interview on 06/03/26 at 3:40 pm with Director of Nursing (DON) stated Resident #1 started as a respite care resident and was transitioning to long term care. The DON stated she had notify physician of the discharge but failed to document it in the EMR and it was standard practice to notify physician of all discharges. The DON stated the discharge summary was the responsibility of social worker and the emergency discharge summary should have been done as well. The DON stated the Resident was sent to hospital as a police decision not the facility and that was why it was not considered to be a facility discharge and the confusion of how the discharge should have been handled. The DON stated the RP and the Ombudsman should have been notified . The DON stated Resident #1's family was trying to place him and his spouse together, because he had a difficult time separating from wife. The DON stated as the separation got more difficult he started to have behaviors, aggression, and was exit seeking. The DON stated hospice tried medication for behaviors, and it worked but then RP stated he was too sedating was not eating. The DON stated when the RP was here Resident #1 behaviors were calmer and did not exit seek, but when the RP was not present the resident would be walking all over the facility with his walker. The DON stated hospice nurse attempted to keep resident on medications, but the RP refused to let the lorazepam continue, so it was discontinued. The DON stated the aggression started escalating and he eventually fell. The DON stated Resident #1 was constantly wondering in the facility. The DON stated they had notified another family member about Resident #1 falling while he swung his walker at somebody. The DON stated they called hospice, EMS, and FM but, the FM did not want Resident #1 sent to hospital. The DON stated she met with the hospice nurse, but the RP refused to put him back on hospice. The DON stated at some point Resident #1 had roommate, but he started arguing with him, so son requested a private room. The DON stated the next day Resident was moved to a private room for the safety of roommate. The DON stated the RP considered placement in another facility where the RP lived. The DON stated Medicaid application was pending so finding placement for him was difficult. The DON stated she received a call at 1:30 am from one of nurses that Resident #1 was out of control and they could not calm him down. The DON stated she directed the staff to call Hospice and hospice came out and Resident #1 refused his PRN medications offered by hospice. The DON stated CCPD was called and Resident #1 was cussing and threatening police. The DON stated the weekend before the police came in and he calmed down, but this time it did not work. The DON stated the day the day of the incident Resident #1 had been on a 1:1 since 04/30/26 and the resident was stared on Depakote. The DON stated the facility had several emergency care plans to get medications on board to manage the behaviors of Resident #1. The DON stated Resident #1 had been doing okay with Depakote so the 1:1monitoring was discontinued and 30 minutes later he had an altercation with another resident. The DON stated Resident #1 approached her and staff intervened. The DON stated both residents were checked and no injuries were noted. The DON stated after that he went back to 1:1. The DON stated Resident #1 started barricading the door and they could hear him moving all the furniture. The DON stated this was the night police was called and he slapped the CNA shoved his walker at another CNA another. The DON stated the charge nurse called me to inform me of what had transpired. The DON stated she told the social worker and the hospice (continued on next page)

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