

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  05/02/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038</b></p> <p>Based on observation, record review and interview, the facility failed to provide pharmaceutical services (including the accurate administering of all drugs) to meet the needs of each resident for 1 (Resident #274) of 5 residents reviewed for medication administration.</p> <p>The facility failed to administer the correct dose of Resident #274's scheduled medication (Pramipexole) according to the physician orders.</p> <p>This failure could place residents at risk of not receiving the therapeutic benefits of their prescribed medications.</p> <p>Findings included:</p> <p>Record review of Resident #274's admission record revealed a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included atrial fibrillation (irregular heartbeat), chronic pain syndrome, restless leg syndrome (condition that causes a very strong urge to move the legs), and ends stage renal disease.</p> <p>Record review of Resident #274's comprehensive MDS dated [DATE] revealed resident had a BIMS score of 15 which indicated no cognitive impairment.</p> <p>Observation of medication administration on 05/02/24 at 08:46 AM revealed MA A administered 1 tablet of Pramipexole 0.125mg (instead of 2 tablets to equal 0.25mg) by mouth to Resident #274 as ordered.</p> <p>Observation of the medication label revealed Pramipexole 0.125mg. Give 2 tablets (0.25mg) by mouth one time a day.</p> <p>Record review of Resident #274's physician orders revealed an order for Pramipexole 0.125mg, give 2 tablets (0.25mg) by mouth one time a day related to Parkinson's.</p> <p>In an interview on 05/02/24 at 09:07 AM, MA A stated that giving less than the prescribed dose of a medication could lead to the resident not getting the full desired effect of the medication. MA A said giving the wrong dose of important medications such as blood pressure medications or narcotics could lead to undesired side effects and hospitalization .</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/02/24 at 02:48 PM, DON stated that a lower dose of some medications could cause the medication to not have its intended effects and giving a higher dose of some medications could cause adverse reactions. DON stated when a medication error occurs, the person who made the error or the person who discovered the error would initiate a medication error, assess the resident for signs/symptoms of an adverse reaction, and notify the physician.</p> <p>In an interview on 05/02/24 at 02:50 PM, ADON A stated depending on the medication error, the outcome could range from nothing all the way to serious adverse reactions. ADON A stated that anytime a medication error occurred, the physician is to be contacted. The physician would advise if any correction was necessary.</p> <p>Record review of facility's policy and procedure on Administering Medications dated 2021 and revised December 2022 stated in part:</p> <ul style="list-style-type: none"> <li>-Medications must be administered in accordance with the orders, including any required time frames.</li> <li>-The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.</li> </ul>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46038</p> <p>Based on observation and interview the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 8 medication carts (500 Hall Medication Cart) reviewed for medication storage.</p> <p>The facility failed to ensure the 500 Hall Medication Cart was locked when left unattended.</p> <p>This deficient practice could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed medications.</p> <p>The findings included:</p> <p>During a medication administration observation on 05/01/24 at 02:44 PM, MA B was preparing to walk into a resident's room to administer medication when MA B failed to lock the 500 Hall medication cart and left the medication cart unattended. There were no residents in the hallway.</p> <p>In an interview on 05/01/24 at 02:48 PM, MA B came out of the resident's room and took ownership of the unlocked medication cart and stated she did not realize she had left the medication cart unlocked. MA B stated she always made sure to lock the medication cart when not in use and stated she became nervous and just forgot. MA B stated the medication cart should be locked at all times when not in use so unauthorized people could not have access to the medications located inside the medication cart. MA B stated staff are reminded frequently to keep unattended medication carts locked.</p> <p>In an interview on 05/02/24 at 11:30 AM the Administrator stated all medications carts should be locked due to resident safety and to keep the medications secure. The Administrator stated if the medication carts are not locked, anyone could have access to medications that do not belong to them and could cause a possible drug diversion.</p> <p>In an interview on 05/02/24 at 02:14 PM, ADON A stated all medication carts should not be unlocked due to possible drug diversion. ADON A stated staff are reminded often on locking medication carts and in-services on keeping medication carts locked while unattended are conducted quarterly and as needed. ADON A stated charge nurses, ADON's, and DON is responsible to make sure medication carts are locked at all time.</p> <p>In an interview on 05/02/24 02:23 PM, the DON stated all medication carts should be locked at all times when unattended due to possible drug diversion.</p> <p>Record review of Storage of Medications Policy dated 4/2007 stated:</p> <p>The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44748</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 nutrition room reviewed for kitchen sanitation.</p> <ol style="list-style-type: none"> <li>1. The facility failed to maintain a temperature log for the nutrition room freezer</li> <li>2. The facility failed to ensure the nutrition room freezer had a thermometer</li> <li>3. The facility failed to ensure the nutrition room freezer was monitored daily for correct temperatures</li> </ol> <p>These failures could place residents at risk of foodborne illnesses.</p> <p>Findings include:</p> <p>Observation of the nutrition room on 05/01/24 at 02:05 PM revealed the refrigerator/freezer did not have a thermometer in the freezer, nor a temperature log for the freezer. The nutrition room freezer had a gel-type ice pack in it.</p> <p>An interview with LVN C and the DON on 05/01/24 02:05 revealed they did not see a thermometer in the freezer, and neither could provide the freezer temperature log. LVN C stated the night shift was responsible for logging the freezer temperatures. The DON stated the freezer log was on top of the refrigerator. The DON showed this State Surveyor a temperature log titled, Refrigerator Log which had no spaces or references for freezer temperatures. The DON stated they did not use the freezer. The DON stated if the freezer went out, it could affect the refrigerator as well. When asked how the facility would know if the freezer was going out, the DON stated, Good point.</p> <p>In an interview with the RDM on 05/01/24 at 02:31 PM, she stated nursing staff was responsible for checking the temperatures of the nutrition room refrigerator and freezer and logging the results. The RDM stated the DON told her she assigned random night shift staff for this task. The RDM stated the nutrition room refrigerator was supposed to have a thermometer and a temperature log. The RDM stated the temperature of the freezer in the nutrition room should be monitored daily to ensure it was operating properly. The RDM stated the nutrition room freezer had not been monitored daily. The RDM stated it was important to keep a freezer log and a refrigerator log to make sure items in the refrigerator/freezer did not spoil and cause residents to become ill if they consumed something that was not properly cooled or frozen.</p> <p>In an interview with the ADM on 05/02/24 at 2:30 PM, she stated the facility never used that freezer in the nutrition room and was unaware of the regulation that required maintenance and monitoring of all temperature-controlled equipment. The ADM stated they put a thermometer in the freezer, created a log for it, and were now monitoring the freezer in the nutrition room.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of the facility policy titled, Food Receiving and Storage revised 07/2014, reflected Policy Interpretation and Implementation-11. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the Food Service Manager or designee and documented according to state-specific requirements.</p> <p>References: <a href="https://www.fda.gov/food/buy-store-serve-safe-food/refrigerator-thermometers-cold-facts-about-food-safety">https://www.fda.gov/food/buy-store-serve-safe-food/refrigerator-thermometers-cold-facts-about-food-safety</a> CHILL. Refrigerate foods promptly. Use an appliance thermometer to be sure the temperature is consistently 40 F or below and the freezer temperature is 0 F or below.</p>		

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<p>F 0814</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>44748</p> <p>Based on observation, interview and record review, the facility must dispose of garbage and refuse properly for 2 of 2 grease barrels reviewed for garbage disposal.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure the grease barrels had tight fitting lids</li> <li>2. The facility failed to ensure the grease barrel lids were secured</li> <li>3. The facility failed to ensure the grease barrel lock rings were secured</li> <li>4. The facility failed to ensure the grease barrels, lids, and lock rings were maintained in good working condition</li> </ol> <p>These failures could place residents at risk of infection from improperly disposed garbage.</p> <p>Findings include:</p> <p>Observation of the outdoor grease barrels on 04/30/24 at 10:55 PM revealed two, partially full 55-gallon metal drums of discarded grease. Both barrels had ill-fitting lids that were rusted and bent. Both barrels were missing the lock rings that kept the lids secured tightly. The lock rings were on the ground near the barrels. The lock rings were bent and rusted.</p> <p>In an interview with the RDM on 05/01/24 at 02:35 PM, she stated the facility did not have a regulation in place for the oil barrel rings, and should they get pushed over, it would be an environmental hazard, and cause cross contamination. The RMD stated they should have a policy on keeping the grease barrels safe.</p> <p>In an interview with the MS on 05/01/24 at 3:00 PM, he stated the locking rings on the oil barrels were very hard to place on the barrels for a while. The MS would not say precisely how long. The MS stated he was able to get the lock rings on, but it took him a while because they were bent, and the lids were rusty. The MS stated the lock rings were supposed to be on the barrels at all times except when pouring old grease into them. The MS stated, If the barrels got knocked over, the grease would spill on the ground and attract rodents and cause an environmental hazard because the grease should not be able to pour out onto the ground because it could get tracked back inside the building.</p> <p>In an interview with the ADM on 05/01/24 at 3:30 PM, she stated she looked at the grease barrels. The ADM stated the lids and lock rings were very hard to place on the barrels because the lids were bent and rusted. The ADM stated she was having them replaced.</p> <p>Record review of the facility's policy titled, Food-Related Garbage and Rubbish revised 12/2008, Policy Statement-Food -related garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters. Policy Interpretation and Implementation-2. All garbage and rubbish containers shall be provided with tight fitting lids or covers and must be kept covered when stored or not in continuous use.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46038</b></p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, for 1 of 6 residents (Resident #54) observed for infection control practices during personal care, in that:</p> <p>Wound Care nurse failed to perform hand hygiene for 20 seconds or greater and exposed Resident #54's wound to an uncleaned surface.</p> <p>This failure could place residents that require assistance with personal care at risk for healthcare associated cross-contamination and infections.</p> <p>The Findings included:</p> <p>Record review of Resident #54's face sheet dated 5/2/2024 reflected a [AGE] year-old-male with an original admitted [DATE]. Diagnoses included cerebral ischemia (insufficient amount of blood flow to the brain also known as a stroke), atrial fibrillation (abnormal rapid and irregular heart rhythm), and hypertension (high blood pressure).</p> <p>Record review of Resident #54's physician orders indicated:</p> <p>Dated 3/14/2024: stage 3 (pressure ulcer that affects the top two layers of skin as well as fatty tissue) left lateral (side of the body farther from the middle of the body) heel.</p> <p>every day shift treatment order: cleanse with wound cleanser pat dry apply santyl (topical medication used to treat skin ulcers by removing dead skin and aid in wound healing) then apply calcium alginate (wound dressing that is highly absorbent) then secure with abd (abdominal) pad (pads used for wounds requiring high absorbency) then wrap with kerlix and secure with tape and as needed.</p> <p>Dated 4/24/2024: stage 3 left pressure ulcer lateral calf.</p> <p>every day shift treatment order: cleanse with wound cleanser pat dry apply collagen flakes to wound bed then apply calcium alginate then secure with dry dressing and as needed.</p> <p>Dated 4/24/2024: stage 3 pressure ulcer right lateral foot.</p> <p>every day shift treatment order: cleanse with wound cleanser pat dry apply calcium alginate then secure with dry boarder dressing and as needed.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 05/02/24 08:42 AM of Resident # 54's wound care, the Wound Care Nurse Washed hands for approximately 15 seconds and put on gloves. After repositioning Resident #54, the Wound Care Nurse took off her gloves and washed her hands for approximately 8 seconds. The Wound Care Nurse put on a PPE gown, gloves, and began Resident #54's wound care to the left lateral heel. The Wound Care Nurse cut off Resident #54's previous bandages, removed and disposed of the PPE gown and gloves and washed hands for approximately 7 seconds and put on a new PPE gown and gloves. The Wound Care Nurse cleansed Resident #54's left lateral heel wound with normal saline and gauze as ordered. The Wound Care Nurse then removed gloves and washed hands for approximately 12 seconds and applied new gloves to pat dry Resident #54's wound. The Wound Care Nurse then applied santyl, calcium alginate and secured with abd pad then wrapped Resident #54's wound in kerlix and secured with tape as ordered. The Wound Care Nurse took off the PPE gown and gloves and washed hands for approximately 8 seconds.</p> <p>The Wound Care Nurse sanitized hands and went to wound care cart to grab the supplies for the next wound care on Resident #54. The Wound Care Nurse washed hands for approximately 13 seconds and put on a new PPE gown and gloves.</p> <p>The Wound Care Nurse removed Resident # 54's previous bandage to the left lateral calf, removed gloves and washed hands for approximately 5 seconds. The Wound Care Nurse then put on new gloves and proceeded with Resident #54's wound care as ordered. The Wound Care Nurse then removed gloves and washed hands for approximately 12 seconds and put on new gloves.</p> <p>The Wound Care Nurse removed previous bandages to Resident # 54's right lateral foot, removed gloves and washed hands for approximately 7 seconds. The Wound Care Nurse put on new gloves, propped up Resident #54's right foot on pillow to gain access to Resident #54's wound on the right later heel, removed previous bandage, removed gloves and washed hands for approximately 10 seconds. The Wound Care Nurse returned to Resident #54's bed which revealed Resident #54's right lateral foot wound had come in contact with mattress. The Wound Care Nurse propped up Resident # 54's right foot with a blanket to remove contact with bed, cleansed wound as ordered and removed gloves and washed hands for approximately 12 seconds.</p> <p>In an interview on 05/02/24 at 09:51 AM, the Wound Care Nurse stated she was nervous and that is why she did not wash hands for 20 seconds or greater and she miscounted. The Wound Care Nurse stated handwashing should be for about 20 seconds or greater to make sure to get any bacteria and organisms off the hands that could come in contact with wounds causing cross contamination. The Wound Care Nurse stated the last hand hygiene in-service was approximately a couple weeks ago. The Wound Care Nurse stated it was important to keep wounds away from a potentially contaminated surface, so bacteria and germs do not get into the wound and cause infections and harm the resident.</p> <p>In an interview on 05/02/24 at 11:35 AM, the Administrator stated staff should wash hands for about 30 seconds or greater or enough time to sing happy birthday twice. The Administrator stated it is important to wash hands correctly to stop the spread of germs.</p> <p>In an interview on 05/02/24 at 02:18 PM, ADON A stated hand washing should be 20 seconds or greater as to kill any bacteria and stop the spread of infection. ADON A stated the last in-service on hand hygiene and infection control was approximately a month or two ago.</p> <p>(continued on next page)</p>

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