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	06/26/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #62) of eight residents reviewed for accidents and hazards. The facility failed on 06/24/2025 to ensure floor mats were in place both sides of Resident #62's bed, as indicated on her current comprehensive care plan dated 03/27/25, Resident #62 had five previous falls in the last three months on 05/18/25, 05/24/25, and 06/01/2025. This failure could place residents at risk for injury. The findings included: Record review of Resident #62's face sheet, dated 06/25/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #62 had diagnoses which included Cerebral Infarction (a type of stroke that occurs when flood flow to the brain is blocked, leading to tissue damage due to lack of oxygen) muscle wasting and atrophy, muscle weakness, and lack of coordination. Record review of Resident #62's MDS assessment dated [DATE] indicated he had a BIMS (Brief Interview for Mental Status) score of 4 which indicated, severe cognitive impairment. The MDS also indicated he was dependent on staff for ADL's (Activities of Daily Living.) Record review of Resident #62's care plan dated 03/27/25 reflected the Following: The resident is at risk for falls related to left sided weakness, cognitive impairment. Date Initiated: 03/27/2025. Fall mats at bedside date initiated 03/27/2025. The resident was on pain medication therapy date initiated 03/27/2025. 05/18/25 unwitnessed fall- without injury. 05/24/25 unwitnessed fall without injury. 06/01/2025 unwitnessed fall with injury physician and patient representative notified. Record review of Resident #62's physician's order reflected no orders for fall mats were ordered before survey team entered the facility on 06/24/25. Record review of Resident #62's progress notes dated 05/27/2025 reflected F/U fall day 3 of 3, patient is in bed resting quietly with eyes closed. No signs or symptoms of pain or distress noted thus far. Uses hand bell, (cannot press call button given hand bell) to call for assistance, is within reach. Bed is in lowest position; floor mat is beside bed for safety. Record Review of Resident #62's Fall Risk Assessment/ Morse Fall Scale reflected no assessment had been conducted before survey team entered the facility on 06/24/25. Observation on 06/24/25 at 11:20 AM, revealed Resident #62 was lying in bed watching a football game. Resident #62 had a floor mat on the floor on the left side of his bed but not on his right side. In an interview on 06/25/25 at 4:46 PM with CNA D who stated she had just started employment 2 weeks ago and was not aware of the one fall mat not being in place. If the resident was to have fallen, he could have gotten seriously get hurt. She said the resident could get severely injured for example a broken bone, hit his head against floor or wall get a concussion, and obtain a tear to his skin. If the resident got severely hurt the fall could lead to death. CNA D said the last training she received on falls and accident prevention was two weeks ago. In an interview on 06/25/25 at 4:52 PM with CNA F who stated the resident was supposed to have fall mats by bed. Every staff member was responsible for making sure the fall mats are in place, but the charge nurse was the one responsible for ensuring fall mats are being placed according to residents orders and care plan. The resident could fall and hurt himself the mats are for safety. The resident could have broken a bone, obtained a back injury and gotten paralyzed, or have received head trauma. These injuries could result in death. She stated the resident has had some falls in past. The last time she had a training on falls accidents hazards was 3 months ago at her hiring. In an interview on 06/25/25 at 5:07 PM ADON C said all staff entering the room should be checking for fall mat placement by the bed when the resident was lying in bed. She said it was the nurse's responsibility for making sure the floor mats are in place correctly. Not having mats can be dangerous for resident as a fall can occur and could cause major injury to the resident. She said some of the major injuries could cause death. The last training for fall and accidents and hazards was a month ago. Record review of the facility's Fall Prevention Program Policy dated 09/22 reflected Based on the preceding assessment, the staff and physicians will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to develop and implement resident care policies based upon current professional standards of practice for the preparation, insertion, administration, maintenance and discontinuance of an IV as well as for the prevention of infection at the site to the extent possible for one (Resident #231) of 8 residents review for IV therapy.The facility failed to provide Resident #231 with dressing changes, as ordered by his physician, to his right arm PICC line dressing. The PICC line dressing was dated 06/01/24 and was not changed until 06/24/24, despite the physician orders indicating to change the dressing every seven days.This deficient practice could result in infection or PICC line malfunction and infection.The findings included:Resident #231's Face Sheet dated 06/24/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of: osteomyelitis (bone infection an inflammation of the bone caused by infection, generally in the legs and arm or spine), Acquired absence of other left toe, diabetes mellitus due to underlying condition with foot ulcer, peripheral vascular disease, chronic kidney disease stage 2 mild and type 2 diabetes.Resident #231's admission Minimum Data Set (MDS) assessment dated [DATE] reflected Resident #231 was still in progress. No information could be obtained from this MDS was from admission and the MDS dated [DATE] was still in progress. No information could be obtained from this MDS.Record review of Resident#231's Care Plan dated 06/11/25 revealed no mention of Resident#231's PICC line or the monitoring or maintenance of his line.Record review of Resident #231's Physician's Orders dated 06/24/25 reflected:- PICC [Peripherally Inserted Central Catheter - A long thin flexible tube inserted into a vein in the arm and threaded into a large vein near the heart right upper arm] change IV dressing every 7 days and PRN-Monitor IV insertion site Right upper arm for signs and symptoms of infection/infiltration every shift.Record review of Resident #231's June 2025 Medication Administration Record/Treatment Administration Record 06/26/25 Medication Administration Record/Treatment Administration Record reflected Resident #231's upper right upper arm PICC line dressing had been initialed to indicate the dressing was changed from 06/06/25-06/24/25.In an observation and interview on 06/24/25 at 10:50 AM with Resident #231 revealed he was observed lying in bed watching television. Resident #231 was alert and able to answer questions appropriately. Resident#231 was observed to have a PICC IV to his right upper arm with a dressing covering the insertion site that was dated 06/01/24. Resident #231 stated he told several staff members (although he was not able to provide names of staff) his dressing needed to be changed every 7 days as it was being done in the hospital.In an interview on 06/25/25 at 9:01 AM with RN A, he stated he did not have much contact with Resident #231 as he had just started working 06/24/25 in the hall the resident was currently staying and was aware that the dressing was changed.In an observation and interview on 06/25/25 at 10:30 AM revealed Resident #231 laid in bed and welcomed this surveyor in his room. Resident #231 said the nurse changed his PICC line dressing yesterday after this surveyor visited him on 06/24/25. Observation of Resident #231's right arm PICC line dressing revealed the dressing was intact and dated 06/24/25.In an interview on 06/26/25 at 9:00 AM with CNA F she said Resident #231 never mentioned to her about the IV dressing needing changing and if he had she would have told the charge nurse. CNA F said had seen the dressing several times and it looked fine her with no signs of infection. CNA F said it was her responsibility to inform the nurse if she saw anything out of the ordinary with the dressing or site.In an interview on 06/26/25 at 9:20 AM with RN H revealed she was not informed about the dressing needing to be changed but did know he had a PICC line. RN H said she noticed the dressing was dated 06/01/25 and she was going to change Resident #231's PICC line dressing on 06/20/25 but could not find the correct dressing to change it. RN H stated when she could not find the correct dressing she told the evening nurse, LVN E, about not being able to find the dressing and asked her if she could find the right one and change it.This surveyor attempted to contact LVN E on 06/26/25 and a text was sent to her on the same day, but no response was received throughout the survey.In an interview on 06/26/25 at 9:50 AM with ADON B she said Resident #231's PICC line dressing should have been changed every seven days according to the resident's orders. ADON B said the facility had the proper dressings for the PICC line and it should have been changed. ADON B said the nurses were responsible for making sure the PICC lines were changed. ADON B said she was not made aware of Resident #231's PICC lines dressings not being changed or of any unavailable dressings. The ADON said annual trainings/competencies that included PICC line dressing changes were performed by all nurses. ADON B said all nurses should dressing change skills and training

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for two of six residents (Resident #10 and Resident #21) reviewed for medication errors in that:The facility failed to ensure MA I did not administer Resident #10's blood pressure/pulse altering medications (Metoprolol ER and Amiodarone) on 06/05/25 when her pulse was not within the required parameters per the two physician's orders. The facility failed to ensure MA J did not administer Resident #21's blood pressure/pulse altering medications (Losartan and Nifedipine ER) on 06/01/25, 06/07/25, 06/08/25, 06/09/25, 06/14/25 and 06/21/25 when her blood pressure/pulse was not within the required parameters per the two physician's orders. These failures could place residents who receive blood pressure/pulse altering medications at an increased risk for complications such as decreased blood pressure, decreased pulse, exacerbation of symptoms and disease process, and potential hospitalization.1. Record review of Resident #10's admission record reflected a [AGE] year-old female originally admitted to the facility on [DATE] and most recent admission on [DATE]. Her diagnoses included non-ST segment elevation MI (heart attack), sick sinus syndrome (heart rhythm problems that happen because the heart's natural pacemaker is not working properly causing it to beat too slow, too fast, or irregularly), atrial fibrillation (an irregular, often fast heartbeat), and hypertension (high blood pressure).Record review of Resident #10's annual MDS dated [DATE] reflected a BIMS score of 8 which indicated moderate cognitive impairment.Record review of Resident #10's physician orders on 06/25/25 reflected the following orders:Amiodarone HCl Tablet 200mg. Give 1 tablet by mouth two times a day for abnormal heart rhythm. Hold if BP is below 110/60 or pulse below 60. Start date 04/29/25.Metoprolol Succinate ER Tablet Extended Release 24 Hour 25mg. Give 1 tablet by mouth one time a day for HTN. Hold if BP below 110/60 or pulse below 60. Start date 04/30/25.Record review of Resident #10's June 2025 eMAR reflected on 06/05/25, MA I documented Resident #10's blood pressure as 142/67 and pulse as 54. MA I documented that she administered Resident #10's Amiodarone at 7:59 pm. 2. Record review of Resident #21's admission record reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hypertension (high blood pressure), atrial fibrillation (an irregular, often fast heartbeat), atherosclerotic heart disease (buildup of fats and other substances in and on the artery walls of the heart causing decreased blood flow and/or clots), and type 2 diabetes (chronic condition that happens when blood sugar levels are persistently high which can lead to heart disease, kidney disease, and stroke). Record review of Resident #21's quarterly MDS dated [DATE] reflected a BIMS score of 12 which indicated mild cognitive impairment.Record review of Resident #21's physician orders on 06/25/25 reflected the following orders:Losartan Potassium Tablet 25mg. Give 1 tablet by mouth two times a day for hypertension. Hold if BP less than 110/60, pulse less than 60. Start date 03/05/25. Nifedipine ER Oral Tablet Extended Release 24 Hour 30mg. Give 1 tablet by mouth one time a day for HTN. Hold if BP is less than 110/60, pulse less than 60. Start date 05/28/25.Record review of Resident #21's June 2025 blood pressure and pulse summaries, June 2025 eMAR and progress notes dated 05/25/25 to 06/25/25 reflected the following:06/01/25 at 7:06 am, Resident #21's blood pressure was 134/74 and pulse was 48. MA J documented on the eMAR an X in the space for both blood pressure and pulse and she did not administer Resident #21's Nifedipine but did administer her Losartan. MA J documented in the progress notes, hold bp for the Nifedipine medication administration note. 06/07/25 there was no documentation of Resident #21's blood pressure or pulse. MA J documented in the eMAR she did not administer Resident #21's Nifedipine but did administer her Losartan. MA J documented in the progress notes, hold bp for the Nifedipine medication administration note. 06/08/25 at 6:29 am, Resident #21's blood pressure was 139/79 and pulse was 50. MA J documented on the eMAR she did not administer Resident #21's Nifedipine but did administer her Losartan. MA J documented in the progress notes, hold bp for the Nifedipine medication administration note. 06/14/25 at 6:43 am, Resident #21's blood pressure was 147/78 and pulse was 45. MA J documented on the eMAR she did not administer Resident #21's Nifedipine but did administer her Losartan. MA J documented in the progress notes, hold bp for the Nifedipine medication administration note.06/21/25 at 6:59 am, Resident #21's blood pressure was 166/89 and pulse was 45. MA J documented on the eMAR she did not administer Resident #21's Nifedipine but did administer her Losartan. MA J documented in the progress notes, ?hold bp [sic] for the Nifedipine medication administration note.In an interview on 06/25/25 at 4:05pm, the DON stated if there was a space for the vital signs to be documented on the eMAR, then they should have been

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments on 1 of 8 medication carts reviewed for storage of drugs. The facility failed to ensure RN A's medication cart located by the nurse's station was locked when not in use on 06/25/2025.This deficient practice could affect residents who have medications on the nurse medication cart and could result in lost medications, drug diversion, or harm due to accidental ingestion of unprescribed medications.During an observation on 06/25/25 at 11:44 AM, a medication cart by the nurse's station appeared to be unlocked. This surveyor opened the top drawer recognizing the medication cart being unlocked while not in use. Multiple medications in bulk bottles and blister packs were easily assessable for removable. RN A was sitting behind the nurse's station and identified himself as being responsible for the unlocked medication cart.In an interview on 06/25/25 at 11:50 AM RN A stated the medication cart should be locked at all times to prevent unauthorized people from accessing the medications within the cart. RN A stated he was getting things out of the cart, went to go chart at the nurse's station and forgot to lock it. RN A stated there was no reason why it was unlocked, and he just forgot. RN A stated staff were in-serviced on locking medication carts when not in use frequently and the DON usually makes rounds throughout the day to ensure all carts are locked. In an interview on 06/25/25 at 04:03 PM the DON stated med carts were supposed to be locked when not in use for safety of the residents, staff, and to prevent a possible drug diversion. The DON stated there was daily in-servicing about ensuring medication carts being locked at all times when not in use. The DON stated she personally makes daily frequent rounds to ensure medication carts were locked. Record review of the facility's Storage of Medications policy dated April 2007 reflected:The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 7. Compartment (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.