STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F948	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coon Memorial Home	210 Texas Blvd Dalhart, TX 79022

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise the comprehensive care plan after each assessment, including both the comprehensive and quarterly review assessments for 2 (Resident #1, Resident #24) of 12 residents reviewed for comprehensive care plans. The facility failed to complete the comprehensive person-centered care plans for Residents #1 and #24 to address resident's needs after completed MDS assessments. This failure could result in delaying treatment, care, and services that could result in residents not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being.Findings included: Record review of admission record, not dated, reflected Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's diagnoses included unspecified dementia (decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), chronic kidney disease (long-term condition in which the kidneys are damaged and lose their ability to filter waste, excess fluid, and toxins from the blood effectively), age related osteoporosis (bone disease that develops as a natural part of aging), altered mental status (any change in a person's normal level of consciousness), and heart failure (body's inability to pump enough blood to meet the body's need for blood and oxygen). Records review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS of 08 (moderate cognitive impairment range). MDS revealed Resident #1 varies with ADL and mobility assistance from setup or clean-up assistance to dependent. Record review of Resident #1's MDS, revealed a quarterly MDS was completed on 9/10/2025. Record review of Resident #1's care plan face sheet revealed a completion date of 9/5/2025. Record review of admission record, not dated, reflected Resident #24 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #24's diagnoses included Alzheimer's disease (progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), anxiety (response to stressful situations), depression (mood disorder characterized by persistent feelings of sadness, loss of interest, and a range of emotional and physical problems), and dementia (decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities). Record review of Resident #24's quarterly MDS, dated [DATE], revealed a BIMS score of 02 (severe cognitive impairment). Resident #24 was dependent on shower/bathing self and substantial/maximal assistance on toilet hygiene. Record review of Resident #24's MDS revealed a significant change of status MDS with completed date of 1/29/2026. Record review of Resident #24's care plan revealed a completion date of 1/27/2026. In an interview on 05/29/2026 at 9:23 AM, the ADON stated she oversaw the MDS assessments. The ADON stated she uses the RAI Manual to complete the MDS. The ADON stated the care plan would not be valid if it was completed before the MDS was completed and it should be completed after the MDS has been completed. The ADON stated a negative outcome of the care plan being completed before the MDS was the MDS triggers could be messed up as the care plan was triggered by the MDS. In an interview on 05/29/2026 at 9:39 AM, the DON stated the ADON oversaw the MDS assessments. The DON stated a care plan could not be completed before the MDS assessment as a lot can happen to a resident and they couldn't get their benefits. The DON stated a (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	negative outcome could be the care plan could have false information on it. Record review of policy titled MDS and Care Planning Policy, dated 1/22/2026, under section 3- Comprehensive Care Planning, line A- Development of Care Plans, Stated: 1. A comprehensive care plan shall be developed within required regulatory timeframes following admission or comprehensive assessment. Under heading 6. Quality Assurance and Compliance, line 3; The facility will maintain compliance with CMS RAI Manual. Record review of RAI, 3.0 User's Manual, dated October 2025, version 1.20.1, stated under Chapter 4, page 12, line 8: A complete care plan is required no later than 7 days after the RAI is completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #1) of 3 residents observed for infection control. -RN D did not wash her hands between glove changes while performing wound care for Resident #1. This deficient practice could lead to the spread of infections, tissue breakdown, and feelings of isolation related to poor hygiene.Findings included: Record review of Resident #1's face sheet printed 05/28/26 revealed she was a [AGE] year-old female resident admitted to the facility originally on 03/29/23 and readmitted on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interfere with daily functioning), venous thrombosis (a medical condition where a blood clot (thrombosis) for in a vein, blocking or slowing blood flow back to the heart), methicillin resistance staphylococcus aureus (a strain of staphylococcus aureus (staph) bacteria that has developed resistance to methicillin, and antibiotic), and unspecified open wound of the right lower leg. Record review of Resident #1's MDS assessment printed 05/28/26 revealed a quarterly assessment completed on 03/25/26 with a BIMS of 08 indicating she was moderately cognitively impaired, she had a functional status of requiring substantial/maximal assistance with her activities of daily living. Resident #1 was listed as having and MDRO (Multidrug Resistant Organism) and having one wound. Record review of the care plan printed 05/28/26 with admission date of 02/25/26 for Resident #1 revealed the following: Focus:Resident is on enhanced barrier precautions r/t leg wound. Date initiated 07/15/25.Resident has wound management for venous stasis ulcer to right lower leg. Date initiated 03/04/26.Resident has a venous stasis ulcer of the right lower extremity on contact precautions until healed. Date initiated 03/30/26. Record review of Resident #1's Orders Summary Report with Active Orders As Of: 05/26/26 revealed the following order:- Contact Precautions when providing care until wound to R lower leg is healed: Wear gown and gloves when Dressing, showering, transferring, changing linens, providing hygiene, wound care changing brief or assisting with toileting changing. every shift related to METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS INFECTION AS THE CAUSE OF DISEASES CLASSIFIED ELSEWHERE. Active 05/18/2026 During an observation on 05/27/2026 at 11:14 AM Resident #1 was in her bed resting. Resident #1 was awake but did not respond to questions appropriately. Resident #1 was observed falling asleep during her wound care. Resident #1's wound care was completed by RN D with CNA C assisting. Prior to starting RN D reported Resident #1 had a history of MRSA with her wound and that was why Resident #1 currently was on precautions. RN D was observed washing her hand before starting the wound care. RN D then removed the outer dressing, changed her gloves, removed the surface dressing, changed her gloves, used a 4x4 soaked with vinegar to loosen the dressing to the wound bed, changed her gloves, applied a vinegar soaked 4x4 to the wound bed and allowed the wound to soak for 10 minutes, changed her gloves, wiped the wound clean, changed her gloves, applied a cream to the wound bed, changed her gloves, applied a powder to the wound bed, changed her gloves, covered the wound bed with an absorbent dressing, changed her gloves, wrapped the wound, changed her gloves, dated the wound with a sharpie, removed her gown and gloves, placed new gloves, removed the trash and used dressing, removed her gloves and washed her hands. RN D changed her gloves 10 times during Resident #1's wound care and did not perform hand hygiene between each glove change. During an interview on 05/27/2026 at 11:48 AM RN D reported she did not perform hand hygiene between the steps of wound care completed for Resident #1. RN D reported she should have performed hand hygiene to prevent contamination and the spread of infection. RN D reported the DON was the current ICP and was responsible for training staff on hand hygiene. During an interview on 05/29/2026 at 8:52 AM the DON reported she was the ICP and she provided training to staff on infection control to include hand hygiene. The DON reported (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	handwashing/hand hygiene should be performed when a staff member removes dirty dressings and removes their dirty gloves. They clean their hands and then place new gloves. The DON reported staff should wash hands with all glove changes. If hand hygiene was not performed then the care provided could be contaminated and the resident could get an infection. During an interview on 05/29/2026 at 9:15 AM CNA B (the CNA working on the unit Resident #1 was on this shift) reported staff should perform hand hygiene between glove changes to prevent contamination when providing care. CNA B reported the DON was the person who provides the training for hand hygiene. During an interview on 05/29/2026 at 9:18 AM RN A (the RN working on the unit Resident #1 was on this shift) reported staff should perform hand hygiene between every glove change because gloves were not 100% barrier proof and hand hygiene was performed to prevent the spread of infection. During an interview on 05/29/2026 at 9:34 AM CNA C (the CNA assisting RN D during Resident #1's wound care) reported hands were to be washed between each glove change and if a sink was not available then staff could use hand sanitizer. CNA C reported if staff did not perform hand hygiene, then germs could spread and residents could get an infection. Record review of the training provided by the DON dated 03/20/2026 revealed the following: Inservice Description: Hand washing.Policy - Handwashing/Hand Hygiene (revised August 2015)Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections.Policy Interpretation and Implementation:7. Use an alcohol-based hand rub. or, alternatively, soap and water for the following situations:m. After removing gloves.-RN D signed she completed this training.