STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675017	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cross Country Healthcare Center	1514 Indian Creek Rd Brownwood, TX 76801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 44728 Based on interview and record review the facility failed to provide an activities program directed by a qualified professional for 1 of 1 activity directors (AD) reviewed for qualifications. The facility failed to ensure the AD was a qualified therapeutic recreation specialist or an activities professional that met state licensing requirements. This failure could place residents at risk for reduced quality of life due to lack of activities that were individualized to match the skills, abilities, and interests/preferences of each resident. The findings included: Record review of the AD's employee file revealed the AD took the position on 06/03/2024, and evidence of training beginning 02/13/2025 as a qualified therapeutic recreation specialist or an activities professional that met state licensing requirements. Record review revealed once the course was done (May 2025), it would have been almost a year since being hired to be certified. During an interview on 04/03/2025 at 11:23 AM, the AD stated she was hired 8 months ago. She stated she had no prior experience nor prior SW experience. The AD stated she did not have her AD certification upon hire. She stated she was supposed to have started her certification in October of 2024, but the company changed the course they used which in turn pushed them back to January 2025. The AD stated the ADMN stated to her when hired, she needed to get certified as soon as possible. She stated she felt there was no harm to the residents. During an interview on 04/03/2025 at 1:08 PM, the ADMN stated she had never been told the time frame but assumed during the first year. She stated she worked with the AD as a CNA and felt with her leading the residents in attending AD events was enough to be hired for the position. The ADMN stated it was HR who monitored the certifications and the paperwork for staff members. She stated her expectations would be for AD to have her certification within a year of being hired. She stated she did not feel there was a failure nor a negative impact to residents. During an interview on 04/03/2025 at 5:01 PM, HR stated there was not a check off list for the AD staff member's hiring. She stated she was unaware of her certification status. Record review of the AD's application dated 08 May 2024 with an updated date of 03 June 2024, revealed: (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 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	License and Education: Valid professional license or certification-yes License /certification: (was unanswered) License/number: (was unanswered) Issuing Organization: (was unanswered) State: (was unanswered) Issue date: (was unanswered) Expiration date: (was unanswered) Record Review of the facility Activity Director's job application agreement dated and signed on 08 May 2024 revealed: I understand that, if hired, (a) I am required to abide by all rules and regulations . Record review of the facility's job description for Activity Director signed on 6/3/24 revealed, I will perform the duties and responsibilities of that position and further agree to conform to the rules and regulation

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45216 Based on observation, interviews and record review the facility failed to ensure the environment was as free of accident hazards was possible and each resident receives adequate supervision to prevent accidents for 1 of 21 resident (Resident #55) reviewed for accidents and hazards, in that: On 03/20/2025 at about 9:30pm, Resident #55 was able to get out of a window in a common room on the secure unit without staff's knowledge, pull off 3 wood fence pickets and leave the premises. Facility staff were not aware Resident #55 was not in the building until he was returned by law enforcement at approximately 01:00 AM on 03/21/2025. A past non-compliance Immediate Jeopardy (IJ) situation was identified on 04/02/2025 at 3:37 PM. The Immediate Jeopardy began on 03/20/2025 and ended on 03/24/2025. The facility had corrected the non-compliance before the survey began. The failure placed residents at risk for weather exposure, injury, hospitalization and/or death. Findings included: Review of Resident #55's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with medical diagnoses of dementia, late onset Alzheimer's disease, anxiety, bipolar disorder, high blood pressure, non-insulin dependent diabetes mellitus, and psychosis. Review of Resident #55's Quarterly MDS dated [DATE] revealed in Section C Cognitive Patterns, subsection C0500 BIMS Score Summary, the resident scored 3 out of 15 indicating severe cognitive impairment. Section E - Behavior, subsection E0900 - Wandering, Prescence & Frequency, Has the resident wandered? 1. Behavior of this type occurred 1 to 3 days was selected. Review of Resident #55's physicians orders dated 02/26/25 revealed an order May reside on secure unit r/t Dx: (diagnoses) Dementia, Bipolar disorder, Anxiety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #55's Comprehensive Care Plan dated 03/04/25 and reviewed/revised 03/21/25 revealed Focus: I have been evaluated as a wandering risk r/t specify: decreased safety awareness, confusion, wandering behavior [Resident] resides on the secure unit. [Resident] has a history of elopement from other prior facilities. [Resident] carries around a bed roll packs bag to leave everyday. Date initiated 03/21/25. Goal: I will remain free of injuries associated with wandering behaviors thru this review period with a target date of 06/10/2025. Interventions/Tasks: attempt to redirect resident when packing items and remind resident he resides in facility. Check my location frequently. Encourage me to participate in activities of my preference. Engage me in diversional activities when indicated. Observe me for s/s of agitation, pacing, repetitive verbalization of wanting to leave/go home, restlessness, report increased behaviors to nurses for further interventions. Offer resident the ability to call his family when behaviors are occurring. Provide me re-orientation as needed. Focus: [Resident] has a behavior problem AEB resident eloped out of a window, through a privacy fence which he ripped fence panels off of, and was found walking the streets. Date initiated 03/21/25. Goal: [Resident] will remain in facility without further elopements. Interventions/Tasks: ADMNister medications as ordered. Monitor for side effects and effectiveness. Anticipate and meet The resident's needs. Caregivers to provide the opportunity for positive interaction, attention. Stop and talk with him/her as passing by. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Monitor resident whereabouts frequently to ensure not attempting to elope. Provide a program of activities that is of interest and accommodates residents status. During an observation on 04/01/2025 at 02:13 PM, revealed Resident #55 was sitting in the common room on the secure unit working on a diamond painting project with a staff member present recording resident's activity every 15 minutes. During an observation on 04/01/2025 at 02:15 PM, revealed the windows in the common room on the secure unit, had window stops secured which allowed the window to raise 6 or less. During an observation on 04/02/25 at 07:00 AM, revealed a new gate with a keypad and doorbell noted along the fence surrounding the secure area. There were no bowed, cracked or loose pickets noted around the secure area. On the east side of the facility, an old gate was open, and the fence was missing 2 pickets, but with no access to the secured area. On the south side of the facility the gate was open, but with no access to the secure unit. Observation of the road in front of facility revealed a speed limit of 30. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 04/02/25 at 08:21 AM, Resident #55's Guardian stated she was assigned to Resident #55 2 weeks ago. She stated the current facility was the 3rd facility the resident has been admitted to in the past month or so. The Guardian stated she felt the facility addressed the elopement appropriately and she was fine with every 15-minute checks instead of 1:1. She stated she had talk with Resident #55's family member in who resided in another state about relocating him closer, but the family member was not able to care for him. The Guardian explained Resident #55 was living with a family member in another city but was repeatedly being found and returned by law enforcement. The guardian stated the problem was not the facility but the system. She stated the facility communicated with her very well. She stated the facility was working overtime to keep the resident safe but he was cognizant enough to develop a plan and carry it out. The Guardian had offered to purchase and install window alarms but was waiting on decision from facility. She stated the window stops were on the windows prior to the elopement but were placed higher than they were. The Guardian stated the maintenance man immediately lowered the stops after the elopement. She stated the facility was not failing, or had an issue of poor care, it was the archaic system. During an observation on 04/02/25 at 08:20 PM, revealed one nurse and one CNA were present on the secure unit. During an interview on 04/02/25 at 08:20 PM, LVN G stated he was on duty the night of the elopement. He stated as soon as they were made aware of the elopement, a head count was done, doors were checked, and the outside perimeter was checked. LVN G explained he discovered the pickets missing in the wood fence outside the windows in the common room. He also noted the window in the common room was open and indicated with hands approximately 8. He stated he thought it was interesting that the resident chose fence pickets between the 2 windows in the common room. The fence pickets removed by Resident #55 were not visible when looking straight out either window. LVN G stated he did not hear any unusual noises the evening of the incident. LVN G explained Resident #55 received a sandwich at approx. 9:00 PM, ate it at the nurse's station then walked down the hall towards his room. LVN G stated he gave the Resident #55 his evening and the resident stated he was going to bed. The nurse observed the resident enter his room and shut the door. He stated since the roommate had already received his PM meds, the nurse did not enter the room again until doing the head count. LVN G explained they tried to not wake the roommate (in bed A) because he became agitated. He stated the CNA working on the night of the incident was new to the unit. He stated the usual CNA had called in sick. LVN G stated the replacement CNA had trained for almost 2 shifts. He explained the Activity Director was assisting on the unit until approximately 9:00 PM. LVN G stated when Resident #55 returned, he was wearing a long sleeve shirt, pants, shoes and was carrying his blanket roll. LVN G stated policy was to conduct rounds every 2 hours. LVN G stated Resident #55 made verbal statements about leaving but did not actively exit seek. He stated he did not feel the incident was a facility failure, measures were in place to prevent elopement such as keypad locks on all the exit doors, screws or stops in all the windows to limit height they could be raised, a 6' wood privacy fence around the courtyard and walk-way bordering the unit. LVN G stated he was told the resident was found on the access road. When asked how to get to the access road he stated a turn left or right onto a nearby street would get there. No one knew which direction the resident took. LVN G stated an elopement drill was done after the incident and the following week. He stated Resident #55 was put on 1:1 supervision with every 15-minute activity documentation. He stated in-services were done on elopement and every 2-hour rounds. LVN G stated the census on the secure unit the night of incident was 21. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 04/02/25 at 08:49 PM, the local county Sherriff's Deputy stated she received the first call about the resident walking along the side of the road sometime after 9:00 PM on 03/20/25. The Deputy stated she interviewed him at the time and considered it a consensual stop. She stated the resident seemed cognizant and he explained to her that he was going to his family member's. The Deputy stated the resident was alert, oriented, answered questions appropriately, there were no signs of distress, and his walking ability was steady. She saw no reason to investigate further. The Deputy stated she received a 2nd call at approximately 11:00 PM about a man walking along the roadside a couple miles from the facility. She stated the resident appeared more altered but again was able to tell his name and that he was going to his family member's house. She explained that she called EMS to assess and checked the resident's driver's license for flags. She explained flags were put on the DL for situations like dementia. She stated the resident had no emergency contact information on him or linked to his DL. She contacted the address on his DL, no one knew who he was. She then made a report to APS. The Deputy stated APS told her they had information in bits and pieces on the resident d/t all the times he left his family member's house and was returned by law enforcement. She explained APS also stated the resident had been in other places but had left each of them several times. The Deputy stated she checked the missing person's report, but the resident's name was not listed. She stated EMS checked the resident, obtained a full set of vital signs, and determined he was in perfect health. She stated EMS reported his body temperature was normal. The Deputy stated she then decided to take him to the sheriff's department while trying to find out where he needed to be. She stated she finally reached his family, but they were not able to tell her where he was supposed to be. She explained one family member told her he was supposed to be in a nursing home 124 miles north. She stated she had other officers calling different facilities in surrounding counties. She stated one county reported notes on the resident that he lived with his [family member]. The deputy stated the resident was with her from 11:00 PM until she returned him to the facility. She described his reaction upon returning was pleasant, no behavior or statement of distress, only stated he wanted to see his family member that lived by the base. The deputy stated once inside the building the resident knew exactly how to get to his room. The Deputy stated when she located the resident, he was appropriately dressed and was carrying a bed roll with snacks so he was prepared. She stated the resident was not walking in the roadway either time, he was well off to the side. Review of weatherspark.com (https://weatherspark.com/h/d/7167/2025/3/20/Historical-Weather-on-Thursday-March-20-2025-in-Brownwood-Texas-United-States#metar-22-55) revealed the weather on 03/20/2025 at 10:55 pm, was 48.4 F, with no precipitation. During an observation on 04/02/25 between 09:00 PM and 09:20 PM of the road in front of the facility revealed 4 vehicles traveling south and 3 vehicles traveling north. During an interview on 04/03/25 at 05:51 AM CNA H stated she was scheduled to work the night of the incident but was sick. She stated she worked 2 partial shifts with the CNA that covered for her. CNA H stated training on elopement prevention included on-line modules and in-services. She explained training monitored by HR. CNA H stated the night of the incident, HR called her and had her participate in the elopement drill via phone. She explained the effect on residents of failing to provide training would be bad. She stated staff was trained to not give out the door codes and methods to block a resident from attempting escape without antagonizing the resident. She stated elopement drills were done for both day and night shifts. CNA H stated the best training to prevent elopement was to know the residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/03/25 at 08:43 AM, the Administrator stated staff call-ins were covered by PRN staff or having one of the 3 CNAs assigned to the front hall to float to the secure unit. She stated every 2-hour rounds were not done on Resident #55 because staff knew if the resident and/or his roommate were woken up by staff, they became agitated and were up all night. She stated because both residents in the room were independent, staff avoided irritating them. She stated her expectations were for rounds to be done every 2 hours but also wanted to keep in mind resident rights and preferences. She stated a few residents on other halls specifically requested not to be bothered. The Administrator stated policy was for law enforcement to be called when a resident was discovered missing, an eyes on count done, and the facility and perimeter checked. Review of the facility policy titled Wanderer Management, Monitoring System & Resident Elopement Protocol dated reviewed 01/2023 revealed 1. If a resident is noted to be missing, the following must be initiated immediately: Notify the Administrator/designee immediately. Perform a complete search of the interior of the building. This should include every room, including bathrooms, break rooms, storage rooms, closets, etc., Initiate an external search outside of the building, including the facility grounds and community, on foot and by vehicle. Interview staff to determine who may have seen the resident last and try to determine when they may have been seen last, including what they were wearing, etc. Notify local law enforcement and provide them with a complete description of the individual. Notify the resident's family and physician. Call area hospitals, bus stations, train stations, grocery stores, liquor stores, etc. Notify state agency per state law. Notify other nearby nursing homes. Postscript added to end of policy: Education: Staff to physically see and check on patients every 2 hours to ensure safety. The facility implemented the following corrections prior to survey entrance on 04/01/2025. The facility was evaluated to be in past noncompliance based on the corrections implemented prior to entrance. The following records of interventions were reviewed: 1. Record review of 1:1 supervision and every 15 minute activity documentation of Resident #55 revealed supervision began on 03/21/25 and was ongoing. 2. Record review revealed the facility conducted elopement policy and every 2-hour resident checks in-services. Documentation of interviews with multiple staff members on their knowledge of elopement procedures and every 2-hour resident checks was on file. 3. Record review of the facilities An elopement drill revealed an elopement drill was conducted on 03/21/2025 and again on 03/28/2025. 4. Record review of maintenance records on 04/03/25 revealed the door to the secure unit and outside fence gate lock codes were changed on 03/24/2025. 5. Record review of maintenance documentation revealed the broken fence pickets were replaced, and all pickets were reinforced with screws on 03/21/2025. 6. An Ad hoc committee (a temporary group formed to address a specific issue or task) was created to evaluate effectiveness of interventions weekly for 8 weeks. Meetings were conducted on 03/21/2025 and again on 03/28/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Residents with wandering/elopement risks were to be reviewed for risk potential daily for 30 days. Documented reviews began 03/22/2025 and were conducted daily.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51721 Based on observation, interview and record review, the facility failed to promptly notify the resident's physician when there was radiology results outside of clinical reference range for 1 of 5 residents (Resident #17) reviewed for physician notification of radiology results. The facility failed to promptly notify Resident #17's physician by phone per facility protocol on 02/12/25 when x-ray results falling outside of clinical reference ranges reflected Resident #17 had a right femur fracture This failure could place residents at risk of a delay in medical treatment and could result in not receiving appropriate care and interventions. The findings included: Record review of Resident #17's face sheet dated 04/03/2025 revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: Schizoaffective disorder (mental health condition), major depressive disorder (mental health condition), hypothyroidism (an underactive thyroid), unspecified dementia (cognitive decline), hypertension (high blood pressure), osteoporosis (weakened bones), iron deficiency anemia (body does not have enough iron for healthy red blood cell production), gastro-esophageal reflux disease without esophagitis (reflux without inflammation or damage to the esophageal lining). Record review of Resident #17's quarterly MDS dated [DATE] revealed a BIMS score of 00 which indicated a severe cognitive impairment and required extensive assistance and/or two plus persons physical assist for ADL care. Record review of Resident #17's care plan report dated 02/09/2025 revealed focus areas that included moderate risk for falls related to confusion, gait/balance problems, psychoactive drug use as well as impaired cognitive function/dementia or impaired thought processes related to dementia. Record review of Resident #17's care plan report dated 03/11/2025 revealed added focus areas of has had an actual fall and lists dates of falls as 02/26/24, 04/01/24, 04/19/24, 06/24/24, 11/01/24 (all with no injury), 02/04/25 (with abrasion to right knee), and 02/10/25 (fall with late onset right hip fracture resulting in hospital stay). Record review of Resident #17's progress notes revealed: 02/10/25 at 01:08 AM, RN A noted Resident #17 was found lying in the floor, she was assisted back to bed after being assessed with noted hip bruising. The MD (on call), DON, and family were notified. 02/11/25 at 03:38 AM, LVN B noted Resident #17 was up in her wheelchair, eyes open, respirations even and unlabored, denied any pain or discomfort, and refused help to get back in bed. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/11/25 at 01:18 PM, RN C noted in a Weekly Skin Observations Summary [in part]: Skin Condition Site(s) / Description(s): Face - forehead (bruise), Right trochanter (hip) - bruise, Other (specify) - right side (bruise) Skin condition(s) requires no treatment/dressing. Monitoring ongoing. Treatment/Care Plan Status: Skin condition(s) were not resolved. Continue current treatment plan. Education/Training Provided was described as: staff informed to round on resident every 2 hours and monitor the sides with bruising and to assess her to prevent anymore falls. Turning and repositioning outcome: The resident allowed clinician to reposition them for pressure redistribution and comfort. The resident was also left clean and dry. Referrals and/or additional notes if applicable: the nurse was notified of the resident, x-ray to be ordered. 02/11/25 at 03:34 PM, LVN D noted a portable x-ray bilateral (both sides) hip 3 views and cervical 2-3 view, due to post fall pain. 02/12/25 at 00:59 AM(12:59AM), RN A noted the x-ray results were received, and faxed to the MD for review. Xray report reflected: Impression: 2. Mildly displaced fracture of the right femoral neck(upper long bone of leg). 02/12/25 at 09:24 AM, RN C noted in a Weekly Wound Observation Summary Note [in part]: The resident allowed clinician to reposition them for pressure redistribution and comfort. No new referrals / consultations were needed currently. 02/12/25 at 10:27 AM, the ADON noted they called and spoke with receptionist at MD's office related to fracture report and increased pain to right hip. The MD ordered to send the resident to the ER to eval and treat. 02/12/25 at 04:55 PM, the ADON noted they called and spoke with the ER. The resident admitted for a fracture from ortho. Record review of Resident #17's Hospital Notes dated 02/12/25 - 02/16/25 revealed: Resident #17 underwent a right hip arthroplasty(joint replacement) to repair the fracture. In an observation of Resident #17 on 04/02/25 at 8:20 AM, revealed the resident was lying in bed stated, I'm good, then closed her eyes and turned over towards the wall. Hydration at bedside, the call light was within reach, the fall mat was on the floor by the bed, and the bed was in a low position. In an interview on 04/03/25 at 11:10 AM, the DON stated he was unsure what took place or what was going on at the time but that when it was brought to his attention the morning of 2/12/25, that the physician was not called with the x-ray results report that night. He stated he and the ADON completed an in-service over the phone with RN A, that reporting abnormal x-rays and labs to the MD, DON, and RR with all critical/abnormal findings must be done by phone. He further stated that for no reason should abnormal results be faxed. At that time the DON provided the policy for Fall Prevention Program and Medication Orders. The DON stated those were the only policies he had for falls and orders/reporting to physicians. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/03/25 at 01:26 PM, LVN E stated the process for reporting an abnormal x-ray or lab report was to call the ordering physician immediately. She stated when a resident fell , the nurse did a head toe assessment making sure the resident was ok, a neuro check was done at that time and then every 30 min for 4 hours and then every hour for 4 hours. After the assessment, if at night, call the DON, family, and MD to inform of the incident and receive any orders the MD adds. She stated if the MD ordered an x-ray, the nurse placed the order in the computer, called the mobile x-ray provider to complete the order, then once the report was back call the MD with the results especially if they were positive for a fracture, or if a lab level was abnormal. She further stated that was the expectation. She also stated an adverse outcome, if a positive x-ray was reported and not immediately reported, could be the resident suffered in pain for a prolonged period of time and didn't get the care needed, also if staff did not know of the fracture, staff would do ADL's and activities with the resident like normal. In a telephone interview on 04/03/25 at 4:28 PM, the MD for the facility stated the expectation when a resident fell was, he was immediately contacted via call or text, and informed if there was an injury or no injury. He stated the adverse outcome in the situation was the delay in care from the time the x-ray was done, the day after the fall, to the time he was notified of the fracture the next day 02/12/2025. He further stated when he was notified of the fall it was reported as no injury therefore an x-ray was not ordered at that time. An attempt for phone interview on 04/03/25, at 4:40 PM and 5:15 PM to contact RN A and was unsuccessful. Unable to reach her with two attempts and voicemails were left. In an interview on 04/04/25 at 8:10 AM, the ADON stated she called the MD's office on 02/12/25 as soon as she was made aware with the report of Resident #17's hip fracture. She stated the expectation of the nurses when an abnormal lab or x-ray came across the fax was to call the MD and speak to them directly. She further stated an adverse outcome was a delay in care. In a record review of the facility policy labeled Fall Prevention Program last reviewed date 06/10/2024 reflected [in part]: #5 If a fall occurs, the following will be done: k. If the resident with dementia sustains a fall, in addition to the nursing assessment, the facility will also prioritize diagnostics such as STAT x-ray/transfer to the ER for appropriate investigation and intervention. In an interview on 4/4/25 at 9:45 AM , the ADMN stated there was no further documentation or evidence to provide.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675017	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cross Country Healthcare Center	1514 Indian Creek Rd Brownwood, TX 76801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51720 Based on observation, interviews 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 kitchen reviewed in that: The facility's kitchen staff failed to clean the kitchen as directed by daily cleaning lists. The facility's kitchen staff failed to store food properly. The facility's kitchen staff failed to remove expired food from the refrigerator. The facility's kitchen staff failed to keep clean and dirty dishes separated during meal service. The facility's kitchen staff failed to cover drinks that were placed on delivery trays and sent to the hall during meal service. These failures placed residents at risk for food borne illness and cross-contamination. Findings included: During observation on [DATE] beginning at 9:10 AM the following was noted: 1. A box of [NAME] biscuits in the freezer #1 was soiled with an orange liquid. 2. Crumbs and an unknown soiled substance was at the bottom of refrigerator #1. 3. Crumbs and an unknown dried substance was on a shelf containing plastic lids and napkins. 4. The bottom shelf of the food prep table contained clean pans. Wax paper underneath the clean pans contained dried cooked food, crumbs, and was soiled with an unknown substance. 5. Behind the stove contained dirt, dust, and dried food. 6. Walls were noted to be soiled with dried liquid. 7. The door leading to the dining room was soiled with dirt and unknown substances. 8. The ice machine was soiled with unknown dried liquids. 9. Upside down pans beneath the food prep tables were noted to have dried food sitting in the rim of the pan. 10. The cleaning checklist had not been completed since February of 2025. The cleaning check list for February 2025 was incomplete. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11. A bag containing sliced cheese was open to air in refrigerator #1. 12. A bag containing cookies was left open to air in the food storage area. 13. A bag containing cereal was left open to air in the food preparation area of the kitchen. 14. Peach cobbler found in refrigerator #1 had an expiration date of [DATE]. During an interview with the DM on [DATE] at 11:45 AM, she reported her first day on the job was Friday ([DATE]). The facility had not had a dietary manager for about a month. She continued to say the last cleaning log that was completed was from February 2025. She was in the process of putting together a new log. In the meantime, she had been instructing kitchen staff on what needed to be cleaned. During an interview with the Administrator on [DATE] at 9:32 AM, she reported the facility went 3 weeks without a dietary manager. She stated, I was in charge of the kitchen while she was gone. I don't know if cleaning lists were being completed or not. I know we were doing cleaning every day. It's just a really old kitchen. It's hard to make it look pretty. We came in Sunday ([DATE]) and worked a lot on cleaning. We have a verbal action plan in place to come in a clean. When asked what negative outcomes could occur if proper cleaning was not completed, she stated, There is a potential for illness. During an interview with the DM on [DATE] at 8:25 AM, she reported that she reviewed the policy on cleaning. The policy stated that the manager came up with the cleaning schedule and monitored if it's being completed. She stated that illness could occur if the kitchen was not cleaned properly. During an interview on [DATE] at 2:25 PM, the DM stated that all food being stored must be sealed and dated when opened. It was everyone's job to monitor for that. If left open to air food could go bad or develop bacteria that could cause illness. During an interview on [DATE] at 2:20 AM, the DA reported that opened food was to be stored in two-gallon bags, dated, and sealed. If left open to air it could get stale, grow mold, and get bugs. Serving food that was left open to air could cause residents to get sick. She continued to say its everyone's responsibility to ensure bags were sealed properly. During an interview on [DATE] at 2:25 PM, the DM stated it was everyone's responsibility to check for expired food daily and throw it out. If that was not done, it could get served out and everyone could get sick. During an interview on [DATE] at 2:20 AM, the DA reported everyone was responsible for checking the refrigerator and storage area for expired food daily. Failure to do so could allow the food to be served. That could cause residents to get sick. During observation on [DATE] at 11:56 AM, the following was noted: 1. The [NAME] was observed removing used lids from the steam table and returning them to racks containing clean pans underneath a food preparation table. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the DM on [DATE] at 11:56 AM, she reported that it was not standard practice for kitchen staff to remove used lids off the steam table and return them to racks with clean pans. She stated, No. That is not supposed to happen. That causes cross contamination and can cause illness. During observation on [DATE] at 12:33 PM, the following was noted: 1. Trays being delivered down hall 300 contained glasses of tea that were not covered with plastic lids. During an interview with the DM on [DATE] at 12:41 PM, she reported if drinks and food were being sent to the hall, they must be covered. If not covered particles and dust could get in the drink causing illness. During an interview with the Administrator on [DATE] at 12:42 PM, she reported there was not a specific policy that stated drinks must be covered; however, that was the expectation. She was aware of the issue and had put together an in-service for staff. Record review of the policy titled Sanitization revealed [in part]: -Policy Statement The food service area shall be maintained in a clean and sanitary manner. -Policy Interpretation and Implementation 1. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies, and other insects. 2. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Record review of the daily dietary start up tool provided by the Dietary Manager revealed [in part]: 1. Storage Room: All items sealed. 2. Freezer: All foods sealed. 3. Refrigerator: All items sealed. 4. Daily Cleaning schedule - initialed and completed. 5. Weekly Cleaning schedule - initialed and completed. 6. Post weekly cleaning schedule. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the Cook's Deep Cleaning List for February 2025 revealed [in part]: 1. Clean under prep tables. 2. Clean behind stove. 3. Change paper under prep tables. Record review of the new Daily Cleaning List created by the Dietary Manager revealed [in part]: 1. Work tables/shelves after each use. 2. Prep area/shelves after each use. 3. Shelves/underneath shelves. 4. Reach in cooler - shelving clean daily. 5. Inside/outside clean daily 6. Ice machine - inside ice guard and outside