STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675291	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crosbyton Nursing and Rehabilitation Center	222 N Farmer Crosbyton, TX 79322

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on interviews, and record review, the facility failed to develop and implement a baseline care plan within 48 hours for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (Resident #1) of 5 residents reviewed for baseline care plans. The facility failed to complete a baseline care plan within 48 hours of admission for Resident #1. This failure could place newly admitted residents at risk for not receiving the necessary care and services needed. The findings included: Record review of the face sheet, dated 11/06/2024, revealed Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with the following diagnoses: vascular dementia (memory loss caused by impaired blood supply to the brain), unspecified sequelae of cerebral infarction (alteration of sensation following stroke), receptive-expressive language disorder (difficulty understanding and expressing self through language), type 2 diabetes mellitus (uncontrolled blood sugar), hypertension (elevated blood pressure), Crohn's Disease (bowel disease affecting the lining of the digestive tract). Record review of Resident #1's initial MDS, dated [DATE] revealed a BIMS score of 99, indicating the resident was unable to complete the interview. Section GG - Functional Abilities and Goals - Admission revealed Resident #1 was independent with eating and transfers, required partial/moderate assistance to shower/bathe self and required supervision or touching assistance with tub/shower transfers, dressing and personal hygiene. 11/05/2024 Record review of Resident #1's electronic medical record revealed no baseline care plan. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/05/24 at 3:17 PM with the ADON/MDS-Care Plan Nurse, she stated each resident should have a baseline care plan in place within 48 hours of admission to the facility. She stated the DON and ADON were responsible for assuring baseline care plans were being completed. She stated the charge nurse was responsible for entering resident information into the baseline care plan during the admission process. The ADON stated the facility had been having issues with their electronic health system failing to prompt nurses to initiate the baseline care plan. She stated, we knew this was a problem and have been trying to fix it. She stated a potential negative outcome for failure to implement a baseline care plan was that it could lead to problems such as falls, or elopement based on staff not knowing the resident was at risk for certain things. During an interview on 11/06/24 at 10:57 AM with the DON, she stated she was not aware that Resident #1 did not have a baseline care plan until yesterday (11/05/24). She stated the baseline care plan should be completed within 48 hours of admission. She stated the purpose of the baseline care plan was to inform staff of what care is required for the resident and it was used by all direct care staff and ancillary staff. The DON stated nursing administration was responsible for assuring baseline care plans were complete and accurate. She stated she was aware that the facility had an issue with care plans being completed and planned to conduct a full audit of care plans for all residents. She stated she would be re-educating nursing staff on initiating the baseline care plan in the next few days. She stated a potential negative outcome for failure to develop and implement a baseline care plan was that the resident would not get the care they required. During an interview on 11/06/24 at 11:08 AM with the ADM, he stated he was not aware that Resident #1 did not have a baseline care plan. He stated the purpose of the baseline care plan was to know how to care for folks. He stated the baseline care plan should be completed within 72 hours of admission. He stated nursing staff and nursing administration were responsible for completing the baseline care plan in an accurate and timely manner. The ADM stated the care plan was used by everyone-mainly nursing staff and therapy. He stated his expectation of staff was that baseline care plans were accurate and were completed timely. He stated a potential negative outcome for failure to develop and implement a baseline care plan was that staff would not be able to care for someone 100% without an accurate care plan. Record review of the facility policy titled Care Plans - Baseline, revised March 2022, revealed the following: Policy Statement A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendation, if applicable

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #2) of 5 residents reviewed for care plans. The facility failed to develop an accurate, consistent, and complete care plan for Resident #2's activities of daily living (ADL's), mobility, disease process, cognition, communication, falls, and medications. This failure could place residents at risk of not receiving the care required to meet their individualized needs. Findings included: Record review of the face sheet, dated 11/05/2024, revealed Resident #2 was a [AGE] year-old male who admitted to the facility on [DATE] with the following diagnoses: malignant neoplasm of unspecified bronchus or lung (lung cancer), generalized muscle weakness (decreased strength), unsteadiness on feet, other lack of coordination. Record review of Resident #2's initial MDS dated [DATE], revealed Resident #2 did not have a BIMS score due to being rarely or never understood. Section GG - Functional Abilities and Goals - Admission revealed Resident #2 required supervision or touching assistance with eating and required partial/moderate assistance to shower/bathe self and partial/moderate assistance with tub/shower transfers. Section N - Medications revealed Resident #2 was taking an antidepressant medication while a resident in the facility. Section V - Care Area Assessment Summary revealed Resident #2 was triggered for communication and falls and the Care Planning Decision column indicated these areas were to be addressed in the care plan. Record review of Resident #2's comprehensive care plan initiated on 11/05/24 revealed the following: A focus area for an ADL self-care deficit had a goal section that was blank and interventions for bathing/showering, eating and transfers that were blank. A focus area for limited physical mobility contained no interventions. A focus area that stated the resident was resistive to care, contained no interventions. A focus area for congestive heart failure contained no goals. A focus area for impaired cognitive function/dementia or impaired thought process had incomplete sections for focus, goals, and interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A focus area for communication problems had an incomplete focus statement, incomplete goal, and a blank section for interventions. A focus area for actual falls, initiated on 10/08/24, had a blank section for interventions. A focus area for antidepressant medication had a blank section for interventions. During an interview on 11/06/24 at 10:57 AM with the DON, she stated she was not aware that Resident #2's comprehensive care plan was incomplete until yesterday (11/05/24). She stated the comprehensive care plan should be completed by 48 hours after admission and should be updated quarterly and as needed. She stated nursing administration was responsible for completing the comprehensive care plan based on nursing assessment and input from members of the IDT. She stated the purpose of the comprehensive care plan was to inform staff of what care was required for the resident and it was a tool used by all direct care staff and ancillary staff. The DON stated nursing administration was responsible for monitoring and assuring comprehensive care plans were complete and accurate. She stated she was aware that the facility had an issue with care plans being completed and planned to conduct a full audit of care plans for all residents. She stated a potential negative outcome for failure to implement a complete comprehensive care plan was that the resident would not get the care they required. During an interview on 11/06/24 at 11:08 AM with the ADM, he stated he was not aware that the comprehensive care plan for Resident #2 was incomplete. He stated the purpose of the comprehensive care plan was to know how to care for folks. He stated nursing administration was responsible for completing the care plan in an accurate and timely manner. The ADM stated the care plan was used by everyone-mainly nursing staff and therapy for obtaining information about a resident's care needs. He stated his expectation of staff was that comprehensive care plans were complete, accurate and updated. He stated a potential negative outcome for failure to develop and implement a complete comprehensive care plan was that staff would not be able to care for someone 100% without an accurate care plan. Record review of the facility policy, Care Plans, Comprehensive Person-Centered, Revised March 2022, revealed the following documentation: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . . 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.