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	07/31/2024

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49927 Based on interviews and record review the facility failed to ensure the residents had the right to participate in his or her treatment, which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment, and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 1 of 15 residents (Resident #20) reviewed for resident rights. The facility failed to obtain a signed informed consent based on information of the benefits, risks, and options available for Resident #20, prior to administering psychotropic medications (a psychoactive drug taken to exert an effect on the chemical make-up of the brain and nervous system). This failure could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party or being aware of the benefits and risks of the medications prescribed. Findings included: Record review of Resident #20's face sheet, dated 7/30/2024, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include mood disorder due to known psychological condition with depressive features (mental health conditions that primarily affect emotional state), urinary tract infection (an infection in any part of the urinary system), muscle weakness, and unspecified lack of coordination. Record review of comprehensive MDS assessment dated [DATE] revealed Resident #20 had a BIMS score of 12 which indicated the resident's cognition was moderately impaired. Record review of a care plan for Resident #20 dated 6/7/2023 revealed a focus area of depression: Resident will take antidepressant medication as prescribed to assist with this area of concern. Record review of Resident #20's order summary report dated 7/30/2024 revealed the following orders: Escitalopram Oxalate oral Tablet 10 MG (Escitalopram Oxalate), Give 1 tablet by mouth in the evening related to mood disorder due to known physiological condition with depressive features. RisperDAL oral Tablet 0.25 MG (Risperidone), Give 1 tablet by mouth in the evening related to psychotic disorder with hallucinations due to known physiological condition. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #'20s electronic medical record of scanned consents on 5/15/24 revealed a consent for RisperDal. However, there was no consent for Escitalopram found. During an interview on 7/31/24 at 11:40AM with the DON, she verified the consent for Resident #20 for Escitalopram was not completed. The DON stated she was aware of the policy stating residents were required to have a completed consent for antipsychotic or psychotropic medications. The DON stated the DON and the ADON were responsible for ensuring each resident had a completed consent for antipsychotic or psychotropic medications at admission, and they were both responsible for ensuring new medications had a consents. The DON stated she and the ADON completed an audit periodically to ensure the consents were current and completed. The DON stated the ADON was not available for interview as she was on vacation at this time. She stated the potential negative outcome could be medications being administered against the residents' or family wishes. During an interview on 7/31/24 at 12:40PM, the ADM stated nursing staff were responsible for ensuring consents for antipsychotic and psychotropic medications were completed and updated at admission as well as when new medications were added to a resident's order. The ADM stated she was unaware of what the policy stated regarding consents. The ADM stated a potential negative outcome to the residents were the resident may not know what mediation they were taking. Record review of the facility policy titled Resident Rights (revised February 2021) revealed: Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: be treated with respect, kindness, and dignity; be notified of his or her medical condition and of any changes in his or her condition; be informed of, and participate in, his or her care planning and treatment; access personal and medical records pertaining to him or herself; choose an attending physician and participate in decision-making regarding his or her care .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42515 Based on interview, 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 include measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 3 of 14 residents (Residents #1, #8 and #21) reviewed for care plans. The facility failed to develop a care plan for Resident #1's cognitive loss, communication, psychosocial well-being and pressure ulcer risk. The facility failed to develop a care plan for Resident #8's cognitive loss, vision, falls, nutrition and psychotropic drug use. The facility failed to develop a care plan for Resident #21's delirium, communication, urinary function, psychosocial well-being, mood, dental care, pressure ulcer risk and pain. These failures could place residents at risk of not receiving the care required to meet their individualized needs. Findings included: Resident #1 Record review of the admission record for Resident #1, dated 07/29/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: parkinson's disease (brain disorder that causes uncontrollable movements), essential hypertension (high blood pressure), and muscle weakness. Record review of Resident #1's comprehensive MDS assessment dated [DATE] revealed Section V Care Areas triggered were 02. Cognitive loss/dementia, 04. Communication, 07. Psychosocial well-being, and 16. Pressure ulcer were checked as triggered. Record review of the current care plan for Resident #1, undated, revealed there was no specific care plan regarding cognitive loss, communication, psychosocial well-being and pressure ulcers. Resident #8 Record review of the admission record for Resident #8, dated 07/29/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: altered mental status (memory problems), dehydration (loss of body fluids), and type 2 diabetes mellitus (blood sugar problems). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's comprehensive MDS assessment dated [DATE] revealed Section V Care Areas triggered were 02. Cognitive loss/dementia, 03. Visual function, 11. Falls, 12. Nutritional Status, and 17. Psychotropic drug use were checked as triggered. Record review of the current care plan for Resident #8, undated, revealed there was not a completed care plan regarding cognitive loss, visual function, falls, nutritional status or psychotropic drug use. Resident #21 Record review of the admission record for Resident #21, dated 07/29/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's disease (memory problems), anxiety (mood disorder) and dementia (cognitive loss of function). Record review of Resident #21's comprehensive MDS assessment dated [DATE] revealed Section V Care Areas triggered were 01. Delirium, 04. Communication, 06. Urinary Incontinence and Indwelling catheter, 07. Psychosocial well-being, 08. Mood State, 15. Dental Care, 16. Pressure ulcer, and 19. Pain were checked as triggered. Record review of the current care plan for Resident #21, undated, revealed there was not a completed care plan regarding delirium, communication, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, dental care, pressure ulcers, or pain. During an interview on 07/31/24 at 10:24 AM, the DON stated the ADON was responsible for completing the care plans and she was responsible for ensuring the care plans were getting completed. The DON stated the ADON was out of the facility at this time on vacation and was not available by phone for interview. The DON stated she did not know why the care plans for Resident #1, Resident #8 and Resident #21 were not completed. The DON stated care plans are reviewed by her when there is a concern, and she cannot remember the last time the care plans were audited. The DON stated a potential negative outcome to the residents was they may not get the care they need. During an interview on 07/31/24 at 10:51 AM, the ADM stated the ADON was responsible for completing the care plans at the facility. The ADM stated the DON is responsible to ensure the ADON is completing the care plans. The ADM stated she did not know why the ADON did not complete the care plans for Resident #1, Resident #8 and Resident #21. The ADM stated they were not able to get ahold of the ADON at this time as she was on vacation. The ADM stated a potential negative outcome to the residents was they may get improper care from staff. Record review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, with a revised date of March 2022, reflected the following: 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

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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. 49305 Based on observations, interviews, and record review, the facility failed to ensure that drugs and biologicals were properly secured for 1 of 1 treatment carts reviewed for proper medication storage. LVN A left the treatment cart containing medications unlocked and unsupervised in the hallway near the nurse's station. The DON left the treatment cart containing medications unlocked and unsupervised in the hallway near the nurse's station. These failures could place residents at risk of having access to unauthorized medications and/or lead to possible harm, drug overdose, or drug diversions. Findings included: During an observation on 07/29/2024 at 06:58 AM the treatment cart across from the nurse's station and across from the resident living area was observed to be unlocked and unattended. This state surveyor observed residents in close proximity to the treatment cart and no staff were present to supervise the cart. Upon inspection of the second drawer of the cart with LVN A, several prescription medications and creams were observed. During an observation and an interview on 07/29/2024 at 08:07 AM the treatment cart across from the nurse's station and across from the resident living area was observed to be unlocked and unattended. This state surveyor observed residents in close proximity to the treatment cart and no staff were present to supervise the cart. The DON stated she was on duty as the floor nurse, due to the daytime nurse calling in sick, and stated she was responsible for the treatment cart. She stated the treatment cart should be locked when unattended, but she was busy and being pulled in different directions and forgot to lock the cart. During an interview on 07/29/2024 at 07:02 AM LVN A stated she was the nurse on duty, and she was responsible for the treatment cart. She stated the cart should be locked at all times. She stated she has been trained to keep the cart locked as part of her nurse training and it was a standard of nursing knowledge. She stated she was about to lock the cart up just before the survey team entered the building, but she got sidetracked. She stated a potential negative outcome of failing to lock the treatment cart was that residents could access any medications stored on the cart and be injured. During an interview on 07/31/24 at 11:27 AM the DON stated all nursing staff were responsible for assuring treatment carts were locked when unattended. She stated staff were trained on properly securing carts annually and as needed. She stated her expectations of staff for properly securing treatment carts were that the carts were always locked when unattended. She stated a potential negative outcome of failing to secure treatment carts was residents can get into the cart and ingest medications and be harmed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/31/24 at 12:18 PM the ADM stated the nursing staff was responsible for assuring treatment carts containing medications were locked when unattended. She stated staff were trained on securing carts by the DON through periodic in-servicing. She stated her expectation was that staff properly secure treatment carts at all times when unattended. She stated a potential negative outcome for failure to secure treatment carts containing medications was that a resident could get a hold of a medication or substance and become sick or die. Record review of the facility provided polity titled Storage of Medications, revised November 2020, revealed the following: Policy: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments . Only persons authorized to prepare and administer medications have access to locked medication. 6. Compartments (including . carts .) containing drugs and biologicals are locked when not in used. Unlocked medication carts are not left unattended.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42515 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 in 1 of 1 kitchen reviewed for dietary services. 1) The facility failed to keep food properly labeled and sealed in the refrigerator, freezer and pantry. These failures could place residents at risk for food contamination and foodborne illness. The findings included: Observation during a kitchen tour on 07/29/24 at 7:45 AM revealed the following in the refrigerator: 1 pitcher of orange liquid, no label and no date noted on the pitcher and 1 bag of oven roasted turkey breast sandwich meat not sealed properly, dated 7/23/24. The following was noted in the freezer: 1 bag of fried chicken not sealed properly, dated 6/19/24 and 1 bag of 3 biscuits not sealed properly, dated 7/23/24. The following was noted in the pantry: 1 bag of brown gravy mix not sealed properly, dated 7/15/24. Interview on 07/31/24 at 10:02 AM, the DM stated all the dietary staff were responsible for properly labeling and storing food items. The DM stated she was ultimately responsible to ensure dietary staff was properly labeling and storing food items. The DM stated she did not know why some food items were not closed all the way or why the orange liquid was not labeled or dated. The DM stated there was no good reason these things were not done. The DM stated all dietary staff are trained on hire and verbally throughout their shifts as needed. The DM stated a potential negative outcome to the residents was they could get sick due to cross contamination or the food could go bad. Interview on 07/31/24 at 10:40 AM, the DM stated she brought the only policy she could find related to food labeling and storage. Interview on 07/31/24 at 10:51 AM, the ADM stated she expected food storage to be correct at the facility, meaning food should be properly labeled and sealed. The ADM stated the DM was responsible for ensuring the food items were labeled and sealed properly. The ADM stated she did not know why some food items were not sealed all the way or why something was not labeled in the refrigerator. The ADM stated a potential negative outcome to the residents was it could make them sick. Record review of the facility's policy and procedure titled, Nutrition Policies and Procedures Subject: Safe Food Handling, dated 10/2009, reflected the following: Policy: Food acquisition, storage, and distribution will comply with accepted food handling practices. Proper food handling is essential in preventing food borne illness. Procedures: .Refrigerated potentially hazardous (PHF) leftover foods are properly covered, labeled, and date marked with a use by date

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on observations, interviews, and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of communicable diseases for 4 of 4 (Residents #17, #2, #6, #7) and 4 of 4 staff (ADM, DON, CNA A, CNA B) reviewed for infection control. 1. The facility failed to implement and maintain contact precautions and ensure staff utilized Personal Protective Equipment (PPE) appropriately to prevent cross contamination from residents positive with COVID-19. 2. The facility failed to place readily visible signage on the door of Resident #17 who was actively on contact precautions. 3. The administrator entered the room of a resident who was on transmission-based precautions without proper PPE. 4. The DON entered the room of a resident who was on transmission-based precautions without proper PPE. 5. CNA A failed to sanitize hands between glove changes during incontinent care for Resident #2 and Resident #7. 6. CNA B failed to sanitize hands between glove changes during incontinent care for Resident #6. These failures could place residents at risk for spread of infection and cross contamination. Findings included: Resident #17 Record Review of Resident #17's face sheet revealed a [AGE] year-old female that was initially admitted to the facility on [DATE], with the following diagnoses: chronic embolism and thrombosis of unspecified deep veins of right lower extremity (blood clot that has formed in a deep vein and lasted for at least a month), essential (primary) hypertension (a form of high blood pressure that has no identifiable secondary cause), hypothyroidism (condition resulting from decreased production of thyroid hormones), and encephalopathy (altered mental state and confusion). Record Review of Resident #17's MDS assessment dated ,d+[DATE], revealed under Section C, Cognitive Patterns, a BIMS score of 12, indicating the resident was slightly, cognitively impaired. Record Review of Resident #17's nursing progress notes dated 07/28/2024 indicate Resident #17 tested positive for COVID-19 on 07/27/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/29/2024 at 06:55 AM with LVN A, LVN A advised that Resident #17 tested positive for COVID-19 and advised state surveyors to wear a mask. LVN A stated Resident #17 was in and out of her room, but she stated Resident #17 wore a mask. During an observation on 07/29/2024 at 07:55 AM there was no visible PPE outside of Resident #17 's room. There was no visible signage on or around Resident 17's room to indicate transmittable based precautions were in place for Resident #17. During an observation on 07/29/2024 at 08:05 AM the ADM was observed entering Resident #17's room. The ADM was observed wearing a mask but was not seen wearing any additional PPE. During an observation on 07/29/2024 at 8:15 AM a dining staff was observed delivering a breakfast tray to Resident #17's room. The dining staff was observed wearing a mask and obtained a gown from a nearby storage closet before entering the room. The dining staff was observed taking off the gown, upon exiting Resident 17's room, but she could not find a trash can to dispense of the gown. During an observation on 07/29/2024 at 8:20 AM the DON was observed entering Resident #17's room. The DON was observed wearing a mask but was not seen wearing any additional PPE. During an observation on 07/29/2024 at 2:00 PM there was no visible PPE outside of Resident #17's room. During an observation and interview on 07/30/2024 at 9:30 AM there was no visible PPE outside of Resident #17's room. There was no signage indicating Resident #17 was on transmission-based precautions. The Activities Director was asked for PPE for Resident #17's room. The AD obtained a PPE cart and placed it outside of the room. The PPE cart included gowns, gloves, and hand sanitizer. During an observation and interview on 07/30/2024 at 9:35 AM Resident #17 stated she had COVID-19, and she had been positive for 4 days. Resident #17 was observed wearing a mask inside of her room. Resident #17 stated she wore a mask any time she exited her room and stated staff wore a mask as well. Resident #17 stated she felt staff had been safe and cautious when entering her room. It was observed Resident #17 had a trash can near her bed. There were no other trash cans in the room or receptacles available near the door to dispose of contaminated PPE. During an observation on 07/31/2024 at 9:20 AM there was no visible signage on or near Resident 17's room that indicated Resident #17 was on transmission-based precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/31/2024 at 11:40 AM the DON stated Resident #17 was positive for COVID-19. The DON stated she was advised by her corporate office that the procedures for residents with COVID-19 had changed. However, the DON stated the facility's policy was not changed nor updated to reflect the changes. The DON was unaware of the specific changes and stated she thought only wearing a mask was necessary. The DON stated it was explained to her that it would be treated as if a resident had the flu. The DON stated when a resident had the flu, they were placed on enhanced barrier precautions. The DON stated Resident #17 was not placed on enhanced barrier precautions either. The DON stated she did not know why. The DON stated COVID-19 was a transmissible infection that could be spread by droplets. The DON stated per the facility's policy Resident #17 should have been placed on transmission-based precautions. The DON stated this would include a sign being placed on the resident's door indicating she was on transmission-based precautions. The DON stated all staff and visitors that entered Resident #17's room should have worn all necessary PPE including a mask, gloves, and a gown. The DON stated all nursing staff were trained on transmission-based precautions. The DON stated she and the ADON were responsible for ensuring staff received this training. The DON stated it was communicated to nursing staff that Resident #17 tested positive for COVID-19 via nursing reports that were reviewed daily. The DON stated visitors would not have known that Resident #17 was on transmission-based precautions since there was no sign indicating such. The DON stated a sign should have been placed on Resident #17's door, and a PPE cart should have been placed outside of the door to provide necessary PPE for visitors and staff. The DON stated she did not know why this was not done. The DON stated nursing staff was responsible for ensuring the sign was placed on the door and the PPE cart was set up outside of the door. The DON stated there should have been a receptacle for soiled PPE inside of Resident #17's door, and she was not sure why there was not one. The DON stated there was a risk of the spread of infection to staff and other residents due to policy not being followed for transmission-based precautions. During an interview on 07/31/2024 at 12:40 PM the ADM stated the facility was advised that the facility policy was being updated and only a mask was necessary for the care of a resident with COVID-19. The ADM stated the policy she provided was the current policy and it had not been updated recently. The ADM reviewed this policy provided and stated COVID-19 was a transmissible infection and Resident #17 should have been placed on transmission-based precautions based on droplet transmission. The ADM stated, per the facility's policy, there should have been a sign placed on Resident #17's door indicating she was on transmission-based precautions. The ADM stated there should have been a PPE cart outside of Resident #17's room, and she stated she was not aware that there was not one on previous days. The ADM stated it was the responsibility of the nursing staff to ensure the transmission-based precautions were being followed, and it was her responsibility to follow up as well. The ADM stated the DON was responsible for training staff on transmission-based precautions. The ADM stated that not following transmission-based precautions places other residents and staff at risk of spreading infections. Resident #2 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the face sheet for Resident #2 revealed an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Alzheimer's Disease with late onset (a progressive disease that destroys memory and other important mental functions), shortness of breath, dysphagia (swallowing difficulties), cerebral infarction (damage to brain tissue due to a loss of oxygen), iron deficiency anemia (too few healthy red bloods cells due to too little iron), unspecified dementia (a range of neurological conditions affecting the brain), chronic congestive heart failure, (condition in which the heart does not pump enough blood), polyosteoarthritis (arthritis involving two or more joints), and essential hypertension (high blood pressure that does not have one distinct cause). Record review of Resident #2's annual MDS, dated [DATE] revealed Resident #2 had a BIMS score of 06, indicating severe cognitive impairment and was always incontinent of bowel and bladder. Record review of Resident #2's care plan dated 08/24/23 revealed resident had a stroke and was incontinent of bowel and bladder. Observation on 07/30/24 at 1:42 PM of incontinent care on Resident #2 with CNA A revealed CNA A washed hands prior to resident care. Resident was informed of care that was to be performed and gave verbal permission for the state surveyor to observe. Supplies were gathered prior to entering the room. CNA A put on gloves and elevated the bed then performed female incontinent care. Resident #2 was then turned to right side and incontinent care was performed to buttocks area. CNA A was then observed to change gloves. A new brief was placed, and the resident was placed in a position of comfort. CNA A failed to sanitize hands between glove changes. CNA A washed hands following procedure. Resident #6 Record review of the face sheet for Resident #6 revealed an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: dementia (the loss of cognitive functioning), cerebral infarction (damage to brain tissue due to a loss of oxygen), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dysphagia, (swallowing difficulties), and anxiety (a feeling of worry or nervousness). Record review of Resident #6's annual MDS, dated [DATE] revealed Resident #6 had a BIMS score of 02, indicating severe cognitive impairment and was frequently incontinent of bowel and bladder. Record review of Resident #6's care plan dated 12/14/2023 revealed the resident has impaired cognitive function and dementia and has bowel incontinence, requiring frequent staff assistance. Observation on 07/30/24 at 1:56 PM of incontinent care on Resident #6 with CNA B revealed, CNA B washed her hands prior to resident care. Resident was informed of care that was to be performed. Supplies were gathered prior to entering the room. CNA B put on gloves and transferred Resident #6 from the chair to the bed with the assistance of CNA A. Observed CNA B perform female incontinent care. Resident #6 was then turned to the right side and incontinent care was performed to the buttocks area. CNA B was then observed to change gloves. A new brief was placed, and the resident was placed in a position of comfort. CNA B failed to sanitize hands between glove changes. CNA B washed her hands following the procedure. Resident #7 (continued on next page)

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	675291	A. Building B. Wing	07/31/2024

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the face sheet for Resident #7 revealed an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: dementia (the loss of cognitive functioning), schizoaffective disorder (a mental health problem with confusion and mood issues), major depressive disorder (persistently depressed mood causing impairment in daily life), heart failure (the heart does not pump blood as well as it should), and peripheral vascular disease (a circulatory condition with reduced blood flow to the limbs). Record review of Resident #7's annual MDS, dated [DATE] revealed Resident #6 had a BIMS score of 09, indicating moderately impaired cognition, and was occasionally incontinent of bladder. Record review of Resident #7's care plan dated 06/06/2024 revealed the resident had impaired cognition and frequent bladder incontinence, requiring staff assistance. Observation on 07/30/24 at 02:10 PM of incontinent care on Resident #7 with CNA A revealed, CNA A washed her hands prior to resident care. Resident was informed of care that was to be performed and gave verbal permission for the state surveyor to observe. Supplies were gathered prior to entering the room. CNA A put on gloves and elevated the bed then performed female incontinent care. Resident #7 was then turned to the left side and incontinent care was performed to the buttocks area. CNA A was then observed to change gloves. A new brief was placed, and the resident was placed in a position of comfort. CNA A failed to sanitize hands between glove changes. CNA A washed her hands following the procedure. During an interview on 07/30/2024 at 02:49 PM CNA A stated she failed to sanitize her hands between glove changes during incontinent care for Resident # 2 and Resident #7 because she forgot. She stated she has been trained on proper hand hygiene through the agency she was employed with. She stated a potential negative outcome of failure to sanitize hands between glove changes was spreading infection to the residents or herself. During an interview on 07/30/2024 at 02:49 PM CNA B stated she failed to sanitize her hands between glove changes during incontinent care for Resident #6 because she was nervous and forgot. She stated she has been trained on proper hand hygiene through her CNA training. She stated a potential negative outcome of failure to sanitize hands between glove changes was passing disease. During an interview on 07/30/2024 at 3:07 PM the DON stated staff should perform hand hygiene between glove changes. She stated she and the ADON were responsible for training staff and training was usually conducted on a 1:1 basis with each staff member. She stated a potential negative outcome of failing to use proper hand hygiene was infection. During an interview on 07/31/24 at 12:18 PM the ADM stated nursing administration was responsible for ensuring staff were properly trained on hand hygiene. She stated staff were trained periodically by receiving in-services and yearly skills checks. She stated her expectation of staff regarding handwashing was that it was done correctly every time. She stated a potential negative outcome of failing to use proper hand hygiene was making the residents or staff sick. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility provided policy titled Isolation - Categories of Transmission-Based Precautions (revised 09/2022) revealed: Policy Statement: Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Policy Interpretation and Implementation: I. Standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status. 2. Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet and airborne. 3. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. b. Signs and notifications comply with the resident's right to confidentiality or privacy. Droplet Precautions I. Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 microns in size) that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning). 2. Masks are worn when entering the room. 3. Gloves, gown and goggles are worn if there is risk of spraying respiratory secretions. 4. Resident Transport a. A mask is placed on the resident during transport from his or her room. Record review of facility provided policy titled Isolation - Initiating Transmission-Based Precautions, (dated August 2019) revealed: Policy Statement: Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Policy Interpretation and Implementation: If a resident is suspected of, or identified as, having a communicable infectious disease, the charge nurse or nursing supervisor notifies the infection preventionist and the resident's attending physician for evaluation of appropriate transmission-based precautions. 1. Transmission-based precautions are utilized when a resident meets the criteria for a transmissible infection AND the resident has risk factors that increase the likelihood of transmission. When transmission-based precautions are implemented, the infection preventionist (or designee): a. clearly identifies the type of precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used; b. explains to the resident (or representative) the reason(s) for the precautions; c. provides and/or oversees the education of the resident, representative and/or visitors regarding the precautions and use of PPE; d. determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type of precautions: (I) The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. (2) Signs and notifications comply with the resident's right to confidentiality or privacy. e. ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Handwashing/Hand Hygiene (revised August of 2019) revealed: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 2. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; Or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a residence intact skin; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on observation, interview and record review, the facility failed to ensure the resident bedroom measured at least 80 square feet per resident in multiple resident bedrooms for 7 of 26 resident semiprivate rooms (Rooms #6, 13, 14, 19, 20, 21 and 30), in that, The facility failed to provide 80 square feet per resident in 7 of 26 semiprivate resident rooms. This failure could result in crowding, cause difficulty in providing ADL services, and placing residents at risk for decreased quality of life. Findings included: On 07/29/24 at 7:33 AM an interview was conducted with the ADM, at the time of the entrance conference. She stated the facility wanted to apply for a room square footage waiver for the semiprivate rooms that did not meet the 80 square foot requirement. Observations were made during a general observation tour on 07/30/23 beginning at 2:00 PM and indicated the following: room [ROOM NUMBER] had 156.54 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 156.58 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 152.37 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 154.03 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 152.2 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 154.03 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 155.25 square feet for 2 residents instead of the required 160 square feet. Interview on 07/31/24 at 10:51 AM, the ADM stated there have not been any changes to the floor plan recently. The ADM stated regarding inadequate room square footage in semiprivate rooms, a potential negative outcome to the residents was it could affect the residents related to crowding and clutter. The ADM stated the facility did not have a policy related to room square footage requirements for residents.