

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Crosbyton Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview, and record review, the facility failed to provide a resident or family group with private space for the residents' monthly council meetings and the confidential resident group meeting during survey (09/24/2025) for eight of eight confidential residents reviewed for resident council. The facility did not provide private space for resident council meetings. This failure could place residents at risk of not being able to exercise their rights of being able to voice their grievances in private, without uninvited staff being present. Findings Included: Observation and interviews on 09/24/2025 at 2:00 PM in a Resident Council meeting, conducted during survey, revealed the following: The Resident Council meeting was held in the activities room. The area contained two open doorways that did not have a door closure. The activities room was outside of the DON's and ADON's offices. There were numerous staff members observed walking past the open room during the Resident Council meeting. The noise from the hallway was heard in the activities room, causing distraction to residents. A staff member entered the room during the Resident Council meeting, speaking to residents, which caused a disruption to the meeting. Staff were observed sitting in the hallway, within hearing distance, during the Resident Council meeting. Six of Eight Residents attending the meeting stated they had Resident Council meetings in the activities room every month, and there was not another, more private, area utilized for residents to meet. Six of Eight Residents attending the meeting stated the area was distracting and difficult to hear at times, during meetings. Six of Eight Residents attendign the meeting stated they did not feel the area was private, as staff could overhear their conversations. During an interview on 09/25/2025 at 10:15 AM the AD stated she was responsible for scheduling and organizing Resident Council meetings monthly. The AD stated Resident Council meetings were held in the activities room monthly. The AD stated the activities room does not have doors to ensure the meetings are private. The AD stated she usually ensures staff stay out of the area when Resident Council meetings are being held, but she was not present on the day of the Resident Council meeting held during survey (09/24/2025). The AD stated the Resident Council meetings could be held in the therapy room if they needed to be private. The AD stated she would ensure that future Resident Council meetings were held in a private space to ensure residents felt comfortable to voice their opinions more openly. The AD stated if the resident council meetings were not held in a private space, it could have caused the residents to be fearful of speaking openly or fearful of retaliation. During an interview on 09/25/2025 at 11:00 AM the ADON stated Resident Council meetings were usually held in the activities room, but the therapy room could be utilized if the residents wanted a private space to meet. The ADON stated the AD was responsible for organizing resident council meetings monthly. The ADON stated she was aware staff members were within hearing distance of the resident council meeting held during survey (09/24/2025). The ADON stated staff members should have been aware the Resident Council meeting was confidential, and they should not have been present and should not have interrupted the meeting. The ADON stated, if residents cannot meet in a private area, it could cause residents to be afraid to speak their concerns openly for fear of retaliation. During an interview on 09/25/2025 at 12:30 PM the ADM stated he was aware the Resident Council meeting held during survey (09/24/2025) would be a concern, as it was not held in a private location. The ADM stated the AD was responsible for organizing Resident Council (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675291

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meetings monthly. The ADM stated the AD was on leave on 09/24/2025. The ADM stated there was not a back up plan in place for the AD on 09/24/2025 and stated he should have had someone covering for the AD on that day. The ADM stated the Resident Council meetings should have been held in a private location, and staff should not interrupt those meetings. The ADM stated it was important for residents to be able to voice their concerns openly without fear of retaliation. The ADM stated residents cannot speak freely if the meetings were not held in a private location. The ADM stated he would look for a more private location for Resident Council meetings in the future. Record Review of the facility's document titled, Resident Council revised February 2021, revealed the following:Policy StatementThe facility supports residents' rights to organize and participate in the resident council.Policy Interpretation and Implementation3. The resident council group is provided with space, privacy, and support to conduct meetings.		

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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. 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, in that: The facility failed on 09/23/25 to seal food stored in pantry. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observation was made on 09/23/25 at 09:40 AM during the initial tour of the kitchen: Bag of brownie mix in plastic bag not sealed. Bag of Pasta in original bag with large hole in bag in a plastic container not covered or sealed. The container lid was under plastic container to the right. Plastic container of sugar with lid not sealed. Bag of brown gravy mix in plastic bag not sealed. During an interview on 09/23/25 at 03:15 PM with DM she stated all food items in plastic bags should be sealed when stored on the shelf in pantry. She stated it was everyone's responsibility to seal items when storing them in the pantry. She stated all plastic container lids should be sealed when stored. She stated the flour bin should not have a hole in the lid. She stated the potential negative outcome could be bugs get in the food and could cause harm to the residents. She stated if bugs get in the food, it could cause residents to get an infection. She stated all kitchen staff have been trained in proper food storage and have safe serve certificates. During an interview on 09/25/25 at 09:30 am with [NAME] A, she stated all staff were responsible for making sure food put in the pantry was sealed. She stated she had been trained on how to properly store food in the pantry. She stated the potential negative outcome could be bugs or other stuff getting in the food and making the residents sick. During an interview on 9/25/25 at 11:19 am with the ADM, he stated all food stored in the pantry should be dated and sealed. He stated he was not aware food was being stored open. He stated kitchen staff have been trained to properly store food. He stated his expectations were for staff to follow policy and procedure. He stated the potential negative outcome could be cross contamination and environmental stuff getting in food making residents sick. He stated kitchen staff and ADM were responsible for making sure all food is sealed. He stated he makes weekly rounds. Record review of the facility's policy, titled Food Receiving and Storage dated revised November 2022, reflected the following: Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: .3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, for 1 of 1 facility roof. The facility failed to ensure the roof of the facility was in good repair. This failure could cause leaking and water damage and cause the facility to have an unsightly appearance. The findings included: On 09/23/25 at 9:30 AM, upon entrance to the facility, an observation was made of the roof of the facility. A large blue tarp was noted to cover a large portion of the roof. The areas of the roof that were uncovered by the blue tarp were noted to have shingles missing in places. On 09/23/25 at 9:55 AM, during entrance conference, the ADM stated several rooms on the front hall and the North hall were leaking water during the last storm. The ADM stated the residents were moved out of those rooms at that time and trash cans were used to collect the leaking water. The ADM stated he put up blue tarps with the MS after the last storm about 3 weeks ago and the roof has not leaked water since then. The ADM stated he was unsure exactly when the roof would get fixed as it was out of his hands and the owners were responsible for writing the check. During an observation on the front hall on 09/23/25 at 10:10 AM, it was noted that rooms [ROOM NUMBER] were closed and did not have any residents. room [ROOM NUMBER] was noted to have a large brown ring noted on the ceiling with some of the ceiling hanging down. A medium sized trash can was noted on the floor under the air vent half full of brown water. During an interview on 09/25/25 at 9:36 AM, the MS stated the roof has been having problems at the facility for as long as he had worked there, which was around 3 years. The MS stated the facility had gone through several administrators and he told all of them about the roof problems. The MS stated every time a storm went through the town, the roof shingles would come off in spots and he would go up there and patch up the spots. The MS stated over time, it was a battle after battle with the roof and he could not keep up. The MS stated the big storm that affected the town a few weeks ago was when the roof started leaking. The MS stated the ADM got tarps and they put tarps on the roof to prevent any leaking until the roof can get fixed. The MS stated insurance adjustors had gone out to the facility and approved the roof to be fixed, but that was all he knew. The MS stated it was out of his hands at that point and the ADM and the owners were responsible. The MS stated the residents had a risk of too much water getting in and the sheet rock collapsing on them. During an interview on 09/25/25 at 10:38 AM, the MS stated he could not find a policy related to the facility roof conditions or environment that included the roof. During a phone interview on 09/25/25 at 11:26 AM, the Previous ADM stated he had worked at the facility for about 1 year before leaving in August 2025. The Previous ADM stated the roof had issues with shingles coming off during his time working at the facility. The Previous ADM stated a big windstorm occurred in March or April of 2025 and the roof began having leaking issues at that time. The Previous ADM stated the leaking was not bad, but he did reach out to Facility Owner A and notify him of the roof damages from that storm. The Previous ADM stated another big storm occurred in June 2025 and he again reached out to Facility Owner A to notify him of the roof damages from the storm. The Previous ADM stated that was when insurance became involved. The Previous ADM stated the roof required constant attention at that time and some emails he sent to Facility Owner A and Facility Owner B went unanswered. The Previous ADM stated he did not have record of the emails due to them being deleted when he stopped working at the facility. The Previous ADM stated when he stopped working at the facility, the insurance check had not been provided to the facility. During an interview on 09/25/25 at 12:22 PM, the ADM stated he had worked at the facility for less than a month and the first week he was at the facility a storm went through the town and the roof of the facility started leaking heavily in some areas. The ADM stated Facility Owner A provided payment to him so he could purchase the tarps to put on the roof. The ADM stated it was his understanding that the insurance adjustor had already been out to the facility and (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had approved the roof to be fixed. The ADM stated Facility Owner A told him he was waiting for the insurance check for the roof. The ADM stated that was several weeks ago and the facility was still waiting for the roof to be fixed. The ADM stated the residents had a risk of mold or pest problems. During a phone interview on 09/25/25 at 12:40 PM, Facility Owner A stated he had filed a claim with insurance for the roof damage that occurred from the storm back in June 2025. Facility Owner A stated the facility had a mold air quality test done that revealed no mold in the facility, so the roof was not an immediate concern with the tarps being in place at this time. Facility Owner A stated the insurance company sent an engineer to the facility about 3 weeks ago to approve the claim and he has been waiting for the approval check. Facility Owner A stated he was not aware that the facility had been in bad condition for 3 years. Facility Owner A stated he did not know why he did not submit an insurance claim to fix the roof back from the storm in March or April 2025. Facility Owner A stated he did not think the roof needed replacement at that time. Facility Owner A stated he does not get the roof replaced with every storm. Facility Owner A stated a blue tarp was placed on the roof when it began leaking and to hold it over for the next couple of weeks. Facility Owner A stated it may be inconvenient for the residents who had to change rooms because their room was leaking and stated no rooms were leaking at that time.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 2 of 16 residents (Residents #4, and #8) reviewed for advanced directives. Residents #4, and #8 were listed as a DNR (Do Not Resuscitate) but had Out-of-Hospital Do Not Resuscitate (OOH-DNR) forms that were missing required information. This failure could place residents at risk of not having their end of life wishes honored and incomplete records. Findings included: Record Review of Resident #4's face sheet, dated [DATE] , revealed a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses that included: muscle weakness, Major Depressive Disorder (a mental disorder characterized by pervasive low mood, low self-esteem, and loss of interest or pleasure in activities), and problem related to life management difficulty. Record Review of Resident #4's Care Plan dated [DATE], revealed: The resident request code status of: DNR. Record Review of Resident #4's physician orders dated [DATE] revealed: verbal orders placed for DNR. Record Review of Resident #4's OOH-DNR records dated [DATE] revealed: Under the section labeled, Physician's Statement,, next to the Physician's signature/name, a physician's license number was not listed. Record Review of Resident #8's face sheet, dated [DATE] , revealed a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses that included: vascular dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain), muscle weakness, and problem related to life management difficulty. Record Review of Resident #8's Care Plan dated [DATE], revealed: The resident request code status of: DNR. Record Review of Resident #8's physician orders dated [DATE] revealed: verbal orders placed for DNR. Record Review of Resident #8's OOH-DNR records dated [DATE] revealed: Under Section B, labeled, Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication, was not dated next to the Legal Guardian. Under the Physician Statement, next to the Physician signature was not dated. During an interview on [DATE] at 11:10 AM the ADON stated Advance Directives were reviewed by the admitting nurse and administrator to ensure accuracy. The ADON stated Advance Directives should be completed thoroughly. The ADON verified there were no additional advance directives for Resident #4 or Resident #8. The ADON verified the current Advance Directives for Resident #4 and Resident #8 were not completed, as they were both missing dates. The ADON stated it was important for Advance Directives to be completed thoroughly to ensure the documents were legally binding. The ADON stated if an advance directive was not completed, the resident's wishes may not be honored. The ADON stated she would ensure the advance directives were updated as soon as possible. During an interview on [DATE] at 12:35 PM the ADM stated the admitting nurse was responsible for ensuring the resident's advance directive was completed thoroughly. The ADM stated this should have been completed within 24 hours of admission. The ADM stated all nursing staff were responsible for ensuring advance directives were complete and accurate. The ADM stated he did not know how often advance directives should be checked, but he stated they should be checked regularly to ensure they were accurate. The ADM stated it was his expectation that advance directives would be completed properly and reviewed regularly. The ADM stated a resident could have been assaulted if the advance directive was not completed properly. The ADM stated a resident's wishes may not have been followed if their advance directive was not completed. Record review of the facility's policy, Advance Directives, Revised [DATE], revealed the following documentation: Policy Statement: The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Policy Interpretation and Implementation: Definitions b. Advance Directive - a written instruction, such (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated (per 5489.100).(3) Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident has a right to a safe, clean, comfortable, and homelike environment for 1 of 16 residents (Resident #13) reviewed for physical environment. The facility failed to ensure Resident #13 had a safe and secure toilet in the bathroom. This failure could place residents at risk for injuries and falls. Findings included: Record review of Resident #13's face sheet dated 9/25/2025 revealed a [AGE] year-old female, admitted to the facility on [DATE]. The face sheet indicated, under Diagnosis Information, diagnoses that included the following: Unspecified sequelae of nontraumatic intracerebral hemorrhage (bleeding in the brain which could result in motor and sensory deficits such as weakness or paralysis in the limbs and cognitive impairments), unsteadiness on feet, muscle weakness, other abnormalities of gait and mobility, and unspecified lack of coordination. Record review of Resident #13's Annual MDS assessment, dated 08/13/2025, revealed under Section C, Cognitive Patterns, a BIMS score of 15 indicating the resident was cognitively intact. The MDS assessment indicated under Section H, H0300, Resident #13 was occasionally urinary incontinent and always continent of bowel. Record review of Resident #13's most recent care plan, dated 09/26/2025, reflected a focus area ADL Self Care Performance Deficit t CVA with left hemiparesis. The goals for the focus area included, The resident will improve current level of function in transfers, dressing through the review date. The Interventions/Tasks for the focus area included, TOILET USE: The resident is able to use toilet with assist. During an interview with Resident #13 on 09/24/2025 at 02:45 PM Resident #13 stated her toilet was wobbly and moved back and forth, from side to side and front to back. Resident #13 stated she had not reported the loose toilet yet. Resident #13 stated she had not had an accident because of the loose toilet. Resident #13 stated she received assistance, by facility staff, when transferring to the toilet. An observation on 9/24/2025 at 3:15 PM revealed the toilet in Resident #13's room was not secure and could be moved from side to side and front to back, by several inches, with only a gentle nudge. During an interview on 09/24/2025 at 03:30 PM the ADM stated he was not aware of Resident #13's concern of her toilet being loose. The ADM stated he would have the toilet fixed as soon as possible. During an interview on 09/25/2025 at 11:30 AM the MS stated he was not aware Resident #13's toilet was loose. The MS stated Resident #13's toilet had become loose previously, and it was tightened as soon as it was observed or when Resident #13 reported it. The MS stated he had already secured the toilet on 09/24/2025, and he stated it was no longer loose. The MS stated he planned to replace the seal on the toilet to ensure it did not become loose again. The MS stated he did regular checks weekly to ensure Resident #13's toilet was secured, since it had become loose previously. The MS stated the toilet was still bolted down, but the bolts became loose and allowed for the toilet to move some. The MS stated he did not feel there was a risk to the resident because the toilet was still bolted down, and it would not tip from side to side. The MS stated he did not feel the resident was at risk of falling or obtaining an injury due to the loose toilet. An observation on 9/25/2025 at 11:35 AM revealed the toilet in Resident #13's room was secure and could no longer be moved from side to side or front to back. During an interview on 09/25/2025 at 1:05 PM the ADM stated the MS and nursing staff were responsible for ensuring Resident #13's toilet was safe and secure. The ADM stated he was ultimately responsible for ensuring this was followed up on. The ADM stated he was not aware Resident #13's toilet was loose prior to 09/24/2025. The ADM stated the MS does regular checks of each resident's bathroom to ensure everything is functioning properly. The ADM did not know how often the MS completed maintenance checks of the residents' bathrooms. The ADM stated he would make sure the maintenance checks were completed regularly. The ADM stated the resident was at risk of falling and incurring an injury if her toilet was loose. Record review of the facility's policy, Bathrooms, Revised February 2020, revealed the following documentation: Policy (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Statement:Resident rooms are equipped with (or located near) toilet and bathing facilities. Policy Interpretation and Implementation:I . Residents who can independently use the toilet (including chair-bound residents) are ensured timely access to a safe, clean, sanitary, and accessible toileting facility. (Note: if certified after November 28, 2016, resident rooms come equipped with a minimum of one toilet/commode and sink.)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident had the right to be treated with respect and dignity, including the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 of 15 residents (Resident #2) observed for physical restraints in that; The facility failed to ensure Resident #2 had a consent and an evaluation for scoop mattress for fall prevention. This failure could place residents at risk of injuries or entrapment. Findings include: Resident #2 Review of Resident #2's Face Sheet, dated 09/24/25, revealed she was an 83 -year-old female admitted on [DATE] and readmitted on [DATE] with the following diagnoses: dementia (loss of brain function), major depression, diabetes (high blood sugar), epilepsy (seizure disorder), muscle weakness and hypertension (high blood pressure). Review of Resident #2's Comprehensive MDS, dated [DATE] stated she was not cognitively intact with a BIMS score of 00. She required extensive assistance and total dependence on one person for bed mobility, toilet use, dressing, and personal hygiene. She requires substantial/maximal assistance with roll left and right, sit to lying, lying to sitting, and transfers. Further review of the MDS revealed resident had one fall since admission with no injury and did not address restraint. Record review of Resident #2's Care Plan dated 03/25/25 revealed the resident had an actual fall (fell from bed) with injury (wound to left side of the forehead). The interventions included bed in low position, fall matt beside bed, and scoop mattress to bed. Record review of Resident #2's orders dated 09/24/25 revealed a Physician Order dated 03/03/25 for a scoop mattress on bed to prevent unintentionally rolling off the bed. Record review Resident #2's medical record revealed no consent for scoop mattress. Observation on 09/23/25 at 10:30 AM revealed Resident #2's bed with a scoop mattress. During an interview on 09/24/25 at 03:45 pm the ADON stated restraint consents were scanned into resident electronic medical records. She stated, I bet she don't have a consent for scoop mattress, because I did not think about it. During an interview on 09/25/25 at 10:15 am the ADON stated Resident #2 had a scoop mattress to keep her from rolling over and accidentally falling out of bed. She stated consent for restraints should be obtained at the time the restraint is applied. She stated the scoop mattress could be a restraint for certain residents. She stated Resident #2 does not try to get up out of bed, she just rolls. She stated ADON and DON were responsible for obtaining consent. She stated the potential negative outcome could be residents and families not getting notified of the restraint and making them mad. During an interview on 09/25/25 at 11:19 AM, the ADM stated a scoop mattress could be a restraint. The ADM stated nursing staff were responsible for making sure consent was obtained before applying the scoop mattress to the bed. The ADM stated the potential negative outcome could be lowering the resident's quality of life. Record review of the facility policy titled, Bed Safety and Bed Rails, with a revised date of August 2022 reflected the following: Policy Statement: Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. Policy Interpretation and Implementation: 1. The resident's sleeping environment is evaluated by the interdisciplinary team. 2. Physical restraints are any manual method, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. a. The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting movement or normal access to one's body could be considered a restraint.		

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NAME OF PROVIDER OR SUPPLIER Crosbyton Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 222 N Farmer Crosbyton, TX 79322	
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations, interviews, and record review, the facility failed to provide an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being for 1 of 16 residents reviewed for activities, in that: The facility failed to ensure there were organized activities available to residents on 09/23/2025 and 09/24/2025. This failure placed residents at risk for a diminished quality of life, isolation, and lack of stimulation. Findings included: During observation of the facility's activities area on 09/23/2025 at 10:30 AM, the wall-sized, centrally located group activities board was observed to have a large print calendar posted. There was not a month identified on the activities calendar. During observation of the facility's activities area on 09/23/2025 from 10:00 AM to 04:00 PM, there were no observed group activities conducted. During observation of the facility's activities area on 09/24/2025 from 06:30 AM to 03:30 PM, there were no observed group activities conducted. During a confidential interview held on 09/24/2025 at 1:00 PM an anonymous resident stated the facility's activities director was on leave and the residents had not had any scheduled activities while she was out. The residents stated the facility did not have a full time activities director to facilitate activities daily and residents were organizing their own activities at times, due to this. The resident stated the activities director was also working as the facility's business office manager which took away time from organizing activities. During confidential interviews held on 09/24/2025 at 02:00 PM 1 of 6 confidential residents stated they did not have any activities on 09/23/2025 or 09/24/2025. The Residents stated the activities director was out and that was why they did not have activities on these days. 5 of 6 confidential residents stated they were not bothered by not having activities on 09/23/2025 or 09/24/2025. One resident stated she was frustrated that the facility did not coordinate any activities on these dates. During an interview on 09/24/2025 at 03:30 PM the housekeeping supervisor stated she was hired as the housekeeping supervisor, but she was also a certified activities director. The housekeeping supervisor stated she recently started working at the facility on 09/24/2025, and she planned to help organize activities for the residents going forward. During an interview on 09/25/2025 at 10:00 AM the AD stated her job title was business office manager, but she also worked as the AD. The AD stated she has worked at the facility as the AD for the past 5 years. The AD stated she ensured the residents had ongoing activities daily, but she was on leave on 09/23/2025 and 09/24/2025. The AD stated the housekeeping supervisor was also a certified AD and was supposed to cover activities on the days she was out, but the housekeeping supervisor was out, unexpectedly, as well. The AD stated she tried to complete her business office management tasks during the mornings, around scheduled activities with the residents. The AD stated residents should not have to organize their own activities, and the ADM should have ensured activities were conducted while she was on leave. The AD stated it was important for residents to have ongoing activities to keep their minds busy and for enjoyment. During an interview on 09/25/2025 at 12:25 PM the ADM stated the facility did not have any activities on 09/23/2025 or 09/24/2025 due to the AD being out on leave. The ADM stated he did not have a back up plan for activities during this time, and this was his responsibility. The ADM stated he should have had someone organizing activities while the AD was out. The ADM stated the facility did not have a full time AD due to budgeting constraints. The ADM stated the business office manager was the part-time AD and she tried to balance both job duties. The ADM stated he recently hired a housekeeping supervisor who was also a certified AD, so she will coordinate with the business office manager/AD to fill in the gaps when the business office manager was unavailable to conduct activities, but the housekeeping supervisor was out on the same days, so he did not have anyone to help conduct activities for the residents. The ADM stated it was not the responsibility of the residents to organize their own activities. The ADM stated if the residents did not have organized activities it could lead to boredom, lower quality of life, increased behaviors, and (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents not feeling important. Record review of the facility's policy, Activity Programs, Revised June 2018, revealed the following documentation: Policy Statement:Activity programs are designed to meet the interests of and support the physical, mental, and psychosocial wellbeing of each resident. Policy Interpretation and Implementation:3. The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities.6. Activities are scheduled 7 (seven) days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup, and critique of the programs.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail and ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements: Assess the resident for risk of entrapment from bed rails prior to installation and/or Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 1 of 15 residents (Resident #17) observed for physical restraints in that; The facility failed to ensure Resident #17 had a physician order, consent and evaluation for side rails used for positioning and mobility. This failure could place residents at risk of injuries or entrapment. Findings include: Resident #17 Review of Resident #17's admission record, dated 09/23/25, revealed he was an 89 -year-old female admitted on [DATE] with the following diagnoses: essential hypertension (high blood pressure), radiculopathy (pinched nerve), and nutritional anemia (body lacks enough healthy blood red cells to transport oxygen due to lacking diet). Review of Resident #17's Comprehensive MDS assessment, dated 03/23/25 stated she required partial assistance of one person for bed mobility. Further review of the MDS revealed bed rails were not addressed as a restraint. Record review of Resident #17's order summary report dated 09/23/25 revealed no physician order for side rails. Record review Resident #17's medical record revealed no consent or evaluation of need for side rails on her bed. Observation on 09/23/25 at 3:16 PM revealed Resident #17 lying in bed with 1/4 side rails to both sides of the head of bed. Both of the side rails were observed to be raised at this time. During an interview on 09/25/25 at 11:06 AM, LVN B stated nursing staff were responsible for ensuring a resident had an order for side rails. LVN B stated the admitting nurse usually put the orders in, or the nurse who determined the resident required the side rails. LVN B stated Resident #17 has had side rails on her bed for as long as she could remember, at least a few years. LVN B stated Resident #17 used the side rails for mobility and positioning before she had a decline in health and went on hospice services. LVN B stated the resident had an increased risk of falling with the bed rail, if she tried to climb over it or it could impede the resident from getting out of bed. During an interview on 09/25/25 at 12:00 PM, the ADON stated she did not know why Resident #17 did not have a physician order, consent or evaluation for side rails. The ADON stated the DON and her recently did an audit on side rails in the facility and it must have been missed. The ADON stated the DON and herself were ultimately responsible for ensuring residents had orders and consents for side rails. The ADON stated the residents had a risk for entrapment and the doctor not being aware of a need for side rails. During an interview on 09/25/25 at 12:16 PM the DON stated the nursing staff were responsible for ensuring side rail orders were initiated by calling the physician. The DON stated it was the ADON's and her responsibility to ensure all side rails used in the facility had a physician order, consent and evaluation done. The DON stated side rails were considered a restraint and residents had a risk of falling over it and injuring themselves. During an interview on 09/25/25 at 12:22 PM, the ADM stated a physician order was required if a resident needed to use side rails. The ADM stated a side rail was considered a restraint if it did not have a physician order for use. The ADM stated the DON and himself were responsible for ensuring side rails had orders, consents and evaluations in place. The ADM stated the resident was at an increased risk for restraint. Record review of the facility policy titled, Bed Safety and Bed Rails, with a revised date of August 2022 reflected the following: Policy Statement: Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. Policy Interpretation and Implementation: 1. The resident's sleeping environment is evaluated by the interdisciplinary team. Use of Bed Rails 1. Bed rails are adjustable metal or rigid plastic bars that attach to the bed .For the (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	purpose of this policy bed rails include:a. side rails;b. safety rails; andc. grab/assist bars.2. Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.a. The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting movement or normal access to one's body could be considered a restraint.3. The use of bed rails or side rails.is prohibited unless the criteria for use of bed rails have been met, including attempts to alternatives, interdisciplinary evaluation, resident assessment, and informed consent.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, and record reviews, the facility failed to ensure menus were followed for 2 of 2 meals observed. (Lunch meal 9/23/25 and 9/24/25) The facility failed to follow the week 1 menu for two lunch services served at the facility on Tuesday 09/23/25 and Wednesday 09/24/25. These failures could place residents that eat food from the kitchen at risk of poor intake, and/or weight loss. The findings included: Observation on 09/23/25 at 11:45 AM of dining room puree lunch meal trays being served consisting of spaghetti with white gravy and green beans. No puree bread on plate. Observation on 09/24/25 at 11:45 AM of dining room puree lunch meal trays being served consisting of roasted thyme chicken with gravy, mashed potatoes with gravy, and mixed vegetable florets. No puree bread on plate. Record review of the Tuesday Week 1 menu dated 05/07/25 revealed the noon menu was changed to the meal of the month spaghetti with meatballs, green beans and garlic bread. Record review of the Wednesday Week 2 menu dated 05/07/25 revealed the noon menu was roasted thyme chicken, mushroom rice, broccoli florets, wheat dinner roll, margarine, confetti cake, 2 percent milk, coffee. During an interview on 09/25/25 at 09:30 a.m., [NAME] A stated she should have served puree bread with the noon meals on 09/23/25 and 09/24/25. She stated she got nervous and forgot to puree the bread. She stated she was training on following the menu and substitutions. She stated the negative outcome could be decrease in calories and weight loss. During an interview on 09/25/25 at 09:45 a.m., the DM stated the cooks were responsible for properly preparing the puree diets. She stated the cook forgot to puree the bread on 09/23/25 and 09/24/25 and the cook had been trained to follow the menu. She stated she was responsible for monitoring staff, and the cook was responsible for following the menu when preparing the meal. She stated the potential negative outcome could be weight loss and residents feeling left out. During an interview on 9/25/25 at 11:19 a.m., the ADM stated dietary staff should follow the menu and make appropriate substitutions. He stated he was not aware the menus were not being followed. He stated he expected the dietary staff to follow the menus correctly and substitute foods correctly. He stated the potential negative outcome could be calorie and nutritional deficiencies. Record review of Menus policy revised 10/2017 revealed the following: Policy statement - menus are developed and prepared to meet resident choices including religious, cultural, and ethnic needs while following established national guidelines for nutritional adequacy. Policy interpretation and implementation: .6. Deviations from posted menus are recorded (including the reason for the substitution and/or deviation) and archived.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 of 2 residents (Resident #11) reviewed for meals. The facility failed to ensure that Resident #11 was served pureed spaghetti meat, chicken and vegetables that were the proper texture. This deficient practice could affect residents by placing them at risk for choking and weight loss. The findings include: Record review of Resident #11s face sheet dated 09/25/25 revealed a [AGE] year-old female with an admission date of 07/06/2023 with the following diagnoses: gastro-esophageal reflux disease (stomach disease), problem related to life management and weakness. Record review of Resident #11s physician orders dated 09/24/25 revealed an order dated 10/19/24 for regular diet, pureed texture and regular thin liquid consistency. During an observation on 09/23/25 at 11:45 AM, 1 puree plate was served to Resident #11. Resident #11 was observed picking large chunks out of puree spaghetti out of her mouth and placing them on the edge of the plate. During an observation on 09/23/25 at 12:00 PM a test tray with puree spaghetti had large chunks of noodles and meat that had to be chewed. During an observation on 09/24/25 at 09:45 AM [NAME] A prepared puree chicken that had chunks that had to be chewed. Prepared puree vegetables had chunks that had to be chewed. During an observation on 09/24/25 at 11:45 AM observed Resident #11 picking chunks out of puree chicken and vegetable out of her mouth with her fingers and placing them on the edge of the plate. During an interview on 09/25/25 at 09:20 AM with Resident #11 she stated she was on a puree diet because she cannot chew food. She stated if it was not smooth, she cannot swallow the food. She stated she had to pick out the chunks of food in the puree to swallow it. She stated It looks bad; it (the food) gets your fingers messy. She stated the texture of the food depends on the cook. She stated some cooks puree the food good and some do not. During an interview on 09/25/25 at 09:30 am with [NAME] A, she stated puree should be smooth with no chunks. She stated she looks at the puree to make sure it does not have chunks. She stated she has been trained in how to puree food. She stated the purpose of puree diet was the resident cannot chew or swallow food. She stated she was responsible for making sure food was properly pureed. She stated the potential negative outcome could be a resident choking. During an interview on 09/25/25 at 09:45 am with DM she stated puree should be pudding like consistency with no chunks. She stated all staff have been trained in how to prepare puree diets. She stated staff should taste puree for texture not just look at it. She stated puree diets were ordered for residents who had a hard time chewing or swallowing food. She stated the potential negative outcome could be resident choking. During an interview on 9/25/25 at 11:19 AM with the ADM, he stated puree food should be pudding like consistency and should not have chunks. He stated he was not aware the puree meals had chunks. He stated all staff have been trained in how to prepare puree diets. He stated his expectations were for food to be prepared properly. He stated the ADM was responsible for monitoring puree diets. He stated he gets a test tray weekly but has not tested the puree meal. He stated the potential negative outcome could be resident choking or aspirating on chunks. Record review of the facility policy titled Nutrition Policies and Procedures, dated 9/25, revealed the following: Subject: Diet Definitions.2. Puree recipes that do not specify portions for combined foods such as casseroles that include the starch with the meat will serve a 6-ounce portion (#6 scoop).a. Place the number of portions you need in the food processor.b. You may need to add liquid such as broth, juice or milk as appropriate to make a fluffy, mashed potato-like consistency.c. You may need to add thickener to produce a fluffy, mashed potato like consistency.e. Blenderize until there are no small pieces of lumps in food.f. Final product should hold its shape (not runny) and have a fluffy, moist consistency with no lumps.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were provided with the therapeutic diets as prescribed by the attending physician for 1 of 2 residents (Resident #11) reviewed for therapeutic diets and food and nutrition services. The facility failed to ensure Resident #11 received ice cream with noon meals on 09/23/25 and 09/24/25 as ordered by the physician. This failure could place residents with diet needs at risk for weight loss and potential decline in health. The findings included: Record review of Resident #11's admission record dated 09/25/25 revealed she was [AGE] years old and admitted on [DATE] with muscle weakness, gastro esophageal reflux disease (stomach acid flows back into the esophagus), and problem related to life management difficulty. Record review of the physician's orders dated 09/24/25 revealed Resident #11's diet was Regular, puree texture, regular/thin consistency, ice cream with noon meal for unplanned weight loss with a start date of 10/20/24. Record review of the MDS comprehensive assessment dated [DATE], revealed Resident #11's BIMS score was 10 indicating moderate impairment with cognition. No weight loss or gain of 5% or more in the last month or loss of 10% or more in the last 6 months was noted. Therapeutic diet was noted. Record review of the care plan dated 05/27/25 revealed Resident #11 had a potential nutritional risk (such as weight loss) related to requesting to be on a pureed diet at every meal. Record review nutrition data collection dated 08/06/25 revealed Diet Order/Consistency: puree diet, ice cream with noon meal and supplements at all meals. It further revealed annual evaluation - weight remains stable and she is on supplements and ice cream to compliment her meal intake to promote stable weight. Record review of the diet card dated 09/23/25 and 09/24/25 revealed puree diet with supplement handwritten below diet order. During an interview on 09/25/25 at 09:20 am with Resident 11 she stated she was on a puree diet because she cannot chew food. She stated she does like ice cream but does not always get it with her noon meal. During an observation on 09/23/25 at 11:45 am Resident #11's meal provided was puree spaghetti, puree veggie and puree dessert. No ice cream was provided. During an observation on 09/24/25 at 11:45 am Resident #11's meal provided was puree chicken, mashed potatoes, puree veggie and puree dessert. No ice cream was provided. During an interview on 09/25/25 at 09:30 am with [NAME] A, she stated Resident #11 should have been served ice cream with noon meal on 9/23/25 and 9/24/25. She stated the diet orders and supplements were written on the dietary tray ticket. She stated she forgot to serve Resident #11 ice cream both days (9/23/25 and 9/24/25). She stated she had been trained on following physician diet orders. She stated the potential negative outcome could be the residents not getting proper nutrition and weight loss. During an interview on 09/25/25 at 09:45 am with DM she stated Resident #11 was not served ice cream for the noon meal on 9/23/25 and 9/24/25 because they were out of ice cream and magic cups (frozen supplement). She stated she did receive them on the truck today (9/25/25). She stated the diet order and supplements were printed on the tray card. She stated the DM is responsible for printing the tray tickets. She stated the order was not on the tray card for 9/23/25 and 9/24/25 because she was not able to print the original tray cards because she was out of printer ink. She stated the potential negative outcome could be weight loss from not receiving the proper supplements. During an interview on 9/25/25 at 11:19 am with the ADM, he stated the purpose of ice cream ordered at noon meal is to boost the residents' calories to maintain weight. He stated he was not aware ice cream was not served. He stated all staff have been trained to follow physician diet orders. He stated the person responsible for following the diet order was the cook, DM and ADM. He stated the potential negative outcome could be weight loss. Interview on 9/25/25 at 11:30 am with ADON, she stated the facility did not have a policy on therapeutic diets.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Resident #13 and Resident #20) reviewed for infection control. 1. LVN B did not perform hand hygiene between all glove changes when providing wound care to Resident #13 and Resident #20. These failures could place residents at risk for cross contamination and infection. The findings include: Resident #13 Record review of the admission record for Resident #13, dated 10/01/25 revealed a [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: unspecified dementia (a group of conditions that cause a decline in cognitive abilities), schizoaffective disorder, depressive type (mental health disorder) and peripheral vascular disease (a slow and progressive circulation disorder). Record review of the comprehensive MDS assessment for Resident #13, dated 07/03/25 revealed Resident #13 had a total of 1 venous and arterial ulcer present. Record review of the order summary report for Resident #13, dated 10/01/25 revealed the following order: Wound care to RLE [Right lower extremity] every day and PRN as follows: Cleanse with wound cleanser, pat dry with gauze, apply Collagen then calcium alginate, may cover with dry nonadherent dressing or foam dressing one time a day for wound care with a start date of 09/24/25 and no end date. Record review of the current care plan for Resident #13, undated, revealed there was a focus area: The resident has a chronic stasis ulcer of the right lower leg. Goal: The resident will have no signs or symptoms of infection through the review date. Last revised on 08/26/25. During an observation on 09/24/25 at 3:28 PM, LVN B provided wound care to Resident #13's lower leg wound. LVN B put on a clean gown before entering the room. LVN B used hand sanitizer and put on a pair of clean gloves. LVN B removed the old bandage from Resident #13's wound and cleansed the area with wound cleanser and 4x4 gauze. LVN B then patted dry and measured the open area. LVN B placed a 4x4 gauze to cover the open area and stated she needed to go back to her wound cart to get calcium alginate that she thought she had. LVN B then removed her gloves and gown and put them in the trash. LVN B did not perform hand hygiene. LVN B then walked out of the room and went to the wound cart for the calcium alginate. LVN B then applied hand sanitizer to her hands and put on a clean gown and gloves before going back in Resident #13's room to finish wound care. LVN B then placed collagen powder and calcium alginate on the wound bed and covered it with a silicone border dressing. LVN B then removed her gown and gloves and washed her hands with soap and water. Resident #20 Record review of the admission record for Resident #20, dated 09/25/25 revealed an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: heart failure (heart muscle cannot pump blood effectively through the body), osteoarthritis (wear and tear condition of a joint), and edema (swelling). Record review of the quarterly MDS assessment for Resident #20, dated 07/14/25, revealed Resident #20 was at risk for developing pressure ulcers/injuries. Record review of the order summary report for Resident #20, dated 10/01/25, revealed the following order: Pressure wound to coccyx: Cleanse with Wound Cleanser or Normal Saline, pat dry with gauze. Apply collagen and silicone super absorbent daily. Monitor for signs and symptoms infection. Notify MD if infection noted. One time a day with a start date of 09/06/25 and no end date. Record review of the current care plan for Resident #20, last revised on 09/04/25, revealed there was a focus area: Documented Pressure Ulcer (episodic) arrived 9/3 with sacral pressure wound. Goal: Wound will show signs of improvement. During an observation on 09/24/25 at 2:09 PM, LVN B provided wound care to the pressure wound on Resident #20's coccyx. LVN B put on a clean gown outside the room and used hand sanitizer before going in Resident #20's room. LVN B put on a pair of clean gloves when she entered the room and began preparing the wound supplies for Resident #20. After prepping the supplies, LVN B removed her gloves and used hand sanitizer. LVN B put on a (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Crosbyton Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pair of clean gloves and Resident #20 was turned on her side. LVN B then cleansed Resident #20's coccyx wound with wound cleanser and 4x4 gauze. LVN B patted the wound bed dry and applied collage powder to the wound bed. A hydrocolloid foam dressing was used to cover the wound. LVN B then removed her gloves and put on a clean pair of gloves without performing hand hygiene. During an interview on 09/25/25 at 11:06 AM, LVN B stated she had been trained to perform hand hygiene with glove changes. LVN B stated she received an in-service on infection control and hand washing a few weeks ago but she could not remember the exact date. LVN B stated it slipped her mind when she was providing wound care to Resident's #13 and #20 and that was why she did not perform hand hygiene between all the glove changes. LVN B stated there was a risk of spreading infection to the residents. During an interview on 09/25/25 at 12:00 PM, the ADON stated she expected the staff to sanitize their hands between glove changes. The ADON stated she did not know why LVN B did not sanitize her hands between all glove changes. The ADON stated the DON was usually responsible for educating the staff on infection control practices, but the DON was new to the facility and had not worked there long. The ADON stated the residents had a risk for infection spreading. During an interview on 09/25/25 at 12:16 PM, the DON stated she expected the staff to perform hand hygiene between glove changes. The DON stated she was new to the facility and had not provided education on hand hygiene yet. The DON stated the residents had a risk for spreading infection. During an interview on 09/25/25 at 12:22 PM, the ADM stated the ADON was the IP at the facility. The ADM stated he expected the staff to perform hand hygiene between glove changes. The ADM stated he did not think the staff had been trained on infection control practices in the few weeks he had worked at the facility. The ADM stated the residents had a risk for cross-contamination. Record review of the facility policy titled, Infection Prevention and Control Program, with a revised date of October 2018 reflected the following: Policy Statement: An Infection Prevention and Control Program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Record review of the facility policy titled, Handwashing/Hand Hygiene, with a revised date of August 2019 reflected the following: 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 handwashing/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: g. before handling clean or soiled dressings, gauze pads, etc.; m. after removing gloves.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Crosbyton Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** 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 resident rooms #6, 13, 14, 19, 20, 21 and 30. This failure could result in crowding, cause difficulty in providing ADL services, and place residents at risk for decreased quality of life. Findings included: On 9/23/25 at 9:55 AM an interview was conducted with the ADM, at the time of the entrance conference. He 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 with the MS on 09/25/25 beginning at 9:20 AM and indicated the following: room [ROOM NUMBER] had 158.22 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 156.44 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 151.55 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 152.41 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 151.18 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 154 square feet for 2 residents instead of the required 160 square feet. room [ROOM NUMBER] had 156.10 square feet for 2 residents instead of the required 160 square feet. Interview on 09/25/25 at 12:22 PM, the ADM stated the semi-private rooms that do not meet the requirement for square footage requirement were typically used as private rooms, but not recently with the water leaking from the roof. The ADM stated regarding the inadequate room square footage in semi-private rooms, the residents were at risk for a lower quality of life. The ADM stated the residents could feel like there was not enough room to move around. The ADM stated the facility did not have a policy related to room square footage requirements for residents.		