

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 7 residents (Residents #25) reviewed for care plans in that:</p> <p>Resident #25 did not have a Care Plan addressing his vape use/smoking.</p> <p>This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs.</p> <p>The findings included the following:</p> <p>Review of Resident #25's admission Record dated 6/26/25, revealed he was an [AGE] year-old male admitted to the facility on [DATE] and a re-admission dated of 5/7/25, with diagnoses including unspecified dementia without behavioral disorder.</p> <p>Review of Resident #25's admission MDS assessment, dated 5/10/25, revealed:</p> <p>He had a mental status score of 7 of 15 (indicating his cognition was severely impaired)</p> <p>He was not identified as a current tobacco user.</p> <p>Review of his care plan revealed there was no care plan for his nicotine use.</p> <p>Review of Resident #25's Baseline Care Plan dated 5/7/25 revealed Does the resident smoke? No</p> <p>Review of Resident #25's assessments revealed no smoking assessments.</p> <p>Review of Resident #25's Nurse's Notes dated 5/27/2025 at 6:03 p.m. revealed: Note Text: Resident attempted to elope from facility thru the front door. Nurse and DON stopped resident at door. Resident stated that he was going to the head shop to go get a vape. Resident was educated that he cannot leave facility on his own. Resident verbalized understanding. A wander guard was placed on resident to monitor elopement risk.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and observation on 06/24/25 at 2:43 PM revealed Resident #25 had several vapes on the bedside table, smoking times posted. Resident #25 said he went outside for smoking times but did not on 6/24/25 because he hurt too much.</p> <p>Interview and observation on 06/26/25 at 10:37 AM, Resident #25 stated he was not vaping in the building. Resident #25 said he had to take a vape from another resident and forgot to turn it into the lady. The vape was in same place as 6/24/25.</p> <p>In an interview on 06/26/25 11:23 AM, the DON and Corporate RN stated smoking was assessed on admission and quarterly. The Corporate RN said people who vaped were also assessed. The DON said she talked to Resident #25 and assessed him for pain, and he had two vapes on the bedside table which she took away. The DON said the Administrator was with her where she took them away. The DON checked Resident #25's electronic record and stated he had no assessments and it did not look like he had a care plan for vaping. She said she did not know why he did not. The DON said it should pop up under the initial care plan for nursing and the MDS nurse was responsible for completing the care plan after that.</p> <p>Review of the facility's policy and procedure on Comprehensive Care Plan, revised 4/25/21, revealed: Every resident will have an individualized interdisciplinary plan of care in place. A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of Admission. The Interdisciplinary Team will continue to develop the place in conjunction with the Resident Assessment Instrument completing and conducting Comprehensive Care Plan Meeting and Reviews by day 21 after Admission. The Care Plan is revised every quarter, significant change of condition, Annual or as the resident condition changes on an individualized basis. The Care Plan process is an ongoing review process.</p> <p>To assure that the resident's immediate care needs are met and maintained, the baseline care plan will be developed with forty-eight hours of the residents' Admission. It will be utilized until the Comprehensive Care Plan is developed.</p> <p>The Comprehensive Care Plan is developed within 21 days of Admission.</p> <p>Care Plan Meeting and Care Plan Summary will be completed by the IDT after each Care Plan Review.</p> <p>The resident and their representative will be provided a summary at their request of the baseline care plan that includes but not limited to: Any services and treatment to be administered by the community and personnel acting on the community.</p> <p>Review of the facility's policy and procedure on Smoking, effective 3/1/17, revealed: It is the policy to accommodate residents who desire to smoke by taking reasonable precautions, providing a safe environment for them, and protecting the non-smoking residents.</p> <p>IDT will develop an individualized plan for safe storage, use of smoking materials assistance and required supervision for residents who smoke. This is documented on the Resident Smoking Assessment, the residents' Plan of Care, and discussed with the resident and Responsible Party at resident care conference meetings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 3 of 7 residents (Resident #25, #32 and #37) reviewed for quality of care in that:</p> <ol style="list-style-type: none"> 1. The facility failed to assess and care plan Resident #25 for safe vaping, 2. The facility failed to keep Resident #25's vape secure when it was not a supervised smoking time 3. CNA E and CNA D incorrectly transferred Resident #32 the shower chair to the bed by incorrectly applying the gait belt too loosely and hooking under Resident #32's arms. 3.CNA A and CNA B incorrectly transferred #37 from her wheelchair to the bed by grabbing her from the back of her pants and her under arms. <p>These failures could put residents at risk of accidents and serious injuries which could result in a reduced quality of life.</p> <p>Findings included:</p> <p>RESIDENT #25</p> <p>Review of Resident #25's admission Record dated [DATE], revealed he was an [AGE] year-old male admitted to the facility on [DATE] and a re-admission dated of [DATE], with diagnoses including unspecified dementia without behavioral disorder.</p> <p>Review of Resident #25's admission MDS assessment, dated [DATE], revealed:</p> <p>He had a mental status score of 7 of 15 (indicating his cognition was severely impaired)</p> <p>He was not identified as a current tobacco user.</p> <p>Review of his care plan revealed there was no care plan for his nicotine use.</p> <p>Review of Resident #25's Baseline Care Plan dated [DATE] revealed Does the resident smoke? No</p> <p>Review of Resident #25's assessments revealed no smoking assessments.</p> <p>Review of Resident #25's Nurse's Notes dated [DATE] at 6:03 p.m. revealed: Note Text: Resident attempted to elope from facility thru the front door. Nurse and DON stopped resident at door. Resident stated that he was going to the head shop to go get a vape. Resident was educated that he cannot leave facility on his own. Resident verbalized understanding. A wander guard was placed on resident to monitor elopement risk.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview and observation on [DATE] at 2:43 PM revealed Resident #25 had several vapes on the bedside table, smoking times posted. Resident #25 said he went outside for smoking times but did not on [DATE] because he hurt too much.</p> <p>Interview and observation on [DATE] at 10:37 AM Resident #25 stated he was not vaping in the building. Resident #25 said he had to take vape from another resident and forgot to turn it into the lady. The vape was in same place as [DATE].</p> <p>Interview on [DATE] at 11:23 AM the DON and Corporate RN stated smoking was assessed on admission and quarterly The Corporate RN said people who vaped were also assessed. The DON said she talked Resident #25 and he had two vapes on the bedside table which she took away. The DON checked Resident #25's electronic record and stated he had not assessments and it did not look like he had a care plan for vaping. She said she did not know why he did not. The DON said it should pop up under the initial care plan for nursing and the MDS nurse was responsible for completing the care plan after that. The DON stated no one has caught him vaping in the building. The DON stated Resident #25 was usually up and about and compliant with the smoking policy.</p> <p>Resident #32</p> <p>Review of Resident #32's admission Record, dated[DATE], revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia and gait abnormalities.</p> <p>Review of Resident #32's Annual MDS Assessment, dated [DATE], revealed</p> <p>She had a mental status score of 5 of 15 (indicating severe cognitive impairment)</p> <p>She was totally dependent on staff for transfers.</p> <p>Review of Resident #32's Care Plan, revised [DATE], revealed:</p> <p>Resident #32 had an ADL Self-care performance deficit related to disease process, dementia. The goal was Resident #32 would maintain her current level of function through the review date. Identified interventions included: Transfer: The resident is dependent on staff for assistance with transferring.</p> <p>Observation on [DATE] at 1:46 PM Resident #32 gave permission to watch the transfer. CNA E put the gait belt on Resident #32. CNA E and CNA D stood on either side of Resident #32, hooked their arms under her arms and grabbed the back of the gait belt. While lifting Resident #32, the gait belt slid up Resident #32's chest, Resident #32 did not straighten her legs so all of her weight was hanging by her arms. The aides put Resident #32 in the low bed and removed the gait belt. At that time CNA D said aides were trained on transfers but she did not know why they put the gait belt on when Resident #32 had pants on but Resident #32 being in a shower chair threw her off. CNA E stated Resident #32 could straighten her legs but frequently did not so the majority of the time Resident #32 was not weight bearing because she would not straighten her legs. CNA E said she was pretty sure the charge nurses were aware of that. CNA D said Resident #32 got skin tears easily. Both aides said they would not do anything differently and had check-offs done pretty frequently and that the DON had checked them off for two-person gait-belt transfer. Neither aide was aware of an increased risk of injury to Resident #32 to hooking their arms under her arms since she was non-weight bearing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 11:08 AM the DOR stated a 2-person transfer from the wheelchair would be 1 person put the gait belt on while the other steadied the resident. The DOR said one person should stand in front of the resident while the other guides from the back. The DOR stated after the wheelchair was locked the resident should be cued, stood and then pivoted to sit. The DOR stated if the gait belt slid up it was not a safe transfer. The DOR said if the resident's feet did not touch ground it was not a safe transfer if the resident's feet were not touching ground there was a potential for falls. The DOR stated the potential outcome for the resident was a fall. The DOR stated the gait belt could cause skin tears, the staff could get injured if someone got off balance. The DOR stated potential injuries to hooking under a resident's arms were shoulder injury from stretching and instability which could cause the resident pain.</p> <p>Interview on [DATE] at 11:16 AM the DON and Regional RN stated a safe 2-person gait belt transfer looked like each staff took a side of the resident, grab back and front of the gait belt, come up at the same time and move the resident from one surface to the other. The DON said staff should not grab under resident's arms. The Corporate RN stated non-weight bearing resident was not a safe two-person transfer. The DON stated staff must not have been checking the Kardex (where the resident's ADL status is kept in the electronic monitoring system). The DON looked up Resident #32's status and read the Kardex documented Resident #32 was dependent on staff for transfer so it had to be updated. The Corporate RN asked about the care plan. The DON said it would be easier for staff and safer for resident to be a lift resident.</p> <p>Interview on [DATE] at 12:00 PM the Administrator and [NAME] President of Regional were informed there was an issue with safe two-person transfers for Resident #32. Neither had questions.</p> <p>RESIDENT #37</p> <p>Record review of Resident #37's admission record dated [DATE] indicated she was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease and muscle weakness. She was [AGE] years of age.</p> <p>Record review of Resident #37's MDS dated [DATE] indicated in part: For cognitive Skills for Daily Decision Making, the resident's was severely impaired. Transfers - (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position) the resident required extensive assistance; resident was involved in the activity, staff provide weight-bearing support, and two+ persons were required for physical assistance.</p> <p>Record review of Resident #37's care plan dated [DATE] indicated in part: Focus: I have an ADL self-care performance deficit r/t disease processes Alzheimer's. Goal: The resident will maintain current level of function through the review date. Interventions: Transfer: The resident requires limited to extensive staff assistance with transferring.</p> <p>During an observation and interview on [DATE] at 12:20 PM in the secure unit, CNA A and CNA B transferred Resident #37 from her wheelchair to her bed. Both CNAs took the resident from underneath her armpits and by the back of her pants. The resident was unable to assist with the transfer and the staff had to manually perform the transfer for her. CNA A said she was not sure what the transfer status was for Resident #37, but that they usually did two person transfers on all the residents on the secure unit. CNA B said she believed the transfer status was listed on their POC (plan of care) tablet they charted on but was not sure.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on [DATE] at 03:06 PM, CNAs A and B were seen wearing gait belts around their waists. The CNAs said the gait belts had recently been brought to them so they could use them to transfer residents. The CNAs were asked about the transfer they had performed on Resident #37. The CNAs acknowledged that they should have used a gait belt for Resident #37 but that at the time they did not have the gait belts. The CNAs said if they transferred the residents from under their arms and the back of their pants it could lead to injuries. CNAs said they documented on their POC tablet and that was where the transfer status was listed.</p> <p>During an observation on [DATE] at 03:10 PM, the CNAs POC tablet indicated for Resident #37 transfer self-performance - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position. Total dependence - full staff performance.</p> <p>During an interview on [DATE] at 09:40 AM, the DOR (Director of Rehab) was made aware of the transfers made by the CNAs. The DOR said it was expected for the staff to use a gait belt for all transfers for safety. The DOR said taking the resident's from under their arms could lead to injuries. The DOR said if the resident's care plan indicated to use a mechanical lift, then staff should have used the lift. The DOR said she would do in-services with staff on safety transfers.</p> <p>During an interview on [DATE] at 10:40 AM, the Administrator was made aware of the transfers performed by the CNAs by taking the residents from their armpits and the back of their pants. The Administrator said transferring the residents like that could lead to injuries. The Administrator said the staff should have used a gait belt or the mechanical lift to transfer the residents. The Administrator said they would conduct training and in-services regarding the use of gait belts and the mechanical lift. The Administrator said she believed the DON conducted monitoring rounds of the facility and observed how staff performed tasks.</p> <p>During an interview on [DATE] at 10:45 AM, the DON said the staff was expected to use a gait belt for transferring residents. The DON said the staff were not supposed to transfer the residents by taking them from their underarms and clothing. The DON said if the staff transferred the resident from under their arms, that could lead to injuries. The DON said they would be conducting more training and getting together with the DOR to work together and conduct some training with the staff. The DON said they planned on conducting more observations of staff to make sure staff were following the correct steps.</p> <p>Review of the facility's policy and procedure on Smoking, effective [DATE], revealed: It is the policy to accommodate residents who desire to smoke by taking reasonable precautions, providing a safe environment for them, and protecting the non-smoking residents.</p> <p>Procedure: Incendiary devices will be stored by facility staff. Resident will not be allowed to possess any lighters, cigarettes, or other smoking materials. All vaping material will also be secured. Electronic cigarettes will follow the same rules as tobacco.</p> <p>IDT will develop an individualized plan for safe storage, use of smoking materials assistance and required supervision for residents who smoke. This is documented on the Resident Smoking Assessment, the president's Plan of Care, and discussed with the resident and Responsible Party at resident care conference meetings.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's policy titled Safe lifting and movement of residents and dated [DATE] indicated in part: In order to protect the safety and well-being of staff and residents and to promote quality care this facility uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. Manual lifting of residents shall be eliminated when feasible. Nursing staff in conjunction with the rehabilitation staff, shall assess individual residents needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: Resident mobility, Weight-bearing ability. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 1 of 3 residents (Resident #34) reviewed for nutrition.</p> <p>The facility failed to provide care and services to maintain acceptable parameters of nutritional status for Resident #34.</p> <p>This failure could place residents who are dependent on staff for their nutrition and hydration at risk for nutritional deficit, weight loss, skin breakdown, and overall decline in quality of life.</p> <p>The findings included:</p> <p>Review of Resident #34's admission Record, dated 6/25/25, revealed he was admitted to the facility on [DATE] with diagnoses including partial intestinal obstruction, unspecified cause, unspecified dementia, fecal impaction, malnutrition, stroke with paralysis on left side, and need for assistance with personal care.</p> <p>Review of Resident #34's re-admission MDS Assessment, dated 6/20/25, revealed:</p> <p>He had a mental status score of 5 of 15 (indicating severe cognitive impairment).</p> <p>He had range of motion impairment of the upper and lower extremity on one side.</p> <p>He needed supervision for eating.</p> <p>Review of Resident #34's Care Plan, revised 6/24/25, revealed:</p> <p>Resident #34 was on a large portion diet with regular texture, regular consistency diet. All food should be in a divided plate or in bowls to prevent Resident #34 from throwing and breaking dishes. Fortified cereal for breakfast. The goal was Resident #34 would have adequate nutrition and fluid intake throughout the review date and receive 2 cups per meals of juice and water, coffee and milk in the morning, and water and fruit punch at lunch and supper. Interventions included to monitor and document intake and offer snacks within diet.</p> <p>Review of Resident #34's Care Plan, revised 6/20/25, revealed:</p> <p>Resident #34 was at risk for nutritional risk related to recent weight loss, Body Mass Index was 16.8 (underweight is below 18.5). The goal was Resident #34 will consume 75% or more of meal with no associate weight loss through next quarter, is large portion now and receives sandwiches on tray as well for lunch and supper. Interventions include Provide and serve diet as ordered.</p> <p>Review of Resident #34's Care Plan, revised on 11/27/23, revealed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #34 had an ADL self-care performance deficit related to hemiplegia. The goal was Resident #34 was status would be maintained through the review date. The identified intervention for Eating was the resident required staff set-up or clean-up assistance with meals.</p> <p>Review of Resident #34's Care Plan, revised, 12/7/23 revealed:</p> <p>Resident #34 had a psychosocial well-being problem related to being dependent, behavior and ineffective coping. The identified goal was Resident #34 would demonstrate adjustment to nursing home placement by review date. Interventions included encouraging participation from the resident who depended on other to make his own decisions and to provide opportunities for the resident to participate in care.</p> <p>Review of Resident #34's weights revealed on 4/5/25 his weight was 130.6. On 6/5/25 his weight was 127.0. This was a 2.76% difference in two months that is only significant due to Resident #34 already being below the recommended Body Mass Index.</p> <p>Observation and interview beginning on 6/24/25 of the lunch meal at 11:42 a.m., it was noted Resident #34 had his tray. Resident #34 was placed in a geri-chair with his right side against the table (the dominant side that had movement). Resident #34's divided plate was observed in the center of the table when Resident #34 was at the corner of the table. Observation at 11:59 a.m. revealed Resident #34 was eating the salad which he could reach, but he could not reach the divided plate with the meat and potatoes on it. Observation at 12:06 p.m. revealed the DON offered Resident #34 a sandwich but did not notice his plate was out of reach.</p> <p>In an interview on 6/24/25 at 12:08 p.m., Resident #34 said he was hungry, and he did not eat his plate because he could not reach it. Resident asked surveyor for the plate to be moved. Surveyor moved the plate. Observation after the interview revealed Resident #34 could reach his plate, he immediately started eating the mashed potatoes. Observation at 12:16 p.m., the DON sat to assist Resident #34 to eat. At 12:28 p.m. Resident #34 got his sandwich and the DON pulled the table closer to where Resident #34 was so he could put the sandwich down.</p> <p>In an interview on 11:37 a.m., the DON stated she identified weight loss as an issue at the facility when she took over the facility a month prior and she was making plans every four weeks to see if there was improvement. The DON said that was currently her main clinical focus. The DON stated she just finished assessing what she thought was the issue and sent her recommendations to the Medical Director, changed the appetite stimulant used, is offering a different supplement and more double portions at meals. The DON said she struggled with the kitchen.</p> <p>In an interview on 6/26/25 at 11:53 a.m., the Regional RN stated there was no policy that addressed placing food within reach of the resident. The MDS Coordinator who was present stated, it's like going to a restaurant and they put the food on the other side of the table.</p> <p>In an interview on 6/26/25 at 11:57 a.m., the Administrator and VP of Regional Operations was informed of the meal observation of Resident #34 not having his plate for over half and hour and no one noticing. They were informed Resident #34 could eat food independently and was hungry. The two were told Resident #34 experienced weight loss and there was no policy addressing leaving the food out of reach. The VP of Regional Operations stated it was common sense for the aides to leave it within reach.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/26/25 at 12:05 PM, the Administrator stated weight loss did flag with the facility's Quality Assurance committee and was currently the DON's pet project.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, labeling, dispensing, safe and secure storage of medications for 2 of 2 medication carts(200 hall and 300 hall) checked for storage of medications.</p> <p>-</p> <p>The 200 hall medication cart had a bottle of milk of magnesia with dried drippings on the lid of the bottle.</p> <p>-</p> <p>The 300 hall medication cart had an empty bottle of Pro Stat liquid collagen with dried drippings on the side of the bottle</p> <p>-</p> <p>The 300 hall medication cart had two open undated insulin pens for Resident #7 and Resident #14</p> <p>These failures could affect residents that received medications at the facility by placing them at risk of cross contamination and receiving ineffective insulin therapy.</p> <p>Finding included:</p> <p>Resident # 7</p> <p>Review of Resident #7's face sheet dated [DATE] revealed a [AGE] year-old female with an original admission date of [DATE] and a readmission date of [DATE].</p> <p>Review of Resident #7's history and physical dated [DATE] revealed Type 2 diabetes mellitus with hyperglycemia.</p> <p>Review of Resident #7's quarterly MDS assessment dated [DATE] revealed a BIMS score of 05, indicating severe cognitive impairment.</p> <p>Review of Resident #7's Care Plan dated [DATE] revealed resident has Diabetes Mellitus and received oral medications and insulin to control blood glucose levels.</p> <p>Record review of Resident #7's physician orders reflected the following order:</p> <p>Tresiba FlexTouch Subcutaneous Solution Pen-injector 200 UNIT/ML (Insulin Degludec) Inject 40 unit subcutaneously in the morning for Diabetes Mellitus.</p> <p>Resident # 14</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #14's admission record dated [DATE] revealed a [AGE] year-old female with an admission date of [DATE].</p> <p>Review of Resident #14's history and physical dated [DATE] revealed Type 2 diabetes mellitus with unspecified complication and diabetic polyneuropathy.</p> <p>Review of Resident #14's admission MDS assessment dated [DATE] revealed a BIMS score of 07, indicating severe cognitive impairment.</p> <p>Review of Resident #14's Care Plan dated [DATE] revealed resident has Diabetes Mellitus and received insulin to control blood glucose levels.</p> <p>Record review of Resident #14's physician orders reflected the following order:</p> <p>Basaglar KwikPen 100 Unit/ml solution pen-injector 200 UNIT/ML (Insulin glargine) Inject 27 units subcutaneously once a day.</p> <p>An observation on [DATE] at 10:38 am revealed LVN G's medication cart had an empty bottle of pro stat liquid collagen with dried drippings running down the side of the bottle.</p> <p>An observation on [DATE] at 10:40 am revealed two opened, undated insulin injection pens for two residents (Residents #7 and Resident#14) in LVN G's medication cart.</p> <p>An observation on 06 25/2025 at 11:17 am revealed a bottle of milk of magnesia with dried drippings around bottle cap in LVN F's medication cart.</p> <p>An interview with the DON on [DATE] at 08:40 AM revealed that all insulin pens were dated upon opening. The DON stated that insulin should have been dated upon opening because insulin expired after 28 days putting residents at risk for receiving expired insulin, which could have led residents to receiving ineffective insulin treatment. The DON stated that medication bottles needed to be wiped down after use to prevent bottles from being stored with dried drippings. The DON stated that it was important for bottles to be stored clean to prevent cross contamination. The DON stated that nurses and med aides were responsible for ensuring bottles were clean when being stored. The DON stated that the last in-service done regarding medication storage was done last Friday.</p> <p>An interview with LVN F on [DATE] at 11:27 pm revealed that insulin pens should be dated as soon as they were opened for first use. LVN F stated the nurses were responsible to make sure that all pens were dated. A negative outcome for the resident would be using an old pen that was out of the range of the 28 days and ineffective insulin therapy. LVN F stated that all medication bottles were supposed to be cleaned prior to storing them back into the medication cart to prevent cross contamination.</p> <p>An interview with LVN G on [DATE] at 2:47 pm revealed that the insulin pens were dated as soon as they were opened. LVN G stated that all nurses were responsible to make sure all dates were printed clearly on the insulin pen. A negative outcome of using an undated pen would be not knowing how long ago it was opened thus leading to medication being less effective. LVN G stated that medication bottles were to be cleaned after use and before being stored in medication cart to prevent cross contamination.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility's policy titled Storage of Medications revised [DATE] revealed, . the nurse shall place a date opened sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening unless the manufacturer recommends another date or regulations/ guidelines require different dating .The nurse will check the expiration date of each medication before administering it, no expired medication will be administered to a resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interviews and record review, the facility failed to maintain a quality assessment and assurance committee consisting at a minimum the required committee members for 3 of 4 quarterly meetings reviewed for QAPI.</p> <p>The facility did not ensure the MD, or a representative attended quarterly QAPI meetings.</p> <p>This failure could place residents at risk for quality deficiencies being unidentified, no appropriate plans of action developed and implemented, and no appropriate guidance developed.</p> <p>Findings included:</p> <p>Interview during the Entrance Conference on 6/24/25 at 9:56 a.m. the Administrator identified the Medical Director. The Administrator stated the QA meetings were held monthly with all department heads, a corporate representative, and a representative from the hospital district that owned the facility. The Administrator stated the Medical Director attended occasionally. When asked to specify what occasionally meant, the Administrator stated the Medical Director only attended the QA meetings one time in the last year. The Administrator said the Medical Director was in the building monthly to see residents and his Nurse Practitioner was in the building two times a month. The Administrator stated the facility constantly remained in communication with them.</p> <p>Review of the Quality Assurance Performance Improvement Attendance Sign-In forms revealed:</p> <p>Quarter 1: 6 (June)/2024: The Medical Director attended.</p> <p>Quarter 2: 7/9/24, 8/13/24 - The Medical Director did not attend</p> <p>Quarter 3: 9/10/24, 10/8/24, 11/12/24 - The Medical Director did not attend.</p> <p>(undated 12/??/24 - staff were the staff that were there in 2024), 1/14/24 (error), 2/11/25 - The Medical Director did not attend.</p> <p>Quarter 4: 3/11/25, 4/8/25, 5/13/25- The Medical Director did not attend.</p> <p>6/1/25 - The Medical Director did not attend.</p> <p>In an interview on 6/26/25 at 10:48 p.m., the Regional RN Consultant stated the facility policy on Medical Director attendance was that every Department Head should participate monthly and the Medical Director should attend quarterly. The RN Consultant stated she was unaware of when the last time the Medical Director attended the QA meeting at the facility. When informed he attended one QA Meeting in the last 12 months, the RN Consultant stated she did not know why the Medical Director only attended one time because he should have at least attended over the phone.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility's policy and procedure on Quality Assurance and Performance Improvement, effective 3/1/17, revealed: This facility shall develop, implement, and maintain an ongoing facility wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care, quality, and resolve identified problems.</p> <p>Authority:</p> <p>The owner and/or governing board (body) of our facility shall be ultimately responsible for the QAPI program.</p> <p>The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #21) of 3 residents reviewed for infection control.</p> <p>CNA B failed to change her gloves and wash her hands after they became contaminated during incontinent care while assisting Resident #21.</p> <p>This failure could place resident's risk for cross contamination and the spread of infection.</p> <p>Finding include:</p> <p>Record review of Resident #21's admission record dated 06/25/2025 indicated he was admitted to the facility on [DATE] with diagnoses of dementia and muscle weakness. He was [AGE] years of age.</p> <p>Record review of Resident #21's MDS dated [DATE] indicated in part: Cognitive Skills for Daily Decision [NAME] = Severely impaired - never/rarely made decisions. Urinary continence = Always incontinent. Bowel continence = Frequently incontinent.</p> <p>Record review of Resident #21's care plan dated 06/03/2025 indicated in part: Focus: The resident has occasional bladder incontinence. Goal: The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: Clean peri-area with each incontinence episode.</p> <p>During an observation on 06/24/25 at 03:16 PM, CNA A and CNA B performed incontinent care for Resident #21. CNAs assisted the resident to his bed, put on some gloves and then removed the residents brief which was wet with urine. CNA B took some wet wipes and wiped the resident's penis, scrotum and rectal area and her gloved hands which were observed to come in contact with the Resident #21's skin. CNA B then fastened the resident's brief, and put a pair of clean pants on the resident while still wearing the same gloves.</p> <p>During an interview on 06/24/25 at 03:24 PM, CNA B said she should have changed her gloves after she had performed the incontinent care and assisted with putting Resident #21's brief and pants on him. CNA B said not changing her gloves could lead to cross contamination which could lead to infections such as urinary tract infections.</p> <p>During an interview on 06/26/25 at 10:36 AM, the Administrator was made aware of the observation of incontinent care performed by CNA B. The Administrator said the CNA not changing her gloves after they had become contaminated could lead to cross contamination, and also could lead to the transmission of illnesses. The Administrator said they would have to conduct more training and in-services on infection control.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/26/25 at 10:50 AM, the DON said staff were expected to change their gloves once they became contaminated. The DON said the staff had to do that to prevent cross contamination. The DON said they would have to conduct more training and in-services on glove changes and handwashing, and also conduct more walk through rounds to monitor staff.</p> <p>Record review of the facility's policy titled Perineal Care dated 10/01/2021 indicated in part: To provide cleanliness and comfort to the resident, to prevent infections and skin irritation and to observe the resident's skin condition. Steps in the Procedure - Place the equipment on the bedside stand. Arrange the supplies so they can be easily reached. Wash and dry your hands thoroughly. Put on gloves. Wash perineal area, wiping from front to back Remove gloves and discard into designated container. Wash and dry your hands thoroughly.</p> <p>Record review of the facility's policy titled Infection Control and dated 01/15/2022 indicated in part: This communities' infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. This communities' infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteers, works and the public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status or payor source. The objective of our infection control policies and practices are to: prevent, detect, investigate and control infections in the community. Maintain a safe, sanitary and comfortable environment for personnel, residents, visitors and the public. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities.</p>		