STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676341	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caprock Nursing & Rehabilitation	900 College Ave Borger, TX 79007

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Resident #1) of 7 residents and 3 anonymous residents reviewed for resident rights.The facility failed to prevent RN A from referring to residents in the secured unit as feeders when referring to residents that need assistance in feeding.This failure could negatively impact the self-esteem, self-worth, and identity of residents who need assistance with eating.Record review of Resident #1's admission record dated 08/06/2025 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Unspecified dementia(memory loss), neuroleptic induced parkinsonism(tremors), and Vitamin D Deficiency.Record review of Resident #1's quarterly MDS completed on 05/8/25 revealed the following:Section B Hearing, Speech, and Vision: Resident #1 did not require a hearing aid and had the ability to understand others with only missing some/part of the message but comprehends most conversation.Section C Cognitive Patterns: Resident #1 had a BIMS of 3 out of 15 which indicated severe impaired cognition.Section K Nutritional Approaches: Resident #1 required a mechanically altered diet.Record review of Resident #1's care plan updated on 05/07/2025 revealed Resident #1 had a mechanically altered diet as well as a nutritional problem or potential nutritional problem with interventions to monitor/document signs and symptoms of dysphagia: pocketing, choking, couching, drooling, holding food in mouth, several attempts at swallowing. The care plan also stated Resident #1 had a communication problem and to be conscious of the resident when in groups, activities, dining room to promote proper communications with others.Record review of Resident #1's active orders reports as 08/06/2025 revealed the following orders:Regular diet, Mechanical soft texture, regular consistency . with a start date of 03/10/2025.During an observation and interview on 08/06/2025 at 9:15 AM, RN A, who was observed standing near the dining area, approximately 4 feet from 3 residents seated in the dining room on the secured unit. RN A stated lunch time can be busy because there are a several feeders in the unit. RN A said that she and 2 CNAs assist the feeders during dining. RN A continued with saying sometimes physical therapy will come back and help with the feeders.During an interview on 08/06/2025 at 9:20 AM, CNA C stated it was not okay to refer to residents who needed assistance with eating as feeders. She stated, it could be a dignity issue. She stated she had been trained at orientation and during in-services not to refer to residents who needed assistance eating as feeders.During an interview on 08/06/2025 at 9:45, the DON stated referring to residents as feeders could be a dignity issue no matter their cognitive level, all residents should be treated with respect and dignity. The DON stated she was responsible for training her staff on resident rights and dignity.During an interview on 08/06/2025 at 9:57, CNA E was asked about assisting residents during dining times and if it was appropriate to refer to residents that needed assistance with feeding, feeders. CNA E started apologizing and stated she was sorry for calling residents feeders. CNA E stated all residents, no matter their cognition, deserve to be treated with respect. CNA E stated the DON was responsible for in servicing staff on resident rights and dignity.During an interview on 08/06/2025 at 10:24 AM, LVN B stated she was not going to lie and said that she has heard staff using the word feeders when describing residents that need assistance during dining. LVN B stated she did not think using the word feeders was a dignity issue. LVN B then stated, I guess it could be a dignity issue.During an interview on 08/06/2025 at 10:40 AM, Corp RN was in the building due to the Administrator being on vacation, (and not available for an interview) stated it was not okay to refer to residents who needed assistance with eating as feeders as it was a dignity issue. Corp RN stated staff had been trained not to refer to residents who needed assistance eating as feeders.During an observation and interview on 08/06/2025 at 11:20 AM, RN A was standing at her computer and Resident #1 was in her wheelchair sitting directly by RN A. RN A stated she had been a nurse for 10 years and she was taught to call residents that needed assistance during dining full feeders and feels it was appropriate to call residents full feeders. RN A stated she did not feel it was a dignity issue.During an interview on 08/06/2025 at 11:25AM, HA D stated she has working at the facility for about 5 months and was trained during orientation that it was inappropriate to call residents that need assistance with dining as feeders HA D stated she worked on the secured unit and in the main unit and stated it did not matter what level of cognition a resident had it was not appropriate to call them feeders as it was a dignity issue.Record review of facility policy titled Resident Rights and dated 11/28/2016 revealed the following: The