

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Caprock Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure freezer, refrigerator, and pantry items were properly stored, labeled, and dated. This failure could place residents at risk of food-borne illnesses. Findings included: Observation of the prep area in the kitchen on 07/14/26 at 9:15 AM revealed the following: 1. (12) bowls of cereal sitting on a tray, all bowls were not covered, open to air, not labeled or dated. Observation of the refrigerator on 07/14/26 at 9:17 AM revealed the following: 1. (1) package containing what appeared to be cheese, open to air, not labeled or dated. 2. (2) individual servings of prune juice, not dated. 3. (1) box containing 12 vanilla shakes, not dated. 4. (1) container of oranges, open to air. 5. (1) box of cucumbers, not dated. 6. (1) bag of lettuce, open to air, not dated. Observation of the freezer on 07/14/26 at 9:22 AM revealed the following: 1. (2) cups of ice cream, not labeled or dated. 2. (1) opened box of ice cream sandwiches with 3 sandwiches remaining, not labeled or dated. 3. (1) bag of meat patties, not labeled or dated. 4. (1) bag of some type of meat, not labeled or dated. 5. (1) bag of bread, date was unreadable, not labeled. 6. (15) boxes stored on the floor. 7. (3) pesto containers, not dated. 8. (1) container of what looked like orange ice cream, not labeled or dated. Observation of the pantry on 07/14/26 at 9:32 AM revealed the following: 1. (15) boxes which contained individual oatmeal pies, not dated. 2. (10) pudding containers, not dated. In an interview on 07/14/26 at 9:39 AM, [NAME] H stated she had worked at the facility for one month and was trained to label and date food when they were delivered from the truck and that it was everyone's responsibility to label and date the food as it came in. [NAME] H stated if that did not happen, it could make residents sick since they would not know when it had arrived or what was in the containers if they were not labeled. In an interview on 07/14/26 at 9:41 AM, [NAME] I stated he had worked at the facility for 5 1/2 years and everyone who worked in the kitchen was responsible for labeling and dating food. He stated that if it did not happen, residents could become sick and possibly die. In an interview on 07/14/26 at 9:42 AM, [NAME] J stated it was everyone's responsibility to label and date food and if it was not happening, the kitchen could serve bad food since they may not know how old the food was, which could make residents sick. In an interview on 07/14/26 at 9:46 AM, the DM stated she had worked at the facility for 10 months as the DM and that it was everyone's responsibility to label and date food after it was opened and as the food was delivered from the truck. She stated not doing that could put residents at risk of foodborne illnesses, food poisoning, or they could become sick. Record review of facility policy, titled Food Storage and Supplies, undated, revealed the following information in part: 1. b. All food and supplies are to be stored six (6) inches above the floor. 3. Dry bulk foods are stored in seamless metal or plastic containers with tight covers or bins. Containers are labeled. 4. Open packages of food are stored in (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	closed containers with covers or in sealed bags and dated as when opened. 7. All food shall be appropriately dated to ensure proper rotation by expiration dates. Record review of facility policy titled, Food Safety, undated, revealed the following in part: 2. Food is to be wrapped or sealed and covered in clean containers. Opened food shall be labeled, dated and stored properly		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 1 (Resident #17) of 22 residents reviewed for infection control. The facility failed to ensure Resident #17's catheter bag and catheter tubing were not on the floor on 07/14/26, 07/15/26, and 07/16/26. This failure could place residents at risk of UTIs and spread of bacteria. Findings included: Record review of Resident #17's admission record dated 07/15/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, obstructive and reflux uropathy (urine cannot drain through the urinary tract), acute kidney failure (sudden episode of kidney failure that happens in hours or days), unspecified dementia (breakdown of thought process) and urinary tract infection (common infection that can affect any part of urinary system). Record review of Resident #17's admission MDS assessment completed on 05/21/26 revealed a BIMS score of 12 which indicated moderate cognitive impairment. Section GG Functional Abilities revealed Resident #17 required partial to moderate assistance with toileting hygiene. Section H Bladder and Bowel revealed Resident #17 had an indwelling catheter. Record review of Resident #17's care plan dated 05/21/26 revealed he was on enhanced barrier precautions to avoid transmission of infection from or to the resident. The care plan noted Resident #17 had a catheter related to obstructive uropathy secondary to cancer and he would remove the privacy bag from his catheter. One of the tasks related to his catheter was Check tubing for kinks and maintain the drainage bag off the floor. Record review of Resident #17's active orders revealed the following orders with corresponding order start dates: 05/14/26 Ensure foley (catheter) bag is in privacy bag while in bed or w/c every shift 05/14/26 Foley Catheter: 16F with 10 bulb - change for occlusion, leaking, closed system was compromised 05/18/26 Flush Catheter twice a day and PRN. During an observation and attempted interview on 07/14/26 at 10:37 AM Resident #17 was lying fully dressed on his back on top of his made bed. His catheter bag and approximately 2 inches of the tubing were lying on the floor next to his bed. The catheter bag was not in a privacy bag. The tubing was emerging from the bottom of his left pant leg. During an observation on 07/14/26 at 11:50 AM Resident #17 was lying in bed on his right side. His catheter bag was on the floor next to his bed and not in a privacy bag. During an observation on 07/14/26 at 12:26 PM Resident #17 was lying in bed on his back. His catheter bag was on the floor next to his bed and not in a privacy bag. During an observation on 07/15/26 at 10:40 AM CNA A exited Resident #17's room as this surveyor entered his room. He was lying on his back in bed. His catheter bag was on the floor next to this bed and not in a privacy bag. During an interview on 07/15/26 at 10:42 AM CNA A stated Resident #17's catheter bag was often on the floor. She stated, "I am always getting onto him about that because we (staff) trip over it. CNA A stated she had asked her supervisors for a way to fasten the bag inside Resident #17's pants but he wears tight pants. She stated staff got a smaller catheter bag and fastened it to Resident #17's leg inside his pants but he did not like it. CNA A stated sometimes Resident #17 walked out of his room with his catheter bag dragging behind him on the floor. During an observation and interview on 07/16/26 at 08:43 AM LVN F exited Resident #17's room as this surveyor entered the room. Resident #17 was seated on the edge of his bed putting his socks on. His catheter bag was on the floor with the tubing wrapped around the front left tire of his w/c and several inches of tubing lying on the floor. During an interview on 07/16/26 at 08:53 AM CNA B stated CNAs were responsible for ensuring a resident's catheter bag (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was not on the floor. She stated she did not know what the facility's policy said about catheters. CNA B stated she was not trained by the facility on catheter care. She stated she was trained when she was getting her certification as a nurse aide. CNA B stated she did not remember why catheter bags were not to be on the floor, only that they were not. She stated she thought it could cause negative health effects for the resident but was unsure what the negative effects would be. She also stated if it was her catheter bag she would not want it on the floor and it might leak. During an interview on 07/16/26 at 09:00 AM CNA C stated CNAs were responsible for emptying and cleaning catheter and nurses were responsible for changing them. She stated she did not know what the facility policy stated about catheters. CNA C stated she was not trained on catheter care by the facility. She stated, I watched YouTube (videos on catheter care) honestly. She stated a catheter bag on the floor could result in infections; somebody stepping on it; it busting or getting pulled out. During an interview on 07/16/26 at 09:07 AM CNA D stated CNAs were responsible to ensure catheter bags were not on the floor. She stated she did not know what the facility policy on catheter care said. She stated she was trained on catheter care when she first started working for the facility in 2021 or when she was certified as a nurse aide but had not been trained since. CNA D stated a catheter bag could rip, it could pull, it could leak, or he (Resident #17) could trip on it. During an interview on 07/16/26 at 09:11 AM CNA E stated CNAs were responsible for ensuring resident catheter bags were not on the floor. She stated she was unfamiliar with the facility catheter care policy. She stated she was not trained by the facility on catheter care. CNA E stated she was trained in CNA school on keeping the catheter bag off the floor. She stated residents could get an infection if their catheter bag was on the floor. During an interview on 07/16/26 at 09:17 AM LVN F stated everyday catheter care was the responsibility of CNAs. She stated the nurse was ultimately responsible for the CNAs actions. She stated the facility catheter care policy directed staff to keep the catheter off the floor, provide a privacy bag, change and empty the catheter bag as needed. She stated she could not remember the last time she was trained on catheter care. She stated having a catheter bag on the floor was an infection control issue. She stated, Indwelling catheters already have a high risk of infection but adding the germs on the floor and it (catheter bag) dragging makes the risk of infection worse. LVN F stated Resident #17's catheter bag was on the floor of his room when she was in his room earlier the morning of 07/16/26 she stated she noticed it needed a new hook and she planned to let his charge nurse know but was distracted by another resident. LVN F stated she tried to prop Resident #17's catheter bag on his bed frame. During an interview on 07/16/26 at 09:36 AM RN G (Resident #17's charge nurse) stated all nursing staff were responsible for ensuring a resident's catheter bag was not on the floor. She stated she was not familiar with the facility policy on catheter care. She stated she was unsure when she was last trained on catheter care. RN G stated having a catheter bag on the floor could result in infections or spread of bacteria if the urine contained bacteria. RN G stated Resident #17 gets up and moves around and his catheter bag will fall on the floor. During an interview on 07/16/26 at 09:43 AM ADON stated all of nursing was responsible for ensuring catheter bags were not on the floor. She stated she did skill checks with all new CNAs at hire and when the facility had UTI outbreaks. She stated she did not know what the facility policy said regarding catheter care. ADON stated she trained staff on catheter care in March and June of 2026. She stated a catheter bag on the floor was an infection control issue. During an interview on 07/16/26 at 09:56 AM DON stated all nursing staff were responsible for ensuring catheter bags were not on the floor. She stated having a catheter bag on the floor could result in infection. During an interview on 07/16/26 at 11:25 AM DON stated the in-services mentioned by ADON did not specifically address keeping a catheter bag off the floor except in the instance of keeping the catheter bag in a privacy bag, which would be keeping it (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	off the floor in principle.Record review of staff in-service dated 06/02/26 and taught by [NAME] revealed the following point: Routine hygiene/care - pericare/cath (catheter) care/. No mention of keeping catheter bags off the floor.Record review of staff in-service dated 06/29/26 and taught by DON revealed the following point: All catheters or drainage bags will be in privacy bag at all times including in bed or out of bed to promote privacy, dignity, and infection control. No mention of keeping catheter bags off the floor.Record review of facility policy titled Catheter Care and dated 02/13/07 revealed the following: . 5.Keep tubing off floor and minimize friction or movement at insertion site. 10. Be sure the catheter tubing and drainage bag are kept off the floor.Record review of an undated facility policy titled Fundamentals of Infection Control Precautions made no mention of urinary catheters except a directive to wash hands after handling urinary catheters.		

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the resident the right to receive written notice, including reason for change, before the resident's room or roommate in the facility is changed for 2 (Resident #5 and Resident #24) of 22 residents reviewed for resident rights.1. The facility failed to provide notice to Resident #5 or her representative before a roommate was moved into her room.2. The facility failed to provide notice to Resident #24 or his representative before he changed rooms. These failures could put residents at risk of being uncomfortable or disoriented in their home. Findings Included: 1. Record review of Resident #5's admission record dated 07/15/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia (decline in cognitive function), paranoid schizophrenia (a mental illness characterized by episodes of psychosis including hallucinations, delusions, and disorganized thinking), psychotic disorder with delusions (severe mental illness including distorted beliefs), and major depressive disorder recurrent severe (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities). Resident #5 was noted to be on the secure unit. Record review of Resident #5's quarterly MDS assessment completed on 06/09/26 revealed a BIMS score of 7 which indicate severely impaired cognition. Section E Behavior revealed Resident #5 had exhibited physical and verbal behavioral symptoms directed toward others as well as other behavioral symptoms not directed toward others. Record review of Resident #5's care plan completed on 06/19/26 revealed she had agitation and anxiety r/t Dementia as well as delirium or an acute confusional episode. During an observation and interview on 07/14/26 at 11:59 AM Resident #5 was seated in her recliner in her room. During an interview on 07/14/26 at 07:00 PM Resident #5's family member stated Resident #5 got a roommate and she (family member) was not told in advance. She stated she visited Resident #5 and asked the CNAs on the hall when Resident #5 got a roommate and she overheard one of the CNAs say to the other, See, I told you they didn't tell [name of Resident #5's family member]. Resident #5's family member stated there was an altercation between Resident #5 and her roommate where the roommate pushed Resident #5 and after that the roommate was moved to another room. She stated Resident #5 did not have a roommate prior to the new roommate being moved into her room approximately 2-3 weeks ago. She stated she did not have a problem with Resident #5 having a roommate but would have liked to have been consulted. 2. Record review of Resident #24's admission record dated 07/15/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia (decline in cognitive function), psychotic disorder with delusions (severe mental illness including distorted beliefs), hallucinations (sensory experiences that appear real but are created by your mind), and major depressive disorder recurrent mild (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities). Resident #24 was noted to reside on the secure unit. Record review of Resident #24's admission MDS assessment completed on 07/08/26 revealed a BIMS score of 3 which indicated severely impaired cognition. Section E Behavior revealed he displayed behavioral symptoms not directed at others including disrobing in public. Resident #24 was noted to reject care and to wander 1-3 days of the 7-day look-back period. Record review of Resident #24's care plan completed on 07/10/26 revealed he had impaired cognitive function/dementia or impaired thought processes. Staff were to discuss concerns about confusion, disease process, (continued on next page)		

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Home placement with the resident/family/caregivers. He was noted to be at risk for wandering and elopement and therefore he was noted to reside on the secure unit. During an observation on 07/14/26 at 10:14 AM Resident #24 was lying in the extra bed in a room that was not his (his name plate was on a room two doors up the hallway) under the blanket with his eyes closed. He did not respond to knocking or his name being called. During an interview on 07/14/26 at 10:14 AM CNA D stated Resident #24 was often in the bed he was in because he did not like his roommate. She stated she had spoken to management about allowing him to move permanently into the room he was currently sleeping in but had not heard anything back. During an observation on 07/14/26 at 11:52 AM Resident #24 was lying in the same extra bed in the room that was not his under a blanket with his eyes closed. He did not respond to knocking or his name being called. During an interview on 07/14/26 at 11:55 AM of CNA D and CNA M, CNA D stated night shift staff told her Resident #24's roommate keeps him up all night and that is why he has begun to sleep in the other room. CNA M stated Resident #24 had moved so many times he was confused about where his room was. CNA D agreed. During an interview on 07/14/26 at 06:48 PM Resident #24's family member stated she was not informed of his room changes. She stated he had been in several rooms. She stated she found out Resident #24 had changed rooms when she went to visit him and he was no longer in the room he had been in. She stated he was currently sleeping in a room that was not his. During an observation on 07/15/26 at 10:37 AM CNA E attempted to assist Resident #24 to lie down in his room. He resisted when she attempted to steer him from the room he had been sleeping in to his actual room and continued to wander the hallway. During an interview on 07/16/26 at 08:53 AM CNA B stated if a resident and/or their representative were not notified prior to a room or roommate change it could negatively impact the resident. She stated certain personalities should not be placed together on the locked unit because they brought out negative behaviors in one another. During an interview on 07/16/26 at 09:00 AM CNA C stated the resident and their family were notified prior to a room change or a roommate change. She stated not notifying the resident and family could lead to conflicts between roommates over temperature control and television volume and could cause the family distress if they came to visit and could not find their loved one. She stated DON or the nurse on duty was responsible for making the necessary notifications. During an interview on 07/16/26 at 09:07 AM CNA D stated she was not certain who made the decision to change a resident's room, but she knew HSK was involved in some way. She stated if a resident changed rooms or received a new roommate the resident, family, and DON were notified. She stated not giving notification could cause the resident to be confused, agitated, or angry. She stated nurses were responsible for making the notification. During an interview on 07/16/26 at 09:11 AM CNA E stated when a resident changed rooms or received a roommate the resident and the family were notified. She stated no notification could lead to arguments or altercations. She stated she was unsure who was responsible for making the notification and unaware of what the facility policy stated regarding room and roommate changes. During an interview on 07/16/26 at 09:17 AM LVN F stated HSK was involved in the physical part of changing a resident's room or roommate. She stated families and residents were notified of room or roommate changes. LVN F stated, Family is one of the first people that know. She stated not giving notification to residents and families could lead to conflict as the facility was located in a small town and the resident families might have grudges against one another. LVN F stated, It (room and roommate change) is kinda something that needs to be discussed first. She stated the charge nurse was responsible for notifying the family and resident. During an interview on 07/16/26 at 09:36 AM RN G stated the facility administrator decided if a resident was to change rooms or receive a new roommate. She stated the administrator, DON, or charge nurse was responsible for notifying family (continued on next page)		

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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 residents had the right to formulate an advance directive for 1 (Resident #43) of 22 residents reviewed for advance directives. The facility failed to ensure Resident #43's DNR was dated by the two witnesses thereby rendering it invalid. This failure could place residents at risk of not having their end-of-life wishes honored. Findings Included: Record review of Resident #43's admission record dated [DATE] revealed an [AGE] year-old female admitted to the facility on [DATE]. She was noted to be a DNR under the advance directive portion of the admission record. Record review of Resident #43's admission MDS assessment completed on [DATE] revealed a BIMS score of 7 which indicated severely impaired cognition. Record review of Resident #43's care plan initiated on [DATE] revealed the following focus area, goal, and interventions/tasks initiated on [DATE]: Resident is a Full Code. Request for CPR to be initiated will be followed. Initiate BLS CPR if the resident is without a heartbeat or not breathing. Notify EMS Notify the charge nurse immediately if the resident is not breathing or does not have a heart beat [sic]. Consult with nursing staff on changes in health. Counsel with resident and family regarding any emotional concern arising from the decision. Record review of Resident #43's OOH-DNR revealed it was signed by the physician and her family member on [DATE]. Two witnesses signed but did not date the OOH-DNR. During an interview on [DATE] at 09:17 AM LVN F stated DON, ADON, MDS LVN, and the floor nurse filling out the DNR were responsible for ensuring it was completely filled out. She stated if a DNR was not completely filled out staff would have to initiate CPR and a resident's end-of-life wishes would not be honored. She stated formulating an advance directive was a resident right and it is not okay not to ensure they were honored. During an interview on [DATE] at 09:36 AM RN G stated DON and MR were responsible for ensuring DNRs were completely/accurately filled out. She stated if the DNR was not completely/accurately filled out staff would have to go against the resident's end-of-life wishes. During an interview on [DATE] at 09:43 AM ADON stated all nursing staff were responsible for ensuring DNRs were accurately/completely filled out. She stated staff should check them during admission and then again during care plan meetings. ADON stated an incomplete DNR would result in staff having to go against resident and family wishes for end-of-life care. During an interview on [DATE] at 09:56 AM DON stated she and MR were responsible for ensuring DNRs were filled out completely. She stated if the DNR was not filled out correctly staff would call EMS and go against resident's end-of-life wishes. During an interview on [DATE] at 10:10 AM MDS LVN stated she has no part in checking advance directives for accuracy. She stated if a DNR was not completely filled out a resident's wishes might not be followed. An interview was attempted with MR on [DATE] at 10:16 AM but was unsuccessful. Record review of an undated facility policy titled Do No Resuscitate Order revealed the following: . Out of Hospital DNR Form . 5. In all cases the form must be signed and dated by two witnesses. Record review of a blank Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Texas Department of State Health Services Instructions for Issuing an OOH-DNR Order revealed the following: . The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.		

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NAME OF PROVIDER OR SUPPLIER Caprock Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 900 College Ave Borger, TX 79007	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an assessment accurately reflected a resident's status for 1 of 22 residents (Resident #11) reviewed for accuracy of MDS assessments. The facility failed to address Residents #11's use of BiPAP therapy in her MDS assessment. This failure to accurately assess a resident could place residents at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services. Findings included: Record review of Resident #11's face sheet revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include Amyotrophic Lateral Sclerosis (ALS) (a progressive and fatal neurodegenerative disorder) and malaise (a general feeling of discomfort, illness, lack of well-being). Record review of Resident #11's MDS and completed 6/02/2026 listed Resident #11 with a BIMS of 12 indicating she was moderately cognitively impaired, she had a functionality of requiring supervision/touch assistance with minor adl care to activity not attempted due to her medical condition with more complicated adl's such as dressing and showering. Resident #11 was not listed for using any non-invasive mechanical ventilator to include BiPAP therapy. Record review of Resident #11's care plan with admission date of 5/22/2026 revealed no care plans to address Resident #11's BiPAP therapy. Record review of Resident #11's Order Summary Report with Active Orders As Of: 7/14/2026 revealed no orders to address BiPAP therapy. Record review of Resident #11's Respiratory Therapy Assessment Note printed 7/15/2026 revealed the following: Initial admission - 5/22/26Effective Date: 5/24/26Treatment Plan:3. CPAP or BiPAP Therapy 3. BIPAP3a. When is the BIPAP or CPAP to be used? -At night.Signed by: ADON 5/24/2026 During an observation and interview on 07/14/2026 at 10:49 AM Resident #11 was in her room lying in her bed. Resident #11 was unable to speak but was able to type her answers on an iPad. A BiPap machine was observed on her bedside dresser. Resident #11 reported via her iPad that she has had BiPAP therapy for a couple of months. Resident #11 shook her head yes when asked if the staff provided good care and care with her equipment to include her BiPAP therapy. During an interview on 07/15/2026 at 2:54 PM the ADON reported Resident #11 had her BiPAP since she was admitted and Resident #11 used the BiPAP therapy every night. During an interview on 07/16/2026 at 8:05 AM SNA K reported Resident #11 did wear BiPAP (her breathing machine) at night but did not use it during the day. SNA K reported the breathing machine should be addressed in the resident's chart and she (SNA K) would have no idea what kind of problem would occur if the breathing machine was not addressed in the residents' chart. During an interview and observation on 07/16/2026 at 8:08 AM LVN L reported she had not seen Resident #11 wearing BiPAP but was aware Resident #11 had been using BiPAP at night. LVN L did not know for how long. LVN L entered Resident #11's room and verified the BiPAP machine was in the room and Resident #11 again shook her head yes that she was using the BiPAP therapy. LVN L reported she was not aware of MDS requirements and therefore would not know if the therapy was included in the MDS. LVN L reported if a Resident did not have BiPAP therapy included or addressed in their chart then staff would not be aware of what the resident was receiving, and the resident might not receive their therapy. During an interview on 07/16/2026 at 8:56 AM the ADON reported she was aware Resident #11 did not have BiPAP therapy addressed on her last MDS assessment. The ADON reported Resident #11's BiPAP therapy should be addressed in her chart. The ADON reported if the BiPAP was not addressed in the chart then that was not accurate documentation and was a safety issue for the residents and could result in her not getting the right thing, the right treatment. During an interview on 07/16/2026 at 8:59 AM the MDS/LVN reported if a resident's BiPAP (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy was not addressed on the MAR (which was generated from the residents' orders) then she (MDS/LVN) would not know to include that therapy on the resident's MDS assessment. The MDS/LVN checked Resident #11's MDS and reported her BiPAP therapy was not included in the MDS assessment. The MDS/LVN reported if the resident had no orders for the BiPAP therapy then most likely the therapy would not be included in the MDS assessment or the care plans and the nursing staff would not know what to give the resident. The residents may not get what they need. The MDS/LVN reported an inaccurate MDS assessment could affect the facility's reimbursement. During an interview on 07/16/2026 at 10:42 AM the DON reported she was aware of Resident #11 not having her BiPAP therapy addressed in her chart, that the BiPAP therapy was missed due to some confusion with the resident privately paying for the therapy, and she corrected the issue yesterday (7/15/2026) with new orders and adding the therapy to Resident #11's care plans. The DON reported if a resident needs assistance with the required therapy and it was not addressed in the resident's records then staff would not be aware of the resident's needs. The DON reported she was not aware of a policy the facility had for the inclusion of BiPAP therapy in a resident's chart, but she would look. During an interview on 07/16/2026 at 10:51 AM the MDS/LVN reported the facility followed the RAI manual for completion of the MDS assessment. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, October 2025, revealed the following: O0110: Special Treatments, Procedures, and Programs (cont.)O0110G1, Non-invasive Mechanical VentilatorCode any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support their own spontaneous respiration by providing enough pressure when the individual inhales to keep their airways open, unlike ventilators that breathe for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes their own BiPAP/CPAP mask/device.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 (Resident #11, and Resident #43) of 22 residents reviewed for comprehensive care plans. 1. The facility failed to address Residents #11's use of BiPAP therapy in her care plans. 2. The facility failed to ensure Resident #43's care plan reflected her DNR status rather than full code. These failures could place residents at risk of receiving inaccurate/incomplete care. Findings Included: Record review of Resident #11's face sheet revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include Amyotrophic Lateral Sclerosis (ALS) (a progressive and fatal neurodegenerative disorder) and malaise (a general feeling of discomfort, illness, lack of well-being). Record review of Resident #11's MDS and completed [DATE] listed Resident #11 with a BIMS of 12 indicating she was moderately cognitively impaired, she had a functionality of requiring supervision/touch assistance with minor adl care to activity not attempted due to her medical condition with more complicated adl's such as dressing and showering. Resident #11 was not listed for using any non-invasive mechanical ventilator to include BiPAP therapy. Record review of Resident #11's care plan with admission date of [DATE] revealed no care plans to address Resident #11's BiPAP therapy. Record review of Resident #11's Order Summary Report with Active Orders As Of: [DATE] revealed no orders to address BiPAP therapy. Record review of Resident #11's Respiratory Therapy Assessment Note printed [DATE] revealed the following: Initial admission - [DATE] Effective Date: [DATE] Treatment Plan: 3. CPAP or BiPAP Therapy 3. BiPAP3a. When is the BiPAP or CPAP to be used? -At night. Signed by: ADON [DATE] During an observation and interview on [DATE] at 10:49 AM Resident #11 was in her room lying in her bed. Resident #11 was unable to speak but was able to type her answers on an iPad. A BiPap machine was observed on her bedside dresser. Resident #11 reported via her iPad that she has had BiPAP therapy for a couple of months. Resident #11 shook her head yes when asked if the staff provided good care and care with her equipment to include her BiPAP therapy. During an interview on [DATE] at 2:54 PM the ADON reported Resident #11 had her BiPAP since she was admitted and Resident #11 used the BiPAP therapy every night. During an interview on [DATE] at 8:05 AM SNA K reported Resident #11 did wear BiPAP (her breathing machine) at night but did not use it during the day. SNA K reported the breathing machine should be addressed in the resident's chart and she (SNA K) would have no idea what kind of problem would occur if the breathing machine was not addressed in the residents' chart. During an interview and observation on [DATE] at 8:08 AM LVN L reported she had not seen Resident #11 wearing BiPAP but was aware Resident #11 had been using BiPAP at night. LVN L did not know for how long. LVN L entered Resident #11's room and verified the BiPAP machine was in the room and Resident #11 again shook her head yes that she was using the BiPAP therapy. LVN L reported that a resident should have care plans to address BiPAP therapy. LVN L reviewed Resident #11's chart and reported Resident #11 did have care plans for BiPAP therapy and the care plans had been entered into Resident #11 chart on [DATE]. LVN L reported if a Resident did not have BiPAP therapy included or addressed in their chart then staff would not be aware of what the resident was receiving, and the resident might not receive their therapy. During an interview on [DATE] at 8:56 AM the ADON reported she was aware Resident #11 did not have care plans to (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	address the use of her BiPAP therapy. The ADON reported Resident #11's BiPAP therapy should be addressed in her chart. The ADON reported if the BiPAP was not addressed in the chart then that was not accurate documentation and was a safety issue for the residents and could result in her not getting the right thing, the right treatment. During an interview on [DATE] at 8:59 AM the MDS/LVN reported if a resident's BiPAP therapy was not addressed on the MAR (which was generated from the residents' orders) then she (MDS/LVN) would not know to include that therapy on the resident's MDS assessment. The MDS/LVN checked Resident #11's MDS and reported her BiPAP therapy was not included in the MDS assessment. The MDS/LVN reported if the resident had no orders for the BiPAP therapy then most likely the therapy would not be included in the MDS assessment or the care plans and the nursing staff would not know what to give the resident. The residents may not get what they need. The MDS/LVN reported an inaccurate MDS assessment could affect the facility's reimbursement. During an interview on [DATE] at 10:42 AM the DON reported she was aware of Resident #11 not having her BiPAP therapy addressed in her chart, that the BiPAP therapy was missed due to some confusion with the resident privately paying for the therapy, and she corrected the issue yesterday ([DATE]) with new orders and adding the therapy to Resident #11's care plans. The DON reported if a resident needs assistance with the required therapy and it was not addressed in the resident's records then staff would not be aware of the resident's needs. The DON reported she was not aware of a policy the facility had for the inclusion of BiPAP therapy in a resident's chart, but she would look. Review of facility provided policy titled Comprehensive Care Planning undated, revealed the following: Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preference and goals, and address the resident's medical, physical, mental, and psychosocial needs. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services. Record review of Resident #43's admission record dated [DATE] revealed an [AGE] year-old female admitted to the facility on [DATE]. She was noted to be DNR under the advance directive portion of the admission record. Record review of Resident #43's admission MDS assessment completed on [DATE] revealed a BIMS score of 7 which indicated severely impaired cognition. Record review of Resident #43's care plan initiated on [DATE] revealed the following focus area, goal, and interventions/tasks initiated on [DATE]: Resident is a Full Code. Request for CPR to be initiated will be followed. Initiate BLS CPR if the resident is without a heartbeat or not breathing. Notify EMS Notify the charge nurse immediately if the resident is not breathing or does not have a heart beat [sic]. Consult with nursing staff on changes in health. Counsel with resident and family regarding any emotional concern arising from the decision. Record review of Resident #43's OOH-DNR revealed it was signed by the physician on [DATE]. During an interview on [DATE] at 09:17 AM LVN F stated everyone who touched a resident's chart was responsible to ensure the EHR was accurate as far as code status. She stated if the EHR was not accurate regarding code status a resident's wishes would not be honored. During an interview on [DATE] at 09:36 AM RN G stated if a resident's EHR was inaccurate as far as code status their wishes might not be honored. During an interview on [DATE] at 09:43 AM ADON stated ensuring a resident's EHR was accurate was a team effort. She stated if a resident's chart was inconsistent regarding code status their end-of-life wishes might not be honored. During an interview on [DATE] at 09:56 AM DON stated she, ADON, and MDS LVN were responsible for ensuring advance directives were accurate throughout a resident's EHR. She stated if these inaccuracies were not addressed there could be a miscommunication in providing care for the residents. During an interview on [DATE] at 10:10 AM MDS LVN stated she has no part in checking advance directives for accuracy. She stated she is a (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	second set of eyes when it came to ensuring EHR accuracy. She stated in the case of code status a resident's wishes might not be followed if the EHR was inaccurate. Record review of and undated facility policy titled Documentation revealed the following: . Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It has legal requirements regarding accuracy and completeness. Special forms in the clinical record are utilized in nursing documentation such as . care plan . 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. Record review of an undated facility policy titled Do No Resuscitate Order revealed the following: . Out of Hospital DNR Form . 5. In all cases the form must be signed and dated by two witnesses. 9. the facility will scan a copy into the documents tab of PCC. Based on the completed OOH DNR form, facility staff will enter a physician order for DNR into PCC that will be displayed in the following modules of PCC, the resident chart, EMAR, and POC. These modules will communicate to staff the resident's code status.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided with such care consistent with professional standards of practice for 1 (Resident #11) of 22 residents reviewed for respiratory care. The facility failed to address Residents #11's use of BiPAP therapy in her physician orders. This failure could place resident at risk for complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition. Findings included: Record review of Resident #11's face sheet revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include Amyotrophic Lateral Sclerosis (ALS) (a progressive and fatal neurodegenerative disorder) and malaise (a general feeling of discomfort, illness, lack of well-being). Record review of Resident #11's MDS and completed 6/02/2026 listed Resident #11 with a BIMS of 12 indicating she was moderately cognitively impaired, she had a functionality of requiring supervision/touch assistance with minor adl care to activity not attempted due to her medical condition with more complicated adl's such as dressing and showering. Resident #11 was not listed for using any non-invasive mechanical ventilator to include BiPAP therapy. Record review of Resident #11's care plan with admission date of 5/22/2026 revealed no care plans to address Resident #11's BiPAP therapy. Record review of Resident #11's Order Summary Report with Active Orders As Of: 7/14/2026 revealed no orders to address BiPAP therapy. Record review of Resident #11's Respiratory Therapy Assessment Note printed 7/15/2026 revealed the following: Initial admission - 5/22/26 Effective Date: 5/24/26 Treatment Plan: 3. CPAP or BIPAP Therapy 3. BIPAP3a. When is the BIPAP or CPAP to be used? -At night. Signed by: ADON 5/24/2026 During an observation and interview on 07/14/2026 at 10:49 AM Resident #11 was in her room lying in her bed. Resident #11 was unable to speak but was able to type her answers on an iPad. A BiPap machine was observed on her bedside dresser. Resident #11 reported via her iPad that she has had BiPAP therapy for a couple of months. Resident #11 shook her head yes when asked if the staff provided good care and care with her equipment to include her BiPAP therapy. During an interview on 07/15/2026 at 2:54 PM the ADON reported Resident #11 had her BiPAP since she was admitted and Resident #11 used the BiPAP therapy every night. During an interview on 07/16/2026 at 8:05 AM SNA K reported Resident #11 did wear BiPAP (her breathing machine) at night but did not use it during the day. SNA K reported the breathing machine should be addressed in the resident's chart and she (SNA K) would have no idea what kind of problem would occur if the breathing machine was not addressed in the residents' chart. During an interview and observation on 07/16/2026 at 8:08 AM LVN L reported she had not seen Resident #11 wearing BiPAP but was aware Resident #11 had been using BiPAP at night. LVN L did not know for how long. LVN L entered Resident #11's room and verified the BiPAP machine was in the room and Resident #11 again shook her head yes that she was using the BiPAP therapy. LVN L reported that a resident should have orders to address BiPAP therapy. LVN L reviewed Resident #11's chart and reported Resident #11 did have orders for her BiPAP therapy that had been entered into Resident #11 chart on 7/15/2026. LVN L reported if a Resident did not have BiPAP therapy included or addressed in their chart then staff would not be aware of what the resident was receiving, and the resident might not receive their therapy. During an interview on 07/16/2026 at 8:56 AM the ADON reported she was aware Resident #11 did not have orders to address the use of her BiPAP therapy. The ADON reported Resident #11's BiPAP therapy should be addressed in her chart. The ADON reported if the BiPAP was not addressed in the chart then that was not accurate documentation and was a safety issue for the (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents and could result in her not getting the right thing, the right treatment. During an interview on 07/16/2026 at 8:59 AM the MDS/LVN reported if a resident's BiPAP therapy was not addressed on the MAR (which was generated from the residents' orders) then she (MDS/LVN) would not know to include that therapy on the resident's MDS assessment. The MDS/LVN checked Resident #11's MDS and reported her BiPAP therapy was not included in the MDS assessment. The MDS/LVN reported if the resident had no orders for the BiPAP therapy then most likely the therapy would not be included in the MDS assessment or the care plans and the nursing staff would not know what to give the resident. The residents may not get what they need. The MDS/LVN reported an inaccurate MDS assessment could affect the facility's reimbursement. During an interview on 07/16/2026 at 10:42 AM the DON reported she was aware of Resident #11 not having her BiPAP therapy addressed in her chart, that the BiPAP therapy was missed due to some confusion with the resident privately paying for the therapy, and she corrected the issue yesterday (7/15/2026) with new orders and adding the therapy to Resident #11's care plans. The DON reported if a resident needs assistance with the required therapy and it was not addressed in the resident's records then staff would not be aware of the resident's needs. The DON reported she was not aware of a policy the facility had for the inclusion of BiPAP therapy in a resident's chart, but she would look. During an interview on 07/16/2026 at 1:48 PM the DON reported the facility did not have a policy pertaining to accuracy of physician orders and what needed to be included.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that menus were followed, for 3 out of 3 residents that received therapeutic pureed diets (Residents #2, #9, #31), in that: The facility failed to ensure all three residents that received pureed diets received fried chicken on 07/14/2026 which was the posted lunch menu item and instead they were served pureed chicken strips. This failure had the potential to place residents at risk for inadequate nutritional consistency with the planned menu, decreased meal satisfaction, diminished dignity related to receiving a different meal than other residents and failure to receive meals prepared in accordance with the planned menu. Findings included: Resident #2 Record review of Resident #2's Face sheet, dated 07/15/26, reflected at [AGE] year-old female admitted to the facility on [DATE] and with the diagnoses that include but not limited to acute and chronic respiratory failure (failure of lungs to provide oxygen), mild protein-calorie malnutrition (inadequate intake of food and other essential nutrients), mild intellectual disabilities (limitations in adaptive behavior and skills), unspecified dementia (breakdown of thought process), and gastro-esophageal reflux disease (risk of stomach acid going back and forth between the mouth and stomach). Record review of Resident #2's Quarterly MDS Assessment, dated 06/24/26, indicated a BIMS score of 03 out of 15, reflecting severe impaired cognition. The assessment reflected Resident #2 had a mechanically altered diet (pureed food). Record review of Resident #2's Comprehensive Care Plan, last revised on 07/10/26 reflected Resident #2 had a puree diet texture, with nectar consistency and interventions that included monitoring meal intake and providing supplements when intake was less than 50 percent or meals were refused. Record review of Resident #2's Active Physicians Orders dated 07/15/26 reflected Resident #2 remained on a pureed textured diet. Resident #9 Record review of Resident #9's Face sheet, dated 07/15/26, reflected a [AGE] year-old female originally admitted to the facility on [DATE] with the diagnoses that include but not limited dementia (loss of cognitive function), unspecified protein-calorie malnutrition (inadequate intake of food and other essential nutrients), and dehydration (lack of water in body). Record review of Resident #9's Quarterly MDS Assessment, dated 06/09/26, indicated a BIMS score of 99 indicating resident was unable to complete the cognitive interview. The assessment reflected Resident #9 was ordered a mechanically altered (pureed) diet. Record review of Resident #9's Comprehensive Care Plan, last revised on 06/19/26 reflected Resident #9 had a mechanical soft diet with interventions to provide meals as ordered by physician. Record review of Resident #9's Active Physicians Orders dated 07/15/26 reflected Resident #9 received a pureed textured diet. Resident #31 Record review of Resident #31's Face sheet, dated 07/15/26, reflected a [AGE] year-old male originally admitted to the facility on [DATE] with the diagnoses that include but not limited Chronic kidney disease (moderate to severe damage to kidneys), dementia (cognitive loss), and gastro-esophageal reflux disease (risk of stomach acid going back and forth between the mouth and stomach). Record review of Resident #31's admission MDS Assessment, dated 06/08/26, indicated a BIMS score of 11 out of 15 indicating moderately impaired cognition. The assessment reflected Resident #31 had a mechanically altered (pureed) diet. Record review of Resident #31's Comprehensive Care Plan, last revised on 06/19/26 reflected Resident #31 had a mechanical soft diet with interventions to provide meals as ordered. Record review of Resident #31's Active Physicians Orders dated 07/15/26 reflected Resident #31 was ordered a pureed diet. During an observation on 07/14/26 at 11:15 AM the posted weekly menu in the main dining room reflected the lunch entree for that day was fried chicken. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Caprock Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation in the kitchen on 07/14/26 at 11:18 AM, revealed fried chicken was being removed from the fryer for the noon meal. During an observation and interview on 07/14/26 at 11:19 AM, [NAME] H was observed placing chicken strips into a mixer to prepare the pureed meals. [NAME] H stated 3 residents received pureed diets and explained she chose chicken strips because she did not want to debone the fried chicken. During an interview on 07/14/26 at 11:21 AM, the DM stated that the night shift failed to thaw the boneless chicken intended for the pureed meals; therefore, chicken strips were used instead. During an observation on 07/14/26 at 12:08 PM in the main dining room, Resident #9 was observed to be assisted by a speech therapist with her pureed meal consisting of chicken strips, mashed potatoes, green beans, and bread. During an observation and interview on 07/14/26 at 12:47 PM, RN G sampled both the regular and pureed test trays with the survey team. RN G stated the pureed chicken tasted different from the fried chicken served on the regular menu, had a different flavor and was saltier. During an interview on 07/15/26 at 1:23 PM, Resident #31 stated he required a pureed diet due to an esophageal condition where he was unable to eat anything sharp. He stated he observed other residents eating fried chicken while his meal did not taste like fried chicken. Resident #31 stated it bothered him that he did not receive the same meal as the other residents. During an interview on 07/15/26 at 3:05 PM, the DM stated the planned menu for both the pureed and regular diets on 07/14/26 for lunch was fried chicken. She stated the original plan was to prepare the boneless chicken by boiling or baking them; however, because the boneless chicken had not been thawed, chicken strips were substituted. The DM stated chicken strips were not nutritionally equivalent to the planned fried chicken and acknowledged she had been educated that menus should remain consistent across diet textures otherwise residents could feel a loss of dignity. The DM further stated that she was responsible for ensuring menus were followed. During an interview on 07/16/26 at 10:02 AM, the DM brought menus and recipes to conference room for the 07/14/26 lunch menu of fried chicken. She stated the recipe allowed breaded chicken as a substitution for fried chicken and clarified the substitution applied to the menu for all residents, not solely those receiving pureed diets. During an interview on 07/16/26 at 10:15 AM, [NAME] H stated she served fried chicken to regular diets and prepared chicken strips for residents receiving pureed diets because deboning fried chicken with the crust was difficult. She stated she believed it was inappropriate for residents who received pureed diet to receive a different menu item than the meal served to other residents and acknowledged the recipe substitution should have been implemented for all residents rather than only those receiving pureed diets. [NAME] H stated that if residents on pureed diets got different menu items from everyone else it could possibly make them feel bad or that they were wronged. During a telephone interview on 07/16/26 at 1:48 PM, the Corporate RD stated staff were expected to follow the written menus and she was not aware substitutions were being made for pureed meals from fried chicken to chicken strips on 07/14/26 until after it happened. The Corporate RD stated a potential negative outcome of not doing so included resident dissatisfaction and residents becoming upset when they did not receive the same menu item as other residents. Record review of Facility Provided Recipe, titled Recipes to Scale dated Tuesday, 07/14/26 -Lunch Fried Chicken 3 oz. reflected under Step 5 that other cuts of chicken or breaded chicken could be substituted. Record review of Facility Provided Menu, titled Weekly Menu for Week 2 - Diet: Regular/Puree, dated 07/14/26 identified fried chicken as the lunch entree. Record review of facility policy titled Consistency Modification dated 2012 reflected the following in part:Policy statement: We will adequately meet nutritional needs of the resident and provide food in a consistency that the resident can tolerate .Guidelines for pureed diets:3. Foods are blended following the regular diet for the day. Record review of facility policy titled Resident Menus, dated 2012 reflected the following in (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	part.Policy Statement: The standard menu will ensure nutritional adequacy of all diets. 3. Alternates for noon and evening meal will be planned and recorded. 4. If any meal served varies from the planned menu, the change and reason for the change shall be noted on the substitution log.5. The menus will be prepared as written using standardized recipes. The Dietary Service Manager and cooks are trained and responsible for the preparation and service of therapeutic diets as prescribed.		

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NAME OF PROVIDER OR SUPPLIER Caprock Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 900 College Ave Borger, TX 79007	
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, in accordance with professional standards and practices, maintain medical records on each resident that are accurately documented for 1 (Resident #9) of 22 residents reviewed for accuracy of medical records. The facility failed to ensure Resident #9's EHR did not contain active orders and care plan interventions for her to reside on the locked unit when she was residing on a different hall. This failure could place residents at risk of not receiving necessary and accurate care/treatment due to inaccurate medical records. Findings Included: 1. Record review of Resident #9's admission record dated 07/15/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia severe with psychotic disturbance (a neurological condition marked by profound cognitive decline and psychotic symptoms requiring comprehensive medical management). Record review of Resident #9's quarterly MDS assessment completed on 06/16/26 revealed she had severely impaired cognition based on a staff assessment. Section E Behavior revealed Resident #9 did not exhibit wandering behavior. Record review of Resident #9's care plan completed on 06/19/26 revealed she was at risk for wandering and would reside in the secure unit. The focus area and the interventions including secure unit were initiated on 12/12/23. Record review of Resident #9's active orders dated 07/15/26 revealed the following order with corresponding start date: 10/06/25 Admit to secure unit d/t hx of elopement with active exit seeking behavior. During an observation on 07/14/26 at 10:26 AM Resident #9 was observed sleeping in her bedroom on 300 hall, which is not the secure hall. During an interview on 07/14/26 at 06:27 PM Resident #9's emergency contact stated Resident #9 used to reside on the locked hall. She stated Resident #9 was no longer as mobile or exit seeking as she had been previously and was now residing on a regular hall. During an interview on 07/16/26 at 09:17 AM LVN F stated everyone who touched a resident's chart was responsible to ensure the EHR was accurate as far as active orders. She stated she thought MDS LVN was ultimately responsible for the EHR's accuracy. She stated if the EHR was not accurate regarding orders the resident might be placed incorrectly within the facility. During an interview on 07/16/26 at 09:36 AM RN G stated if a resident's EHR contained orders for placement on the locked unit and the resident was not on the locked unit the resident might be at risk of elopement. During an interview on 07/16/26 at 09:43 AM ADON stated ensuring a resident's EHR was accurate was a team effort. She stated if a resident had active orders for the locked unit but did not reside on the locked unit it would be improper documentation and inaccurate charting. During an interview on 07/16/26 at 09:56 AM DON stated she was responsible for ensuring resident's active orders accurately reflected their status. She stated she should have removed the order for Resident #9 to reside on the locked unit. She stated if this EHR inaccuracy was not addressed there could be a miscommunication in providing care for the resident. During an interview on 07/16/26 at 10:10 AM MDS LVN stated she was a second set of eyes when it came to ensuring EHR accuracy. She stated there was not really a negative impact if a resident had active orders for the locked unit and resided on a regular hall. Record review of and undated facility policy titled Documentation revealed the following: . Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It has legal requirements regarding accuracy and completeness. Special forms in the clinical record are utilized in nursing documentation such as . care plan . 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.		