

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Big Spring Center for Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3701 Wasson Rd Big Spring, TX 79720	

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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344</p> <p>Based on interview and record review the facility failed to ensure prompt efforts by the facility were made to resolve grievances for the residents for 1 of 6 residents (Resident #1) reviewed for grievances.</p> <p>A. The Social Worker failed to ensure a grievance was filled out and followed up on after Resident #1 requested a room change and reported that she felt uncomfortable because of staff working in the facility.</p> <p>This failure could place residents at risk for decreased quality of life and feelings of neglect.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's face sheet, dated 10/11/24, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include cognitive communication deficit, muscle weakness and urinary incontinence.</p> <p>Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed:</p> <p>*Section B0800. Ability to understand others, Resident #1 had clear speech, could make herself understood and usually understood others.</p> <p>*Section C Brief Interview for Mental Status score revealed a score of 12, which indicated the resident's cognition was moderately impaired.</p> <p>Record review of Resident #1's care plan, dated 08/26/24, did not reveal any indication that Resident #1 had any known behaviors, had frequent room change request or anything concerning her cognition.</p> <p>Record review of Resident #1's progress notes for the time period 08/10/24-10/11/24 did not reveal any information regarding Resident #1 reporting the allegation of abuse or filing a grievance regarding staff treatment.</p> <p>Record review of Resident #1's room form, dated 10/02/24, indicated Resident #1 initiated a room change; however, a reason was not revealed.</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
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility grievance report, dated from August 2024- October 2024 did not reveal a grievance regarding Resident #1 concern for CNA A.</p> <p>During an interview on 10/11/24 at 9:53 AM, Resident #1 stated that she was in a different hall but requested to be moved to a different hall because the staff in her previous hall was mean to her. She said she could not remember the exact date, but it was a weekend. She said CNA A was the primary staff member who was mean to her. She said she told staff she felt uncomfortable with CNA A but cannot remember who she told. She said no one was mean to her but CNA A was the only person that was. She said she felt dirty because when her adult brief needed to be changed, CNA A told her she would not change her. She said that she had not had any contact with CNA A on her new hall and now felt safe, but when she was in her previous hall, she did not feel safe. She stated no one approached her and asked why she moved.</p> <p>During an interview on 10/11/24 at 1:17 PM, the Social Worker stated that Resident #1 had requested to be moved but that she could not remember the exact date. She stated that she did not remember specifically what Resident #1 said but that she had an issue with a CNA. She stated Resident #1 did not name any specific staff but was uncomfortable with the staff on her hall. She stated she did not file a grievance on the resident's behalf. She stated Resident #1 did not appear upset when she requested to move. She stated Resident #1 had issues in the past with other residents. She stated that she may have documentation to support that Resident #1 had a history of having problems with roommates (Documentation was never provided). She stated that she did not take any further action to investigate why Resident #1 wanted to move. She stated that she had been trained and was familiar with the facility's grievance policy and process. She stated that not addressing grievances according to policy could potentially harm residents or cause their rights not to be upheld. The Social Worker stated she was aware that Resident #1 wanted to move but did not know why. She stated that she had not taken any further actions outside of initiating the room change. She said the facility's system was to follow the grievance policy, and the concern would have been assigned to the appropriate department head. She stated if the policy had been followed, Resident #1's concern would have been assigned to the DON. She stated she had not seen any abnormal activity between staff and Resident #1. She stated that if any resident expressed concern, they should look into the situation thoroughly and get back to the resident who expressed concern. She stated she did follow up with Resident #1 to see if she liked her new placement and was told by Resident #1 that she did like her new placement. She stated she and the ADM was responsible for grievances. She stated she did not follow the grievance policy because Resident #1 did not visibly seem upset.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/11/24 at 1:45 PM, the DON stated that Resident #1 room change was made at her request. She said it was her understanding that Resident #1 told the Social Worker that she wanted to move but did not report a reason why. The DON stated she did not follow up with the Social Worker or Resident #1 to see why Resident #1 wanted to move rooms. She stated that it was the resident's right/choice if she wanted to move rooms. The DON stated she was familiar with and had been trained on the facility policy regarding grievances. She stated that the potential negative outcome of not following the grievance policy could affect customer service and keep residents safe. She stated grievances were how residents express their concerns, and not following the policy compromises their ability to express their concerns. She stated she was unaware that a grievance had not been completed on behalf of Resident #1. She stated that the person who received the complaint should have completed a grievance and then provided it to the Social Worker. The Social Worker would then initiate the process in the EMR system. She stated that the abuse prevention ADM would then review all grievances. She stated that the appropriate department head would receive and address the grievance accordingly. She stated that everyone was responsible for grievances and did not have a reason for the Social worker not following the process.</p> <p>During an interview on 10/11/24 at 2:06 PM, the ADM stated she does not recall that room move for Resident #1. She stated she did not have a reason why the policy was not followed. She stated that even if she was not physically in the facility as the administrator, she was responsible for all activity that occurred in the facility. She stated that because she was not made aware of Resident #1 being upset or alleging that staff made her uncomfortable, she did not follow the abuse policy or grievance policy, investigate, or report the incident to HHSC. She stated that she was assigned to the facility as of 10/01/24, and the incident occurred prior to her transition to becoming the facility administrator. She stated she was familiar with and had been trained on the facility grievance policy. She stated that the potential negative outcome of not following the facility's grievance policy was that the residents could be unhappy. She stated that after the complaint was reported to the Social Worker, it should have been reported to the ADM and DON so that additional actions could be taken. She stated that all staff were responsible for grievances. She said she was unaware of any reason why the Social Worker did not follow the policy.</p> <p>Record review of the facility policy, Resident Rights, dated 2003 revealed:</p> <p>Policy</p> <p>We believe each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside our facility. We protect and promote the following right of each resident.</p> <p>Each resident is encouraged and assisted, throughout the period of stay, to exercise her rights as a resident and as a citizen, and to this end, may voice grievances .</p> <p>Record review of the facility policy, Grievances, revised 11/2/2016 revealed:</p> <p>The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal .</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Such grievances include those with respect to care and treatment which as been furnished well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay.</p> <p>The grievance official of the facility is the administrator or their designee.</p> <p>The grievance official will: oversee the grievance process, receive and track grievances to their conclusion, lead any necessary investigations by the facility, issue written grievance decisions to the resident and coordinate with state and federal agencies as necessaries.</p> <p>As needed, the facility will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated.</p> <p>All grievances involving alleged violations of neglect, abuse, injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the abuse preventionist.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344</p> <p>Based on Interviews and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse and neglect for 1 of 6 residents (Resident #1) reviewed for abuse.</p> <p>A. The Social Worker failed to follow the facility's abuse policy by not reporting the allegation/concern to the abuse preventionist when Resident #1 requested a room change and reported that she felt uncomfortable because of staff working in the facility.</p> <p>B. A confidential interview revealed that they did not follow the facility's abuse policy by not reporting the allegation/concern to the abuse preventionist when Resident #1 reported that she felt uncomfortable due to staff treatment from CNA A, CNA D, LVN E, and MA F on an unknown date.</p> <p>C. LVN C failed to follow the facility's abuse policy by not reporting the allegation/concern to the abuse preventionist when an unidentified staff reported that Resident #1 felt uncomfortable/dirty because of staff working in the facility.</p> <p>These failures could place residents as risk for abuse and neglect.</p> <p>Findings included:</p> <p>Record review of the facility policy, Resident Rights, dated 2003 revealed:</p> <p>Policy</p> <p>Each resident is free from mental and physical abuse .</p> <p>Record review of the facility policy, Abuse/ Neglect, revised 03/29/18 revealed:</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property . Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers .</p> <p>The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may continue abuse neglect to any resident in the facility.</p> <p>Prevention</p> <p>The facility will provide the residents, families, and staff an environment free from abuse and neglect.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and or Abuse Preventionist within 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator and per policy.</p> <p>The facility will be responsible to identify, correct, intervene in situations of possible abuse/neglect. The facility has in place a method to identify occurrences, patterns, and trends that may constitute abuse. All occurrences of potential abuse or criminal behavior will be investigated by the Abuse Preventionist and or designee.</p> <p>Identification</p> <p>Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation MUST report this to the DON, administrator, state and or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons.</p> <p>When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the abuse preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and or designee will be called.</p> <p>Record review of the facility policy, Grievances, revised 11/2/2016 revealed:</p> <p>As needed, the facility will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated.</p> <p>All grievances involving alleged violations of neglect, abuse, injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the abuse preventionist.</p> <p>1.Record review of Resident #1's face sheet, dated 10/11/24, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include cognitive communication deficit, muscle weakness and urinary incontinence.</p> <p>Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed:</p> <p>*Section B0800. Ability to understand others, Resident #1 had clear speech, could make herself understood and usually understood others.</p> <p>*Section C Brief Interview for Mental Status score revealed a score of 12, which indicated the resident's cognition was moderately impaired.</p> <p>Record review of Resident #1's care plan, dated 08/26/24, did not reveal any indication that Resident #1 had any known behaviors, had frequent room change request or anything concerning her cognition.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's progress notes for the time period 08/10/24-10/11/24 did not reveal any information regarding Resident #1 reporting the allegation of abuse or filing a grievance regarding staff treatment.</p> <p>Record review of Resident #1's room form, dated 10/02/24, indicated Resident #1 initiated a room change; however, a reason was not revealed.</p> <p>Record review of HHSC reporting intake website did not reveal any reports/intakes of abuse involving Resident #1 from September 2024 through 10/11/24.</p> <p>Record review of the facility grievance report, dated from August 2024- October 2024 did not reveal a grievance regarding Resident #1 concern for CNA A.</p> <p>Record review of HHSC reporting intake website did not reveal any reports/intakes of abuse involving Resident #1 from August 2024 through 10/11/24.</p> <p>During an interview on 10/11/24 at 9:53 AM, Resident #1 stated that she was in a different hall but requested to be moved to a different hall because the staff in her previous hall was mean to her. She said she could not remember the exact date, but it was a weekend. She said CNA A was the primary staff member who was mean to her. She said she told staff she felt uncomfortable with CNA A but cannot remember who she told. She said no one was mean to her but CNA A was the only person that was. She said she felt dirty because when her adult brief needed to be changed, CNA A told her she would not change her. She said that she had not had any contact with CNA A on her new hall and now felt safe, but when she was in her previous hall, she did not feel safe. She stated no one approached her and asked why she moved.</p> <p>During an interview on 10/11/24 at 11:43 AM, LVN C stated that she had been trained on ANE. She said if she suspected or witnessed abuse, she had been trained to ensure resident safety and then report it to the ADM. She said Resident #1 was moved from one hall to another because the staff on her original hall made her feel uncomfortable and dirty because she had lice. She stated she did not know the details of Resident #1's complaint, or the staff involved. She stated that she received the information secondhand in report in between shifts. She said she could not remember which staff member had told her the information but that it was the night nurse from a couple of weeks ago. She stated once she received the information, she did not report the information any further. She said she was told that the ADM and the DON already knew about the situation and that rumors were unnecessary.</p> <p>During an interview on 10/11/24 at 12:29 PM, Family Member B stated she was not notified of Resident #1's room change and had not been notified of any allegations of ANE.</p> <p>An unsuccessful attempt to interview CNA A was made on 10/11/24 at 12:40 PM.</p> <p>An unsuccessful attempt to interview LVN E was made on 10/11/24 at 12:43 PM.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/11/24 at 1:17 PM, the Social Worker stated that Resident #1 had requested to be moved but that she did not remember the exact date. She stated that she did not remember specifically what Resident #1 said but that she had an issue with a CNA. She stated Resident #1 did not name any specific staff but was uncomfortable with the staff on her hall. She stated she did not file a grievance on the resident's behalf. She stated Resident #1 did not appear upset when she requested to move. She stated Resident #1 had had issues in the past with other residents. She stated that she may have documentation to support that Resident #1 had a history of having problems with roommates (Documentation was never provided). She stated that she did not take any further action to investigate why Resident #1 wanted to move. The Social Worker stated she was aware that Resident #1 wanted to move but did not know why. She stated that she had not taken any further actions outside of initiating the room change. She stated she had not seen any abnormal activity between staff and Resident #1. She stated that if any resident expressed concern, they should look into the situation thoroughly and get back to the resident who expressed concern. She stated she had been trained on ANE. If she suspects or witnesses abuse, she was instructed to report it to the ADM so that the allegations of ANE could be investigated and reported to HHSC. She could not recall if the room change, and the root cause of Resident #1 ever came up during morning meetings.</p> <p>During an interview on 10/11/24 at 1:45 PM, the DON stated that Resident #1's room change was made at her request. She said it was her understanding that Resident #1 told the Social Worker that she wanted to move but did not report a reason why. The DON stated she did not follow up with the Social Worker or Resident #1 to see why Resident #1 wanted to move rooms. She stated that it was the resident's right/choice if she wanted to move rooms. She stated she was familiar with and had been trained on the facility's abuse policy. She stated she was unaware that there were staff not following the abuse policy. She stated the potential negative outcome of not following the abuse policy was that it could place residents at risk for abuse. She stated that the facility's system to ensure that they were following the policy was to do annual training and frequent training on ANE. She stated that if the staff suspected or witnessed abuse, they should report immediately to the DON and ADM (also the abuse coordinator). She stated that depending on the specific incident, it would have determined how soon the incident needed to be reported to HHSC. She stated that even though it was a suspected rumor, the staff had been trained to report as it was not a place to investigate the instances. She stated that all residents' concerns should start as grievances. It will then go to the ADM as the abuse coordinator to ensure there were no allegations of ANE. She stated that the allegation of abuse would have been identified when the ADM reviewed the grievance. She stated she was not notified that Resident #1 had any issues. She stated she had not observed any abnormal activity between any staff and Resident #1. She stated all staff were responsible for following the facility's abuse policy. She stated that because she was not made aware of Resident #1 being upset or alleging that staff made her uncomfortable, she did not follow the abuse policy or grievance policy, investigate, or report the incident to HHSC. She stated that even if she was not physically in the facility as the DON, she was responsible for all activities that occurred there.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A confidential interview revealed that Resident #1 disclosed to them that CNA A, CNA D, LVN E, and MA F would not provide care for her. They said they did not see it personally because it happened when they were not in the facility. They said that Resident #1 said that her brief was dirty, that Resident #1 had lice, and that the staff Resident #1 named would not care for her. They said resident #1 felt dirty when the staff did not provide care. They said resident #1 cried when she told her about the staff being mean. They said they did not report this to their abuse preventionist because everyone at the facility knew about the situation. They said it was being passed in report and everyone at the facility discussed it. They said they did report the incident to LVN C and were told by her that she would address it. They stated they had been trained that if they suspected or witnessed abuse, they were to report it to the ADM immediately. They did not have the exact incident date but believed it happened on 9/28/24. They stated they had heard CNA A can be rude, but they never reported it because everyone knew, and nothing was ever done about it because CNA A was related to LVN E.</p> <p>During an interview on 10/11/24 at 2:06 PM, the ADM stated she does not recall that room move for Resident #1. She stated she was familiar with and had been trained on the facility's abuse policy. She stated the potential negative outcome of not following the facility's abuse policy was the residents could be unhappy. She stated she was unaware that there were any staff in the facility not following the abuse policy. She stated the system to monitor was training the staff to follow the abuse policy. She stated staff were trained upon hire, annually, and anytime there is a facility-reported abuse-related incident. She stated she expected the facility staff to follow the abuse policy. She stated all staff were responsible for following the policy. She stated she did not have a reason why the policy was not followed. She stated that even if she was not physically in the facility as the administrator, she was responsible for all activity that occurred in the facility. She stated that because she was not made aware of Resident #1 being upset or alleging that staff made her uncomfortable, she did not follow the abuse policy or grievance policy, investigate, or report the incident to HHSC. She stated that she was assigned to the facility as of 10/01/24, and the incident occurred prior to her transition to becoming the facility administrator.</p>		