

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676385	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/24/2024
NAME OF PROVIDER OR SUPPLIER  Crossroads Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  611 Rose Marie Blvd Hearne, TX 77859	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070</b></p> <p>Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy for 1 of 1 resident (Resident #3) reviewed for privacy.</p> <p>The facility failed to ensure DON, RN A and CNA A provided privacy by closing the privacy curtain during wound care for Resident #3.</p> <p>This failure could place residents at risk of having their bodies exposed to the public, resulting in low self-esteem and a diminished quality of life.</p> <p>The findings include:</p> <p>Record review of Resident #3's admission record dated 05/24/24 revealed an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, but were not limited to, Psychotic Disturbance, Mood disturbance, Anxiety, Hemiplegia and Hemiparesis (weakness or paralysis on one side of the body), Alcohol Dependence, Dysphagia ( difficulty to swallow), Need for assistance with personal care, Hypertension, Cerebral infarction (Stroke), Lack of coordination and Cognitive communication deficit.</p> <p>Record review of Resident #3's MDS dated [DATE] revealed her BIMS assessment was not completed.</p> <p>Record review of Resident #3's careplan dated 05/24/24 reflected the resident had Stage 3 pressure ulcer (a bedsore or decubitus ulcer, is a full-thickness loss of skin that extends into the subcutaneous tissue, or fat layers, but does not reach muscle, tendon, or bone) to her L axilla (a person's armpit) and the relevant interventions were.</p> <p>4. Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressings PRN.</p> <p>5. Assess/record/monitor wound healing at least weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report declines to the MD.</p> <p>6. Follow facility policies/protocols for the prevention/treatment of skin breakdown.</p> <p>Record Review of Resident #3's Order Summary Report dated 05/24/24 revealed the following orders:</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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Cleanse Stage 3 pressure ulcer to L axilla with NS, pat dry, apply med honey, cover with calcium alginate with silver and apply superabsorbent gelling fiber with silicone bordered dressing one time a day for Wound Healing.</p> <p>4. Nystatin External Powder 100000 UNIT/GM (Nystatin (Topical))</p> <p>Apply to under R Axilla topically one time a day for Moisture Associated Skin Damage.</p> <p>During an observation and interview on 05/24/24 at 2:00 pm Resident #3 was sitting in her bed and was awake and alert. She was sharing her room with another resident. Resident #3 resides to the left side of the room when facing her from the entrance door. Her roommate who resides at the right side of the room, was not in the room during the wound care. DON, RN B and CNA C were the designated team to provide the wound care. RN B did the wound care with the assistance of CNA C to Resident #3's pressure ulcer to L axilla. The DON supervised the care, occasionally helping them with wound care. DON, RN B and CNA C entered the room and closed the door however did not draw the privacy curtain of Resident #3. This exposed Resident #3's chest area to the entire room and would have been visible to Resident #3's roommate or anyone if they entered the room unexpectedly. During an attempted interaction by the investigator, Resident #3 was not able to answer questions about her right to have privacy.</p> <p>During an interview on 05/24/24 at 2:15PM., CNA C stated the privacy curtain should have been completely closed to prevent Resident #3 from being exposed to the room. CNA C stated the facility provided in-service on privacy however could not remember when it was exactly.</p> <p>During an interview on 05/24/2024 at 2:20 PM, RN B stated, by not pulling the privacy curtain while providing wound care, the privacy and dignity of resident #3 were compromised, as the exposed body of Resident #3 would have been visible to anyone, who entered the room at that time. When asked about the training she received on wound care, RN B stated she received in-service on resident's rights at least once a year.</p> <p>During an interview with the DON on 05/24/24 at 4:30PM., she stated privacy must be provided during nursing care by drawing the privacy curtain. She stated Resident #3's roommate was the RCR at the facility, was a very active person and go in and out of her room frequently. The DON stated she had many visitors from the community as well as from the facility. Under these circumstances anyone could enter the room without any notice at the time of the wound care. The DON stated the wound care team was very nervous and forgot to draw the privacy curtain. She stated they could have done better to ensure full privacy of Resident # 3 by closing the curtain.</p> <p>During an interview on 05/24/24 at 5:00 pm the ADM stated residents' privacy should be maintained during wound care and other nursing care by closing the room door, window blinds and pulling the curtains.</p> <p>Record review of the in-services records from 01/01/2024 to 05/24/24 revealed there were no in-services conducted on residents' privacy and /or residents' rights during this period.</p> <p>Record review of the facility's policy titled Social Services Manual 2003-Resident Rights, revised on 11/28/16, reflected:</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States .</p> <p>. The resident has a right to be treated with respect and dignity .</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45070</b></p> <p>Based on interview, and record review the facility failed to ensure residents with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 3 (Resident #1, Resident #2, and Resident #3) of 5 residents reviewed for medication/treatment errors.</p> <p>The facility failed to follow physician's orders for providing wound care to Resident #1, Resident #2, and Resident #3, on a regular basis.</p> <p>This failure could place residents at risk of delay in wound infection and healing process.</p> <p>Findings Included:</p> <p>Record review of Resident #1's admission record dated 05/24/24 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Hyperlipidemia (Excess fat in blood), Hypertension, Osteomyelitis of vertebra (infection on the vertebra), Protein-calorie malnutrition, Cerebral infarction (Stroke), Blindness right eye, Low vision left eye, Muscle weakness., Difficulty in walking, Abnormalities of gait and mobility, Muscle wasting, Lack of coordination and Cognitive communication deficit.</p> <p>Record review of Resident #1's MDS dated [DATE] revealed a BIMS score of 11 indicating his cognition was moderately impaired. Section M of the MDS indicates Resident #1 has one unhealed pressure ulcer/injury, presenting as deep tissue injury a scar over bony prominence, or a non-removable dressing/device.</p> <p>Record review of Resident #1's careplan dated 03/04/24 reflected, the resident has a stage 3 pressure ulcer to his R heel and the relevant interventions were:</p> <ol style="list-style-type: none"> <li>1.Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressings PRN.</li> <li>2.Specify Treatment: wound vac to right heel with dressing changes 3xweek.</li> <li>3.Follow facility policies/protocols for the prevention/treatment of skin breakdown.</li> </ol> <p>Record Review of Resident #1's Order Summary Report dated 05/24/24 revealed the following orders:</p> <ol style="list-style-type: none"> <li>1.Cleanse Stage 3 pressure ulcer to R heel with NS, Pat dry, apply Santyl, apply calcium alginate, apply foam dressing one time a day for Wound Healing related.</li> </ol> <p>to unspecified protein-calorie malnutrition.</p> <p>Record review of Resident #1's WAR of April and May,2024 revealed he did not receive this treatment on 04/07/24, 04/14/24, 05/17/24 and 05/21/24.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2.Negative pressure wound therapy granular foam, 125mmHg change 3x a Week one time a day every Tue, Thu, Sat for Wound Healing.</p> <p>Record review of Resident #1's WAR of April and May, 2024 revealed he did not receive this treatment on 04/25/24, 04/27/24, 05/04/24 and 05/11/24.</p> <p>3.Santyl External Ointment 250 unit/gm (Collagenase). Apply to R heel topically one time a day for Wound Healing.</p> <p>Record review of Resident #1's WAR of April and May, 2024 revealed he did not receive this treatment on 04/07/24 and, 04/14/24.</p> <p>Record review of Resident #2's admission record dated 05/24/24 revealed an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, but were not limited to, Hyperlipidemia (excess fat in blood) , Hypertension, Dementia, Type 2 Diabetes Mellitus, Congestive Heart Failure, Major Depressive Disorder, Encounter for orthopedic aftercare following surgical amputation , Muscle weakness, Difficulty in walking, Unsteadiness on feet, Muscle wasting, Lack of coordination and Cognitive communication deficit.</p> <p>Record review of Resident #2's MDS dated [DATE] revealed a BIMS score of 05 indicating her cognition was severely impaired. Section M of the MDS indicated Resident #2 Resident had surgical wounds, stage 2 , stage 3 and unstageable pressure ulcers, a scar over bony prominence, or a non-removable dressing/device.</p> <p>Record review of Resident #2's careplan dated 03/04/24 reflected the resident had:</p> <ol style="list-style-type: none"> <li>1.One non pressure wound L anterior thigh.</li> <li>2.One wound on R Posterior Thigh</li> <li>3.One non pressure wound to L inner leg.</li> <li>4.One Stage 2 pressure ulcer to L hip</li> <li>5.One Stage 3 Pressure ulcer to R lower buttock</li> <li>6.One Stage 3 pressure ulcer to R Lateral hip</li> <li>7.One Stage 3 Pressure ulcer to Sacrum</li> </ol> <p>The relevant interventions were:</p> <ol style="list-style-type: none"> <li>1.Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressings PRN.</li> </ol> <p>Specify Treatment:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2.Assess/record/monitor wound healing at least weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report declines to the MD.</p> <p>3.Follow facility policies/protocols for the prevention/treatment of skin breakdown.</p> <p>Record Review of Resident #2's Order Summary Report dated 05/24/24 revealed the following orders:</p> <p>1.Cleanse non pressure wound to L anterior thigh with NS, pat dry, apply xeroform gauze, cover with gauze island dressing one time a day for Wound Healing.</p> <p>Record review of Resident #2's WAR of April and May, 2024 revealed she did not receive this treatment on 04/25/24, 04/27/24 and 05/12/24.</p> <p>2.Cleanse non pressure wound to L inner leg with NS, pat dry, apply calcium alginate, cover with gauze dressing one time a day for Wound Healing</p> <p>Record review of Resident #2's WAR of April and May, 2024 revealed she did not receive this treatment on 04/21/24, 04/25/24, 04/27/24 and 05/12/24.</p> <p>3.Cleanse R Posterior Thigh with NS, pat dry, apply xeroform gauze, cover with gauze island dressing one time a day for Wound Healing.</p> <p>Record review of Resident #2's WAR of April and May, 2024 revealed she did not receive this treatment on 04/25/24, 04/27/24, 05/04/24 and 05/11/24.</p> <p>4.Cleanse Stage 2 pressure ulcer to L hip with NS, pat dry, apply xeroform gauze cover with gauze island dressing one time a day for Wound Healing.</p> <p>Record review of Resident #2's WAR of April and May,2024 revealed she did not receive this treatment on 04/14 and 04/16/24.</p> <p>5.Cleanse Stage 3 Pressure ulcer to R lower buttock with NS, pat dry, apply med honey, apply calcium alginate, cover with gauze island dressing one time a day for Wound Healing.</p> <p>Record review of Resident #2's WAR of April and May ,2024 revealed she did not receive this treatment on 04/25/24, 04/27/24, 05/12/24.</p> <p>6.Cleanse Stage 3 pressure ulcer to R Lateral hip with NS, pat dry, apply med honey, apply calcium alginate, cover with gauze dressing one time a day for Wound Healing.</p> <p>Record review of Resident #1's WAR of April and May, 2024 revealed she did not receive this treatment on 04/25/24, 04/27/24, 05/12/24.</p> <p>7.Cleanse Stage 3 Pressure ulcer to Sacrum with NS, pat dry, apply med honey, apply calcium alginate, cover with foam dressing one time a day for wound Healing.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's WAR of April and May, 2024 revealed she did not receive this treatment on 04/124/24, 04/21/24, 04/27/24, 05/124/24.</p> <p>Record review of Resident #3's admission record dated 05/24/24 revealed an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, but were not limited to, Psychotic Disturbance, Mood disturbance, Anxiety, Hemiplegia and Hemiparesis (weakness or paralysis on one side of the body) ,Alcohol Dependence, Dysphagia( difficulty to swallow), need for assistance with personal care, Hypertension, , Cerebral infarction (Stroke), Lack of coordination and Cognitive communication deficit.</p> <p>Record review of Resident #3's MDS dated [DATE] revealed her BIMS assessment was not completed . Section M of the MDS indicated Resident #3 had unhealed stage 3 pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device.</p> <p>Record review of Resident #3's careplan dated 05/24/24 reflected the resident had Stage 3 pressure ulcer (a bedsore or decubitus ulcer, is a full-thickness loss of skin that extends into the subcutaneous tissue, or fat layers, but does not reach muscle, tendon, or bone:) to her L axilla and the relevant interventions were:</p> <ol style="list-style-type: none"> <li>1.Administer treatments as ordered and monitor for effectiveness. Replace loose or missing dressings PRN.</li> <li>2.Assess/record/monitor wound healing at least weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report declines to the MD.</li> <li>3.Follow facility policies/protocols for the prevention/treatment of skin breakdown.</li> </ol> <p>Record Review of Resident #3's Order Summary Report dated 05/24/24 revealed the following orders:</p> <ol style="list-style-type: none"> <li>1.Cleanse Stage 3 pressure ulcer to L axilla with NS, pat dry, apply med honey, cover with calcium alginate with silver and apply superabsorbent gelling fiber with silicone bordered dressing one time a day for Wound Healing.</li> </ol> <p>Record review of Resident #3's Wound Administration Record of April and May,2024 revealed he did not receive this treatment on 04/14/24, 04/21/24, 04/22/24, 04/25/24, 04/27/24, 05/5/24, 05/06/24, 05/07/24 and 05/13/24.</p> <ol style="list-style-type: none"> <li>2.Nystatin External Powder 100000 unit/gm (Nystatin (Topical))</li> </ol> <p>Apply to under R Axilla topically one time a day for Moisture Associated Skin Damage.</p> <p>Record review of Resident #3's Wound Administration Record of April and May,2024 revealed he did not receive this treatment on 04/07/24, 04/14/24, 04/21/24, 04/22/24, 04/25/24, 05/5/24, 05/06/24, 05/07/24 and 05/13/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 05/24/24 at 11:30AM, LVN A stated she was the wound care nurse work in days shift at the facility and when on duty took care of the wound treatments for all the residents with wounds, as per the physician's order. She stated she completed her tasks diligently on a day-to-day basis on all the residents with wounds. She stated she accompanied the wound doctor on his weekly visits and participated in the assessment. LVN A stated she was sure she did the wound care without any neglect and if that was not reflecting on the WAR, it was the indication of omission of documentation not the treatment.</p> <p>During an interview on 05/24/24 at 4:30PM, the DON stated LVN A is the ADON at the facility as well as the treatment nurse. She said she was sure, as she observed, LVN A and other nurses on wound care duty, performing the wound care as per physician's order without any neglect. When the investigator showed her the incomplete WAR of April and May 2024, DON stated, by looking at the WAR it appeared the omissions were in documentation of the wound care. She stated neglect in providing care was unlikely, as she observed them completing their tasks without any fail. DON stated LVN A was a committed and hard-working nurse and observed her busy with wound care, every day. When investigator asked, by looking at the incomplete WAR, how she would be able to confirm if it was a documentation error or neglect in wound care, the DON stated she would not be able to distinguish between documentation error and treatment error by looking the incomplete WAR. She stated according to the nursing principles even if you completed a task and was not documented, it was taken as it was not done. The DON stated she did not do any auditing of MAR or WAR on a regular basis to identify mistakes in documentation however observed if the staff were doing their tasks diligently. She stated the progress in wound care were discussed in the daily meetings as well.</p> <p>Record review of facility policy titled Nursing policy and Procedure Manual 2003-Medication Administration Procedures revised on 10/25/2017 revealed:</p> <ol style="list-style-type: none"> <li>1. All medications are administered by licensed medical or nursing personnel.</li> <li>2. Medications are to be poured, administered, and charted by the same licensed person</li> <li>.5. After the resident has been identified, administer the medication and immediately chart doses administered on the medication administration record. It is recommended that medication be charted immediately after administration, but if facility policy permits, medication may be charted immediately before administration. Initials are to be used. Check marks are not acceptable. During the medication administration process, the unlocked side of the cart must always be in full view of the nurse.</li> </ol> <p>All nurses administering medication must sign and initial the designated area of each resident's medication/treatment administration record or resident specific master signature log for identification of all initials used in charting.</p> <p>6. If a dose of regularly scheduled medication is withheld or refused, the nurse is to initial and circle the front of the medication administration record in the space provided for that dosage administration and an explanatory note is to be entered in the nursing notes or in the PRN nurses notes section of the medication administration record. In the presence of individual facility policies concerning refused and held documentation, the facility policy supersedes this policy</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility policy titled Nursing policy and Procedure Manual 2003-Documentation revised in May,2015 revealed:</p> <p>Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility, and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge). Documentation also occurs in the clinical software Point Click Care (PCC). All documentation and clinical records are confidential and can be released only with signed permission of the resident or legal representative.</p> <p>Goal:</p> <ol style="list-style-type: none"> <li>1.The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.</li> <li>2.The facility will ensure that information is comprehensive and timely and properly signed .</li> </ol> <p>. Document completed assessments in a timely manner and per policy.</p> <p>Complete documentation in narrative nursing notes as needed in a timely manner. Each entry will be dated and timed. Each entry will be signed with proper signature and title. If PCC is used for the assessment the signature and title of the person entering the information will be signed by entering their password</p>		