STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676385	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossroads Nursing & Rehabilitation	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)
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** 44700 Based on interviews and record reviews the facility failed to implement a comprehensive person-centered care plan for one (1) resident (Resident #1) of six (6) residents reviewed for care plans. The facility failed to ensure Resident #1 care plan was updated and revised after behavior events on 11/2/2024 and 11/7/2024, causing Resident #1 injuries to her face on 11/7/2024. This failure placed residents at risk of not having their individualized needs met in a timely manner and communicated to providers and could result in injury and a decline in physical well-being for residents. Findings included: 1. Review of Resident #1's face sheet dated 11/19/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: Dementia (memory loss disorder), Diabetes Mellitus (blood sugar disorder), senile degeneration of the brain (age related brain disorder) and abnormality of gait and mobility. Review of Resident #1's admission MDS dated [DATE] reflected a BIMS of 0 suggesting severe cognitive impairment. Review of the Behavior section of the MDS reflected Resident #1 did not have any behaviors since her admission seven days prior on 9/11/2024. Review of Resident #1's progress note dated 11/2/2024 at 10:58 am reflected Resident rolled up to another resident while he was asleep and slapped his arm. Review of Resident #1's progress note dated 11/3/2024 at 10:31 am reflected Resident hit another resident arm Interventions: PRN lorazepam given. Review of Resident #1's progress note dated 11/7/2024 at 9:25 am reflected The resident was involved in an incident where she was sitting next to another resident and was repeatedly putting her hands in his face. The other resident stated that he asked her not to put her hands in his face multiple times, but she continued to do so and laughed about it. The last time he asked her to stop she slapped him in his face causing him to react and hit her back .This resident has an area to the upper right lip, right side of the nose and underneath the right eyebrow that has a scratch from the incident. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's current care plan as of 11/19/2024 reflected no problems related to behaviors. Review of Resident #1's care plan as of 11/20/2024 at 11 am reflected no problems related to behaviors. Review of Resident #1's care plan as of 11/20/2024 at 2 pm reflected a problem: Resident exhibits behaviors of touching other resident on the arm/face/hands with interventions: 1:1 when experiencing this behavior in excess, do no place her close by when she is having this behavior, referral to [behavioral hospital] and resident appropriate activities. During an interview on 11/19/2024 at 3:18 pm, FM #1 stated they were the responsible party for Resident #1 and he had received calls for both incidents involving Resident #1 hitting Resident #2. FM #1 stated during the second incident, Resident #1 had been hit back and got scratched up pretty close to her eye and on her lip. FM#1 stated they were concerned about how close the injury was to Resident #1's eye and that it could have been a lot worse If Resident #1 had been hit in her eye. He stated Resident #1 had severe dementia and didn't even remember what had happened but the FM#1 was still very concerned with how bad it could have been if the injury had been just a little bit closer to her eye. 2. Review of Resident #2's face sheet dated 111/19/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: High blood pressure, vascular dementia (decreased blood flow to the brain causing memory issues) and Diabetes mellitus with diabetic retinopathy. (Vision disorder related to blood sugar disorder) Review of Resident 2's quarterly MDS dated [DATE] reflected a BIMS of 8 suggesting moderate cognitive impairment. During an interview on 11/20/2024, Resident #2 stated he has not had any other problems with Resident #1 since the second time she hit him, and he hit her back. He stated she would wheel up to him and slap him and it would scare him. He stated he had vision problems, and he did not like anyone being all up in my face and she came up and got in my face and I told her to stop, and she didn't so I hit her back. He stated there had been 2 different times when she slapped him, the first time he was sleeping in his wheelchair, and she came up and slapped him and it scared him awake. He stated he hollered for staff, and they came and got her. The second time, he was in the dining room, and she just came up and started hitting his face, so he hit her back and scratched her face and busted her lip. During an interview on 11/10/2024 at 2:00 pm, the ACN stated the care plans in the EMR system were current. She stated when they checked Resident #1's care plan, it was not in there and it should have been, so the DON went in and put it in today. She stated the care plan had not been updated on 11/2/2024 and 11/7/2024 when Resident #1 had behaviors because it had been overlooked. She stated it needed to be in there, so they fixed it this afternoon. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024 at 3:00 pm, the DON stated she had updated Resident #1's care plan today. She stated when the investigator asked for Resident #1's care plan on 11/20/24, she had noticed the care plan had not been updated. She stated the IDT was responsible for updating care plans and it would either have been her (the DON) or the MDS Nurse. She stated the MDS nurse had been out sick and the MDS nurse thought she had done it and she (the DON) had thought the MDS nurse had updated it. She stated updating care plans are important because it tells them how to care for the resident and what's going on with that resident She stated the interventions were in place, but the care plan had not been updated. She stated if care plans are not updated, they won't know what is going on with that resident. During an interview on 11/20/2024 at 4:10 pm, the AD stated he did not know the care plan for Resident #1 had not been updated after the incident on 11/2/2024 or 11/7/2024. He stated the care plan should have been updated right after the first incident on 11/2/2024 and when the DON discovered it today, she went in and updated the care plan. He stated it was important to update care plans quickly because that's how we know how to care for the resident. He stated they will be educating nurses on documentation and updating care plans to address this issue. Record review of undated facility policy Comprehensive Care Planning reflected the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights 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. Further, the policy stated, Residents preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representation, if applicable, so that changes can be reflected in the comprehensive care plan. Also, The resident's care plan with be reviewed after each admission, quarterly, annual and/or significant change MDS assessment, and revised based on changing goals, preferences and needs of the resident an in response to current interventions.