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	09/03/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately inform the resident representative when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention for 1 of 5 residents (Resident #1) reviewed for notification of changes. The facility failed to notify Resident #1's responsible party after Resident #1 experienced an unwitnessed fall on 08/12/2025 that resulted in an abrasion. This deficient practice could place residents at risk of not having their responsible party notified of changes, resulting in a delay in medical intervention and decline in health.Findings included: Review of Resident #1's face sheet dated 09/03/2025 reflected she was admitted to the facility on [DATE] Fracture of left femur (left hip fracture) unsteadiness on feet, diabetes mellitus type II (A condition results from insufficient production of insulin, causing high blood sugar.) and osteoarthritis (happens when the protective cartilage that cushions the ends of the bones wears down over time.), left knee. Review of Resident #1's quarterly MDS dated [DATE] reflected she was assessed to have a BIMS score of 9 indicating moderate cognitive impairment. Resident #1 was assessed to have functional limitation in range of motion on both sides for her upper and lower extremities. Resident #1 was further assessed to require supervision or touching assistance with transfers. Resident #1 was assessed to have falls since admission. Review of Resident #1's comprehensive care plan reflected a focus area dated 01/20/2025 The resident has impaired cognitive function/dementia or impaired thought processes. Interventions included .Discuss concerns about confusion, disease process, NH placement with resident/family/caregivers. Review of Resident #1's fall event note dated 08/12/2025 reflected Resident #1 had a fall in room at 5:44 am which was unwitnessed and resulted in an abrasion to her right forearm. Description of the event Discovered on floor as light was on. Abrasion to right forearm, bruise to wrist lateral and right forearm. 08/12/2025 reflected LVN B documented Resident #1's RP was notified on 08/12/2025 at 5:50 am. Review of Resident #1's nursing progress note dated 08/12/2025 at 5:57 pm entered by the ADON reflected this nurse tried twice to notify RP of resident's fall but kept getting a business signal. In an interview on 09/03/2025 at 12:30 pm Resident #1's RP stated she was not contacted on 08/12/2025 about Resident #1's fall and did not find out until 4 or 5 days later when Resident #1 was complaining of pain. She stated when she asked Resident #1 what happened she told her she fell. Resident #1's RP was asked about the documentation of her being notified at 5:50 am on 09/03/2025. She stated the documentation was not true that she did not get a call. She stated they have called her at all hours of the night before and she answers. She stated she always has her phone by her. She stated she does not have a land line so her cell phone does not have a busy signal if she does not answer it goes to voicemail, she stated the must have been calling the wrong number. In an interview at 1:30 pm the ADON stated she worked on the floor the day of 08/12/2025 and the night nurse LVN B told her he was not able to reach Resident #1's RP after her fall so he passed it on to the ADON. She stated she keep getting a busy signal. She stated she could not remember who came in next and could not remember if she passed on the need to notify the family. She stated she should have followed up to make sure the family was notified of the Resident's fall. She stated she just got caught up with working on the floor and forgot about it. Attempts to contact LVN B during the investigation on 09/03/2025 at 12:20 pm and 3:30 pm were unsuccessful. In an interview on 09/03/2025 at 2:00 pm the DON stated it was her expectation that all resident change in conditions be reported to the responsible party to ensure the resident gets the care they need. In an interview on 09/03/2025 at 2:25 pm the RNC stated Resident#1's RP should have been notified after the fall and staff should have ensured follow up was done if they were not able to reach the family. Review of the facility's undated policy Notifying the physician of change in status reflected .The resident's family member or legal guardian should be notified of significant change in resident's status unless the resident has specified otherwise. Review of the facility's undated policy Resident Rights reflected The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. 4. The right to be informed in advance, of the care to be furnished and the type of care giver or professional that will furnish care.

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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 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. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop, and implement a comprehensive care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 5 residents (Residents #1) reviewed for care plans. The facility failed to ensure Resident #1's comprehensive care plan updated interventions after Resident #1 experienced multiple falls. This deficient practice placed residents at risk of not having their individualized needs met in a timely manner and communicated to providers and could result in injury, a decline in physical, mental and/or psychosocial well-being.Findings include:Review of Resident #1's face sheet dated 09/03/2025 reflected she was admitted to the facility on [DATE] Fracture of left femur (left hip fracture) unsteadiness on feet, diabetes mellitus type II (A condition results from insufficient production of insulin, causing high blood sugar.) and osteoarthritis (happens when the protective cartilage that cushions the ends of the bones wears down over time.), left knee. Review of Resident #1's quarterly MDS dated [DATE] reflected she was assessed to have a BIMS score of 9 indicating moderate cognitive impairment. Resident #1 was assessed to have functional limitation in range of motion on both sides for her upper and lower extremities. Resident #1 was further assessed to require supervision or touching assistance with transfers. Resident #1 was assessed to have falls since admission. Review of Resident #1's Event Nurses' notes-fall reflected she had falls on 01/18/2025, 01/25/2025 x 2, 01/26/2025, 01/29/2025, 02/07/2025, 02/12/2025, 04/19/2025, 06/01/2025, and 08/12/2025. Review of Resident #1's fall event note dated 08/12/2025 reflected Resident #1 had a fall in room at 5:44 am which was unwitnessed and resulted in an abrasion to her right forearm. Description of the event Discovered on floor as light was on. Abrasion to right forearm, bruise to wrist lateral and right forearm. Review of Resident #1 comprehensive care plan reflected a focus area dated 01/20/2025 The resident is risk for falls. Goals included The resident will be free of falls through the review date. Interventions included: call don't fall sign hung in room, Date Initiated: 04/22/2025; Anticipate and meet the resident's needs; Date Initiated: 01/20/2025; Be sure the resident's call light is within reach and encourage the resident to use it, Date Initiated: 01/20/2025; Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, Date Initiated: 01/20/2025; Ensure resident is wearing appropriate footwear when ambulating or mobilizing in w/c, Date Initiated: 01/20/2025;frequent reminders to use call light for assistance, Date Initiated: 01/27/2025, Keep furniture in locked position, Date Initiated: 01/20/2025; Keep needed items, water, etc., in reach, Date Initiated: 01/20/2025; low bed w/ fall mat, Date Initiated: 01/27/2025; mat to floor at bedside, Date Initiated: 01/20/2025; med review, Date Initiated: 02/14/2025; non- skid foot wear, Date Initiated: 01/20/2025; Pt evaluate and treat as ordered or PRN, Date Initiated: 01/20/2025; Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes, Date Initiated: 01/20/2025; Scoop mattress, Date Initiated: 01/27/2025; Staff x 2 to assist with transfers, Date Initiated: 01/20/2025; The resident needs activities that minimize the potential for falls while providing diversion and distraction, Date Initiated: 01/20/2025; therapy screen for cognition/safety awareness Date Initiated: 02/07/2025; Therapy to provide reacher, Date Initiated: 06/04/2025; Toilet and/or ensure clean/dry prior to going to bed, Date Initiated: 01/29/2025. Further review revealed the care plan did not address her actual falls, cause of falls, and was not updated after her unwitnessed fall on 08/12/2025. In an interview on 09/03/2025 at 12:28 pm Resident #1 stated she had a lot of falls, and she was impatient and if they do not come right away, she will just do it herself. Resident #1 stated she could not transfer herself at times. She stated she did not recall her last fall or why she fell. Resident #1 stated she did hurt her wrist. In an interview on 09/03/2025 at 2:00 pm the DON stated the facility only had a regional MDS nurse, and the care plan should have been reviewed and updated after Resident #1's 08/12/2025 fall to prevent further falls. In an interview on 09/03/2025 at 2:25 pm the RNC stated Resident #1's care plan should have been reviewed and interventions updated as appropriate. She stated Resident#1's fall on 08/12/25 had not yet been reviewed and the care plan was updated after the review occurred. She stated it should have been updated after each fall to make sure the root cause of the fall was identified to prevent reoccurrence. Review of the facility's policy comprehensive care planning undated 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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for falls. The facility failed to develop and implement individualized interventions for Resident #1 after the resident experienced multiple falls. This failure placed residents with falls at risk of injury, pain, bruises, fractures, dislocation of joints, and/or significant changes in condition.Findings included: Review of Resident #1's face sheet dated 09/03/2025 reflected she was admitted to the facility on [DATE] Fracture of left femur (left hip fracture) unsteadiness on feet, diabetes mellitus type II (A condition results from insufficient production of insulin, causing high blood sugar.) and osteoarthritis (happens when the protective cartilage that cushions the ends of the bones wears down over time.), left knee. Review of Resident #1's quarterly MDS dated [DATE] reflected she was assessed to have a BIMS score of 9 indicating moderate cognitive impairment. Resident #1 was assessed to have functional limitation in range of motion on both sides for her upper and lower extremities. Resident #1 was further assessed to require supervision or touching assistance with transfers. Resident #1 was assessed to have falls since admission. Review of Resident #1's Event Nurses' notes-fall reflected she had falls on 01/18/2025, 01/25/2025 x 2, 01/26/2025, 01/29/2025, 02/07/2025, 02/12/2025, 04/19/2025, 06/01/2025, and 08/12/2025. Review of Resident #1's fall event note dated 08/12/2025 reflected Resident #1 had a fall in room at 5:44 am which was unwitnessed and resulted in an abrasion to her right forearm. Description of the event Discovered on floor as light was on. Abrasion to right forearm, bruise to wrist lateral and right forearm. 08/12/2025 reflected LVN B documented Resident #1's RP was notified on 08/12/2025 at 5:50 am. Review of Resident #1 comprehensive care plan reflected a focus area dated 01/20/2025 The resident is risk for falls. Goals included The resident will be free of falls through the review date. Interventions included: call don't fall sign hung in room, Date Initiated: 04/22/2025; Anticipate and meet the resident's needs; Date Initiated: 01/20/2025; Be sure the resident's call light is within reach and encourage the resident to use it, Date Initiated: 01/20/2025; Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, Date Initiated: 01/20/2025; Ensure resident is wearing appropriate footwear when ambulating or mobilizing in w/c, Date Initiated: 01/20/2025;frequent reminders to use call light for assistance, Date Initiated: 01/27/2025, Keep furniture in locked position, Date Initiated: 01/20/2025; Keep needed items, water, etc., in reach, Date Initiated: 01/20/2025; low bed w/ fall mat, Date Initiated: 01/27/2025; mat to floor at bedside, Date Initiated: 01/20/2025; med review, Date Initiated: 02/14/2025; non- skid foot wear, Date Initiated: 01/20/2025; Pt evaluate and treat as ordered or PRN, Date Initiated: 01/20/2025; Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes, Date Initiated: 01/20/2025; Scoop mattress, Date Initiated: 01/27/2025; Staff x 2 to assist with transfers, Date Initiated: 01/20/2025; The resident needs activities that minimize the potential for falls while providing diversion and distraction, Date Initiated: 01/20/2025; therapy screen for cognition/safety awareness Date Initiated: 02/07/2025; Therapy to provide reacher, Date Initiated: 06/04/2025; Toilet and/or ensure clean/dry prior to going to bed, Date Initiated: 01/29/2025. The care plan did not address her actual falls and was not updated after her unwitnessed fall on 08/12/2025. In an interview on 09/03/2025 at 2:00 pm the DON stated it was her expectation that all resident change in conditions be reported to the responsible party to ensure the resident gets the care they need. She stated regarding the care plan that the facility only had a [NAME] MDS nurse, and the care plan should have been reviewed and updated after Resident #1's 08/12/2025 fall to prevent further falls. In an interview on 09/03/2025 at 2:25 pm the RNC stated Resident #1's care plan should have been reviewed and interventions updated as appropriate. She stated Resident#1's fall on 08/12/25 had not yet been reviewed by the IDT and the care plan is updated after the review occurs. She stated it should have been up after the fall to make sure the root cause of the fall was identified to prevent reoccurrence. Review of the facility's policy fall policy undated reflected Preventing falls requires an interdisciplinary program that focuses on modifying the extrinsic factors, correcting intrinsic factors, and educating the resident and family. A Fall Risk Assessment will be completed on admission and after each fall. The MDS 3.0 will also assist in determining a resident who is a fall risk. Appropriate interventions will be addressed immediately on the interdisciplinary plan of care. Reassessment will occur after each fall. The DON or designee will be responsible for investigating all