

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/04/2025
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)		
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing activities program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for three of five residents (Resident # 5, Resident # 45 and Resident #46) reviewed for activities. The facility failed to provide Resident #5, Resident #45, and Resident #46 in room activities three to five times per week during the months of October 2025 and November 2025. This failure could place residents at risk for boredom, depression, and a diminished quality of life. Findings included: Resident #5 Review of Resident # 5's face sheet, dated 12/03/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses of contracture of right and left elbow, right and left hand (the muscles, skin , or tissues around these joints have tightened and shortened, severely limiting normal bending and straightening, often due to injury, prolonged in activity, making simple tasks difficult), anoxic brain damage, not elsewhere classified (refers to brain injury from a total lack of oxygen (anoxia) that doesn't fit specific, predefined categories in medical coding (like stroke or drowning), often seen after events like cardiac arrest- sudden, sometimes temporary, cessation of the function of the heart- or carbon monoxide poisoning- happens when you breathe too much of this colorless, odorless gas-, leading to cell death and lasting confusion, physical, or emotional deficits), and cerebral infarction (the death of brain tissue caused by lack of blood flow). Review of Resident #5's Annual MDS Assessment, dated 02/10/2025, reflected Resident #5 was in vegetative state/ no discernible consciousness. Resident #5 was total dependent on staff for eating, oral hygiene, toileting hygiene, dressing, personal hygiene, transfers and bed mobility. Review of Resident #5's Quarterly MDS Assessment, dated 09/05/2025, reflected Resident #5 was in persistent vegetative state. She was dependent on staff for eating, oral hygiene, toileting hygiene, dressing, personal hygiene, transfer and bed mobility. Review of Resident #5's Comprehensive Care Plan, with completion date of 11/12/2025, reflected activity problem and interventions was initiated on 02/11/2025. Resident #5 was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits, immobility, and physical limitations. Interventions: Resident #5 needed in room visits. She preferred activities such as listening to music on personal radio, and 1:1 socialization. Provide Resident #5 an activities calendar. Notify Resident #5 of any changes in activities documented on the calendar. Review of Resident #5's Activity Assessment, dated 11/07/2025, reflected Resident #5 somewhat enjoyed music. It was very important for Resident #5 to do her favorite activities. She cannot comprehend instructions. Signed by the Activity Director. Record review of Resident #5's Activity Participation Records revealed Resident #5 did not receive in-room activities for the months of October 2025 and November 2025. Observation and interview on 12/04/2025 at 11:45 AM, Resident # 5 was in bed. She did have television on in her room. Resident #5 was not interview able. Observation and interview on 12/05/2025 at 12:50 PM, Resident #5 was in bed, the television was turned off, her eyes were opened, and she was staring toward ceiling. She is (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	others, mental stimulation, isolation and decrease of his quality of life. She stated she had been an Activity Director in Nursing homes approximately 25 years. The Activity Director stated she has been certified as an Activity Professional over 15 years. Observation and interview on 12/04/2025 at 12:45 PM, Resident #45 was in his room in his specialty wheelchair, watching television. Resident #45 was not interview able. Observation and interview on 12/05/2025 at 1:30 PM, Resident #45 was in his room sitting in his specialty wheelchair, watching television. Resident #45 was not unreviewable. Interview on 12/04/2025 at 8:40 AM, the Administrator stated she expected in-room activities be provided to the residents needing these types of activities. She stated if a resident was not receiving in room activities there was a possibility a resident may become depressed, bored and isolated. The Administrator stated the Activity Director was responsible for all activities in the facility and all documentation in the Activity Department including in-room activities. She stated the Administrator would be responsible for monitoring the Activity Director. Interview on 12/04/2025 at 2:18 PM, the ADON stated she was not aware of Resident #5, Resident #45, and Resident #46 did not have any significant changes with their emotional, psychosocial, cognitive or physical concerns. She stated Resident #5, Resident #45 and Resident #46 remained at their baseline during months of October 2025, and November 2025 the ADON stated Resident #45 did go into the dining room sometimes, however, he would become anxious when in a group of people and would yell out. She stated he was not anxious when he was in his room. The ADON stated Resident #5, Resident #45, and Resident #46 all needed in room activities. She stated if they did not receive in-room activities there was a possibility the residents may feel isolated, and it would affect their quality of life. Record review of the Activity Director's personnel file revealed she began working at the facility on 09/11/2025. She had her National Certification for Activity Professionals with expiration date of 10/01/2026. The license was to be renewed every two years. Review of the Facility's Activity Programming, dated 2011, revealed The Activity Director and staff will provide for ongoing Activity Programs. Activity Programs are based on the resident's leisure interests and implemented to meet the needs (physical, cognitive, creative, social, spiritual, independent, and sensory) of the residents. Programs will be geared to maintain functional ADL's, provide social interaction and, at the same time, protect residents from environmental over stimulation. Those who cannot participate in group settings are provided individual programming. Inability to participate could include those who refuse to participate in activities. Programming included large groups, small groups, individual and independent opportunities. The resident population is cognitively assessed routinely to determine the number of functional level programs needed. Review of the Facility's Job Description of the Activity Director signed by the Activity Director on 09/11/2025 revealed the following: 1. Ability to organize, document, and implement detailed programs. 2. Ability to develop, organize and implement a program of activities for the social, emotional, physical, and other therapeutic needs of the residents. 3. Maintain detailed records of the activity programs and participation of individual residents, identifying progress toward established care plan goals. Review of the Facility's Activity Documentation-General Guidelines, dated 05/26/2025, revealed A qualified Activity professional will complete all required medical record documentation per state and federal regulations. The Activity Director shall coordinate and supervise all documentation and be responsible for all areas of documentation, according to required time limits and practice guidelines. The following areas are considered documentation responsibilities of the Activity Director and staff and should be completed in a comprehensive and timely manner. 1. Interdisciplinary team will assess the need for activities and reflect on the resident care: Problems, Goals and Appropriate approaches to related problems. 2. Progress Notes at least quarterly. 3. Resident Participation records. General guideline when completing any of the above areas of required documentation include: 1. Documentation is maintained in the residents' clinical medical records. 2. Only approved medically related abbreviations are used. 3. All entries in the medical record are to be signed (including the author's signature and title) and dated by a qualified Activity professional. 4. All documentation is completed consistent with health care center policy and applicable state and federal laws.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 12.9% based on 4 out of 31 opportunities, which involved 1 of 4 residents (Resident #13) and 1 of 2 MAs (MA D) observed during medication administration reviewed for medication error. 1. The facility failed to ensure MA D failed to administer Resident #13's physician ordered medications acidophilus lactobacillus and artificial tears. 2. The facility failed to ensure MA D failed to administer Resident #13's B12 vitamin as ordered by the physician. 3. The facility failed to ensure MA D did not administer Resident #13 a multivitamin tablet without a physician order. These deficient practices could place residents at risk of not receiving therapeutic dosage of medications and symptomatic changes in vital signs. Findings include: Review of Resident #13's face sheet dated 12/03/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: chronic respiratory failure (the lungs cannot adequately exchange oxygen and carbon dioxide leading to decreased oxygen levels and increased carbon dioxide), protein calorie malnutrition, and macular degeneration (eye disease that affects central vision). Review of Resident #13's quarterly MDS assessment dated [DATE] reflected that she was assessed to have a BIMS score of 13 indicating her cognition was intact. Review of Resident #13's comprehensive care plan reflected a focus area dated 05/15/2025 that The resident has nutritional problem related to diagnosis of dysphagia (difficulty swallowing) and malnutrition. Interventions included Administer medications as ordered. Review of Resident #13's consolidated physician orders dated 12/03/2025 reflected orders for acidophilus lactobacillus give one caplet orally one time a day for gut health, artificial tears instill two drops in both eyes two times a day for dry eyes, multivitamin-minerals one tablet by mouth one time a day for protein calorie malnutrition. Cyanocobalamin (B12) 500 mg give two tablets by mouth one time a day related to protein calorie malnutrition. Observation and interview on 12/03/2025 at 8:05 AM, revealed MA D prepared Resident #13's medication for administration. MA D prepared seven medications for administration which did not include her physician ordered acidophilus lactobacillus or artificial tears. MA D pulled out a multivitamin tablet and placed it in the medication cup after already putting in a multivitamin-mineral tablet. Surveyor stopped her and asked if she was sure Resident #13 got both a multivitamin and a multivitamin-mineral tablet and MA D stated Yes, she gets both. MA D then placed one vitamin B12 500 mg tablet into the medication cup. In an interview on 12/03/2025 at 8:49 AM, MA D stated she only gave one vitamin B12 tablet and stated the order did reflect she was supposed to get two tablets to equal 1000mg. MA D stated she did not give Resident #13 her physician ordered acidophilus lactobacillus because it was not on the cart. MA D stated she did not give Resident #13 her artificial tears eye drops and stated she did not know why she did not give it; she stated she was just learning. MA D stated Resident #13 did not have an order for both a multivitamin-mineral tablet and a regular multivitamin. MA D did not provide an explanation as to why she administered Resident #13 a multivitamin tablet that was not ordered. Observation and interview on 12/03/2025 at 9:30 AM, revealed Resident #13 was in her room in bed. Resident #13 stated she was fine and did not have any stomach upset. Resident #13 stated she did not realize she did not get all her medication, and she relied on the medication aids to make sure she received all her medication. In an interview on 12/04/2025 at 9:30 AM, the RNC stated that she felt the medication errors were caused by a lack of training and not following the facility's policy and procedures. She stated she expected staff to ask questions if they do not know what to do and expected staff to stop the medication pass and go find a medication if it is not on the cart. The RNC stated the facility could always get over the counter medications, and there was no excuse for not giving the medication. Review of the facility's Medication Administration and General Guidelines policy dated (with only the year) 2025 reflected Medications are administered as prescribed, in accordance with State Regulations using good nursing (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication, monograph of all medications is available. Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order is unrelated to the resident's current diagnosis or condition, the physician is contacted for clarification prior to the administration of the medication. The interaction with the physician is documented in the nursing notes and elsewhere in the medical record as appropriate. Adheres to the 6 Rights of Medication Administration: 1) Right Dose, 2) Right Route, 3) Right Resident, 4) Right Medication, 5) Right Time, 6) Right Documentation.		

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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 observations, interviews, and record reviews, the facility failed to properly store, prepare, and distribute food under sanitary conditions in accordance with professional standards for food service safety for one of one kitchen. The facility failed to ensure Dietary Aide A and Dietary [NAME] B used proper hand hygiene during food preparation on 12/03/2025. This failure could place residents who ate food from the kitchen at risk for foodborne illness. Findings include: Observation on 12/03/2025 at 10:35 AM, Dietary Aide A was not wearing gloves when she opened the kitchen door leading from kitchen to the dining room. She touched the side of her pants with her ring, middle and fore finger on her right hand as she walked toward the back of the kitchen near the dishwashing room. She returned to the food prep table in front of the steam table without washing her hands. She began to pour salad dressing into small clear cups used for sauces or dressing. Dietary Aide A touched top of the plastic small cups with the salad dressing inside the cups. She continued to pour the dressing into the cups and touched the top of two more of the cups after she poured the salad dressing. Interview on 12/03/2025 at 10:48 AM, Dietary Aide A said she did open the kitchen door and walked near the dishwashing room in back of the kitchen and returned to the food prep table to continue to pour the salad dressing in the cups. She stated she did not wash her hands. Dietary Aide A stated she was expected to wash her hands anytime she touched anything not sanitized. She stated she may have touched her clothes while she was walking sometimes, she accidentally does touch her clothes. She stated her hands was considered contaminated. She stated there was a possibility she did touch the top of the salad dressing when she was pouring it in the small cups and may have touched the top of the cups with her right hand. She stated the salad dressing, and the cups would be considered contaminated. Dietary [NAME] B stated if a resident ate the dressing there was a possibility the dressing became contaminated with bacteria. She stated there was a possibility a resident may become sick and have diarrhea or upset stomach. She stated she had been in-service on hand hygiene; however, she was unable to recall the date of the in-service. Observation on 12/03/2025 at 11:10 AM, Dietary [NAME] B had finished pureeing green beans and removed her gloves. She placed the gloves in the garbage can. When the Dietary [NAME] B was walking from garbage can she touched her scrub top and scrub pants with her little, ring, middle, fore fingers on her right hand. Dietary [NAME] B never washed or sanitized her hands. She walked to the food prep area and pulled aluminum foil with both hands. Dietary [NAME] B's middle, ring, little and fore fingers on both hands touched underneath the aluminum foil. She began to cover the pureed green beans with the aluminum foil and her ring, middle and fore finger touched the pureed green beans inside the silver container. She stated she learned in the hand hygiene in-service to wash hands anytime touch anything contaminated and before placing gloves on hands and after removing gloves. She stated clothes, hair, doorknob, cell phone, or another person hand would be considered contaminated. She stated she did not follow hand hygiene process for the kitchen staff. Interview on 12/03/2025 at 11:15 AM, Dietary [NAME] B stated she did remove her gloves after she pureed the green beans. She stated she did not wash her hands after she placed the gloves in the garbage can and before she covered the pureed green beans with the aluminum foil Dietary [NAME] B stated she did touch her clothes and touches underneath the aluminum foil that touched the pureed green beans container. She stated she accidentally touched the pureed green beans as she was covering them with the aluminum foil. Dietary [NAME] B stated there was a possibility the green beans may be contaminated from her hands. She stated if a resident ate the pureed green beans there was a potential the resident may become ill with stomach issues such as nausea, vomiting or maybe diarrhea. She stated it was possible a resident may need to go to the hospital for further treatment. Dietary [NAME] B stated she had been in-service on hand hygiene; however, she did not recall the date and time of the in-service. She stated she learned in the in-service to wash hands in between tasks if a staff touched any (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contaminated item such as clothes, hair, cell phone or keys. She stated if staff removed gloves to always wash hands before placing new gloves on or doing any type of food prep without gloves. Dietary [NAME] B stated she was expected to wash her hands, and she did not, and she did not follow hand hygiene policy. Interview on 12/03/2025 at 11:25 AM, the Dietary Manager stated she expected all staff to change gloves and wash hands in between tasks and when the staff touched their clothes, doorknob, or anything considered contaminated. She stated she had in serviced all dietary staff on hand hygiene. The Dietary Manager stated she could not recall the date of the in-service. She stated Dietary [NAME] B was expected to wash her hands after she had removed her gloves and before she began covering the pureed green beans. The Dietary Manager stated Dietary Aide A was expected to wash her hands after she touched the doorknob and before began pouring the salad dressing in the cups. She stated a resident could become ill if a resident ate any contaminated food. She stated the resident may develop stomach issues such as vomiting and diarrhea. The Dietary Manager stated she was responsible to ensure all the staff in the kitchen followed hand hygiene protocol. She stated she reviewed the hand hygiene policy during the in-service. Interview on 12/04/2025 at 8:40 AM, the Administrator stated her expectation was that beard restraints were to be worn by all staff in the kitchen., The Administrator stated she expected gloves to be changed, hands washed anytime staff touch contaminated items. She stated clothes and a doorknob would be considered contaminated. She stated there was a possibility if there was bacteria in food, a resident may develop a food borne illness. The Administrator stated the Dietary Manager was responsible for all protocols in the kitchen and she was responsible to monitor the Dietary Manager. Review of the Facility's Inservice Record on Hand Hygiene, dated 09/02/2025, reflected Dietary Aide A and Dietary [NAME] B was in attendance of the hand hygiene in-service. Review of the Facility's Protocol for Hand Hygiene is from the Texas Food Establishment Rules, not dated, reflected S228.38. Hands and Arms.(a) Clean Condition. Food employees shall keep their hands and exposed portions of their arms clean. (b) Cleaning Procedure.(1) except as specified in subsection (d) of this section, food employees shallclean their hands and exposed portions of their arms, including surrogate prosthetic devices forhands or arms for at least 20 seconds, using a cleaning compound in a handwashing sink that isequipped as specified under S228.146 and S228.175. (2) food employees shall use the following cleaning procedure in the order statedto clean their hands and exposed portions of their arms, including surrogate prosthetic devicesfor hands and arms:(A) rinse under clean, running warm water; (B) apply an amount of cleaning compound recommended by the cleaningcompound manufacturer; (C) rub together vigorously for at least 10 to 15 seconds while:(i) paying particular attention to removing soil from underneath thefingernails during the cleaning procedure, and(ii) creating friction on the surfaces of the hands and arms orsurrogate prosthetic devices for hands and arms, fingertips, and areas between the fingers; (D) thoroughly rinse under clean, running warm water. and(E) immediately follow the cleaning procedure with thorough drying usinga method as specified under S228.175(c). S228.38 (b)(3) S228.38 (d)(9)(3) to avoid re-contaminating their hands or surrogate prosthetic devices, foodemployees may use disposable paper towels or similar clean barriers when touching surfacessuch as manually operated faucet handles on a handwashing sink or the handle of a restroomdoor. (4) if approved and capable of removing the types of soils encountered in the foodoperations involved, an automatic handwashing facility may be used by food employees to cleantheir hands or surrogate prosthetic devices. (c) Special Handwash Procedures. Employees not utilizing suitable utensils or single-usegloves when handling ready-to-eat foods shall wash hands using the cleaning proceduresspecified in subsection (b)(2) of this section and follow the approved procedures specified inS228.65(a)(5) of this title.(d) When to Wash. Food employees shall clean their hands and exposed portions of theirarms as specified under subsection (b) immediately before engaging in food preparationincluding working with exposed food, clean equipment and utensils, and unwrapped single serviceand single-use articles and:(1) after touching bare human body parts other than clean hands and clean,exposed portions of arms; (2) after using the toilet room; (3) after caring (continued on next page)		

Department of Health & Human Services
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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.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for or handling service animals or aquatic animals as specified in S228.44(2); (4) except as specified in S228.42(b) after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (5) after handling soiled equipment or utensils; (6) during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (7) when switching between working with raw food and working with ready-to-eat food; (8) before donning gloves to initiate a task that involves working with food; and (9) after engaging in other activities that contaminate the hands.		

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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 of 5 residents reviewed for infection control practices. A) The facility failed to ensure the ADON used aseptic technique during wound care for Resident #16 By not cleaning the wound care supplies prior to treatment, not setting up the clean field per facility policy, not performing hand hygiene or glove changes at all appropriate opportunities not performing hand hygiene or glove changes between wounds, and not re-cleaning the wounds after they were contaminated during the treatment. B) The facility failed to ensure MA D did not contaminate Resident #13's medication during medication pass by not performing hand hygiene during medication administration and not sanitizing the blood pressure cuff prior to using on Resident #13. These failures could place residents at risk for developing wounds, upper respiratory infections and risk for healthcare associated cross-contamination and infections. Findings include: A) Review of Resident #16's face sheet dated 12/03/2025 reflected Resident #16 was admitted to the facility on [DATE] with the following diagnoses coronary artery disease, diabetes mellitus and dementia. Review of Resident #16's quarterly MDS assessment dated [DATE] reflected he was assessed to have a BIMS score of 6 indicating severe cognitive impairment. Resident #16 was assessed to not have wounds at the time of the assessment. Observation on 12/03/2025 at 3:25 PM revealed the ADON was outside of Resident #16's room preparing for wound care. The ADON gathered supplies and placed them on a piece of wax paper. She placed border gauze dressings, four normal saline vials, xeroform dressing, and an entire tube of Medi-honey on the wax paper. The ADON took a pair of scissors out of her pocket and placed them on her clean field without cleaning the scissors. The ADON took the supplies into the room and placed them on his overbed table without cleaning the table. The ADON took a sheet she found in the room to place on the overbed table which had food remnants on it. She then removed the dressing from both the inside right knee and outside of right knee of Resident #16. She changed her gloves then cleaned the inside knee wound and then cleaned the outside knee wound without changing gloves. She then stated she was out of gloves. The ADON used the sheet on Resident #16's bed to cover his leg with the wounds uncovered and left the room. She came back in the room and donned new gloves without hand hygiene. She then uncovered the leg by removing the sheet. Without change her gloves or recleaning the wounds, she used the dirty scissors to cut the xeroform dressing into two small squares. The ADON then applied the Medi-honey to both wounds using a different applicator for each wound, placed the xeroform dressing on the wound, and covered the wound with a dry gauze dressing. After the treatment, the ADON took all the unused supplies back to treatment cart which included the tube of Medi-honey, the remainder of the xeroform dressing, and two vials of normal saline. In an interview on 12/03/2025 at 3:45 PM, the ADON stated she should have cleaned her scissors prior to placing them on the clean field. She stated she should have cleaned the table prior to putting her clean field on it. The ADON stated she should have re-cleaned the wounds after she had covered them with the dirty sheet. The ADON stated she did not think about it at the time. She stated it was the facility's policy to treat each wound independently, and she should have cleaned one wound, performed hand hygiene, and changed gloves between each wound to prevent cross contamination. She stated she should not have brought the unused supplies back to the cart since they were considered dirty. She stated she thought it was ok since Resident #16 was the only one who used it. In an interview on 12/04/2025 at 9:30 AM, the RNC stated the ADON performing wound care should have cleaned the overbed table with an approved cleanser prior to putting down the clean field. The RNC stated the ADON should have cleansed the scissors and should not have brought anything that was in the room back to the treatment cart since it was considered contaminated. She stated the ADON should have treated each wound independently, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and performed hand hygiene and glove changes between each wound. She stated the ADON should have recleaned the wounds after using the sheet the cover the wounds because the wounds were contaminated by the sheet. B) Review of Resident #13's face sheet dated 12/03/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses chronic respiratory failure (the lungs cannot adequately exchange oxygen and carbon dioxide leading to decreased oxygen levels and increased carbon dioxide), protein calorie malnutrition, and macular degeneration (eye disease that affects central vision). Review of Resident #13's quarterly MDS dated [DATE] reflected she was assessed to have a BIMS score of 13 indicating her cognition was intact. An observation on 12/03/2025 at 8:05 AM revealed MA D was finishing a medication pass on another resident on the hall then took her med cart to Resident #13's room. MA D began preparing Resident #13's medication without performing hand hygiene. While placing the medications into the medication cup from the medication bottles, MA D used her fingers to touch the pills to prevent the extra pills from falling into the medication cup. MA D repeated this with each pill dispensed. MA D then opened the bottom drawer of the medication cart, pulled a blood pressure cuff from her personal bag, and took it into Resident #13's room. Without hand hygiene, MA D took Resident #13's blood pressure and administered her medications. MA D then took the blood pressure cuff back to the medication cart. In an interview on 12/03/2025 at 8:49 AM, MA D stated she was new and just learning. She stated she did not perform hand hygiene, and she did touch Resident #13's pills while dispensing them. She stated the blood pressure cuff was her personal cuff and she did not clean it and did not know she could not use it. In an interview on 12/04/2025 at 9:30 AM, the RNC stated staff should always perform hand hygiene during medication administration, should not touch resident medication with their bare hands, and should always clean multi use equipment like blood pressure cuffs prior to each use to prevent cross contamination. Review of the facility's Treatment Table policy dated 2003 reflected 1. Wash hands. Put on gloves. 2. Place wax paper on wound care bedside table or small cart. 3. Gather treatment supplies. (i.e., medicine, dressings, tape, extra gloves, etc.) Open up and place on top of wax paper. One end will be considered clean, and the other end of table will be open for dirty. (To replace scissors, etc. to be cleaned) 4. Place wax paper over top of supplies. 5. On open end place linens, saline, red bag, scissors, pen, camera, etc. on top of second cover of wax paper. 6. Lock up treatment cart and proceed to residents' room. Refer to treatment protocol for treatment procedures and applications. 7. After treatment place dirty linens, red bags, scissors, pen, etc. to be cleaned on open end (considered dirty end of table). 8. Wash hands. Take bedside table/cart to treatment cart. Put on gloves. Discard linens, red bags, etc., using universal precautions. Clean scissors, pen, etc., with alcohol preps. 9. Clean top of treatment cart, bedside table/cart, IV pole and vacu-max if used with disinfectant. (See Infection Control manual for approved type) Remove gloves, wash hands. Review of the facility's undated Dressing Change Checklist policy reflected .Washes hands; Gathers dressing change supplies for each wound according to orders for wound care and facility policy; Prepares a clean/dry surface for dressing change supplies. Demonstrates that cross contamination does not occur for ointments/products applied to wounds; Ointments and creams are appropriately labeled for patient prescribed and in individual containers(do not mix ointments or creams). Washes hands prior to applying gloves, when changing gloves and upon removal of gloves throughout dressing procedure; Utilizes gloves when in direct contact with patient according to facility policy. Changes gloves and wash/sanitize hands after removal of dressing and before cleaning wound or handling dressing supplies. Changes gloves and repeats procedure for each wound (more details) recommend separate set up each time they do a new wound unless in the same proximity or under the same dressing. Review of the facility's Medication Administration and General Guidelines policy dated 2025 reflected .The person administering medications adheres to Universal Precautions, using proper hand hygiene, gloves when appropriate, before beginning a medication pass, prior to handling any medication, and after coming into direct contact with a resident. Checklist for completing proper steps in the administration of medications; Washes hands using proper technique; Does not handle pills with bare hands.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 4 residents reviewed for accommodation of needs (Resident #33 and Resident #45. A) The facility failed to follow their facility policies and procedures and provide full time translation or interpretation services to Resident #33, a Spanish speaking resident. B) The facility failed to ensure Resident #45 specialty wheelchair was in safe working order so he could safely get out of bed. This failure could place residents at risk of miscommunication between the resident and staff, lead to misunderstandings about a resident's medical condition and treatment options, and improper care or inappropriate treatments or prescriptions. This failure further placed residents at risk for decreased quality of life, discomfort, and possible skin alterations. A) Record review of Resident #33's face sheet, dated 12/03/25, revealed a seventy-six-year-old male who was admitted to the facility on [DATE] and readmitted [DATE]. His admitting diagnoses included dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) unspecified severity, acute kidney failure (a sudden and often reversible reduction in kidney function, as measured by increased creatinine or decreased urine volume), and difficulty in walking. Record review of Resident #33's MDS dated [DATE] reflected (clinical assessment to determine resident's strength and needs) Quarterly Assessment reflected a BIMS score of 3 indicating severe cognitive issues, the resident identified an ethnicity of Mexican, Mexican American, Chicano, and preferred language was English. Record review of Resident #33's care plan revealed a focus dated 10/09/25 Resident #33 had a diet order other than regular and was at risk for unplanned weight loss or gain. Hard to make food preferences know Spanish speaking with intervention dated 10/09/25 determine food preferences and provide within dietary limitations and provide Spanish speaking staff to assist with food preferences review as needed. Focus dated 04/02/25 [Resident #33] has a communication problem r/t (no information provided on the care plan focus after the abbreviation r/t) with interventions dated 10/09/24 and 04/02/25: anticipate and meet needs, encourage resident to continue stating thoughts even if resident is having difficulty, focus on a word or phrase that makes sense, or responds to the feeling resident is trying to express, monitor effectiveness of communication strategies and assistive device, monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed, monitor/document frustration level. Wait 30 seconds before providing resident with word, CNA - Monitor/document residents ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend, monitor/document/report to MD PRN changes in: Ability to communicate, potential contributing factors for communication problems, potential for improvement, [Resident #33] is able to communicate by: (SPECIFY Lip reading, writing, using communication board, gestures, sign language, translator, CNA &ndash; [Resident #33] prefers communicating:(Specify; face to face, while family is present to translate, with the TV off etc.), CNA - OT/PT/Nurse to evaluate resident dexterity/ability to use communication board, writing, use computer or use of sign language as alternate communication to speech, provide a program of activities that accommodates the residents communication abilities, refer to speech therapy for (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation and treatment as ordered. Observation on 12/02/25 at 2:30 pm of Resident #33 revealed he spoke Spanish. Interview on 12/02/25 at 3:00 pm with Resident #33 reflected he spoke Spanish. The surveyor attempted to speak with Resident #33 through an approved HHSC translator, but the HHSC translator said Resident #33 was not answering the translator's questions. Interview on 12/3/2025 at 2:55 pm with Resident #33 translated by a Spanish-speaking member of the survey team reflected Resident #33 said he could understand a little English. He said there were staff who spoke to him in Spanish. The Spanish-speaking surveyor was unable to ask additional questions because Resident #33 was responding to the questions with unrelated answers to her questions. Interview on 12/03/2025 at 3:13 pm translated by a Spanish-speaking member of the survey team with Resident #33's Spanish-speaking RP reflected the RP said Resident #33 knew a little English. The RP said that there were a few people at the facility who translated for him. Resident #33's RP said Resident #33 would benefit from a translation or communication service because she was not always there to interpret for Interview on 12/03/25 at 11:01 am with CNA G reflected she worked with Resident #33, and Resident #33 spoke Spanish. She said to communicate with him, she sometimes would get an interpreter and sometimes she would use sign language. She said he did not have a communication board, but she used an App (software application designed to run on a mobile device) to assist with translation. She said the facility did not have an interpreter 24 hours a day. She said language interventions would probably be helpful, but she felt like they had a routine, and they understand each other now. She said if Resident #33 had a fall they could use the google language translation application on their phones to communicate with Resident #33. Interview on 12/03/25 at 2:00 pm with CNA I reflected she worked with Resident #33, and it was kind of hard to communicate with him because he did not speak English at all. She said when she spoke to him, he would direct and point. She said she would get someone to translate. She said because she worked with him a little while, she could make out what he was saying. She said he would use his hands to point to where he was hurt. She said if they worked with him for a little while, they could pick up his pattern and tell what he wanted or needed. She said the facility had not put anything in place to help communicate with Resident #33. She said he did not have a communication board to assist with translations from Spanish to English, but she thought it would be very helpful. She said she had not spoken with anyone about getting a better way to communicate with Resident #33. She thought the Administrator would be responsible for getting something to communicate with Resident #33. She thought that a communication board would be helpful if he had an injury because they might be able to communicate with him better. Interview on 12/04/25 at 10:05 am with the Social Worker reflected there was a translation board for Resident #33 and staff used the google language translation application on their phones to communicate with Resident #33. She said that the therapy department had a translation board and therapy used the google language translation phone application. She said if staff did not speak Spanish, all aides and nurses used the phone App to communicate with Resident #33. She said there was no translator at the facility 24 hours a day and the negative effect of not having effective translation for Resident #33 was miscommunication of the resident's needs. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/4/25 10:30 am with the MDS Coordinator reflected because Resident #33 was a Spanish speaker in a predominantly English-speaking facility, his language needed to be addressed to provide better care for him. She said the social worker was responsible for accommodating any issues involving any possible language barriers. She said there were some Spanish-speaking employees who spoke with him in his language. She said he spoke broken English. She said the possible negative effect of not being able to communicate with a resident who spoke another language was that if the resident was in pain, the resident might not be able to express it fully and might not get what they needed. Interview on 12/04/25 at 10:42 am, CNA J reflected she worked with Resident #33 daily and communicated with him to the best of her ability. She said he did speak some English, and she spoke slowly and tried her best to get him to understand what she was going to do to help him. She said most of the time, he understood and when he did not understand, she tried to find someone to speak Spanish to him. She said the people who spoke Spanish were not at the facility all the time. She said she thought a communication board would be helpful to facilitate some communication. She said she had not spoken with the Administrator or the ADON about how to communicate with him. Interview on 12/04/25 at 10:55 pm with LVN K reflected she worked with Resident #33, and he spoke fluent Spanish and some English. She said Spanish worked better for him. She said some nurses used the google language translation application on their phones to communicate with Resident #33, but there was no communication board. Interview on 12/04/25 at 11:22 am by telephone with RN L reflected she was the weekend supervisor and worked with Resident #33. She said Resident #33 spoke some English, but mostly Spanish. She said sometimes there was someone at the facility who could translate. She said there was nothing in his care plan regarding how to communicate with him and said it for sure would be good to get some interventions. Interview on 12/04/25 at 11:38 pm with the RCN reflected she said Resident #33 did not have a communication board or interventions in place to communicate with Resident #33 as a Spanish speaker. She said it was the responsibility of the whole team to get this together. She said the possible negative effects of not having a communication plan would be to not know Resident #33's wishes and possibly not know when he was feeling bad. Interview on 12/04/25 at 11:50 pm with the ADON reflected she had given care to Resident #33, and he understood simple questions, and she used gestures to communicate with him. She felt like using a more formal way to communicate with Resident #33 could help. Interview on 12/04/25 at 12:59 pm with the Administrator reflected She had not seen the staff communicate with Resident #33. She said she thought they communicated using the google language translation application on their phones and using gestures. She said they did not have a formal program in place to communicate with Resident #33, who was a Spanish-speaking resident. The problem with not following the facility policy for translation was something could be missed in Resident #33's care and a translation policy should be in place for to all for proper resident assessment. Record review of the facility's Interpreter Services, undated, reflected access to basic health care services is the right of every resident. Access to information regarding basic health care services is an essential element of that right. Where language or communication barriers exist, the facility will (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	make provisions to optimize communication between the residents and staff members. When language or communication barriers exist between residents and the staff of Facility, arrangements will be made at the facility level for interpreters. Bilingual professional staff may also be used to facilitate communication between residents and staff. Facility will post notices to advise residents and their families of the availability of interpreters and the procedure for obtaining an interpreter. The facility will also prepare and maintain a list of interpreters in the community. The facility will notify employees of the facility's commitment to provide interpreters to all residents that request them. The facility will have adopted and reviewed annually a policy for providing language assistance services to residents. The policy will include procedures for providing, to the extent possible, the use of an interpreter whenever a language or communication barrier exists. When a resident, after being informed of the availability of the interpreter service, chooses to use a family member or friend who volunteers to interpret, the facility will respect the resident's decision to use the family member. However, the facility will continue to obtain education for the staff or utilize outside resources to enhance communication on the facility's behalf. The procedure used by the facility will ensure to the extent possible, as determined by the facility, that interpreters are available either on the premises or accessible by telephone 24 hours per day. Personnel will contact Social Services or the DON for interpreter resources and for availability for access to TDD phones. Family members and friends should not be used as interpreters. The only case when this is acceptable is when the resident has been made aware of the advisability of qualified interpreters at no additional charge and without any coercion whatsoever, chooses the services of family members or friends. B) Review of Resident #45's face sheet dated 12/04/2025 reflected Resident #45 was admitted to the facility on [DATE] with the following diagnosis spastic quadriplegic cerebral palsy (Spastic quadriplegia cerebral palsy is a type of cerebral palsy that affects both arms and legs and often the torso and face. Quadriplegia is the most severe of the three types of spastic cerebral palsy.), contracture left elbow, contracture right elbow (a condition of shortening and hardening of muscles, tendons or other tissue) and muscle wasting and atrophy. Review of Resident #45's quarterly MDS dated [DATE] reflected he was assessed to have a BIMS score of 99 indicating severe cognitive impairment. Resident #45 was assessed to be dependent on staff for all ADLs. Review of Resident #45's comprehensive care plan reflected a focus area dated 04/17/2023 Resident has an ADL self-care performance deficit. Interventions included Transfer with Hoyer lift times 2 staff and may use Geri-chair. Observation on 12/02/2025 at 9:00 AM revealed Resident #45 was in his room in bed. Observation on 12/02/2025 at 12:10 PM revealed Resident #45 was being fed in his room in bed. Observation on 12/02/2025 at 4:30 AM revealed Resident #45 remained in bed. Observation and interview on 12/03/2025 at 11:55 AM revealed CNA F was working on Resident #45's hall. She stated Resident #45 was able to get up out of bed, but his seat belt is broken in his wheelchair, and it is not safe for him to get up. She stated everyone knows about his wheelchair being broken. She stated she did not know how long it has been broken, but it has been broken awhile. Observation on 12/03/2025 at 12:00 PM revealed Resident #45 was in his room in bed, and was not gotten up for lunch. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/04/2025 at 8:30 AM, the RNC stated she did not know Resident #45's wheelchair was broken. She stated she would investigate it. In an interview on 12/04/2025 at 9:00 AM, the RNC stated Resident #45's wheelchair was broken. The RNC stated the staff told her Resident #45 was not getting up because they did not think he could get in a Geri-chair. She stated they would be getting in touch with physical therapy about getting his wheelchair fixed. She stated, truthfully, the situation had been going on for a while. She stated she would get an order to use the Geri-chair so he can get up. In an interview on 12/04/2025 at 9:43 AM, Resident #45's RP stated he did not know Resident #45 was not getting up. He stated he wanted Resident #45 to be gotten up so he can get out of the room and have stimulation. Observation on 12/04/2025 at 9:47 AM revealed Resident #45 up in a Geri-chair in the communal area. Review of the facility's Resident Rights policy dated 11/28/2016 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.The right to receive the services and/or items included in the plan of care.		

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NAME OF PROVIDER OR SUPPLIER Crossroads Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 611 Rose Marie Blvd Hearne, TX 77859	
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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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs for one (Resident #33) of five residents reviewed for care plans, in that:1. The facility failed to complete a person-centered care plan for Resident #33's primary language as a Spanish . 2. The facility failed develop a care plan for Resident #33's refusals to take showers (refusal timeline unknown). This failure placed residents at risk of unaddressed needs, fragmented care, emotional distress (anxiety, depression), poor health outcomes, and a loss of dignity/autonomy, leading to a lower quality of care and not receiving goals and interventions for the residents' individual needs for person-centered care.Findings included: Record review of Resident #33's face sheet, dated 12/03/25, revealed a seventy-six-year-old male who was admitted to the facility on [DATE] and readmitted [DATE]. His admitting diagnoses included dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) unspecified severity, acute kidney failure (a sudden and often reversible reduction in kidney function, as measured by increased creatinine or decreased urine volume), and difficulty in walking. Record review of Resident #33's MDS dated [DATE] reflected (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns revealed a score of 3 indicating severe cognitive issues and Section A - A1005 Ethnicity Mexican, Mexican American, Chicano and Section A - A1110 what is your preferred language - English. Record review of Resident #33's care plan revealed a focus dated 10/09/25 Resident #33 had a diet order other than regular and was at risk for unplanned weight loss or gain. Resident #33 was not care planned for his primary language being Spanish and that he refuses to take showers. For example, Hard to make food preferences know Spanish speaking with intervention dated 10/09/25 determine food preferences and provide within dietary limitations and provide Spanish speaking staff to assist with food preferences review as needed. Focus dated 04/02/25 [Resident #33] has a communication problem r/t (no information provided on the care plan focus after the abbreviation r/t) with interventions dated 10/09/24 and 04/02/25: anticipate and meet needs, encourage resident to continue stating thoughts even if resident is having difficulty, focus on a word or phrase that makes sense, or responds to the feeling resident is trying to express, monitor effectiveness of communication strategies and assistive device, monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed, monitor/document frustration level. Wait 30 seconds before providing resident with word, CNA - Monitor/document residents ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend, monitor/document/report to MD PRN changes in: Ability to communicate, potential contributing factors for communication problems, potential for improvement, [Resident #33] is able to communicate by: (SPECIFY Lip reading, writing, using communication board, gestures, sign language, translator, CNA - [Resident #33] prefers communicating:(Specify; face to face, while family is present to translate, with the TV off etc.), CNA - OT/PT/Nurse to evaluate resident dexterity/ability to use communication board, writing, use computer or use of sign language as alternate communication to speech, provide a program of activities that accommodates the residents communication abilities, refer to speech therapy for evaluation and treatment as ordered. Observation on 12/02/25 at 2:30 pm of Resident #33 speaking Spanish.Observation on 12/03/25 at 3:00 pm with Resident #33 reflected he smelled of urine. Interview on 12/03/25 at 11:01 am with CNA G reflected she worked with Resident #33, and she said he refused his showers. She said she knew they were supposed to make a documentation in the POC (the act of recording clinical information while providing patient care) that he refused to take a shower. She said she would ask him a couple of (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times to take a shower and if he still refused, she would tell a nurse. Interview on 12/03/25 at 2:00 pm with CNA I reflected Resident #33 refused his showers a lot, and she had reported it to the nurse. She said all she could do was encourage him to take a shower. She said she was not responsible for care plans, but she had looked at resident Kardex (a desktop file system that gives a brief overview of each resident). She said she filled out a shower sheet indicating that a resident refused to take a shower when they refused. Interview on 12/03/2025 3:13 pm by telephone by Spanish speaking member of the survey team with Resident #33's Spanish speaking RP reflected she wanted to know if Resident #33 was getting his showers. The RP said she noticed he smelled and appeared to not have showered. Interview on 12/04/25 at 10:05 am with the Social Worker reflected that she both organized and participated in care plan meeting. She said she can modify and add to a resident's care plan. She said Resident #33 should have been care planned as a Spanish speaker with interventions. She said they should have caught it, and it should be in his care plan. She said he should have had an intervention of a communication board. She said the MDS nurse was responsible for making sure Resident #33 was care planned as a Spanish speaker. She said the negative effect of not care planning Resident #33 as a Spanish speaker was staff could miscommunicate with him. Interview on 12/04/25 10:30 am with the MDS Coordinator reflected care plans were collaborative. She said care plans were individualized for each resident, and it should have been in Resident #33's care plan that he spoke Spanish. She said because he was a Spanish speaker in a predominantly English-speaking facility his language needs needed to be addressed to provide better care for him. It was important to discuss in the care plan how to accommodate him as a Spanish speaker. She said the facility had not had an MDS Coordinator for a while, but she had been going back into care plans as time provided to update resident care plans. She said Resident #33 should have been care planned as a Spanish speaker and for shower refusals. Interview on 12/04/25 at 10:42 am CNA J reflected she worked with Resident #33 daily and communicated with him to the best of her ability. She said he did speak some English, and she spoke slowly, in English, and tried her best to get him to understand what she was going to do to help him. She said most of the time he understood and when he did not understand, she tried to find someone to speak Spanish to him. She said the people who spoke Spanish were not at the facility all the time. She said she thought a communication board would be helpful to facilitate communication. She said she had not spoken with the Administrator or the ADON about how to communicate with him. CNA J said Resident #33 refused showers and was non cooperative no matter if you told him in English or Spanish. She told his nurses that he did not want to take his showers. Interview on 12/04/25 at 10:55 pm with LVN K reflected she worked with Resident #33, and he spoke fluent Spanish and some English. She said Spanish worked better for him. She said some nurses used the google language translation application on their phones to communicate with Resident #33, but there was no communication board. She did not know if Resident #33 was care planned as Spanish speaking. She said she had access to care plans and could amend care plans. She said the definition of a care plan was an outline of the of the care needs for a resident and should include anything including his Spanish speaking. She said the MDS Coordinator did care plans, and not all the nurses knew how to do care plans. She said all resident care refusals should be care planned. She said it was a fight to get Resident #33 to take a shower. She said his shower refusals should have been care planned and documented. She said a possible negative effect of not documenting in the care plan that he was not taking showers was skin breakdown. He could have skin break down because of his refusals to take showers but the reason for the breakdown was not documented. She said the care plan was a complete picture of the resident's care, and if you did not document in the care plan Resident#33's shower refusals or his primary language, you do not have a complete picture of Resident #33's care. Interview on 12/04/25 at 11:22 am by telephone with RN L reflected she was the weekend supervisor and worked with Resident #33. She said Resident #33 spoke some English but mostly Spanish. She said sometimes there was someone at the facility who could translate with Resident #33. She said a care plan was the overview of how they provided the best care for residents (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and listed the interventions of how to meet the residents' needs and track how the residents progressed with goals. She said there was nothing in Resident #33's care plan regarding how to communicate with him and said it for sure would be good to get some interventions. She said the possible negative effect of not having care planned interventions for his language would be a possibility of not being able to have an accurate assessment if he was in pain. She said any resident who required specialized communication should be care planned for ways to communicate. She said she felt like Resident #33 had refused to take showers. She said she felt like shower refusals should be care planned if they were a consistent problem. She said residents with dementia sometimes do not understand the importance of taking showers. She did not know who was responsible for making sure there was a language intervention in Resident #33's care plan, but interventions would help. Interview on 12/04/25 at 11:38 pm with the RCN said Resident #33's shower refusals and his language preference should have been care planned. A possible negative effect of Resident #33 refusing showers was that no one would know he refused and therefore staff did not discuss ideas on how they could get him to take a shower. It was the responsibility of the whole team to put together communication interventions for Resident #33 and his communication as a Spanish speaker should have been care planned. The possible negative effects of not having a communication plan would be not knowing his wishes and possibly not knowing when he was feeling bad or if he could not tell staff how he was feeling. She said the whole IDT team was responsible for care plans. She said the IDT team consisted of nurses, the Administrator, CNAs, the social worker, therapy, dietary manager and all department heads. Interview on 12/04/25 at 11:50 pm with the ADON reflected she did not know if Resident #33 was care planned for his language because she did not do care plans. She said the language of a resident should be care planned with interventions on how to communicate. She said a care plan was a plan of how to care for a resident. She said if they knew a resident had a language barrier it should be care planned with set goals for how they would understand the resident. She did not recall if anyone reported to her that he refused showers. She said shower refusal should be care planned. She said a negative effect of not care planning shower refusals would be that staff were not aware of him refusing his showers. Interview on 12/04/25 at 12:59 pm with the Administrator reflected a care plan broke down everything about the residents, including likes and dislikes and how to care for the residents. She said the MDS Coordinator, nurses, the DON, and the activities director were responsible for care plans. She said a resident's primary language of communication should be care planned. She said a negative effect of language preference not being in the care plan was the resident could not get the right type of care that was needed. She said Resident #33's shower refusals should absolutely be care planned. She said the refusal of care needed to be care planned so they knew there was a behavior, and they knew how to address it and put interventions in place. Record review of the facility's Comprehensive Care Planning policy 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 psychosocial needs that are identified in the comprehensive assessment. Each resident will have a person-centered comprehensive care plan developed and implemented to meet preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility. The facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives. Care plans will be person-centered and reflect the resident's goals for admission and desired outcomes. Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home. Residents' goals set the expectations for the care and services he or she wishes to receive. Measurable objectives describe the steps toward achieving the resident's goals, and can be measured, quantified, and/or verified. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. 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.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of eight residents (Resident #27 and Resident #39) reviewed for ADL care. The facility failed to ensure Resident #27 and Resident #39's nails were cleaned and trimmed on 12/04/2025. This failure could place residents at risk of not receiving services or care, diminished quality of life, and decreased self-esteem. Findings included: Record review of Resident #27's face sheet, dated 12/03/2025, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (a stroke where blood supply to part of the brain is cut off, causing brain cells to die. Paralysis (hemiplegia) or weakness (hemiparesis) affecting one side of the body in this case, the right side. Weakness or inability to move the right arm, leg , and potentially the right side of the face), type 2 diabetes mellitus with unspecified complications (a chronic condition where the body either doesn't produce enough insulin or doesn't use insulin effectively (insulin resistance), leading to high blood sugar (glucose) level. Complications can involve damage to blood vessels and nerves, leading to a wide range of chronic issues and potentially acute, life-threatening conditions), and need assistance with personal care (helping someone with daily activities they find difficult, covering physical tasks like bathing, dressing, eating, toileting, and mobility. Resident #27 needed emotional support, and grooming, all to maintain dignity, safety, independence, whether temporarily or long term). Record review of Resident #27's Quarterly MDS Assessment, dated 09/29/2025, reflected the resident had a BIMS score of 6, which indicated his cognition was severely impaired. Resident #27 was dependent on staff for toileting hygiene, showers, and dressing. He required substantial/maximal assistance- (helper does more than half the effort) with personal hygiene and oral hygiene. Record review of a Comprehensive Care Plan, with start date of 10/01/2025 and completed date of 10/19/2025 reflected Resident #27 had an ADL self-care performance deficit - problem initiated on 07/26/2025. Interventions: revised on 10/02/2025 Resident #27 was total dependent on staff for bathing, toileting, bed mobility, dressing, and mobility. During bathing staff was to check nail length and trim and clean on bath day and as necessary. If diabetic, the nurse will provide toenail care. Report any changes to the nurse. Observation and interview on 12/02/2024 at 9:45 AM, revealed Resident #27 was lying in bed watching television. He stated he had concern about his fingernails on his left hand. He held out his left hand and his nails were long, approximately 1 inch pass the tip of all of his fingers on his left hand. His middle, ring and fore finger had blackish / brownish substance underneath his nails. Resident #27 stated he asked a staff if they could cut and clean his nails on Saturday and the staff explained to him, they would trim and clean his nails sometime next week (referring to the week beginning 12/01/2025). Resident #27 did not recall the staff name. He stated he was afraid he would scratch himself and develop a sore on somewhere on his body. Resident #39 Record review of Resident #39's face sheet dated, 12/04/2024, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of cerebral infarction, unspecified (a stroke occurred due to a blocked artery in the brain, causing brain tissue death (infarction), but the specify artery or cause isn't detailed in the medical record), pain in unspecified joint (pain in joints is discomfort you can feel- not specified which joint in medical record), muscle weakness (a loss of strength or inability to move muscles effectively), and other lack of coordination (difficulty performing smooth, controlled movements, resulting in clumsiness, unsteadiness, poor balance, and trouble with tasks needing fine motor skills like writing or gross motor skills like walking). Record review of Resident #39's Quarterly MDS Assessment, dated 08/29/2025, reflected Resident #39 had a BIMS score of 5, which indicated his cognition was severely impaired. Resident #39 required substantial/ maximal assistance (helper does more than half the effort) with personal (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hygiene and showers. He required supervision or touching assistance with the following: dressing, toileting hygiene, oral hygiene, transfers, and bed mobility. Record review of a Comprehensive Care Plan, revised on 09/29/2025, revealed Resident #39 had an ADL Self Care Performance Deficit. Interventions: Resident #39 required one staff assistance with personal hygiene and bathing. Check Resident #39's nail length. Trim and clean Resident #39's nails on bath day and as needed. Report any changes to the nurse. Observation and interview of Resident #39 on 12/02/2025 at 10:15 AM, revealed Resident #39 was lying in bed watching television. He stated he did not have any concerns and then stated look at my fingers. When he stretched out both of his arms and showed his fingernails on both hands, he had a fingernail beginning to curl on his right thumb. His nails was approximately 2 to 3 inches long on every finger on left and right hand. He stated he asked some people to cut and clean his nails, and they tell me they will do it later. He did not recall the name of the staff or the position of the staff. He stated he asked someone few days ago (he did not recall the exact date or time). Observation and interview of Resident #39 on 12/03/2025 at 8:05 AM, revealed Resident #39 was sitting in the dining room finishing his breakfast. Resident #39 smiled and stated, I remember talking to you yesterday about my nails. When he made this statement, he showed his nails and stated no one has cleaned or cut my nails. He stated they are so long it was difficult for him to pick up his fork to eat. Resident #39's nails continued to be 2-3 inches long on every finger on right and left hand. Interview on 12/03/2025 at 8:10 AM, the Regional Nurse Consultant stated Resident #27's are very long, and they are dirty. She stated one of his nails on his thumb was beginning to curl. She stated all residents' nails was expected to be trimmed and cleaned by CNA's and nurses. She stated if a resident was a diabetic the nurses would trim and clean the nails. The Regional Nurse Consultant stated the CNAs would trim and clean the non-diabetic nails. She stated residents was expected to have their nails checked, trimmed and cleaned during showers or as needed. She stated if a resident refused it would be documented in the nurses' notes. The Regional Nurse Consultant stated the CNAs was expected to report any issues with nails to the nurse supervisor. She stated the DON, ADON and Nurse Supervisors was responsible to ensure the residents was receiving ADL care including nail care. Interview on 12/03/2025 at 1:50 PM, CNA G stated nursing staff was responsible for trimming, cleaning and filing resident nails. She stated the CNA's does all nail care on all residents except the residents with diagnosis of diabetes. She stated the nurses was responsible for residents with diabetes. CNA G stated staff was required to perform nail care when residents received showers and as needed. She stated she had given care to Resident # 27 and Resident #39. She stated sometimes Resident # 39 will refuse showers, but he does not refuse nail care. CNA G stated Resident # 27 did not refuse showers or nail care. She stated if a resident nails was too long there was a possibility the resident may scratch themselves or another resident. CNA G stated she did not know when the last time Resident #27 or Resident #39 had their nails trimmed or cleaned. She stated if a resident refused the CNA reports the refusal to the nurse supervisor and they documented in their progress notes. She stated if the scratch was deep enough on the skin it may result in a skin tear. She also stated if resident had blackish/brownish substance underneath their nails and they swallowed the blackish/ brownish substance there was a potential a resident may become physically ill with stomach issues such as nausea, vomiting, and/ or diarrhea. She stated she had been in-service on nail care; however, she did not recall the date and time of the in-service. In an interview on 12/03/2025 at 2:05 PM, CNA H stated the CNAs were responsible for cleaning, trimming, and filing all residents' nails except for the residents with a diagnosis of diabetes. She stated the nurses were responsible for all the residents' nails with a diagnosis of diabetes. CNA H stated the residents' nails were usually cleaned on their shower days and as needed. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill, such as nausea and diarrhea. CNA H stated if a resident's nails were too long there was a possibility the resident cut their eyeball if they scratched their eyes or receive a skin tear. She stated she was in-serviced on cleaning, filing, and trimming residents' nails (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but she did not recall the date. She stated she had given care to Resident # 27 and Resident # 39, and they did not refuse nail care. CNA H stated she did not know the last time these residents' nails were trimmed or cleaned she would need to check the medical records. In an interview on 12/04/2025 at 2:10 PM, the ADON stated if a resident ingested the blackish substance on their fingers or underneath their fingernails, there was a possibility the substance may be some type of bacteria, however it would be difficult to determine if the blackish/ brownish substance was bacteria. She stated it was a possibility a resident may become ill with stomach issues such as vomiting and nausea if they ingested the blackish/ brownish substance. She stated the CNAs were responsible for all residents' nails such as cleaning, trimming, and filing except for the residents with diabetes. She stated for any resident with a diagnosis of diabetes the nurse was responsible for these residents' fingernails. The ADON stated the nurse supervisor was responsible for monitoring CNAs giving ADL care which included nail care, and the ADON and DON was responsible for monitoring the nurse supervisors. The ADON stated if a resident refused nail care the CNA was expected to report any issues to the nurse and the nurse would document refusal in the nurses' notes. She stated she was not aware of Resident # 27 or Resident #39 refusing nail care. She stated she was not aware of any resident in the facility refusing nail care. ADON stated she knew Resident # 39 sometimes refused showers but not often. She stated it was not reported in morning meetings or any type of nursing meetings of Resident #39 or Resident # 27 refusing nail care. She stated anytime a resident refused care it was mentioned in reports with nurses and in morning meetings. Review of the Facility's Policy on Nail Care, not dated, reflected Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath. Nails can become thinner and more brittle in the elderly and thicker if peripheral circulation is impaired. Nails are also important in assessment, as changes occur with certain medical conditions, such as clubbing with chronic pulmonary disease (long term lung conditions that block airflow, making it hard to breathe and leading to shortness of breath, wheezing, and a persistent cough with mucous), or cardiac disease (conditions affecting the heart and blood vessels, including blocked arteries, irregular heartbeats, or heart failure). Goals1. Nail care will be performed regularly and safely.2. The resident will be free from abnormal nail conditions.3. The resident will be free from infection.When nail care performed at bath time, the nail care can be done following the procedure or as a separate procedure when needed at the convenience of the resident.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure the storage of medications used in the facility in accordance with currently accepted professional principles for 1 of 3 medication carts reviewed. The facility failed to ensure potential contaminants, including personal items, were not on the medication carts. This failure could place residents at risk of receiving contaminated medications resulting in adverse health consequences. Findings include: Observation and interview on 12/03/2025 at 8:05 AM revealed MA D during medication preparation for Resident #13. MA D opened the bottom drawer of the medication cart to reveal a large bag. MA D removed a blood pressure cuff from the bag. MA D stated the bag was hers, and that the blood pressure cuff was her personal blood pressure cuff. In an interview on 12/03/2025 at 8:49 AM, MA D stated she did not know she could not put her bag on the medication cart, and did not know why she should not have her bag on the medication cart. In an interview on 12/04/2025 at 9:30 AM, the RNC stated staff should absolutely not store personal items on the medication carts, because it can cause cross contamination. Review of the facility's Medication Storage policy dated (with only the year) 2025 reflected Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication storage areas are kept clean, well lit, and free of clutter.		