STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455522	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tlc West Nursing and Rehabilitation	1700 Marlandwood Rd Temple, TX 76502

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49410 Based on interview, and record review, the facility failed to care for residents in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 4 residents (resident #17) reviewed for resident rights. The facility failed to ensure Resident #17 was not given showers late at night since that was not his preference. This failure could place residents at risk for diminished quality of life. The findings include: Record review of Resident #17's face sheet revealed Resident #17 was a [AGE] year-old male with an admitted [DATE] into the facility. Resident #17 has a primary diagnosis of bacterial infection (infection inside the body created by bacteria), resistance to carbapenem (when germs are not healed by antibiotics), acute respiratory failure (not enough oxygen or too much carbon dioxide in your body), and quadriplegia (paralysis of all four limbs). Record review of Resident #17's MDS assessment revealed a BIMS score of 15 which noted the resident had no cognitive impairment. The MDS revealed that Resident #17 was dependent for ADL needs including showering and bathing. Resident #17 being dependent meant the helper does all of the effort while the resident does not effort in completing the task. Or the assistance of two or more helpers is needed to complete the task. Record review of Resident #17's care plan revealed there were no preferences for a late shower at the facility. It also revealed that Resident #17 is dependent for ADL's due to a diagnosis of functioning quadriplegia, with staff would anticipate and meet the needs of the resident. Record review of Resident #17's shower log revealed he had received his showers multiple times after 09:00 PM in the month of August and September. The log showed: 1. Shower provided on 08/25/2024 at 12:10AM with total assistance provided 2. Shower provided on 08/31/2024 at 11:10PM with total assistance provided (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Shower provided on 09/07/2024 at 11:53PM with total assistance provided 4. Shower provided on 09/11/2024 at 12:03AM with total assistance provided 5. Resident's shower schedule was for Tuesday, Thursday and Saturdays provided on the evening shift. On 09/15/2024 at 01:54 PM, an interview was conducted with Resident #17. Resident #17 stated that he received showers three times a week at night. On 09/16/2024 at 11:00 AM, an interview with Resident #17 revealed that his typical shower times had been any time after 9:00 pm. He stated that it was not a preference of his, but the staff shower everybody else first before him. He stated they wait to shower him so that he can get his treatment and then go to bed. He stated that a late shower was better than no shower. Resident #17 stated that he would wait in his wheelchair until after staff gave him a shower so he could go to bed. On 09/17/2024 at 12:03 PM an interview was conducted with CNA G that revealed Resident #1's showers were provided at night. CNA G stated that Resident #17 would often leave the premises early in the morning and would be gone all day. CNA G believed that it was preference of Resident #17 to receive showers late at night. On 09/17/2024 at 12:45 PM, an interview was conducted with CNA F that revealed residents are offered at least 3 showers per week. CNA F stated that Resident #17 typically received showers on Tuesdays, Thursdays and Saturdays at night. CNA F stated that Resident #17 is provided showers late at night due to Residents #17 being out of the facility until 9 PM. CNA F believed that it was Resident #17's preference to shower at night then go to bed. CNA F stated Resident #17 has not wanted to take a shower early. CNA F stated that Resident #17 could feel upset for having to wait for showers until late at night. CNA F reported she received training on resident rights. She stated an example of resident rights are the right to be treated with dignity and respect, right to take showers and the right to come and go whenever they want. On 09/17/2024 at 01:47PM, an interview was conducted with DON that revealed residents are offered showers three times a week at minimum with Sunday being a day without showers. DON A stated showers are provided on day and evening shifts depending on where the resident resided in the facility. DON A stated there was not a specific time that the showers should get completed each day. DON A stated that the schedule is flexible for residents. DON A stated that there are residents that leave the facility in their wheelchair and do not return until late at night which resulted in late showers. DON A stated it is not normal to receive a shower after midnight but it has happened before due to residents not returning to the facility until late at night. DON A stated that there is no documentation to identify when a resident was late to the facility resulting in a late shower. DON A stated that residents have the right to shower when they want to. DON A stated that Resident #17 will typically arrive back to the facility late at night and refuses a shower. DON A stated Resident #17 likes to get up in the morning and leave the facility. DON A denied offering an earlier shower time to Resident #17. DON A stated documentation for late showers for Resident #17 meant that Resident #17 got back to the facility late that night. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/17/2024 at 2:09PM, an interview was conducted with ADM. ADM reported that showers are provided during the day and night shift depending on the preferences of the resident. ADM reported his expectation is that all residents are offered showers 3 times a week or as needed. ADM reported that there was no expectation for when showers should be completed by during the night shift due to residents not wanting to take a shower until later. ADM stated Resident #17 would stay out in the community a lot, and he will come and go late at night. ADM stated that Resident #17's out of the facility schedule is not routinely documented to know when a late night shower occurred due to resident being out of the facility. ADM stated that Resident #17 had been offered earlier shower times but denied Resident #17 wanting an earlier shower time. RR of facility provided policy titled Your Rights and Protections as a Nursing Home Resident with an unknown date revealed that resident have the right to: 1. To participate in the decisions that affects your care.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 3 (Resident # 5, Resident # 25, and Resident # 39) of 13 resident reviewed for resident rights. 1. The facility failed to ensure Resident # 5 and # 25's bedroom had no foul odors, the restroom floor did not have bags of soiled briefs in the corner by the toilet, and pair of pants with a soiled brief on the restroom floor. 2. The facility failed to ensure Resident # 25's over bed table was clean and free from food and beverage debris. 3. The facility failed to ensure Resident # 5 and # 25's restroom baseboard was secured to wall and not a fall hazard. 4. The facility failed to ensure Resident # 5 and # 39's bed sheets were clean. These deficient practices could place residents at risk of infection and a decreased quality of life. Findings included: 1. Record review of Resident # 5's Admission Face sheet dated 9/16/24 reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of dementia, chronic kidney disease stage 3, type 2 diabetes, hypertension, atherosclerotic heart disease, acute pain due to trauma, severe protein calorie malnutrition, chronic foot ulcers due to diabetes, diabetic retinopathy, history of pulmonary embolism, febrile neutrophilic dermatosis, and vascular dementia. Record review of Resident # 5's Quarterly MDS assessment dated [DATE] reflected, Resident # 5 had a BIMS score of 13 indicating the Resident's cognition was intact. Resident # 5 had a diagnosis of non-Alzheimer's dementia, diabetes mellitus, renal insufficiency, renal failure, or end stage renal disease, diabetic retinopathy with macular edema, and chronic foot ulcers related to diabetes. Resident # 5 needed partial to moderate assist for toileting transfers and supervision or touching assist for toileting hygiene. Record review of Resident # 5's Comprehensive Care Plan initiated 2/25/23 revised on 6/20/24 with a target date of 9/10/24 reflected Resident # 5 has an ADL self-care deficit related to history of falls, diabetic foot ulcer, macular degeneration, and retinopathy due to diabetes. Interventions include resident requires supervision of staff for toileting, personal hygiene, and transfers. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident # 25's Admission Face sheet dated 9/16/24 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of hemiparesis and hemiplegia following CVA, hypertension, major depressive disorder, anxiety disorder, insomnia, GERD, muscle weakness, epilepsy, anemia, acquired absence of kidney, disorder of kidney and ureter, convulsions, dementia, obstructive and reflux uropathy. Record review of Resident # 25's Quarterly MDS assessment dated [DATE] reflected, Resident # 25 had a BIMS score of 15 indicating the Resident's cognition was intact. Resident # 25 had a diagnosis of obstructive uropathy, non-Alzheimer's dementia, hemiplegia or hemiparesis, Epilepsy, disorder of kidney and ureter, and acquired absence of kidney. Resident # 25 was dependent on staff for all toileting needs. Record review of Resident # 25's Comprehensive Care Plan initiated 2/10/21 and revised on 8/28/24 reflected Resident # 25 has mobility impairment and is dependent for ADL's. Interventions include staff will ensure resident has access to needed DME and assist resident with ADL's without prejudice throughout stay. Resident # 25 has an ADL performance self-care deficit related to hemiplegia due to stroke. Interventions include resident is not toileted resident is incontinent of bowel. Resident requires total assist x 2 staff per mechanical lift for all transfers. Resident # 25 requires assistance by 1 staff with personal hygiene. Resident # 25 has bowel incontinence. Interventions include check resident every 2 hours and assist with toileting as needed. Provide peri care after each incontinence episode. See care plans on mobility, ADL's, cognitive deficit, and communication. 3. Record review of Resident # 39's Admission Face sheet dated 8/16/24 reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of dementia, spinal stenosis, depressive episodes, hypercholesterolemia, cervical disc disorder, chronic obstructive pulmonary disease, vascular dementia, and vitamin D deficiency. Record review of Resident # 39's Quarterly MDS assessment dated [DATE] reflected, Resident # 39 had a BIMS score of 9 indicating the Resident's cognition was moderately impaired. Resident # 39 had a diagnosis of non-Alzheimer's dementia. Resident # 39 was partial to moderate assist for toilet transfer and supervision or touching assist for toileting and personal hygiene. Record review of Resident # 39's Comprehensive Care Plan initiated 2/24/21 and revised on 2/26/24 and a target date of 8/28/24 reflected Resident # 39 has an ADL self-care performance deficit related to cervical myopathy. Interventions include the resident requires assist by 1 staff for personal hygiene and supervision of staff for toileting. Resident # 39 is incontinent of urine at times and resident refuses to allow staff to assist during incontinence episodes. Interventions include clean peri area after each incontinence episode. Encourage resident to allow assistance during incontinence episode. Check resident every 2 hours and as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after episodes. Monitor and document for signs and symptoms of UTI. Monitor, document, and report PRN any possible causes of incontinence. Observation on 9/15/24 at 10:15 am of Resident # 5 and Resident # 25's room revealed the room to have a foul odor of urine. Resident # 25's over bed table to had food debris and red sticky dried liquid substance all over table. Observation of resident restroom revealed 2 bags of soiled briefs in the corner next to the toilet. Observation of baseboard wall molding to be loose and away from wall falling onto floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation 9/15/24 at 2:06 pm of Resident # 39's room revealed Resident # 39's room to have a foul odor of urine. Observation of Resident # 39's bed linen had what appeared to be urine stain covered in flies and gnats on side of bed linen. Observation on 9/16/24 at 9:41 am of Resident # 5 and Resident # 25's room revealed room to have a foul odor of urine. Resident # 25's over bed table to had food debris and red sticky dried liquid substance all over table. Observation of resident restroom revealed pair of pants and soiled brief on restroom floor. Observation of baseboard wall molding to be loose and away from wall falling onto floor. Observation of Resident # 5's bed linen to have what appeared to be dried feces and brown stain on side of bed linen. Interview on 9/15/24 at 10:15 am with Resident # 5 revealed Resident # 5 said they have no concerns and are happy with their care. When asked about the bags of soiled briefs in the restroom Resident # 5 said housekeeping will be around later today and get them then. Resident # 5 was in bed watching television at time of interview. Resident # 5 gave short answers then went back to watching television. Interview on 9/15/24 at 10:15 am with Resident # 25 revealed Resident # 25 said housekeeping comes in and cleans the room daily. Resident # 25 said they had no concerns and wanted to get back to their television program. Interview on 9/17/24 at 1:15 pm with HSK M revealed when cleaning resident rooms the first thing done would be to gather all the trash and remove from room. HSK M said the restroom is cleaned first starting with the toilet, behind toilet, baseboard, mirrors, replace paper goods, clean the sink, underneath the sink, sweep, and mop then change mop head prior to cleaning the rest of the room. In resident room clean over bed table the tops and side, then windowsills, blinds, corners, door frames, bed rails, under beds, bedside table, light fixture, vents, sweep, and mop then change mop head between resident rooms. Last, clean door handles and perform hand hygiene before moving to next resident room. HSK M said mop water is changed after 3 rooms. Interview on 9/17/24 at 1:30 pm with MD L revealed MD L said for any building maintenance issues that a work order is put into the maintenance documentation system. MD L said all staff have access to be able to put work orders in. MD L said once a work order is received then he addresses whatever the need is. MD L said if a resident reports a issue to staff then that staff member is responsible for creating the work order. Interview on 9/17/24 at 2:07 pm with the DON revealed it would be their expectation that housekeeping, nursing, and CNAs are responsible for keeping resident rooms clean. DON said whoever sees an issue first is to address the issue. DON said a negative outcome for residents of not maintaining clean resident rooms could be infection control and odors. Interview on 9/17/24 at 2:40 pm with the Administrator revealed his expectation of room cleanliness was that the rooms would be clean. Administrator said a negative outcome to residents of not keeping their rooms clean could be unsanitary and unsafe conditions. Record review of Cleaning and Disinfecting Residents' Rooms with a revision date of 8/2013 reflected (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Purpose: The purpose of this procedure is to provide guidelines for cleaning and disinfecting resident rooms. General Guidelines: 1. Housekeeping surfaces (floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 2. Environmental services will be disinfected (or cleaned) on a regular basis (daily, three times a week) and when surfaces are visibly soiled. Under Resident Room Cleaning 4. Change mop solution water at least every three (3) rooms, or as necessary. 5. Change cleaning cloths when they become soiled. Wash cleaning cloths daily and allow cloths to dry before reuse. 6. Clean horizontal surfaces (e.g., bedside tables, overbed tables, and chairs) daily with a cloth moistened with disinfectant solution. Do not use feather dusters. 7. Clean personal use items (e.g., lights, phones, call bells, bedrails, etc.) with disinfectant solution at least twice weekly. 8. When cleaning rooms of residents on isolation precautions, use personal protective equipment as indicated.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917 Based on interview and record review, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASARR) Level I screenings were completed correctly and residents with a mental illness were provided with a PASSAR Level II assessment for 2 (Resident #33 and Resident # 32) of 8 residents reviewed for PASARR assessments. 1. Resident #33 did not have a new PASARR Level I although diagnosis of mental illness was diagnosed after the admitted . 2. Resident # 32 did not have a PASARR Level I completed correctly although diagnosis of mental illness was diagnosed upon admission. These failures could place all residents who had a mental illness or intellectual or developmental disability at risk for not receiving needed assessment, care, and services to meet their needs. Findings included: 1. Record review of Resident #33's Face sheet, dated 09/17/2024, reflected at [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of post-traumatic stress disorder (a disorder that develops in some people who have experienced a shocking, scary, or dangerous event) with onset of 07/14/2023, anxiety disorder (a condition in which a person has excessive worry and feeling of fear, dread or uneasiness), dependence on renal dialysis (someone who uses technology to sustain their life because their kidneys are no longer able to perform their normal functions) and chronic pain syndrome (a constant condition that involves persistent pain that lasts longer than the usually recovery period, or that occurs along with a chronic health condition). Record review of Resident #33's Face sheet, dated 9/17/2024, reflected Resident #33 had a new diagnosis of post-traumatic stress disorder with onset of 07/14/2023. Record review of Resident #33's Quarterly MDS Assessment, dated 08/13/2024, reflected Resident #33 had a BIMS score of 15 indicating the Resident's cognition was intact. Resident #33 had a diagnosis of anxiety disorder and Post Traumatic Stress Disorder. She was assessed to require pain management. Record review of Resident #33's Comprehensive Care Plan, with start date of 08/19/2024 and completion date of 8/27/2024 reflected Resident #33 used psychotropic medications (a drug or other substance that affects how the brain works and causes change in mood, awareness, thoughts, feelings, or behavior) related to anxiety and Post Traumatic Stress Disorder. Interventions: Monitor for side effects and effectiveness every shift. Consult with pharmacy, medical doctor to consider dosage reduction when clinically appropriate at least quarterly. Monitor/ document/report as needed any adverse reactions of psychotropic medications. Reduce the number of psychotropic medications. Resident received hemodialysis. Intervention: Work with resident to relieve discomfort for side effects of the disease and treatment. Resident was assessed to be at risk for pain. Intervention: anticipate the resident's need for pain relief and respond immediately to any complaint of pain. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #33's PASSAR records reflected a PASSAR Level 1 was completed on 04/13/2023 indicated Resident did not have a mental illness. Resident #33 had a Mental Illness/ Dementia Resident review by the facility on 05/09/2023 reflected Resident #33 did not have a mental illness. Reviewed Resident #33's PASRR Level 1 Screening dated 01/01/2024 reflected Resident #33 did not have a mental illness. 2. Record review of Resident 32's Admission Face sheet dated 9/16/24, reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnoses of cerebral infarction (Stroke), dysphagia following cerebral infarction (difficulty swallowing foods or liquids), age-related physical debility, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), left knee contracture, heart failure, mixed hyperlipidemia (a genetic disorder that causes high levels of cholesterol, triglycerides, and other lipids in the blood), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), anxiety disorder (a condition in which a person has excessive worry and feeling of fear, dread or uneasiness), insomnia (persistent problems falling and staying asleep), chronic pain (persistent pain that last weeks to years), hypertension (high blood pressure), contracture of muscle multiple sites, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), muscle wasting and atrophy, vitamin B12 deficiency anemia (a condition where the body doesn't have enough vitamin B12 to produce healthy red blood cells, which results in anemia), convulsions, shortness of breath, and benign prostatic hyperplasia (enlarged prostrate). Record review of Resident # 32's Quarterly MDS assessment dated [DATE], reflected Resident # 32 had a BIMS score of 15 indicating the Resident's cognition was intact. Resident # 32 had a diagnosis of anxiety disorder, depression, and bipolar disorder. He was assessed to require pain management. Record review of Resident # 32's Comprehensive Care Plan, with an initiation date of 2/26/24 and a target date of 8/21/24 reflected Resident #32 used psychotropic medications (a drug or other substance that affects how the brain works and causes change in mood, awareness, thoughts, feelings, or behavior) related to depression. Interventions include administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. Resident # 32 has a mood problem related to bipolar disorder, anxiety, and major depression. Interventions include Administer medications as ordered. Monitor for side effects and effectiveness. Behavioral health consults as needed. Resident # 32 has chronic pain. Interventions include Anticipate the resident's need for pain relief and respond immediately to any pain complaint. Monitor and document for probable cause of each pain episode. Monitor and document for side effects of pain medications. Monitor, record, and report to nurse any signs or symptoms of non-verbal pain. Notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's experience of pain. Record review of Resident # 32's PASSAR records reflected a PASSAR Level 1 was completed on 2/24/21 indicated Resident did not have a mental illness. Resident #32 had a Mental Illness/ Dementia Resident review by the facility on 5/9/23 reflected Resident #32 did not have a mental illness. Reviewed Resident #32's PASRR Level 1 Screening dated 3/19/24 reflected Resident #32 did not have a mental illness. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/15/2023 at 10:45 AM Resident #33 stated she had anxiety and there were times when she had triggers of her PTSD. She stated she had several triggers especially when someone comes in her room, and she does not know they are in the room, and they don't knock on the door. She stated there were certain sounds when staff was talking to each other in the room and was very loud. Resident #33 stated it would help her anxiety and PTSD if the staff did know her triggers. She stated sometimes after staff leaves her room, she becomes more anxious, and it affects her PTSD. Resident #33 did not specify how it affected her PTSD. She stated she did receive psych services at one time when she lived at the facility. She stated she did feel she may benefit from a lot of services if she was assessed by someone from the state office gives services for people with PTSD. In an interview on 09/17/2024 at 8:25 AM the Assistant Director of Nurses LVN A stated anyone with a new mental illness diagnosis was expected to have a PASSR 1 reflected the resident had a new mental illness. She stated if the mental illness was PTSD the resident had a potential to benefit from different services. The Assistant Director of Nurses LVN A stated she did not know all the services provided but she did believe psychiatric care would benefit the resident. In an interview on 09/17/2024 at 8:45 AM, MDS Coordinator LVN B stated if any resident had a new diagnosis of PTSD, the resident was required to have a new PASRR Level 1 completed if the previous PASRR reflected the resident did not have a mental illness. LVN B stated a resident may need psychiatric services or any services that was not being provided for the resident. She stated a resident's PTSD may become worse and the resident may isolate themselves in their rooms or not want to interact with anyone. In an interview on 09/17/2024 at 9:10 AM, the Director of Nurses stated she would need to review the PASRR policy before she could respond to any questions related to PASRR's. In an interview on 9/17/24 at 9:12 am. the MDS Coordinator LVN B stated if a resident came into the facility with a positive diagnosis of mental illness on their PASSAR Level 1 then they would trigger for a PASSAR Level 2 to be completed. MDS Coordinator LVN B then said if a resident was already at the facility and later received a mental illness diagnosis then a new PASSAR Level 1 would be completed which in turn would trigger a PASSAR Level 2 to be completed. MDS Coordinator LVN B said there would not be a reason as to why a resident with a diagnosis of mental illness would not trigger a PASSAR Level 2 to be completed unless it was just missed. In an interview on 9/17/24 at 2:07 pm, the DON reflected she did not know much about PASSAR except that a screening must be completed, and 6 months of data is required. DON said I refer all PASARR questions to my MDS Coordinator LVN B. In an interview on 9/17/24 at 2:40 pm, the Administrator reflected their expectation concerning PASSAR was that the facility remained compliant and that the residents received the needed services. Administrator said a negative outcome of the facility not following PASSAR's was resident not receiving needed services. Record review of the facility PASSAR policy, not dated, reflected facility provided the Preadmission Screening and Resident Review Critical Element Pathway as their policy.

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	455522	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tlc West Nursing and Rehabilitation	1700 Marlandwood Rd Temple, TX 76502

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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** 40884 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 residents (Resident #7) reviewed for care plans. The facility failed to ensure the comprehensive care plans for Resident #7 included ADLs. This failure could affect residents by placing them at risk of not receiving appropriate physical care. Findings included: Record review of Resident # 7's Face Sheet dated, 09/16/2024, reflected a [AGE] year-old female admitted on [DATE] with diagnoses of polyosteoarthritis, unspecified (five or more joints in the body have arthritis at the same time), anxiety disorder (a condition in which a person had excessive worry and feelings of fear, dread, and uneasiness), and combined forms of age-related cataracts (a common eye condition characterized by the clouding and thickening of the natural lens in the eye, leading to decreased vision) Record review of Resident #7's Quarterly MDS Assessment, dated 07/11/2024, reflected the resident had a BIMS score of 9 indicating her cognition was moderately impaired. Resident #7 required set up assistance with personal hygiene, repositioning in bed, and dressing. She required supervision with bathing, repositioning in bed and transfers. Record review of Resident #7's Comprehensive Care Plan dated, 07/19/2024, reflected Resident #7's ADLs was not assessed on her care plan. Resident #7 had impaired visual function related to age-related cataract bilateral. Intervention: Inform Resident #7 where her personal items are being placed. Resident #7 had a mood problem related to anxiety. Resident #7 referred to Senior Psych services. Intervention: Behavioral health consults as needed. In an interview on 09/17/2024 at 8:25 AM, the Assistant Director of Nurses LVN A stated all residents ADLs was expected to be documented on the care plan. She stated if a resident's ADLs were not on their care plan, it would be difficult to know the exact type of care a resident would need during bathing, hygiene, transfers, eating, etc. (other similar things). She stated the staff was to follow the comprehensive care plan. She stated there was a possibility the wrong type of ADL care may be given to a resident if it was not documented on their care plan. She stated it was the MDS Coordinator LVN B responsibility to ensure all the care plans were documented correctly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/17/2024 at 8:45 AM, MDS Coordinator LVN A stated all areas of care and psycho-social needs assessed from the MDS were to be care planned. She stated the ADLs were expected to be documented on every resident's comprehensive care plan. MDS Coordinator LVN A stated if the ADLs were not documented on a resident's care plan, it would be difficult for the nursing staff to know what type of care the resident needed and could result in an injury. MDS Coordinator LVN A stated it was her responsibility to ensure all residents care plans had information coded on the MDS Assessment. She stated Resident #7's ADLs was not documented on the care plan. In an interview on 09/17/2024 at 9:10 AM, the Director of Nurses stated she would need to review the protocol for care plans and would need to discuss with the MDS Coordinator LVN A of her process of completing care plans. In an interview on 09/17/2024 at 10:05 AM, CNA E stated it would be difficult to know the care of residents if the ADLs were not entered into the computer on the resident plan of care. CNA E stated he did give care sometimes to Resident # 7 and he did not recall if the ADLs was on the care system he reviewed. He stated he would always ask the nurse about the resident's care if he never gave care to a resident or if he only gave care very few times, such as 4 times. In an interview on 09/17/2024 at 10:15 AM, the Administrator stated anything documented on the MDS was to be documented on the care plan. He stated all residents' ADLs were expected to be documented on the comprehensive care plan. He stated the staff may not know what type of ADL care to give the resident. The Administrator stated it was the MDS Coordinator LVN A responsibility to ensure all care plans were completed according to the MDS and each residents' needs. On 09/17/2024 at 9:10 AM , requested policy from MDS LVN A policy on comprehensive care plan. This was not provided at time of exit.

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	455522	A. Building B. Wing	09/17/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32452 40884 Based on observations, interviews, and record review, the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for four of eight residents (Resident # 5, Resident #6, Resident #7, and Resident #20) reviewed quality of life. 1. The facility failed to ensure Resident #5's facial hair was removed. 2. The facility failed to ensure Resident # 6's, Resident # 7's and Resident #20's nails were cleaned and trimmed. These failures could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings included: 1. Record review of Resident # 5's Face Sheet dated,09/16/2024, reflected a 73 -year-old female admitted on [DATE] with a diagnoses of type 2 diabetes mellitus with unspecified complications (a chronic condition that occurs when the body does not produce enough insulin), unspecified dementia without behaviors (dementia- a general term for a range of brain conditions that cause a loss such as thinking, remembering, and reasoning- unspecified means- without a specific diagnosis), and macular cyst, hole, or pseudo hole, left eye (can cause loss of central vision). Record review of Resident #5's Quarterly MDS Assessment, dated 08/30/2024, reflected the resident had a BIMS score of 13 indicating her cognition was intact. Resident #5 had impaired vision. Resident #5 required supervision or touching assistance with personal hygiene, oral hygiene, showers, and dressing. Resident #5 required partial/moderate assistance with transfers. Record review of Resident #5's Comprehensive Care Plan , dated 09/11/2024 , reflected Resident #5 had ADL self -care performance deficit related to history of falls and macular degeneration of bilateral eyes and retinopathy (an eye disease that damages a part of the retina- a light sensitive layers of nerve tissue at the back of the eye- that controls central vision) related to diabetes mellitus. Intervention: Resident #5 required supervision of staff with personal hygiene. Observation on 09/15/2024 at 12:30 PM revealed Resident #5 was sitting in the main dining room alone at a table. Her tablemates had already left the dining room. She had facial hair on the right side, middle and underneath her chin. The hair was approximately 1 inch long. Observation on 09/15/2024 at 1:33 PM revealed Resident #5 was sitting in her wheelchair near the television in her room. The facial hair on and underneath her chin had not been removed. (continued on next page)

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	455522	A. Building B. Wing	09/17/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/15/2024 at 1:35 PM with Resident #5 revealed she did not realize she had facial hair. Resident #5 stated she would not have left her room with facial hair on her face. Resident #5 stated she was very embarrassed. She stated she was not leaving her room until someone removed the facial hair. 2. Record review of Resident #6's Face Sheet , dated 09/16/2024, reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses of other lack of coordination (uncoordinated movement due to a muscle control problem that causes inability to coordinate movements), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (impairment of memory) and muscle weakness (a loss of muscle strength that can make it difficult to move a muscle normally). Record review of Resident #6's Quarterly MDS Assessment, dated 06/04/2024, reflected the resident had a BIMS score of 3 indicated her cognitive status was severely impaired. Resident #6 was also assessed to require substantial/maximal assistance with the following ADLs: personal hygiene, oral hygiene, upper body dressing, transfers, and toileting hygiene. Resident #6 was dependent on staff for showering and, lower body dressing. Record review of Resident #6's Comprehensive Care Plan, revised on 08/13/2024, reflected Resident #6 had an ADL self- care performance deficit. Interventions: Bathing/Showering: check nail length, trim and clean on bath days and as needed. Report any changes to the nurse. Personal hygiene: Resident #6 required one staff assistance. Observation on 09/15/2024 at 9:19 AM revealed Resident #6 was in her room lying in bed. Resident #6 had blackish/ brownish substance underneath the forefinger, ring finger and middle fingernails on her right and left hand. There was an odor of excreta (excreted matter, like feces) near her fingernails on her right hand. An attempted interview on 07/29/2024 at 9:02 AM with Resident #6 revealed she was not interview able. Record review of Resident # 7's Face Sheet dated, 09/16/2024, reflected a [AGE] year-old female admitted on [DATE] with diagnoses of polyosteoarthritis, unspecified (five or more joints in the body have arthritis at the same time), anxiety disorder (a condition in which a person had excessive worry and feelings of fear, dread, and uneasiness), and combined forms of age-related cataracts (a common eye condition characterized by the clouding and thickening of the natural lens in the eye, leading to decreased vision) Record review of Resident #7's Quarterly MDS Assessment, dated 07/11/2024, reflected the resident had a BIMS score of 9 indicating her cognition was moderately impaired. Resident #7 required set up assistance with personal hygiene, repositioning in bed, and dressing. She required supervision with bathing, repositioning in bed, and transfers. Record review of Resident #7's Comprehensive Care Plan dated, 07/19/2024, reflected Resident #7's ADLs was not assessed on her care plan. Resident #7 had impaired visual function related to age-related bilateral cataracts. Intervention: Inform Resident #7 where her personal items were being placed. Resident #7 had a mood problem related to anxiety. Resident #7 was referred to Senior Psych services. Intervention: Behavioral health consults as needed. (continued on next page)

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	455522	A. Building B. Wing	09/17/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/15/2024 at 9:35 AM revealed Resident #7 was lying in bed. She had blackish substance underneath her middle finger, ring finger and fore fingernails on her right hand. There was an odor of excreta (excreted matter, like feces) near her fingernails on her right hand. Interview on 09/15/2024 at 9:35 AM with Resident # 7 revealed she had asked someone the previous day to clean her nails. She stated she did not recall the staff name. Resident #7 stated the person worked there said it was not her day for a shower, and they only cleaned nails during showers. Resident #7 stated she was embarrassed for anyone to get near her because it was stuff from her bottom on her fingernails. She stated it was poop (feces) from her bottom. Resident #7 stated sometimes her bottom itched, she has to scratch her bottom, and gets poop on her fingers and in her fingernails. Resident #7 stated it had been on her fingers and under her fingernails since past Friday (09/13/2024). Review of Resident #20's Face sheet reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses chronic respiratory failure with hypoxia (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide. It can leave you with low oxygen, high carbon dioxide, or both.), cerebral palsy (A group of disorders that affect movement, muscle tone, balance, and posture.) and tracheostomy status (hole that surgeons make through the front of the neck and into the windpipe (trachea). Review of Resident #20's quarterly MDS assessment dated [DATE] reflected Resident #20 was assessed to have a BIMS score of 00 indicating severe cognitive impairment. Resident #20 was assessed to be dependent on staff for all ADLs. Review of Resident #20's comprehensive care plan reflected a problem with the initiation date of 06/07/2022 The resident has an ADL self-care performance deficit . Interventions included .check nail length and trim and clean on bath day and as necessary . Observation on 09/15/2024 at 10:00 AM revealed Resident #20 in her room in bed. Resident #20 was not interview able. Resident #20 was observed to have mycotic (is a fungal infection that affects your toenails or fingernails. It separates your nail from your nail bed, making it thick and fragile.) fingernails to her right hand . Resident #20's left hand fingernails were long and observed to have a dark substance underneath the nails. In an interview on 09/15/2024 at 3:14 PM, LVN H stated Resident 20's fingernails were dirty. LVN H stated the brown substance was probably blood from her scratching her face. He further stated Resident #20's fingernails were long and should be trimmed to prevent her from scratching her face. In an interview on 09/17/2024 at 8:25 AM, ADON LVN A stated the nurses and the CNAs were responsible for nail care. She stated the nurses were responsible to trim and clean all residents' nails with a diagnosis of diabetes. ADON LVN A stated it was the CNA's responsibility to clean and trim all other residents' nails. She stated if there was a blackish substance underneath the residents' nails, there was a possibility the substance had bacteria underneath the residents' nails. She stated if a resident swallowed the bacteria there was a possibility a resident may become extremely ill with stomach issues such as diarrhea or vomiting. ADON LVN A stated she was only aware of one resident refusing nail care. ADON LVN A stated it was not Resident #6 or Resident #7. She stated if a female resident had facial hair on their chin, there was a possibility the resident may become embarrassed with their appearance and may isolate themselves in their room. (continued on next page)

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	455522	A. Building B. Wing	09/17/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/17/2024 at 9:10 AM, the DON stated it was a joint effort between the CNAs and the nurses to complete nail care on the residents. She stated the nurses was responsible for residents with diagnosis of diabetes (a disease in which the body's ability to produce or respond to the hormone insulin was impaired). The DON stated nail care was given during showers and as needed. She stated if a resident had blackish substance underneath their nails there was a possibility the substance may be some type of bacteria. The DON stated she could not answer any further questions about dirty fingernails and the potential of a resident becoming ill. She stated if a female resident had facial hair there was a possibility the female resident may not want to leave their room due to embarrassment of the hair on their face. In an interview on 09/17/2024 at 10:05 AM, CNA E stated the nurses completed all diabetic fingernails and the CNAs were responsible for all other residents' nails. He stated the CNAs were responsible to complete nail care such as trimming, filing, and cleaning the nails. CNA E stated if a resident's nails needed to be cleaned, trimmed, or filed, and it was not their shower day, the staff were expected to do any type of nail care as needed. He stated if a resident had blackish substance underneath their nails, it was probably some type of bacteria such as bowel movements. He stated if a resident swallowed bacteria it was a potential the resident may become ill with major stomach problems such as diarrhea. He stated he had given care to Resident #5, Resident #6, and Resident #7 , and he was not aware of them refusing nail care. CNA E stated if a female resident had facial hair on their chin, a resident may become embarrassed over their appearance and there was a possibility the resident may isolate themselves in their room. CNA E stated it was the CNAs or nurses' responsibility to remove facial hair from the female's chin in the resident's room or during showers. CNA E stated she was not aware of any female resident refusing to allow staff to remove unwanted facial hair from their face. Record review of the facility's Policy on ADLs revised March 2018 reflected A resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal, and oral hygiene.

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	455522	A. Building B. Wing	09/17/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on interview, observation, and record review, the facility failed to ensure the resident environment remained free of accident hazards and each resident received adequate supervision and assistance devices for 1 (Resident #31) of 2 residents reviewed for quality of care. The facility failed to ensure there was supervision present for Resident # 31 while he was smoking. The facility failed to provide Resident # 31 with a smoking apron listed under adaptive equipment in this smoking-safety screen. This failure could place residents at risk of harm and/or injury and contribute to avoidable accidents. Findings included: Record review of Resident 31's Admission Face sheet dated 9/16/24, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), severe protein calorie malnutrition, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), legal blindness, hypertension (high blood pressure), schizoaffective disorder bipolar type (a rare mental health condition that involves a combination of schizophrenia and bipolar disorder), gastro-esophageal reflux disease (a digestive disease in which stomach acids or bile irritates the food pipe lining), bullous pemphigoid (a rare skin condition causing large fluid filled blisters), personal history of TIA (mini stroke) and cerebral infarction (stroke). Record review of Resident 31's Quarterly MDS assessment dated [DATE] reflected Resident # 31 had a BIMS score of 15 indicating the Resident's cognition was intact. Resident # 31 had a diagnosis of non-Alzheimer's dementia, bipolar disorder, schizophrenia, and legal blindness. Resident # 31 ability to see in adequate light documented as moderately impaired. Resident # 31 documented under behaviors as having delusions. Resident #31 documented as needing supervision or touching assistance for all types of transfers. Record review of Resident # 31's Comprehensive Care Plan with a start date of 9/14/23 and a revision date of 3/6/24 reflected Resident # 31 was ambulatory with a walker due to impaired vision and unsteady gait. Interventions of assist resident as needed. Monitor resident during ambulation. Resident # 31 is a smoker and requires a smoking apron during smoke breaks. Intervention of redirect resident when noted in designated area smoking without smoking apron. Inform resident of the risk of smoking without apron. Supervision during smoking. Staff should monitor resident after each smoke break for burns in clothing or skin. Resident may not have cigarettes or a lighter on his person at any time while resident in this facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455522	A. Building B. Wing	09/17/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review Resident # 31 Smoking Safety Screen with date of 8/19/24 reflected Resident # 31 has documented need for adaptive equipment of smoking apron and supervision. Resident # 31 was deemed safe to smoke with supervision. Resident # 31 smoking screen states it is the facility policy for all smokers to be supervise while smoking. Resident has vision deficit and uses a smoking apron. Observation on 9/16/24 at 11:28 pm of designated smoking area revealed 2 residents sitting in smoking area without staff supervision. Resident # 31 observed smoking while talking with fell ow resident. Resident # 31 did not have smoking apron on or supervision present. Interview on 9/17/24 at 2:07 pm with the DON revealed their expectation would be that smoking evaluations are completed for all residents who admit that are known smokers. If a resident is not a smoker upon admission and later starts smoking, then a smoking evaluation is completed. DON said after the smoking evaluation is completed it would then be uploaded into the resident chart and their expectation is that the staff would follow the recommendations from the smoking evaluation. DON said a negative impact to residents of not completing a smoking evaluation could be multiple things hazards, decrease in health status, burns and basic common-sense things. Interview on 9/17/24 at 2:40 pm with the Administrator revealed the Administrator said his expectation would be that if the resident is deemed safe to smoke then the lighters be checked in with the facility and smoking screen completed for all residents. Administrator said after the smoking screen was completed his expectation would be for staff to follow the recommendations in the smoking screen. Administrator said a negative outcome for not completing a resident smoking screen could be resident injury. Record review of facility's undated smoking policy reflected under heading General Guidelines: A resident will be evaluated upon admission to determine if he or she is a smoker or non-smoker. If a smoker the evaluation will include: 1. Current level of tobacco consumption 2. of tobacco consumption 3. Desire to quit smoking 4. Ability to smoke safely with or without supervision (Resident ability to smoke safely will be updated quarterly, upon significant change, and as determined by staff) Any smoking privileges, restrictions, and concerns shall be noted in the care plan, and all persons caring for resident shall be notified.

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	455522	A. Building B. Wing	09/17/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided consistent with professional standards of practice for 2 of 4 Residents (Resident #38 and #20) reviewed for quality of care. A1. The facility failed to ensure Resident #38 received aseptic technique (a procedure that healthcare providers use to prevent the spread of germs that cause infection. Placing barriers, using sterile equipment, and following strict guidelines that help create an environment free of germs.) during tracheostomy care. 2. The facility further failed to ensure Resident #38's oxygen concentrator and oxygen compressor air intake filters were clean and free from dust and debris. B. The facility failed to ensure Resident 20's oxygen concentrator air intake filter was clean and free from dust and debris. These failures could place residents who use respiratory equipment and have tracheostomies at risk for respiratory infections. Findings included: A) Review of Resident #38's face sheet dated 09/16/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses, tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe (trachea), hemangioma of skin and subcutaneous tissue (growths of blood vessels found on your skin. These growths can appear anywhere on your body, especially on your face, chest and back, as red, or purple lumps.), Anoxic brain damage (damage to the brain due to a lack of oxygen supply) and chronic respiratory failure with hypoxia (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide. It can leave you with low oxygen, high carbon dioxide, or both). Review of Resident #38's quarterly MDS assessment dated [DATE] reflected she was assessed to be in a persistent vegetative state with no discernible consciousness. Resident #38 was assessed to be dependent on staff for all ADLs. Resident #38 was further assessed to receive oxygen therapy, suctioning and require tracheostomy care. Review of Resident #38's comprehensive care plan reflected a problem dated 11/18/2022 Resident has a tracheostomy. Interventions included .oxygen setting via tracheostomy per MD orders . Review of Resident #38's consolidated physician orders reflected an order dated 05/22/2024 Oxygen at 6 LPM via trach collar continuously . Further review of Resident #38's physician orders reflected an order dated 11/01/2023 Check O2 filter for placement and cleanliness every week on Sunday and PRN .Trach Care every shift and PRN . (continued on next page)

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	455522	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tlc West Nursing and Rehabilitation	1700 Marlandwood Rd Temple, TX 76502

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/15/2024 at 9:21 AM revealed Resident #38 in room in bed. Resident #38 was observed to have a tracheostomy with oxygen being administered via a tracheostomy mask from an oxygen concentrator set at 6 LPM with a 50-psi air compressor and large volume nebulizer in use (A 50 psi air compressor usually powers the large volume nebulizer which is used to turn liquid into a mist so that it can be inhaled. A large volume nebulizer may be used for patients who have a tracheostomy or otherwise need to deliver a mist that moisturizes their airway.) Observation of the oxygen concentrator revealed the air intake filter was covered in a gray substance. Further observation revealed the 50-psi air compressors air intake filter was also covered in a gray substance. In an interview on 09/15/2024 at 3:14 PM, LVN H stated Resident #38's filters on her oxygen concentrator and compressor were dirty and needed to be cleaned. He stated they were supposed to be cleaned on Sunday nights. He stated failure to keep them clean could lead to a respiratory infection. Observation on 09/16/2024 at 10:00 AM revealed Resident #38's oxygen concentrator's filter remained covered in a gray substance. Further observation revealed the 50-psi air compressor filter also remained covered with a gray substance. Observation on 09/16/2024 at 10:41 AM revealed RN I entered Resident #38's room to perform tracheostomy care. RN I entered Resident #38's room with a small bottle of mouth wash and two oral swabs. RN I obtained an incontinent wipe from Resident #38's dresser and wiped the over bed table with the incontinent wipe and placed the items on the table. RN I then donned gloves without washing her hands and removed the soiled gauze from under Resident #38's trach and trach ties (ties that go around the neck to ensure the trach stays in place). RN I then, without washing her hands, donned a new pair of gloves then left the room and came back with a piece of wax paper. Without cleaning the overbed table, placed the wax paper on the over bed table. Using the same pair of gloves RN I gathered supplies from a cart in Resident #38's room that included a new inner cannula for her trach and a sterile suction tubing. RN I grabbed Resident #38's old Yankauer suction wand (used for oral suctioning) which was attached to the suction machine. RN I removed the suction wand from the suction machine, attached the new suction tubing ,and placed it on the over bed table; partly on the wax paper and partly on the table. RN I removed the water basin from the suction kit and filled with distilled water. RN I left Resident #38's side, went to the bathroom, and got a new pair of gloves from a box stored there. Further observation of Resident #38 revealed her tracheostomy mask (used to deliver oxygen) had an accumulation of mucus in the mask covering the exhalation port. RN I, without washing her hands, donned the new gloves and returned to Resident #38's bed side. RN I then inserted the suction tubing through the exhalation port on the mask through the mucus and into her tracheostomy and began suctioning Resident #38. RN I repeated this action one more time. RN I then removed her gloves and went to the bathroom. RN I washed her hands and donned new gloves. RN I returned to Resident #38's bedside and pulled down her trach mask, removed the old inner cannula from Resident #38's trach, and inserted a new inner cannula without changing her gloves, cleaning around the trach, or cleaning the trach mask. RN I was further observed to not have a trach care kit. RN I then replaced the mucus filled trach mask over Resident #38's trach. RN I stated she was going to do oral care for Resident #38 , and she was done with trach care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/16/2024 at 10:52 AM, RN I stated she wiped Resident #38's over bed table with an incontinent wipe. When asked if the incontinent wipe would sanitize the table, she stated no she should have used the purple top wipes (a disposable germicidal wipe). RN I stated she only washed her hands one time during the procedure. RN I stated she should have washed her hands at the beginning of the procedure and before donning new gloves. When RN I was asked why she did not wash her hands, she only stated she used hand sanitizer before coming into the room. When asked if she cleaned around Resident #38's trach stoma or cleaned Resident #38's trach mask to remove the mucus build up, she stated she did not. RN I further stated she should not have introduced the suction tubing through the trach mask exhalation port and through the old mucus. RN I stated by doing so, she could introduce bacteria into Resident #38's trach and it could cause an infection. B) Review of Resident #20's face sheet reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses chronic respiratory failure with hypoxia (a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide. It can leave you with low oxygen, high carbon dioxide, or both.), cerebral palsy (A group of disorders that affect movement, muscle tone, balance, and posture.) and tracheostomy status (a hole that surgeons make through the front of the neck and into the windpipe (trachea). Review of Resident #20's quarterly MDS assessment dated [DATE] reflected Resident #20 was assessed to have a BIMS score of 00 indicating severe cognitive impairment. Resident #20 was assessed to be dependent on staff for all ADLs. Resident #20 was further assessed to receive oxygen therapy, suctioning, and tracheostomy care. Review of Resident #20's comprehensive care plan reflected a problem with the initiation date of 05/03/2022 The resident had a tracheostomy related to acute respiratory failure . Interventions included oxygen setting apply O2 at 4-5 liters per [minute] trach mask . Review of Resident #20's consolidated physician orders reflected an order dated 05/22/2024 oxygen at 4 LPM continuously via trach collar . Observation on 09/15/2024 at 10:00 AM revealed Resident #20 in her room in bed with the oxygen concentrator on and set at 4 LPM. Observation of her concentrator revealed the air intake filter was covered in a gray substance. In an interview on 09/15/2024 at 3:14 PM, LVN H stated Resident #20's filter on her oxygen concentrator was dirty and needed to be cleaned. He stated they were supposed to be cleaned on Sunday nights. He stated failure to keep them clean could lead to a respiratory infection. Observation on 09/16/2024 at 10:15 AM revealed Resident #20 in her room in bed with the oxygen concentrator on and set at 4 LPM. Observation of her concentrator revealed the air intake filter was still covered in a gray substance. In an interview on 09/16/2024 at 3:24 PM, the DON stated that the respiratory equipment should be cleaned on Sundays and the filters should be cleaned at that time. The DON stated it was an expectation that they should remain clean to prevent infections. The DON stated she expected the nurses to perform trach care as outlined in the facilities policy and failure to do so could cause residents infections. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy tracheostomy Care dated August 2013 reflected The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas . 1.Aseptic technique must be used: a. During cleaning and sterilization of reusable tracheostomy tubes; b. During all dressing changes until the tracheostomy wound has granulated (healed), and c. During tracheostomy tube changes, either reusable or disposable. 2. Gloves must be used on both hands during any or all manipulation of the tracheostomy. Sterile gloves must be used during aseptic procedures. 3. A mask and eyewear must be worn if splashes, spattering, or spraying of blood or body fluids is likely to occur when performing this procedure . tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies, and at least every eight hours for residents with unhealed tracheostomies. 6. A replacement tracheostomy tube must be available at the bedside at all times. 7. A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times . Procedure Guidelines: Preparation and Assessment; .3. Wash hands. 4. Put exam gloves on both hands. 5. Remove supplemental oxygen mask from tracheostomy. 6. Inspect skin and stoma site for signs or symptoms of infection, leakage, subcutaneous crepitus, or dislodged tube. 7.Assess resident for respiratory distress. a. Measure resident's oxygen saturation with pulse oximeter. b. Listen to lung sounds with a stethoscope. c. Observe for asymmetrical chest expansion. 8. Remove old dressings. Pull soiled glove over dressing and discard into appropriate receptacle. 9. Wash hands. Clean the Removable Inner Cannula: l. Open tracheostomy cleaning kit. 2. Set up supplies on sterile field. 3. Maintaining sterile field, pour equal parts hydrogen peroxide and normal saline in one compartment of opened kit. Pour normal saline in another compartment. 4. Open four gauze pads and saturate with hydrogen peroxide. 5. Open two gauze pads and saturate with antiseptic solution. 6.Open two gauze pads and saturate with sterile saline. 7. Open two gauze pads; keep them dry. 8.Put on sterile gloves. 9. Secure the outer neck plate with non-dominate gloved hand. 10.Unlock the inner cannula with gloved dominate hand. 11. Gently remove the inner cannula, rotating counterclockwise while lifting away from the resident. 12. Soak the cannula in hydrogen peroxide/saline mixture. 13. Clean with brush. Rinse with saline and dry with pipe cleaners. 14. Remove and discard gloves into appropriate receptacle. 15.Wash hands and put on fresh gloves. 16.Replace the cannula carefully and lock in place. 17. Ensure there is an emergency tracheostomy set up at resident's bedside. Site and Stoma Care: 1.Apply clean gloves. 2.Clean the stoma with two peroxide-soaked gauze pads (using a single sweep for each side). 3. Rinse the stoma with saline-soaked gauze pads (using a single sweep for each side). 4. Wipe with dry gauze (using a single sweep for each side). 5. Disinfect the stoma with the antiseptic-soaked gauze pads (using a single sweep for each side). Allow to air dry or wipe with clean, dry gauze. 6. Remove neck ties and replace with clean ones. a. If the resident's condition is unstable, or if the stoma is less than two weeks old, apply new ties before removing old ones. 7.Apply a fenestrated gauze pad around the insertion site. 8. Replace supplemental oxygen mask over tracheostomy. 9. Remove gloves and discard into appropriate receptacle. 10.Wash hands . Review of the facility's policy Respiratory therapy- prevention of infection dated November 2011 reflected The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and team .Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on interviews and record reviews, the facility failed to ensure residents who are trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for 1 (Resident # 33) of two residents reviewed for quality of care. The facility failed to ensure that Resident #33's potential triggers were care planned. This failure could place residents at increased risk for psychological distress due to re-traumatization. Findings included: Record review of Resident #33's Face sheet, dated 09/17/2024, reflected at [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses of post-traumatic stress disorder (a disorder that develops in some people who have experienced a shocking, scary, or dangerous event) with onset of 07/14/2023, anxiety disorder (a condition in which a person has excessive worry and feeling of fear, dread or uneasiness), dependence on renal dialysis (someone who uses technology to sustain their life because their kidneys are no longer able to perform their normal functions) and chronic pain syndrome (a constant condition that involves persistent pain that lasts longer than the usually recovery period, or that occurs along with a chronic health condition). Record review of Resident #33's Quarterly MDS Assessment, dated 08/13/2024, reflected Resident #33 had a BIMS score of 15 indicating the Resident's cognition was intact. Resident #33 had a diagnosis of anxiety disorder and Post Traumatic Stress Disorder. She was assessed to require pain management. Record review of Resident #33's Comprehensive Care Plan, with start date of 08/19/2024 and completion date of 8/27/2024 reflected Resident #33 used psychotropic medications (a drug or other substance that affects how the brain works and causes change in mood, awareness, thoughts, feelings, or behavior)related to anxiety and Post Traumatic Stress Disorder. Interventions: Monitor for side effects and effectiveness every shift. Consult with pharmacy, medical doctor to consider dosage reduction when clinically appropriate at least quarterly. Monitor/ document/report as needed any adverse reactions of psychotropic medications. Reduce the number of psychotropic medications. Resident #33's triggers was not assessed and documented on comprehensive care plan. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/15/2023 at 10:45 AM, Resident #33 stated she did not have anxiety and there were times when she did have triggers of her PTSD. She stated she had several triggers especially when someone comes in her room and she does not know they are in the room and they don't knock on the door. She stated there were certain sounds when staff was talking to each other in the room and was very loud. Resident #33 stated it would help her anxiety and PTSD if the staff did know her triggers. She stated sometimes after staff leaves her room she becomes more anxious and it affects her PTSD. Resident #33 did not specify how it affected her PTSD. She stated she did receive psych services at one time when she lived at the facility. She stated she did feel she may benefit from a lot of services if she was assessed by someone from the PASRR office. In an interview on 09/17/2024 at 8:45 AM, MDS Coordinator LVN A stated that a resident with a diagnosis of PTSD should identify the resident's triggers of PTSD on the resident's care plan. The MDS Coordinator LVN A stated failure to properly care plan a resident for PTSD and triggers could result in a resident being re-traumatized. She stated she was responsible for including PTSD with triggers in resident's care plan. In an interview on 09/17/2024 at 9:10 AM, The Director of Nurses stated if a resident had PTSD (post-traumatic stress disorder) the residents' triggers were expected to be documented on their comprehensive care plan. She stated if the staff was not aware of the triggers for the resident there was a possibility it could affect their quality of life. She did not respond to any further questions about PTSD triggers such as how it would affect their quality of life. The Director of Nurses stated the MDS Coordinator LVN A was responsible to care plan triggers of any resident with PTSD. Requested policy on revision of care plans and comprehensive care plans and it was not provided at time of exit. In an interview on 09/17/2024 at 10:15 M, the Administrator stated care plans were individualized and specific to the resident's needs and must be accurate. The Administrator stated care plans were accomplished with input from the interdisciplinary team and the DON signs off on them. The Administrator stated a resident with PTSD care plan should have included the residents' triggers to help manage behaviors that may arise during the resident's care.

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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. 48917 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for sanitation. 1. The facility failed to ensure sanitation practices (covering waste receptacles, sanitizing the thermometer prior to use, cleaning the ice machine, cleaning the juice gun nozzle, cleaning utensil storage drawers, cleaning of ice scoop bin) were occurring in the kitchen. 2. The facility failed to ensure temperature logs were being completed. 3. The facility failed to ensure cleaning logs were being completed. 4. The facility failed to ensure all items were covered and stored properly. These failures could place residents at risk of foodborne illness. Findings included: Observation on 9/15/24 at 9:08 am of the facility kitchen reflected 55-gallon trash can in kitchen prep area without lid. Observation of utensil storage drawers with food debris and tiny bits of paper on bottom surface of drawer and lip of drawer where clean utensils were stored. Observation of leftover scrambled egg in blender uncovered, steamtable pan of sausage links uncovered sitting on prep counter, steamtable pan of toast and pancakes uncovered on prep table, baking sheet of chicken strips and chicken nuggets uncovered on prep table, steamtable pan of what appears to be melted butter on top of oven, and steamtable pan of white gravy on prep table. Observation of reddish pink buildup inside the juice gun nozzle. Observation of ice machine bucket for ice scoop with standing water in bottom with food debris and filmy substance floating on top of water. Observation of ice machine door upper inside of door and seal around ice machine entrance with what appeared to be black and gray dirt and mold buildup. Observation of trash can near hand hygiene sink in dish room revealed no cover on trash can. Observation on 9/16/24 10:36 am of facility kitchen pureed production of butter beans revealed [NAME] K did not clean the thermometer prior to taking temperatures. Observation on 9/17/24 10:05 am of facility kitchen pureed production of green beans, scalloped potatoes, sliced bread, and cornmeal crusted tilapia revealed [NAME] K did not clean the thermometer prior to taking temperatures. Record review of facility kitchen ice machine cleaning log reflected last documented cleaning dated 6/7/24. (continued on next page)

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	455522	A. Building B. Wing	09/17/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility kitchen weekly cleaning schedule reflected the only documented cleaning to be of convection oven and sweeping and moping storeroom during week 1 of September. Weekly cleaning schedule had 5 weeks listed for September. Record review of facility kitchen daily cleaning schedule reflected documentation of cleaning log between 9/1/24-9/16/24 reflected missing documentation for 47 different tasks. Interview on 9/17/24 at 1:30 pm with [NAME] K revealed [NAME] K said the proper way to take food temperatures was to use an alcohol swab prior to taking food temperatures, again in between each food item, and then again after taking food temperatures. Interview on 9/17/24 at 1:42 pm with the DM J revealed DM J said it was their expectation for [NAME] K to use an alcohol swab to clean the thermometer prior to taking food temperatures, again in between each food item, and finally after taking all temperatures. DM J said it was their expectation for the kitchen to be clean and all staff to be completing the cleaning lists. DM J said each different staff member had cleaning duties depending on their job title. DM J said their expectation was for all food items to be covered and stored properly. DM J said it was their expectation for the cooks to be taking the temperature of the food items and completing the temperature logs. DM J said a negative of not completing cleaning lists, taking temperatures correctly storing food properly could be cross contamination for residents and write ups for staff. DM J said they make rounds in the kitchen frequently to ensure tasks are being completed and the RD makes monthly sanitation audits of the kitchen to ensure sanitation practices are being maintained. Interview on 9/17/24 at 2:40 pm with the Administrator revealed his expectation of the kitchen regarding sanitation was for the kitchen to be clean. The Administrator said a negative effect to residents of the kitchen not having good sanitation could be foodborne illness. Record review of Cleaning Schedules policy UNDATED reflected under heading Policy: The facility will maintain a cleaning schedule prepared by the Nutrition & Foodservice Manager and followed by employees as assigned to ensure that the kitchen is clean and free of hazards. Procedure: 1. The Nutrition & Foodservice Manager will develop a cleaning schedule for daily, weekly, and monthly cleaning. 2. Cleaning tasks will be assigned to positions and included in the job description. 3. The cleaning list will be posted weekly and initialed off and dated by each employee upon completion of the task. The Nutrition & Foodservice Manager or designee will verify that the tasks were completed as assigned. Record review of General Kitchen Sanitation policy dated 10/1/18 reflected under heading (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition & Foodservice employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes to minimize the risk of infection and food borne illness. Procedure: 1. Clean and sanitize all food preparation areas, food-contact surfaces, dining facilities and equipment. After each use, clean and sanitize all tableware, kitchenware, and food-contact surfaces of equipment, except cooking surfaces of equipment and pots and pans that are not used to hold or store food and are used solely for cooking purposes. 2. Clean food-contact surfaces of grills, griddles and similar cooking devices and the cavities and door seals of microwave ovens at least once a day: except for hot oil cooking equipment and hot oil filtering systems. 3. Keep food-contact surfaces of all cooking equipment free of encrusted grease deposits and other accumulated soil. 4. Clean and sanitize all multi-use utensils and food-contact surfaces of equipment used in the preparation or storage of potentially hazardous food prior to each use. Clean and sanitize food-contact surfaces of equipment and multi-use utensils used for preparation of potentially hazardous foods on a continuous or production line basis at scheduled intervals throughout the preparation period based on food temperature, type of food and amount of food particle accumulation. 5. After cleaning and until use, store and handle all food-contact surfaces of equipment and multi-use utensils in a manner that protects the surfaces from manual contact, splash, dust, dirt, insects, and other contaminants 6. Clean non-food-contact surfaces of equipment at intervals as necessary to keep them free of dust, dirt, and food particles and otherwise in a clean and sanitary condition. 7. Store, handle and dispense all single-service articles in a sanitary manner and use only once. 8. Make sure that cloths used for wiping occasional food spills on tableware are clean, dry, and not used for any other purpose. 9. Clean and rinse immediately prior to use, moist cloths used for wiping food spills on kitchenware and food-contact surfaces of equipment. Clean frequently during use in a sanitizing solution and do not use for any other purpose. When not in use, hold in a sanitizing solution of the proper concentration (100 ppm Chlorine, 200 ppm Quaternary Ammonia, or 25 ppm Iodine). 10. Clean and rinse in a sanitizing solution, moist cloths used for cleaning non-food-contact surfaces of equipment such as counters, dining tabletops and shelves and do not use for any other purpose. 11. Check restrooms regularly throughout the shift, and be sure they are stocked with soap, toilet paper and paper towels. If automatic hand dryers are used, make sure they are working properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. Make sure hand-washing facilities are easily accessible and supplied with soap and paper towels. 13. Have a professional pest-control program in place. 14. Store toxic chemicals away from food products and be sure they are properly labeled.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 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 and follow accepted national standards for one of two residents reviewed infection control (Resident #38). The facility failed to ensure RN I used aseptic technique during tracheotomy suctioning and tracheotomy care for Resident #38. These failures could place residents at risk for developing wound and upper respiratory infections. Findings included: Review of Resident #38's Face Sheet dated 09/16/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses Tracheostomy (hole that surgeons make through the front of the neck and into the windpipe (trachea)., Hemangioma of skin and subcutaneous tissue (growths of blood vessels found on your skin. These growths can appear anywhere on your body, especially on your face, chest and back, as red, or purple lumps.), Anoxic brain damage (is damage to the brain due to a lack of oxygen supply) and chronic respiratory failure with hypoxia (is a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide. It can leave you with low oxygen, high carbon dioxide, or both). Review of Resident #38's Quarterly MDS dated [DATE] reflected she was assessed to be in a persistent vegetive state with no discernible consciousness. Resident #38 was assessed to be dependent on staff for all ADLs. Resident #38 was further assessed to have oxygen therapy, suctioning and require tracheostomy care. Review of Resident #38's Comprehensive Care Plan reflected a problem dated 11/18/2022 Resident has a tracheostomy. Interventions included .oxygen setting via tracheostomy per MD orders . Review of Resident #38's consolidated physician orders reflected an order dated 05/22/2024 Oxygen at 6 liters via trach collar continuously . Further review of Resident #38's physician orders reflected an order dated 11/01/2023 Check O2 filter for placement and cleanliness every week on Sunday and PRN .Trach Care every shift and PRN . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455522	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tlc West Nursing and Rehabilitation	1700 Marlandwood Rd Temple, TX 76502

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/16/2024 at 10:41 AM revealed RN I entered Resident #38's room to perform tracheostomy care. RN I entered Resident #38's room with a small bottle of mouth wash and two oral swabs. RN I obtained an incontinent wipe from Resident #38's dresser and wiped the over bed table with the incontinent wipe and placed the items on the table. RN I then donned gloves without washing her hands and removed the soiled gauze from under Resident #38's trach and trach ties (ties that go around the neck to ensure the trach stays in place). RN I then without washing her hands donned a new pair of gloves then left the room and came back with a piece of wax paper and without cleaning the overbed table placed the wax paper on the over bed table. Using the same pair of gloves RN I gathered supplies from a cart in Resident #38's room that included a new inner cannula and a sterile suction tubing. RN I then grabbed Resident #38's old Yankauer suction wand (used for oral suctioning) which was attached to the suction machine. RN I then removed the suction wand from the suction machine and attached the new suction tubing and placed it on the over bed table partly on the wax paper and partly on the table. RN I then removed the water basin from the suction kit and filled with distilled water. RN I left Resident #38's side and went to the bathroom and got a new pair of gloves from a box stored there. Observation of Resident #38 revealed her tracheostomy mask (used to deliver oxygen) had an accumulation of mucus in the mask covering the exhalation port. RN I without washing her hands donned the new gloves and returned to Resident #38's bed side. RN I then inserted the suction tubing through the exhalation port on the mask through the mucus and into her tracheostomy and began suctioning Resident #38. RN I repeated this action one more time. RN I then removed her gloves and went to the bathroom. RN I washed her hands and donned new gloves. RN I returned to Resident #38's bedside and pulled down her trach mask removed the old inner cannula from Resident #38's trach and inserted a new inner cannula without changing her gloves, cleaning around the trach, or cleaning the trach mask. RN I then replaced the mucus filled trach mask over Resident #38's trach. RN I then stated she was going to do oral care for Resident #38 stating she was done with trach care. In an interview on 09/16/2024 at 10:52 AM RN I stated she wiped Resident #38's over bed table with an incontinent wipe. When asked if the incontinent wipe would sanitize the table she stated no she should have used the purple top wipes (a disposable germicidal wipe). RN I stated she only washed her hands one time during the procedure. RN I stated she should have washed her hands at the beginning of the procedure and before donning new gloves. When RN I was asked why she did not wash her hands she only stated she used hand sanitizer before coming into the room. When asked if she cleaned around Resident #38's trach stoma or cleaned Resident #38's trach mask to remove the mucus build up she stated she did not. RN I further stated she should not have introduced the suction tubing through the trach mask exhalation port and through the old mucus. RN I stated by doing so she could introduce bacteria into Resident #38's trach and it could cause an infection. In an interview on 09/16/2024 at 3:24 PM The DON stated she expected the nurses to perform trach care as outlined in the facilities policy and procedure. The DON stated that failure to do so could cause residents infections. The DON further stated she expected the nurses to use aseptic technique when performing trach care. Review of the facility's policy Tracheostomy Care dated August 2013 reflected The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas . 1. Aseptic technique must be used: a. During cleaning and sterilization of reusable tracheostomy tubes Gloves must be used on both hands during any or all manipulation of the tracheostomy. Sterile gloves must be used during aseptic procedures (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy Handwashing- Hand Hygiene dated August 2019 reflected This facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infection . The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48917 Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that facility was free of pests and rodents for the facility's only kitchen and dining room reviewed for physical environment. 1.The facility did not ensure the facility was free of flies and crickets in the kitchen. 2. The facility did not ensure the facility was free of flies in the dining room This failure could place residents at risk for an unsanitary environment and a decreased quality of life. The findings included: Observation and resident interviews on 9/15/24 at 11:38 am of the dining room revealed flies throughout dining room in windowsills (20 counted), on resident tables, landing on resident plates of food. Resident # 5 said the flies were always terrible in the dining room. Residents were observed covering their drinks with paper towels to keep flies out. Resident # 13 said he brings his own personal fly swatter to the dining room with him because of the flies. Resident # 26 was observed swatting at flies with an assistive eating built up spoon as flies were landing on his mashed potatoes and ground chicken. Observation on 9/15/24 at 12:11 pm of covered smoking patio area with door leading out from dining room revealed 4 cats lounging on patio, bird feathers all over patio, and a clump of unidentified biological material near entry door to dining room covered in flies. Observation on 9/15/24 12:19 pm of the kitchen revealed 1 dead fly on kitchen floor near the stove, 1 live fly in the dry storage on storage rack, dead crickets in kitchen dish room near storage rack of clean dishes. Interview on 9/17/24 at 1:30 pm with MD L revealed MD L said the facility had a contract with a company to come out once a month and spray for pests. MD L said he conducted rounds in the morning of the exterior of the facility looking for any evidence of pests. MD L said the facility has not had a problem with flies previously. MD L said the Administrator had asked him a couple of months ago to get something for the flies because flies had been seen in the room the department heads hold meetings. MD L said after that, he went and purchased Fly bait granules and placed them in the meeting room, near the dining room exit to the smoking patio, in the puzzle room, behind the vending machines in dining room, and outside on the patio. MD L said he went and got 2 fly traps and hung them outside on the covered patio smoking area. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 9/17/24 at 1:42 pm with DM J revealed DM J said for any pests, they would MD L, and MD L will take care of the issue. DM J said they were aware of the problem with the flies, and they had discussed this matter with the MD L to address the issue. DM J said the pest control company comes once a month and sprays for pests. DM J said the facility had in the past had bug lights in the hallway across from kitchen door to catch flying pests, but they no longer has those, and she was unsure as to why. Interview on 9/17/24 at 2:07 pm with the DON revealed they deferred all pest control questions to the MD L as that is not their area of knowledge, but any pest control concerns are discussed in the staff morning meetings. DON said they could not answer any questions concerning pest control. Interview on 9/17/24 at 2:40 pm with the Administrator revealed he expected the facility to be pest free. The Administrator said a negative outcome of not being pest free could be that first it would be gross, resident bites or stings, and dirtiness. Record review of the facility's pest control invoices reflected the facility common areas, kitchen, 400 and 500 halls were treated for roaches and ants with last service being on 8/26/24. Record review of facility maintenance logs reflected daily monitoring of outside of building for pests by MD L with last documented date of 9/14/24. Requested pest control policy on 9/16/24 at 8:54 am, and facility administrator said they did not have a pest control policy.