

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455554	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Coral Rehabilitation and Nursing of McGregor		STREET ADDRESS, CITY, STATE, ZIP CODE 414 Johnson Dr MC Gregor, TX 76657	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772</p> <p>Based on observations, interviews, and record reviews, 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 dietary services.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure the DOM and KA A were wearing effective hair restraint, while in food prep areas. 2. The facility failed to ensure air vents were free from dirt and debris. 3. The facility failed to ensure 2 bottles of metal polish, 2 bottles of cleaner, with bleach, and a small bottle of PVC cement were kept separated from the food prep area. 4. The facility failed to ensure the kitchen's only industrial can opener was clean. 5. The facility failed to ensure the facility's only dishwasher was cleaned and de-limed. 6. The facility failed to ensure the facility's only dishwasher had the correct PPM of sanitizer to sanitize kitchen equipment. <p>These failures could place residents at risk of ingesting chemicals and food-borne illnesses.</p> <p>Findings included:</p> <p>Observation on 7/29/2024 at 9:36 AM revealed KA A in the kitchen's food prep area. KA A was not wearing effective hair restraint. His beard and mustache were not covered with a form of hair restraint.</p> <p>Observations and interview on 7/29/2024 at 10:00 AM revealed the facility's only industrial can opener had an accumulation of a black sticky substance coating the sharp piece of metal used to [NAME] the metal can. The gears, inside the can opener, which turned to rotate the can, were coated in a layer of a black sticky substance. The mounting bracket, which held the can opener to the kitchen counter, had traces of a black sticky substance. Interview with KA B revealed she did not know the last time the industrial can opener was cleaned. KA B was observed having taken the industrial can opener to the dish room area.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 7/29/2024 at 11:26 AM revealed the DOM walking through the kitchen's food prep area. The DOM was not wearing effective hair restraint. His goatee and mustache were not covered with a form of hair restraint.</p> <p>Observation on 7/29/2024 at 11:30 AM revealed on the far-right end of the 3-compartment sink (while facing it,) there was a 3-foot-long metal shelf (1 foot in depth.) The metal shelf was not connected on the right side. The shelf was on an angle downwards from left to right (while facing it.) The right side of the shelf was 6 inches lower than the left. There was a dry white flaky substance covering 50 percent of its surface. The white flaky substance had leaked over the lip of the shelf on the shelf's low end. There were 2 bottles of metal polish, a small bottle of PVC cement, a stained yellow rubber glove, and 2 bottles of liquid cleaner, with bleach. The shelf was 3 feet away from the kitchen's only oven. The shelf was 3 feet away from the kitchen's food prep area. The shelf was 3 feet above, and to the right, of the area for dirty dishes.</p> <p>Interview on observation on 7/30/24 at 8:25 AM with the KM revealed the shelf, did not know why the small bottle of PVC cement was still there. He stated the small bottle of PVC cement was used to fix PVC piping under the steam table, but it must not have been removed afterwards. The KM stated cleaning products were supposed to be kept away from the food prep area in a designated area for chemicals and cleaners. The KM threw away the small bottle of PVC cement in the trash, having removed the cleaning products from the shelf. The KM cleaned the dry white flaky substance from the shelf.</p> <p>Interview on 7/30/2024 at 8:28 AM the FD revealed cleaning supplies were supposed to be kept separated from the kitchen in a designated area. She stated cleaning supplies were not supposed to be kept on the shelf near the 3-sink system area.</p> <p>Observation and interview on 7/30/2024 at 8:30 AM revealed the facility's three sink system to sanitize, rinse, and soak/wash kitchen equipment in the facility's only kitchen. A 25 x 25 air duct, with venting slots, was located 1.5 feet above the 3-compartment sink. The 25 x 25 air duct had a thick layer of grease on its vertical surfaces and a thick layer of grease inside the venting slots. A 12 x 12 air duct, with venting slots and a screen, was located 2 feet above the 3-compartment sink. The vent's vertical surfaces had an accumulation of grease. The venting slots had an accumulation of grease. The screen contained clumps of dust and debris. The KM revealed it was unknown the last time the 25 x 25 or the 12 x 12 vents were cleaned. The KM stated the contaminates on the screens risked contamination of food in the food prep area and risked contamination of clean dishes around the facility's 3 sink-system.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation and interview, on 7/30/2024 at 8:35 AM of the facility's only dishwasher revealed the outer front cover, at waist level, was discolored with a thick 3 horizontal layer of lime. The top of the machine, on both the entrance and exit sides, had an accumulation of a light brown gritty substance. The light brown gritty substance was not stuck to the machine. The light brown gritty substance was easy to pinch and rub between an index finger and a thumb. The information placard, attached to the dishwashing machine, required 50 PPM available for a chlorine rinse. KA C revealed he was trained to operate the facility's only dishwasher. He stated he was trained to evaluate PPMs, which was the chemical concentration of chlorine in the dishwasher's final rinse cycle, with a strip of chemical detection paper. The required chlorine concentration for the rinse water was 50 PPM. KA C allowed the machine to run the rinse cycle; he ripped off a 2 section of chlorine detection paper; and he rested the strip of chlorine detection paper against a dish removed from the dishwasher. He stated the chlorine detection paper, which began as white, was supposed to identify the required PPM of chlorine in the rinse water and was supposed to turn a specific shade of purple. The 1.5 x 1.5 plastic container, which held the chlorine detection paper, had a color chart on the back of the container. From left to right, the colors of the chart stated off as light beige and continued getting darker. 10 PPM was light beige; 25 PPM was light purple, 50 PPM was purple, 100 PPM was blue, and 200 PPM was black. KA C held the 2 inch strip of chlorine detection paper against the chart on the plastic container. The 2 inch strip of chlorine detection paper did not change color. The 2 inch strip of chlorine detection paper was still white. He stated the results of the test signified there was not enough chlorine in the water to sanitize the dishes. KA C stated he noticed the chlorine chemical, which was held in a 5-gallon bucket under the dishwasher, was empty about a week ago. He tried to change the chlorine chemical himself, but the connector and the tube that ran to the bottom of the 5-gallon bucket deteriorated in his hands. It was no longer functional. He stated he told the KM. He stated the PPM were usually written down in the purple log, but he had not checked the chlorine PPM and recorded the results for about a week. Anything broken was supposed to be written in the maintenance book.</p> <p>Record review of the July 2024 page in the undated purple kitchen logbook, reflected the last entry of chlorine PPMs, which was 50 PPM, had not been recorded since 7/26/2024. Record review of the maintenance book reflected no entry since for the month of July having pertained to the broken chlorine equipment or the facility's only dishwasher.</p> <p>Observation and interview on 7/30/2024 at 8:45 AM of the KM inspected the bottle of chlorine under the dishwasher having tried to figure out why water in the sanitizing cycle did not have 50 PPM of chlorine. The 5-gallon bucket of chlorine was empty; the top connection of the 5-gallon bucket of chlorine was broken; and the tube that was supposed to stretch into the bottle from the connection was not connected. The KM changed out the chlorine bottle and tubing and having evaluated the water of the sanitizing cycle. The 2nd test of the chlorine PPM reflected the chlorine detection paper was still white. The water in the sanitizing cycle did not contain 50 PPM. The KM stated KA C informed him last week that the chlorine bottle was empty, and the connector and tubing were broken. The KM stated the maintenance issue slipped him mind. He did not write it in the book or tell the DOM. The KM stated that processes to identify and correct issues with dishwasher were to log the PPMs every day and enter broken equipment issue in the kitchen maintenance book. The KM stated he called the contracted company, 7/30/2024, to make repairs on the facility's only dishwasher. The kitchen staff was preparing to use plastic flatware and paper plates for the next meal service.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 7/30/2024 at 10:35 AM with the DOM revealed the facility's rule was to wear effective hair restraint while in the kitchen area. He stated he was not wearing hair restraint to cover his goatee and mustache, on 7/29/2024 because there were not any hair restraints in the small metal basket attached to the wall by the entrances. The DOM stated hair restraints were required to keep hair from getting into the resident's food. He stated he was stopped by the KM for not wearing hair restraint, and corrected, on the morning of 7/29/2024. The DOM stated there was a maintenance book in the kitchen to report faulty equipment. He stated there was no documentation about the dishwasher or the broken chlorine tubing in the maintenance logbook. He stated the KM usually just called him when things were broken. He was not made aware there was an issue with the dishwasher, or the broken chlorine tubing.</p> <p>Interview and observation on 7/30/2024 at 12:00 PM with the CT revealed he was called to the facility to make a repair to the facility's only dishwasher. The CT stated he adjusted the connections and the tubing; primed the chlorine tube entering the machine; and retested the chlorine PPM, which resulted in 50 PPM. He was observed running the machine and having evaluated the chlorine PPM. The results of the chlorine detection paper, having reacted with the chlorine in the water of the sanitizing cycle, resulted with the chlorine detection paper turning purple. There was 50 PPM of chlorine in the sanitizing cycle.</p> <p>Interview and observation on 7/31/2024 at 1:57 PM KA A revealed he was trained to wear hair restraint while in the kitchen. Hair restraints were worn to keep hair from getting into resident's food. KA A stated he was not wearing hair restraints on 7/29/2024. KA A state he knew that he should have worn facial hair restraint. KA A stated the hair restraints, provided by the facility, were poorly made, stretched out easily, and fell off frequently. KA A stated the vents were supposed to be cleaned on a regular basis but were not on the kitchen's cleaning schedule. KA A stated the dust and debris in, and on, the vents, was a contamination [NAME] for clean dishes and food. The kitchen staff worked as a team and cleaned their respective areas, but the vents were not assigned to a team member.</p> <p>Interview on 7/31/2024 at 12:05 PM KA C revealed he had not cleaned, or de-limed, the facility's only dishwasher; he had not been instructed to do so. KA C stated the light brown gritty substance on top of the dishwasher, could contain bacteria, which could contaminate clean dishes. If a resident ingested bacteria, they risked an illness such as upset stomach or diarrhea.</p> <p>Interview on 7/31/24 at 12:06 PM the KM revealed staff were trained to wear effective hair restraints, while in the kitchen area, to keep hair and any contaminate the hair contained, out of the resident's food. Frequent cleaning and sanitizing of the kitchen, and its equipment, was required to have a clean environment and have reduced the chance of food-borne pathogens. The KM stated he had a cleaning schedule in the purple book. The strategy in place to have ensured the kitchen staff was cleaning as scheduled, was to have observed staff progress and follow-up as needed. He had not been checking the condition of the dishwasher area; and the 2 air ducts were not on the cleaning schedule and went overlooked. Residents who consumed food made through unsanitary practices risked risk food-borne illnesses, such as diarrhea, vomiting, headaches, dehydration. The KM had not received complains of gastrointestinal issues from residents.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Telephone interview on 7/31/2024 at 12:30 PM the FD revealed her role was to be present at the facility once or twice a month to coordinate dietary concerns with the residents. She had left the day-to-day operation of the kitchen to the KM. The FD had not received any complaints related to gastrointestinal issues with residents. The FD stated kitchen surfaces, and kitchen equipment, were supposed to be cleaned and sanitized regularly to reduce the risk of cross-contamination. The facility's residents were high-risk, and consumption of unwanted contaminants posed health concerns, such as vomiting, dehydration, or an upset stomach.</p> <p>Interview on 7/31/2024 at 12:38 PM with the DON revealed she did not have a role with the dietary department, except to work with the FD and resident's diets. She left the day-to-day operations to the KM. The DON stated it was important to keep kitchen surfaces, and kitchen equipment, clean to prevent cross-contamination and the growth of food-borne pathogens. Had a resident consumed contamination or food-borne pathogens, the resident risked gastrointestinal issues, such as nausea, vomiting, and diarrhea. She had not received any resident complaints of stomach illnesses.</p> <p>Interview on 7/31/2024 at 2:48 PM with the ADM revealed he expected his staff to policy and any cleaning scheduled the KM created. The failure to clean and sanitize kitchen equipment and instill hygienic practices fell upon communication and training. The lack of cleaning risked the growth of bacteria and other food-borne pathogens. The ADM had relied upon the FD to ensure the kitchen's staff had cleaned properly and followed hygienic practices in the facility's only kitchen; as well, the ADM relied upon the KM's assignment, and delegation, of sanitization through the kitchen's cleaning schedule. If a resident consumed food, that had been contaminated, they risked gastro-intestinal illnesses.</p> <p>Record review of the FD's Registered Dietician Certificate, through Texas Department of Licensing and Regulation, was dated effective as of 9/1/2023 through 8/31/2024.</p> <p>Record review of the KM's Food Manager Certification, through State Food Safety, was dated effective as of 3/24/2022. Valid 5 years.</p> <p>Record review of KA A's Food Manager Certification, through State Food Safety, was dated effective as of 7/12/2020. Valid 5 years.</p> <p>Record review of KA B's Food Handler Certificate, through Food card, was dated 4/15/2023. Valid 2 years.</p> <p>Record review of KA C's Food Handler Certificate, through Food card, was dated 3/15/2023. Valid 2 years.</p> <p>Record review of the dishwasher's Sanitizer Test Procedures, affixed to the wall next to the dishwasher, reflected a set of 4 instructions to evaluate the level of sanitizer in the rinse cycle and ensure the results were 50 PPM.</p> <p>Record review of the Dietary Cleaning Schedule, found in the kitchen' undated purple book, reflected instructions to wipe storage shelves clean daily; wipe the dishwasher clean after each use; and de-lime the dishwasher every Tuesday.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of the facility's Sanitization Policy, dated October 2008, reflected the kitchen, the kitchen areas, and dining areas shall be kept clean. All counters, shelves, seals, edges, fasteners, and equipment shall be kept clean and in good repair. Non-removable equipment will be disassembled, removable parts will be scraped and washed to remove food particle accumulation. Kitchen services, not in contact with food, shall be cleaned on a regular schedule and frequently enough to prevent the accumulation of grime. The facility's dishwasher required 50 PPM of chlorine for sanitization. The food service manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff were supposed to have been trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.</p> <p>Record review of the 2022 Food Code; Section 2-402 Hair Restraints, from the United States Food and Drug Administration, revealed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that were designed and worn to effectively keep their hair from contacting exposed food. Section 6-501.14 Cleaning Ventilation Systems revealed intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination of dust, dirt, and other materials. Section 4-703.11 revealed efficacious sanitization depends on ware washing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning. Other parameters, such as rinse pressure, temperature, and chemical concentration are used in combination with time to achieve sanitization.</p> <p>Record review of a facility document, labeled Hair Restraint; 228.43, undated, reflected employees shall wear hair restraints, such as hats, hair coverings or Nets, beard restraints, and clothing that covers body there, that are designed and warrant to effectively keep their hair from contacting exposed food, clean equipment, and utensils.</p>		