

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/20/2024
NAME OF PROVIDER OR SUPPLIER  Garden Terrace Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1224 Corvadura St Graham, TX 76450	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944</b></p> <p>Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 1 of 6 residents (Resident #40) reviewed for accuracy of assessments.</p> <p>1. The facility failed to ensure Resident# 40's MDS accurately reflected that he was not on an anticoagulant.</p> <p>This failure could place residents at risk for not receiving care and services to meet their physical needs.</p> <p>The findings included:</p> <p>Record review of Resident #40's admission profile, dated 7/20/24, reflected a [AGE] year-old male whose most recent admitted was 04/26/24. Resident #40 had diagnoses which included: cerebral infarct (a dead A condition caused by disrupted blood flow to the brain causing brain cells to die), hypertension (high blood pressure) arteriosclerotic heart disease (a vascular disease where the blood vessels carrying oxygen away from the heart become damaged, hardened and blocked), dysphasia (a condition that affects your ability to produce and understand spoken language).</p> <p>Record review of Resident #40's Significant change MDS, dated [DATE], Section K0415 reflected Resident #40 did take a high-risk drug, which was an anticoagulant. Section C revealed he had a BIMS score of 4 (severe cognitive impairment).</p> <p>Record review of Resident # 40's physician order summary report dated 7/20/24 reflected he was on clopidogrel (an anti-platelet medication, which prevents platelets from sticking together and causing a stroke) which had a start date of 4/27/24. He was not on an anticoagulant (a medication that prevents or reduces the time it takes for the blood to clot).</p> <p>In an interview with the Resident's family member, and an observation of the resident on 07/16/24 at 6:58 PM, the family member stated she did not think he was on an anticoagulant.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an Interview on 07/19/24 at 3:38 PM the CCM stated that the Clopidogrel on Resident #40's orders was not an anticoagulant, it was an antiplatelet. She stated Clopidogrel should not be counted as an anticoagulant. She stated the anticoagulant marked on the significant change MDS, was marked in error and she should not have classified it as such. She stated Resident # 40 did not receive an anticoagulant during the 7 days prior to 6/13/24. She stated it was a documentation error which she made because she was not paying attention. She stated failure to document the MDS properly could result in the resident not receiving needed care She stated she was responsible for the accuracy of the MDS, and no one other than herself monitored her for accuracy. She stated the facility followed the RAI Manual as their policy for completing Resident Assessments.</p> <p>In an interview on 6/06/24 at 12:00 PM, the ADON said she expected the MDS to accurately reflect the resident's condition at the time of assessment. She stated the Clinical Care Manager was responsible for monitoring the accuracy of the assessment.</p> <p>Review of CMS'S RAI Version 3.0 Manual version 1.18.11 dated October 2023 revealed:</p> <p>The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g) and (h) require that.</p> <p>(1) the assessment accurately reflects the resident's status</p> <p>(2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals</p> <p>(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.</p> <p>Nursing homes are left to determine.</p> <p>(1) who should participate in the assessment process</p> <p>(2) how the assessment process is completed</p> <p>(3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.</p> <p>N0415 High Risk Drug Classes Use and Indication:</p> <p>Coding tips and special populations:</p> <p>Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as anticoagulants, N0415E.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944</b></p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences for 1 of 1 residents (#41) reviewed for respiratory care.</p> <p>A. The facility failed to ensure oxygen tubing for Residents #41 were changed weekly.</p> <p>These failures could place residents at risk for infections and transmission of communicable diseases.</p> <p>Findings included:</p> <p>Resident #41</p> <p>Record review of Resident #41's Face Sheet, dated 07/20/2024, revealed she was a [AGE] year-old female, admitted to the facility on [DATE]. Diagnoses included respiratory failure (difficulty breathing on her own), pain, shortness of breath, myocardial infarction (heart attack), Hypertension (high blood pressure), and depression.</p> <p>Record review of Resident #41's MDS Annual Assessment, dated 06/17/2024 revealed a BIMS score of 15 (cognitively intact). Care plan dated 6/17/2024 revealed in part Focus: oxygen therapy related respiratory failure, ineffective gas exchange. Intervention/tasks: Weekly tubing and nasal cannula change and check oxygen concentrator. Date and tag tubing, change date.</p> <p>Record review of Resident #41's Physicians' orders dated 07/20/24 revealed albuterol sulfate. Solution for nebulization; 2.5 mg /3 mL (0.083 %); inhalation Solution administer 3ml via handheld nebulizer every four hours prn. Change oxygen tubing, Cannula/Mask once a week. On Sunday</p> <p>In an observation and interview on 07/16/2024 at 09:15 AM during initial rounds, Resident #41 was sitting in her recliner receiving humidified oxygen via nasal cannula at 2 liters per minute. Her oxygen tubing and humidifier bottle was not dated. The resident stated she did not remember when her oxygen tubing was changed.</p> <p>In an observation on 07/16/2024 at 11:00 AM Resident #41's nasal cannula and humidifier bottle was not dated, and the nasal cannula was lying on the resident's floor.</p> <p>In an Interview on 07/17/2024 at 11:45 AM with the ADON stated oxygen tubing was changed weekly based on the resident's orders, or as needed if they become contaminated or occluded. The ADON stated oxygen tubing and the humidifier bottle should be changed per doctor's orders. If they were not labeled, she stated she would discard them and replace it with a new nasal cannula. She stated nebulizer masks should be stored in a plastic bag when not in use to prevent cross contamination and infection.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy Respiratory Therapy-Prevention of Infection dated as revised on 11/2011, revealed the following [in part]:</p> <p>Purpose: To guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff.</p> <p>Procedure: 7. Change the oxygen cannula and tubing every seven (7) days, or as needed.</p> <p>8. keep the oxygen cannula and tubing used PRN in a plastic bag when not in use.</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>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>14408</p> <p>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 in one of one kitchen., in that:</p> <p>The reach-in freezer was not maintained at an interior temperature of zero degrees or below and food stored in the freezer was not frozen solid.</p> <p>The reach-in-freezer temperature was documented on a Refrigerator and Freezer Temperature Log and 10 degrees F was recorded two times daily during May 2024, June 2024, and July 1 - 15, 2025.</p> <p>This failure placed the residents at risk for foodborne illness from being served food that had not been stored at the proper temperature.</p> <p>The findings included:</p> <p>Observation on 7/16/24 at 9:52 AM revealed a commercial stainless steel freezer unit in the dietary department. The reach-in freezer had 2 doors. The interior thermometer measured a temperature of 22 degrees F and food items were not frozen solid. A box contained French toast which was soft; a raw boneless turkey breast was soft and thawed; a pre-cooked boneless ham was soft and thawed; a box contained corn dogs that were soft; and a box contained individual containers of lime sherbet that were soft and melted.</p> <p>Observation on 7/16/24 at 9:56 AM revealed a Refrigerator and Freezer Temperature Log, dated July 2024, was taped to the door to the refrigerator located to the right of the freezer unit. Daily temperatures were documented two times daily for each unit. The freezer temperature was documented at 10 degrees F daily from 7/01/24 through 7/15/24. Temperature #1 on 7/16/24 was documented at 20, and a line was drawn through it and 10 written by it.</p> <p>During an interview and observation on 7/16/24 at 9:58 AM, the Dietary Manager stated the Maintenance Supervisor had replaced the freezer unit interior door seals (gaskets) yesterday (on 7/15/24). She opened the freezer doors and indicated the new black rubber gaskets on the insides of the doors. The Dietary Manager stated the freezer unit had to work harder to stay cold this time of year when it was hot outside. She stated she would remove the food from the freezer unit and place it in the chest freezer in her office. She stated she had just defrosted the chest freezer overnight and it was empty.</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>During an observation and interview on 7/16/24 at 10:02 AM, accompanied by the Dietary Manager, it was observed her office was located on Hall B. There were 3 chest freezers positioned against the wall. The first chest freezer filled to capacity with packages of vegetables which frozen solid. The second chest freezer was empty. The Dietary Manager stated it was defrosted overnight and was turned on this morning. The chest freezer did not have an internal thermometer and the Dietary Manager proceeded to place a thermometer inside the freezer. The third chest freezer contained food items that were frozen solid, including two cardboard boxes with peperoni slices. The Dietary Manager stated she had placed the food from the second freezer in the first and third freezers last night before defrosting the second chest freezer.</p> <p>In an interview on 7/16/24 at 10:51 AM, the Maintenance Supervisor stated he had inspected the reach-in freezer unit in the kitchen per the request of the Dietary Manager and saw the gasket seals were cracked and deteriorating. He stated he had ordered new gaskets and had replaced the gaskets yesterday (on 7/15/24). He stated he spoke with the Dietary Manager regarding the freezer unit and the food stored in it not being frozen solid this morning. He stated he went into the kitchen this morning and found the center gasket strip had slid down where the two doors meet when closed. He stated the doors had not been sealed. He stated he moved up the gasket strip, put it in place, and trimmed off the excess length at the bottom of the gasket strip. The Maintenance Supervisor stated the doors were now sealed and the temperature of the freezer unit was already cooling down. He stated he would provide the invoice for the ordering and purchase of the new gasket seals.</p> <p>During an interview and record review on 7/16/24 at 11:29 AM, the Maintenance Supervisor provided copies of the invoice for the freezer unit gasket seals for review.</p> <p>Review of the invoice revealed 2 gaskets were ordered on 7/09/24. The Maintenance Supervisor stated they were delivered yesterday, 7/15/24, and he had installed them.</p> <p>During an observation and interview on 7/18/24 at 9:46 AM, the reach-in freezer unit interior thermometer measured 10 degrees F. The food was frozen solid. The Dietary Manager stated the food order had been delivered yesterday (on 7/17/24) and was placed in the freezer. She stated the food was frozen and the freezer temperature was still going down. She did not know if anything else was going to be done about the freezer and stated to ask the Maintenance Supervisor about that.</p> <p>In an interview on 7/18/24 at 10:10 AM, the Maintenance Supervisor stated the freezer unit temperature had gone down but it should be at 0 degrees F or less. He stated if there continued to be problems with the freezer unit not keeping the food frozen, he would notify the Corporate Maintenance Director about the problem.</p> <p>During an interview and record review on 7/19/24 at 2:06 PM, the Dietary Manager provided the Refrigerator and Freezer Temperature Logs, dated May 2024 and June 2024, that documented freezer temperatures #1 and #2 daily. The Dietary Manager stated #1 was for the morning, usually by 6:00 AM and #2 was for the evening, usually at 2:00 PM. She stated the freezer temperatures were measured by the thermometer placed inside the freezer. The freezer temperatures documented 10 degrees F two times daily every day during May and June. The Dietary Manager stated that was what the freezer temperature always was, and the temperature just recently started going up.</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>In an interview on 7/20/24 at 4:35 PM, the Administrator stated the Corporate Maintenance Supervisor came to the facility Thursday evening and looked at the freezer unit in the kitchen. She stated he said it could not be repaired and was old. She stated the freezer unit would be replaced with a new one and she was researching on-line for freezers and prices.</p> <p>Review of the facility policy and procedure for Food Storage, dated 2018, revealed it directed [in part]:</p> <p>Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines.</p> <p>Procedure:</p> <p>3. Freezers</p> <p>a. Store all frozen meats, poultry, seafood, fruits and vegetables, and some dairy products, such as ice cream, in the freezer at a temperature that maintains the frozen state of the foods .</p> <p>g. Open freezer doors only when necessary to prevent the freezer temperature from increasing.</p> <p>h. Place a thermometer inside freezers near the door where the temperature is warmest. Check the temperature of all freezers using the internal thermometer to make sure the temperature stays at 0 degrees F or below. Temperatures should be checked each morning when the kitchen is opened, once during the day and in the evening when the kitchen is closed. Record temperatures on a log that is kept near the freezer .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944</b></p> <p>Based on observations, interviews and record reviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 (Resident #9) of 2 residents reviewed for infection control , in that:</p> <p>RN A failed to follow EBP (enhanced barrier precautions) signage instructions for Resident #9 by not donning a gown when caring for and administering medications via his gastrostomy (an opening into the stomach through the abdominal wall to provide medication and nourishment) tube, and while performing care for his Tracheostomy (a surgically created hole with a tube inserted into the windpipe to provide an alternative airway for breathing).</p> <p>This failure could affect residents and place them at risk for cross contamination and infections.</p> <p>The findings included:</p> <p>Record review of Resident #9's electronic face sheet dated 7/20/2024 reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: Diarrhea, Acute Upper Respiratory Infection, Tracheostomy (a surgically created hole with a tube inserted into the windpipe to provide an alternative airway for breathing), protein calorie malnutrition(condition in which a reduced availability of nutrients causes adverse effect on the body function and clinical outcome) and aphasia (a disorder that affects speech as well as the away a person writes and understands both spoken and written language).</p> <p>Record review of Resident #9's comprehensive person-centered care plan reflected a last care conference date of 6/18/2024 reflected Problem: Feeding tube and Problem: tracheostomy. There was no Problem or intervention for enhanced barrier precautions.</p> <p>During an observation on 7/16/2024 at 1:43 PM of Resident #9's room revealed he had a sign which indicated he was on EBP.</p> <p>Review of the EBP sign on Resident #9's door reflected STOP, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Wear gloves and a gown for the following High-Contact Resident Care Activities .Changing briefs and assisting with toileting .Wound Care: Any skin opening requiring a dressing .indwelling medical devices.</p> <p>During an observation on 07/16/24 at 7:30PM, RN A enter Resident #9's room to administer bedtime medications which he received via gastrostomy tube. The Enhanced Barrier Precautions sign was posted on Resident #9's door. She did not put a gown on to administer the medication through the indwelling gastrostomy tube.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 7/18/2024 at 3:00 PM of RN A providing Tracheostomy care to Resident #9, she performed hand hygiene and applied gloves after entering the room. She cleaned her work area, removed her gloves, and performed hand hygiene again. She did not put on a gown. She Cleaned around Resident 39's trach tube and applied new ties and collar to the tube to secure it in place. She disposed of the soiled supplies removed her gloves and performed hand hygiene.</p> <p>During an interview on 7/18/2024 at 03:25 PM with RN A, she stated she did not think about wearing a gown when she administered medication or did tracheostomy care for Resident #9, she stated it could cause cross contamination not to use PPE properly. She stated she was trained on the new EBP guidelines which included to wear a gown when working with a resident who had a wound or indwelling medical device.</p> <p>During an Interview on 7/18/2024 at 3:30PM with the ADON/Infection Preventionist, she stated EBP was now in effect for Resident #9 because he had a gastrostomy tube and a tracheostomy and RN A entered Resident #9's room to provide care. She stated by not following the guidance or infection control practices, cross contamination could occur, and the residents could acquire infections. She stated RN A was trained on EBP and knew she needed to wear a gown.</p> <p>Record review of facility policy and procedure titled Enhanced Barrier Precautions, dated March 20, 2024, reflected It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .all staff receive training .an order for enhanced barrier precautions will be obtained for residents with any of the following: wounds .High-contact resident care activities include: . changing briefs or assisting with toileting .wound care; any skin opening requiring a dressing indwelling medical devices.</p> <p>Review of website <a href="https://www.cdc.gov/preventmdro">https://www.cdc.gov/preventmdro</a> on 7/20/24, revealed the following:</p> <p>Multi drug resistant organism transmission is common in skilled nursing facilities, contributing to substantial resident, morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident activities. EBP may be indicated when contact precautions do not apply for residents with any of the following: wounds or indwelling medical devices regardless of multidrug resistant organism colonization status</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>14408</p> <p>Based on observation, interview, and record review, the facility failed to ensure the maintenance of mechanical and electrical equipment in safe operating condition in 1 of 1 kitchen, in that:</p> <p>The reach-in freezer was not maintained at an interior temperature of zero degrees or below and food stored in the freezer was not frozen solid.</p> <p>This failure placed the residents at risk for foodborne illness from being served food that had not been stored at the proper temperature.</p> <p>The findings included:</p> <p>Observation on 7/16/24 at 9:52 AM revealed a commercial stainless steel freezer unit in the dietary department. The reach-in freezer had 2 doors. The interior thermometer measured a temperature of 22 degrees F and food items were not frozen solid. A box contained French toast which was soft; a raw boneless turkey breast was soft and thawed; a pre-cooked boneless ham was soft and thawed; a box contained corndogs that were soft; and a box contained individual containers of lime sherbet that were soft and melted.</p> <p>Observation on 7/16/24 at 9:56 AM revealed a Refrigerator and Freezer Temperature Log, dated July 2024, was taped to the door to the refrigerator located to the right of the freezer unit. Daily temperatures were documented two times daily for each unit. The freezer temperature was documented at 10 degrees F daily from 7/01/24 through 7/15/24. Temperature #1 on 7/16/24 was documented at 20, and a line was drawn through it and 10 written by it.</p> <p>During an interview and observation on 7/16/24 at 9:58 AM, the Dietary Manager stated the Maintenance Supervisor had replaced the freezer unit interior door seals (gaskets) yesterday (on 7/15/24). She opened the freezer doors and indicated the new black rubber gaskets on the insides of the doors. The Dietary Manager stated the freezer unit had to work harder to stay cold this time of year when it was hot outside. She stated she would remove the food from the freezer unit and place it in the chest freezer in her office. She stated she had just defrosted the chest freezer overnight and it was empty.</p> <p>During and observation and interview on 7/16/24 at 10:02 AM, accompanied by the Dietary Manager, it was observed her office was located on Hall B. There were 3 chest freezers positioned against the wall. The first chest freezer filled to capacity with packages of vegetables which frozen solid. The second chest freezer was empty. The Dietary Manager stated it was defrosted overnight and was turned on this morning. The chest freezer did not have an internal thermometer and the Dietary Manager proceeded to place a thermometer inside the freezer. The third chest freezer contained food items that were frozen solid, including two cardboard boxes with pepperoni slices. The Dietary Manager stated she had placed the food from the second freezer in the first and third freezers last night before defrosting the second chest freezer.</p> <p>(continued on next page)</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview on 7/16/24 at 10:51 AM, the Maintenance Supervisor stated he had inspected the reach-in freezer unit in the kitchen per the request of the Dietary Manager and saw the gasket seals were cracked and deteriorating. He stated he had ordered new gaskets and had replaced the gaskets yesterday (on 7/15/24). He stated he spoke with the Dietary Manager regarding the freezer unit and the food stored in it not being frozen solid this morning. He stated he went into the kitchen this morning and found the center gasket strip had slid down where the two doors meet when closed. He stated the doors had not been sealed. He stated he moved up the gasket strip, put it in place, and trimmed off the excess length at the bottom of the gasket strip. The Maintenance Supervisor stated the doors were now sealed and the temperature of the freezer unit was already cooling down. He stated he would provide the invoice for the ordering and purchase of the new gasket seals.</p> <p>During an interview and record review on 7/16/24 at 11:29 AM, the Maintenance Supervisor provided copies of the invoice for the freezer unit gasket seals for review.</p> <p>Review of the invoice revealed 2 gaskets were ordered on 7/09/24. The Maintenance Supervisor stated they were delivered yesterday, 7/15/24, and he had installed them.</p> <p>During an observation and interview on 7/18/24 at 9:46 AM, the reach-in freezer unit interior thermometer measured 10 degrees F. The food was frozen solid. The Dietary Manager stated the food order had been delivered yesterday (on 7/17/24) and was placed in the freezer. She stated the food was frozen and the freezer temperature was still going down. She did not know if anything else was going to be done about the freezer and stated to ask the Maintenance Supervisor about that.</p> <p>In an interview on 7/18/24 at 10:10 AM, the Maintenance Supervisor stated the freezer unit temperature had gone down but it should be at 0 degrees F or less. He stated if there continued to be problems with the freezer unit not keeping the food frozen, he would notify the Corporate Maintenance Director about the problem.</p> <p>During an interview and record review on 7/19/24 at 2:06 PM, the Dietary Manager provided the Refrigerator and Freezer Temperature Logs, dated May 2024 and June 2024, that documented freezer temperatures #1 and #2 daily. The Dietary Manager stated #1 was for the morning, usually by 6:00 AM and #2 was for the evening, usually at 2:00 PM. She stated the freezer temperatures were measured by the thermometer placed inside the freezer. The freezer temperatures documented 10 degrees F two times daily every day during May and June. The Dietary Manager stated that was what the freezer temperature always was, and the temperature just recently started going up.</p> <p>In an interview on 7/20/24 at 4:35 PM, the Administrator stated the Corporate Maintenance Supervisor came to the facility Thursday evening and looked at the freezer unit in the kitchen. She stated he said it could not be repaired and was old. She stated the freezer unit would be replaced with a new one and she was researching on-line for freezers and prices.</p> <p>Review of the facility policy and procedure for Food Storage, dated 2018, revealed it directed [in part]:</p> <p>Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines.</p> <p>Procedure:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/20/2024
NAME OF PROVIDER OR SUPPLIER  Garden Terrace Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1224 Corvadura St Graham, TX 76450	

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. Freezers</p> <p>a. Store all frozen meats, poultry, seafood, fruits and vegetables, and some dairy products, such as ice cream, in the freezer at a temperature that maintains the frozen state of the foods .</p> <p>g. Open freezer doors only when necessary to prevent the freezer temperature from increasing.</p> <p>h. Place a thermometer inside freezers near the door where the temperature is warmest. Check the temperature of all freezers using the internal thermometer to make sure the temperature stays at 0 degrees F or below. Temperatures should be checked each morning when the kitchen is opened, once during the day and in the evening when the kitchen is closed. Record temperatures on a log that is kept near the freezer .</p>