STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455592	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Side Campus of Care	1950 S Las Vegas Trail White Settlement, TX 76108

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. 1. The facility failed to ensure that eight 64-ounce pitchers of dark brown liquid were labeled and dated. 2. The facility failed to ensure that four 4-ounce canned food items were free of dents. These failures had the potential to affect residents by placing them at risk for cross-contamination and foodborne intoxication. Findings included: Observation on 03/24/26 at 7:31 AM, upon entry to the kitchen, reflected that eight 64-ounce pitchers of dark brown liquid were on the beverage station counter without labels or use-by dates. Observation on 03/24/26 at 7:46 AM of the dry food storage area reflected a 4-ounce dented can labeled apple slices, a 4-ounce dented can labeled mandarins, and two 4-ounce dented cans labeled grape jelly stored with the regular stock of canned goods. In an interview on 03/25/26 at 12:50 PM, [NAME] Z stated that it was not okay to store dented canned goods with the regular stock of canned goods. [NAME] Z stated that all staff were responsible for making sure dented canned goods were not stored with the regular stock of canned goods. [NAME] Z stated that the dented cans had been mixed in with the regular canned goods because the vendors had not thoroughly checked the cans when they stocked them. [NAME] Z stated that the dented cans were supposed to be placed in a separate area so they could be discarded. [NAME] Z stated that dented canned goods were stored at the bottom of the shelf when first walking into the dry food storage area. [NAME] Z stated that the risk of having dented canned goods with the regular stock of canned goods was that there could be lead or residue in the dented cans if they were served to residents. [NAME] Z stated that this could be prevented in the future by checking all the cans to make sure there were none mixed in and by placing dented cans where they should have been stored on the bottom shelf to be discarded. [NAME] Z stated that the liquid that were in the eight 64-ounce pitchers were tea. [NAME] Z stated that the tea pitchers should have been labeled and dated with the name and use-by date. [NAME] Z stated that [NAME] D had filled the tea pitchers but was not working that day. [NAME] Z stated that the person responsible for labeling and dating the pitchers was the person who filled them. [NAME] Z stated that the risk of the pitchers of tea not being labeled or dated with a use-by date was that residents could feel the beverages were not fresh or were old. In an interview on 03/25/26 at 1:05 PM, [NAME] Y stated that she had been working in the kitchen for 2 years. [NAME] Y stated that all cooks were responsible for checking labels and dates on beverages. [NAME] Y stated that once staff filled the drink pitchers, they were supposed to place the date the beverage was made and the expiration date on the label. [NAME] Y stated that she could not say why the pitchers were not labeled or dated because she was not sure but [NAME] D had filled the pitchers that day. [NAME] Y stated that the policy required beverages to be labeled with the name of the drink and dated, and she stated that dietary staff changed the drinks every morning. [NAME] Y stated that the risk of not labeling and dating beverages was that residents would not know if the beverages were fresh. [NAME] Y stated that staff had an in-service on March 19th and discussed labeling and dating, making sure products were placed in the correct spot in the kitchen, and ensuring everything was correct on the tickets when serving trays. [NAME] Y stated that this could be prevented next (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455592	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Side Campus of Care	1950 S Las Vegas Trail White Settlement, TX 76108

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time by double-checking to make sure all beverages were labeled and dated with the use-by date. [NAME] Y stated that all cooks were also responsible for checking all canned goods to ensure there were no dented canned goods. [NAME] Y stated that dented canned goods were stored in the dry storage room on the bottom shelf with a sign that said dented cans. [NAME] Y stated that the dented canned goods had not been removed from the regular stock of canned goods because they had not gotten to that task yet. [NAME] Y stated that the policy for dented canned goods was that staff were supposed to inspect canned goods when first received from the vendor, and if the canned goods were dented, they were supposed to place them at the bottom of the shelf with the other dented canned goods, and they would eventually be discarded. [NAME] Y stated that the risk of dented canned goods being served to a resident was that it could cause the resident to get sick. [NAME] Y stated that next time this could be prevented by slowing down and double-checking to see if there were any dented canned goods and, if so, removing them immediately when found. In an interview on 03/25/26 at 1:21 PM, [NAME] X stated that she had been working in the kitchen since 2013. [NAME] X stated that all dietary staff had been in-serviced earlier that month and discussed labeling and dating, how to serve food and drinks to residents, what temperatures food should have been tempted at, and resident rights. [NAME] X stated that labels and dates were supposed to have been on all beverages. [NAME] X stated that all cooks, the Dietary Manager, and whoever filled the beverages were responsible for making sure the drinks were labeled with the name of the drink and dated with the use-by date. [NAME] X stated that she was not sure why the pitchers of tea were not labeled and dated, but she was aware that everything should have been labeled and dated. [NAME] X stated that [NAME] D had filled the tea pitchers and was not working that day. [NAME] X stated that the risk of not putting labels and dates on the beverages was that staff would not have been sure when the tea pitchers were made, and it was a health problem if served to someone. [NAME] X stated that all dietary staff were responsible for checking to see if any dented cans were with the regular stock of canned goods and, if found, they were supposed to be removed immediately. [NAME] X stated that dented canned goods being stocked with the regular canned goods were not okay. [NAME] X stated that dented canned goods were kept on the left side of the dry food storage area at the bottom of a shelf. [NAME] X stated that their policy was that when a can was dented, it was supposed to be placed at the bottom of the shelf and then discarded. [NAME] X stated that when the vendor delivered products, staff were supposed to check for dented canned goods, and sometimes the vendor would take the canned goods back or throw them away. [NAME] X stated that the risk of keeping dented canned goods with the regular canned goods was that, if served to a resident, it could cause food poisoning. [NAME] X stated that next time this could be prevented by all dietary staff by checking canned goods and removing dented canned goods immediately. In an interview on 03/25/26 at 1:47 PM, the Dietary Manager stated that she had conducted an in-service yesterday on 03/24/26 and they discussed removing dented cans and labeling and dating items in the kitchen. The Dietary Manager stated that all staff were responsible for making sure all beverages were labeled and dated with the use-by date. The Dietary Manager stated that staff were expected to ensure all beverages were labeled and dated when they were opened, and pretty much as soon as staff were done with the item it needed to be labeled and dated with the use-by date. The Dietary Manager stated that [NAME] D had filled the tea pitchers on the morning of 03/24/26 and was not at work on 03/25/26. The Dietary Manager stated that the risk of beverages not being labeled and dated was that if something was not labeled and dated, it posed a potential risk that a resident could become sick. The Dietary Manager stated that all dented canned goods needed to be removed from the regular stock of canned goods and placed with the dented cans so the facility could receive credit from the vendor when the dented canned goods were returned. The Dietary Manager stated that all kitchen staff were responsible for removing dented canned goods from the regular stock of canned goods. The Dietary Manager stated that the risk of having dented canned goods with the regular stock of canned goods was that a resident could get sick if served, especially if something was growing inside the dented canned goods and staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455592	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Side Campus of Care	1950 S Las Vegas Trail White Settlement, TX 76108

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were unaware of it. In an interview on 03/26/26 at 2:35 PM, the administrator stated that the expectation of dietary staff was that they should have been following policy for the dented canned goods and the pitchers of tea that were found. The administrator stated that the policy for dented canned goods was that they had to be separated and, if dented, they could not be used. The administrator stated that the policy for labeling and dating was that all dietary staff had to label and date all items in the kitchen. The administrator stated that the risk of the pitchers of tea not being labeled and dated was that staff would not know what was in the pitcher, and the contents could be given to a resident who was not supposed to have it. The administrator stated that the risk of dented canned goods being with the regular stock of canned goods was that it could affect the contents of the food, which might not have been safe for consumption if staff used the dented canned goods. Record review of the facility's policy titled Food Storage, dated 12/2020, reflected in part: Purpose: To establish guidelines for storing, thawing, and preparing food. Policy: Food items would be stored, thawed, and prepared in accordance with good sanitary practice. C. Dented or bulging cans should have been placed in a separate storage area and returned for credit. H. Products should have been labeled and dated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455592	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Side Campus of Care	1950 S Las Vegas Trail White Settlement, TX 76108

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to ensure an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 3 medication carts reviewed for medical waste and for 2 of 3 halls reviewed. 1.The facility failed to perform appropriate disposal of medical waste. 2. The facility failed to ensure medical waste container was covered on the medication cart located on secure unit These failures could place residents at risk of cross-contamination, increased risk of infection, and the spread of infection. The findings include: Durning an observation on 03/26/2026 at 9:38 AM revealed alcohol wipe on the floor with blood stain located on the floor in the hallway of the secure unit. During an observation on 03/26/2026 at 09:52 AM revealed, on the secure unit the lid on the medical waste container was open and unsecured. During an interview on 03/26/2026 at 9:44 AM with LVN B stated she was responsible for conducting a capillary blood glucose test (fingerstick blood glucose check) for residents on the secure unit. She stated that when the test was completed, the alcohol wipe should be disposed of in the medical waste bin located on the side of the medication cart. The risk of not properly disposingdisposing of the alcohol wipe was possible for infection transfer because it had blood on it. Durning an interview on 03/26/2026 at 9:52 AM, MA C stated the risk of having the side trash open was the resident could get into the trash and would be at risk for cross-contamination or infection if they met medical waste. The lid should be closed after use. Durning an interview on 03/26/2026 at 1:15 PM with the DON stated the expectation was for those (medical waste) things to be discarded appropriately in the trash. The risk of not properly discarding medical waste was infection and cross-contamination. The DON said after you place the medical waste in the trash, close the lid to ensure that the residents are not getting in them. Record Review of policy titled Medical Waste Management Program revised: December 01, 2017 revealed; D. Disposable items soiled with visible blood (or feces from a resident with a disease transmitted through feces) are placed in designated medical waste containers. A. Medical waste containers are located throughout the Facility and are kept covered at all times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455592	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Side Campus of Care	1950 S Las Vegas Trail White Settlement, TX 76108

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care that met professional standards of quality care within 48 hours of a resident's admission for 1 (Resident #179) of 6 residents reviewed for baseline care plans. The facility failed to develop a baseline care plan for Resident #179 within 48 hours of admission. This failure had the potential to place newly admitted residents at risk of not receiving effective, person-centered care.Findings included:Record review of Resident #179's face sheet, dated 03/26/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of the bladder (bladder cancer), acute ischemic heart disease (reduced blood flow of the heart), orthostatic hypotension (a sudden drop in blood pressure), hypercalcemia (abnormally high calcium levels in the blood), anemia (low levels of healthy red blood cells), Type 2 diabetes, insomnia (difficulty falling asleep), hypertension (high blood pressure), extrarenal uremia (buildup of waste products in the blood), adult failure to thrive, cachexia (wasting syndrome), and systemic inflammatory response syndrome (inflammation throughout the whole body).Record review of Resident #179's MDS assessment dated [DATE], reflected a BIMS score of 10.Record review of Resident #179's EHR under the assessments tab reflected no baseline care plan, and the baseline care plan was shown in red with the date 03/14/26.In an observation on 03/24/26 at 9:21 AM, Resident #179 was lying down in bed asleep he was observed breathing but he was not alerted to be interviewed. In an interview on 03/24/26 at 9:25 AM, the ADON stated Resident #179 was a new admit and he had come from the hospital. The ADON stated that she was unsure how many days he had left to live but Resident #179 was dying due to the diagnosis of bladder cancer. In an interview on 03/26/26 at 10:35 AM, LVN E stated that she had been working for the facility since November 2024. LVN E stated that the RN was responsible for making sure all baseline care plans were completed. LVN E stated that the baseline care plan was supposed to have been entered into the EHR within 24 hours of a resident being admitted . LVN E stated that the baseline care plan was located under the assessments tab in PCC and would not have been anywhere else in the system. LVN E stated that if the baseline care plan was not in PCC and appeared in red, it meant it was overdue. LVN E stated that the risk of a resident not having a baseline care plan was that the resident would not have been able to receive proper care.In an interview on 03/26/26 at 10:48 AM, RN F stated that she had been working for the facility since May 2021. RN F stated that the DON was responsible for making sure baseline care plans were completed and entered into PCC. RN F stated that baseline care plans were supposed to have been entered into PCC within 24 hours of discussing the plan with the family after reaching an agreement. RN F stated that the risk of a resident not having a baseline care plan was that the resident might not have received the correct treatment or could have experienced delayed care.In an interview on 03/26/26 at 1:08 PM, LVN G stated that she had been working for the facility for a year. LVN G stated that the IDT was responsible for completing baseline care plans and entering them into the EHR system. LVN G stated that the ADON, the DON, therapy nurses, treatment nurse, MDS, and even the kitchen staff were all part of the IDT. LVN G stated that baseline care plans should have been completed right after the resident was admitted or within 48 hours. LVN G stated that there was only a risk if a nurse did not know what was going on. LVN G stated that the policy for completing a baseline care plan was that it should not have exceeded 48 hours.In an interview on 03/26/26 at 1:32 PM, the MDS Coordinator stated that the baseline care plan was a user-defined assessment and automatically opened in PCC when a resident was admitted , and the IDT was supposed to go in and edit the assessment. The MDS Coordinator stated that if the baseline care plan was in red in PCC, that meant it was overdue. The MDS Coordinator stated that the baseline care plan (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455592	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Side Campus of Care	1950 S Las Vegas Trail White Settlement, TX 76108

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was supposed to be completed within 72 hours. The MDS Coordinator stated that she did not believe the baseline care plan not being in PCC posed a risk because they discussed every morning what needed to be done for the residents. She then stated that it could have posed a risk if the baseline care plan was not in PCC. She stated that she would have had to look at the policy on baseline care plans to know what it said, but she presumed it stated the baseline care plan had to be in PCC within 72 hours.In an interview on 03/26/26 at 1:44 PM, the Social Worker stated that the IDT was responsible for making sure baseline care plans were completed and entered in PCC. The Social Worker stated that the baseline care plan was supposed to have been completed within 24 to 48 hours of a resident being admitted . The Social Worker stated that if the baseline care plan was in red in PCC, that could have indicated that the care plan was not completed. The Social Worker stated that a resident could have been at risk for unmet needs because the care plan was missing, and staff could not have fully identified the resident's needs. The Social Worker stated that the IDT had completed the baseline care plan on 03/13/26, but there was a failure to enter the plan into the system. The Social Worker stated that the baseline care plan was supposed to have been entered into the system the same day the plan was completed with the IDT team. The Social Worker stated that they had an in-service on 03/26/26 due to the baseline care plan not being entered into the system for Resident #179.In an interview on 03/26/26 at 2:10 PM, the DON stated that all nurses were responsible for completing the baseline care plan, and it was usually the admitting nurse who was supposed to make sure it was completed and entered in PCC. The DON stated that the baseline care plan should be completed within 48 hours of admission. The DON stated that she was unsure why the baseline care plan was not in PCC, but that it had been completed. The DON stated that the baseline care plan should have been entered into PCC within 48 hours and on the same day the meeting was held. The DON stated that social services audited the charts to ensure the baseline care plan was completed. The DON stated that she also typically audited the charts to ensure the baseline care plan was completed. The DON stated that the risk of the baseline care plan not being in PCC was that the information would not have been shared with the rest of the team. The DON stated that they had completed a refresher in-service on baseline care plans on 03/26/26. In an interview on 03/26/26 at 2:35 PM, the administrator stated that staff should have been following policy with baseline care plans and that it should have been completed within 48 hours unless it was a weekend, which could have caused a delay when staff were not around. The administrator stated that the expectation of staff was that they should had completed the baseline care plan as soon as possible. The administrator stated that ideally the baseline care plan should be entered into PCC as soon as the meeting with the IDT was completed. The administrator stated that the risk of the baseline care plan not being completed and entered in PCC was that resident care could be affected.Record review of the facility policy titled Care Planning, dated 06/2020 reflected the following, in part:Purpose: To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs.Policy: I. The Facility's Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with OBRA and MDS guidelines.II. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs.III. A Licensed Nurse will initiate the Care Plan.Procedure: I. The Facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455592	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Side Campus of Care	1950 S Las Vegas Trail White Settlement, TX 76108

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to accommodate resident's allergies for 1 of 6 (Resident #180) residents reviewed for food allergies. The facility failed to ensure Resident #180 did not receive two ketchup packets on his lunch tray which were listed as a food allergy in his medical record. This failure could cause an allergic reaction, a decrease in resident choices, and a diminished interest in meals placing him at risk for contributing to poor intake and/or weight loss. Findings included: Record review of Resident #180's quarterly MDS, dated [DATE], reflected he was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #180 was diagnosed with malnutrition (deficiencies, excesses, or imbalances in a person's intake of energy and/or nutrients), bipolar disorder (chronic mental health condition characterized by intense fluctuating mood shifts between high energy [mania or hypomania] and low energy [depression], and complication of diabetes (chronic metabolic disorder characterized by insulin resistance and relative insulin deficiency, leading to high blood sugar) that affects the eyes by causing damage to the blood vessels. Record review of the quarterly MDS also reflected a BIMS score was 15 which indicated he was cognitively intact. Record review of Resident #180's admission Record, dated 03/26/26, reflected Resident #180 had an allergy to tomato, neutral red, and red dye. Record review of Resident #180's Food and Nutrition Profile, dated 03/26/26, reflected Resident #180 had allergies to tomato, neutral red, and red dye. Record review of Resident #180's care plan, dated 1/1/26, reflected: Focus: Allergic to Tomato, Neutral Red, Red Dye Goal: Will not receive Tomato, Neutral Red, Red Dye Interventions/Tasks: Do not administer and/or come in contact with allergen, Inform MD if the allergen is ordered, Make note on chart of all allergies, Notify MD and family of any changes. Observation on 03/26/26 at 12:32 PM of Resident #180's tray revealed two tomato ketchup packets on Resident #180's lunch tray. Observation of Resident #180's tray ticket, dated 03/26/26, reflected: Allergies: Red Food Color; Tomatoes. Interview on 03/26/26 at 12:35 PM revealed Resident #180 had received his lunch tray with the ketchup packets on the tray. Resident #180 stated that the kitchen had put the ketchup on the tray. Resident #180 stated he would not eat the ketchup because he was allergic to it. Resident #180 stated that if he ate the ketchup, he would begin to itch all over his body, and his throat would begin to close. Resident #180 said that he must take an antihistamine to relieve the symptoms. Resident #180 stated that these symptoms were uncomfortable, and he did not want to experience these types of symptoms. Resident #180 also stated that he had informed the nursing staff on multiple occasions that he was allergic to these types of foods, but the types of foods continued to be put on his tray and served to him. Resident #180 stated that he would usually send his tray back if an item like tomatoes was on his plate and requested an alternative. And due to the length of time it took to get a new tray, he would normally not end up eating his meal. Interview and observation on 03/26/26 at 1:05 PM with LVN A revealed that nurses should check their residents' trays before they are given to their residents. LVN A stated that when the nurses checked the residents' trays, they should check to verify the residents' meal ticket order versus what was served from the kitchen. LVN A said that the nurses should check the residents' allergies that are listed on their meal tickets. LVN A stated that she was Resident #180's nurse, but she did not check Resident #180's tray on 03/26/26. LVN A stated that Resident #180 was cognitive and aware of his allergies. LVN A revealed that Resident #180 knew not to use ketchup due to his allergy to tomatoes. LVN A stated she would have served him the tray the way it came from the kitchen and would not have removed the ketchup packets on Resident #180's tray because of his high cognition. LVN A stated that if a resident had low cognition, she would remove any item they were allergic to when checking their trays before serving them. LVN A stated that when Resident #180 ate food that he was allergic to, he would get a rash that irritated him. LVN A said that Resident #180 did not require an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455592	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Side Campus of Care	1950 S Las Vegas Trail White Settlement, TX 76108

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	epinephrine injector (a prescription auto-injector device used for immediate self-administration of epinephrine to treat life-threatening, emergency allergic reactions) if he ate tomato or ketchup. LVN A stated that she would notify the DON, dietary manager, and physician if a resident experienced a negative allergic reaction from eating an item that should not have been on their tray during a meal. LVN A was observed by the surveyor discussing the incident with the dietary manager immediately after the interview. Interview on 03/26/26 at 1:16 PM with the Dietary Manager revealed that she had just been informed by LVN A that her staff served Resident #180, who has an allergy to tomatoes, his lunch tray with ketchup packets. The Dietary Manager stated that when a resident has a food allergy, that allergy should be printed on their meal tickets to alert staff of the allergy and remind them not to include those items on the resident's tray. The Dietary Manager said the serving staff was responsible for ensuring that nothing with that product was placed on the tray. The Dietary Manager revealed that the resident's nurse should check the resident's tray before it was served to the resident to ensure that there was no item on the plate that could cause an allergic reaction. The Dietary Manager also stated residents could get sick from the allergic reaction to the food they ate served on their tray. The Dietary Manager said that she would in-service her staff immediately to look closer at residents' tickets to ensure they were following the tray tickets when plating residents' meals. Interview on 03/26/26 at 1:23 PM with the Certified Registered Dietician revealed that residents' allergies were obtained through the facility electronic health record system and then put into the facility dining electronic system. The Certified Registered Dietician revealed that this process ensures that residents' allergies are printed on all their tickets. The Certified Registered Dietitian said that the staff who were responsible for preparing the tray should refer to the ticket to ensure that no item that could cause an allergic reaction was placed on the tray. She stated that once the tray gets to the floor, the nursing staff should look at the tray to ensure that the allergy printed on the ticket was not on the tray before given to the resident. The Certified Registered Dietician revealed this was important to prevent an allergic reaction which could cause harm to the residents. She stated the dietary department would in-service their staff to check their tickets when preparing residents' trays. Interview on 03/26/26 at 2:20 PM with the DON revealed that she expected each resident to receive a tray with their correct order including no items they could cause an allergic reaction. The DON stated that the kitchen staff should check each resident's ticket in the kitchen while they prepare the resident's tray. The DON then stated that residents' charge nurses should check their residents' trays before they were passed to verify that residents' ticket orders match their trays to ensure there were no foods on their trays that conflict with their allergy orders. The DON stated that if this process was not followed, a resident could eat something they were allergic to causing anaphylactic shock (severe potentially life-threatening allergic reaction) or some other adverse event. The DON revealed that since she learned about the error on the resident's lunch tray, she began in-servicing her nursing staff. The DON also said that if a resident ate something that caused an allergic reaction, she would notify the resident's physician, responsible party, the administrator, and her regional nurse consultant. Record review of the facility policy, Nutrition/Hydration Management dated 06/20, reflected, Purpose: To Ensure that each resident maintains acceptable parameters of nutritional status, such as body weight, and protein levels, unless the resident's clinical condition demonstrates that this is not possible based on the resident's comprehensive assessment. To ensure that a resident receives a therapeutic diet when there is a nutritional problem.A registered dietician completes a thorough nutritional assessment providing a more detailed profile of the resident's overall nutritional status within 14 days.Key data points to gather include but are not necessarily limited to: C. Food allergies.