

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455989	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Borger Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 S Florida Borger, TX 79007	

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (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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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident received food prepared in a form designed to meet individual needs for 1 (Resident #13) of 12 residents reviewed for dietary needs. The facility failed to prepare Resident #13's pureed diet appropriately. This failure could place residents at risk of aspiration, choking, and/or weight loss. Findings Included: Record Review of Resident #13's admission record dated 08/26/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia severe (a group of thinking and social symptoms that interferes with daily functioning), unspecified protein-calorie malnutrition (state of inadequate intake of food), dysphagia oropharyngeal phase (swallowing disorder that makes it difficult or unsafe to move food from the mouth to the esophagus), and other dietary vitamin B12 deficiency anemia (a form of anemia that occurs when the body lacks sufficient vitamin B12 due to an inadequate intake of natural sources, such as meat and dairy, or fortified foods). Record review of Resident #13's quarterly MDS completed 08/22/25 revealed no BIMS score as Resident #13 was rarely to never understood. The staff assessment revealed her cognition was severely impaired. Section GG Functional Abilities revealed Resident #13 was dependent across all ADLs except for eating where she required substantial/maximal assistance. Section K Swallowing/Nutritional Status revealed she received a mechanically altered diet while a resident. Record review of Resident #13's care plan completed 08/20/25 revealed the following: Nutrition: . physician/NP diet orders, functional assistance level with eating, swallowing precautions as needed will be maintained until further nutritional evaluation is completed. Resident #13 was noted to have impaired functional abilities r/t severe dementia. One of the approaches to address this problem area was Eating: usual performance: dependent Staff assistance: X 1 Assistive device, if applicable: food separated into bowls. Resident #13 was noted to have a regular puree diet order. The goal for this problem area was I will be offered an appetizing meal . help me avoid choking on food that I cannot eat over the next 90 days. This goal was edited on 08/11/25. One of the approaches regarding this goal was My texture is puree. Record review of Resident #13's active orders as of 08/27/25 revealed the following order: Order start date of 06/05/25 Diet: regular diet Texture: PUREE . Special Instructions: Serve food in bowls During an observation on 08/25/25 at 8:07 AM Resident #13 was seated in the dining room being fed by a CNA from bowls on the table in front of her. During an observation and interview on 08/26/25 at 07:26 AM DA B was taking temps of breakfast foods on the steam table. The breakfast was scrambled eggs, oatmeal, sausage patties, and toast. There were two bowls in a steam pan. One bowl contained a brown, dry, crumbly substance and the other contained a yellow substance that appeared to be the texture of cottage cheese. DA B stated the bowls were the puree diet and she had not added the gravy to the bowls yet. During an observation on 08/26/25 at 07:28 AM DA B asked DA A what liquid to add to the puree. DA A told DA B to add apple juice to the pureed sausage and eggs. During an observation on 08/26/25 at 07:32 AM DA B opened a small plastic, single serve container of apple juice and poured half of it into the bowl of ground eggs and half (approximately 1/4 cup) of it into the bowl of ground sausage. She then heated each bowl in the microwave. During an observation on 08/26/25 at 07:37 AM this surveyor tasted the pureed eggs and found them to be sweet from the addition of the applesauce. The flavor was not appetizing, and the texture was watery with small lumps of egg. This surveyor then tasted the pureed sausage patty. The sausage tasted better than the eggs but was still on the sweet side. The sausage texture was watery with grainy lumps and larger lumps. There was no pureed bread. During an observation on 08/26/25 at 07:49 AM The bowls of pureed food for Resident #13 were placed by DA A on the wrong tray and delivered to the wrong resident. During an observation on 08/26/25 at 07:53 AM DA B began to remake the puree. She placed a serving of eggs in the blender with approximately 1/4 cup of apple juice. DA B ran the blender for about 30 seconds and poured the egg mixture into a bowl. During an observation on 08/26/25 at 07:56 AM DA B rinsed the blender and added a sausage patty and approximately 1/4 cup of apple juice. She ran the blender for about 30 seconds and poured the sausage mixture into a bowl. During an observation on 08/26/25 at 07:58 AM DA B scooped oatmeal from the pan on the stove, added it to a bowl and placed the bowl of oatmeal, pureed eggs, and pureed sausage on a tray to be delivered to Resident #13. During an interview on 08/26/25 at 11:33 AM RD stated pureed food needed to be the consistency of thick pudding or mashed potatoes. She stated correctly pureed food should not fall through and fork and should fall off a spoon in one lump. She stated grainy or watery texture was not correct. RD stated regular oatmeal was not</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>(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>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 1 of 1 kitchen reviewed for food service safety. The facility failed to ensure stored food was properly labeled and dated. The facility failed to ensure dented cans were placed in the specified area to be returned. The facility failed to discard leftover food by use by date on the label. The facility failed to ensure the floor, walls, trashcan, and bathroom of the kitchen were clean and sanitized. The facility failed to ensure food was stored at least 6 inches off the floor. These failures could place residents at risk of food borne illness. Findings included: An observation on 08/25/25 at 05:35 AM revealed a meal trolley outside the door to the kitchen. It was full of dirty dishes and trays with two dirty trays and their dirty dishes sitting on top of the trolley. An observation on 08/25/25 at 05:36 AM revealed the sink next to the dishwasher was full of dirty dishes, pots, and pans and the three compartment sink on the other side of the dishwasher was full of dirty dishes, pots, and pans. An observation on 08/25/25 at 05:37 AM revealed three round, 5-gallon, opaque plastic, lidded containers stacked on top of one another on the floor of the kitchen next to the stand mixer. The bottom container was 1/4 full of yellow substance and labeled Cornmeal 07/17/25 use by 08/17/25. The middle container was 1/2 full of white substance and labeled Sugar 07/17/25 use by 08/17/25. The top container was 1/6 full of white powdery substance and had no label or date. An observation on 08/25/25 at 05:39 AM revealed the kitchen floor around the step-to-open trashcan was littered with white crumbs which were stuck to the floor but could be scraped off using the toe of this surveyor's shoe. The trash can did not have a liner and the inside of the trashcan is smeared. The bottom of the trash can contained crumbs, two individual ketchup packets, and one individual butter packet. An observation on 08/25/25 at 05:40 AM revealed the kitchen floor next to the stove, steam table, and prep table was littered with crumbs and black/brown streaks and smears that were sticky to the bottom of this surveyor's shoes. An observation on 08/25/25 at 05:42 AM of the counter next to the microwave revealed the following: two bags of circular fruit flavored breakfast cereal open to air a bag of cheese sauce mix open to air with no date a banana peeled 1/3 of the way down and open to air. An observation on 08/25/25 at 05:43 AM of the shelving under the microwave counter and the steam table revealed clean steam pans and a scattering of white crumbs. An observation on 08/25/25 at 05:46 AM of the walls next to and behind the oven revealed brown/orange substance splattered from about 6 feet high to the bottom of the walls. An observation on 08/25/25 at 05:48 AM of the prep table reveals a brown/grey smear approximately the size of a dessert plate that is sticky and greasy to touch on the end of the table closest to the serving door. An observation on 08/25/25 at 05:48 AM of the refrigerator and freezer temperature logs revealed the last entry was 08/20/25. An observation on 08/25/25 at 05:51 of the large freezer revealed the following: 1 zip topped plastic bag contained what appeared to be pancakes no label or date 1 zip topped plastic bag contained breaded meat patties no label or date 2 large plastic bags of what appeared to be fried shrimp no label or date 1 plastic bag labeled cookies open to air. An observation on 08/25/25 at 05:55 AM of the walk-in refrigerator revealed the following: 2 individual butter spread containers on the floor 1 unopened, clear plastic bag labeled coleslaw and dated 07/22/25 1 zip topped plastic bag labeled cucumber onion dated 08/21/25 use by 08/24/25 1 large opaque circular tub 1/3 full of what appears to be chopped carrots in liquid no label or date 1 plastic circular opaque tub 1/3 full labeled cream of chicken and dated 08/19/25 use by 08/22/25 1 rectangular, metal, lidded steam table pan 1/2 full of what appears to be oatmeal no label or date 1 zip topped plastic bag labeled Roast dated 08/20/25 use by 08/23/25 1 buffet ham in original packaging dated 07/29/25 1 package of what appears to be round luncheon meat with no label or date. 1 package of sliced ham no date 1 box of bacon open to air. An observation on 08/25/25 at 06:07 AM revealed a round, lidded, plastic tub of chocolate frosting with 1/6th used sitting on the counter next to the coffee maker. Manufacturer's label stated, Refrigerate leftovers for up to 2 weeks. An observation on 08/25/25 at 06:08 AM of the pantry revealed the following: 1 can of apples dented on the side and top seam of the can 1 large bag of parboiled rice open to air 1 undated box of small macaroni noodles open to air 1 zip topped plastic bag with open cheese sauce package inside with no open date 1 zip topped plastic bag with open bag of potato chips inside with no open date 4 macaroni noodles and lots of crumbs and dirt on the floor behind the pantry door. An observation on 08/25/25 at 06:23 AM of the kitchen bathroom revealed the following: 1 wet spot under the sink the size of a sheet of letter paper, with dirty end of plunger resting in the wet spot toilet bowl was speckled with brown spots yellow stains on underside of toilet seat in a splatter pattern sink drain is broken</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #5) of 3 residents observed for infection control practices. The DON did not wear a gown when performing wound care for Resident #5. This failure could place residents at risk of cross-contamination and infections. Findings include: Record review of Resident #5's clinical record revealed a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include stage 4 pressure ulcer of the sacral region (a severe, full-thickness skin and tissue injury that extends into the muscle, tendon, and ligament, or bone at the base of the spine, below the lumbar vertebrae and above the coccyx (tailbone) and dysphagia (difficulty or discomfort in swallowing). Record review of Resident #5's clinical record revealed his last MDS was a quarterly completed 7/25/25 listing him with a BIMS of 15 indicating he was cognitively intact, he had a functionality of requiring supervision for most of his activities of daily living, and he had an unhealed stage 4 pressure ulcer. Record review of Resident #5's care plan with admission date of 11/06/24 revealed the following: Problem Start Date: 06/05/2025 Category: General require enhanced barrier precautions due to the following: I am at increased risk of a MDRO acquisition due to having a wound. Approach Start Date: 06/05/2025 PPE will be available (including gowns/gloves/face shield or goggles) will be available right outside my room, in the shower room. Problem Start Date: 06/05/2025 Category: General require enhanced barrier precautions due to the following: pressure ulcer and colostomy. Approach Start Date: 06/05/2025 Staff will wear PPE during high-contact activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, incontinent care, wound care of any type requiring a dressing, device care or use. Problem Start Date: 05/29/2025 I have a colostomy R/T chronic wound infection to buttocks. Record Review of Resident #5's Orders printed 8/26/25 revealed the following order: -Enhanced Barrier Precautions - I have a pressure ulcer and colostomy. Start Date: 6/05/25. During an observation on 08/26/2025 at 09:42 AM the DON performed Resident #5's wound care to his Stage 4 Pressure Ulcer on his coccyx. The DON did not put on a gown at any time during the care. During an interview on 08/26/2025 at 9:56 AM the DON verified she did not put on a gown during the wound care for Resident #5's pressure ulcer on his coccyx. The DON reported this did violate EBP precautions because he had a wound and he had a colostomy. The DON reported not following EBP would result in violating infection control. During an interview on 08/26/2025 at 1:20 PM RN E reported any resident on EBP was on that process to maintain infection control. Anyone with a catheter, wound, or something similar to that should be on EBP which means they should have a station placed outside their room with gowns, gloves, and goggles if needed. RN E reported EBP was done to prevent the spread of infection. During an interview on 08/27/2025 at 8:52 AM the CN reported EBP should be utilized with any resident that has a catheter, wound, ostomy, PICC line, or something like that. The CN reported she expects staff to wear the appropriate PPE with any of these procedures. The CN reported if staff do not follow EBP then they violate infection control and can spread infections. Record review of the facility provided policy titled, Enhanced Barrier Precautions date implemented 6/25, revealed the following: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. 3. Implementation of Enhance Barrier Precautions: b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. 4. High-contact care activities include: h. Wound care: any skin opening requiring a dressing.</p>		