STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675001	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands	125 Inspiration Blvd Eastland, TX 76448

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary drugs for 1 (Resident #315) of 18 residents whose medications were reviewed. The facility failed to ensure Resident #315 (a male) received a female hormone replacement drug (Medroxyprogesterone) due to inappropriate sexual behaviors without review for continued necessity and documented rational for the benefit or adequate monitoring from 06/14/2024 until current. This failure could place residents at risk of being over-medicated or experiencing undesirable side effects and cause a physical or psychosocial decline in health. The findings included: Record review of Resident #315's electronic face sheet revealed: [AGE] year-old-male admitted [DATE]. Resident #315's diagnoses included: Depression, Type II diabetes mellitus, Mood disorder, Generalized Anxiety, Other sexual dysfunction not due to substance or known physiological condition, Hypertension (high blood pressure) Chronic Obstructive Pulmonary Disease (lung disease). Record review of Resident # 315's Admission MDS assessment dated [DATE] revealed: Section C Cognitive Patterns BIMS score was 06 (severe cognitive impairment). Section E Behaviors-A. Physical behavioral symptoms directed toward others (sexual) 2. Behaviors of this type occurred 4 to 6 days, but less than daily. Record review of Resident #315's Physician orders dated 07/01/2024 revealed: medroxyprogesterone (Hormone used for the treatment of sexually inappropriate behavior in patients with dementia) tablet 10 mg 1 tablet by mouth once a day. Record review of Resident #315's Care plan dated 06/18/2024 revealed: Problem start date 06/18/2024, I have been sexually inappropriate with female staff and residents. I have touched their breasts and have verbalized my wishes to touch them again. I wander in and out of rooms but am easily redirected. Goal: Problem: Resident sexual behavior will decrease. Approach: Review medications as needed. 1. Psych consult for possible medication change to decrease sexual behaviors. 2. Close monitoring and frequent rounds on Resident. 3. Redirect and correct sexual behaviors. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/10/2024 at 10:05 AM, the ADON stated the admitting nurse was responsible for getting consents signed for anti-psychotics, anti-depressants and all medications that require a consent. The ADON stated she checks and was to follow up to make sure all consents were signed. She stated this one just got missed due to agency staff working. She stated the negative impact on the resident would be that side effects could have been missed or why they had taken the medication. She stated Resident #315's family was aware of the medication administered for behaviors but had no consent for this one. During an interview on 07/10/2024 at 2:00 PM, Resident #315's representative stated he had not signed any consents or gave a verbal consent for this medication. He stated he knew of the medication and was accepting of it being provided to this resident but had not known there needed to be a consent signed. He stated the resident has been on this medication before entering the facility and was asked to sign the consent this day of 07/10/2024. During an interview on 07/10/2024 at 2:42 PM, the DON stated they had gotten a verbal consent from the representative and should have been in the residents' EMR. She stated the facility was to obtain consents for everything and did not know why this one was missed. The DON stated the admitting nurse monitors the consents as she was responsible for the admitting paperwork to be completed. She stated Resident #315's representative lived out of state and there would have been no way for him to sign the consent. The DON stated it was partly her fault as she had only gotten verbal consents. She stated she did not think there was a negative impact to Resident #315 since the Resident Representative was aware. She stated a negative effect on the resident were that if it wasn't the correct dose there could have been different behaviors. The DON stated it was herself as well as the ADMN give the consent trainings to the admission staff and should have done a checklist upon admission. She stated the failure was not having the communication between staff with her expectations to have the consents completed on admission. The DON stated there was no consents policy to provide.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on interviews and record reviews, the facility failed to develop a comprehensive person-centered care plan based on assessed needs that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #41 and Resident #315) of 18 residents reviewed for comprehensive person-centered care plans. The facility failed to ensure Resident #41's comprehensive care plan was person centered and measurable when addressing Residents delusions behavior. The facility failed to ensure Resident #315's comprehensive care plan contained Resident's medication prescribed for the treatment of sexually inappropriate behavior in patients with dementia. These failures could affect the residents by placing them at risk for not receiving care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Findings included: Resident #41 Record review of Resident #41's Admission MDS assessment dated [DATE] revealed: Section A- Identification Information revealed Resident #41 was an [AGE] year-old female admitted on [DATE] with an original admitted [DATE]; Section C-Cognitive Pattens reflected she had a BIMS score of 9 (moderately impaired cognitive status); Section D- Mood reflected Resident #41 had felt down and depressed (nearly every day); Section E- Behavior reflected Resident had delusions; Section I- Active Diagnoses reflected Resident #41 had the following diagnoses: osteoarthritis (Chronic disease that causes the breakdown of joint cartilage), Diabetes mellitus Type II, Fracture of shaft of right femur, Fracture of upper end of right humerus (upper arm), Insomnia (persistent problems falling and staying asleep), depression, dementia, and depression; Section N- Medications revealed no evidence that Resident #41 received antipsychotic, antianxiety or antidepressant medications. Record review of Resident #41's Physician Orders dated 07/01/2024 revealed no evidence of medication ordered for antipsychotic, antianxiety or antidepressant medications. Record review of Resident #41's care plan dated 05/28/2024 revealed: Problem start date 05/28/2024 Resident's RP is reluctant to consent to psychoactive medications. Family prefers to take a holistic approach to medical care. Problem: Resident will not experience any adverse effects from holistic approach. Approach Base POC on minimal pharmacological interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Problem: start date 05/28/2024 Resident has episodes of anxiety and is at risk of fluctuations in moods; Goal: Resident anxiety will be maintained at the level tolerable to resident and will demonstrate reduced anxiety AEB response to proper medication over the next quarter; Approach: administer medications as ordered; monitor and document s/sx of medications; monitor and documents s/sx of adverse effect of medications given r/t the underlying health problem. Problem: start date 05/28/2024 Resident has a diagnosis of depression and is at risk for fluctuations in mood, little interest or pleasure in doing things and decreased socialization; Goal: Resident will have fewer or no episodes of depression and will voice positive feeling about self over the next quarter; Approach Administer medication as ordered, monitor labs-report abnormal to MD Resident #315 Record review of Resident #315's electronic face sheet revealed: [AGE] year-old-male admitted [DATE]. Resident #315's diagnoses included: Depression, Type II diabetes mellitus, Mood disorder, Generalized Anxiety, Other sexual dysfunction not due to substance or known physiological condition, Hypertension (high blood pressure), Chronic Obstructive Pulmonary Disease (lung disease). Record review of Resident # 315's Admission MDS assessment dated [DATE] revealed: Section C Cognitive Patterns BIMS score was 06 (severe cognitive impairment). Record review of Resident #315's Physician orders dated 07/01/2024 revealed: medroxyprogesterone (Hormone used for the treatment of sexually inappropriate behavior in patients with dementia) tablet 10 mg 1 tablet by mouth once a day. Record review of Resident #315's Care plan dated 06/18/2024 revealed: Problem start date 06/18/2024, I have been sexually inappropriate with female staff and residents. I have touched their breasts and have verbalized my wishes to touch them again. I wander in and out of rooms but am easily redirected. Goal: Problem: Resident sexual behavior will decrease. Approach: Review medications as needed. 1. Psych consult for possible medication change to decrease sexual behaviors. 2. Close monitoring and frequent rounds on Resident. 3. Redirect and correct sexual behaviors. During an interview on 07/10/2024 at 6:15 PM the ADON stated she and the DON were responsible for creating care plans. The ADON stated care plans should have been individualized, person centered and measurable. The ADON stated interventions should be individualized for each resident. The ADON stated Resident #41should not have had interventions for antidepressant, antipsychotics and antianxiety because she was not taking any of those medications. During an interview on 07/10/2024 at 6:41 PM the DON stated her expectation was that care plans should have been personalized and measurable. The DON stated the affect on residents not having a person specific care plan could have resulted in care or monitoring not being provided. The DON stated oversight led to failure of care plans not being person specific. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled, Care Plans- Comprehensive dated September 2010 revealed , An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident .Incorporate identified problem areas; Incorporate risk factors associated with identified problems; Build on the resident's strengths; Reflect the resident's expressed wishes regarding care and treatment goals . Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. No single discipline can manage the task in isolation. The resident's physician (or primary healthcare provider) is integral to this process. 44728

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44722 Based on observations, interviews, and record reviews, the facility failed to maintain an environment that was as free from accident hazards as was possible for 2 of 4 (Hall 300 and Hall 400) halls reviewed for accident hazards. The facility failed to ensure a spray bottle of grill and oven cleaner, a bottle of rubbing alcohol, a wire metal brush and a steel wool cleaning pad were stored in a cabinet on Hall 300 that was locked and not accessible to the residents on Hall 300. The facility failed to ensure a bottle of shaving cream, a tube of antifungal powder, a tub of zinc oxide, body lotion, deodorant bottles, and a bottle of shampoo/body wash were stored in a locked shower room and not accessible to the residents on Hall 400. This failure could place residents at risk of injury due to hazardous chemicals. Findings include: During an observation on 07/08/2024 at 11:48 AM, an unlocked cabinet in the Hall 300 kitchen contained the following items: a spray bottle of grill and oven cleaner, a bottle of rubbing alcohol; a wire metal brush and a steel wool cleaning pad. During observation on 07/09/2024 at 3:37 PM, Hall 400 (MCU) shower was unlocked with chemicals and cleaners that included: shampoo and body wash, deodorant bottles, shaving cream, Antifungal powder, Zinc Oxide paste skin protectant and moisturizing body lotion. During an interview on 07/08/2024 at 12:16 PM, LVN A stated cleaning items should not have been stored in the kitchen on Hall 300. LVN A stated the kitchen was only used to serve food. LVN A stated the kitchen staff were responsible for monitoring items in the Hall 300 kitchen. LVN A stated chemicals should have been stored where residents were not able to have access. During an interview on 07/10/2024 at 6:15 PM, the ADON stated cleaning chemicals, rubbing alcohol, shampoo, lotions, and zinc oxide cream should not have been stored where residents could have been able to ingest them. The ADON stated all staff should have been monitoring and making sure hazardous items were locked where residents were not able to get to them. The ADON stated if a resident were to eat or drink hazardous materials it could have caused serious harm. During an interview on 07/10/2024 at 7:07 PM, the ADMN stated chemicals should not have been stored in a location where residents were able to access them. The ADMN stated the shower rooms should have been locked when not in use. The ADMN stated residents could have had a hazardous effect if they were to eat or drink something they were not supposed to. The ADMN stated what led to the failure was staff were not following their policies and procedures . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled, Environmental Services Safety Procedures dated 01/01/2023 revealed Staff will ensure equipment (e.g., cords, ladders, or chemicals) is properly stored and not left unattended in areas that are accessible to residents. When not in use, equipment will be stored in a locking closet, cabinet, laundry carts, or storage area for safety.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 44722 Based on interviews, and record review the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment for 7 of 10 days reviewed for sufficient staffing. The facility failed to maintain nurse staffing at the level indicated by the PPD budget on 03/23/2024, 05/11/2024, 06/13/2024, 06/18/2024, 07/02/2024, 07/05/2024 and 07/07/2024. This failure could place the residents at risk of resident's needs, safety and psychosocial well-being not being met. Findings included: Record review of timesheets dated 03/23/2024 revealed 168.63 hours worked by direct care staff. Per facility PPD and census, 176.70 direct care staff hours were needed. Record review of timesheets dated 05/11/2024 revealed 137.36 hours worked by direct care staff. Per facility PPD and census, 156.75 direct care staff hours were needed. Record review of timesheets dated 06/13/2024 revealed 162.33 hours worked by direct care staff. Per facility PPD and census, 171 direct care staff hours were needed. Record review of timesheets dated 06/18/2024 revealed 166.40 hours worked by direct care staff. Per facility PPD and census, 173.85 direct care staff hours were needed. Record review of timesheets dated 07/02/2024 revealed 169.02 hours worked by direct care staff. Per facility PPD and census, 176.70 direct care staff hours were needed. Record review of timesheets dated 07/05/2024 revealed 147.80 hours worked by direct care staff. Per facility PPD and census, 176.70 direct care staff hours were needed. Record review of timesheets dated 07/07 /2024 revealed 148.32 hours worked by direct care staff. Per facility PPD and census, 173.85 direct care staff hours were needed. During an interview on 07/09/2024 at 9:25 AM Resident # 26 stated the facility was short staffed and it took staff a long time to respond to call lights. Resident # 26 stated the most recent time she remembered taking a long time to answer the call light was on July 5th. She had pushed her call light because she had urinated on herself, and the aide came in and told her she would come back to change her and did not come back for over 2 hours. Resident #26 stated she did not have any skin breakdown, but that she had sensitive skin and it hurt when she had to sit in urine. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/09/2024 at 10:34 AM Resident #9 stated the staff take a long time to answer call lights and there have been times when there were only 2 aides to take care of the entire building. Resident # 9 stated he has had to call his family member to have someone come to his room to assist him to the restroom because no one had answered his call light. During a confidential interview on 07/09/2024 at 3:30 PM the confidential interview stated they were happy that State was in the facility as they had asked upper management for more staff as they were being told that the CNA's were to clean the MCU while working their shift. Confidential interview stated HK would go clean only on Fridays. Confidential interview stated HK had not always cleaned on Fridays and that was why it smelled of urine. Confidential interview stated it took them away from resident care and was unable to keep up with both jobs. During an interview on 07/09/2024 at 4:00 PM the HK Supervisor stated her HK staff stayed mostly on the 1-3 halls M-F and there was no specific day for those halls to be cleaned. She stated the MCU was designated to be cleaned only on Fridays, but at times had not been cleaned on a weekly basis because the CNA's were to clean that hallway. The HK Supervisor stated she had spoken to ADMN about getting more staff for HK, but no staff had been hired. She stated she only had 3 HK all day on Fridays and the aides do all the cleaning on hall 4 (MCU) due to not having enough HK staff to help clean there. The HK Supervisor stated she did not keep a cleaning log for the MCU. The HK supervisor stated she was responsible for monitoring Hall 4 (MCU). Her expectations were to have someone to help check the laundry and to check for any chemicals, clear the hallways and rooms for trash and dirty dishes. She stated the negative impact for the MCU residents were, they could not realize something was dirty because of their conditions and it was not acceptable for them to be in this environment. The HK Supervisor stated there was sometimes only one aide on the MCU, and it would be hard to watch the residents and keep it clean the way it was supposed to be. During an interview on 07/10/2024 at 6:41 PM the DON stated her expectation was for staffing to be at corporate PPD rate. The DON stated the PPD rate was 2.85 and was only hours for direct care staff. The DON stated not meeting the PPD could affect residents by the staff could have had a slower response time. During an interview on 07/10/2024 at 7:07 PM the ADMN stated her expectation was to staff the building with direct care staff at the PPD rate set by corporate. The ADMN stated the PPD rate was 2.85, and the PPD hours were determined by multiplying the rate (2.85) by the census and that would give you the number of hours needed. The ADMN stated the DON and herself were responsible to monitor staffing. The ADMN stated not meeting the PPD hours could have affected the residents by resident care could have been delayed. The ADMN stated she thought what led to the failure was the retention of staff and difficulty of staffing. Record review of facility policy titled, Hours of Work dated December 2009 revealed: facility has established hours of work in accordance with resident needs and current regulations governing our facility's staffing requirements.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44722 Based on record review and interviews, the facility failed to ensure the use of the services of a registered nurse for at least 8 consecutive hours a day, seven days a week for 15 (01/01/2024, 01/07/2024, 01/13/2024, 01/14/2024, 01/27/2024, 01/28/2024, 02/03/2024, 02/04/2024, 02/10/2024, 02/11/2024, 02/17/2024, 02/24/2024, 02/25/2024, 03/02/2024 and 03/03/2024) of 91 days reviewed for RN coverage. The facility failed to provide evidence that a Registered Nurse (RN) worked 8 consecutive hours a day, seven days a week on 01/01/2024, 01/07/2024, 01/13/2024, 01/14/2024, 01/27/2024, 01/28/2024, 02/03/2024, 02/04/2024, 02/10/2024, 02/11/2024, 02/17/2024, 02/24/2024, 02/25/2024, 03/02/2024 and 03/03/2024. This failure placed the residents at risk for not having decisions made that would have required an RN to make in the management of the residents' healthcare needs and in managing and monitoring of the direct care staff. Findings included: Review of facility's Direct Care Staff Daily Report from 01/01/2024 to 01/31/2024 revealed on 01/01/2024, 01/07/2024, 01/13/2024, 01/14/2024, 01/27/2024 , 01/28/2024, 02/03/2024, 02/04/2024, 02/10/2024, 02/11/2024, 02/17/2024, 02/24/2024, 02/25/2024, 03/02/2024 and 03/03/2024 there was no evidence of RN coverage. During an interview on 07/09/2024 at 3:30 PM, HR stated she had been responsible for scheduling. HR stated she had a staff rotation in place where an RN would be scheduled daily. HR stated when one RN needed time off she did not think about needing to have an RN cover. During an interview on 07/10/2024 at 6:41 PM, the DON stated she was hired to be the DON in January of 2024. The DON stated when she started, HR was scheduling nursing staff, and within the last few weeks she had taken over the responsibility. The DON stated when she started there was a schedule in place that had an RN scheduled each day. The DON stated what led to the failure was HR and herself not able to find RN coverage if one of the RNs scheduled had taken time off. The DON did not think there was a negative effect to residents because the DON and ADON were always on call and able to come in or answer questions over the phone. During an interview on 07/10/2024 at 7:07 PM, the ADMN stated the expectation was to have 8 hours of continuous RN coverage daily per federal guidelines. The ADMN stated the facility did not have a policy for RN daily coverage. The ADMN stated when she started, 4 weeks ago, she realized there was not a system to track RN coverage. The ADMN stated the HR person had been doing the scheduling prior to her starting at the facility. The ADMN stated she and the DON had taken the responsibly of monitoring RN coverage. The ADMN stated she did not think having missed RN coverage had a negative effect to the residents because they had LVN coverage, and staff had access to the DON and ADON. The ADMN stated she thought what led to the failure was the retention of staff and challenge of staffing. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled, Hours of Work dated December 2009 revealed: facility has established hours of work in accordance with resident needs and current regulations governing our facility's staffing requirements.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44722 Based on observation, interview, and record review, the facility failed to ensure that each resident received food that is palatable, attractive, and at a safe and appetizing temperature for 1 of 2 lunch meals tested for nutritive value, flavor, and appearance: The facility failed to provide palatable food served at an appetizing temperature to residents, during lunch on 07/08/2024. There were no temperatures logged for the morning meal of 07/08/2024. This failure could affect the residents who ate food from the facility kitchen by placing them at risk of poor food intake and/or dissatisfaction of the meals served. The findings included: During observation on 07/08/2024 at 11:33 AM of the temperature logbook, the breakfast temperature were not logged. During observation on 07/08/2024 at 11:34 AM, the [NAME] had not temped the food before plating began. The puree food temperatures (which were below the required temperature of 135 degrees) included: 1. pureed broccoli rice at 119 degrees 2. mechanical chicken at 117 degrees 3. pureed chicken at 132 degrees 4. pureed green beans 130 degrees During an interview on 07/08/2024 at 11:45 AM, the DM stated the food temperatures were not hot enough. The DM stated temperatures should have been done prior to plating. She stated she monitored the dietary staff and food temperatures prior to serving residents. She stated since they were not up to correct temperatures it would have to be warmed up. She stated the dietary staff have had training, but it was on a one-to-one verbal training and had not documented them. During an interview on 07/08/2024 at 11:49 AM, the Dietary [NAME] stated she did not temp the food because they were running behind with serving. She stated she was not the morning cook, but the staff should have recorded them in the logbook if they had been done. She stated the staff have one to one in-service with the DM. She stated if the food was too cold, residents may not have eaten it, with that leading to weight loss. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/10/2024 at 6:30 PM, the ADMN stated all food temperatures should have been taken and food kept at proper temperatures before serving residents. She stated in not doing so the negative impact for residents could have caused bacteria to build with residents possibly getting a food borne illness. She stated the failure was with the cook and not temping the food, and the staff should never be in too much of a hurry having placed the residents in jeopardy. She stated the DM was to have monitored the temperatures and food temp logs. The ADMN stated the failure was with dietary staff being in a hurry. She stated her expectations were for all food temperatures to be completed and logged into the food temperature logbooks. Record review of facility policy titled Food Preparation and Service with revised date of 2014 revealed: Policy Stated Food service employees shall prepare and serve food in a manner that complies with safe food handling practices. Food Preparation, Cooking, and Holding Temperatures and Times: 1. The danger zone open the temperature is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness . Review of facility policy titled Resident Nutrition Services with the revised date of November of 2009 revealed: 4. To minimize the risk of foodborne illness, the time that potentially hazardous foods remain in the danger zone (45 F to 135 F) will be kept to a minimum .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. 1. Foods were not sealed and/or labeled properly in dry food storage, refrigerator, and freezer. 2. Ice machine scoop was not stored in proper container while not in use. 3. Hairnets not being worn when needed. 4. Uncovered trash receptacle bin 5. Scoop was left inside the dry storage oatmeal container. 6. Expired food products in the dry storage area. These failures could place residents that eat out of the kitchen at risk for contamination and food borne illnesses. Findings included: During an observation on [DATE] at 9:57 AM of the kitchen revealed: Dry Storage: 1. dry oatmeal with scoop placed and left inside container dated [DATE] 2. unsealed opened 50 lb. bag of dry oats 3. opened bag of dry cereal not labeled 4. 1 box dry cereal with an expired date of [DATE] 5. 1 unsealed loaf of bread with no open date 6. 1 unsealed package of hotdog buns 7. 1 bag of 2 round kaiser rolls with an expired date of [DATE] 8. 3 loaves of bread with an expired date of [DATE] 9. 1 unsealed 16 oz bag of potato chips (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. 1 opened 49.6 oz bag of cornbread stuffing mix not labeled or dated 11. 1 opened unsealed 24 oz bag of gelatin dessert 12. 1 opened unsealed bag of Buttermilk Biscuit Mix 13. 1 bag of spaghetti noodles unlabeled and undated Refrigerator #1 1. 1 gallon of opened lime juice with no open date 2. 1 quart of opened Half and Half with no open date 3. 1 gallon of opened whole milk with no open date 4. opened sliced sandwich cheese with no open date or label 5. 9 unopened plastic bags of yellow liquid with no in date or label 6. 15 dessert bowls of pudding with no label or date. Freezer #1 1. ,d+[DATE]-gallon tub of ice cream with no open date 2. 1 unsealed bag of frozen okra with no label or open date 3. 1 opened unsealed bag of frozen pasta with no label or open date Kitchen 1. Ice machine was observed with ice scoop on top of unit and not stored in the proper area 2. Open trash receptacle with no lid in cooking area During observation on [DATE] at 11:00 AM the DA was observed not wearing a hair restraint on his beard. During an interview on [DATE] at 11:00 AM the DA stated he was supposed to be wearing a hairnet over his beard and it had been about 3 months since he had worn one. He stated he had had in-services on doing so. The DA stated not doing so, could cause residents to possibly get hair in their food, and would be contaminated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:53 AM the DM stated there should have been no expired products in the pantry and was not aware there were. She stated all products should have had an in date, and once opened or taken out of the original box, they should have been labeled with an opened date. The DM stated she monitored for expired dates as well as monitored products being labeled and stored properly twice a week. She stated the staff usually used the products before they would have expired so had not monitored the expired products as closely. The DM also stated, hairnets should be worn on all exposed hair, even beards, in the kitchen. She stated she had told her staff multiple times a hairnet should be worn, but they had not listened to her. She stated it was unclean to not wear one, with the possibility of hair getting into the resident's food. The DM stated the uncovered trashcan receptacle was unsanitary and was always to be covered. She stated it was not to be placed in the prep and cooking area without a lid. The DM stated dietary staff knew they were to have kept the trash receptacle covered at all times. The DM stated the ice scoop was to be stored on top of the ice machine. She stated the top of the ice machine had not been cleaned or sanitized, and she never thought it was an unsanitary place to store it. She stated the negative impact to residents possibly could have been bacteria getting into resident drinks when ice was being placed in their cups causing them to get sick. The DM stated the scoop in the oatmeal should not be stored inside the bin. She stated it was unsanitary and could cause cross contamination with staff touching it. She stated all dietary Infection Control was monitored ultimately by her, as the residents were vulnerable to increased bacteria. She stated they could get sick. The DM stated all staff should also wear hairnets on any loose hair. She stated the failures were staff not doing what was asked of them and to follow through with rules and regulation of what was taught in her in-services and trainings. She stated her expectations were for the residents' food to not be contaminated with germs and bacteria. The DM stated ultimately, she had not monitored her staff or followed through with rules and regulations and keeping staff accountable. The DM stated her expectations were for staff the follow all trainings and protocols. During an interview on [DATE] at 6:27 PM, the ADMN stated the DM monitored the kitchen sanitation, cleanliness and all food preparation and products. She stated she had not seen or performed any follow up of dietary staff since she had recently started the position as ADMN. She stated she felt the failure was with staff not following through with their in-services. The ADMN stated the negative impact to residents could have been cross contamination with residents getting sick. She stated her expectations were for all staff to follow the guidelines and regulations for the health of the residents. Record review of facility policy Food Receiving and Storage dated and revised [DATE] revealed: Policy Statement-Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation-Clean Storage area: Food Services, or other designated staff, will maintain clean food storage areas at all times . Dry Foods Stored in Bins: dry foods that are stored in bins will be removed from original packaging, labeled, and dated (use by date). Such foods will be rotated using a first in-first out system. Labeling Foods Stored in Refrigerator/Freezer: All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Expiration Dates: supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes Record review of facility policy Food Preparation and Service dated, [DATE] revealed: 7. Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of food borne illness. 7. Dietary staff shall wear hairnet (hairnet, hat, beard restraint, etc.) so that hair does not contact food. Record review of the Texas Food Establishment Rules accessed at https://www.dshs.texas.gov/foodestablishments/pdf/Laws/TFERFieldInspectionManual032416.pdf on [DATE] revealed: Food storage containers, identified with common name of food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food . is in a container or package that does not bear an expiration date or day .food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44728 Based on observations, interviews, record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 4 hallways (Memory Care Unit) and reviewed for safe, functional, sanitary, and comfortable environment. The facility failed to have residents' environment clean and without damage for 1 (MCU) of 4 hallways. These failures could place residents who reside in the facility in an unsafe and uncomfortable environment. Findings included: During observation on 04/08/2024 at 9:45 AM revealed: 1. Smell of urine upon entrance 2. Debris and trash in the hallway and resident rooms 3. Window frame unpainted with exposed wood and debris During a confidential interview on 07/09/2024 at 3:30 PM, the confidential interview stated they were happy that State was in the facility as they had asked upper management for more staff as they were being told that the CNA's were to clean the MCU while working their shift. Confidential interview stated HK would go clean only on Fridays. Confidential interview stated HK had not always cleaned on Fridays and that was why it smelled of urine. Confidential interview stated it took away them away from resident care and was unable to keep up with both jobs. During an interview on 07/09/2024 at 4:00 PM, the HK Supervisor stated her HK staff stayed mostly on the 1-3 halls M-F and there was no specific day for those halls to be cleaned. She stated the MCU was designated to be cleaned only on Fridays, but at times had not been cleaned on a weekly basis because the CNA's were to clean that hallway. The HK Supervisor stated she had spoken to ADMN about getting more staff for HK, but no staff had been hired. She stated she only had 3 HK all day on Fridays and the aids do all the cleaning on hall 4 (MCU) due to not having enough HK staff to help clean there. The HK Supervisor stated she did not keep a cleaning log for the MCU. The HK supervisor stated she was responsible for monitoring Hall 4 (MCU). Her expectations were to have someone to help check the laundry and to check for any chemicals, clear the hallways and rooms for trash and dirty dishes. She stated the negative impact for the MCU residents were, they could not realize something was dirty because of their conditions and it was not acceptable for them to be in this environment. The HK Supervisor stated there were sometimes only one aid on the MCU, and it would be hard to watch the residents and keep clean the way it was supposed to be. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/10/2024 at 2:42 PM, the DON stated the protocols for HK and cleaning the MCU was to be designated on Fridays, but they could not always clean that day due to low staffing. She stated the CNA's and Aids do a cleaning sweep with the day and night shift splitting the duties. The DON stated the staff as a whole should have been cleaning the facility areas but ultimately it fell on the Director of HK. She stated it was nursing and CNA's that monitored and clean up and if they were not able to finish it, it was HK was that finished the job. The DON stated if the environment were not cleaned the residents could possibly get sick, but it depended on what their diagnosis was. She stated the failure occurred with not having enough cleaning staff, and her expectations was that the residents environment be cleaned and completed in a timely manner. During an interview on 07/10/2024 at 6:42 PM, the ADMN stated the MCU should be cleaned before any other halls in the facility, as that hall was a high touch area. She stated the MCU hall would be more likely to spread bacteria. The ADMN stated it was the HK supervisor who should have monitored as well as herself as ADMN, but she had not had the time since being hired in that position. She stated it fell on the HK to clean in the MCU on Fridays and the CNA's being told to clean on the other days. The ADMN stated since the CNA's cleaning prior to Fridays it most likely would cause for a decrease in proper resident care when needed. She stated the failure to having done it that way was not having enough staff but had not been aware of the dirty environment. The ADMN stated her expectations were to add more staff to help on that hallway to better the environment for the residents. Record Review of facility policy Quality of Life-Homelike Environment with revised date of April 2014 revealed: Policy Statement: Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation: 1. Staff shall provide person centered care that emphasizes the residents comfort, independence and personal needs and preferences. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order; b. Comfortable lighting c. Inviting colors and decor d. Personalized furniture and room arrangements e. Pleasant neutral scents; f. Plants and flowers, where appropriate; g. Comfortable temperatures; and (continued on next page)

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