

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2025
NAME OF PROVIDER OR SUPPLIER  Haskell Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1504 North First St Haskell, TX 79521	

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 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality and the facility failed to protect and promote the rights of the resident for 2 of 18 residents (Resident #5 and Resident #11) reviewed for resident rights in that:-CNA A stood next to Resident #5 while feeding him during lunch services on 07/15/25.-CNA D stood next to Resident #11 while feeding her during lunch services on 07/15/25.These failures could place residents at risk for weight-loss, diminished quality of life and loss of dignity and self-worth. The findings included: Record review of the face sheet for Resident #5, dated 07/15/25, revealed a [AGE] year-old male originally admitted to the facility 10/04/23 and readmitted to the facility on [DATE]. Resident #5 had a medical history of cerebral palsy (a group of disorders that affect movement and posture due to brain damage or abnormal brain development), abnormal involuntary movements, and muscle wasting and atrophy (gradual shrinking).Record review of Resident #5 of annual MDS, dated [DATE], Section C revealed Resident #5 had a BIMS score of 09, indicating moderate cognitive impairment. Section GG revealed Resident #5 required partial/moderate assistance with eating - helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.During an observation in the dining room on 07/15/25 at 12:34 PM, CNA A was observed standing next to Resident #5 feeding him lunch. Record review of the face sheet for Resident #11, dated 07/15/25, revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #11 had a medical history of alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), unspecified dementia (loss of cognitive thinking and skills) and vitamin deficiency. Record review of Resident #11's annual MDS, dated [DATE], Section C revealed Resident #11 had a BIMS score of 03, indicating severe cognitive impairment. Section GG of the MDS revealed Resident #11 required partial/moderate assistance with eating - helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.During an observation in the dining room on 07/15/25 at 12:52 PM, CNA D was observed standing next to Resident #11 feeding her lunch. During an interview on 07/15/25 at 3:13 PM, CNA D stated she knew she was supposed to sit while feeding Resident #11 at lunch, but she did not see any seats available for her to use. CNA D stated there were normally extra chairs in the dining room, but not today. CNA D stated a risk to the resident was he could feel like she was hovering above her. During an interview on 07/15/25 at 3:42 PM, CNA A stated she had been trained to sit down while feeding residents. CNA A stated she did not sit down to feed Resident #11 at lunch because she could not find any available seats for her to use. CNA A stated there were usually enough stools and chairs to use to feed the residents and there was an extra stool in the staff break room that could have been used. CNA A stated she did not know why the stool in the break room was not pulled out to be used at lunch. CNA A stated a potential negative outcome to the residents was they could get [NAME] easier with staff not being able to see their mouth as easily. Attempted interview on 07/16/25 at 1:52 PM, Resident #5 refused interview with surveyor. During an interview on 07/17/25 at 8:42 AM, the DON stated he usually expected staff to sit down while feeding residents. The DON stated the CNAs were trained to sit while feeding residents but maybe they did not because Resident #5 and Resident #11 sit a little higher up in their chairs. The DON stated this could cause a dignity issue with the resident and they may feel uncomfortable. During an interview on 07/17/25 at 10:10 AM, the ADM stated she expected staff to be at the resident's level when feeding them and that was how they were trained. The ADM stated she was not sure why the CNAs stood to feed Resident #5 and Resident #11 at lunch on 07/15/25. The ADM stated a risk to the residents was the staff could have a harder time seeing if the resident was struggling while eating if standing above them. Record review of the facility policy titled, Dignity, with a revised date of February 2021, reflected the following: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self- esteem.Policy Interpretation and Implementation1. Residents are treated with respect and dignity.5. When assisting with care, residents are supported in exercising their rights. For example, residents are:e. provided with a dignified dining experience.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 18 residents (Resident #45) reviewed for call light placement. The facility failed to ensure the resident call light system was within reach for Resident #45. This failure could place residents at risk of not receiving the necessary assistance they need to maintain their highest level of well-being. Record review of Resident #45's face sheet dated 07/16/2025 revealed an [AGE] year-old-male admitted on [DATE] with the following diagnoses: diabetes (high blood sugar), glaucoma (eye disease), muscle spasm, cervical (neck) fracture, gastro-esophageal reflux disease (digestive disease), and hyperlipidemia (high cholesterol). Record review of Resident #45's comprehensive MDS dated [DATE] revealed the MDS was in progress. Record review of Resident #45's baseline care plan dated 07/15/2025 revealed Resident #45 will receive necessary setup, cueing, support and assistance for daily living. An interview with Resident #45 on 07/17/2025 at 08:50 AM revealed he could not get out of bed on his own and could not transfer himself or use the bathroom without assistance. Resident #45 stated he had a fall at home and had neck fractures. He stated his call light cord was not always given to him. He stated to get assistance from staff he had to push his call light. During an observation on 07/15/2025 at 11:15 AM of Resident #45 revealed Resident #45 lying in his bed with the lift sling under him and his call light cord laying on the floor at the head of the bed. During an interview on 07/15/2025 at 11:20 AM with CNA A she stated she was getting Resident #45 ready to get up out of bed and he had no clothes in his room. She stated she went to look for his clothing in the laundry. She stated he should have had his call light cord within reach. She stated Resident #45 was a new resident and she was not sure what assistance he needed. She stated she had been trained to make sure residents had the call light cord within reach before leaving the room. She stated she forgot to provide him with his call light cord before leaving the room to get clothes. She stated the potential negative outcome would be the resident would not be able to call for help or assistance. During an observation on 07/16/2025 at 02:00 PM Resident #45 was lying in bed with his right shoulder hanging off the bed. The call light cord was hanging on the privacy curtain out of the resident's reach. During an interview on 07/16/2025 at 02:05 PM with LVN C, she stated Resident #45's call light cord should be within reach of the resident and not hanging on the privacy curtain. She stated Resident #45 required assistance with all transfers. She stated all staff have been trained on providing the call light cord for residents to use. She stated the call light cord was used to call for assistance when needed and should always be available to the resident. She stated the potential negative outcome of not having a call light cord could be resident falls and not being able to call for help. During an interview on 07/16/2025 at 02:15 PM with CNA B, she stated she had transferred Resident #45 back to bed from the toilet and forgot to give Resident #45 his call light cord. She stated she was rushing to finish passing out meal trays on the hallway and forgot to give Resident #45 his call light cord. She stated the resident was not able to self-transfer. She stated she had been trained on providing the call light cord to residents before leaving residents' rooms. She stated the potential negative outcome could be resident falls and residents could not call for help. During an interview on 07/16/2025 at 03:00 PM with the DON, he stated all residents should always have the call light cord within reach unless out of their rooms. He stated call light cords were used to alert staff of resident needs or emergency. He stated he was not aware staff were not providing residents with the call light cord. He stated all staff had been trained to provide residents with the call light cords. He stated the potential negative outcome could be resident falls, care could be delayed up to 2 hours and the resident not being able to call staff for help. During an interview on 07/17/2025 at 08:57 AM with the ADM, she stated all residents should always have the call light cord within reach when in their room. She stated all nursing staff was responsible for making sure residents have the call light cord within reach. She stated she was not aware Resident #45 did not have his call light cord within reach. She stated Resident #45 was not able to move around or care for himself independently. She stated all staff have been trained on call light cord placement for residents. She stated the potential negative outcome could be resident falls, could be choking and not able to call for help, and not being able to call for help or assistance. Record review of the facility's policy, titled Resident Call System revised date 6/2025, reflected the following: Policy - The facility is equipped with a functioning communication system from rooms, toilets, and bathing facilities in which resident calls are received and answered by staff Procedure Resident calls are relayed directly to a</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly for 1 of 2 medication carts (Medication Cart B) and 1 of 1 medication rooms, reviewed for medication storage.-The facility failed to ensure there were no expired items in the medication room.-LVN C left Medication Cart B unlocked and unattended in Hall 2. These failures could place residents at risk of receiving expired supplies and drug diversion. The findings included:During an observation of the medication room on 07/15/25 at 3:27 PM the following items were available for use by staff: Xeroform Medicated Petrolatum Dressing with an expiration date of 05/25 x 2 dressings. During an interview on 07/15/25 at 3:35 PM, the DON stated he did not know why expired items were found in the medication room. During an observation on 07/16/25 at 2:01 PM, Medication Cart B was observed sitting at the entrance to Hall 2 unlocked and unattended. During an interview on 07/16/25 at 2:03 PM, LVN C stated she had been trained to lock the medication cart when she walked away from it. LVN C stated she left the medication cart opened when she stepped away to get another medication. LVN C stated the risks to the residents was they could get in and take medications that did not belong to them. During an interview on 07/17/25 at 8:42 AM, the DON stated he did not know why the expired supplies were in the medication room. The DON stated the ADON did a good job at looking for expired medications and he did not know they were also supposed to check the wound supplies. The DON stated all staff were trained to look at expiration dates. The DON stated the nurses were trained to keep their medication carts secured. The DON stated a risk to the residents involved resident safety concerns. During an interview on 07/17/25 at 10:10 AM the ADM stated she expected the medication carts to be locked at all times when the nurse walked away from them. The ADM stated staff were trained on locking their medication carts when not in use. The ADM stated a risk to leaving a medication cart unlocked and unattended was someone could get into the medication cart. The ADM stated she expects expired supplies to be removed. The ADM stated the ADON did a good job at checking the medication room so it was most likely an accidental oversight to miss the expired items. The ADM stated expired supplies could not be as effective for the resident. The ADM stated expired supplies could have a negative impact on the resident. Record review of the facility policy titled, Medication Storage in the Facility, with an effective date of 06/01/22 reflected the following: Policy - Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures:.B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: The facility failed on 07/15/2025 to seal and date food stored in the refrigerator and dry storage room. These failures could place residents at risk for food contamination and foodborne illness. The following observations were made on 07/15/2025 beginning at 9:29 AM during initial tour of the kitchen: Observation of the following stored in the dry storage room: Bag of powdered milk open. Container of rice with lid open. Container of elbow macaroni with lid open. Observation of the following stored in the refrigerator: Bowl of watermelon with no date. Cheese slices open with no date. Butter sticks open with no date. During an interview on 07/15/2025 at 01:30 PM with the DM, she stated all food placed in the pantry and refrigerator should be sealed and dated. She stated the bowl of watermelon had no date. She stated cheese slices and butter should be placed in a bag and sealed and dated when opened. She stated the bag of powdered milk should be stored sealed. She stated the containers of rice and elbow macaroni should be sealed. During an interview on 07/16/2025 at 01:31 PM with the DM, she stated she was not aware the food in the pantry was not sealed. She stated she was not aware the food in the refrigerator was not dated and sealed. She stated all staff had been trained to seal and date food. She stated all staff were responsible for making sure food was sealed and dated when stored in the refrigerator and pantry. She stated the purpose of sealing and dating food was to make sure it stayed good. She stated the potential negative outcome was food could become contaminated and spoil causing residents to get sick. During an interview on 07/17/2025 at 08:57 AM with the ADM, she stated food stored in the pantry and refrigerator should be sealed and dated. She stated the cook [KS1] and DM were responsible for making sure food was sealed and dated. She stated all staff had been trained on food storage. She stated the potential negative outcome of not dating and sealing food could be the food spoiling and being harmful to residents. Record review of the facility's policy, titled Kitchen Sanitation and Cleaning Schedules undated, reflected the following: Food Storage and Sanitation. Food removed from its original packaging must be dated and labeled with name of food. All opened containers or leftover food is to be tightly wrapped or covered in clean containers. It should be labeled, dated with the opened or use by date.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>(continued on next page)</p>

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to follow their policy on personal resident refrigerators for 3 of 16 personal resident refrigerators reviewed for food safety (room [ROOM NUMBER], #28, and #31) in that the refrigerators located in room [ROOM NUMBER], #28, and #31 were not being monitored for internal temperature and expiration/used by dates. The refrigerators located in room [ROOM NUMBER], #28, and #31 were not being monitored for internal temperature and expiration/used by dates. These failures could place residents at risk for food borne illnesses. Findings include: During an observation on 07/15/2025 at 09:30 AM, Resident room [ROOM NUMBER] contained a personal refrigerator. The refrigerator contained perishable food items. The refrigerator was observed to contain a cup of juice dated 06/19/2025, an undated/unlabeled bowl of mixed fruit, an undated/unlabeled bowl of chopped onions, an undated/unlabeled bowl of a pudding-like substance, an unlabeled/undated bowl of pears, an unlabeled/undated bowl containing a pastry, an unlabeled/undated plastic container of white sauce, an undated melted cup of ice cream, an undated/unlabeled plastic container with an unknown substance, two bags of opened popcorn, one bag of opened chips with an illegible expiration date, one cup of juice with no expiration date, and a tube of sour cream with an illegible expiration date. The refrigerator also contained cans of unopened soda. During an observation on 07/15/2025 at 09:58 AM, Resident room [ROOM NUMBER] contained a personal refrigerator. The refrigerator contained perishable food items such as two unlabeled/undated glasses of milk and three containers of protein shakes. The refrigerator was soiled with melted popsicles in the freezer portion. The refrigerator also contained a build up of ice inside of the refrigerator. During an interview on 07/16/2025 at 3:30 PM, the DON stated the nursing staff were responsible for cleaning the residents' personal refrigerators once a week and ensuring each refrigerator was working properly. The DON stated the facility did have a log at the nurse's station to verify residents' refrigerators were being maintained. The DON stated any spoiled or expired food should have been thrown away by the nursing staff during each check. The DON stated food could have also become expired throughout the week, and it would not have been discarded unless the resident threw it out. The DON stated all food items should have been labeled and dated when they were stored in the resident's refrigerator. The DON stated he was not aware that the personal refrigerator in Resident room [ROOM NUMBER] and #31 contained undated and unlabeled perishable items. The DON stated he was unaware the personal refrigerator in room [ROOM NUMBER] contained expired juice. The DON stated he had not been notified by nursing staff of any residents refusing to discard of expired food in their refrigerator. The DON stated a resident could become ill if they consumed expired food and/or drinks, and it was important for the refrigerators to be cleaned out by nursing staff to prevent illness. Record review of the facility's document titled Personal Resident Refrigerator Weekly Temperature Log revealed the following: Resident room [ROOM NUMBER] July 5, 2025 (highlighted date) - contained no staff signature and the temperature field was blank. July 10, 2025 (highlighted date) - contained no staff signature with a temperature of 38 degrees. July 15, 2025 (highlighted date) - contained no staff signature and the temperature field was blank. There was no log found for Resident room [ROOM NUMBER] or #31. During an interview on 07/16/2025 at 3:55 PM, the DON stated the Personal Resident Refrigerator Weekly Temperature Log for Resident room [ROOM NUMBER] indicated staff did not check the refrigerator on 07/05/2025 or 07/15/2025 since the temperature field was blank. The DON stated the check did not appear to be completed by nursing staff, according to the log. The DON did not know why this was not completed. The DON stated he would have nursing staff check all resident's personal refrigerators as soon as possible to ensure they did not contain any expired food or drinks. During an observation on 07/16/2025 at 3:50 PM, the refrigerator in Resident room [ROOM NUMBER] was observed to contain the same perishable food items observed on 7/15/2025. During an observation on 07/16/2025 at 4:15 PM, Resident room [ROOM NUMBER] contained a personal refrigerator. The refrigerator contained perishable food items such as unlabeled/undated glasses of tea, an unlabeled/undated dish of cake, two unlabeled/undated dishes of an unknown food item, and an unlabeled/undated Ziplock bag of an unknown food item. The refrigerator also contained a half gallon container of Silk non-dairy milk. During an interview on 07/17/2025 at 09:30 AM the ADM stated nursing staff were responsible for cleaning the residents'</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to establish and 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 3 of 6 residents (Residents #4, #5, and #16) reviewed for infection control. 1. CNA B failed to wash hands with soap and water after gloves became visibly soiled when providing incontinence care for Resident #16. 2. CNA E failed to utilize proper hand hygiene between glove changes when providing incontinence care for Resident #5. 3. LVN C failed to follow Enhanced Barrier Precautions (EBP) and wear a gown when providing wound care to Resident #4. These failures could place residents at risk for cross contamination and infection. The findings include: Record review of Resident #16's face sheet, dated 07/17/25, revealed a [AGE] year-old female originally admitted to the facility 02/15/24 and readmitted to the facility on [DATE]. Resident #16 had a medical history of atherosclerotic heart disease (plaque builds up and hardens the arteries), urinary tract infection (bladder infection), and acute upper respiratory infection (a common cold). Record review of Resident #16's annual MDS dated [DATE] Section H- Bladder and bowel revealed Resident #16 was always incontinent of bowel and bladder. During an observation on 07/16/25 at 10:37 AM, CNA B washed her hands with soap and water and donned (put on) clean gloves to provide incontinence care for Resident #16. CNA B unfastened the brief and Resident #16's vaginal area and groin were cleansed with wipes with no concerns. CNA B then turned Resident #16 on her side and used a wipe to wipe the anus. CNA B's glove became visibly soiled, and CNA B removed her gloves and used ABHR. CNA B donned clean gloves and continued wiping Resident #16's anal area and buttocks. CNA B did not use soap and water to wash her hands when her gloves became visibly soiled. During an interview on 07/16/25 at 4:36 PM, CNA B stated she had been trained to wash her hands with soap and water when her gloves became visibly soiled. CNA B stated she thought using ABHR was good enough but she should have washed her hands with soap and water when they became visibly soiled during the incontinence care for Resident #16. CNA B stated she was last trained about a month ago regarding incontinence care and hand hygiene. CNA B stated a potential negative outcome to the residents was cross contamination. Record review of Resident #5's face sheet, dated 07/15/25, revealed a [AGE] year-old male originally admitted to the facility 10/04/23 and readmitted to the facility on [DATE]. Resident #5 had a medical history of cerebral palsy (a group of disorders that affect movement and posture due to brain damage or abnormal brain development), abnormal involuntary movements, and muscle wasting and atrophy (gradual shrinking). Record review of Resident #5's annual MDS dated [DATE] Section H- Bladder and bowel revealed Resident #5 was frequently incontinent of bowel and bladder. During an observation on 07/16/25 at 11:25 AM, CNA E washed her hands with soap and water and donned clean gloves to provide incontinence care for Resident #5. CNA E unfastened the brief and cleansed Resident #5's penis and groin area with wipes. CNA E turned Resident #5 on his side and wiped his anus and buttocks with wipes. CNA E removed her gloves and applied ABHR to her hands. CNA E then donned clean gloves and applied protectant cream to Resident #5's buttocks with her right gloved hand. CNA E then removed her Right-hand glove and donned a clean glove to her Right hand. CNA E did not use hand hygiene between all glove changes for her Right hand. During an interview on 07/16/25 at 4:50 PM, CNA E stated she was last trained about a month ago regarding incontinence care and hand hygiene. CNA E stated she should have removed both gloves and washed or sanitized her hands between all glove changes, but she did not think about it. CNA E stated a potential negative outcome to the residents was the lack of hand hygiene could cause sickness. Record review of Resident #4's face sheet, dated 07/17/25, revealed a [AGE] year-old male originally admitted to the facility 04/13/23 and readmitted to the facility on [DATE]. Resident #4 had a medical history of cerebral infarction (stroke), aphasia (language disorder that affects a persons ability to communicate), and open wound of the left foot. Record review of Resident #4's annual MDS dated [DATE] Section M- Skin Conditions revealed Resident #4 had 1 unhealed Stage 3 Pressure Ulcer. Record review of Resident #4's active physician orders, undated, revealed an order: Wound Treatment Order: Location: Left Heel - Clean with Normal Saline/Wound Cleanser. Pat dry with 4x4s. Apply: Collagen Flakes with Hydrogel with Silver. Apply skin prep to area around wound. Cover with silicone foam dressing. With a start date of 07/07/25 and no end date. Record review of Resident #4's care plan, last revised on 06/17/25 revealed a Problem: I have a pressure ulcer to left heel. Approach: Resident needs</p>		