

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Childress Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 7th St NW Childress, TX 79201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 6 (Resident #5, Resident #9, Resident #18, Resident #35, Resident #36, and Resident #42) of 13 residents and for 1 (hall 600) of 6 halls reviewed for residents' rights.</p> <ol style="list-style-type: none"> The facility failed to keep the floor of Resident #5's room clean. The facility failed to keep the floor and walls of Resident #35's room clean. The facility failed to keep the floor of Resident #36's room clean. The facility failed to keep the floor of Resident #42's room clean. The facility failed to keep the bathroom of Resident #9 and Resident #18 clean. The facility failed to keep the floor of hall 600 clean. <p>These failures could lead to residents being harmed due to falls, feeling uncomfortable in their surroundings, or becoming sick due to spread of germs.</p> <p>Findings Included:</p> <ol style="list-style-type: none"> Record review of Resident #5's undated face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), need for assistance with personal care, unsteadiness on feet, muscle wasting and atrophy, weakness, lack of coordination, and difficulty in walking. <p>Record review of Resident #5's quarterly MDS completed on 01/23/24 revealed a BIMS of 12 which indicated moderately impaired cognition. Section GG of the MDS revealed Resident #5 used a walker and was independent in toileting, transferring from lying to sitting, sitting to standing, and walking.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #5's care plan completed on 01/23/24 revealed Resident #5 was at risk of falling.</p> <p>During an observation on 04/07/24 at 10:13 AM Resident #5 was lying in her bed. Next to her bed on the floor were 2 one-to-two-inch brown crumb or dirt-like things. On the bedside table was an empty bag with crumbs. The floor of the room appeared to be stained in several places with brown/yellow splotches.</p> <p>2. Record review of Resident #35's undated face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (partial paralysis following stroke), need for assistance with personal care, reduced mobility, lack of coordination, muscle wasting and atrophy, end stage renal disease (kidney failure), acquired absence of left leg below the knee, and morbid obesity (complex chronic disease in which a person has a high body mass index and is experiencing health conditions related to obesity).</p> <p>Record review of Resident #35's quarterly MDS with an ARD dated of 04/05/24 revealed a BIMS of 13 which indicated intact cognition. Section GG of the MDS revealed Resident #35 utilized a w/c and was dependent for toileting and transfers.</p> <p>Record review of Resident #35's care plan completed on 01/16/24 revealed Resident #35 required a mechanical lift for all transfers and was at risk for falls.</p> <p>During an interview and observation on 04/07/24 at 11:17 PM Resident #35 was in his bed which was pushed into the corner of the room leaving only the foot and left side of the bed free. On the wall behind and beside Resident #35 were dark brown smears. On the floor of Resident #35's room were several small pieces of paper, and his trash can was overflowing with trash. Resident #35 stated he did not remember housekeeping ever cleaning the walls next to his bed.</p> <p>3. Record review of Resident #36 undated face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Guillain-Barre syndrome (disorder of the immune system where nerves are attacked by immune cells causing weakness and tingling and sometimes paralysis in arms and legs), muscle weakness, need for assistance with personal care, lack of coordination, muscle wasting and atrophy, and unsteadiness on feet.</p> <p>Record review of Resident #36's annual MDS completed on 04/01/24 revealed a BIMS of 15 which indicated intact cognition. Section GG of the MDS revealed Resident #36 used a w/c and was dependent for toileting and transfers.</p> <p>Record review of Resident #36's care plan completed on 03/12/24 revealed Resident #36 had an indwelling urinary catheter, paralysis/parathesia (a feeling of tingling or numbness), and was at risk or falls. The care plan noted Resident #36 required a mechanical lift for transfers.</p> <p>An observation on 04/07/24 at 11:04 AM revealed a large sticky spot on the floor of Resident #36's room. The shoes of the surveyor stuck to the sticky spot when attempting to exit the room.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Record review of Resident #42's undated face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, metabolic encephalopathy (problems in the brain from chemicals in the blood), chronic kidney disease stage 5 (longstanding disease of the kidneys leading to kidney failure), muscle wasting and atrophy, difficulty in walking, unsteadiness on feet, lack of coordination, and weakness.</p> <p>Record review of Resident #42's quarterly MDS completed on 01/08/24 revealed a BIMS of 10 which indicated moderate cognitive impairment. Section GG of the MDS revealed Resident #36 used a w/c and required substantial to maximal assistance with toileting and transfers.</p> <p>Record review of Resident #42's care plan completed on 01/09/24 revealed Resident #42 required a mechanical lift for transfer and was at risk for falls. The care plan revealed Resident #42 had a catheter.</p> <p>During an observation on 04/07/24 at 10:02 AM Resident #42 was lying in bed on her right side under a blanket. Her catheter bag was in a privacy bag hanging off the bed frame. The floor under the catheter bag was stained in a spill pattern with a yellow-brown color 8-10 inches in diameter.</p> <p>During an observation and interview on 04/08/24 at 10:08 AM Resident #42 was lying on her back in bed. She stated sometimes her catheter bag runs over if the morning staff miss it because staff had been wanting her to drink a lot of water.</p> <p>5. Record review of Resident #9's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, heart failure (heart muscle fails to pump blood as it should), rheumatoid arthritis (inflammatory disease causing painful swelling in affected areas of the body), muscle weakness, lack of coordination, unsteadiness on feet reduced mobility, need for assistance with personal care, abnormalities of gait and mobility, difficulty in walking and muscle wasting and atrophy.</p> <p>Record review of Resident #9's annual MDS completed on 04/02/24 revealed a BIMS of 15 which indicated intact cognition. Section GG of the MDS revealed Resident #9 used a w/c and substantial/maximal assistance with toileting and transfers. Section H revealed Resident #9 was always continent of bladder and bowel.</p> <p>Record review of Resident #9's care plan completed on 04/02/24 revealed Resident #9 used a sit to stand lift and was at risk for falls.</p> <p>Record review of Resident #18's undated face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, congestive heart failure (a progressive heart disease that affects the pumping action of the heart muscles resulting in shortness of breath and fatigue), muscle weakness, lack of coordination, unsteadiness on feet, need for assistance with personal care, muscle wasting and atrophy, chronic obstructive pulmonary disease (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath, and fatigue), weakness, and repeated falls.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #18's quarterly MDS completed on 01/23/24 revealed a BIMS of 5 which indicated severely impaired cognition. Section GG of the MDS revealed Resident #18 used a w/c and was dependent for toileting and transfers. Section H of the MDS revealed Resident #18 was always incontinent of bowel and bladder.</p> <p>Record review of Resident #18's care plan completed on 01/30/24 revealed Resident #18 was at risk of falls. The care plan noted Resident #18 was occasionally agitated when receiving incontinent care.</p> <p>During an observation and interview on 04/07/24 at 11:11 AM Resident #9 was seated in her w/c in the hall outside of her room. She asked if the surveyor could smell the odor in the air and stated her roommate (Resident #18) had a blow out and their room had to be cleaned. The smell was overwhelming. Upon entering Resident #9's room and peering into the bathroom what appeared to be feces was noted in the toilet, on the toilet seat, and on a shower chair that appeared to be used as a toilet chair for its height. A pot on the floor contained what appeared to be urine and toilet paper. CNA G walked up and stated she had just cleaned Resident #18 up and bagged and thrown away everything outside. When asked if anyone was coming to clean the bathroom, CNA G stated HSK was making his rounds and would be there to clean things up shortly.</p> <p>During an observation on 04/07/24 at 01:09 PM the bathroom shared by Resident #9 and Resident #18 had what appeared to be feces in the toilet, on the toilet seat, on the shower chair, and on the floor. The pot containing what appeared to be urine and toilet paper was still sitting on the floor of the bathroom. The bathroom had a foul odor.</p> <p>During an observation on 04/08/24 at 08:22 AM the bathroom shared by Resident #9 and Resident #18 had what appeared to be feces in the toilet and on the toilet seat. The bathroom had a foul odor.</p> <p>During an observation on 04/08/24 at 02:41 PM the bathroom shared by Resident #9 and Resident #18 had what appeared to be feces in the toilet and on the toilet seat. The bathroom had a foul odor.</p> <p>During an observation on 04/09/24 at 08:32 AM the bathroom shared by Resident #9 and Resident #18 had a yellow/orange substance on the shelf of the toilet next to where the toilet was bolted to the floor. It appeared to be dry and grainy and stuck to the toilet in a spill or splatter pattern. Around the edges of where the floor met the base of the toilet was a dark brown area that extended 4-5 inches and at that point became a lighter brown/tan color for 4-6 more inches. Inside the toilet bowl was a smear of brown matter and the bathroom had a foul odor.</p> <p>6. An observation on 04/07/24 at 10:11 AM revealed a trail of drops of clear liquid running down hall 600 from room [ROOM NUMBER] to room [ROOM NUMBER]. Each drop was approximately the size of a dime or a little smaller. The trail stayed on the right side of the hallway and crossed to the left side of the hallway near room [ROOM NUMBER] and seemed to disappear into room [ROOM NUMBER].</p> <p>During an observation on 04/08/24 at 03:08 PM the trail down hall 600 from room [ROOM NUMBER] to room [ROOM NUMBER] was dried and sticky to the touch and to the bottom of this surveyor's shoes. Around the edges of each individual drop mark was a dark brown line.</p> <p>During an observation on 04/09/24 at 08:37 AM the trail of spots down hall 600 from room [ROOM NUMBER] to room [ROOM NUMBER] was now uniformly dark brown in color and sticky to the touch.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 04/09/24 at 08:40 AM the end of 600 hall closest to the nurses' station had a large tan colored smear on the floor with several pieces of what looked like crumbs in and around the smear. It appeared that something had spilled on the floor and had been partially wiped off the floor as the smear had defined trails in it that appeared to be wipe marks.</p> <p>During a Resident Council meeting on 04/08/24 at 10:09 AM several residents in the meeting stated housekeeping staff did not mop bathrooms. They stated bathrooms stunk and were dirty and the floors in many resident's rooms were sticky.</p> <p>During an interview on 04/09/24 at 09:45 AM LVN L stated having a substance that appeared to be feces on the toilet was a dignity issue for residents as well as an infection control issue. She stated any nurse or CNA who noticed a dirty bathroom was responsible to clean the bathroom. She said a sticky or dirty floor could contribute to falls for residents.</p> <p>During an interview on 04/09/24 at 09:54 AM LVN A stated having what appeared to be feces on the seat of a resident's toilet could cause the resident to slide and fall. She stated a sticky or dirty floor could cause a resident's shoe to fall off or cause a resident to fall.</p> <p>During an interview on 04/09/24 at 10:01 AM RN A stated having what appeared to be feces on the seat of a resident's toilet could cause the resident to slip and could cause infections and germs to be passed from resident to resident. He stated dirty or sticky floors could cause residents to fall.</p> <p>During an interview on 04/09/24 at 10:10 AM ADON stated having what appeared to be feces on the seat of a resident's toilet could spread infections. She stated it was the job of HSK to clean the bathrooms in the facility, but she stated, If a nurse or CNA walks in there and notices it, it is also their job to clean it up. ADON stated sticky or dirty floors could cause residents to fall.</p> <p>During an interview on 04/09/24 at 10:14 AM DON stated having what appeared to be feces on the seat of a resident's toilet could spread germs. She said having a dirty or sticky floor could also spread germs.</p> <p>During an interview on 04/09/24 at 10:34 AM HSK stated he was responsible for the cleanliness of the facility. He stated he mopped the floors of the facility every day. He stated he cleaned the bathrooms in resident rooms daily.</p> <p>During an interview on 04/09/24 at 01:46 PM CNA G stated she remembered the bathroom shared by Resident #9 and Resident #18 had poop everywhere on the morning of 04/07/24. When asked how that might affect residents she stated, It is just disgusting for the residents. I mean, who would want to go use the restroom and it be nasty? CNA G stated HSK was responsible for cleaning restrooms. She said of Resident #9 and Resident #18's bathroom, I guess yesterday he missed that one. CNA G stated, Things don't get cleaned around here like they should.</p> <p>Record review of facility policy titled Resident Rights and dated February 2021 revealed no mention of safe and clean living conditions.</p> <p>Record review of Attachment G of the facility's admission packet revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>RESIDENT'S RIGHTS UNDER TEXAS LAW . You have a right: . 2) to safe, decent, and clean conditions; .</p> <p>Record review of facility policy titled Environmental Services and dated 3/3/2023 revealed the following:</p> <p>. Safety: Safety is improved through use of standardized training. Employees are taught proper cleaning methods and follow proper procedures and protocol in completing job routines. The result is a safe and accident-free workplace. This Environmental Services Operations Manual . details the . procedures necessary to provide quality service to our clients.</p> <p>Record review of procedures and protocols for floor care revealed the following:</p> <p>DUST MOPPING . Pick up trash. CERAMIC FLOORS . Wire block Try using the wire block to scrub. Wire brush Use wire brush to scrub by wall. Scraper to remove caked-on soap, etc.</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>46534</p> <p>Based on interview and record review the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident's property for two (Cook C and DA E) of 14 employees reviewed for criminal history background checks prior to or at hire.</p> <p>The facility failed to implement their policy and complete a criminal history background check on Cook C and DA E prior to hire.</p> <p>This failure could place residents at risk of abuse, neglect, exploitation, or misappropriation of their property by staff members.</p> <p>Findings Included:</p> <p>Record review of facility policy titled, Abuse, Neglect, and Exploitation and dated 10/2023 revealed the following:</p> <p>. The facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Screening A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' checks shall be conducted on potential employees .</p> <p>Record review of Cook C's employee record revealed he was hired on 03/19/24.</p> <p>Record review of Cook C's criminal history background check revealed it was completed on 04/08/24.</p> <p>Record review of DA E's employee record revealed she was hired on 03/12/24.</p> <p>Record review of DA E's criminal history background check revealed it was completed on 04/08/24.</p> <p>During an interview on 04/09/24 at 11:53 AM HR stated when she began pulling employee records on 04/08/24 she discovered criminal history background checks for Cook C and DA E were not completed prior to or at hire so she ran them that day.</p> <p>During an interview on 04/09/24 at 12:21 PM HR stated the facility did not have an HR staff but that was no excuse for the criminal history background checks not being run prior to hire for Cook C and DA E.</p> <p>During an interview on 04/09/24 at 01:40 PM RN K stated not doing a criminal history background check prior to hire would put the facility in the position of not knowing if the new employee had criminal activity that could bar them from employment.</p> <p>During an interview on 04/09/24 at 01:45 PM DON stated not doing a criminal history background check prior to hire could affect the direct care of residents and place them at risk.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/09/24 at 02:04 PM ADON stated not doing a criminal history background check prior to hire meant someone working with the residents could have a history of abuse.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534</p> <p>Based on observations, interviews, and record reviews the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (Resident #97) of 13 residents reviewed for baseline care plans.</p> <p>The facility failed to address Resident #97's oxygen therapy in her baseline care plan.</p> <p>This failure could place residents at risk of not receiving correct and/or necessary care/treatment.</p> <p>Findings included:</p> <p>Record review of Resident #97's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, disease of biliary tract (disease of the network of organs and vessels that make, store and transfer bile through the body), peritonitis (inflammation of the membrane that lines the inner abdominal wall and encloses organs within the abdomen), and wheezing (shrill whistle or coarse rattle heard when the airway is partially blocked).</p> <p>Record review of Resident #97's MDS face sheet revealed her admission MDS was not yet completed.</p> <p>Record review of Resident #97's baseline care plan completed on 04/05/24 revealed no mention of oxygen therapy.</p> <p>Record review of Resident #97's active orders revealed no mention of oxygen therapy.</p> <p>Record review of Resident #97's vitals taken from admission to 04/08/2024 revealed her oxygen saturation was taken 3 times on 04/04/24, once on 04/05/24, twice on 04/06/24, once on 04/07/24, and once on 04/08/24. Record review of oxygen saturation documentation revealed 8 of the 8 times Resident #97's oxygen saturation was taken since she was admitted to the facility, she was receiving oxygen at 2-3 lpm.</p> <p>During an observation and interview on 04/07/24 at 09:57 AM Resident #97 was seated in her recliner in her room receiving O2 via NC at 3 lpm. She stated her O2 concentrator was set at 3 lpm because 2 (lpm) did not feel like anything. She stated staff changed the setting on the concentrator when she told them 2 did not seem high enough. She stated she had been receiving oxygen since last month when she had pneumonia.</p> <p>During an observation on 04/08/24 at 09:29 AM Resident #97 was seated in her recliner in her room receiving O2 via NC at 3 lpm.</p> <p>During an observation on 04/08/24 at 01:54 PM Resident #97 was seated in her recliner in her room receiving O2 via NC at 3 lpm.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 04/09/24 at 09:26 AM Resident #97 was seated in her recliner in her room receiving O2 via NC at 3 lpm.</p> <p>During an interview on 04/09/24 at 09:45 AM LVN L stated the admitting nurse was responsible for completing a baseline care plan for each resident. She said if a baseline care plan was incomplete the resident might not receive needed care.</p> <p>During an interview on 04/09/24 at 09:54 AM LVN B stated an RN was responsible for writing baseline care plans. She said if a baseline care plan was not complete it could negatively affect the care the resident received.</p> <p>During an interview on 04/09/24 at 10:01 AM RN A stated the baseline care plan should be done on admission by an RN on shift. He stated several negative things could happen to a resident if a baseline care plan was incomplete due to missed care and/or treatment.</p> <p>During an interview on 04/09/24 at 10:10 AM ADON stated she was responsible for completing baseline care plans for residents. She said a baseline care plan being incomplete could cause problems for a resident regarding care received versus care needed. She stated she completed the baseline care plan for Resident #97. She looked through Resident #97's EHR to find orders for oxygen. She stated Resident #97's daughter may have requested oxygen therapy but we don't have orders.</p> <p>During an interview on 04/09/24 at 10:14 AM DON stated the nurse who admitted the resident was responsible for completing a baseline care plan. She said if a baseline care plan was incomplete some of the care the resident needed could get missed.</p> <p>Record review of a facility policy titled Care Plans - Baseline and dated December 2016 revealed the following:</p> <p>. 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. implement a baseline care plan to meet the resident's immediate care needs including but not limited to : a. Therapy services; . summary of the baseline care plan that includes but is not limited to: . c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; .</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #97) of 13 residents reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #97 had physician's orders for oxygen before administering oxygen.</p> <p>This failure could place residents at risk for receiving oxygen at the wrong rate which could lead to hypercapnia (too much carbon dioxide in the blood), pulmonary oxygen toxicity (damage to the lung lining tissues and air sacs), hypoxemia (low levels of oxygen in the blood, decreasing the oxygen supply to vital organs), and shortness of breath.</p> <p>Findings included:</p> <p>Record review of Resident #97's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, disease of biliary tract (disease of the network of organs and vessels that make, store and transfer bile through the body), peritonitis (inflammation of the membrane that lines the inner abdominal wall and encloses organs within the abdomen), allergies, and wheezing (shrill whistle or coarse rattle heard when the airway is partially blocked).</p> <p>Record review of Resident #97's MDS face sheet revealed her admission MDS was not yet completed.</p> <p>Record review of Resident #97's baseline care plan completed on 04/05/24 revealed no mention of oxygen therapy.</p> <p>Record review of Resident #97's active orders revealed no mention of oxygen therapy.</p> <p>Record review of Resident #97's vitals taken from admission to 04/08/2024 revealed her oxygen saturation was taken 3 times on 04/04/24, once on 04/05/24, twice on 04/06/24, once on 04/07/24, and once on 04/08/24. Record review of oxygen saturation documentation revealed 8 of the 8 times Resident #97's oxygen saturation was taken since she was admitted to the facility, she was receiving oxygen at 2 or 3 lpm.</p> <p>During an observation and interview on 04/07/24 at 09:57 AM Resident #97 was seated in her recliner in her room receiving O2 via NC at 3 lpm. She stated her O2 concentrator was set at 3 lpm because 2 (lpm) did not feel like anything. She stated staff changed the setting on the concentrator when she told them 2 lpm did not seem high enough. She stated she had been receiving oxygen since last month when she had pneumonia.</p> <p>During an observation on 04/08/24 at 09:29 AM Resident #97 was seated in her recliner in her room receiving O2 via NC at 3 lpm.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 04/08/24 at 01:54 PM Resident #97 was seated in her recliner in her room receiving O2 via NC at 3 lpm.</p> <p>During an observation on 04/09/24 at 09:26 AM Resident #97 was seated in her recliner in her room receiving O2 via NC at 3 lpm.</p> <p>During an interview on 04/09/24 at 09:45 AM LVN L stated nurses were responsible for setting lpm levels on O2 concentrators. She stated CNAs did not have anything to do with setting O2 levels. LVN L stated nurses knew what lpm to set the O2 to by reading the doctor's orders found in the EHR. She stated a resident receiving O2 without a doctor's orders could impede their health.</p> <p>During an observation and interview on 04/09/24 at 09:54 AM LVN B stated nurses were responsible for setting lpm levels on O2 concentrators to match the physician's orders found in the EHR. She said a resident's drive to breathe could be impeded if they received O2 without a physician's order. LVN B attempted to locate orders for O2 in the EHR of Resident #97. She was unable to locate orders for Resident #97 to receive O2.</p> <p>During an interview on 04/09/24 at 10:01 AM RN A stated nurses were responsible to set the lpm levels on O2 concentrators. He stated the physician's orders would specify which lpm, which route, and how often O2 was to be administered. He stated a resident's ability to breathe could be negatively affected by receiving O2 without a physician's order.</p> <p>During an observation and interview on 04/09/24 at 10:10 AM ADON stated nurses were responsible to set lpm levels on O2 concentrators. She said the nurses would refer to physician's orders to find out the lpm. ADON stated a resident receiving O2 without physician's orders could have their condition exacerbated. ADON looked at her computer and attempted to find orders in the EHR of Resident #97 for O2 therapy. She said, I am not seeing any (orders) here.</p> <p>During an interview on 04/09/24 at 10:14 AM DON stated nurses were responsible for setting lpm levels on O2 concentrators. She said nurses would follow physician's orders in setting the lpm level. She stated she did not think a resident would be negatively affected by receiving O2 without a physician's order.</p> <p>Record review of facility policy titled Oxygen Administration and dated October 2010 revealed the following:</p> <p>. The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.</p> <p>Record review of facility policy titled Medication and Treatment Orders and dated July 2016 revealed the following:</p> <p>. 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Orders for medications must include: a. Name and strength of the drug; b. specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration; .</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>46534</p> <p>Based on interview and record review the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility reviewed for RN hours.</p> <p>The facility failed to have RN coverage for one day in October 2023, for two days in November 2023, and for four days in December 2023.</p> <p>This failure could negatively affect residents in the facility by leaving residents and staff without supervisory coverage for coordination of events such as emergency care and disasters.</p> <p>Findings Included:</p> <p>Record review of the facility's Payroll Based Journal Staffing Data Report for fiscal year quarter 1 2024 (October 1-December 31) revealed the facility triggered for no RN hours on 10/01/23, 11/18/23, 11/19/23, 12/02/23, 12/03/23, 12/16/23, and 12/17/23.</p> <p>During an interview on 04/08/24 at 08:41 AM DON stated there were no RN hours on 10/01/23, 11/18/23, 11/19/23, 12/02/23, 12/03/23, 12/16/23, and 12/17/23. She stated she had been employed by the facility for 2 months in October of 2023 and the other RN who worked for the facility went on maternity leave around that time. DON stated she was responsible for creating nursing schedules and she had no excuse, there just was not RN coverage on those days.</p> <p>During an interview on 04/09/24 at 09:45 AM LVN L stated she could not think of a negative outcome of not having an RN in the building at least 8 hours a day. She stated, We have some days that are bad and we might need the extra help but for the most part everything pretty much (runs) smoothly.</p> <p>During an interview on 04/09/24 at 09:54 AM LVN B stated an RN was needed in the building each day because an LVN was not able to delegate to another LVN. LVN B stated RNs were trained at a higher level and if there was not an RN in the building that level of training was missing from the care of residents.</p> <p>During an interview on 04/09/24 at 10:01 AM RN A stated not having an RN in the building at least 8 hours a day could make it more difficult to do certain tasks that only an RN was able to do. He gave the example of staging a pressure ulcer and delegating certain duties. He also stated RNs had extra knowledge that LVNs did not have.</p> <p>During an interview on 04/09/24 at 10:10 AM ADON stated regarding the facility not having RN coverage each day, My personal opinion, I think most of us as LVNs are good at assessing the patients and doing our job. We know what we can handle and if we need help, we know the steps we need to take for that situation.</p> <p>(continued on next page)</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/09/24 at 10:14 AM DON stated she did not think there was a negative outcome to residents when there was no RN in the building for at least 8 hours every day. She stated, Well, I mean, most of our staff are LVNs anyway I think they are very much qualified to take care of residents.</p> <p>Record review of facility policy titled Staffing and dated 09/28/23 revealed the following:</p> <p>. 4. The facility utilizes the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>47159</p> <p>FACILITY</p> <p>Kitchen</p> <p>Based on observation, interview and record review the facility failed to employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service for 1 of 1 kitchen staff (Dietary Manager) reviewed for qualifications.</p> <p>The facility failed to appoint a dietary manager with the appropriate license, certification, or qualifications.</p> <p>This failure could place the residents who consume food prepared from the kitchen at risk of not receiving services to meet their nutritional needs, contributing to food dissatisfaction, and placing residents at risk of food-borne illness.</p> <p>Findings included:</p> <p>The initial tour of the kitchen on 4/7/24 at 9:52AM revealed two workers (Cook D and DA I) in the kitchen preparing food for the luncheon service. The Investigator asked DA I if they (the Investigator) could speak with the Dietary Manager and was told that currently, the facility did not have a Dietary Manager, and that facility staff had been preparing meals, since his dismissal on 4/1/24.</p> <p>Cook D and DA I stated they did not have food handler's cards and had not received any training on how to run the kitchen. When asked who the full-time dietitian was, DA I stated she did not know and would have to ask the Administrator.</p> <p>On 4/7/24 at 11:04AM an interview with the Administrator revealed the Dietary Manager had been dismissed from his position on 4/1/24 due to disciplinary reasons. Facility staff, mainly dietary aides, were helping to prepare food until someone could be hired. The Administrator was asked if there was a full-time Dietitian on staff and stated the Dietitian worked as a consultant and came to the facility on ce per month to review resident nutrition plans. When asked to provide the food handler's cards for all the employees working in the kitchen, the Administrator stated she did not have any food handler's cards on file for these employees.</p> <p>Record review of employee records revealed Cook D and DA I did not have food handler's cards.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview on 4/7/24 at 1:47PM DA I stated she did not have a food handler's card and was asked the negative outcome of not having a Dietary Manager. She stated the kitchen was a mess, and no one knew what their job assignments were or how to do them properly. She stated no one was keeping track of what workers were doing and there had been no guidance given on how to run the kitchen. When asked why lunch was served so late today, she stated it was hard to get trays ready with only two people in the kitchen, and no one had been trained on portion sizes, food temperatures or tray readiness. She worked regularly in the kitchen as a dietary aide, but needed more guidance if she were expected to run the kitchen properly.</p> <p>DA J stated the current kitchen staff, including herself, were handling and preparing food without the proper certification. No one knew who was supposed to be cooking and she had received no training on how to run the kitchen. She stated she knew residents were hungry and felt bad that they could not be served in a timelier manner. When there was a Dietary Manager, he kept a list of kitchen tasks and how to complete them. People who were working in the kitchen currently, were doing whatever they pleased. They used to have food prepped for the next meal of the day, but that is not being done currently. No communication was being kept between staff who worked opposing shifts.</p> <p>In an interview on 4/7/24 at 2:21PM the Administrator stated there was no corporate policy regarding the employment of a Dietary Manager and they were using the state and federal regulations as a guideline. She stated it was difficult hiring a Dietary Manager in such a small community.</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>47159</p> <p>Based on observation, interview and record review the facility failed to ensure residents received, and the facility provided three meals daily, at regular times comparable to normal mealtimes in the community, as well as suitable, nourishing alternative meals and snacks for residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident's plan of care.</p> <p>The facility failed to ensure all residents in the facility, received food trays at times comparable with normal mealtimes in the community.</p> <p>The facility failed to provide all residents who wanted snacks, at regular intervals between the three daily meals.</p> <p>These failures could place residents at risk of diminished nutritional status, food dissatisfaction and diminished physical well-being.</p> <p>Findings included:</p> <p>On 4/7/24 at 11:32PM 6 residents were observed sitting in the dining room, waiting for lunch service.</p> <p>On 4/7/24 at 12:00PM an observation of the dining room revealed the posted luncheon mealtime was 12:00PM and there were 27 residents sitting in the dining room, waiting to be served lunch.</p> <p>The first resident tray was delivered at 12:25PM</p> <p>On 4/7/24 at 12:33PM LVN L stated it had taken that long to serve meals for a while. When asked if it were the same when the facility had a Dietary Manager, she stated it had gotten worse since he had been fired.</p> <p>On 4/7/24 at 12:37PM Resident #5 was heard saying to her three table mates, I'm hungry!</p> <p>On 4/7/24 at 12:38PM there were still 5 tables of residents with no food.</p> <p>On 4/7/24 at 12:43PM Resident #5 was heard saying to her three table mates, I am so hungry! There were 11 residents in the dining room who had not yet been served their meals.</p> <p>On 4/7/24 at 12:48PM there were 6 residents in the dining room who had not yet been served their meals.</p> <p>On 4/7/24 at 12:56PM the final resident in the dining room received his meal.</p> <p>(continued on next page)</p>

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/8/24 at 9:40AM a snack cart was observed behind nurse's station with graham crackers, pudding, Jello and mini cinnamon donuts. The posted resident schedule revealed morning snack was to be served at 9:00AM.</p> <p>On 4/8/24 at 9:43AM, 5 people who were in the living room were asked if they had gotten a morning snack and all 5 stated that they had not. When asked if they had been offered a snack, all 5 stated they had not.</p> <p>On 4/8/24 at 9:49AM an interview with the DON regarding the snack cart revealed that someone must have already taken the cart back to the kitchen. We proceeded to the kitchen and found the snack cart. The DON was informed there were 5 people in the living room who had not been offered a morning snack. She took the snack cart and went to living room where she asked each of the 5 residents if they wanted a snack. All 5 residents said yes. They were given their snack of choice.</p> <p>On 4/8/24 at 10:09AM during a Resident Council Meeting the members were asked about the availability and frequency of snacks. The President, Resident #9, stated they were not offered snacks on most days and were only getting one today, because state surveyors were in the building. Resident #9 stated they had to use their own money to purchase snacks from the vending machine if they wanted an evening snack, even though the resident schedule stated it should be provided by the facility at 7:00PM.</p> <p>On 4/8/24 at 12:02PM the luncheon service was observed.</p> <p>On 4/8/24 at 12:23PM the first meal tray was delivered to a resident.</p> <p>On 4/8/24 at 12:31PM there were 7 tables of residents who had not been served lunch.</p> <p>The last resident luncheon tray was served was served on 4/8/24 at 12:46PM.</p> <p>In an interview on 4/8/24 at 2:13PM RN A and LVN B stated they had been at the nurse's station for about 30 minutes and neither had seen the afternoon snack cart.</p> <p>On 4/8/24 at 2:37PM an observation of the nurse's station revealed no afternoon snack cart. The posted resident schedule revealed snacks were to be distributed to at 2:00PM. DA I was standing by the nurse's station and when asked, stated she forgot to get the snack cart ready.</p> <p>On 4/8/24 at 2:41PM an interview with the Administrator revealed residents were to receive snacks on a daily basis. She stated the snack times were posted on the resident's daily schedule, up by the nurse's station. When asked the negative outcome of residents not receiving daily scheduled snacks, she stated many of the residents are hungry all the time and was not aware residents had not been receiving daily snacks. When asked if residents could be harmed by not receiving daily snacks, she stated the residents eat breakfast at 8:00AM and eat lunch at noon, so they shouldn't be all that hungry. She stated there was no specific facility policy for the service of meals and snacks and they follow the state and federal guidelines. She stated she was not aware that residents were using their own money to purchase snacks in the evening.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47159</p> <p>FACILITY</p> <p>Kitchen</p> <p>Based on observation, interview and record review the facility failed to store and distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure stored foods were properly labeled and dated. 2. The facility failed to ensure expired foods were discarded. 3. The facility failed to store foods in accordance with professional standards. <p>This failure could place residents at risk of acquiring a food-borne illness and a diminished quality of life.</p> <p>Findings included:</p> <p>The initial tour of the kitchen on [DATE] at 9:52AM revealed no free-standing thermometers in the refrigerator, freezer, or dry pantry.</p> <p>The temperatures being checked and logged were taken from the manufacture's thermometers on the outside of each appliance.</p> <p>There was no thermometer or logbook for the dry pantry.</p> <p>Inspection of the refrigerator revealed:</p> <p>,d+[DATE]oz. boxes of thickened cranberry juice with no date,</p> <p>,d+[DATE]oz. glasses of tomato juice: open to air, with no date,</p> <p>,d+[DATE]-gallon pitcher of fruit juice: no label designating contents, open to air, with no date,</p> <p>,d+[DATE]oz glasses of milk: open to air, with no date,</p> <p>,d+[DATE]oz glasses of orange juice: open to air, with no date,</p> <p>,d+[DATE] oz. glasses of cranberry juice: open to air, with no date,</p> <p>,d+[DATE]oz. boxes of thickened dairy drink with no date,</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>,d+[DATE]oz. jar of strawberry jam with no date,</p> <p>,d+[DATE]-gallon pitcher of tea: open to air with no date,</p> <p>,d+[DATE]oz boxes of thickened orange juice with no date,</p> <p>1 food service box of mini cinnamon donuts with no date,</p> <p>1 large food service bowl of tomato soup: open to air with no date,</p> <p>,d+[DATE]-gal. zip closure bag marked onions, with ham slices inside, with no date,</p> <p>,d+[DATE]-gal. zip closure bag marked hash browns with sausage patties inside, with no date,</p> <p>1-food service cooked ham with no date,</p> <p>,d+[DATE]lb. package of ham lunch meat with an expiration date of [DATE], and</p> <p>,d+[DATE] lb. box of pepperoni: open to air.</p> <p>Inspection of the freezer revealed:</p> <p>,d+[DATE]oz bag frozen cauliflower with no date,</p> <p>20 lbs. of frozen corn: open to air with no date,</p> <p>,d+[DATE]oz bag frozen okra with no date,</p> <p>,d+[DATE].5 lb. container of frozen strawberries with no date,</p> <p>1 frozen pie shell with no date,</p> <p>,d+[DATE]lb. bag of frozen zucchini with no date, and</p> <p>1 doz. flour tortillas with no date.</p> <p>Inspection of the dry pantry revealed:</p> <p>1 grocery store bag of fresh tomatoes with no date,</p> <p>3 loose apples in a grocery store bag with no date,</p> <p>1 plastic cereal container of Corn Flakes Cereal: no label and no date,</p> <p>1 plastic cereal container of Cheerios Cereal: no label and no date,</p> <p>,d+[DATE]-gal. zip closure bag of Honeycomb Cereal: no label and no date,</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024
NAME OF PROVIDER OR SUPPLIER Childress Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 7th St NW Childress, TX 79201	

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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>1 large plastic container marked pinto beans with what appeared to be breadcrumbs inside,</p> <p>1 large plastic container of what appeared to be sugar: no label and no date,</p> <p>1 food service box of individual mayonnaise packets with no date,</p> <p>,d+[DATE]lb. can of caramel fudge topping with no date,</p> <p>2 gallons of vegetable oil with no date,</p> <p>6-#10 cans of red beans sitting on floor of the dry pantry, and</p> <p>50 lbs. of fresh potatoes sitting outside the door to the dry pantry, on floor of the kitchen.</p> <p>In an interview on [DATE] at 1:47PM, DA I was asked about the negative outcome of not having foods properly labeled and dated. She stated that residents could become sick if they eat food that is expired or if they are served foods which they should not have. DA I was asked how she knew when something was to be disposed of and she stated that she would have to find the policy for food retention.</p> <p>In an interview on [DATE] at 2:21PM the Administrator stated the negative outcome of not having foods properly labeled and dated would be that residents could become sick.</p> <p>Record review of the facility's Food Storage Policy dated 2018 revealed the following:</p> <p>Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines.</p> <p>Procedure: Dry storage rooms</p> <ol style="list-style-type: none"> 1. For maximum shelf-life, dry foods should be stored at 50-degrees Fahrenheit, however, , d+[DATE]-degess Fahrenheit was an adequate temperature for most products. 2. Use a wall thermometer to check the temperature of the dry-storage facility regularly. 3. To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. 4. Where possible, leave items in the original cartons placed with date visible. 5. Use the first-in, first-out rotation method. Date packages and place new items behind existing supplies, so that the older items are used first. 6. Store all items at least 6 above the floor with adequate clearance between goods and ceiling to protect from overhead pipes and other contamination. <p>Refrigerators:</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Childress Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 7th St NW Childress, TX 79201	
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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>	<ol style="list-style-type: none"> 1. Keep fresh meat, poultry, seafood, dairy products, and most fresh fruit and vegetables in the refrigerator at an internal temperature of 41 F or less. 2. Store all foods on racks or shelves off the floor. 3. Do not line shelves with foil or paper. Do not over stock the refrigerator and leave space between items to further improve air circulation. 4. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. 5. Use all leftovers within 72 hours. Discard items that are over 72 hours old. 6. Store raw meats and eggs on the bottom shelf to prevent contamination of other foods. To avoid cross-contamination, store raw or uncooked food and produce away from and below prepared or ready-to-eat food. 7. Store dairy products separately from foods with strong odors such as onions, cabbage and seafood. 8. Place a thermometer inside refrigerators near the door where the temperature is warmest. Check the temperature of all refrigerators using the internal thermometer to make sure the temperature stays at 41 F or below. 9. Temperatures should be checked each morning when the kitchen is opened, once during the day and in the evening when the kitchen is closed. Record the temperatures on a log that is kept near the refrigerator. A sample Refrigerator and Freezer Temperature Log follows this policy. 10. When temperatures are outside of the designated range, notify Maintenance immediately. <p>Freezers:</p> <ol style="list-style-type: none"> 1. Store all frozen meats, poultry, seafood, fruits and vegetables, and some dairy products, such as ice cream, in the freezer at a temperature that maintains the frozen state of the foods. 2. Store frozen foods immediately upon receiving. 3. Store all foods on racks or shelves off the floor. 4. Do not line shelves with foil or paper. Do not over stock the freezer and leave space between items to further improve air circulation. 5. Store frozen foods in moisture-proof wrap or containers that are labeled and dated. 6. Store meat, fish and poultry below fruits, vegetables, juices, and breads. 7. Open freezer doors only when necessary to prevent the freezer temperature from increasing. <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>8. Place a thermometer inside freezers near the door where the temperature is warmest. Check the temperature of all freezers using the internal thermometer to make sure the temperature stays at 0 F or below. Temperatures should be checked each morning when the kitchen is opened, once during the day and in the evening when the kitchen is closed. Record the temperatures on a log that is kept near the freezer. A sample Freezer Temperature Log follows this policy.</p> <p>9. Once frozen food has been thawed, it must be maintained at 41 F or less prior to cooking.</p>