

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/18/2024
NAME OF PROVIDER OR SUPPLIER  Azalea Heights		STREET ADDRESS, CITY, STATE, ZIP CODE  3505 Old Jacksonville Rd Tyler, TX 75701	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27140</b></p> <p>Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen observed for kitchen sanitation.</p> <p>The paper towel dispensers at the hand wash sink and employee restroom had no paper towels.</p> <p>The bulk flour bin had a large scoop stored inside the product on 09/16/24 and 09/17/24.</p> <p>The utensil drawer was soiled with food debris and dried liquid.</p> <p>A 25 lb. bag of brown sugar and 2-16 oz. bags of potato chips were opened and not re-sealed.</p> <p>The 3 compartment sink was not sanitizing and was being used.</p> <p>The 3 compartment sink and dish machine logs had been pre-filled with results for the entire day (09/16/24) when the noon and evening meals had not occurred. The results indicated temperatures and sanitizing conditions.</p> <p>The large ice machine in the dining area contained copious amounts of black debris on the ice chute.</p> <p>In the 2 door stainless steel reach in cooler 1-46 oz. nectar thick orange juice had been opened and not labeled with the open date.</p> <p>These failures could place residents who ate food from the kitchen at risk of foodborne illness.</p> <p>Findings included:</p> <p>During observations, interviews and record reviews on 09/16/24 of the kitchen the following was noted:</p> <p>*at 9:10 AM there were no paper towels in the dispenser at the hand washing sink by the dish room.</p> <p>*at 9:18 AM in the employee restroom there were no paper towels in the dispenser.</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*at 9:21 AM the bulk flour bin contained a scoop in the flour.</p> <p>*at 9:26 AM the utensil drawer under the prep table by the French door oven had dried food debris in the bottom of the drawer and the edge of the drawer had dried liquid where food crumbs had stuck to it. The DM said the drawer was cleaned weekly and then said 2 to 3 times.</p> <p>*at 9:30 AM in the dry pantry one light brown sugar 25 lb bag was opened and not re-sealed,</p> <p>*at 9:32 AM 2-16 oz. potato chip bags were opened and the tops were rolled down and not secured or placed in a re-sealable bag,</p> <p>*at 9:42 AM [NAME] A was washing pans and placing them in the rinse water sink and then into the sanitizing sink. The DM checked the sanitizing sink with a quarternary test strip and the test strip indicated the solution was not sanitizing. [NAME] A said she had just made up the 3 sinks but did not test the sink for sanitizing solution. She said she did not take the temperatures because she knows the temperature by the feel of it on her hands. The DM said they are supposed to check the sanitizer when they make a fresh sink. He asked [NAME] A when they put on the new bottle of sanitizer and she said on Saturday. The DM said the sanitizing solution should test between 200 and 400 ppm. He said the kitchen staff were to check the sanitizer when they wash the dishes for each meal and log it on the Test Strip Log for the Three Compartment Sink. Review of the log at 9:54 AM on 09/16/2024 indicated the whole day (3 meal times) had already been filled in. It indicated the sanitizer was reading 200 ppm and the temperatures of the wash and rinse water were 150 degrees. A review of the Dish Machine &amp; Sanitizing Log on 09/16/2024 at that same time indicated the log had been filled out for the lunch and evening meals. The DM was asked about the log being pre-filled and he got a liquid paper dispenser in order to cover the entries. A copy was made before it was changed. The DM said he would call the vendor to recalibrate the dispenser.</p> <p>*at 10:00 AM in the large ice machine in the dining area the ice chute was wiped with a paper towel and returned with copious amounts of black debris. The Maintenance Supervisor said the machine was cleaned one month ago by the vendor. He said the vendor said the black debris was from the local water supply. He said there was a filter on the incoming water line into the machine. He said the vendor deep cleaned the machine every 3 months and he cleaned the coils, emptied the bin and cleaned it, cleaned the fins, and put in a new filter. He said the filter usually just had a bit of silt or [NAME] material. He showed his receipt on his phone from the vendor where the machine had been deep cleaned on 08/27/2024. He said he cleaned the machine on 09/02/2024. He said the kitchen staff were supposed to clean the chute, door and entry front of the machine at least weekly if not more often. There was no documentation provided by the dietary manager as to the kitchen cleaning the front of the ice machine. The small ice machine adjacent to the large machine was clean and received water through the same water line as the large machine. There was no debris on the chute.</p> <p>During an observation of the kitchen on 09/17/24 at 11:27 AM the bulk flour bin had a large scoop stored in the flour. At 11:28 AM the 2 door stainless steel reach in cooler had 1-46 oz. nectar thick orange juice that had been opened and not labeled with the open date. The package indicated Once opened may be kept up to 7 days under refrigeration.</p> <p>Record review of a Dietary Service policy, revised date of January 2023, indicated the following:</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>.The community ensures that the nutritive value of food is not compromised and destroyed by the following: prolonged food storage and exposure to light and air .</p> <p>.The community procures food from sources approved or considered satisfactory by federal, state, or local authorities and stores, prepares, distributes, and serves food under sanitary conditions.Sanitary conditions are defined as the proper storage, preparation, distribution, and serving of food to prevent food borne illness.</p> <p>.Water temperatures .Manual: Compartment sink (wash, rinse, sanitize): Sanitizing solution used according to manufacturer's instructions.</p> <p>Record review of the General Kitchen Sanitation policy, undated, indicated the following:</p> <p>. 5. After cleaning and until use, store and handle all food-contact surfaces of equipment and multi-use utensils in a manner that protects the surfaces from manual contact, splash, dust, dirt, insects and other contaminants .11. Check retrooms regularly throughout the shift, and be sure they are stocked with soap, toilet paper and paper towels 12. Make sure hand-washing facilities are easily accessible and supplied with soap and paper towels.</p> <p>Record review of the Manual Cleaning and Sanitizing of Utensil and Portable Equipment policy, undated, indicated the following:</p> <p>.6. In the first sink, immerse the equipment or utensils in a hot, clean detergent solution at a temperature of no less than 120 degrees F. 7. Rinse in the second sink using clear, clean water between 120 degrees F and 140 degrees F to remove all traces of food, debris and detergent. 8. Sanitize all multi-use eating and drinking utensils and the food-contact surfaces of other equipment in the third compartment by one of the following methods: . b. Immerse for t least 60 seconds in a clean sanitizing solution containing: . iii. Any other chemical sanitizing agent which has demonstrated to be effective and non-toxic under use conditions and for which a suitable field test is available. Such other sanitizing agents, in-use solutions, shall provide the equivalent sanitizing effect of a solution containing at least 50 parts per million of available chlorine at a temperature not less than 75 degrees F. The concentration and contact time for quaternary ammonium compounds shall be in accordance with the manufacturer's label directions. 9. Test and record the parts per million concentration of the solution.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47723</b></p> <p>Based on observations, interviews, and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were completed and accurately documented for 1 of 4 residents (Resident #281) reviewed for medical records accuracy.</p> <p>The facility failed to ensure an order for enteral feedings (liquid nutrition delivered via a tube inserted into the body) from the hospital was documented in Resident #281 s physician's orders at the facility.</p> <p>The facility failed to document the administration of liquid nutrition for 4 consecutive days after Resident #281 was admitted to the facility.</p> <p>These failures could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being.</p> <p>Findings included:</p> <p>Record review of Resident #281's face sheet and physician's orders dated 09/17/2024 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included, dysphagia (difficulty swallowing), gastrostomy tube (a tube inserted through the abdominal wall, into the stomach for the purpose of delivering liquid nutrition), cardiac arrest, respiratory failure, and hypertension.</p> <p>Record review of the physician's orders dated 09/13/2024 indicated there was no order for Resident #281 to receive any enteral nutrition.</p> <p>Record Review of Resident #281's MAR for September 2024, indicated there was no documentation he received Jevity 1.2 @ 70 ml/hour with 60 ml water flushes every 4 hours on 9/13/2024, 9/14/2024, 9/15/2024, 9/16/2024, and 9/17/2024.</p> <p>Record review of Resident #281's Hospital Discharge Records indicated an order for him to receive Jevity 1.2 at 70ml/hour with a water flush of 30ml/hour via the gastrostomy tube.</p> <p>During an observation on 09/16/2024 at 10:20 a.m., Resident #281 was non-interview able and was observed to be lying in bed with his eyes closed with the head of the bed elevated approximately 30 degrees. A container of Jevity 1.2 (liquid nutrition) was noted to be hanging from a metal pole and infusing via a tube leading to the resident's stomach at a rate of 70ml/hour. Resident #281 was again observed to be receiving the same liquid nutrition on 09/16/2024 at 3:30 p.m., on 09/17/2024 at 9: 30 a.m., and on 09/18/2024 at 10:00 a.m .</p> <p>During an interview on 09/18/2024 at 1:30 p.m., the MDS RN said a physician order for Jevity 1.2 @ 70 ml/hr. with 60 ml water flush every 4 hours, was entered into electronic health records, and on the MAR but it was entered late at 3:30 p.m., as a start date for 09/17/2024 .</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/18/2024 at 2:30 p.m., the Director of Clinical Operations Nurse said, LVN B received report at the change of shift from the day shift agency nurse and completed the New Admission form. She said LVN B failed to enter Resident #281's physician order for external feedings into his EHR. She said all of Resident #281's other admission orders were entered into his EHR accurately .</p> <p>During an interview on 09/18/2024 at 4:30 p.m., LVN B said he had worked for the facility for [AGE] years, he stated on 09/13/2024, he received, and accepted report at the change of shift from the day shift agency nurse, she had received a verbal order from the hospital for the external feeding. LVN B stated, the agency nurse had completed the setup and the external feeding (Jevity 1.2 @ 70 ml/hour.), it was already hanging. LVN B stated he proceeded with the admission assessment and failed to enter Resident #281's external feeding order into his EHR. LVN B said all other orders were entered into the electronic health records accurately .</p> <p>During an interview on 09/18/2024 at 5:30p.m., the DON, said the two facility's ADON's were responsible for checking and reviewing all new admissions, re-admissions, check lists, and physician orders to ensure orders were put in accurately. She said the ADON's were responsible for ensuring Medication administration orders were entered into the EHR for the correct patient, correct time, correct route, correct dose, correct medication, and the correct documentation accurately .</p> <p>Reviewed the facility Professional Standard of Care Policy dated implemented 02/2017 and revised on 01/2024 stated, . Nurses should conduct assessments or evaluations and document within the medical record in the following instance: 1) admission, re-admission, and as clinically indicated. 2) at the time of an incident or change in conditions. 3) when exceptions are identified. 4) as otherwise directed.</p>		