STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675374	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irving Nursing and Rehabilitation	619 N Britain Rd Irving, TX 75061

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on interview, and record review, the facility failed to ensure residents were free from abuse for one of eight residents (Resident #32) reviewed for abuse. The facility failed to ensure Resident #32 was free from physical abuse when the Former Staffing Coordinator grabbed Resident #32's hand hard enough to cause bruising, while attempting to get the resident to allow himself to be taken to the shower. This failure placed residents at risk for abuse. Findings included: Review of Resident #32's face sheet reflected an [AGE] year-old male, admitted on [DATE], with diagnoses of Acute embolism and thrombosis of unspecified deep veins of left lower extremity (a blockage caused by a blood clot in the leg), Urinary tract infection, site not specified, lack of coordination, Spondylolisthesis, lumbar region (a condition in which vertebra slip out of place, and cause pain), and Cauda equina syndrome (a rare condition in which nerve roots at the bottom of the spinal cord are compressed, considered a medical emergency.) Review of Resident #32's care plans reflected the following care plans: - Urinary Incontinence and pain, dated 11/27/24 - ADLs re: Non-compliant behavior dated 11/19/24 Review of Resident #32's Admission MDS Assessment, dated 10/04/24, reflected his sight and hearing were adequate, and he was able to express himself, be understood by others, and to understand others. His BIMS score was 12, indicating possible moderate cognitive impairment. He had no indicators of depression, or psychosis, and exhibited no behavioral problems. Resident #32 indicated it was very important to him to take care of his personal belongings or things, and to have a place to keep them safe. He was able to eat with only set-up or clean-up assistance, but was dependent on staff for toileting and bathing. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation documentation for a self-reported allegation of abuse by a resident, submitted to HHSC by the Former Administrator on 10/31/24, reflected Resident #32's allegation that some female staff members had entered his room, and tried to get him to take a shower on 10/29/24, which he refused. The document reflected that he stated one of the women (thought to be the Former Staffing Coordinator) handled him roughly and bruised his hand. In the investigation materials provided, a statement by CNA I, dated 11/04/24, (appearing to be a text message) reflected that the CNA had been in the room during this incident, and observed the (Former) Staffing Coordinator was asked to come into the room to assist. The facility investigation reflected the resident was observed to have a small bruise on his left hand, where he was allegedly grabbed. An interview with Resident #32 on 12/03/24 at 3:04 PM, with his friend, Visitor K, present, revealed him to be alert, and oriented, with some forgetfulness. He said that some women came into his room, and told him he had to take a shower. He said that he told them he would do it the following day, and they said no and that he always said that, but he would not do it, so they wanted him to do it right then. He said they removed his clothing and stripped his bed, and he did not remember when he ended up in the chair to go to the shower. He said he did not remember their names, but one of them was a huge woman who was tall, and very strong, and he could not remember if he had seen her before that, but did not think he had seen her since. He thought someone told him she was no longer working there. He said during the disagreement the large woman grabbed his left hand so hard he could not pry her hand off, and she left a bruise. He said they hauled him out of his room. He could not remember when he got into the chair, but he said the abuse happened in the room, and down to the shower room. He said that two male staff then showered him, and were very nice, and repeatedly apologized, though it was not their fault. He said that the staff were all very nice, and he liked them, except for the woman who grabbed his hand. He did not feel afraid of anyone. Observed at the time of this interview was an assortment of disposable plastic cups on his bedside table with items like sugar and salt packets, and margarine packets. He explained there were usually more things on the table and when he left the room the staff took advantage of his absence, and cleaned his room, getting rid of his things, which was why he insisted on having his showers when one of his friends was there, to make sure that did not happen. The surveyor confirmed with the resident that the items on his table were the belongings he was referring to. He said he did not report the incident to anyone when it happened, because he did not know that he could, so they did not know about it right away. He said the staff now knew he wanted to take showers only when his friend was there to watch his things. An interview on 12/04/24 at 12:43 PM with CNA I revealed Resident #32 was very aware of what was happening, during the incident. He said the resident often refused showers, and he thought it had been about a week since he allowed them to shower him. CNA I said the DON and LVN G seemed stuck on doing it (showering the resident), and he kept refusing. He said the Former Staffing Coordinator came into the room, and he thought he remembered her holding the resident down so they could try to clean him, while he tried to push them off, and she held his arm down. He said the Former Staffing Coordinator quit soon after the incident. He said Resident #32 did allow him, another male CNA (CNA J) to take him down to the shower room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/04/24 at 1:27 PM with the Former Staffing Coordinator revealed she had been called into Resident #32's room, and when she got there, CNA I, the DON, and LVN G were in the room. She said she did not know what they wanted her to do, because Resident #32 did not want to shower, so there was nothing she could have done. She said the resident was new to the facility, and she did not really know him well. She said she talked to him, and said it was his shower day, but the resident said he wanted no ladies so she was trying to leave the room. She said she did not remember if she touched him, but she denied ever grabbing him. She said the resident said he would take a shower if all the women left, and CNA I showered him, and she left the room. She said she was not suspended as a result of the incident, and she was never made aware that anyone thought she hurt his arm. While she was in the room, she said, she never saw anyone be rough, or grab at him or his bedding, and everyone was being nice. An interview on 12/04/2024 at 3:16 PM with the Former Administrator revealed on 10/31/24 the SW told her there was a potential abuse report by Resident #32, who said large black ladies went into his room, hurt him, mistreated him, grabbed his arm, and made him take a shower. The SW told her that the DON was in the room during the incident. The Former Administrator went to Resident #32's room, and he told her that it was three, large, black women who came into his room, and asked him about taking a shower. He said he refused and one of them grabbed his arm so tight he had to pry her fingers off his wrist. The Former Administrator said she saw he had about an inch and a half bruise, with a small skin tear in the middle of it. The resident did not know names, and could only describe them as three large, black women and he could not tell her which one grabbed his arm, and could not say an exact time it happened, only the day. She interviewed staff to see who was there. She said someone told her a male CNA entered the room at one point, but Resident #32 did not say anything about any males in the room. She self-reported it and did what she could to protect the resident, not knowing who had been in the room. She said she suspended the Former Staffing Coordinator, who fit the description of the one who hurt his arm, but was not able to get a statement from her, because she left before she could speak to her, and quit and would not return her calls. They had one nurse who was African American, but she was slender, and the resident insisted the one who hurt him was larger, and had been in the room, pulling at his blankets, and trying to get him to take a shower. She had the Social Worker do safe resident surveys, and talked to any staff who were there and might have observed anything. She had some trouble getting CNA I's statement, but later in the investigation, when she got it she found the statement kind of disturbing, but she turned it in with the rest and considered that part of the original self-report. When she finally got his statement, she saw that he said it was the DON, LVN G, and the Former Staffing Coordinator (who was already gone at the time she received the statement.) As part of the investigation she got statements from everyone else, and suspended the perpetrator if one was confirmed or someone fit the description. She said she put the Former Staffing Coordinator on suspension, but she never returned back to work, and even though she tried several times to get her to give a statement, she was never able to get one. An interview on 12/04/2024 at 4:08 PM with the VP revealed it was their protocol to suspend anyone with an allegation. She said when the Former Administrator called her with the original allegation she told her to immediately suspend the Former Staffing Coordinator, who was the staff member who fit the description the resident gave them. The Former Administrator said the Former Staffing Coordinator had left early because she was sick, but she would suspend her, but they never got to suspend her because she never came back to the facility and would not return phone calls. She told the Former Administrator to call the police, and to get statements from anyone who was there, and talk to the DON and other residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/04/2024 at 4:33 PM with the DSM revealed she was notified to go investigate the incident with Resident #32. Resident #32 had alleged that a larger African American woman had grabbed his wrist, and that there were 3-4 ladies trying to get him to take a shower, and the lady who grabbed him left a bruise. He said everyone there had been professional, and friendly, and that the woman who had grabbed his arm was no longer there and he had never seen her again. He said women had looked at his bottom due to an abscess he had, and tried to get him to take a shower, but they were not the one who grabbed him. He said he felt safe, and comfortable, and this had been an isolated incident. She said she talked to him and learned that he preferred to be showered by males, and that he wanted his friend to be there to watch his things while he was out of the room. The DON was inserviced. An interview on 12/05/2024 at 5:10 PM with LVN G revealed she and the DON had not originally gone to Resident #32's room to get him to shower. She said he had an abscess on his bottom they needed to check on. She said when he rolled to his side to let them look they could see that his bed was filthy with urine, BM, food, and they could see flakes of skin, and he and his bed needed to be cleaned up. She said it had been a while, but she remembered that they talked him into taking a shower. She said they told him he hadn't taken one the day before, she thought. He didn't want to, because he had for a friend, or family member, she thought, but she was having trouble remembering. They told him that they could make sure that someone told his visitor that he would be right back from the shower soon. She thought he said he would consider it if males could shower him. She thought that the Former Staffing Coordinator had also been in the room part of the time, and a male CNA, but she did not know when they came into or left the room. Someone assisted him into the shower chair and took him to the shower room, and while he was gone she and the DON, and the other person she thought was the Former Staffing Coordinator, washed the bed with a basin of water, sanitized it, and wiped down the whole room. They did not throw away anything, just cleaned everything. She said she did not see anyone grab him, or be abusive in any way. If she had, she said she would have reported it to the (former) Administrator immediately. She said that residents had a right to refuse care. An interview on 12/05/2024 at 5:45 PM with the DON revealed she went with LVN G and the Former Staffing Coordinator because they needed to look at Resident #32's abscess. She said the abscess was healed, but his bed was filthy and his brief was soaking wet and had BM on him. He said not right now because he had family coming, and they told him they could tell his family he would be right back when they arrived. He said that was OK, and he wanted male CNAs so they called two male CNAs, and they took him to shower. She and LVN G washed and sanitized the bed, and put clean linen on. She was normally part of the investigations of self-reports, but she was never shown that one. She was informed that there had been an allegation a heavy-set black women going into his room, and making him take a shower. She remembered the bruise on the back of his hand, and he told her it was from scratching himself when he took his watch off. She said the lady who fit the resident's description was no longer working there when the corporate person came. Review of a skin assessment done on 11/08/24 at revealed Resident #32 refused the assessment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Abuse Prevention Program policy, dated 04/08/21, reflected: 1) Prevention Component: Abuse Policy Requirement: It is the policy of this facility to prevent abuse by providing residents, families and staff information and education on how, when, and to whom to report concerns, incidents, and grievances without the fear of reprisal. The facility will then provide feedback regarding those concerns or complaints. The facility administrative staff will consistently reinforce this information to residents, families and staff. Procedures: There are policies and procedures written in this program on detecting and preventing abuse, neglect and exploitation. The facility will monitor activities to identify indicators for abuse, neglect and exploitation. Organizational practices that influence quality of care and quality of life including staffing levels, certified nursing assistant involvement in planning and evaluating care, and environmental considerations are monitored. Basic problem-solving components include periodic reviewing and revising policies and procedures for State and Federal compliance, analyzing all incidents, reviewing incident reports, reviewing reports on abuse, neglect, and exploitation and assessing for trends and analyzing satisfaction surveys.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35489 Based on interview and record review, the facility failed to use the services of a Registered Nurse for a minimum of eight consecutive hours a day, seven days a week, for 13 of 26 weekend days. The facility failed to have RN coverage on the following dates in 2024: -April 6, 7, 13, 14, 20, and 21. -May 4, 5, 11, 12, 18, 19, and 26. This failure could place residents at risk of not having their nursing and medical needs met, and not receiving proper care. Findings included: Review of the CMS PBJ Staffing Data Report, a report reflecting data self-reported to CMS by the facility, dated 11/26/24, reflected the facility had not reported RN coverage hours for the weekend dates of April 6, 7, 13, 14, 20, 21, and May 4, 5, 11, 12, 18, 19, and 26. Review of an undated excel file, covering the RN time stamp hours for weekend dates of the second fiscal quarter of 2024 reflected no RN coverage on the following dates of 2024. -April 6, 7, 13, 14, 20, and 21. -May 4, 5, 11, 12, 18, 19, and 26. An interview on 12/05/2024 at 5:45 PM with the DON revealed she started working at the facility in August of 2024, and her weekend RN had to be off twice since then, and she had covered those days herself. She did not know why they were missing RN hours prior to her getting there. An interview on 12/05/2024 at 6:13 PM with the Administrator revealed he had only been in the facility for two weeks, so he did not know why they were missing days of RN coverage. An interview on 12/05/2024 at 7:19 PM with the DON revealed the importance of having RN coverage was that someone in the building might require a higher level of knowledge and training than an LVN. Review of the undated facility policy Nurse Staffing Requirements reflected POLICY: Nurse Staffing Requirements in Nursing Facilities; REQUIREMENT: The requirements for long-term care facilities require that nursing facilities provide 24-hour licensed nursing, provide a Registered Nurse (RN) for eight (8) consecutive hours a day, seven (7) days a week, and that there be a RN designated as Director of Nursing on a full-time basis.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for one of Two residents (Resident#18) reviewed for medication adminstration via gastrostomy tube (G-tube). RN H did not check placement of Resident #18's G-tube prior to medication administration and feeding. This failure could place residents who had gastrostomy tubes at risk for complications, aspiration, and pneumonia. Findings included: Review of Resident #18's face sheet dated 12/03/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (this is a brain condition that progressively destroys memory and other important mental functions), muscle weakness, lack of coordination, adult failure to thrive and gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individuals who have difficulty swallowing). Review of Resident #18's annual MDS assessment dated [DATE] reflected Resident #18 had a BIMS score of 0 out of 15, indicating severe cognitive impairment and was unable to make self-understood by others and she was dependent on staff for all ADLs and required a feeding tube to obtain 51 % or more nutrition. MDS reflected Resident #18 was dependent on staff for all upper and lower bed mobility including turning and repositioning in bed. Review of Resident #18's physician orders dated December 2024, revealed, Resident #18 had a g-tube and to check g-tube placement prior to feeding and/or medication administration, and by aspiration of gastric contents every shift; check for residual every shift. The resident was to receive formula Isosource 1.5 at 45 ml per hour and water flush of 175 ml every 4 hours via g-tube for 22 hours. Formula: Isosource 1.5 at 45 ml/hour X 20 hours. Off at 8AM and ON at 12 Noon. Twice Day 08:00 AM, 12:00 PM. Enteral Feeding: Water flush Special Instructions: Flush g-tube with 30ml of water before and after medication administration every shift. Every Shift: days, evenings, nights. Baclofen tablet; 10 mg; amt: 1 tab; gastric tube special instructions: Give 1 tab via g/tube 3x daily three times a day 09:00 am, 01:00 pm, 06:00 pm. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #18's care plan dated 08/28/24 revealed resident had an enteral feeding tube related to adult failure to thrive. The goal was not to have any problems from g-tube use through the next review date. The interventions were always to elevate head of bed 30-45 degrees, to check residual by aspirating stomach content and to check tube placement by auscultating (listening to) air passage. During an observation and interview on 12/03/24 at 12:08 pm., Resident #18 was in bed with feeding disconnected. RN H administered 30 ml of water, via Resident #18's g-tube. She then administered medication Baclofen, and then another 30 ml of water after medication administration. RN then attached the formula feeding tube to Resident #18's g-tube and restarted the feeding pump. RN H did not check Resident #18's g-tube placement before administering water, medication, and/or feedings. RN H stated she turned off Resident #18's feeding at 08:00 AM for ADL care. RN H stated ADL care included bed bath, incontinent care, oral care, and linen change. RN H stated she listened to Resident #18's g-tube placement and checked the residue this morning before turning it off at 08:00 AM. She stated she forgot to re-check the g-tube placement before medication administration again and before restarting feedings. She stated the reason she forgot was because she was nervous being watched. RN H stated it was important to check placement each time the g-tube was accessed to make sure that the g-tube was still in place due to the risk of tube displacement during ADL care and down time which could cause contents to go into the lungs if the g-tube is not in the correct place. During an interview on 12/05/24 at 5:45 p.m., DON stated the orders for Resident #18 indicated to check placement and residual prior to feeding and medication administration. The DON said RN H should have checked for placement for Resident #18. She stated that not checking placement before medication administering and feeding placed the resident at risk for tube migration (movement). She stated the expectation was to check g-tube placement because it might be dislodged while providing care. She stated the risk of not checking placement was you can administer into the peritoneal cavity (membrane that lines the abdomen and pelvis) and cause infection, or they may put medication in the wrong place and cause the resident to get an infection in the stomach. The DON indicated she expected the nurses to follow the physician orders, and it was the nurse's responsibility to follow orders as prescribed. The DON stated RN H had completed g-tube competency prior to taking care of residents with g-tubes and she had done a 1:1 Inservice after this incident. In an interview with the Administrator on 12/05/24 at 6:14pm., he stated even though he was not clinical, he expected the nursing staff to follow proper policy and procedure, to have job knowledge, and to know the proper channel to go to like the DON or ADON in case they did not know how to do something. He stated the risk to the resident for not following proper procedures can be pretty harmful. Review of facility clinical competency reflected RN H completed check off for g-tube medication administration competency on 10/31/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Administering Medication through an Enteral Tube, dated 08/26/22 reflected . The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube Verify that there is a physician's medication order for this procedure . Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed) . Confirm placement of feeding tube. 19. If you suspect improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician. 20. Check gastric residual volume (GRV) to assess for tolerance of enteral feeding. 21. When correct tube placement and acceptable GRV have been verified, flush tubing with 15-30 mL warm water (or prescribed amount) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for one of four residents (Resident #7) reviewed for storage of medication. The facility failed to ensure Resident #7's blood pressure patch medication Clonidine was secured by CMA F and not let unattended on top of the medication cart. This deficient practice could place residents at risk of accidental ingestion of unprescribed medications and adverse reactions. The findings included: Review of Resident #7's face sheet on 12/04/24 revealed a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included unspecified dementia (this is a brain disease that alters brain function and causes a cognitive decline), high blood pressure, and stroke. Review of Resident #7's active physician order for December 2024 revealed Clonidine patch weekly; 0.1 mg/24 hr; amt: 1 patch; transdermal Special Instructions: Apply patch to chest wall once weekly. Remove old patch prior to applying new patch. Rotate sites Once a Day on Wed 08:00 AM. Review of Resident #7's annual MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15 indicating Resident #7 had moderate cognitive impairment. Review of Resident #7's care plan dated 10/23/23 revealed resident had malignant hypertension (this is a condition that can cause blood pressure to suddenly and severe increase and can lead to heart attack, stroke, and other life-threatening problems). The goal was for Resident #7's blood pressure would range between - greater than 90/less than140 systolic (top number of blood pressure reading) and less than 90_diastolic (bottom number of blood pressure reading). The intervention was to administer medication as ordered, to evaluate/record/report effectiveness or adverse effects, to administer oxygen for shortness of breath or oxygen less than 90% room air, to assess for chest pain and intervene as indicated. During medication observation on 12/04/24 from 07:56 AM to 08:15 AM., CMA F was observed leaving medication Clonidine patch 0.1 mg on top of the medication cart. A staff member was observed passing by the medication cart. CMA F could not see the medication cart due to the privacy curtain in Resident #7's room. The medication cart was unattended and out of view. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Irving Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 619 N Britain Rd Irving, TX 75061	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CMA F on 12/04/24 at 08:15am., she stated the Clonidine patch was used to treat high blood pressure and she should have locked the medication in the medication cart since the medication cart was out of view or she could have taken the medication in the room with her. She stated that she left the medication on top of the medication cart by accident. CMA F stated anyone could have taken the medication that was left unattended. She said the resident could eat it and have adverse effects to the medication like low blood pressure. She stated it was her responsibility to lock and secure medication when not in use and when unattended. CMA F stated, it was an honest mistake that she forgot to lock up or take the medication with her. In an interview with the DON on 12/04/24 at 08:18 am., she stated the expectation was for the person to take the medication inside the room or to lock it in the cart. The risk was that a resident or anyone could take it. She stated that she would in service the staff. She stated that she had done a medication check off twice since CMA F had been employed by the facility. Review of the facility's policy titled Medication Storage, dated 08/26/22, reflected: The facility shall store drugs and biologicals in a safe, secure, and orderly manner . Drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications, . Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 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. The facility failed to ensure food items in dry storage were dated, labeled, and securely stored. The facility failed to ensure frozen and refrigerated food items were dated, labeled, and securely stored. The facility failed to ensure that a metal container of butter was covered to avoid risk of contamination. A pastry brush was left inside the melted butter container. The facility failed to ensure that prepared foods were held correctly and maintained safe temperatures. The facility failed to ensure that prepared foods were free of cross-contamination risk. The facility failed to ensure that dishwashing protocol was followed. The facility failed to ensure that food temperatures on the steam table were taken and logged according to food service policy. The facility failed to ensure clean dishware was stored in a clean, dry location and not exposed to other contaminations by splash, dust, and other means. The facility failed to ensure bleach was stored away in the janitorial closet. The facility failed to ensure the ice machine was cleaned. The facility failed to dispose of expired foods in the dry storage room. The facility failed to ensure bulk storage containers for dry foods were not kept under the preparation table open and had lids that were clean. The facility failed to ensure personal items were not being stored in the dry storage closet. These failures could place residents at risk for foodborne illnesses and foodborne intoxication. Findings included: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 8:37 AM upon entry to the kitchen with the Dietary Manager revealed the following: A bag of open bread was on the food preparation counter with the date [DATE]. The steam tray table was open and held pans of breakfast food items, including eggs, bacon, and biscuits, that were uncovered. Parts of the steam table had no pans being held in it and showed the conditions of the grates that held the water for steaming. The spillage pans appeared to have had an accumulation of dark, fuzzy debris covering the water and inside of the container. The griddle on the stove top had an uncovered metal container with melted butter and pastry brush inside of it with a wrapper from a stick of butter under it. The kitchen preparation counter had an opened bottle of ketchup on it without a date or label. The ketchup was room-temperature and had a dark red brownish color. And a container of food thickener without a label to clarify the reason for the date written on the lid. The date written on the lid needed some clarification. Under the kitchen preparation counter, there were four large white storage containers with lids. Two containers had lids that were not sealed and not labeled. One container had a sealed lid with a rag on top of the lids and labeled flour. All containers were dirty with brown- and yellow-colored dried stains of unknown substance on the lids, brown and black patches of stains were noted on the sides of containers. Observation on [DATE] at 9:04 AM of walk-in refrigerated food items revealed the following: One container of cottage cheese dated [DATE] and one container of cocktail sauce dated [DATE] had no use by date. A pitcher of red liquid was undated and unlabeled. Cooked sausage patties wrapped in foil were undated and unlabeled. A clear bag with pureed sausage was undated and unlabeled. A clear bag with eggs was undated and unlabeled. Observation on [DATE] at 9:09 AM of frozen food items in the freezer revealed the following: Frozen food items pancakes, fries, and hash browns were undated and unlabeled One bag of frozen vegetable egg rolls was unsealed and, in a box, dated [DATE]. One bag of frozen chicken breasts was unsealed and, in a box, dated [DATE]. One bag of frozen vegetables opened and resealed in saran wrap, not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 9:09 AM with the Dietary Manager revealed labels did not stick to frozen items. He also stated that using a marker did not work due to the ink being wiped away when touched. Observation on [DATE] at 9:12 AM of the dry storage closet revealed the following: Dry food items that had been opened, including cereals and seasoning mix, were not labeled with a date of opened on nor use by. Red potatoes were stored in a plastic bin without a lid. The bin was labeled potatoes [DATE]X and check for freshness daily. The red potatoes showed signs of sprouts growing out of the potatoes. A box of gallon-sized jugs of bleach was stored on a bottom shelf next to a crate of serving utensils exposed to air in the dry storage closet with food items. A black jacket and a green backpack hung on the food shelf next to exposed paper napkins and open Styrofoam cups. Interview on [DATE] at 09:22 AM with [NAME] A he stated the jacket and purse belonged to kitchen Aide C. He stated he did not know why the jacket and bag were stored in the dry food storage. He stated some staff did not like to leave their things out in the kitchen and he said, I do not steal. [NAME] A stated the bleach was placed in the dry food storage because he did not know where it belongs. He stated, If this was my kitchen bleach would not be in the kitchen at all. [NAME] A stated bleach should not be stored next to food for risk of it spilling and contaminating food. [NAME] A stated all kitchen staff were responsible for labelling and dating the food. He said that all the food that came in during delivery had to have a receive date on it. [NAME] A said all kitchen staff were responsible for cleaning out any expired foods including the potatoes that had wilted and sprouted. He stated he did not do it because he was off on the weekend, and he did not work yesterday. Interview on [DATE] at 09:32 AM with Kitchen Aide C, she stated the coat hanger outside the dry food storage area is usually full, so she keeps her personal items in the dry food storage room. She stated that she should have put her items in the breakroom or on the coat hanger outside. She stated the risk of having her jacket and bag in the dry food storage was cross contamination. Kitchen Aide C stated when she did not know where to store something like bleach, she would ask her manager or take it to his office. Interview with Dietary Manager on [DATE] at 09:34 AM, he stated he had placed the bleach in the dry food storage and forgot to move it. He stated the bleach and other cleaning products go into the Maintenance closet or he will take it to the laundry room for storage. He said the kitchen is very small and they have limited storage space. However, it was an oversight that he got busy and forgot to move the bleach from the dry food storage. The Dietary Manager stated the risk for having bleach in dry food storage was that fumes could leak and contaminate the food in the pantry. The Dietary Manager said some of the staff in the kitchen had had their stuff stolen and that was why they kept their items in the dry food storage room. He stated the expectation was that all personal items were stored on the coat hanger or in the breakroom. He stated potatoes were still good to eat. He said last week some that were wilted were thrown away by [NAME] B. He stated everything should be labelled with date of delivery, then a use by date after opening. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 9:24 AM of the dishwashing area (referred to as dish room by dietary manager) revealed the following: The low-temperature dishwashing machine temperature gauge read 103 degrees Fahrenheit when running. The temperature inside the dishwashing machine was not checked during the cycle. The 1st-compartment contained used dishes, without a washing solution to soak dishes. The 2nd-compartment sink had water running, with no drain stopper to hold water in the compartment to rinse dishes. The 3rd compartment for sanitizing dishes, and after rinsing dishes, contained a water and sanitizer solution. The drainpipe under the 3-compartment sink had water running through it and into the floor drain. The drain appeared to have bacteria and dirt built up around it. The pipe did not reach into the floor drain. The water that ran through the pipe splashed when it drained into the floor ' s drain. The floor's drain cover was not in place. The temperatures and chemicals ppm for the 3-compartment sink had not been logged for the month of [DATE]. Cleaned dishware was stored on metal shelves and uncovered in the dishwashing area. Observation and interview on [DATE] at 9:38 AM of [NAME] A cleaning the steam table revealed the following: Breakfast foods had been removed from the steam table. Surveyors had observed [NAME] A using a liquid solution in a clear container to clean the steam table. In regard to if [NAME] A had used the sanitary solution in the standard red sanitary bucket used to clean kitchen equipment and preparation areas, he responded, I'd be the stupidest dietary manager to use sanitary water for this (pointing to the steam table). No, it ' s not the same (referring to the cleaning solution he used not being the same as the solution in the sanitary buckets). [NAME] A further informed surveyor he used a pot and pan cleaning solution. Observation and interview with the dietary manager and housekeeper on [DATE] at 10:32 AM of the ice machine revealed the following: The ice machine had water marks on the outside. The dietary manager unlocked the ice machine. Inside of the ice machine had a dark moldy/mildew like substance on the left side. Slimy substance was observed across the back where ice fell out of the machine. The ice machine appeared dirty and was full of ice. The dietary manager stated that housekeeping was in charge of cleaning the ice machine. At that time, the housekeeper had walked by and housekeeper was not aware that she was responsible for cleaning the ice machine, she stated, Oh, I guess it is my responsibility. She stated that she had never cleaned the ice machine, but she would notify maintenance to empty it since she could not do it herself and she would then clean it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further Observation on [DATE] at 3:37 PM of the kitchen revealed the following: Turkey deli meat had been placed in a plastic container and sat on the food preparation countertop. Later observation on [DATE] at 4:47 PM would reveal the same items would remain on the food preparation countertop, uncovered. The metal container with melted butter and a pastry brush remained uncovered and on the stove top griddle. Cook B was washing dishes in the 3-compartment sink. The 1st compartment had a washing solution and dishes in it. [NAME] B rinsed dishes under running water through the faucet in the 2nd compartment, the compartment was not full of rinse water. In the 3rd compartment, [NAME] B used the sanitizer dispenser tube to distribute and cover the rinsed dishes in sanitizer. [NAME] B then placed the sanitized dishes on the bottom of the 3rd compartment sink. There was not a sanitizing solution in the 3rd compartment. Interview on [DATE] at 3:50 PM with [NAME] B revealed she placed the dishes in the 1st-compartment to soak and wash off dishes. She then used the 2nd-compartment to rinse the dishes, using the faucet. After rinsing the dishes, she used the 3rd compartment to sanitize the dishes by using the sanitizer dispenser tube and placed them in the 3rd-compartment to dry. Then the dishes were washed again in the low temperature dish washer. Interview on [DATE] at 4:05 PM with the Dietary Manager revealed how to turn the sanitizer dispenser on, and the tube dispensed sanitizer that could be used to cover the dishes. He stated he didn ' t always dilute the sanitizer and would use the tube because the sanitizer was dispensed with water and diluted. The dietary manager stated that after dishes were washed using the 3-compartment sink, they were not washed again in the low-temperature dish machine. Observation on [DATE] at 4:10 PM of the low-temperature dish machine revealed the thermometer gauge attached to the machine continued to show the water temperature as 103 degrees Fahrenheit. The correct sanitizing chemicals matched the required PPM. The dietary manager ran the dish machine ,d+[DATE] times to test the water temperature. The dietary manager then used a digital thermometer to test the temperature in the dishwasher. The digital thermometer read the temperature to be 126 degrees Fahrenheit, further finding dish machine thermometer gauge appeared broken as it did not change or move according to the change in temperature. Tthe dish washer ran 3 times and the gauge remained at 126 F, not matching the thermometer gauge. Observation on [DATE] at 4:12 PM of steam table temperature checks revealed the following: Cook B used a digital thermometer to check temperatures of foods held on the steam table. Mashed potatoes, peas and carrots, and pureed mashed potatoes at temperatures above 135F. Pureed chicken temperature read 133.5 F and Chicken strips temperature read 132.8 F. When [NAME] B used the digital thermometer, she had laid the thermometer against the side of the metal food pans and touched the probe to the bottom of the metal food pans and measured the temperatures of the metal pans. Observation on [DATE] at 4:47 PM of kitchen revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Turkey deli meat remained on the kitchen preparation countertop. The metal container of butter remained on the stove top griddle, uncovered. Baked biscuits on a sheet pan sat uncovered and on top of the steam table since 3:37 PM. Observation and interview on [DATE] at 4:51 PM with [NAME] B and the Dietary Manager revealed the butter was used on foods like the biscuits that were baked. The container was cleaned once a day every day and new butter was put in it in the morning. [NAME] B temperature checked the turkey deli meat, temperature read 56.4F. [NAME] B rechecked the steam table foods. Pureed chicken temperature read 161.2F. The chicken strip temperature read 126.3F. [NAME] B and the Dietary Manager stated the temperature to be around ,d+[DATE]F. [NAME] B placed the chicken strips in the oven to reheat them to meet the required minimal temperature. [NAME] B stated the lunch meat should be around 40F. The dietary manager stated that [NAME] B was going to make sandwiches but was distracted by having to take temperatures and discarded the deli meat. Observation revealed bristles, from the pastry brush used for butter, on the uncovered biscuits on top of the steam table. [NAME] B stated its spots were normally on the biscuits when frozen. After further discussion, [NAME] B confirmed it was pastry brush bristles. The dietary manager stated that it looked like the bristles from the pastry brush. He then discarded the biscuits. The dietary manager and [NAME] B responded with residents would be at risk for foodborne illness regarding food temperatures not meeting range and biscuits containing butter from the butter left out on the food preparation counter. Interview on [DATE] at 1:41 PM with the Dietitian revealed she was at the facility once a month for , d+[DATE] hours. During that time, she would conduct a kitchen audit by observing the cleanliness, temperature logs of foods, fridge, freezer, and dishwashing area. She stated that in the past she had noticed concerns, like those found during observations. However, she had found no issues with temperature logs. She shared her expectations on temperature levels for hot and cold foods, temperature check process, foods held on the steam table, labeling, storage of foods and chemicals, dish washing process, ice machine cleaning, and cleanliness of the kitchen. The dietitian stated that she didn ' t typically do in-service training, and the dietary manager was responsible for doing them. She stated she had done in-service for labeling and dating foods, and temperature logging because they had been issues. She stated she provided the dietary staff with results of her audits and for issues to be resolved. She said If in-service was not followed, she would talk with staff about room for improvement and what she could do to help implement changes. The dietary manager was responsible for following up with her. Interview on [DATE] at AM with Kitchen Aide E revealed the role and responsibilities was divided between the dietary manager, the cooks, and the kitchen aides. Kitchen Aide E explained that food items without labels and dates could be a problem because it was unknown how old the item was. He stated that chemicals should be kept in the closet with other chemicals outside the kitchen. He confirmed that he had seen the large containers of ingredients under the kitchen preparation counter. Kitchen Aide E confirmed the protocol for the 3-compartment sink and low-temperature dish machine but was unsure of the reasons for testing the ppm for chemical solutions. Kitchen Aide E stated no one has asked him to clean the ice machine but he had volunteered ,d+[DATE] months ago. Kitchen Aide E explained the correct process of temperature checking foods and why it must be done that way. He explained the importance of meeting required temperatures and solutions for temperatures that were not within a safe range. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Dietary Manager on [DATE] at 10:28 AM revealed the expectation of staff was to label food items by use by day and expiration. He stated food in the fridge that was old, like lettuce, to toss it out. The Dietary Manager stated if something wasn ' t labeled, to toss it out, as it was uncertain how long the food item was in the fridge for. He stated dates and labels were important to know freshness of food and to avoid using old foods, as old food used could cause harm to residents. The Dietary Manager stated cleaning chemicals should be in chemical closet. He stated staff were sidetracked on that day and left the chemicals in dry storage closet. He stated the risk was if the cap to the bottle of chemicals wasn ' t on and was open, the vapor and fumes could seep into foods or if cooking, could infuse with foods. Residents could get sick by that too. The Dietary Manager stated bleach was used for floors and for areas where dirt and grime was hard to get off. The Dietary Manager stated the dry storage bin should have been wiped down and cleaned and dust free to look presentable. He stated if there are dry foods (rice, flour, sugar), it was important to keep clean and secure to avoid getting something like dust and liquids on them. He stated the cook was normally responsible for the storage bins. The Dietary Manager stated the butter bristle appearing on the biscuits happens from the brush being cleaned, and he had since gotten a rubber, silicone brush. He stated the expectation of staff was to clean the steam table after every meal or at the end of the day. He stated staff often clean when the steam table was not in use or when making cold meals. He stated the risk of a dirty steam table was the water could get dirty and contaminated which would cause the steam to be hazardous, and the steam table could potentially not work well. The Dietary Manager stated he did not do an in-service with staff regarding the steam table lately but stated his staff know how to clean the steam table. He stated, after serving, the steam table should be kept on for about ,d+[DATE] minutes after serving. He stated food should be covered when not serving since anyone could cough in it and dust could get into food. He stated he would want to keep food hot and warm at temperature. The Dietary Manager stated the risk of food if not tested correctly was food could be uncooked or cold if not reaching proper temperature. There would be a risk of foodborne illness. He stated worst-case scenario could lead someone into going into the hospital and passing away. The Dietary Manager stated he expected staff to first rinse dishes (that were not going into the low-temperature dishwasher) in the 3-compartment sink before dipping them into water to submerge them and put sanitizer in the sink. Afterwards, the pans and other dishware were left to dry. He stated staff were to follow guidelines, fill the sink with water and use sanitizer. He stated staff were supposed to test the sanitizer and ppm to make sure it was not too high. The Dietary manager stated when the sanitizer was dry, it would evaporate and not too much would be on dishes and (residents) would not be eating off sanitizer. The Dietary manager stated too strong sanitizer could potentially be still on the dishes and could cause food to taste weird. He stated pure, undiluted sanitizer should not be poured on dishes as it could cause someone to get sick. He stated he would tell staff guidelines for washing dishes in the low-temperature dishwasher. He stated the instructions were right there. The Dietary Manager stated he had not trained them on using thermometers for water, one digital and 3 standards. He stated the risk of not knowing how to take the temperature of the low-temp dishwasher was dishes would not get thoroughly cleaned, risking bacteria on plates. He stated someone could get sick if they eat off it, maybe something worse, sickness could spread back into kitchen. The Dietary Manager stated he was not aware dietary was to clean inside of the ice machine, only outside. He was not sure of what chemicals to use. He stated the ice machine dated back to [DATE] when the ice was removed, and the machine was cleaned. He told his staff yesterday he was not aware it fell on them to clean it. The Dietary Manager stated when it came to food items in the freezer, it was hard to get labels or markers to stick to them, which was why some labels were missing. The Dietary Manager stated he was responsible for in-servicing staff for cleaning the kitchen, including the sink and drain. He stated he didn ' t do this due to lack of staff. He stated the risk was bacteria, mold, and critters could appear in the sink and lead to illness. The Dietary Manager stated food in the refrigerator, if used, could only be kept three days after first opened before it should be tossed away. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Administrator on [DATE] at 6:14 PM, revealed his expectation for the kitchen was for it to be clean and sanitary. He stated, if you have good food, good care, and good activities there is nothing to complain about. He stated he had a dietary background, and he did not appreciate a dirty kitchen. He stated they were going to have an overnight kitchen scrub pizza party and that they bought a water pressure washer to clean the kitchen. He stated the chemical should never be kept where the food was. He stated he did not know what the risk of the sanitizer not being diluted was, but he knew the process and it should be diluted and tested . The administrator stated the food service director (referring to Dietary manager) was responsible for making sure those things were done; it's his goal to run a safe, clean kitchen. He did not know why the dietary manager did not follow the Dietitian recommendations when she audited the kitchen. He stated he couldn 't say why the recommendations from the dietitian audits from September were not done. He stated in the future, they would be coming together and meet with the Dietitian and set dates for when things should be done/corrected. He stated the risk of what was described to him (dish washer temperature not working, incorrectly measurement of food temperatures, personal items in kitchen, food undated and unlabeled, bulk containers with stains and dirty, steam tray table food left open and missing lids, slimy rusted steam table water, chemicals in dry food storage, incorrect sanitization and dirty moldy ice machine) to the resident was the resident not getting the proper care and they could get infections from the dirty sinks. He stated cleanliness was next to godliness. Record Review of kitchen audit titled Quality Assurance Monitor 1 completed by the Dietitian on [DATE] recommendations revealed No sanitization bucket in use, prep area with no lid there appear to be mold in the ice machine .pork tips thawing on counter .turkey slices in fridge open, unlabeled .receive dates not on all items .No use by dates on open items, not all open items covered properly, many items missing receive by dates .no temperature logs for this week . Record Review of kitchen audit titled Quality Assurance Monitor 1 completed by the Dietitian on [DATE] recommendations revealed . Dirt or mold inside ice machine .Right side of plate warmer not working vegetables with no label/date (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675374	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irving Nursing and Rehabilitation	619 N Britain Rd Irving, TX 75061

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility ' s Nutrition & Foodservice Policy and Procedures Manual for Long-term Care, dated 2018, revealed, .To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated . Where possible, leave items in the original cartons placed with the date visible . Store all items at least 6 above the floor with adequate clearance between goods and ceiling to protect from overhead pipes and other contamination .Do not use or store cleaning materials or other chemicals where they might contaminate foods. Label and store them in their original containers when possible. Store in a locked area away from any food products .Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage Use all leftovers within 72 hours. Discard items that are over 72 hours old . Store frozen foods in moisture-proof wrap or containers that are labeled and dated . Use clean, sanitized surfaces, equipment and utensils .Take temperatures throughout the preparation process to ensure that food is safe .Cook comminuted meat (such as hamburger) products thoroughly to heat all parts of the meat to a minimum temperature of 155 F for at least 15 seconds .Heat stuffing and poultry throughout to a minimum temperature of 165 F for at least 15 seconds .Cook raw animal products such as eggs, fish, lamb, pork or beef, except roast beef, and foods containing these raw ingredients to an internal temperature of 145 F or above for at least 15 seconds . Prepare cold foods no further in advance than necessary .Prepare cold foods in small batches and place in cold storage immediately .Prepare potentially hazardous foods, such as meat and poultry salads, potato and egg salads and cream-filled dishes using only chilled products that have been refrigerated below 41 F. Prepare foods immediately upon removing the products from the refrigerator and immediately refrigerate after preparation .Maintain all cold prepared items at a temperature of 41 F or below until ready to serve. Do not remove from refrigeration until ready to serve . If a potentially hazardous food is not at the proper temperature, further investigation is required to determine how long the food has been outside the safe temperature zone to determine if it is safe to restore the food to the correct temperature. If food has been outside the safe zone for over 2 hours, discard the food immediately. If food has been outside the safe zone for less than 2 hours, reheat per guidelines . Clean and sanitize all food preparation areas, food-contact surfaces, dining facilities and equipment. After each use, clean and sanitize all tableware, kitchenware and food-contact surfaces of equipment, except cooking surfaces of equipment and pots and pans that are not used to hold or store food and are used solely for cooking purposes . Keep food-contact surfaces of all cooking equipment free of encrusted grease deposits and other accumulated soil . Clean and rinse immediately prior to use, moist cloths used for wiping food spills on kitchenware and food-contact surfaces of equipment. Clean frequently during use in a sanitizing solution and do not use for any other purpose. When not in use, hold in a sanitizing solution of the proper concentration (100 ppm Chlorine, 200 ppm Quaternary Ammonia, or 25 ppm Iodine) . Store toxic chemicals away from food products and be sure they are properly labeled . The Nutrition & Foodservice Manager will develop a cleaning schedule for daily, weekly and monthly cleaning . Use a three-compartment sink with running hot and cold water for cleaning, rinsing and sanitizing . In the first sink, immerse the equipment or utensils in a hot, clean detergent solution at a temperature of no less than 120 F . Rinse in the second sink using clear, clean water between 120 F and 140 F to remove all traces of food, debris and detergent . 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: . a. Immerse for at least 30 seconds in clean, hot water at a temperature of 170 F or above. When hot water is used for sanitizing, the facility must have and use: i. An integral heating device or fixture installed in, on, or under the sanitizing compartment of the sink capable of maintaining the water at a temperature of at least 170 degrees Fahrenheit and ii. A digital or numerically scaled indicating thermometer, accurate to plus or minus three degrees Fahrenheit convenient to the sink for frequent checks of water temperature. Immerse for at least 60 seconds in a clean sanitizing solution containing: A minimum of 50 parts per million of available chlorine at a temperature not less than 75 F or ii. A minimum of 12.5 parts per million of available iodine in a solution with a pH not higher than five and a temperature not less than 75 F or iii. Any other chemical sanitizing agent which has been 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 F. The concentration and contact time for quaternary ammonium compounds

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irving Nursing and Rehabilitation	619 N Britain Rd Irving, TX 75061

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the U.S. FDA Food Code 2022 reflected: . C. Packaged Food shall be labeled as specified in LAW , including 21 CFR 101 Food Labeling [* .(b) A food which is subject to the requirements of section 403(k) of the act shall bear labeling, even though such food is not in package form .9 CFR 317 Labeling, [*(a) When, in an official establishment, any inspected and passed product is placed in any receptacle or covering constituting an immediate container, there shall be affixed to such container a label .Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S ,d+[DATE].18. Section ,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food: Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, her [TRUNCATED]

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NAME OF PROVIDER OR SUPPLIER Irving Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 619 N Britain Rd Irving, TX 75061	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 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 1 of 2 (Resident #18) residents reviewed for enhanced barrier precaution infection control. The facility failed to ensure RN H wore a gown for PPE while providing care to Resident #18 who was on enhanced barrier precaution. This failure could place residents that require assistance with personal care at risk for healthcare associated cross-contamination and infections. Findings included: Review of Resident #18's face sheet dated 12/03/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (this is a brain condition that progressively destroys memory and other important mental functions), muscle weakness, lack of coordination, adult failure to thrive and gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individuals who have difficulty swallowing). Review of Resident #18's annual MDS assessment dated [DATE] reflected Resident # required a feeding tube to obtain 51 % or more nutrition. Review of Resident #18's physician orders dated December 2024, revealed, Resident #18 reflected Enhanced Barrier Precautions for Wound and G-Tube: Gown and gloves for High contact. Every shift Days, evening, Nights. Review of Resident #18's Care Plan initiated 10/22/24, revealed Resident #18 was on Enhanced Barrier precautions related to feeding tube and wound to lower extremity. The goal was for enhanced barrier precaution would reduce the risk of transmission (spread) of known and unknown MDRO. The interventions were to alert the provider for signs and symptoms of an active or worsening infection, to wear EBP which included use of gowns and gloves during high contact resident care, EBP to remain in place for the duration of the resident's stay OR until resolution of the wound or removal of the indwelling medical device, and EBP will be utilized during High-Contact resident care activities including bathing, dressing, and transfer, linen changes, incontinent care, wound care and/or indwelling device care. During an observation and interview on 12/03/24 at 12:08 pm., for Resident #18, revealed door signage read . STOP Enhanced Barrier Precautions. Everyone must clean their hands before entering the room and when leaving the room. Providers and staff must wear gloves and gown for the following: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use such as; central lines, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN H did not wear a gown for PPE while providing g-tube care for Resident #18 who was on enhanced barrier precaution isolation. RN H stated, I do not wear a gown for G-tube care, I wear a gown when providing wound care for the resident. RN H did not respond when asked if g-tube was considered an indwelling medical device and PPE should be worn. RN H did not state the risk for not following enhanced barrier precautions. During an interview on 12/05/24 at 5:45 p.m., the DON stated she was also the infection control preventionist. She stated all nursing staff were expected to follow EBP when providing care for residents with indwelling medical devices and that included g-tube care. She stated RN H may have misunderstood the EBP questions when surveyor asked her due to communication barrier. DON stated nursing staff are responsible for making sure that they follow the policy of preventing the spread of infection. The DON stated that not following infection control precautions can cause spread of infection. She stated she had done a 1:1 Inservice after the incident. In an interview with the Administrator on 12/05/24 at 6:14pm., he stated even though he was not clinical, he expected the nursing staff to follow proper policy and procedure, to have job knowledge, and to know the proper channel to go to like the DON or ADON in case they did not know how to do something. He stated the risk to the resident for not following proper procedures can be pretty harmful. Review of the facility's Implementation of Standard and Transmission-Based Precautions policy, dated 03/24, revealed, .EBP are indicated for residents with any of the following: 1. Infection or colonization with a CDC-targeted MDRO .Wounds and/or indwelling medical devices even if a resident is not known to be infected or colonized with a MDRO .post signage .high-contact resident care activities requiring gown and glove use .