STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675439	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mullican Care Center	105 N Main St Savoy, TX 75479

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 16 residents (Resident #17) reviewed for grievances. The facility did not ensure a grievance was filed and Resident #17 was appropriately apprised of progress toward a resolution when Resident #17 reported to the Administrator that she was missing her $250 from her room on 1/31/25. This failure could place residents at risk for a decreased quality of life, and grievances not being addressed or resolved promptly. Findings included: Record review of Resident #17's face sheet dated 05/29/25 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with diagnoses of high blood pressure, chronic obstructive pulmonary disease (a disease in which the pulmonary system has limited airflow), anxiety, and congestive heart failure. Record review of Resident #17's quarterly MDS dated [DATE] indicated she made herself understood and was able to understand others. The MDS also indicated she had a BIMS score of 15 which meant she was cognitively intact. Record review of Resident #17's care plan dated 05/19/25 indicated she required supervision with ADLs. The care plan also indicated she made negative statements about staff and false allegations with interventions for the social worker and staff to listen to her concerns and encourage resident to attend activities to occupy her mind. Record review of the facility grievances dated 11/01/24-05/27/25 indicated there was not a grievance filed for Resident #17 on 01/31/25. (continued on next page)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/25 at 10:10 AM Resident #17 said she told the facility Administrator she was missing the $250 and she did not feel the facility believed her. Resident #17 said someone had just taken it from her wallet in her room. Resident #17 said she usually kept a percentage of her money in her wallet and now the facility has given her a lock box to keep her money in for it to be safe. Resident #17 said she was keeping a percentage of the money she was getting from the facility and was saving it to get her some new clothes. Resident #17 said she had not had any more issues with her money coming up missing since the incident. She said the facility staff looked everywhere for the money, but it was not found . During an interview on 05/29/25 at 09:41 AM the Social Worker said she did not handle the missing money for Resident #17 because it was out of her scope with the amount of money. The Social Worker said grievance forms should have been filled out when the incident was reported in order for the staff to follow up with the issues noted. She said without the form others would not be aware of what had happened with Resident #17's missing money but it was not a grievance she completed. The Social Worker said the failure placed risk for staff not knowing if this was a reoccurring incident. She said Resident #17 has had issues with having false allegations. The Social Worker said Resident #17 gets money monthly, but she buys snacks and other things. During an interview on 05/29/25 at 09:51 AM the DON said all the Administrator did, related to Resident #17 was to let her know that Resident #17 was missing the money, and the administrator called the police. She said Resident #17 talked to the police and the officer asked her about pressing charges and Resident #17 said no. The DON said they normally would not fill out a grievance since it was reported to the state and the facility provided Resident #17 a lock box for the future since she carries her own money. During an interview on 05/29/25 at 10:20 AM Administrator said Resident #17 came to him and told him she was missing her money. The Administrator said she told him she was saving the money for clothing. He said he called the police, and Resident #17 did not want to press charges. The Administrator said he talked to the staff to see if any were aware of the missing money. He said he could not determine if she had that much money or not. The Administrator said after the incident the facility got her a lock box to place in her room. The Administrator said the facility did typically complete the grievance forms for the missing money and the importance was to ensure the resident needs were being met. He said the failure placed risk for others not knowing if an incident even occurred or resolved. Record review of the facility policy Resident Rights dated 11/28/2016 indicated: The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy .Grievances. 1. The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination .4. The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding residents' rights contained in this paragraph. Upon request the provider must give a copy of the grievance policy to the resident .e. Ensuring that all written grievance decision include the date the grievance was received, a summary of thee statement of the resident's grievance, the steps taken to investigate the grievance and the summary of pertinent findings or conclusions .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to coordinate assessments with the PASRR program to the maximum extent practicable to avoid duplicative testing and effort for 1 of 5 residents (Resident #34) reviewed for PASRR. The facility failed to coordinate quarterly PASRR IDT meetings to discuss specialized services with the PASRR Coordinator for Resident #34. This failure could place residents with positive PASRR status at risk of not receiving specialized services which would enhance their highest level of functioning and could contribute to residents decline in physical, mental, and psychosocial well-being. Findings included: Record review of Resident #34's face sheet dated 05/29/2025 indicated he was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included schizoaffective disorder (mood disorder that can include depression, delusions, hallucinations, disorganized thoughts, speech and behavior) and major depressive disorder, recurrent (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks). Record review of Resident #34's Comprehensive MDS assessment dated [DATE] indicated Resident #34 understood others and was understood. The MDS assessment indicated Resident #34 was considered by the state level II PASRR process to have serious mental illness. The MDS assessment indicated Resident #34 had a BIMS score of 14, which indicated his cognition was intact. Record review of Resident #34's care plan reviewed 05/27/2025 indicated, he had mental illness and was PASRR positive. Resident #34's goal indicated he would have the specialized services recommended by the local authority per PASRR specialized services program as needed. Resident #34's interventions indicated the local authority would be invited annually to the care plan meeting for review of specialized services. Record review of Resident #34's PASRR Level 1 Screening completed 05/17/2024 indicated there was evidence or an indicator that he had a mental illness. Record review of Resident #34's PASRR Evaluation dated 05/20/2024 indicated based on the Qualified Mental Health Professional Assessment Resident #34 met the PASRR definition of mental illness. The recommended services were not listed. Record review of Resident #34's PCSP Forms indicated the following meetings: On 06/10/2024, an initial IDT meeting was held. The PCSP Form indicated the following specialized services psychosocial rehabilitative services group and individual and routine case management. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/17/2025, a quarterly meeting was held. The PCSP Form indicated the following specialized services were ongoing psychosocial rehabilitative services group and individual and routine case management. This indicated the facility did not conduct IDT meetings quarterly. During an interview on 05/28/2025 at 2:07 PM, the MDS Coordinator said Resident #34's PASRR IDT meetings were not completed quarterly because his Medicaid had lapsed, and he did not qualify for services. During an interview on 05/28/2025 at 3:45 PM, PASRR Coordinator E said the MDS Coordinator had called her earlier today (05/28/2025) to schedule Resident #34's PASRR IDT meeting. PASRR Coordinator E said the MDS Coordinator told her some of his IDT meetings had been missed because there had been a gap in Resident #34's Medicaid. PASRR Coordinator E said when a resident lost Medicaid and then regained it an IDT meeting should be conducted when they regained their Medicaid. PASRR Coordinator E said IDT meetings should be conducted quarterly, and the facility reached out to coordinate them. During an interview on 05/29/2025 at 8:57 AM, the BOM said Resident #34 had a lapse in his Medicaid between 02/01/2024-07/31/2024, and his Medicaid had picked back up again on 08/01/2024. During an interview on 05/29/2025 at 9:06 AM, the MDS Coordinator said she was responsible for coordinating PASRR services and ensuring the quarterly IDT meetings with PASRR were conducted. The MDS Coordinator said Resident #34's IDT meetings with PASRR should be done quarterly. The MDS Coordinator said they were not scheduled quarterly because his Medicaid had lapsed, and if the residents did not have Medicaid the meetings could not be done. The MDS Coordinator said she was not aware Resident #34's PASRR IDT meetings were not completed quarterly. The MDS Coordinator said Resident #34 did not miss any of his specialized services. The MDS Coordinator said it was important PASRR IDT meetings to be conducted for the residents to have the best outcome they could have while they were at the facility. During an interview on 05/29/2025 at 10:44 AM, the Administrator said he expected for residents who qualified for PASRR services to have quarterly IDT meetings completed. The Administrator said the MDS Coordinator was responsible for coordinating with the PASRR coordinators. The Administrator said it was important for the residents to have quarterly PASRR IDT meetings to update their condition at the facility and ensure they qualified for services. Record review of the facility's policy titled, Preadmission Screening and Resident Review (PASRR) Survey Requirements 12/4/14 Provider Letter 14-21, did not address the frequency of the PASRR IDT meetings.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #39) reviewed for treatment and services related to indwelling catheters. The facility failed to ensure Resident #39's foley catheter was secured on 05/27/2025. This failure could place residents at risk for urinary tract infections and a decreased quality of life. Findings included: Record review of a face sheet dated 05/28/2025 indicated Resident #39 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of the prostate (prostate cancer) and benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of the prostate which results in difficulty urinating). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #39 understood others and was understood. The MDS assessment indicated Resident #39 had a BIMS score of 12, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #39 required supervision or touching assistance with toileting, showering/bathing, dressing, and personal hygiene. The MDS assessment indicated Resident #39 had an indwelling catheter (tube inserted into the bladder). Record review of Resident #39's Order Summary Report dated 05/28/2025 indicated an order to ensure catheter strap was in place and holding every shift change as needed with a start date of 03/05/2025. Record review of Resident #39's care plan last reviewed 05/27/2025 indicated he had an indwelling foley catheter. Resident #39's goal was for him to show no signs and symptoms of a urinary infection and remain free from catheter related trauma through the next review date. Resident #39's interventions included to ensure the tubing was anchored to his leg or linens so that the tubing was not pulling on the urethra (tube connects the urinary bladder to the external opening of the body). During an observation and interview on 05/27/2025 at 9:58 AM, Resident #39 was in his wheelchair in his room. Resident #39 showed surveyor his foley catheter was not secured to his leg. Resident #39 said it had been unsecured for days. Resident #39 said he had reported it to the staff, but they still had not fixed it. During an interview on 05/28/2025 at 8:39 AM, LVN C said she did not know why Resident #39's foley catheter was not secured. LVN C said the catheters are checked daily by the nurses to ensure they were secured. LVN C said if the catheter was not secured it could cause trauma to the urethra, the catheter could dislodge causing trauma, and the catheter could cause sores from it rubbing the penis. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/29/2025 at 10:08 AM, the DON said the nurses, CNAs, and anybody giving care to the residents should be checking to ensure the foley catheters were secured. The DON said she had not noticed any issues with the foley catheters not being secured, and the nurses should be doing rounds to ensure they had the catheters secured. The DON said it was important for the foley catheters to be secured because they did not want them to pull it out and hurt their urethra. During an interview on 05/29/2025 at 10:40 AM, the Administrator said Resident #39 should have an order for his foley catheter to be secured to his leg, and the nurse was responsible for ensuring it was secured. The Administrator said it was important for the foley catheter to be secured to keep it flowing correctly and where it needed to be, so it was not tugging. Record review of the facility's undated policy titled, Catheter Care, indicated, Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Keep tubing off floor and minimize friction or movement at insertion site. The policy did not further address securement of the foley catheter.

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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** Based on observation, interview and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 6 residents (Resident #28) reviewed for pharmacy services. The facility failed to ensure RN A accurately reconciled Resident #28's narcotic medication log when she disposed Resident #28's clonazepam (controlled medication used for anxiety) tablet on 05/27/25. This failure could place residents at risk for loss of prescribed medications, resident's safety, and drug diversion. Findings included: Record review of Resident #28's face sheet dated 05/28/25, indicated a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included anxiety and gastrostomy status (surgical opening into the stomach for nutritional support and medication administration). Record review of Resident # 28's quarterly MDS assessment dated [DATE], indicated she was rarely/never understood and usually understood others. Resident #28 had short/long term memory problems and her cognition was severely impaired. Resident #28 was dependent on staff on all ADLs and had a feeding tube. The MDS assessment indicated Resident #28 had received an antianxiety medication during the 7-day look back period. Record review of Resident #28's comprehensive care plan revised on 12/19/23, indicated she used antianxiety medications. The care plan interventions included to administer anti-anxiety medications as ordered by the physician. Record review of Resident #28's order summary report dated 05/28/25, indicated she had an order for clonazepam 0.5mg give one tablet via g-tube two times a day related to anxiety with a start date of 10/20/24. Record review of Resident #28's treatment administration record dated 05/01/25-05/31/25, indicated Resident #28 had received one tablet of clonazepam 0.5mg daily at 7:00 AM and 3:00 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/27/25 at 3:23 PM, RN A opened the narcotic box located on the nurse's medication cart and removed one tablet of Clonazepam 0.5mg from the medication card. RN A crushed the tablet and poured it in a medicine cup. RN A proceeded to apply PPE and administer Resident #28's clonazepam via her gastrostomy tube. RN A obtained the narcotic book from under the nurse's station and signed off the clonazepam tablet she administered. There was only 1 tablet of clonazepam 0.5mg left in the medication card. The narcotic record indicated Resident #28 should have had 2 tablets of Clonazepam 0. 5mg tablets remaining. When asked how come the narcotic record indicated there should have been 2 tablets remaining, RN A said she was fixing to administer the tablet when she remembered the state surveyor wanted to observe the medication being administered so she disposed the tablet. RN A said she did not get a witness to the disposal of the medication because she had already disposed the medication and she had panicked. RN A said she had just started at the facility 3 days ago and did not know the policy on narcotic medication disposal. RN A said at previous facilities she was responsible for obtaining a witness when she disposed the clonazepam tablet and failure to do so was a discrepancy. During an interview on 05/29/25 at 09:13 AM, the DON said she expected a witness be obtained when narcotic medications were being disposed. She said the nurse was responsible to get a witness while they were wasting the medication and not after. She said failure to have a witness would lead to a drug diversion. During an interview on 05/29/25 at 09:20 AM, the Administrator said when narcotic medications were disposed, there should be a witness. He said the nurse and nursing administration were responsible for ensuring a witness was obtained when disposing a narcotic medication. He said failure to obtain a witness could lead to a drug diversion. Record review of the facility's undated policy Controlled Medications- Administration, indicated . Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. 6. When a controlled medication is administered, the license nurse administering the medication immediately enters all of the following information on the accountability record: date and time of administration, amount administered, signature of the nurses administering the dose, completed after the medication is actually administered. 7. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. If allowed by your state, they may be destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record on the line representing that dose .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure laboratory services were obtained to meet the needs of 1 of 16 residents reviewed for laboratory services (Residents #4). The facility failed to obtain Resident #4's Keppra level (level obtained to ensure medication is in therapeutic range) as ordered. This failure could place residents at risk of not receiving timely diagnoses, treatment, and services to meet their needs. Findings included: Record review of Resident #4's face sheet dated 05/28/25 indicated a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included dementia (memory loss) and epilepsy (seizures). Record review of Resident #4's quarterly MDS assessment dated [DATE], indicated she was usually understood and usually understood others. The MDS assessment indicated she had a BIMs score of 9, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #4 had a seizure disorder or epilepsy and had taken anticonvulsant medication within the 7-days of the look back period. Record review of Resident #4's comprehensive care plan revised on 04/27/21, indicated Resident #4 had a seizure disorder and was at risk for injury. The care plan interventions included to monitor labs and report any subtherapeutic or toxic results to the medical director. Record review of the Resident #4's hospice admission orders dated 02/22/25, indicated . DC routine labs except Keppra level as ordered. Record review of Resident #4's order summary report dated 05/28/25, indicated she had the following orders: Keppra level every 3 months. **[Hospice] no further labs without prior approval** with an order date of 02/22/25. Keppra 500mg give one tablet 2 times a day related to epilepsy with an order start date of 11/05/24. Record review of Resident #4's progress notes dated 04/28/25-05/29/25, did not indicate Resident #4 had any seizures. Record review of Resident #4's medication administration record dated 05/01/25-05/31/25, indicated she had received one tablet of Keppra 500mg tablet twice daily in the morning and at night. Record review of Resident #4's lab results dated 02/13/25, indicated Resident #4's Keppra level was 35.1 and within therapeutic range. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's lab requisition dated 02/23/25, indicated to discontinue standing orders of HGBA1C, CBC, CMP, and Lipid. The lab requisition did not indicate to discontinue the Keppra level. Record review of Resident #4's lab order report dated 05/06/25 for the Keppra level indicated . cancelled order . draw later- third party with the cancellation reason d/c all labs due to hospice 04/18/25. During an interview on 05/28/25 at 10:01 AM, the Regional Compliance Nurse said they did not have the Keppra level for the Month of May. She said they were redrawing today 05/28/25. She said the lab was cancelled by a third party as per the lab report printed from the lab site. She said she was unsure of how it was cancelled. During an interview on 05/29/25 at 1:50 PM, the Phlebotomist/Processor of the lab company said the phlebotomist assigned to the facility was not available. She said when a lab was preordered, it was listed on the draw report sheet. She said the assigned technician for day would print the draw report sheet, obtain those labs listed and any new labs the facility had completed a requisition for. She said when a lab was cancelled, the requisition with the request to cancel the labs listed was completed. The lab processor said there was a miscommunication somewhere where they were told to discontinue all labs with no clarification the Keppra was to be continued. She said the facility and the lab company were responsible for ensuring the labs were obtained as orders. She said failure to obtain the lab as ordered placed the resident at risk for her levels not to be within range. During an interview on 05/29/25 at 09:13 AM, the DON said she when the lab requisition was filled out to discontinue Resident #4's lab the Keppra level was not included. The DON said Resident #4 was on hospice and the Keppra level was the only lab the hospice continued. The DON said Resident #4 had not had any seizures. The DON said she was unsure as to how the lab delayed the lab draw that day. She said failure to obtain the Keppra level as ordered could cause Resident #4 to have a seizure or her level would not be within therapeutic range. The DON said the nurse was responsible for ensuring the labs were drawn as ordered. The DON said nursing administration should have gone behind the nurse to check the lab was obtained as well. During an interview on 05/29/25 at 09:20 AM, the Administrator said he expected labs to be obtained as ordered. The Administrator said the nurse and nursing administration were responsible for ensuring labs were obtained and labs were not missed. He said the risks depended on lab being drawn. He said by not obtaining Resident #4's Keppra level could place Resident #4 at risk for her levels to be out of therapeutic range. During an interview on 05/28/25 at 2:12 PM, the Regional Compliance Nurse said they did not have a policy on labs.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to provide food that was palatable, attractive and at a safe and appetizing temperature for 1 of 3 meals (lunch) reviewed for palatability and temperature. 1. The facility failed to provide food that was palatable and appetizing temperature for 1 of 3 meals observed on 5/28/25 (lunch) meal. 2. The facility failed to follow puree recipe for lunch meal served on 5/28/25. These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: 1. Record Review of the facility week 1 menu dated on 5/28/25, indicated the lunch meal (A) items included Chicken Parmesan, Bowtie Pasta, Italian Blend vegetables, garlic bread, margarine, chocolate turtle poke cake, and iced tea. During an interview on 5/27/25 at 10:10 a.m., Resident #6 stated most of the times she liked the food. Resident #6 stated the hamburger meat made her stomach upset so she was always asking for alternative meal like a peanut butter and jelly sandwich. During an interview on 05/27/25 at 11:26 AM, Resident #17 said sometimes there was not enough food, and the meat was tough. Resident #17 said, I say you eat with your eyes and sometimes I look at it and say I don't want to eat it, it does not look appetizing. During an observation on 5/28/25 at 12:30 p.m., observations of food temperatures were made on the steam table by [NAME] B. The results were as followed, regular chicken parmesan was 87°F; the regular spaghetti noodles were 166.2°F; the green beans was 149.9°F; the spaghetti sauce was 100. 4°F; the chocolate cake was 72.6°F; the puree chicken parmesan was 109°F; the puree spaghetti noodles was 106.1°F; the puree green beans was 115.5°; the puree garlic bread was 108.1°F and the puree chocolate cake was 54.3°F. During interview and food tasting on 5/28/25 at 1:12 p.m., the Dietary Manager stated the chicken parmesan was no hot but could have been a little warmer; the green beans was bland, needed more seasoning and was cool not warm; the chocolate cake was good; garlic bread was not sampled. During food tasting on 5/28/25 five surveyors stated the chicken parmesan was warm not hot; the green beans was bland; the chocolate cake was good; garlic bread was not sampled. (continued on next page)

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	675439	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mullican Care Center	105 N Main St Savoy, TX 75479

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/25 at 8:24 a.m., the Dietary Manager stated he had been employed for 7 months. The Dietary Manager stated the Administrator oversaw him at the facility. The Dietary Manager stated he tasted the food served from the kitchen daily. The Dietary Manager stated he tasted the foods for the lunch meal on 5/28/25 prior to the test tray. The Dietary Manager stated he handled food complaints at the facility by having a one-on-one conversation with the resident along with another staff member and addressing the residents' needs face to face. The Dietary Manager stated he also address the complaints during resident council meetings when he was invited to attend. The Dietary Manager stated, It was important to ensure the food was palatable, attractive and appetizing because it was the only thing the residents looked forward to and it was the only thing the residents could control, it's a consistency 7 days a week. During an interview on 5/29/25 at 8:40 a.m., the Administrator stated he had been the Administrator since November of 2024. The Administrator stated he oversaw the Dietary Manager. The Administrator stated he tried getting test trays once a week. The Administrator stated in the past residents did not complain much about the foods served from the kitchen. The Administrator stated in the past he received a food complaint about the pork meat being too tough. The Administrator stated he told the dietary staff to make sure the meat was tender because some residents could not chew the meat. The Administrator stated he was not aware of any recent food complaints. The Administrator stated food complaints were handled at the facility by social worker. The Administrator stated the social worker would take the complaints to whatever department that needed to handle the complaint. The Administrator stated it was important that food was palatable, attractive, and appetizing to the residents because, He liked to see the people enjoy the food and because the residents looked forward to good food. 2. Record Review of the puree green beans indicated the following: (1) For Pureed Italian blend vegetables: add liquid, if needed (ex: reserved liquid broth, juice, milk, gravy, or sauce) to assist with pureeing. Puree with a blender or food processor until smooth NOTE: Water should not be used as a liquid to puree foods. Serve with a #10 scoop. Record Review of in-services on following the menu was last completed by staff on 4/1/25. During observation and interview of puree meal prepared by [NAME] B for the lunch meal served on 5/28/25 at 12:43 p.m., the following was noted: [NAME] B added 7 servings of regular green beans, 1 cup of water and 2 cups of food thickener. [NAME] B was observed not using the recipe book. [NAME] B stated he thought he had completed in-services on following the recipe book a few months ago. [NAME] B stated it was important to follow the recipe book for flavor and texture of the foods pureed. [NAME] B stated in the past of pureeing foods that he used water to mix with food thickener. [NAME] B stated he was the cook at the facility. [NAME] B stated he did not review the recipe book prior to pureeing foods for the lunch meal on 5/28/25. When asked why he did not review the recipe book prior to pureeing foods the cook stated, I do what I do, I been doing this since '93 and I get everything changes from 20 to 30 years ago. During an interview on 5/29/25 at 8:22 a.m., the Dietary Manager stated he had been the Dietary Manager for 7 months. The Dietary Manager stated the Administrator oversaw him at the facility. The Dietary Manager stated he was responsible for ensuring staff were following the recipe book. The Dietary manager stated he was not made aware of staff not following the recipe book. The Dietary Manger stated staff were last in serviced on following the recipe last month. The Dietary manager stated it was important for staff to follow the recipe book for consistency and proper nutrition. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/25 at 8:55 a.m., the Administrator stated he had been the Administrator since November of 2024. The Administrator stated he was not made aware of staff not following the recipe book. The Administrator stated he did expect the dietary staff to follow the recipe book. The Administrator stated he oversaw the Dietary Manager. The Administrator stated he was not sure if staff completed in-services on following the recipe. The Administrator stated he inspected the kitchen daily.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review, the facility failed to ensure that each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community, in that: The facility failed to serve meals, at the specific times posted, in the main dining room. This failure placed residents at risk of increased hunger, thirst, frustration, and decreased feelings of self-worth. Findings included: Record Review of in-services on time management was last completed by staff on 4/29/25. Record review of the facility's posted meal service reflected breakfast mealtime was 7:00 AM; lunch mealtime was 12:00 PM; and dinner mealtime was 5:00 PM. During an interview in the dining room on 5/28/25 at 9:00 a.m., Resident #38 stated that the breakfast and lunch meal was always served late. During observations on 05/28/25 at 12:42 PM, in the facility's main room, lunch meal service had not begun, and the residents had not begun to eat lunch. During an interview on 5/29/25 at 8:15 a.m., the Dietary manager stated he had been employed at the facility for 7 months. The Dietary Manager stated the meal serving times were 7am for breakfast, 12pm for lunch and 5pm for dinner. The Dietary Manager stated the reason why the lunch meal on 5/28/25 was late was because the cook folded under pressure and because the cook was in his own head. The Dietary Manager stated staff had been in serviced on serving the meals timely. The Dietary Manager stated it was important to serve the meals timely because the residents were in routine and the residents needed to be fed on time. During an interview on 5/29/25 at 8:37 a.m., the Administrator stated he had been the Administrator since November of 2024. The Administrator stated he was made aware of the lunch meal being served late on 5/28/25 (lunch meal) by the Dietary Manager. The Administrator stated staff had been in serviced on serving the meals timely. The Administrator stated in the past the Dietary staff had been 5 minutes late serving the meals and he in serviced staff on being on time to serve the meals timely. The Administrator stated, It was important to serve the meals timely because the residents needed to eat on time, for weight loss and for blood sugars; we have to keep the residents on their schedules.

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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. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in (1 of 1) kitchen reviewed for dietary services. 1) The facility failed to dispose of expired food items. 2) The facility failed to label and date all food items in the refrigerator and freezer. 3) The facilty failed to main safe holding temps on the steam table. These failures could place residents at risk for food contamination and foodborne illness. The findings included: Record Review of in-services on labeling and dating was last completed by staff on 5/27/25. During observation in the kitchen refrigerator 1 of 2 on 5/27/25 at 9:25 a.m., the following was observed with the Dietary Manager: -2 quarts of BBQ Beef had an expiration date of 5/22/25. (Expired) -1/2 quart of container of Jelly had a preparation date of 5/19/25 and no expiration date. -2 quarts of ketchup in a container had a preparation date of 5/17/23 and no expiration date. -1 quart of diced tomatoes was not labeled, had no preparation date and no expiration date. During observation of freezer #1 of 2 on 5/27/25 at 9:35 a.m., the following was observed with the Dietary Manager: -(1) frozen roll of hamburger meat in a zip lock bag had a received date of 5/24/25 and no expiration date. During observation in the kitchen on 5/27/25 at 9: 52 a.m. the following was observed with the Dietary Manager: -(1) 16 ounces of celery seed seasoning had an open date of 12/4/23 and a expiration date of 10/21/24. (Expired) -(1) 16 ounces of Ground red pepper seasoning had a open date of 1/2/23 and a expiration date of 4/3/25. (Expired) -(1) 16 ounces of [NAME] sugar seasoning had a open date of 5/19/25 and expiration date of 5/4/25. (Expired) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 5/28/25 at 12:30 p.m., observations of food temperatures were made on the steam table by [NAME] B. The results were as followed, regular chicken parmesan was 87°F; the regular spaghetti noodles were 166.2°F; the green beans was 149.9°F; the spaghetti sauce was 100. 4°F; the chocolate cake was 72.6°F; the puree chicken parmesan was 109°F; the puree spaghetti noodles was 106.1°F; the puree green beans was 115.5°; the puree garlic bread was 108.1°F and the puree chocolate cake was 54.3°F. During an interview on 5/29/25 at 8:28 a.m., the Dietary Manager stated he had been employed at the facility for 7 months. The Dietary Manager stated the Administrator oversaw him at the facility. The Dietary Manager stated all items in the refrigerator and freezer were to be labeled, dated with receive date, open date and expiration date. The Dietary Manager stated staff had completed in-services on labeling and dating all food items on Tuesday (5/27/25). The Dietary Manager said he conducted walk throughs in the kitchen every morning. The Dietary Manager stated he was not aware of the expired food items found in the kitchen. The Dietary Manager stated it was important to ensure staff were labeling and dating all food items so the staff knew when the food was bad so the food would not affect the residents or guests. During an interview on 5/29/25 at 8:44 a.m., the Administrator stated he had been employed at the facility since November of 2024. The Administrator stated all food items found in the kitchen were to be labeled, dated with receive date, open date and expiration date. The Administrator stated staff completed in-services on labeling and dating but he was not sure when the last in-service on labeling and dating was last completed. The Administrator stated he conducted walk throughs daily. The Administrator stated he was not aware of the expired food items found in the kitchen until yesterday on (5/28/25) when the Dietary Manager told him. The Administrator stated he was not made aware of staff not labeling and dating all food items until yesterday on (5/28/25) when the Dietary Manager told him. The Administrator stated he did expect the Dietary Manager to report to him of any issues noted in the kitchen. The Administrator stated, It was important to ensure staff were labeling, dating and discarding expired food items because staff have to know when the food was close to being discontinued because if the food went bad, we definitely don't want to serve bad foods. Record Review of the food and storage policy dated 2012 indicated, (6) When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it so it is readily visible and noticeable. It is important to distinguish between an expiration date and a production date, or a best by or use by date. Production dates indicate when the product was manufactured, not when it expires, and should not be interpreted as a best by or use by date. Best by or use by dates indicate when a product will have best flavor or quality and are not an indicator of the product's safety. As the quality may deteriorate after the date passes, the dietary manager should closely inspect any products that are past the best by date to determine if they are still good quality. If in doubt, discard the product. If any stamped date is unclear, contact the food vendor for clarification. If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received, and shelf-stable items will be stored in a first in, first out manner, to be used within one year. After one year, any product that is shelf stable will be inspected by the dietary manager to ensure that it is good quality before it is used. Any product with a stamped expiration date will be discarded once that date passes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record Review of FDA dated 2022 indicated, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above for hot foods, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or (2) At 5°C (41°F) or less for cold food.

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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** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (Resident #11) reviewed for infection control. The facility failed to ensure LVN C and CNA D followed enhanced barrier precautions while providing wound care to Resident #11 on 05/28/2025. This failure could place residents at risk for cross contamination and the spread of infection due to lack of implementation of orders. Findings included: Record review of a face sheet dated 05/28/2025 indicated Resident #11 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities severe enough to interfere with daily life) and peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #11's Comprehensive MDS assessment dated [DATE] indicated she sometimes understood others and was sometimes able to understand others. The MDS assessment indicated Resident #11's BIMS score was 2, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #11 received pressure ulcer/injury care. Record review of Resident #11's Order Summary Report dated 05/28/2025 indicated to cleanse right heel with wound cleanser, pat dry, mix collagen and anasept (used to treat or prevent infections) to create a paste and cover with a dry dressing one time day every other day for wound care with a start date of 05/19/2024. Resident #11's Order Summary Report did not indicate the use of enhanced barrier precautions. Record review of Resident #11's care plan last reviewed 05/16/2025 indicated she was on enhanced barrier precautions related to a wound. Resident #11's interventions included gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, or bathing. During an observation of wound care on 05/28/2025 at 08:22 AM, LVN C provided wound care to Resident #11's right heel with the assistance of CNA D. Resident #11 was in her bed. LVN C provided the wound care while CNA D assisted by holding Resident #11's leg. LVN C and CNA D donned gloves, but they did not put on a gown. During an interview on 05/28/2025 at 8:36 AM, LVN C said EBP are required when providing wound care, and she should have worn a gown and gloves. LVN C said she forgot to put on the gown probably because she did not see the PPE. LVN C said the PPE was usually located outside of the resident's room, and Resident #11's was inside her room. LVN C said EBP were required to protect them and the residents form MDROs and bacteria. LVN C said not following the EBP could result in the spread of germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/2025 at 9:09 AM, CNA D said Resident #11 required the use of EBP. CNA D said a gown and gloves should be worn anytime they were doing care on a resident who required EBP. CNA D said she forgot to put the gown on when she assisted LVN C with Resident #11's wound care. CNA D said EBP should be followed to help with infection control and to prevent the spread of diseases. During an interview on 05/29/2025 at 10:06 AM, the DON said the ADON and herself were responsible for ensuring the staff followed the enhanced barrier precautions. The DON said when they were out on the halls, they checked to ensure the staff was wearing the appropriate PPE for the EBP. The DON said the staff had been wearing the appropriate PPE. The DON said while wound care was provided the staff should wear a gown and gloves. During an interview on 05/29/2025 at 10:42 AM, the Administrator said he expected the staff to follow the enhanced barrier precautions. The Administrator said nursing administration was responsible for monitoring to ensure the staff followed the enhanced barrier precautions. The Administrator said not following the enhanced barrier precautions could result in cross contamination for the residents and staff. Record review of the facility's policy titled, Enhanced Barrier Precautions, effective 04/01/2024, indicated, EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .EBP are indicated for residents with any of the following .Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .