

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Slaton Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 630 S 19th Slaton, TX 79364	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49927</p> <p>Based on observations, interviews, and record reviews the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional or special dietary needs for 1 of 5 residents (Resident #1).</p> <p>The facility failed to provide Resident #1 with double portions at meals 3 times a day, per physician orders.</p> <p>This failure could place residents at risk for weight loss, altered nutritional status and diminished quality of life.</p> <p>Findings Included:</p> <p>Record review of Resident #1's face sheet, dated 01/28/2025, revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #1 had the following diagnoses: quadriplegia (paralysis of all four limbs), Other Cystostomy Status (procedure wherein the urinary bladder and the skin are surgically connected to drain the urine through a tube that comes out through the abdominal wall), Seborrheic dermatitis (scaly patches, inflamed skin, and dandruff.), muscle weakness unspecified, unspecified lack of coordination, cognitive communication deficit (difficulty with any aspect of communication), major depressive disorder (mental health condition), Generalized Anxiety disorder (mental health condition), and personal history of traumatic brain injury (brain injury that is caused by an outside force).</p> <p>Record review of Resident #1's MDS dated [DATE] Section C- Cognitive patterns revealed a BIMS score of 15 which indicates resident was cognitively intact. Section GG- Functional Abilities - Functional Limitation in Range of Motion indicated the resident had impairment on both sides on upper and lower extremities. Section GG- Functional Abilities - OBRA/Interim, revealed resident was dependent on all assistance with eating.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan dated 3/5/2024 revealed a focus area that indicated the resident had potential risk for malnutrition with a goal that stated, maintain stable weight and nutritional parameters, and the interventions included the following: offer diet as ordered by the physician. The care plan included a focus area that indicated the resident has a nutritional problem or potential nutritional problem with a goal that stated, the resident will maintain adequate nutritional status through review date, and interventions that included the following: provide and serve diet as ordered. The care plan also included a focus area that indicated the resident has 3 pressure ulcers with a goal stating, the resident's Pressure ulcer will show signs of healing and remain free from infection through review date, and interventions that included the following: Monitor nutritional status. Serve diet as ordered, monitor intake and record</p> <p>Record review of Resident #1's order summary report dated 01/28/2025 revealed an order dated 04/25/2024 that stated DBL portions with meals three times a day. The order did not indicate an end date.</p> <p>During an interview on 01/29/2025 at 10:18 AM Resident #1 stated he was supposed to receive double portions at each meal, but he has only received regular portions.</p> <p>During an interview on 01/29/2025 at 11:55 AM the DM stated that the dietary staff were able to see a resident's portion size order for their meal on the resident's meal ticket. The DM stated a regular tray usually consisted of 4 oz of protein and a scoop of each side item. The DM stated if the meal card indicated large portions on the top, this indicated the resident received large portions of protein. The DM stated a large portion of protein is usually 6 oz of protein. The DM stated large portion on a resident's meal card only applied to the protein item on the meal and not the side items or desserts. The DM stated meatloaf was served on this day as the residents' protein. The DM stated the meatloaf squares were cut into 4 oz squares, so a large portion of meatloaf was 1 1/2 squares which equaled to 6 oz of meatloaf.</p> <p>During an observation on 01/29/2025 at 12:52 PM Resident #1's meal card indicated the following: Large Portions; [NAME] Texture - Regular; Entree - 1 Svg Large Portion, 4 oz Meatloaf; Starch - 1/2 c Black-eyed Peas; Vegetable - 1/2 c Braised Cabbage, Bread - 1 2x2 Square Cornbread; Condiment - 1 Ea Margarine; Dessert - 1/2 C Apple Cobbler; Beverage - 8 fl oz Iced Tea It was observed Resident #1 received one tray of food containing 1 1/2 squares of meatloaf, 1/2 cup of cabbage, 1/2 cup of black eyed peas, 1 2x2 square of cornbread, and 1/2 cup of pudding. The resident also received a side of margarine and a glass of iced tea.</p> <p>During an interview on 01/29/2025 at 1:02 PM the DM stated there were no residents on double portioned meals. The DM stated a resident required a physician's order to receive double portions. The DM stated double portioned meals were two trays of food and two servings of all food items for the meal. The DM stated there were numerous residents that received large portions, and large portions did not require a physician's order. The DM stated large portions could be requested from the resident. The DM stated if a resident was changed to double portions, the nursing staff completed a dietary slip and turned this into the dietary manager. The DM stated she obtained copies of all changes in her office. The DM stated all physician's orders for specific dietary needs were communicated by the DON or charge nurse via the dietary form, as the DM stated she did not have access to the resident's physician's order. The DM stated the DON or nursing staff were responsible for making sure the DM had accurate information regarding the resident's physician's orders.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility provided dietary communication forms revealed there were no communication forms found for Resident #1.</p> <p>During an interview on 01/29/2025 at 2:50 PM CNA A stated she assisted with feeding Resident #1 often. CNA A stated Resident #1 received double portions at meals. CNA A stated double portions were only one tray of food with extra portions of each item on the plate. CNA A stated she had observed the portions to appear more than an average tray, but she was not certain. CNA A was not certain the difference between large and double portions. CNA A stated she thought it meant the same thing.</p> <p>During an interview on 01/29/2025 at 3:22 PM CNA B stated she assisted with feeding Resident #1 often. CNA B stated Resident #1 was on a regular diet with regular portions. CNA A stated she had observed Resident #1's meals to be regular portions. CNA B stated Resident #1 was supposed to get double portions, so she has obtained more food for him if he is still hungry.</p> <p>During an interview on 01/29/2025 at 4:04 PM LVN A stated Resident #1 was on a regular diet with regular portions. LVN A stated the CNA assigned to Resident #1 was responsible for assisting Resident #1 with eating at each shift. LVN A stated a resident's dietary order should have been the same on the resident's meal card as it was in the resident's physician's order.</p> <p>During an interview on 01/29/2025 at 4:30 PM CNA C stated she assisted with feeding Resident #1 often. CNA C stated Resident #1 was on a normal diet. CNA C stated if Resident #1 requested additional food, he may have more portions on his plate, but it was normally a regular portion size. CNA C stated if Resident #1 was still hungry, he requested additional food and she obtained it for him.</p> <p>During an interview on 01/29/2025 at 05:30 PM the DON stated she was not certain what Resident #1's dietary orders stated. The DON stated there were no residents at the facility with double portions. The DON stated there were several residents at the facility that received large portions. The DON stated she was not certain what the measurements were for large or double portions. The DON stated dietary orders were communicated to the dietary manager via a dietary form for each resident. The DON stated the charge nurses or DON was responsible for communicating dietary orders to the dietary manager. The DON stated the dietary orders from a resident's physician should have been reflected on the resident's meal card at each meal. The DON stated dietary orders were reviewed during care plan meetings to ensure accuracy. The DON stated she has not reviewed all residents' dietary orders since she began working at the facility in November 2024. The DON stated if a resident's dietary order was not followed it would be a concern for the resident's health.</p> <p>During an interview on 01/29/2025 at 5:49 PM the AIT stated he had worked at the facility for over 6 years and was currently the administrator in training as well as being over the therapy department. The AIT stated he was familiar with Resident #1. The AIT stated Resident #1 was on a regular diet with large portions. The AIT stated there were no residents at the facility that received double portions of meals. The AIT stated large portions were a portion and a half of each item and double portions were two portions of each item. The AIT stated dietary forms were updated with the dietary staff when a resident was admitted or when a change was made. The AIT stated dietary orders were also reviewed at care plan meetings to ensure they were being followed. The AIT stated the resident's meal card should have reflected the resident's physician order for the resident's diet. The AIT stated he was not aware Resident #1 had an order for double portions at each meal. The AIT stated if Resident #1's physician order was not being followed for double portions it could lead to weight loss for Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 01/29/2025 at 6:10 PM Resident #1's meal tray was observed empty as it was picked up by staff. Resident #1 stated he did not receive double portions at dinner. Resident # 1 stated he only received one portion of food at dinner.</p> <p>During an interview on 01/29/2025 at 6:35 PM the NP stated she was familiar with Resident #1. The NP stated the facility should have followed the physician order for Resident #1's diet to include double portions. The NP stated there was a potential for weight loss with Resident #1 if he did not receive the physician's order of double portions at meals. The NP reviewed and verified Resident #1's recent weights and stated his weights have been consistent with no significant changes. The NP stated she has not had concerns with weight loss for the resident.</p> <p>During an interview on 01/29/2025 at 7:30 PM the Interim ADM was unable to provide a policy specifically related to following physician orders in relation to dietary orders for residents.</p>		