

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 12/04/2025
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)		
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 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 (Kitchen A) reviewed for dietary services. 1. The facility failed to ensure dietary staff (DA C and [NAME] D) ensured food was stored, prepared, and served under sanitary conditions. Multiple food items which included cornbread mix, cooked cornbread, bread pudding, salad ingredients, and grilled cheese sandwiches were repeatedly left uncovered for extended periods while in the kitchen and on the serving line 2. The facility failed to ensure Dietary staff (Cook D) consistently performed required hand hygiene. The cook repeatedly donned and removed gloves without washing hands before or after glove use while preparing multiple food items. 3. The facility failed ensure resident drink cups were stored on 12/3/25: Trays were stacked directly on top of uncovered cups, exposing the rims of the cups to the unsanitary underside of serving trays. The DOR was later observed moving and serving these cups to residents without correcting the contamination risk. These failures could place residents at risk for food contamination and foodborne illness. The findings include: The following observations were made on 12/2/25 in Kitchen A between 10:19 AM-12:53 PM :-Cornbread mix was uncovered during the following times:-Dry cornbread mixture was observed uncovered upon entry into the kitchen at 10:32 AM. At 10:48 AM, [NAME] D poured milk and began mixing the cornbread mixture (16 minutes). -At 11:17 AM, [NAME] D was observed pulling the cornbread mixture out of the oven. He placed it on the serving table uncovered and went to complete other duties (obtaining other dishes and taking dishes to the dishwasher). The cooked cornbread remained uncovered until 11:23 AM, when the Dietary Manager walked by and placed foil on top of the cooked cornbread and then placed it on top of the oven (6 minutes). -The bread pudding was observed uncovered during the following times: At 11:05 AM, DA C pulled the bread pudding out of the oven and placed it on a side table within the kitchen uncovered. DA C did not start cutting the bread pudding until 11:23 AM. At 11:24 AM, DA C was observed placing the bread pudding on plates. Thirty-eight plates of bread pudding remained uncovered from 11:24 AM until 11:41 AM (20 minutes). At 11:41 AM, 24 plates of bread pudding were observed covered while 14 plates of bread pudding remained uncovered. At 11:44 AM, DA C obtained two plates of bread pudding to puree. Twelve plates of bread pudding were observed uncovered. The 12 plates of regular bread pudding were observed uncovered from 11:41 AM to 11:44 AM (3 minutes). At 11:44 AM, DA C added one container of pureed bread pudding to the 12 regular plated bread puddings that were uncovered. The 12 plates plus the one pureed serving of bread pudding remained uncovered from 11:46 AM to 12:49 PM when the first plate was served (1 hour and 3 minutes). -The salad was observed uncovered during the following times: At 11:02 AM, [NAME] D was observed obtaining the green cutting board and the lettuce. [NAME] D chopped the lettuce and placed it in a metal bowl. The lettuce remained uncovered in the metal bowl until [NAME] D placed sliced tomatoes in the salad at 11:23 AM. The lettuce in the bowl remained uncovered while not being served or prepared for a total of 21 minutes. [NAME] D walked away from the salad at 11:23 AM, and 6 minutes later at 11:27 AM, he placed shredded cheese in the salad and then placed it in the refrigerator at 11:28 AM. -The grilled cheese sandwiches were observed uncovered during the following times: (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 4 residents (Resident #44) reviewed for respiratory care. The facility failed to ensure Resident #44 had orders for the administration of oxygen. This failure could place residents at risk of not receiving the care and services to maintain their highest level of well-being. Record review of Resident #44's face sheet dated 12/02/25 reflected a [AGE] year-old male who was initially admitted to the facility on [DATE]. Resident #44 had diagnoses which included: respiratory failure (lung condition causing lack of oxygen in the blood), congestive heart failure (heart condition in which the heart muscle does not pump adequate amount of blood), and hypertension (high blood pressure). Record review of Resident #44's EMR reflected he did not have a completed MDS assessment. Record review of Resident #44's physician's order listing report, dated 12/02/25, reflected no order of oxygen. Record review of Resident #44's comprehensive care plan, revised on 12/03/25, reflected the resident used oxygen therapy related to chronic respiratory failure with intervention, monitor for signs and symptoms of respiratory distress and report to MD PRN. During observations, Resident #44 had oxygen being administered as follows: 12/02/25 at 10:50 AM, O2 on via oxygen concentrator at 3 liters per minute via nasal cannula. 12/03/25 at 10:52 AM, O2 on via oxygen concentrator at 3 liters per minute via nasal cannula. 12/04/25 at 12:44 PM, O2 on via oxygen concentrator at 3 liters per minute via nasal cannula. During an interview on 12/03/25 at 12:46 PM with Resident #44, he stated he was admitted with oxygen and had worn it continuously since admission. He stated he had been dependent on oxygen for several years. During an interview on 12/04/25 at 12:28 PM, the ADM stated he was not aware Resident #44 did not have an order for oxygen. He stated the admission charge nurse, who was no longer employed at the facility, was responsible for obtaining and entering orders. He stated nursing administration was responsible for monitoring orders for accuracy. He stated the facility had a form for new admissions and any concerns for a newly admitted resident were discussed in the morning meeting. The ADM stated a potential negative outcome for failure to obtain an order for oxygen therapy was that the resident would not receive the correct care as ordered by the physician. During an interview on 12/04/25 at 12:50 PM, the DON stated a physician's order was required for oxygen administration. She stated Resident #44 did not have an order for oxygen and had been on oxygen since being admitted to the facility. The DON stated the admitting nurse was responsible to clarify and obtain an order for oxygen administration. She stated she did not know how the order was missed. She stated nursing staff were trained to clarify and obtain orders and enter them in the EMR. The DON stated it was the responsibility of nursing administration to reconcile orders on new admissions. She stated a potential negative outcome for failure to obtain an order for oxygen therapy was the resident would not receive the oxygen he needed. Record review of the facility's undated policy titled, Oxygen Administration, reflected: . The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician.		

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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** 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 permitted only authorized personnel to have access to the keys for 2 of 2 medication carts (Medication Cart A, and Medication Cart B), reviewed for medication storage. 1. The facility failed to ensure Medication Cart B did not contain a loose pill. 2. The facility failed to ensure Medication Cart A did not contain a loose pill. These failures could place residents at risk of not receiving prescribed medications as ordered and place the facility at risk of drug diversions. Observation on [DATE] at 3:09 PM, of Medication Cart B with MA A revealed a small, white, round, loose pill (1/2 pill) found in a drawer of the medication cart. MA A placed the pill in a dispensing cup and took it to the DON for identification. The DON identified the medication as Metoprolol 25mg tablet (1/2 tablet). MA A destroyed the loose pill by placing it in a bottle of liquid utilized for medication destruction. Observation on [DATE] at 3:21 PM, of Medication Cart A with MA A revealed a small, white, round, loose pill (1/2 pill) found in a drawer of the medication cart. MA A placed the pill in a dispensing cup and took it to the DON for identification. The DON identified the medication as Metoprolol 25mg tablet (1/2 tablet). MA A destroyed the loose pill by placing it in a bottle of liquid utilized for medication destruction. During an interview on [DATE] at 11:44 AM, MA A stated she was unsure why the carts (Medication Carts A & B) contained loose pills. She stated the blister packs could get bumped around and knock the pills loose. MA A stated she usually checked the medications carts daily for loose and expired pills and cleanliness. She stated she was trained on proper medication storage through in-services and through occasional cart audits conducted by the pharmacy consultant. MA A stated a potential negative outcome for loose pills on the cart was the resident could miss a dose of medication. During an interview on [DATE] at 12:28 PM, the ADM stated he was not aware there were loose pills on the medication carts. He stated nursing staff and nursing administration were responsible for assuring proper storage of medications on the carts. He stated monitoring of the medication carts was done through random cart audits conducted by nursing administration. The ADM stated a potential negative outcome for failure to properly secure medications on the carts was missed counts and not having enough medication for a resident. During an interview on [DATE] at 12:50 PM, the DON stated there should not be loose pills on the medication carts. She stated the nursing staff and MA's were responsible for the proper storage of medications on the carts. She stated nursing staff and MA's were trained on proper storage of medication through in services and annual competency checks conducted by nursing administration. The DON stated the pharmacy consultant conducted medication cart audits during monthly visits. The DON stated a potential negative outcome for failure to properly secure medication on the carts was a resident could get the wrong medication or miss a scheduled dose of medication. Record review of the facility's undated policy titled, PCU027 - Medication Storage in the Facility reflected: Policy Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. 1. [Dispensing Pharmacy] dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure menus were followed for 1(Resident #28) of 17 residents reviewed for food and nutrition services. The facility failed to follow the week 1 menu for one lunch service served at the facility on Tuesday 12/2/25 for the one and only resident (Resident #28) that was on a puree therapeutic diet. This failure could place residents at risk of poor intake, and/or weight loss. The findings include: Record review of Resident #28's face sheet, dated 12/02/25, reflected a [AGE] year-old-female who was admitted to the facility on [DATE]. Resident #28 had a diagnosis which included gastro-esophageal reflux disease without esophagitis (may experience heartburn, regurgitation, and chest pain with no visible damage or inflammation). Record review of Resident #28's Comprehensive Minimum Data Set, dated [DATE], reflected: -Section C Brief Interview for Mental Status score reflected a score of 01, which indicated the resident's cognition was severely impaired. -Section K Swallowing/Nutrition Status reflected Resident #28 was 115 pounds, no weight loss of 5% or more. -Section V reflected nutritional status was triggered on the CAAs. Record review of Resident #28's physician order, dated 12/2/25, reflected the following: Resident #28 was on a regular diet, pureed texture with a start date 11/05/25. Record review of Resident #28's care plan, dated 11/05/25, reflected the following: Resident #28 had a diet order other than regular and was at risk for unplanned weight loss. It was the goal for Resident #28 to maintain ideal weight and to receive proper nutrition for 90 days. Interventions included offering substitutions if Resident #28 ate less than 50 % and to serve diet and snacks as ordered. Record review of Resident #28's, undated, weight list, pulled from the EMR 12/3/25 reflected: Resident weighed 115. 5 lbs on 11/3/25, 115.00 on 11/5/23 and as of 11/18/25 she weighed 115.00. Record review of Resident #28's lunch ticket, dated 12/2/25, reflected:Entree: Chicken and Sausage GumboStarch: Steamed [NAME] Salad: Soft Cooked vegetable Bread: CornbreadCondiment: MargineDessert: Bread PuddingBeverage: Iced Tea Record review of the facility's weekly menu, dated 10/16/25, revealed the following would have been served for week 5 on Tuesday 12/2/25:Chicken and Sausage GumboSteamed RiceTossed SaladCornbreadMargarineBread Pudding Iced Tea The following observations were made on 12/2/25 between 11:41 AM and 12:20 PM in the kitchen: DA C pureed the bread pudding at 11:41 AM. [NAME] D pureed the rice at 12:07 PM and pureed the gumbo at 12:20 PM. [NAME] D, DA C, or the DM were not observed to puree a soft vegetable or cornbread. The following observations were made on 12/2/25 at 12:58 PM in the dining room: At 12:58 PM, Resident #28's lunch tray contained the following: a bowl of gumbo, a bowl of rice, and bread pudding. There was no cornbread or soft vegetable observed. During an interview on 12/4/25 at 2:09 PM, Resident #28 stated she did not remember whether she received all the items listed on the menu on 12/2/25. She stated she did not always receive bread. She stated she would like a whole piece of bread because she could dip it in the sauce to make it soft. She stated she could not remember if she received all menu items regularly. She stated she did remember not always receiving condiments such as butter and jelly. During an interview on 12/4/25 at 12:02 PM, the DM stated on 12/2/25 the facility menu reflected the residents should have received gumbo, rice, cornbread, salad, and bread pudding. The DM stated Resident #28 was on a puree diet, but she would have received the same items listed on the menu. The DM stated everyone in the facility who was able to eat would receive everything on the menu or something comparable. The DM stated she was familiar with the facility policy, which required staff to follow the menu. She stated the purpose of following the menu was that it was something they were required to do. The DM stated the potential negative outcome for not following the menu was residents may not receive adequate nutrition. The DM stated on 12/2/25 Resident #28 did not receive a vegetable or bread on her tray, and she became aware of this after the state surveyor left the kitchen. The DM stated she did not know who served the tray directly to the (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident but she was the one who warmed it up and did not catch the mistake. She stated the nurse checked the tray, but she was not sure which nurse was working that day. She stated she was in the process of receiving items from the delivery truck and warming up items for the meal that day. She stated the system to ensure residents received what was on the menu or something comparable was that staff should follow the cards, read them, and prepare the tray as indicated. She stated the cook should follow the card, hand the tray to the aide, the aide would add her portion, and then the aide would hand the tray to the nurse. She stated the nurse should also read the card to ensure everything was on the tray. The DM stated she was trained to follow the menu and ensure all items on the dietary card were placed on the tray. She stated she expected all staff to follow the menu because it was easy to read. She stated she, as the DM, was responsible for ensuring the menu was followed. She stated she did not have a reason why Resident did not receive a vegetable or cornbread on 12/2/25. During an interview on 12/4/25 at 12:38 PM, the DON stated nurses should check the ticket while in the dining room. The DON stated the only time the meal on the tray would differ from the menu was if the resident requested an alternate, which would be indicated by an A on the ticket. The DON stated the nurse checked the tray, and if anything was missing, the nurse should notify dietary staff. The DON stated she was unaware Resident did not receive a vegetable or cornbread on 12/2/25. She stated their system to ensure residents received all menu items was that the nurse should check the tray before giving it to the resident. She stated the potential negative outcome of not following the menu was the resident could have a lack of nutrients, which could affect wound healing, leave the resident hungry, or affect mood. She stated she expected nurses to check the trays and address any issues. She stated she did not know why Resident did not receive all of her meal items. The DON stated staff were trained that before giving a meal tray to a resident, the tray should be checked in full. She stated the last person to check the tray, usually the nurse, would be responsible. During an interview on 12/4/25 at 12:52 PM, the ADM stated he did not know specifically what was served on 12/2/25 but he had the ability to see menus each morning. He stated everyone who consumed meals orally should receive everything on the menu or something comparable. The ADM stated he did not have a reason why Resident #28 did not receive cornbread or a vegetable on 12/2/25. He stated he was familiar with policy and procedure regarding following the menu. He stated diet texture would not prevent a resident from receiving all menu items. He stated failure to follow the menu could affect the resident's mood or weight. He stated he was unaware Resident #28 did not receive cornbread and a vegetable on 12/2/25 and did not know who checked her tray. He stated the system to ensure trays were correct was that trays were checked each time they moved down the serving line. He stated the resident trays started from the cook, to the aide, and ended at the nurse. He stated he and his staff were trained to follow the menu and expected all staff to follow it regardless of diet texture. He stated the cook, DM, and ADM were responsible for ensuring the menu was followed. During an interview on 12/4/25 at 1:17 PM, [NAME] D stated according to the facility menu for 12/2/25 the residents should have received gumbo, rice, salad, bread pudding, and cornbread. He stated all residents who consumed meals orally should have received everything on the menu or something comparable. He stated he was familiar with the facility policy requiring menu compliance. He stated if staff did not follow the menu, the resident could become sick or lose weight if they were not eating. He stated the system to ensure all residents received everything on the menu was staff would notify them if something was left off. He stated all staff who came in contact with the tray checked it. He stated he did not know who served Resident #28 her tray but believed LVN E may have done so. He stated he was responsible for ensuring the menu was followed. He stated he was unaware Resident #28 did not receive cornbread or a vegetable, until after the state surveyor left and the DM informed him. He stated he was trained to follow the menu. He stated Resident #28 did not receive the items because he did not read her ticket correctly and was reading quickly. During an interview on 12/5/25 at 2:25 PM, DA C stated she did not prepare Resident #28's tray but did place pureed bread pudding on it. She stated she did not know the tray lacked cornbread and a vegetable. (continued on next page)		

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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.			
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated once the items reached the correct temperature the DM told her the tray was ready. She stated she did not know who served the tray. She stated the potential negative outcome of not following the menu was weight loss. She stated she was trained to follow the menu. She stated she did not have a reason why the menu was not followed on 12/2/25 for Resident #28. During an interview on 12/4/25 at 2:36 PM, LVN B stated she worked in the dining room on 12/2/25. She stated the facility process was for the nurse to check the tray before serving it to the resident. She stated she and LVN E worked in the kitchen that day, but did not recall which of them checked Resident #28's tray. She stated she knew all trays were checked but could not say who checked hers or why the issue was not caught. She stated she was trained that dietary staff should be notified if a tray was incorrect. She stated this had never been an issue before. During an interview on 12/4/25 at 4:02 PM, LVN E stated she worked in the dining room on 12/2/25 but believed she entered late. She stated she did not know who served Resident #28 her tray. She stated they were trained that a nurse must check trays before giving them to residents and trays not matching the menu should be returned. Record review of Resident Menus policy, dated 2012, revealed the following: We will strive to assure the residents nutritional needs are provided. The standard menu will ensure nutritional adequacy of all diets, offer a variety of food and adequate amounts at each meal, and standardized group production. ProcedureMenus are planned to meet the recommended dietary allowances of the food and nutritional board, National Research council, adjusted to the age, activity, and environment of the group involved. A 5 week cycle of meetings are planned by the menu committee which may consist of facility dietary service managers and registered dietitians in conjunction with the food supplier. All dyes including therapeutic dyes are recognized in these names. Will be prepared as written using standardized recipes. The dietary service manager includes our training and responsible for the preparation and service of therapeutic diets as prescribed.		

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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 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 3 residents (Resident #20) reviewed for infection control. LVN A failed to wear proper PPE (a gown) when providing wound care for Resident #20 who was on EBP. This failure could place residents at risk for the spread of infection and cross contamination. Record review of Resident #20's face sheet, dated 12/03/25, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #20 had diagnoses which included: non-pressure chronic ulcer of right ankle, Type II Diabetes Mellitus (condition in which the body does not use insulin effectively), and cerebral infarction (stroke). Record review of Resident #20's annual MDS, dated [DATE], reflected a BIMS score of 09, which indicated the resident had moderate cognitive impairment. Section - M - Skin Conditions reflected the resident had an ulcer requiring a nonsurgical dressing. Record review of Resident #20's Comprehensive Care Plan, revised on 08/28/25, reflected the resident was on Enhanced Barrier Precautions with interventions: 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, trach care or other high-contact activity. The care plan further reflected the resident had a non-pressure wound to the right ankle with interventions: Administer treatments as ordered and monitor for effectiveness. Record review of Resident #20's current physician's orders, dated 12/03/25, reflected an order with a start date of 11/12/25 to treat venous wound of the right ankle daily. During an observation on 12/03/25 at 11:09 AM, LVN A performed wound care to Resident #20's right ankle wound, per physician's orders. LVN A put on gloves but failed to put on a gown prior to performing wound care for Resident #20. Enhanced Barrier Precaution signage was noted to the door of Resident #20's room and a storage cart for PPE was noted sitting at the entrance to Resident #20's room. During an interview on 12/03/25 at 11:21 AM, LVN A stated she did not put on a gown prior to performing wound care for Resident #20 who was on EBP. She stated she did not think to put on the required PPE (gown) due to being focused on performing wound care correctly. She stated she was trained on EBP through in-services conducted by nursing administration, as well as by computer-based training. LVN A stated PPE should be worn when conducting direct care on any resident who was on EBP. She stated a potential negative outcome for failure to implement EBP would be contaminating wounds, passing bacteria between residents, and causing an infection. During an interview on 12/04/25 at 12:28 PM, the ADM stated he was not aware staff were performing wound care on EBP residents without utilizing proper EBP. He stated nursing administration was responsible for training staff on EBP and for assuring staff were following proper EBP guidelines. The ADM stated his expectation of staff was to follow the facility policy for EBP at all times. He stated a potential negative outcome for failure to properly observe EBP was the spread of infection. During an interview on 12/04/25 at 12:50 PM, the DON stated EBP should be implemented on a resident with a wound and staff should follow EBP guidelines when performing wound care. She stated nursing administration was responsible for training staff on the use of PPE for EBP residents. The DON stated staff were trained on EBP through in-services conducted by nursing administration. She stated EBP was monitored by random checks during the direct care of residents on EBP. The DON stated a potential negative outcome for failure to utilize PPE on a resident with EBP was infection. Record review of the facility's policy titled, Enhanced Barrier Precautions, dated 04/01/2024 reflected: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A single set of PPE cannot be used for more than 1 patient.EBP are indicated for residents with any of the following:.Wounds and/or indwelling medical devices .		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident bedrooms measured at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms for 1 of 17 semi-private (room shared by two people, typically with a curtain dividing the room and providing some privacy) rooms (room [ROOM NUMBER]) reviewed for useable living space. The facility failed to ensure room [ROOM NUMBER] (a semi-private room) provided 80 square feet per resident. The square footage was 153 instead of 160 square feet. This failure could place residents at risk of crowding in resident rooms and cause difficulty in providing resident care. The findings include: Observation on 12/3/25 at 3:50 PM revealed room [ROOM NUMBER] measured 153 square feet (14 feet x 10 feet) instead of the 160 square feet for a semi-private room for 2 residents using state issued apple phone. During an interview on 12/5/25 at 2:36 PM, the ADM stated during entrance conference, when the room waiver was discussed, he was aware room [ROOM NUMBER] was smaller than required. He stated he wished to continue filing the waiver. He stated room [ROOM NUMBER] was used as an office and he had no intention of using it for residents or remodeling it to meet the 160-square foot requirement. He stated if it were used for a resident in its current 153-square foot condition, the potential negative outcome would be limited space. He stated the facility did not have a policy regarding room size, but did have the room dimensions and would provide them. Record review of the ADM's email, dated 12/10/25, revealed the following measurements: for room [ROOM NUMBER] Width: 14 feet Depth: 11 feet Height: 8 feet Record review of Texas Health and Human Services Form 3762 (Room Size Waiver for Facilities) dated 12/2/25, documented room [ROOM NUMBER] did not meet the justification criteria. Record review of Texas Health and Human Services Form 3740 (Bed Classifications [Numbers and Location]) dated 12/2/25, documented room [ROOM NUMBER] was listed as a Title 18 bed classification semiprivate room for two residents.		