STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER: Wooldridge Place Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 7352 Wooldridge Rd Corpus Christi, TX 78414	

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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 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 for 1 of 1 kitchen and 1 of 1 nutrition room (ice room) reviewed for sanitation in that: 1.The facility failed to ensure the convection oven was opening properly and safely. 2.The facility failed to ensure [NAME] A did not place personal items on prep tables. 3.The facility failed to ensure [NAME] A were washing their hands. 4.The facility failed to ensure prep tables, the underside of the steam table shelf, and the underside of the stove shelf was clean and sanitized. 5.The facility failed to ensure a dented can of fruit was removed from the in-use shelf of cans. 6.The facility failed to ensure dry goods were sealed properly. 7.The facility failed to ensure items in the refrigerator were labeled and dated. 8.The facility failed to ensure trash bins in the kitchen were covered. 9.The facility failed to ensure trash was not on a prep table. 10.The facility failed to ensure the daily cleaning schedule of the kitchen was followed. 11.The facility failed to ensure boxes of frozen food in the walk-in freezer were not stacked to the ceiling. 12.The facility failed to ensure temperatures of the ice room refrigerator were documented properly. 13.The facility failed to ensure the ice room freezer had a thermometer. 14.The facility failed to ensure items in the ice room refrigerator were not expired. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15.The facility failed to ensure items in the ice room refrigerator and freezer were labeled and dated. 16.The facility to ensure the ice room refrigerator and freezer logs were not missing data. These failures could place residents at risk of foodborne illnesses. Findings included: Observation and initial tour of the kitchen on [DATE] at 7:05 AM revealed the right-side door of the convection oven did not open without extreme force as demonstrated by [NAME] A. The convection oven tipped back and forth when [NAME] A tried to open the right-side door. There was an eyeglasses case and partially empty 16 oz. bottle of water and a 1-gallon bag of chips that was open to air on a prep table next to the microwave. [NAME] A removed the items with a gloved hand and did not change her gloves or wash her hands before handling food (a biscuit) to place on a plate for breakfast. The bottom shelf of the steam table had dried, reddish brown discolorations that resembled leaking water. The underside of the shelf directly above the steam table had a thick dark brown substance on it directly above the food in the steam table. The substance was in the form of thick droplets. The underside of the shelf directly above food in a pan on the stove had a thick dark brown substance in the form of droplets. There was a dented 6.5 pound can of fruit on the shelf with other canned foods that were in use in the dry storage room. There was a carton type container of powdered mashed potatoes that was not sealed in the dry storage room. There was a partially full 3.5-liter container of a light tannish substance in the refrigerator that was unlabeled and undated. There was a tray in the refrigerator with 1 bowl, 1 Styrofoam cup, and 3 glasses of juice that were unlabeled and undated. There was a cardboard box with what appeared to be trash in it on the drink prep table. There was a case of food in the walk-in freezer stacked on the top shelf that was less than 6 inches below the ceiling and obstructing the water sprinklers. There was a trash bin near the 3-compartment sink that had trash in it but was not actively in use and was not covered. Observation of the nutrition room (ice room) on [DATE] at 8:50 AM revealed the temperature reading from the thermometer inside the ice room refrigerator was 29F. There was no thermometer in the freezer. There were no freezer temperatures logged on the refrigerator/freezer temperature template. There was a 1-pint container of ice cream that was unlabeled and undated in the freezer. There was thick ice build-up covering the back wall of the refrigerator. There was an unremovable 330 ml carton of an unknown substance frozen into the ice in the refrigerator. There was a sticky, thick brown substance spilled on the shelf of the door of the refrigerator. There was a 10 oz. jar of jelly, a plastic container with 8 shriveled strawberries, a drinking glass with an unknown brown substance and frozen, a large bowl full of an unknown semi liquid reddish substance, and a15 oz. partially full jar of cheese that was frozen, all unlabeled and undated in the refrigerator. There was a 46 oz. carton of liquid with an expiration date of [DATE], a full, 1-pint take-out container dated [DATE], and a 46 oz. frozen container of thickened liquid with an expiration date of [DATE] in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Return visit and observation of the kitchen on [DATE] at 2:45 PM revealed 6 cases of frozen food in the walk-in freezer stacked on the top shelf that were less than 6 inches below the ceiling and obstructing the water sprinklers. 5 of 5 steam table wells were crusted and flaking a whitish yellow substance approximately 2 inches up the insides and bottoms of each one. There was debris floating in the water of the steam table wells. The dented can of fruit remained on the shelf intended for use. The carton of powdered mashed potatoes that was open to air on [DATE] was in a large zip top type bag that was not sealed, leaving the carton exposed and open to air. In an interview with [NAME] B on [DATE] at 7:10 AM, she said the cardboard box on the drink prep table should not have been there because trash was not supposed be on a prep table at all and she said it could cause cross contamination and make residents sick. She said the uncovered trash bin was supposed to be covered unless they were actively using. She moved it without covering it underneath the 3-compartment sink. In an interview with [NAME] A on [DATE] at 7:15 AM, she said the door on the convection oven had been that way for about a month. [NAME] A said the eyeglasses and water on the prep table belonged to her. She said there were cubbies in the DM's office with their names on them to store personal items. She said she should have had her glasses and water in her cubby. She said she cross contaminated the biscuit by not changing gloves and not washing her hands. She said she contaminated the food and that was bad because the residents could get sick. She said she did not usually do that (not change her gloves and wash her hands after touching a contaminated item while serving food). She said she was in a hurry at that time. She said she was always in a hurry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the FSM on [DATE] at 2:30 PM, she said the convection oven door had been hard to open for about a month. She said she started working at this facility on [DATE]. She said she told the MS about it a couple of weeks ago and he told her he was looking into the parts for it. She said the process for having equipment repaired was to let the MS know verbally. She said there were certain things he could do, otherwise the company for a particular piece of equipment did the repair, such as the dishwasher. She said personal items were never allowed in the kitchen because of sanitation issues and could contaminate food being prepped. She said hand washing rules were staff had to wash their hands as soon as they came into the kitchen and every time they touched something other than food. She said kitchen staff were required to wear gloves for all food preparations. She said if they changed gloves, they were required to wash their hands again and put on fresh gloves. She said contamination and bacteria could be transferred from the hands to the food and that was how germs were spread. She said the residents were already compromised and if they got something in them, one of the residents could easily get sick. She said there was a specific area for dented cans in the dry storage room that was labeled Dented Cans and did not know why or how the dented can was placed on the shelf with cans that were to be used for service. She said she and the rest of the kitchen staff were responsible for placing dented cans in the dented can area. She said once the cans were dented, the food inside could go bad. She said the trash on the prep table should have never been there because of cross contamination. She said the uncovered trash can was supposed to be covered unless it was actively being used and moving the trash bin under the 3-compartment sink did not count as covering it-it needed to have the lid on it. She said keeping trash cans covered was necessary because there was food scraps in there and could cause cross contamination and attract gnats, roaches or other bugs. She said the carton of powered mashed potatoes in the dry storage room should have been sealed with the date, labeled, and in a bag big enough to seal it properly. She said sealing dry storage items was important because the items could go bad or attract flies, gnats, roaches, etc. She said the items in the refrigerator should have been labeled and dated, always. She said it was important for food to be labeled and dated because they needed to know the date to tell if it was bad. She said 4 days was the cut-off for leftover food and then it should be discarded. She said the shelves over the stove and steam table were very hard to clean and it was cleaned weekly. She said the shelves were on the weekly cleaning schedule. She said the shelves did not look like they had been cleaned regularly. She said food was not allowed to be within 13 inches of the ceiling in the walk-in freezer because it could get contaminated from pipes above if they broke, and in the freezer, food would not get the circulation necessary to keep it at temp (frozen). She said frozen cases of food stacked to the ceiling in the walk-in freezer could also be a safety hazard in that it would be hard to reach and could fall on someone or catch fire because the boxes were blocking the fire sprinklers. The facility policy for personal items, handwashing, cleaning schedule, disposal of garbage, food storage, trainings and in-services were requested. In an interview with the FSM on [DATE] at 2:45 PM, she said the steam table wells were supposed to be cleaned weekly but did not look like they had been cleaned regularly. She said the open carton of powdered mashed potatoes was not sealed properly within the zip top type bag and was still open to air. In an interview with the MS on [DATE] at 2:52 PM, he said he knew nothing about the convection oven door. He said the process the kitchen was supposed to follow for repairs was they were supposed to write it in the work order book at the nurse's station. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on [DATE] at 9:11 AM, she said the housekeeping supervisor was responsible for the ice room. She said he was responsible for logging the temperatures, cleaning the refrigerator, and checking the temperatures for the logbook for. She said resident families put items in the ice room refrigerator without labeling or dating them. She said there was no process in place to educate staff, families, or the housekeeping supervisor about regulations regarding nutrition room refrigerators. In an interview with the ADM on [DATE] at 9:19 AM, he said the HSK S was responsible for the ice room that included cleaning the refrigerator and freezer and logging the temperatures. He said his expectations were that the HSK S was doing his due diligence and should notify him if anything was going on with the ice room. Observation of the ice room refrigerator and freezer and interview with the HSK S on [DATE] at 9:19 AM, he said he had been working at the facility for approximately 3 years and was assigned as the housekeeping supervisor in March of 2024. He said he started taking the temperatures of the ice room refrigerator in [DATE]. He said his responsibility for the ice room included checking the refrigerator and freezer for cleanliness and expired items, defrosting as needed, cleaning the refrigerator and freezer, and logging the temperatures daily. He said the refrigerator and freezer temperature logs should have included the freezer temp. He said resident's food was kept in the refrigerator and the freezer. He said there was no thermometer in the freezer. He said he did not know how cold freezing was. He said the ice room refrigerator and freezer template for logging temperatures was titled, Refrigerator/Freezer Temperature Log and the note below the title described the temperature ranges for the refrigerator and freezer and who to notify if the temperatures were out of range (the FSM or MS). He was informed the refrigerator temperature was 29F. He said that would explain the ice inside the refrigerator. He said he was responsible for defrosting. He said the facility got new refrigerator in [DATE]. He said he delegated his staff to log the temperatures and he had not looked inside the ice room or monitored his staff. Observation of the ice room refrigerator with HSK S revealed he said it needed to be defrosted and could not remove or identify the item that was frozen into the back of the refrigerator wall. He said he had 6 staff and there were 2 that switched for the ice room. He said, They were supposed to look inside, log the correct temp and clean and or defrost it. He said he was not sure of their names. He said he did not have any policy on the upkeep of the ice room. He said he did not know where the temperature log template came from. He said he did not know who was responsible for labeling and dating resident items. He said he did not know how to educate families and residents on labeling and dating foods in the ice room refrigerator and freezer. Record review of the monthly ice room refrigerator/freezer logs dated [DATE]-Nov. 2024 revealed The frozen temperature must remain 0 F or below, and the refrigerator temperature should be between 34F and 38F but no greater than 40F. If the temperatures are not within these ranges, notify the Director of Food and Nutrition Services or Maintenance immediately. New fridge was written [DATE]. Temperatures from [DATE]-[DATE] and [DATE]-[DATE] were marked at 40F except [DATE] the temperature documented was 48F. Temperatures from [DATE]-[DATE] were the same at 39F. The month of [DATE] was missing temperatures every day except [DATE] was 43F. [DATE] and [DATE] were marked 44F. Each day for the month of [DATE] was marked 40F. The month of [DATE] temperatures ranged from 37F to 40F. Each day for the months of Aug. 2024 and Sept. 2024 were marked 39F. Temperatures for the month of Oct. 2024 were marked 40F from Oct.1-Oct.21 and marked 34F to 35F from Oct. 22-Oct. 31. The month of Nov. 2024 temperatures ranged from 35F to 38F. No temperatures for the freezer in any month were documented. (continued on next page)

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	675637	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wooldridge Place Nursing Center	7352 Wooldridge Rd Corpus Christi, TX 78414

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the kitchen daily cleaning log listed 20 opportunities for daily cleaning including can opener, blender, steam table, slicer, table surfaces, stove top and grill, plate warmer, food processor, knife rack, floors (each shift), all sinks, cabinet area in dining room, beverage area, microwaves, ice machine scoops, utility carts (after each use), food carts (after each meal), mop bucket (empty and clean), mop heads and rags (sent to laundry), garbage cans and lids. The partial month of Sept. 2024 indicated for the week of [DATE]-[DATE], the steam table, slicer, knife rack, floors (each shift), garbage cans and lids were not done daily. Mop heads sent to laundry was done once on [DATE]. For the week of [DATE]-[DATE], the floors (each shift), all sinks, garbage cans and lids were not done daily. Mop heads sent to laundry was done once on [DATE]. For the week of [DATE]-[DATE], the steam table, stove top and grill, plate warmer, knife rack, floors (each shift), all sinks, cabinet area in dining room-now crossed off the list, beverage area, ice machine scoops, utility carts (after each use), food carts (after each meal), mop bucket (empty and clean), mop heads and rags (sent to laundry), and garbage cans and lids were not done daily. For the week of [DATE]-[DATE], [DATE]-[DATE], [DATE]-[DATE], and [DATE]-[DATE] none of the 20 opportunities were completed daily. For the week of [DATE]-[DATE], only 2 opportunities were missed daily- garbage cans and lids. For the week of [DATE]-[DATE], the kitchen daily cleaning log was revised at this time to list only 16 opportunities. The can opener, floors (each shift), all sinks, beverage area, microwaves, ice machine scoops, mop bucket (empty and clean), and garbage cans and lids were not done daily. For the week of [DATE]-[DATE] (only including to ,d+[DATE]), there were no concerns identified. Record review of the facility policy revised [DATE] and reviewed [DATE], titled Cleaning Schedule under Policy revealed .to ensure that the food and nutrition services department remains clean and sanitary at all times. Record review of the undated facility policy titled Chapter 9: Food and Nutrition Services revealed under Sanitation .It is necessary for the highest sanitary standards to be maintained throughout the department. Under bacteria and food-borne illness prevention .It is imperative that food-handling equipment and all persons associated with the handling of food be trained in this area. All foods are properly stored at the required temperatures. Refrigerators should be maintained between 34F to 38F to keep the temperature from reaching 45F or higher when the door is opened .Freezers are to be maintained at 0 F or lower. Under Garbage and waste disposal .Garbage cans are routinely cleaned and kept covered when not in use . keeping garbage areas clean and covered at all times will help prevent issues from arising. Under Hand washing/proper use of gloves .It is important that hands be properly washed .Hands are washed before beginning any job requiring food handling, after breaks, sneezing, etc. Proper use of gloves is as important as hand washing since they can become contaminated as easily as the hands .they are changed between tasks to prevent the contamination of food. Under refrigeration: Any food not in its original container must be labeled with the date and contents and must be securely covered.

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	675637	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wooldridge Place Nursing Center	7352 Wooldridge Rd Corpus Christi, TX 78414

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 46038 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, for two residents (Resident #26 and Resident #118) of six residents observed for infection control practices in that: The facility failed to ensure the WCN performed adequate hand hygiene by scrubbing hands with soap for at least 20 seconds or greater before and after performing wound care on Resident # 26 and Resident #118. This failure could place residents that require wound care at risk for healthcare associated cross-contamination and infections. The findings included: Record review of Resident #26 ' s face sheet dated 11/14/24 reflected an [AGE] year-old- female with an admitted [DATE]. Diagnoses included Alzheimer ' s disease (gradual decline in memory, thinking, behavior and social skills), type 2 diabetes (insufficient production of insulin in the body), and heart failure. Record review of Resident #26 ' s care plan dated 9/6/24 stated Resident #26 had a wound infection. Interventions included enhanced barrier precautions. Record review of Resident #118 ' s face sheet dated 11/14/24 reflected a [AGE] year-old-female with an admitted [DATE]. Diagnoses included end stage renal (kidney) disease, type 2 diabetes (insufficient insulin production in the body), and aftercare following surgical amputation (right 5th toe). Record review of Resident #118 ' s care plan dated 11/12/24 stated Resident #118 had actual impairment to skin integrity due to surgical wound. Interventions included enhanced barrier precautions (risk-based approach to personal protective equipment to reduce the spread of multidrug-resistant organisms). During an observation on 11/14/24 at 9:36 AM of wound care, the WCN performed hand hygiene for 17 seconds prior to Resident #118 ' s wound care. After wound care was performed as ordered, the WCN performed hand hygiene for 12 seconds. During an observation on 11/14/24 at 10:02 AM of wound care, the WCN performed hand hygiene for 17 seconds prior to Resident #26 ' s wound care. After wound care was performed as ordered, the WCN performed hand hygiene for 10 seconds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/14/24 at 10:19 AM the WCN stated it was important to wash and lather hands for 20 seconds or greater to prevent infection and stop the spread of germs. The WCN stated by not washing hands for the appropriate amount of time, it could put residents at risk of getting their wounds infected or slow the healing process. The WCN stated she was nervous and did not realize she was not washing her hands for at least 20 seconds. The WCN could not state when the last in-service on performing hand hygiene was. In an interview on 11/14/24 at 10:24 AM the DON stated all staff are expected to wash hands for at least 20 seconds or greater to maintain infection control measures and stop the spread of germs. The DON stated not performing hand hygiene as recommended could cause the residents wounds to get infected. The DON stated the last skills check off for hand hygiene was around May of 2024. The DON stated she was going to conduct a one-on-one training with the WCN and in-service all staff on hand washing. Record review of the facility ' s Infection Prevention and Control Program and Plan dated 6/13/24 stated: Policy The facility has an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible and reviews and updates the IPCP annually and as necessary. This would include revision of the IPCP as national standards change; Infection Control The facility must 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.