STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675646	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snyder Oaks Care Center	210 E 37th St Snyder, TX 79549

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on interviews and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days unless the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days and documented their rationale in the resident's medical record and indicated the duration for the PRN order, for 1 of 17 residents (Resident #19). Resident #19 continued to have a PRN order for Clonazepam 0.5mg after 14 days without an evaluation by the physician for continued treatment. This failure could result in residents receiving psychotropic and antipsychotic medications when contraindicated and could also result in residents experiencing adverse drug reactions, decreased quality of life and dependence on unnecessary psychotropic medications. The findings included: Record review of Resident #19's face sheet, dated 10/14/24, revealed a [AGE] year-old-male who was admitted to the facility on [DATE] with diagnoses to include anoxic brain injury (lack of oxygen to the brain), myoclonus (involuntary muscle jerks), and encephalopathy (a change in how the brain functions). Record review of Resident #19's comprehensive MDS assessment, dated 02/14/24, revealed Section N - Medication Section N0415 - Medications Received: B - Antianxiety was marked - Is Taking. Record review Resident #19's comprehensive care plan, last review completed 08/14/24, revealed a care area Potential for complications related to antianxiety medication use, I take Klonazepam [Clonazepam]. Record review of Resident #19's active orders dated 10/14/24 revealed the following orders: Clonazepam 0. 5mg; oral twice a day - PRN, with a start date of 06/01/22 and no end date. Record review of Resident #19's medication administration record, dated 10/14/24, for the months of July 2024, August 2024, September 2024 and October 2024 revealed Resident #19 had not received the medication clonazepam that was ordered as needed. (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: 675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Snyder Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 E 37th St Snyder, TX 79549	

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the pharmacy reviews for May 2024, June 2024, July 2024, August 2024, and September 2024 revealed Resident #19 did not have any pharmacy recommendations for the medication Clonazepam. Record review of Resident #19's medical records revealed no evaluation and no rationale for the continued PRN use past 14 days for the prn Clonazepam. During an interview on 10/14/24 at 3:45 PM, the DON stated she was responsible for checking the residents' medications for PRN psychotropic medications. The DON stated Resident #19's PRN Clonazepam was put in the wrong category in the orders and that was why this medication was missed. The DON stated she received training from corporate on doing chart audits but does not know exactly when the last training was. The DON stated the potential negative outcome to the resident was a risk of non-use of the medication or a possibility of continued use of the medication when there was no need. The DON stated another potential negative outcome to the resident was they could be overmedicated. During an interview on 10/15/24 at 8:36 AM, the Adm stated the DON was responsible for ensuring the residents did not have an order for a PRN antianxiety medication over 14 days. The Adm stated the DON should have been trained on this but does not know when. The Adm stated she did not know why Resident #19 had an order for Clonazepam 0.5mg PRN for longer than 14 days. The Adm stated a potential negative outcome to the resident was they could have side effects, or the medication could be outdated/old. Record review of the facility policy titled, Psychoactive Medications, dated July 2024 reflected the following: Policy: Residents are not given psychotropic medications unless the drug is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Definition: A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. Guidelines: 7. PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e., 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the prn order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the prn order. 8. PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snyder Oaks Care Center	210 E 37th St Snyder, TX 79549

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 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49279

Based on observation, interview, and record review the facility failed to ensure that its medication error rate was less than 5 percent. The facility had a medication error rate of 7.14% based on 2 out of 28 opportunities, which involved 2 of 5 Residents (Residents #4 and #36) reviewed for medication administration, in that:

1. LVN A failed to verify the dosage and amount on Resident #4's Seroquel medication order prior to administering the medication, resulting in Resident #4 being underdosed.

2. LVN B was unable to give Resident #36 the ordered medication for Multi Vitamin with iron, due to not having the correct multi vitamin available, resulting in a missed dose.

These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health.

Findings included:

Resident #4

Record review of Resident #4's undated face sheet revealed an [AGE] year-old female, originally admitted to the facility on [DATE]. Resident #4 had a medical history of Chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breathe), schizoaffective disorder bipolar type (a rare mental illness that combines schizophrenia symptoms with bipolar disorder), and Generalized anxiety disorder.

Record review of Resident #4's physician orders revealed an order for Seroquel (quetiapine) tablet 50 mg; amt: 1.5 tabs; oral with special instructions Add to 100 mg to = 175 mg twice a day 06:15 AM - 10:00 AM and 06:00 PM - 10:00 PM dated 03/07/24 and an order for Seroquel (quetiapine) tablet; 100 mg; amt:100, twice a day, 06:15 AM - 10:00 AM and 06:00 PM to 10:00 PM dated 03/07/24.

During a medication administration observation on 10/14/2024 at 06:42 AM, for Resident #4, LVN A was observed dispensing one 100mg tablet of Seroquel and half a tablet of the Seroquel 50mg tablets. Total dosage administered at this time was 125mg of Seroquel.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Snyder Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 E 37th St Snyder, TX 79549	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN A on 10/14/2024 at 10:04 AM, she stated Resident #4 had been ordered 150mg of Seroquel and she had given one 100mg tablet and half of a 100mg tablet making it 50mg and giving a total of 150mg of Seroquel. LVN A reviewed the order and stated, I guess they must have changed her dosage recently as now it states to give 175mg, so I was short 25mg. LVN A grabbed Resident #4's medication blister pack and confirmed it had pre-cut tablets in each individual compartment and had the following order Seroquel (quetiapine) tablet 50 mg; amt: 1.5 tabs. LVN A stated she verified with the DON the medication blister pack contained tablets cut in half making them 25mg each and she had not given the resident 50mg of her ordered dose. LVN A stated she had been trained on verifying orders before giving them. She stated dosage changes are usually communicated between shift change reports and are placed in the 24 hours notes. She stated the potential negative outcome of not giving residents the correct dose could be a medication error, residents having a change in mental status or them not reaching their desired therapeutic outcome. Resident #36 Record review of Resident #36's undated face sheet revealed an [AGE] year-old male originally admitted to the facility on [DATE]. Resident #36's had a medical history of dementia (a chronic condition that causes a loss of cognitive function, such as thinking, remembering, and reasoning, that interferes with daily life), muscle wasting (loss of muscle mass and strength due to disease or lack of use), and muscle weakness. Record review of Resident #36's physician orders revealed an order for Adults Multivitamin (multivitamin-minerals-iron-folic acid-vitamin k), strength 18 mg iron-400 mcg-25 mcg with a start date of 03/21/23. During a medication administration observation on 10/14/2024 at 07:05 AM, for Resident #36, LVN B verified the physician order with the available medication and determined the medication was not the same as what was ordered. LVN B stated the multi vitamin bottle available did not have the iron or vitamin k that was on the physician order. LVN B did not administer this medication, resulting in a missed dose. During an interview with LVN B on 10/14/2024 at 12:26pm, she stated she had notified the DON about not having the correct multi vitamin for Resident #36. She stated she is an agency nurse and today was her first day at this facility, so she was not sure why the facility did not have the medication available. She stated the risk of the residents not receiving their ordered medication could be causing a medication variance and not following the residents' therapeutic plan. During an interview with the ADM on 10/15/2024 at 9:33 AM, she stated all nurses are trained to verify orders prior to giving the medication. She stated the DON is responsible for making sure the nurses are trained on medication administration. She stated the potential negative outcome of residents not receiving the correct ordered dose could be, not reaching the therapeutic effect. The ADM stated if they are unable to obtain the ordered medication through their suppliers they can go to a pharmacy and obtain the right medication. She stated in Resident #36's case the risk of him not getting his multi vitamin could be him not receiving the proper nutrition or increasing his iron. She stated her expectation of staff is no ensure the right medication is being ordered and provided to residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Snyder Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 E 37th St Snyder, TX 79549	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 10/15/2024 at 10:01 AM, she stated all nurses are trained on medication administration and medication rights. She stated the last training was on 8/2024. She stated the DON and Assistant DON are responsible for that training. She stated the potential negative outcome of not verifying orders before administering the medication could be causing a medication error and residents not receiving what they need. The DON stated for Resident #4 the risk of her not receiving the correct ordered dose could be an increase in behaviors, adverse reactions, and not reaching therapeutic effect. She stated each medication should be verified each time, with each medication, and with each resident. She stated the over-the-counter multi vitamins are usually obtained through a contracted supplier or if they do not have a certain medication, they can go out and obtain in separately. She stated the potential negative outcome of not having the correct medication could be residents having an adverse effect or not having their therapeutic desired outcome. She stated they monitor compliance by performing audits for medications that were not administered. She stated the pharmacist that does their monthly review will also notify the DON and ADON of any areas of concerns. Record review of facility policy titled MEDICATION ADMINISTRATION-GENERAL GUIDELINES dated 6/1/2022, revealed: .4) FIVE RIGHTS - Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. a. Check # 1: Select the Medication - label, container and contents are checked for integrity, and compared against the medication administration record (MAR) by reviewing the 5 Rights. b. Check #2: Prepare the dose -the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights . 11) If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted, or medication removed from the night box/emergency kit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Snyder Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 E 37th St Snyder, TX 79549	

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 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. 49279 Based on observations, interviews, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles and ensure all drugs and biologicals are stored in locked compartments and permit only authorized personnel to have access to the keys, for 1 of 2 medication carts (Med Cart B) reviewed for medication storage. 1. The facility failed to ensure that all medications stored in Med Cart B were stored in their original container/packaging. 2. LVN B failed to lock Med Cart B before stepping away from the cart. These failures could result in medication administration error or misappropriation of drugs. Findings Included: During an observation of Med Cart B on 10/14/2024 at 12:00 pm, one round white pill was found in the second drawer and one round white pill was found in the third drawer. LVN B took the medication to RN C who identified the two pills as Lasix 20mg. The medication was disposed of by RN C and LVN B in their designated receptacle. During an observation of Hall 3 on 10/14/2024 at approximately 1:30 PM, Med Cart B was observed unlocked and unattended with 1 Resident in a wheelchair within 10 feet of the cart. During an interview with LVN B on 10/14/2024 at 1:33 PM, she stated she had not been trained on checking the carts at this facility. She stated she was an agency nurse and it had been her first day back at this facility after a few months. She stated the potential negative outcome of medications being loose in the cart could be a medication error or a resident being short on their medication amount. She stated she was not aware of the loose pills in the cart prior to assuming care over the cart. LVN B stated she was aware she had left the med cart unlocked. She stated she should not have done that, and she should have locked it before stepping away. LVN B stated a potential negative outcome for leaving the med cart unlocked was a resident could get into something they were not supposed to. During an interview with the ADM on 10/15/2024 at 9:33 AM, she stated all nurses are trained to check the medications carts and they should be checking them daily. She stated the DON is responsible for training the nurses. She stated the carts should be locked at all times if the nurse steps away. The ADM stated the potential negative outcome of not keeping the carts free of loose pills is potentially giving the wrong medication to a resident and could cause harm. She stated the DON and ADON conduct rounds on the carts and monitor for med cart compliance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER: Snyder Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 210 E 37th St, Snyder, TX 79549	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 10/15/2024 at 10:01 AM, she stated all nurses are trained on checking the medication carts and the last training was on 6/20/2024. She stated the DON and ADON are responsible for the training. She stated she did not believe there was a set day or time for carts to be checked but anytime the nurse comes on shift, they should be checking the carts. She stated the potential negative outcome of not keeping the carts free of loose pills could be the nurse grabbing the wrong medication and the cleanliness of the cart not being kept. She stated medication carts should not be left unlocked at any time. She stated the potential negative outcome of leaving the med cart unlocked could be a resident getting into the med cart or medication being tampered with. Record review of facility policy titled Storage of Medications dated 11/2020 revealed: Policy heading: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 2. Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . 6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Snyder Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 E 37th St Snyder, TX 79549	

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42515 Based on observation, interview and record review, the facility failed to provide food and drink that was palatable, attractive and at a safe and appetizing temperature for one of one kitchen. A. Resident #7, #18, #53, #159 voiced concerned of cold food, flavor and/or texture. B. Six of the 12 foods sampled on the meal tray were cold. C. Two of the 12 foods sampled on the meal were salty. D. One of the 12 foods sampled on the meal tray was tough. These failures could affect the forms of food provided in the facility (regular, mechanical chopped and pureed) and could result in a decline in residents' consumption of food and residents to have unwanted weight loss. The findings include: On 10/13/24 during initial tour of facility, three residents (#7, #53, #159) voiced concerns of the food. During the initial tour process on 10/13/24 between 10:55 AM and 11:30 AM, 2 confidential interviews with residents revealed the following comments regarding the food at the facility, The food is not good and is cold at times. Another resident stated, The food is undercooked and tastes terrible. During an interview on 10/13/24 at 03:22 PM, Resident #7 was asked how the food was and he responded by saying the food is ok, but it's getting bad occasionally, no taste. Stated he has spoken with kitchen staff, and they do nothing. During an interview on 10/13/24 at 03:27 PM, Resident #53 was asked how the food tasted and she stated the food is of poor quality, some of it has blend taste, processed meat, and soiled. The food occasionally is hot but cold by the time it gets to us. Occasionally we get chicken. They don't provide us with quality food, either because of the budget or vendor's choice. During an interview on 10/13/24 at 04:00 PM, Resident #159 was asked how the food was and she responded by saying the food is not good at all, meat is tough and usually cold most times. Observed [NAME] B at 12:07 PM scoop out three & half scoops of greens bean with half cup of milk into the food processor. The cook processed the green beans with milk for about three minutes and [NAME] B looked at the puree and stated it was smooth. A sample tray was requested on 10/14/24 at 11:15 AM of all the food forms served including the alternate plate and requested to have the sample trays delivered after the last hall tray was delivered. The sample tray on 10/14/24 was delivered to the survey room [ROOM NUMBER]:54 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Snyder Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 E 37th St Snyder, TX 79549	

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sample tray findings found by the survey team and ADM were the following: FOOD ITEMS Taste, Tempt, Texture Regular Sandwich Cold Regular Turkey Cold/tough Regular Corn Cold Mechanical Corn Bread Cold Mechanical Tomatoes Salty Puree Turkey Cold/Salty/blend Puree Tomatoes Cold/no flavor During an interview on 10/13/24 at 03:07 PM, Resident #18 said sometimes the food is good and most times it's not, cold sometimes, the facility serve him the same type of meal every morning (oatmeal). During an interview on 10/14/24 at 1:05 PM, ADM stated the puree turkey was very salty. During an interview on 10/15/24 at 10:00 AM, [NAME] C stated some of the residents don't come into the dinning, so the food is covered before resident comes in. She stated, I agree that you can't serve someone that's not physically present because the resident should be at the dinning before meal is provided. During an interview on 10/15/24 at 10:27 AM, DM A stated honestly, when we put it out, I don't know how long it takes to get to the resident. DM A stated she and other kitchen staff were responsible for monitoring of food temperature, texture, and flavor. Again, it depends on how long the cart seat there. During an interview on 10/15/24 at 11:01 AM, ADM stated there's no excuse, food should be kept at the right temperature, the cook knows that it should be at the right temperature. A request was made for palatability or texture policy from the Facility ADM; did not provide a requested policy. 48275

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675646	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snyder Oaks Care Center	210 E 37th St Snyder, TX 79549

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. 48275 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in one of one kitchen reviewed for dietary services. 1) The facility failed to ensure foods were covered, labelled & dated. 2) The facility failed to protect foods from potential contamination. 3) The facility failed to ensure foods were stored under sanitary conditions. These failures could place residents at risk for food-borne diseases. The findings included: - The following observation was made during a kitchen tour on 10/13/24 that began at 10:49 AM and concluded at 12:07 PM: - Dirty unknown black particles around the sink. - Dirty and sticky front doors of 2 freezers and 1 refrigerator. - Undated, uncovered, and unlabeled Sandwich inside the refrigerator. - Undated, uncovered, and unlabeled small donut shaped item on a tray inside the refrigerator - Undated, uncovered, and unlabeled round shape vegetable inside the refrigerator - Undated Swiss cheese inside the refrigerator. - Undated Tortillas inside the refrigerator. - Undated Pimento cheese inside the refrigerator. - Undated American sliced Cheese inside the refrigerator. - Undated Peas inside the refrigerator. - Undated Sausage inside the refrigerator. - Unlabeled small donut shaped items in a clear plastic bag inside the freezer. - Unlabeled brown pecan shaped like items in a clear plastic bag inside the freezer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Snyder Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 E 37th St Snyder, TX 79549	

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	- Unlabeled and undated long green pepper shaped item in a clear plastic bag inside the freezer. - Unlabeled and undated shredded pinkish raw meat like item covered in a clear plastic wrapping inside the freezer. - Unlabeled and undated red raw meat like item covered in a clear plastic wrapping inside the freezer. - Unlabeled and undated long pinkish raw meat like item covered in a clear plastic wrapping inside the freezer. Interview on 10/15/24 at 09:35 AM, the Dietary aid stated the cook would be responsible for ensuring food items were covered, labelled, and dated. The Dietary aid stated most of the time, Dietary staff are in a rush, so they forgot to cover, label and date the food items. The Dietary aid stated she was not trained in labelling and dating food items. The Dietary aid stated the potential negative outcomes to the residents with unlabeled, uncovered, and undated food items, the food could go bad, and the residents can get sick from it. The Dietary aid stated the black unknown particles on the sink has been there since she started, could be build up, that she does not know what it could be. The Dietary aid stated stains on the freezer and refrigerator should have been wiped down. The Dietary aid stated thermometers for the food trays should have been cleaned. The Dietary aid stated she was not told anything about policy for food storage/labelling. Interview on 10/15/24 at 10:00 AM, the Kitchen chef stated the responsibilities for ensuring food items were covered, labelled, and dated depend on Dietary staff that is on duty when the truck comes in. The Kitchen chef stated maybe someone took off the labels and dates. The Kitchen chef stated she, Head cook, and Dietary Manager were responsible for ensuring/monitoring food items were covered, labelled, and dated, The Kitchen chef stated she was trained but have not seen any policy for food storage/labelling. The Kitchen chef stated the potential negative outcomes to the residents with unlabeled, uncovered, and undated food items, the potential of serving them spoilt food that would make them sick. The Kitchen chef stated that she does not work that side of the kitchen sink that had black unknown particles that look like mold, and which was not safe for the residents. The Kitchen chef stated and confirmed that those unclean food tray thermometers were the ones surveyor brought back to them at the kitchen and are not safe to be used. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Snyder Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 210 E 37th St Snyder, TX 79549	

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	Interview on 10/15/24 at 10:27 AM, the Dietary Manger stated whoever was on duty was responsible for ensuring food items were covered, labelled, and dated. The Dietary Manager stated she had no clue why the food items were not covered, labelled, and dated. The Dietary Manger confirmed the following items from the refrigerator/freezer as: undated, uncovered, and unlabeled small donut shaped item on a tray as Mini donut, undated, uncovered, and unlabeled round shape vegetable as Cabbage, unlabeled small donut shaped items in a clear plastic bag as Mini donut, unlabeled brown pecan shaped like items in a clear plastic bag as Pecans, unlabeled and undated long green pepper shaped item in a clear plastic bag as Chili, unlabeled and undated shredded pinkish raw meat like item covered in a clear plastic wrapping as Pulled pork, unlabeled and undated red raw meat like item covered in a clear plastic wrapping as Ground beef, unlabeled and undated long pinkish raw meat like item covered in a clear plastic wrapping as Pork tenderloin. The Dietary Manager stated she was responsible for ensuring/monitoring food items were covered, labelled, and dated. The Dietary Manager stated the potential negative outcomes to the residents with uncovered, unlabeled, and undated food items, cooking something leading to residents getting sick. The Dietary Manger stated the black unknown particles at the sink which she identified as mold and uncleaned food tray thermometers are not safe for the residents. The Dietary Manger stated that she has the policy for food storage/labelling. Interview on 10/15/24 at 11:01 AM, the ADM stated the Dietary Manager, [NAME] and anyone there in the kitchen were responsible for covering, labelling, and dating of food items. The ADM stated kitchen staff members have all been trained on covering, labelling/dating of food items. The ADM stated the Dietary Manager was responsible for making sure food items were properly covered, labelled, and dated. The ADM stated food items should be covered, labelled, and dated but the kitchen staff must have forgotten. The ADM stated the potential negative outcomes to the residents with uncovered, unlabeled/undated food, could cause the residents to be sick. The ADM stated she knew that the kitchen staff have been cleaning the sink that contain those black unknown particles. She informed the staff about getting a new sink and think they should be cleaning the sink daily when shown the unknown black particles. The ADM stated, the black unknown particles could lead to residents getting sick. The ADM stated the food tray thermometers need to be cleaned after each use. The ADM stated that they do have a policy on food storage/labelling. Record review of the facility policy and procedure titled, Food storage, dated 10/01/2018, revised date 06/01/2019, reflected the following: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Code and HACCP guideline. Procedure: 2. Refrigerators d. Date, label and tightly seal all refrigerated food using clean, nonabsorbent, covered containers that are approved for food storage. 3. Freezers e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER: Snyder Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 210 E 37th St Snyder, TX 79549	

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	Record review of the facility policy and procedure titled, General kitchen sanitation, undated, reflected the following: Policy: The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition & Food service employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes to minimize the risk of infection and food borne illness. Procedure: 1. Clean and sanitize all food preparation areas, food-contact surfaces, dining facilities and equipment. After each use, clean and sanitize all tableware, kitchenware, and food-contact surfaces of equipment, except cooking surfaces of equipment and pots and pans that are not used to hold or store food and are used solely for cooking purposes. 3. Keep food-contact surfaces of all cooking equipment free of encrusted grease deposits and other accumulated soil. 6. Clean non-food-contact surfaces of equipment at intervals as necessary to keep them free of dust, dirt, and food particles and otherwise in a clean and sanitary condition. 7. Store, handle and dispense all single-service article in a sanitary manner and use only once.