

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675709	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER Timberidge Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 315 W Gibson Jasper, TX 75951	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an encoded, accurate, and complete MDS assessment was electronically transmitted to the CMS System within 14 days after completion for 1 of 4 residents (Resident #22) reviewed for encoding/transmitting assessments. The facility failed to transmit a death record assessment for Resident #22 within 14 days of completion. This failure could place residents at risk of not having records completed and submitted in a timely manner as required. Findings include: Record review of a face sheet dated [DATE] indicated Resident #22 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included cirrhosis of the liver (chronic liver damage leading to scarring and liver failure), hepatitis (inflammation of the liver), and hepatomegaly (enlarged liver). Record review of progress notes dated [DATE] indicated Resident #22 expired on the evening of [DATE] while a resident in the facility. Record review of Resident #22's electronic medical record indicated a death in facility tracking record was completed with an A2000 (date of death) of [DATE]. There was no evidence in the medical record to indicate the record had been electronically transmitted. Record review of a MDS 3.0 NH Final Validation report dated [DATE] indicated the death in facility tracking form assessment was submitted after surveyor intervention. The Validation report included the following information: Warning: Record Submitted Late: The submission date is more than 14 days after A2000 on this new death in facility tracking record. During an interview on [DATE] at 02:10 PM with the MDS Coordinator, she said she was not an employee of the facility at the time of Resident #22's death and was not aware the death in facility tracking form assessment had not been submitted. She said she did not know why it had not been transmitted to the CMS system. The MDS Coordinator said the death in facility tracking record assessment should have been completed and submitted via electronic transmission to the MDS data base within 14 days of Resident #22's death. The MDS Coordinator said it was important to complete and transmit the MDS assessments timely because they affect quality of care measures. She said failure to complete and transmit discharge MDS assessments could result in inaccurate Quality Measures. The MDS Coordinator said the facility used the RAI 3.0 Manual's schedule for completing and transmitting all MDS assessments. During an interview with the Administrator on [DATE] at 02:20 PM, she said she expected the MDS Coordinator to complete and transmit the MDS assessments as scheduled and required by state and federal governing agencies. Record review of the CMS's RAI Version 3.0 Manual dated [DATE], Chapter 5: Submission and Correction of Resident Assessments indicated the following: Tracking Information Transmission: For Death in Facility tracking records, information must be transmitted within 14 days of the date of death (recorded in section A2000 for Death in Facility records).</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen observed for kitchen sanitation. The facility failed to ensure:- the dish machine was not sanitizing- the ice machine ice chute and air intake vent were not clean- in the reach in cooler chocolate milk pints were out of date - 2 packages of dry pasta were no re-closed after opening- freezer #1 had a package of frozen fried eggs open and not secured closed- the pan rack had 8 pans stacked wet, 1 with food debris present and 1 greasy full size baking sheet- the deep fryer had cornmeal-like debris floating on the surface of the oil, stuck to both fry baskets, and covering the drain tray.- the spice rack had brown sugar and powdered sugar packages opened and not re-sealed.- the 3 compartment sink was not sanitizing and the QA test strips were out of date. These failures could place residents who ate food from the kitchen at risk of foodborne illness. Findings included: During observations, interviews and record reviews on 08/04/2025 of the kitchen the following was noted: At 10:43 AM the DM tested the dishwashing machine and the chlorine test strip did not react indicating it was not sanitizing. The container of sanitizer connected to the machine was empty. She said when she checked the machine earlier around 8:30 AM and it was sanitizing and she logged it on the sanitizer log. The dish machine sanitizing log indicated it tested at breakfast on 08/04/2025 at 50 ppm. The manufacturer's recommendations accepts 50 ppm-200 ppm as adequate for sanitizing. At 10:46 AM the ice chute inside the ice machine was swiped with a clean paper towel and returned with some black and brown debris and discoloration. The air vent above the ice machine door was caked with greasy, black lint-type debris. At 10:47 AM the DM said the ice machine vendor cleaned the machine and was at the facility on Friday, 07/25/2025 and Monday, 07/28/2025. She said dietary did not clean the inside of the machine and said the vendor only came every 6 months and maintenance called them to come do the routine cleaning. She said she had only been at the facility for 4.5 months and this was the first time she had seen him. She said dietary wiped down the gasket area and the lid routinely as needed or daily. At 11:00 AM in the 2 door reach in cooler there were 23 pints of chocolate milk dated 08/01/25. The DM removed the out of date chocolate milk pints from the cooler. She said they only had 1 resident that drank chocolate milk. At 11:08 AM in the dry pantry there was 1-16 oz box of lasagna sheets opened and not re-sealed and 1-10 lb. bag of elbow macaroni that was open and not re-sealed. The DM said staff were to close up bags and boxes after opening or place items in zippered bags. At 11:10 AM in freezer #1 in the pantry there was 1 unlabeled, thin plastic bag containing what appeared to be frozen, fried eggs that was opened and the product was visible with nothing covering the product. Freezer frost had fallen from the shelf above the frozen fried eggs into the bag. The DM said 2 residents ate the frozen fried eggs because they could eat them easily with their fingers. She took the bag and tied it in a knot so it was closed and returned it to the freezer. At 11:20 AM the following pans on the pan rack were stacked wet. 1-full size 4 deep stainless steel pan 1-1/2 size 6 deep stainless steel pan 1-1/2 size 8 deep stainless steel pan 3-1/4 size 6 deep stainless steel pan 1 had visible white food debris 1-1/4 size square 4 deep stainless steel pan 1-1/4 size square 2 deep stainless steel pan 1-full size baking sheet was greasy and had visible solidified grease droplets in the center of the sheet. The baking sheet was greasy to the touch on the cooking surface and the bottom of the tray. At 11:23 AM the deep fryer had cornmeal-like debris floating on the surface of very dark oil, cornmeal-like debris was stuck to both fry baskets, and cornmeal-like debris was covering the drain tray. At 11:25 AM on the spice rack there was 1-1 lb. bag of brown sugar opened and not re-sealed and 2-1 lb. boxes of powdered sugar were opened and placed inside an open zip bag. At 11:40 AM the DM said she knew the dishes and pans were not to be stacked wet. She said she was not sure if the staff knew the pans had to be dry when stacked. She said she would have to ask [NAME] A which she did not do. She said she was responsible for training staff on kitchen procedures and monitoring them to ensure compliance with regulations and policy. At 11:42 AM [NAME] A said the pots, stainless steel pans, and dishes were to be stacked when they had air dried. At 11:48 AM the dish machine was checked again after the DM had connected a fresh container of sanitizing solution and the solution was not pumping into the machine. The DM said maybe the maintenance man could get it fixed. At 11:55 AM the DM said the three compartment sink was not used for sanitizing. She said dishes, pans, pots and other items were washed in the sink and then placed in the dish machine for sanitizing. Quaternary Ammonium (QA) was used for sanitizing/disinfecting in the three-compartment sink and also in the red buckets staff used to wipe down prep surfaces and kitchen areas. A red bucket with clear solution and a kitchen cloth was on the stainless steel</p>		