STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675886	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coryell Health Rehab Living at the Meadows	110 Chicktown Rd Gatesville, TX 76528

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to establish a system of record of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for 5 of 8 medication carts (Medication Aide Cart and Nurse Cart for Unit 2, Medication Aide Cart and Nurse Cart for Unit 3, and Medication Aide Cart for Unit 4) reviewed for pharmacy services.The facility failed to record narcotic receipt and reconciliation documentation for the medication aide cart on unit 2, the nurse cart on unit 2, the medication aide cart on unit 3, the nurse cart on unit 3, and the medication aide cart on unit 4 during each shift change.This failure could place residents at risk of drug diversions and could result in missed medication, diminished health and well-being.Findings Include:Review of the Change of Shift Narcotic Count Sheets on the Medication Aide Cart for Unit 2 reflected missing narcotic receipt and reconciliation documentation on 02/07/2026 for the off-going night shift.Review of the Change of Shift Narcotic Count Sheets on the Nurse Cart for Unit 2 reflected missing narcotic receipt and reconciliation documentation on 02/07/2026 for the off-going night shift and on 02/08/2026 for the off-going day shift.Review of the Change of Shift Narcotic Count Sheets on the Nurse Cart for Unit 3 reflected missing narcotic receipt and reconciliation documentation on 02/01/2026 for the on-coming day shift and on-coming night shift, 02/03/2026 for the off-going night shift, and on 02/10/2026 for the on-coming and off-going day shift.Review of the Change of Shift Narcotic Count Sheets on the Medication Aide Cart for Unit 3 reflected missing narcotic receipt and reconciliation documentation on 02/03/2026 for the off-going day shift and off-going night shift.Review of the Change of Shift Narcotic Count Sheets on the Medication Aide Cart for Unit 4 reflected missing narcotic receipt and reconciliation documentation on 02/05/2026 for the off-going day shift.During an interview with LVN G on 02/11/2026 at 2:03 p.m., she stated that it was required for the off-going and on-coming staff to count the narcotic medications and sign the narcotic count sheet. She stated that a negative outcome of not consistently following the narcotic count expectations was a possibility of drug diversion.During an interview with LVN E on 02/11/2026 at 2:12 p.m., she stated that it was required for the off-going and on-coming staff to count the narcotic medications and sign the narcotic count sheet. She stated that a negative outcome of not consistently following the narcotic count expectations was a possibility of drug diversion.During an interview with MA on 02/11/2026 at 2:15 p.m., she stated that it was required for the off-going and on-coming staff to count the narcotic medications and sign the narcotic count sheet.During an interview with LVN F on 02/11/2026 at 2:22 p.m., she stated that it was required for the off-going and on-coming staff to count the narcotic medications and sign the narcotic count sheet. She stated that a negative outcome of not consistently following the narcotic count expectations was a possibility of drug diversion.During an interview with the DON on 02/12/2026 at 12:18 p.m., she stated that it was required for the off-going and on-coming staff to count the narcotic medications and sign the narcotic count sheet. She stated that a negative outcome of not consistently following the narcotic count expectations was a possibility of drug diversion. She stated that she plans on re-educating staff over this expectation. Review of the facility's Controlled Substances policy titled Dispensing and Reconciling Controlled Substances last revised on 11/2022, reflected: Nursing staff count controlled (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.

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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 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. Based on observations, interviews, 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 reviewed for kitchen sanitation. The facility failed to ensure the kitchen dishwasher contained sanitizer. The facility failed to ensure expired items were removed from the reach in refrigerator in the dining room containing residents' beverages. (individual milk cartons with best by date of 02/08/26). The facility failed to ensure food remained off the ground in the walk-in freezer. (individual serve cups of ice cream). The facility failed to ensure CK A, CK B, and CK H properly sanitized a food thermometer before and after use when taking food temperatures for lunch service on 02/10/26. The facility failed to ensure DA wore a hairnet while in the kitchen during meal preparation for lunch service on 02/10/26. These failures could place residents who received prepared meals from the kitchen at risk for foodborne illness and cross-contamination.The findings included: During an initial tour of the kitchen and dining room on 02/10/26 at 08:27 a.m. the following was observed:In a walkthrough with the ND, he was asked to run the dishwasher to test the sanitizer. It was ran and the chemical strip returned indicating no sanitizer was being released into the dishwasher. It was then observed that the sanitizer container to the dishwasher was empty. The ND stated the sanitizer was empty and he would need to place a call to have some ordered since they did not have any more. ND was observed placing the call to order sanitizer.The walk-in freezer contained multiple single-serve vanilla ice cream cups on the floor.The reach in refrigerator contained multiple single-serve milk cartons with a best buy date of 02/08/26. During an observation on 02/10/26 at 10:34 a.m. in a follow up to the kitchen for pureed food observation, CK B was observed taking the temperature of a chicken gumbo without sanitizing the thermometer probe before use. CK B was then observed wiping the thermometer probe with a dry rag before closing it and putting it away without sanitizing it. During an observation on 02/10/26 at 11:00 a.m. in a follow up to the kitchen for pureed food observation, CK A was observed pulling a thermometer out of his pocket to take the temperature of ravioli (no sauce) that had just finished cooking. The thermometer probe was not sanitized prior to using it on the ravioli. The thermometer was then observed left opened sitting on top of the prep station countertop. CK A then pureed ravioli with Marinara sauce and after finishing the puree was observed grabbing the thermometer from the counter and taking the ravioli puree temperature without sanitizing the thermometer probe. After taking the temperature of the pureed ravioli CK A was observed wiping the thermometer probe with a dry rag taken off the prep station counter and then using it to take the temperature of a soup. During an observation on 02/10/26 at 11:52 a.m. during lunch service in the main dining room, CK H was observed wearing gloves throughout the entire service while serving residents food from the steam table. CK H was observed completing several different tasks without changing his gloves or washing his hands. CK H was observed taking food temperatures from the steam table then wiping the thermometer probe with a dry rag and not sanitizing it. CK H recorded the temperatures in a logbook, took temperatures of other food items, but did not change gloves while in contact with different surfaces. During an interview on 02/10/26 at 11:11 a.m. with CK A, he stated that he was supposed to sanitize the thermometer probe with an alcohol wipe before and after use. CK A stated there were stations around the kitchen that contained alcohol wipes, and pointed to an area near the prep station across the ovens where a small bin hung containing alcohol wipes. CK A stated that a negative outcome of not using an alcohol wipe before and after using the thermometer probe could result in cross contamination and spread of allergens. CK A stated he failed to use the wipes because he forgot and did not like carrying them around in his pockets, but did not remember to grab them from the bin when it was time to clean the thermometer probe. During an interview on 02/10/26 at 11:15 a.m. with CK B, he stated it was the expectation that the thermometer probes be sanitized before and after use. CK B stated he believed they had sanitizing wipes that could be used. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He stated a negative outcome of not using alcohol wipes was cross contamination. After the interview CK B was observed asking CK A where the alcohol wipes were located. During an observation and interview on 02/10/26 at 11:17 a.m., the DA was observed entering the kitchen without a hairnet and walking through the food preparation area while food was being prepared for lunch services. DA stated that she had just started 02/09/26 and completely forgot to wear a hairnet. She stated it was the expectation that hairnets were put on before entering the kitchen and failure to do so could result in hair/ allergens getting into the food and cross contamination. During an interview on 02/10/26 at 01:42 p.m. with CK H, he stated that it was the expectation when taking food temperatures that he wiped the thermometer probe with an alcohol wipe before taking the temperature of the next food item. CK H stated he was also required to change gloves between tasks. He stated failure to do each of these food safety tasks could result in cross contamination, and residents had the potential to become ill if not done. CK H stated that the facility emphasized hand hygiene daily. During an interview on 02/12/26 at 02:12 p.m. with the ND he stated it was his expectation that expired items be removed from the refrigerator before its expiration, he stated if they expired on the 8th then it should have been removed on the 7th when referring to the expired milk cartons with the best by date of 02/08/26 that were still in the dining room reach in refrigerator on 02/10/26. He stated it was all dietary staff responsibility to ensure that it was occurring and being checked daily. He stated that it was his expectation that dishes being washed via the 3-compartment sink and the dishwasher included sanitizer, and the dishwasher should include detergent, sanitizer, and rinse aide. He stated that he expected the dishwasher staff, assigned each shift, to ensure sanitizer was always in use at the dishwasher and that it be checked 3 times a day. He stated, ultimately as the supervisor, he was in charge of ensuring all these processes were being carried out. The ND stated that a potential negative outcome of not pulling expired items from the refrigerators would be, health and safety and nutrition could be compromised. In terms of the sanitizer at the dishwasher, he stated, not using sanitizer could result in germs being present on the dishes and could endanger the health and safety of residents. The ND stated that it was his expectation that hairnets were always worn while in the kitchen, and all exposed hair should be restrained by an effective hair restraint which can include hairnet or hat. He stated food items should be stored after delivery so that they are 6 inches off the ground, and after delivery no food items should be on the ground. He stated dietary staff should be checking regularly to ensure if food items fell on the ground they were discarded and not used. He stated his expectation was that gloves were used when working with food, and changed regularly if contaminated. He stated, gloves don't replace handwashing, hands should be washed after gloves are used. He then stated his expectation for the thermometer probes was that they were sanitized before use and after each item was checked for temperature to make sure there was no cross contamination of the food. During an interview on 02/12/26 at 04:02 p.m. with the ADM, she stated that it was her expectation that if staff were in the kitchen they should have a hairnet or beard guard if required. She stated that the thermometer probe should be sanitized in between each use. She stated the procedure for gloves is that in between touching surfaces or changing duties they should be changed. She stated it was her expectation that there should not be any expired items in the refrigerator, and that they be maintained in an area where they can be credited back. When asked about sanitizer for the dishwasher, she stated she was unable to answer in that moment and would need to review the policy before answering. She stated food should not be on the floor. She stated a negative outcome of not wearing a hairnet while food was being prepared had the potential to result in hair getting in the food. She stated a negative outcome of not sanitizing the thermometer probe or changing gloves if changing tasks would be cross contamination. Review of the facility's Policy and Procedure Manual Food Safety and Sanitation policy Chapter 4: Sanitation and Infection Control 4-2 2023 reflected: Policy: All local, state, and federal standards and regulations will be followed to assure a safe and sanitary food and nutrition services department.Procedure:.2. Employeesa. All staff will be in good health, will practice good personal hygiene and will use safe (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food handling practices. Hair restraints are required and should cover all hair on the head.4. Food Storage (see Chapter 3: Food Production and Food Safety for Food Storage)a. Stored food is handled to prevent contamination and growth of pathogenic organisms.Perishable foods with expiration dates should be used prior to the use by date on the package.Food stored in dry storage will be placed on clean racks at least 6 inches above the floor. Review of the 2022 U.S. Food and Drug Administration Food Code revealed: 2-301.12 Cleaning Procedure. (A)Except as specified in (D) of this section, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a HANDWASHING SINK that is equipped as specified under S 5-202.12 and Subpart 6-301. P 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES P and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P(E) After handling soiled EQUIPMENT or UTENSILS; P(F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands. P (A)Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. 4-204.117 Warewashing Machines, Automatic Dispensing of Detergents and Sanitizers A WAREWASHING machine that is installed after adoption of this Code by the REGULATORY AUTHORITY, shall be equipped to: (A) .Automatically dispense detergents and SANITIZERS; Pf and (B) Incorporate a visual means to verify that detergents and SANITIZERS are delivered or a visual or audible alarm to signal if the detergents and SANITIZERS are not delivered to the respective washing and SANITIZING cycles. Pf 4-301.12 Manual Warewashing, Sink Compartment Requirements. (A)Except as specified in (C) of this section, a sink with at least three (3) compartments shall be provided for manually washing, rinsing, and SANITIZING EQUIPMENT and UTENSILS. Pf (B)Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: Pf 1. The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; Pf and 2. The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Pf 3-304.15 Gloves, Use Limitation. (A)If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 3-305.11 Food Storage. (A)Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (3) At least 15 cm (6 inches) above the floor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews and record reviews, 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 communicable disease and infections for 4 (Resident #35, Resident #52, Resident #84, and Resident #88) of 8 residents and 1 of 1 laundry room reviewed for infection control practices, in that: The facility failed to ensure CNA C performed hand hygiene while seated with Residents #88 and #52 during lunch and while assisting Residents #35 and #84 during the lunch meal on 02/10/2026.The facility failed to monitor and ensure laundry room practices were followed to prevent the spread of infection. in laundry room was observed unclean with thick lint clusters behind and around the dryers; staff failed to ensure the washing machine was being sanitized after washing soiled linen from a TBP room. These failures had the potential to place residents at risk for crossˆcontamination and healthcareˆassociated infections.Findings included: 1.During an observation of the secured memory care dining room on 02/10/2026 between 12:03 p.m. and 12:41 p.m., C.N.A C was observed assisting with the lunch meal and feeding Residents #35 and #84 without performing hand hygiene. At 12:03 p.m., C.N.A C sat at a table with Residents #52 and #88 and used a paperclip to scrape under his fingernails, push up his cuticles, and blow nail debris in the direction of the table. He performed hand hygiene, then reached into his pocket, removed a pen, wrote on his hand, and returned the pen to his pocket. He wiped crumbs from a table with his bare hand and continued picking at his fingernails. He rubbed his nose and mouth with both hands, walked down the hallway, scratched his hair, and entered the employee lounge. At 12:14 p.m., C.N.A C returned to the dining room and continued picking at his fingers. He touched Resident #35's wheelchair and clothing without performing hand hygiene. At 12:17 p.m., he touched Resident #84's plate and retrieved silverware to assist with feeding without performing hand hygiene. At 12:18 p.m., he touched Resident #84's wheelchair, straw in drink, and shirt while holding a fork and feeding the resident without performing hand hygiene. At 12:20 p.m., he rubbed his face and did not perform hand hygiene. At 12:24 p.m., he yawned into his hand, rubbed his face, touched Resident #35's plate, removed utensils, and assisted with feeding without performing hand hygiene. At 12:26 p.m., he wiped his nose with his thumb, picked up a fork to feed Resident #84, and then resumed feeding Resident #35 without performing hand hygiene. At 12:29 p.m., he touched Resident #35's wheelchair and shirt and continued feeding without performing hand hygiene. At 12:32 p.m., he touched Resident #35's bare arm and hand, touched an earring in his ear, and resumed feeding without performing hand hygiene. At 12:39 p.m., he touched Resident #84's bare hand and then fed Resident #35 without performing hand hygiene. During an interview on 02/10/2026 at 12:41 p.m., C.N.A C stated he was agency staff and had been trained in hand hygiene. He stated he knew he should wash his hands before entering a resident's room or assisting with feeding. He stated he used hand sanitizer after picking his nails and touching his face. When asked why he did not sanitize between feeding residents or after touching wheelchairs, clothing, or skin, he stated he did not think he needed to because he did not directly touch the residents' food. He apologized and stated he did not think performing nail care at the table was inappropriate because the residents had not yet been served. During an interview on 02/11/2026 at 9:24 a.m., LVN E stated she had been trained in hand hygiene (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and that staff were expected to perform hand hygiene anytime they touched a resident, before feeding, and before and after handling a resident's food. She stated failure to do so could cause illnesses such as MRSA, flu, or colds. During an interview on 02/11/2026 at 9:30 a.m., C.N.A D stated she had been trained in hand hygiene and sanitized her hands anytime she touched a resident, delivered a meal tray, entered or exited a room, or provided care. She stated staff were expected to sanitize before feeding, after touching a resident, and when moving between residents to prevent cross^contamination which could make residents sick. During an interview on 02/11/2026 at 9:39 a.m., the ADON stated she had been trained in hand hygiene and that staff were expected to perform hand hygiene before and after assisting a resident, between passing meal trays, and after touching a resident. She stated it would not meet expectations for C.N.A C to clean underneath his fingernails at a table with residents or to fail to sanitize after touching a resident's clothing or skin before feeding. She stated that proper hand hygiene, particularly during feeding, was important due to infection control concerns and not wanting to spread germs or bacteria that can make the residents sick. During an interview on 02/11/2026 at 9:49 a.m., the DON stated she had been trained in hand hygiene and that staff were expected to sanitize between patient care tasks, when entering and exiting rooms, and between handling trays or food. She stated failure to do so could cause the spread of pathogens, which could make the residents sick. She stated it would not meet expectations for staff to perform personal nail care at a table with residents or fail to sanitize after touching a resident's body, clothing, or dining room surfaces. She stated she intended to contact the agency to request hand hygiene training before CNA C returned to the facility. During an interview on 02/12/2026 at 8:30 a.m., the ADM stated she had trained staff on proper hand hygiene and expected staff to wash hands with soap and water if visibly soiled and use hand sanitizer before and after donning gloves, providing care, touching a resident, touching their own body, or touching multiple surfaces. This was important due to infection control concerns of not wanting to spread germs, which could lead to an outbreak and make residents sick. The ADM stated C.N.A C's behavior on 02/10/2026 did not meet expectations and that she placed him on the Do not Rehire list. 2. During an observation on 02/11/26 at 02:04 p.m., in the one and only laundry room, one staff member was observed working with both clean and soiled linen. The areas around the dryers were observed unclean with lint and other items which included hangers, wood block, sock/clothing items, and what appeared to be a duster that had fallen behind the machine. Behind the dryers appeared an inch thick film of lint on the machines in addition to the items that had fallen behind the machines. An observation around the washing machines there was no observed chemical sanitizer in use or available. During an interview on 02/11/26 at 02:15 p.m. with the LA, she stated that when clothing came in from a TBP room or from anyone on any contact isolation, they arrived in yellow bags and are washed in hot water. She stated that after the items are washed the machines were not sanitized and they simply continued to wash the next residents' items. She stated she believed the machine remained clean since it used hot water. The LA stated the washing machines were only cleaned once a week (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with a TIDE product and not a chemical sanitizer. The LA stated there was no tracking that the facility used for cleaning to provide evidence of sanitation. She stated they did not use cleaning logs, or lint logs; they just cleaned daily. The LA stated that the housekeeping staff was in charge of cleaning the laundry room and ensuring it was kept in sanitary condition. She stated maintenance was responsible for pulling the machines forward so that lint and debris or items could be cleaned from behind it. She stated she did not know when the last time maintenance went in to pull the machines and allowed them to clean behind them. She stated it was the expectation that the laundry room remained clean and a potential negative outcome of not sanitizing the machines after contamination from TBP clothing would be cross contamination and the ability to transfer infections if the clothing is not processed correctly. During an interview on 02/11/26 at 02:18 p.m. with the HSK, she stated there was no checklist for housekeeping that monitored cleaning and sanitation practices. She stated she did not know the machines, to include the dryer, were supposed to be cleaned from behind, and she was unaware that it was maintenance who assisted. The HSK stated that what was observed with the lint and other items accumulating around the machines that day on the floor did not meet her expectations. She stated a potential negative outcome was that dust and particles could get on clean clothing and trigger residents' allergies. The HSK stated that if clothing is coming from a room that is excessively soiled or from certain precautions such as MRSA that it was the expectation that the machines are sanitized after. She stated she was not sure why staff was saying they did not sanitize the machines after clothing was washed from rooms with special precautions. She stated that could result in cross contamination. During an interview on 02/12/26 at 03:38 p.m. with the MMD, she stated it was her expectation that the laundry room be cleaned daily to maintain a sanitary environment. She stated it is the responsibility of the laundry attendants to clean the laundry room and to clean behind the dryers. She stated maintenance can assist with pulling the machines out, but the attendants must clean it. The MMD stated failure to clean and remove lint and debris buildup could cause allergies and could pose a fire risk. She stated that it was expectation that the HSK was going into the laundry room daily to do spot checks and conducting weekly full inspections. The MMD stated it was her expectation that the washing machines were sanitized daily, and that if clothing was washed from an isolation room or special precaution room it should be sanitized after that load before the next use. She stated the method used is a Fuzion Clorox based spray that should be sprayed in the machine, they should wait for the appropriate kill time to pass and then wipe down. She stated failure to sanitize the machines after exposure to clothing from an isolation or special precaution room could result in other residents getting sick. She stated after observing the images of the conditions of the laundry room they did not meet her expectations for a sanitary environment. Training documentation was requested from the MMD for in-services provided to laundry staff on the sanitizing procedures for the washing machines and maintaining a sanitary environment; the MMD stated there was no training available that had been completed with staff. During an interview on 02/12/26 at 04:02 p.m. with the ADM, she stated it was her expectation that the laundry room was cleaned daily, and as needed, when soiled. She stated a negative outcome to lint behind a dryer would be the potential for a fire. She stated it was the responsibility of the laundry attendants to ensure a clean and sanitary environment. She stated she did not believe the washing machines needed to be sanitized because it was her understanding that they were cleaned as clothing was washed with the soap and hot water. She stated she did not oversee laundry services. She stated she would need to review the policy to determine the expectations. After reviewing images taken on 02/11/26 in the laundry room, the ADM stated that it did not meet her expectations of a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675886	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coryell Health Rehab Living at the Meadows	110 Chicktown Rd Gatesville, TX 76528

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitary environment. Record review of the facility policy Handwashing/Hand Hygiene, revised October 2023, reflected that the facility considered hand hygiene the primary means to prevent the spread of healthcareˆassociated infections and required staff to perform hand hygiene immediately before touching a resident, after touching a resident, and after touching the resident's environment. Record review of the facility's inˆservice training titled Infection Control dated 10/24/2025 reflected staff were trained in hand hygiene, including Your 5 Moments for Hand Hygiene, which required cleaning hands before touching a patient, after touching a patient and their surroundings, and after touching any object or furniture in the patient's immediate environment. Review of the facility Laundry Dryer Safety & Laundry Area Care Policy effective 01/01/26 reflected: Purpose To ensure safe operation of laundry dryers and maintain a clean, sanitary laundry environment in order to prevent fire hazards, ensure infection control, and comply with Life Safety Code and regulatory standards. Scope This policy applies to all Environmental Services staff, laundry personnel, and any facility staff responsible for operating laundry equipment or maintaining the laundry area. Policy Statement The facility is committed to maintaining a safe and sanitary laundry operation. Dryers and laundry equipment shall be operated, maintained, and monitored in accordance with manufacturer guidelines, Life Safety Code requirements, and facility safety standards. Fire prevention, equipment maintenance, and environmental cleanliness are essential components of laundry operations. Preventative Maintenance EVS Supervisors shall coordinate with Maintenance to ensure: Dryer panels are routinely removed and cleaned. Internal lint accumulation is removed. Equipment is serviced per manufacturer recommendations. Laundry Area Environmental Care The laundry area must be maintained in a: Neat Clean (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sanitary Clutter-free condition At all times. Routine Cleaning & Disinfection Laundry areas and equipment shall cleaned in the following way: Empty trash receptacles Clean horizontal surfaces Spot clean vertical surfaces Dust mop floors Damp mop floors Environmental Cleaning – Laundry Area Laundry areas must be cleaned daily and when visibly soiled, including: Sorting tables Machines Carts Floors Door handles Hampers EPA-approved disinfectants must be used.