STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675889	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Manor Healthcare Rehabilitation	3650 S Ih 35 E Waxahachie, TX 75165

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observation, interview, and record review the facility failed to ensure the resident had a right to be treated with respect and dignity for 1 of 6 residents (Resident #66) reviewed for dignity. The facility failed to promote resident independence and dignity while dining when staff stood over Resident #66 while assisting them to eat on 01/07/25. This failure could have compromised residents' independence and dignity for those who require feeding assistance. Findings included: Record review of Resident #66's quarterly MDS dated [DATE] reflected the resident was an [AGE] year-old female with an admitted [DATE]. Resident #66 had diagnoses which included Alzheimer's (a type of brain disorder that causes problems with memory, thinking, and behavior), difficulty in walking, muscle weakness, cognitive communication deficit, and osteoporosis (a condition when bone strength weakens and is susceptible to fracture). Resident #66's BIMS score was left blank. The MDS indicated the resident started speech-language and audiology services therapy on 12/09/24 for 4 days a week. Record review of Resident #66's care plan dated last revised 11/20/24 reflected she had a nutritional problem or potential nutritional problem related to disease process and ADL self-care performance deficit. In an observation on 01/07/25 at 01:05 PM Resident #66 was being assisted with her lunch tray by a SLP who was standing over Resident #66 the entire duration of assistance. In an interview on 01/07/25 at 01:20 PM with the SLP she stated she had worked at the facility since September of 2024. She stated that she was conducting an evaluation on Resident #66 due to a recent weight loss. She stated Resident #66 had poor attention span, could feed herself but may require assistance, and she was checking for Dysphasia (a language disorder that affects the ability to produce and understand spoken language). When asked if the SLP had been trained on how to provide feeding assistance she stated Yes, I am sure there was something in the LMS trainings but was unable to recall if she was supposed to sit or stand next to a resident when providing assistance. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/07/25 at 2:15 PM with the DOR she stated she had worked at the facility for 3 years. When asked what her expectation was for feeding assistance, she stated that she would need to be notified by nursing that certain signs were occurring so that an SLP could evaluate the residents' cognition and swallowing. She stated that normally CNA's assist residents with feeding, but it would not be out of the ordinary that SLP's would be available and/or assisting. The expectation would be for the SLP to be seated next to the resident while providing assistance, and they were informed that they should be sitting for respect purposes, but this was not necessarily talked about for the evaluations. Review of the facility's Feeding checklist for training staff revealed The following table lists the steps that are expected of you in order to feed an individual. The table also provides rationales that explain why you perform some of these steps. The use of this content is for educational purposes only and should only be used as a guide in performing the below skill, subject to the terms and conditions of the Master Services Agreement. no instruction for the employee being trained, to sit next to residents while providing feeding assistance was listed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record review, the facility failed to coordinate assessments with the PASARR program for 1 of 8 Residents (Resident #63) reviewed for PASARR services. 1. The SW failed to assess Resident #63, based on his behaviors, for a referral for PASARR services. 2. The MDSC failed to refer Resident #63 for a Level II PASARR Evaluation by the local LIDDA. This failure placed residents in the facility at risk for exclusion for PASARR Services. Findings Included: RR or Resident #63's AR, dated 1/10/2025, reflected an [AGE] year-old male, who admitted to the facility on [DATE]. RR of Resident #63's Medical Diagnosis, downloaded from PCC on 1/10/2025, reflected Resident #63 was diagnosed with Depression, Unspecified (which was a mental condition characterized by depressed mood, loss of pleasure, or interest in life) and Schizophrenia, Unspecified (which was a chronic mental illness that affected a person's thoughts, feelings, and behavior.) RR of Resident #63's BIMS Score assessment, administered on 1/10/2025, reflected a score of 6, which indicated the resident had severe cognitive impairment. RR of Resident #63's CP reflected a Focus area for impaired cognition or impaired thought, initiated on 12/6/2024, R/T disease process. The Goal, revised on 12/29/2024, indicated the resident was supposed to maintain their current level of functioning through 3/5/2025. The Intervention, initiated on 12/6/2024, delegated nursing home to engage in simple structured activities that avoid overly demanding tasks; a Focus area for psychotropic medication, unknown date of initiation, R/T Schizophrenia. The Goal, initiated on 12/13/2024, indicated the resident would not have reactions to antipsychotic drug therapy (Seroquel 25 MG). Antipsychotic was discontinued on 12/19/2024 / Replaced with Anti-Anxiety Drug Therapy (Hydroxyzine 25 MG) The Intervention, initiated on 12/13/2024, delegated nursing home staff to check blood pressure monthly. RR of Resident #63's P-1, located in PCC, reflected a document sent from Resident #63's referring entity. The document was dated 12/5/2024. Page 4 of 12 indicated resident did not have evidence of an MI, ID, or DD. RR of Resident #63's P-1, located in Simple, reflected a document sent from Resident #63's referring entity. The document was dated 12/5/2024. Page 3 of 8 indicated resident did have evidence of an MI. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 1/7/2025 at 12:14 PM with Resident #63 revealed him in bed in his room. He was able to respond to questions, clean, and appropriately dressed. He was new to the facility and stated it was rough getting used to the routine. It was hard remembering who provided which services. Interview and RR on 01/10/25 at 10:56 AM with the SW, revealed that she was the facility designee to collaborate with residents and their PASARR eligibility/referrals. Based on Resident #1's P-1, located in PCC, Resident #63 presented to the facility on [DATE] with a negative P-1, meaning he did not have evidence of a MI, ID, or DD. The SW stated she had spent time with Resident #63, who had exhibited changes in his alertness, orientation, mood, and cognition. She was unaware Resident #63 had diagnosis of Depression, Unspecified and Schizophrenia, Unspecified. Had she been aware of his mental health diagnosis, she would have had him re-assessed by a medical provider and then referred him to the LIDDA for the P-2 evaluation as needed. However, she had not discovered the mental health diagnosis; she had not referred the resident for mental health services; she had not referred the resident for a P-2 evaluation. RR of the resident medical records in PCC did not reveal a P-2 or referral to the LIDDA. Interview and observation on 1/10/25 at 1:21 PM with the MDSC revealed she was the MDSC at the facility until last week, 1/2/2025. She was responsible, along with the SW, for residents and their PASARR eligibility/referrals. She had been trained as an MDSC at the facility, taken on-line training, and completed the classes for CMAC (Certified MDS Assessment Certification.) The facility followed the guidelines in the RAI for PASSAR processing. Observation of the MDSC revealed her search Simple, a 3rd party data base with HHSC and PASARR, for a P-2 for the LIDDA for Resident #63. Instead of a P-2 for the LIDDA, a P-1 was found. The P-1 found in Simple, was different from the P-1 that was found in PCC. The P-1 found in Simple reflected Resident #63 did have evidence of a MI. Based on the P-1 in simple. The MDSC stated, I just did not see it and there should have been a P-2 submitted for the LIDDA. RR of Simple did not reveal a P-2 for Resident #63. Residents who qualified for PASARR services were available to receive NFSS services, such as PT/OT/ST/DME. Residents who were qualified for, but did not receive NFSS services, were placed at risk for a decrease in options for quality of care. Since she had been removed from her position, CMDSC M and CMDSC N oversaw the MDS/PASARR entries. She was unaware of any support structure in place to catch errors in the PASARR process. Interview on 1/10/25 at 2:23 PM with the ADM stated that the SW and the MDSC were responsible for the residents' PASARR eligibility/referrals to the LIDDA. The facility followed the guidelines of the PASARR division. Residents, who benefitted for PASARR services, were eligible for benefit's such, as DME, assistance post DC from the facility with housing, and therapeutic services. Residents who were eligible, but not afforded the opportunity, risked the loss of services provided through the PASRR program. Safeguards in place to ensure residents get linked to PASARR services were team meetings, MDSC checks, morning meetings, and corporate resource personal. In a situation where there were two conflicting P-1s for a resident, the ADM stated the document in Simple would have taken precedence over the one found in PCC. The failure for the SW to assess the resident for MI and make the appropriate referral, along with the MDSC's failure to retrieve the P-1 from Simple, was a process failure. The staff members responsible for the PASARR eligibility/referrals were the SW and the MDSC. RR of the CMS RAI Version 3.0 Manual, dated 10/2024, reflected: Referral for Level II Resident Review Evaluations is required for individuals previously identified by PASRR to have MI, ID, or a related condition in the following circumstances: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Referral for Level II Resident Review Evaluations is also required for individuals who may not have previously been identified by PASARR to have MI, ID, or a related condition in the following circumstances: 1. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan furnishing services to attain, or maintain, the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #30) reviewed for comprehensive care plans. The facility failed to care plan Resident #30's high risk of elopement. This failure placed resident at risk of their needs having gone unmet. Findings included: Record review of Resident #30's quarterly MDS assessment dated [DATE], reflected the resident was a [AGE] year-old male with an admitted [DATE]. Resident #30 had diagnoses which included Parkinson's Disease (a neurodegenerative disease primarily of the central nervous system, affecting both motor and non-motor systems), cognitive communication deficit (impairment in thought organization, attention, memory, and safety awareness), hallucinations, and anxiety. The MDS reflected the resident had a BIMS score of 07, which indicated the resident had severe cognitive impairment. Record review of Resident #30's elopement/wandering evaluation dated 10/23/2024 reflected a score of 14, indicating the resident was a high risk of elopement. Record review of Resident #30's care plan dated last revised on 10/13/24 reflected no interventions for elopement or wandering. In an observation on 01/07/25 at 10:53 AM resident #30 was standing in his room watching television. In an interview on 01/08/25 at 01:58 PM with the DON she stated the MDS Coordinator was responsible for creating the care plan. She stated there had recently been a change in the MDS Coordinator because the previous MDS person at the facility did not work out for them, and the DON did not see where Resident 30 had been care planned for elopement. In an interview on 01/10/25 at 10:04 AM with the MDSR she stated that she had held that position since about 2019. She stated she worked as an MDS resource for multiple facilities. She stated that if a resident had any risk of elopement, the resident should be care planned for elopement interventions. Record review of facility policy titled Care and Treatment, Care Planning dated reviewed on 08/2015 reflected, It is the policy of this facility that the interdisciplinary team shall develop a comprehensive care plan for each resident. A comprehensive care plan is developed within seven days of completion of the resident minimum data set.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on observations, interviews, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 6 Residents (Resident #3) reviewed for respiratory care. The facility failed to place Resident #3's oxygen tubing in a bag when not in use. This failure could place residents at risk of not receiving appropriate respiratory care. The findings were: Resident #3 Record review of Resident #3's undated face sheet reflected she was a [AGE] year-old female admitted on [DATE] with diagnoses of Heart Failure, Acute upper Respiratory Infection, Obstructive Sleep Apnea, and Shortness of Breath. Record review of Resident #3s care plan dated 03/31/2022 reflected she had Chronic Obstructive Pulmonary Disease (a group of lung diseases that make it difficult to breath) her Goal was to be free of signs and symptoms of respiratory infections through review date. Interventions included to give oxygen therapy as ordered by the physician. Record review of Resident #3's quarterly MDS dated [DATE] reflected she had a BIMS score of 15 indicating she was cognitively intact. Record review of Resident #3's physicians' orders summary dated 01/08/2025 reflected an order to change oxygen tubing and humidifier bottle, clean filter weekly as needed if equipment is used, every night shift, every Sunday. Keep tubing inside plastic bag when not in use dated 04/22/2021. In an observation and interview on 01/07/25 at 11:49 AM Resident #3s oxygen tubing was laying on top of her concentrator out of the bag and not dated. Resident #3 stated for the most part the nurses changed her oxygen tubing weekly. She stated occasionally she got sick and required her oxygen machine due to her respiratory disease. She stated she liked for it to be clean. In an interview on 01/10/25 at 01:25 PM LVN A stated oxygen tubing was supposed to be changed weekly. She stated the tubing should be in a bag when not in use. She stated the nurses had been instructed on changing the tubing and keeping it covered by the DON. She stated there was a physician's order in the computer to change the tubing. Night shift nursing staff were responsible for changing the tubing on Sundays. The risk to residents for having dirty oxygen tubing included respiratory infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/10/25 at 1:31 PM the DON stated staff were educated by the DON, ADON and LVN resource team. The DON stated if a resident had respiratory equipment tubing it should have been bagged, even if it was used as needed it should be bagged. She stated negative effects for residents having unbagged oxygen tubing could include respiratory infections. She stated staff were instructed to remove oxygen equipment in rooms if not used. The DON stated the department heads do angel room rounds every morning to monitor for things that could negatively affect the resident. Record review of facility policy titled Oxygen Equipment dated 05/2017 reflected It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner and to use disposable prefilled humidifiers, tubing, masks, and cannulas for residents receiving oxygen. The equipment is to be discarded after use. The facility will maintain clean tanks, connectors, and concentrators. When oxygen mask or cannula is temporarily not being used it will be covered loosely to prevent contamination from airborne microorganisms. It will not be covered tightly.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on interviews and record review, the facility failed to ensure residents' drug regimen was adequately monitored and free from unnecessary drugs for 1 (Resident #26) of 6 residents reviewed for pharmacy services. The facility failed to obtain a stop date for Resident #26's Cipro (an antibiotic used to treat an acute infection) started on 01/01/2025. These failures could place residents at risk of side effects (gastrointestinal upset, multiple drug resistant infections) related to long term antibiotic use. Findings included: Record review of Resident #26's undated face sheet reflected he was a [AGE] year-old male admitted on [DATE] with diagnoses of neuromuscular dysfunction of the bladder (the nerves and muscles that control the bladder aren't working properly), hypertension (elevated blood pressure), legal blindness, and personal history of malignant neoplasm of brain (history of brain cancer). Record review of Resident #26's quarterly MDS dated [DATE] reflected he had short term memory problems. His cognitive skills for daily decision making were severely impaired. The MDS reflected Resident #26 required an indwelling catheter. Record review of Resident #26's care plan dated 01/01/2025 reflected he had a urinary tract infection. The care plan reflected he had started Cipro 500mg active date 01/01/2025 to 01/06/2025. The goal reflected the urinary tract infection will resolve without complications by the review date. Interventions included to give antibiotic therapy as ordered, monitor/document for side effects and effectiveness. Record review of infection surveillance assessment dated [DATE] reflected Resident #26 had a urinary tract infection with an indwelling catheter. He had purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate. The assessment reflected Resident #26 had started Cipro oral tablet 500mg 1 tablet by mouth two times a day for UTI for 5 days. Record review of the progress notes for Resident #26 dated 01/01/2025 reflected he had swelling to penis, small amount of pus noted with no noted odor to area, doctor and RP were notified and a new order for Cipro 500mg, BID x 7 days for UTI and discharge was obtained. The progress note was signed by the DON. Record review of the infection surveillance assessment dated [DATE] reflected Resident #26 had a urinary tract infection with an indwelling catheter. He had other infection of epididymitis (an infection or inflammation of the testis). The assessment reflected Resident #26 had started Levofloxacin Oral (an antibiotic used to treat infection) Tablet 500 MG to start on 01/03/2025, Give 500 mg by mouth one time a day for Bilateral epididymitis (inflammation of the testis) until 01/10/2025. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #26's Physicians order summary dated 01/08/2025 reflected an order for Cipro Oral Tablet 500 MG (Ciprofloxacin HCl an antibiotic), Give 1 tablet by mouth two times a day for UTI, monitor swelling to penis, dated 01/01/2025. The order did not contain a stop date /duration for antibiotic therapy. Record review of Resident #26's Physicians order summary dated 01/08/2025 reflected an order for Levofloxacin Oral (an antibiotic used to treat infection) Tablet 500 MG to start on 01/03/2025, Give 500 mg by mouth one time a day for Bilateral epididymitis (inflammation of the testis) until 01/10/2025. Record review of Resident #26 Medication Administration Record dated 01/08/2025 reflected resident had received 14 doses of Cipro 500mg starting 01/01/2025. Record review of Resident #26 Medication Administration Record dated 01/08/2025 reflected resident had received Levofloxacin Oral Tablet 500 MG (Levofloxacin) Give 500 mg by mouth one time a day for 6 doses. In an interview on 01/10/2025 at 1:25 PM LVN A stated there should be a stop date on all antibiotic orders used for short term treatment of acute infections. She stated the nurses should have clarified the order with doctor. She stated nurses were instructed to get the stop dates on any short-term medications by in-services monthly given by don. LVN A stated she was unsure why a stop date was not obtained at the time of order for the Cipro order. She stated she was unsure what the negative effects of long-term use of Cipro could be, but she could find out the information. In an interview on 01/10/25 at 1:31 PM the DON stated the Cipro for Resident #26 should have been for 5 to 7 days only. She stated the nurses were instructed to obtain a stop date for all antibiotics used for treatment of acute infections at the time of the order being received. She stated the DON and ADON were responsible for the review of orders daily. She stated they review daily for acute changes in residents' condition by looking at daily reports, review electronic medical records dashboard, and clarifying with the doctors for stop dates. The DON stated negative effects for residents that use long term antibiotic could lead to antibiotic resistant infections or intestinal infections. In an interview on 01/10/25 at 1:53 PM the PA stated Cipro for Resident should have been for 7 days. She stated the staff should have obtained a stop date at time the order was given. She stated the Levofloxacin Oral Tablet 500 MG (Levofloxacin) 1 po q day ordered on 1/3/24 was ordered by another practitioner. She stated it was not protocol to have two antibiotics at the same time. She stated the facility should have stopped the cipro once the Levofloxacin order was received. She stated the Levofloxacin was ordered when the urine culture came back. The PA stated orders were given by encrypted text messages services. The orders were given to the DON or nurses. She stated she did not see any negative effects for Resident #26 being on the cipro for the time he was on it. She stated she would have caught the error at his next visit she sees the resident weekly. Record review of facility policy titled Unnecessary Drugs dated 04/2012 and last revised on 11/12/2015 reflected It is the policy of this facility that each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An unnecessary drug us any drug when used: For excessive duration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on observation, interview, and record review the facility failed to ensure medications and biologicals were stored in locked compartments for 1 of 1 medication carts and 1 of 1 medication rooms reviewed for medication storage. The facility failed to ensure the medication cart and medication room was locked and medications were secure and not accessible to other staff, resident, or visitors while unattended by MA on 01/08/2025. This failure could have resulted in harm due to unauthorized access to medications, biologicals, and needles. Findings included: Observation on 01/08/2025 at 9:02 MA B left the medication cart unlocked outside of room [ROOM NUMBER] in the hallway with the keys on top of the cart while she washed hands inside of the restroom and obtained gloves to administer eye drops. Observation on 01/08/25 at 9:05 AM the facility's only medication storage room was unlocked, and no facility staff were present. In an interview on 01/08/2025 at 9:30AM MA B stated she should never walk away from the cart leaving it open with keys on top. She stated she had been trained to never walk away from an unlocked medication cart. She stated she was sidetracked looking for large gloves. MA B stated the negative effects for leaving the cart unlocked could be a resident may take the keys, other could have access to the medications in the cart. MA B stated she had been visually checked off on med pass monthly with the Pharmacist and DON. In an interview on 01/08/25 at 9:17 AM with the DON she stated the medication storage room was supposed to be locked and that another staff member thought the door locked automatically as the doorknob was recently replaced. In an interview on 01/10/25 at 1:31 PM the DON stated it was her expectation for the medication assistants and Nurses to lock the medication cart when unattended. She stated the staff had been instructed to never leave the keys on top of the cart, always keep the keys on their person, and keep the cart locked. She stated the DON and ADON make rounds frequently and monitor staff as well as instruct them through in-services and when they are checked off visually on medication pass. She stated potential negative effects for the leaving the medication cart open could be missing medications, possible drug diversion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675889	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Manor Healthcare Rehabilitation	3650 S Ih 35 E Waxahachie, TX 75165

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 - Some	Review of the facility's Medication Access and Storage/Drug Destruction Policy revealed: It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications: Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety and sanitation in the facility's only kitchen. The facility failed to ensure all expired pantry items were discarded. This failure could place residents at risk for health complications, foodborne illnesses and decreased a quality of life. Findings include: Observation of the kitchen pantry on [DATE] at 10:28 AM revealed: 1 large container of Italian Seasoning with Rec [DATE], open [DATE] Ex ,d+[DATE] written in black permanent marker on the side. 1 large container of Parsley Flakes with R [DATE] Ex [DATE] written in black permanent marker on the side. 1 container of Ground Cumin Seeds with Rec [DATE] Ex [DATE] written in black permanent marker on the side. 1 container of Ground Turmeric with R [DATE] Ex [DATE] written in black permanent marker on the side. 1 container of Curry Powder with R [DATE] E [DATE] written in black permanent marker on the side. Interview with the DM on [DATE] at 10:34 AM revealed that employees who received the food delivery would label the items received with the received date, date of opening, and expiration date based off the open date if a use by date was not printed on the product. Interview with the ADM on [DATE] at 11:00 AM revealed the facility kitchen follows guidance from the TFER. Review of the FDA 2022 Food Code revealed, ,d+[DATE].18 Disposition of Ready-to-Eat, Time/Temperature Control for Safety Food o Food held beyond its labeled use-by or expiration date, or past the allowed storage time for safety reasons, must be discarded. ,d+[DATE].12 Food Storage Containers Identified with Common Name of Food (continued on next page)

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Pleasant Manor Healthcare Rehabilitation	3650 S Ih 35 E Waxahachie, TX 75165

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o This section indirectly reinforces the importance of proper labeling and identifying food to avoid usage of expired or unsafe items. ,d+[DATE].11 Discarding or Reconditioning Unsafe, Adulterated, or Contaminated Food o This section states that food that is unsafe, adulterated, or not honestly presented must be discarded. Expired food often falls into this category if it is deemed unsafe. ,d+[DATE].14 Return of Food to Prevent Contamination o This section implies that food returned or deemed unfit for service should be discarded to avoid risks.

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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** 47926 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 1 (Resident #75) of 6 residents reviewed for infection control. CNA C and NA D failed to wash their hands and change their gloves when removing a soiled brief and placing a clean brief during peri care for Resident #75. These failures could place residents at-risk of cross contamination which could result in infections or illness. Findings included: Record review of Resident #75s undated face sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of acute respiratory failure, age-related physical debility, and chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breath). Record review of Resident #75's care plan dated 01/02/25 reflected she had bowel and bladder incontinence related to physical dependence with ADL and cognitive deficit related to new surroundings. Her goal was to remain free from skin breakdown due to incontinence and brief use through the review date. Interventions included: incontinent checks as required, wash rinse and dry perineum, and change clothing as needed after incontinent episodes. Goals also included to monitor for signs and symptoms of urinary tract infection including pain, burning, blood, cloudiness, no output, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, and changing behavior. Record review of Resident #75's MDS dated [DATE], reflected she had a BIMS score of 15 indicating the resident was cognitively intact. The MDS also indicated that Resident #75 was always incontinent of urine and bowel. Resident #75 required substantial/maximal assistance indicating the helper does more than half the effort with toileting hygiene. In an observation on 01/07/25 at 3:18 PM of Peri Care on Resident #75 CNA C and NA D Did not wash hands or use alcohol-based hand sanitizer when changing gloves while removing a soiled brief and application of a clean brief. In an interview on 01/07/25 at 3:42 PM NA D stated she was trained on Infection control through Inservice and in meetings by the DON. She stated staff were trained to wash hands or use ABH each time they removed their gloves. She stated risk to residents for not cleansing hands between gloving could spreading of infections. (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 01/07/25 at 3:50 PM CNA C stated she would normally use her ABH or wash her hands after removing her gloves. She stated it just slipped her mind. She stated she has been visually checked off on peri care twice in the last 6 by her DON. CNA stated the Risk to residents for not changing her gloves would be urinary tract infections. In an interview on 01/10/25 at 1:31 PM the DON stated her expectation was for staff to hand sanitize before and after gloving. She stated staff were educated by the DON, ADON and LVN resource team. The CNAs perform visual check offs on peri care and teaching upon hire and quarterly. She stated the negative effects for staff not washing their hands between glove changes could possibly be the spreading of infection. Record review of facility policy titled Hand Hygiene dated 05/2007 and revised 10/2022 reflected to use an alcohol-based hand rub containing at least 62%; or, alternatively, soap and (antimicrobial or non-antimicrobial) and water for the following situations: After removing gloves.