

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675933	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/20/2024
NAME OF PROVIDER OR SUPPLIER  Treasure Hills Healthcare and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE  2204 Pease St Harlingen, TX 78550	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50487</b></p> <p>Based on observations, interviews, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice for 1 of 6 (Resident #293) residents reviewed for oxygen.</p> <p>Resident #293's oxygen was administered at 3 Lpm and the physician's order was written for 2 Lpm.</p> <p>This failure could place Residents, who received oxygen, at risk of developing respiratory complications and a decreased quality of care.</p> <p>The findings included:</p> <p>Record Review of Resident #293's face sheet dated 9/17/2024 indicated she was a [AGE] year-old female initially admitted on [DATE], with the diagnoses of sleep apnea (is a potentially serious sleep disorder in which breathing repeatedly stops and starts) and hypertension (a condition in which the force of the blood against the artery walls is too high).</p> <p>Record review of Resident #293's comprehensive care plan dated 9/5/24 indicated Resident #293 had oxygen therapy related to ineffective gas exchange, oxygen at 2 Lpm via nasal cannula every shift to relieve signs and symptoms of hypoxia related to shortness of breath, Date Initiated: 09/6/2024 and Revision on: 09/6/2024.</p> <p>Record Review of Resident #293's significant change Minimum Data Set assessment dated [DATE] indicated she received continuous oxygen therapy . Residet #293 BIMS score was 12 (moderately imparied).</p> <p>Record review of Resident #293's July 2024 physician's orders indicated OXYGEN at 2 liters per minute via Nasal cannula every shift for to relieve signs and symptoms of hypoxia related to shortness of breath.</p> <p>Observation of Resident #293 on 09/16/24 at 13:05 PM revealed her oxygen concentrator was set at 3 liters per minute, the concentrator setting was not set to the doctor's orders .</p> <p>During an interview on 09/19/24 at 9:05 AM LVN A stated the physician's orders had to match with the concentrator settings. LVN A stated if a resident were to receive too much oxygen, it could hurt the resident.</p> <p>(continued on next page)</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/19/2024 at 09:10 AM the ADON stated nurses were responsible to check the O2 settings. The ADON stated if nurses don't follow the physician orders, it could cause hyperoxygenation to the resident .</p> <p>During an interview on 9/19/2024 at 4:10 PM the DON stated if the concentrator settings were not followed as per doctor's orders, it could cause an increase of carbon dioxide in the blood.</p> <p>Record review of the facility's oxygen administration policy dated 05/2007, reflected it is the policy of this facility that oxygen therapy is administered, as ordered by the physician, or as an emergency measure until the order can be obtained. Reassess oxygen flowmeter for correct liter flow.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761</b></p> <p>Based on interviews and record review the facility failed to ensure residents who have not used psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 (Resident #68) of 3 residents whose records were reviewed for pharmacy services.</p> <p>The facility failed to ensure Resident #68 was not prescribed Zyprexa (an antipsychotic) without appropriate diagnosis for its use.</p> <p>This deficient practice could place residents without a diagnosis for taking psychotropic medications at risk for receiving unnecessary medications.</p> <p>The findings were:</p> <p>Review of Resident #68's admission record, dated 09/17/2024, revealed he was a [AGE] year old male, admitted to the facility on [DATE], with diagnoses that included, dementia (a group of thinking and social symptoms that interferes with daily functioning), unspecified severity, with other behavioral disturbance, type 2 diabetes mellitus with hyperglycemia (high blood glucose), and neurocognitive disorder with Lewy bodies (Lewy body dementia [LBD] is a progressive brain disease that causes a decline in thinking and other abilities over time. It is the second most common type of dementia after Alzheimer's disease.)</p> <p>Review of Resident #68's quarterly MDS assessment dated [DATE], revealed Resident #68 had a BIMS score of 04 which indicated his cognition was severely impaired. Resident #68 was always incontinent of bladder and frequently incontinent of bowels.</p> <p>Review of Resident #68's comprehensive person-centered care plan revised date of 09/12/2024 revealed, Focus .is on Psychotropic medications use r/t LEWY BODY DEMENTIA WITH BEHAVIORAL DISTURBANCE 4/11/24 ZyPREXA Oral Tablet 2.5 MG (Olanzapine) Give 1 tablet by mouth at bedtime. Interventions/Tasks .Administer medications as ordered .06/13/2023.</p> <p>Review of Resident #68's Consent for Antipsychotic or Neuroleptic Medication Treatment dated and signed by the DON on 06/13/2023 and the NP on 07/29/2023, revealed My diagnosis is based on the following dominant characteristics exhibited by this individual: Anxiety with aggression. The need for, and benefits of, the proposed treatment with antipsychotic or neuroleptic medication(s) is indicated: Improve aggression and anxiety.</p> <p>Review of Resident #68's Physician Orders dated 06/04/24 revealed, Order Date: 06/04/24 Start Date: 06/05/24 Doctor; Summary: ZyPREXA Oral Tablet 2.5 MG (Olanzapine) Give 1 tablet by mouth at bedtime related to unspecified dementia related to UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL DISTURBANCE (F03.918); NEUROCOGNITIVE DISORDER WITH LEWY BODIES (G31.83).</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #68 did not have a diagnosis of psychosis and Resident #68 was a [AGE] year-old male who had a diagnosis of dementia.</p> <p>Review of Resident #68's Medication Administration Record for July 2024, August 2024, and September 2024 revealed Resident #68 received ZyPREXA Oral Tablet 2.5 MG (Olanzapine) Give 1 tablet by mouth at bedtime related to unspecified dementia related to UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL DISTURBANCE (F03.918); NEUROCOGNITIVE DISORDER WITH LEWY BODIES (G31.83) 07/01/2024 - 09/16/2024 at bedtime. On 09/17/2024, order was changed to read, ZyPREXA Oral Tablet 2.5 MG (Olanzapine) Give 1 tablet by mouth at bedtime related to MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL WITH MANIC FEATURES (F06.33) Start Date: 09/17/2024 1900 (07:00 pm) and administered at bedtime 09/17/2024 - 09/19/2024.</p> <p>In an interview on 09/17/24 at 03:04 p.m., the DON stated Resident #68 was getting Zyprexa for aggression. The DON stated Resident #68 had been getting the antipsychotic for a long time. The DON said she was unaware that an antipsychotic being given with a diagnosis of dementia was not allowed. The DON stated they would get the indication on the medication changed .</p> <p>In an interview on 09/17/24 at 03:10 p.m., the Administrator stated she had not known a dementia diagnosis could not be given with an antipsychotic medication. The Administrator stated she had asked several other people about a dementia diagnosis for an antipsychotic, some said yes it could and some said no it could not, but now she knew that an antipsychotic could not be given with the diagnosis of dementia. She stated they would talk to the doctor to get the order changed .</p> <p>Record review of the facility's Psychotropic Medication Policy, dated 05.2007 Revision/review date(s): 12.2019; 02.2022; 12.2023, revealed:</p> <p>Policy</p> <p>It is the policy of this facility to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Psychotropic medications shall not be administered for the purpose of discipline or convenience. Based on a comprehensive assessment, the facility will ensure that:</p> <ul style="list-style-type: none"> <li>- Residents who use psychotropic drugs receive gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</li> <li>- Residents do not receive psychotropic drugs pursuant to an as needed (PRN) order unless medication is necessary to treat a diagnosed specific condition that is documented in the clinical record;</li> </ul> <p>Procedure</p> <p>5. Medications not classified as one of the psychotropic medication categories can also affect brain activity and should not be used as a substitution for another psychotropic medication unless prescribed with a documented clinical indication consisted with accepted clinical standards of practice.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>50487</p> <p>Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored and labeled in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions, and the expiration date when applicable in 1 of 3 medication carts (medication cart located in A wing hallway) reviewed for medication storage and labeling.</p> <p>The facility failed to ensure that all insulin in medication cart A wing hallway were not past their expiration date.</p> <p>The facility's failure could result in residents receiving expired insulin not being maintained at their best therapeutic level.</p> <p>The findings included:</p> <p>During an observation on 09/17/24 at 04:10 PM the medication cart on A wing hallway revealed 1 insulin vial passed the 28th day, opened date was 8/12/2024.</p> <p>During an interview on 09/17/24 at 04:30 PM the ADON stated the last time the insulin was given was on 9/16/24 at 09:02 PM. The ADON stated the insulin must be discarded after 28 days from the opened date. The ADON also stated the charge nurse of each wing had to make sure the insulin was not expired, and it was not appropriate to give expired insulin to residents because it could cause an adverse reaction.</p> <p>During an interview on 09/17/24 at 04:29 PM LVN A stated residents could get reactions if expired medications were given to the residents. LVN A stated insulins need to be discarded after 28 days from the opening date. LVN A stated expired insulin was not as potent as it supposed to be, residents could get a false reading because of the expired insulin administered.</p> <p>During an interview on 09/18/24 09:20 AM RN A stated the insulin vials needed to be discarded in the sharps container and the vials were good for 28 days after the opened date. RN A stated if given to a resident after the 28 days, the insulin could cause an adverse reaction, or the insulin would not work as it is supposed to.</p> <p>During an interview with on 09/19/24 at 04:10 PM the DON stated the insulins were good for 28 days after the insulins were open. The DON stated the lifetime of the insulin could be altered.</p> <p>Record review of policy titled Storing and Controlling medications with revision date of May 2023 revealed:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>It is the policy of this Facility to store medications safely, securely, and properly following manufacturer's recommendations or those of the supplier, and in accordance with federal and state laws and regulations. The medication supply is accessible only to authorized personnel. Medications that are discontinued, expired contaminated, or deteriorated, and those that are in containers that are cracked, soiled, o without secure closures are immediately removed from the locked medication storage area and disposed of in accordance with the Facility policies and procedures.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>44748</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the meals served reflected the nutritional needs of residents in accordance with established national guidelines for all residents when the facility failed to ensure menus were followed for all residents for 2 of 2 meals observed.</p> <p>The facility failed to follow the posted menus for two lunch services served at the facility on Wednesday, 09/17/24 and Thursday, 09/18/24.</p> <p>These failures could place residents that eat food from the kitchen at risk of poor intake, chemical imbalance, and/or weight loss.</p> <p>The findings included:</p> <p>Observation of the dining room on 09/17/24 at 11:53 AM revealed the trays were being checked by RN A to ensure preference cards were correct and whether the resident was present. There were several trays that were held back due to missing items on the meal trays. All plates served revealed no Spanish rice or peach cobbler. Pinto beans or green beans with carrots, dry beef enchiladas, and what appeared to be apple pie with crust and cornbread were served. The cycle menu called for enchiladas/chili gravy with Spanish rice or grilled chicken, fettuccini Alfredo, tossed salad/dressing, garlic bread or tortilla, peach cobbler, and beverage choice. The posted menu called for beef enchiladas, Spanish rice, tossed salad/dressing, and pie/beverage.</p> <p>Observation of the dining room on 09/18/24 11:45 AM revealed the posted menu was not what the residents had on their trays. The cycle menu called for meat loaf/brown gravy or Mexican meatloaf, scalloped corn, breaded okra, cornbread, fudge cake and beverage choice. The posted menu called for Mexican meat loaf, buttered corn, coin carrots/cornbread, and banana/beverage. The food on the resident's trays was meatloaf, corn, carrots, and a banana.</p> <p>In an interview with RN A on 09/17/24 at 12:43 PM, she said she asked residents sometimes about their food when she did her rounds. RN A stated the CNAs should be asking the residents if there was anything they needed or if the food needed to be warmed. She said the residents had not complained to her about the food but did not ask directly about the food. She said the menu posted on the wall in the dining rooms should reflect what the residents were being served. She said she was neither informed of substitutions nor checked the menu to the trays. She said she only checked the trays to the preference cards for texture and likes/dislikes. She said the temperature of the food or not getting what was on the menus could cause weight loss. She said the residents could be adversely affected because they wouldn't eat at all or eat less and could cause a decline in their health, dehydration and/or grow weak. She said no one was responsible, that she was aware of, to ensure the trays were passed out in a timely manner, food was warm, and the residents were receiving the correct foods.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In a phone interview with the RD on 09/18/24 at 3:45 PM, she said a vegetable was a vegetable and if the menus did not match the trays, it was because a substitution was needed. She said she did not know if the FPM made the residents or staff aware of substitutions. She said breaded okra had a similar nutritional value to carrots. She said if residents were not eating because the food was not right, it could adversely affect the residents in that they could possibly have weight loss and depending on their disease processes, could cause other health problems such as dehydration. She said she came to the facility twice a month and checked on new admissions, re-admissions, and anyone who triggered weight loss. She said she did not necessarily communicate with the FPM. She said she expected the FPM to follow the menus.</p> <p>In an interview with the ADM on 09/19/24 at 1:12 PM, she stated the FPM was responsible for overseeing the process of making sure menus were being followed. She said the RD and the FPM should have been working together to make sure menus were followed and that residents could be affected by weight loss or dehydration and dissatisfaction if they were not eating because they were not getting what they expected on their trays. Training for the kitchen staff was requested. Kitchen Policies pertaining to distribution of food, food holding/time/serving temperatures were requested.</p> <p>Record review of QAPI dated 09/17/24 revealed problems: Meal service issues during lunch and grievances received from residents regarding meals. Root Cause Analysis: Dietary manager (FPM) not supervising kitchen process, meal distribution, and meal services. Serving cold food, late trays, not following menus, and resident meal choice not followed. Interventions included Additional training for all dietary staff and FPM, new food warming tray carts and a hot plate warmer, review of seating charts, resident interviews for meal choices, likes, and dislikes, menus, changes to menus. Assignments: FPM, RD, DON.</p> <p>Record review of facility kitchen policies titled, Food and Nutrition Services revised 09/2017, Menus, it is the policy of this facility to assure that menus are developed and prepared to meet the nutritional needs of the residents and resident choices including their nutritional, religious, cultural, and ethnic needs while using established national guidelines. Procedures 4. If any meal served varies from the planned menu, the change and the reason for the change are noted on the posted menu in the kitchen and/or in the record book used solely for recording such changes.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>46038</p> <p>Based on observations, interviews, and record review, the facility failed to provide residents with food that was at an appetizing temperature by failing to ensure meal trays were served with food at a preferred temperature to 2 of 5 residents (Resident #83 and Resident #85). checked for appropriate temperatures.</p> <p>The facility failed to ensure food was palatable and at an appetizing temperature for Resident #83 and Resident #85 on 09/17/2024 for the lunch meal.</p> <p>This failure could affect the residents who received oral nutrition, by placing them at risk for weight loss and/or altered nutritional status.</p> <p>The findings included:</p> <p>During an observation and interviews beginning on 09/17/24 at 11:53 AM in the second dining area, 7 staff members were observed checking preference cards prior to taking meal trays off the meal cart and properly handling of meal trays. The meal trays were being checked by RN A to ensure preference cards were correct and whether the residents were present. There were several trays that were held back due to missing items on the meal tray.</p> <p>On 09/17/24 at 12:10 PM 15 meal carts were observed in the second dining room with meal trays on them. At 09/17/24 at 12:12 PM a third cart with 8 meal trays arrived. Temperatures taken on 5 plates revealed the enchiladas ranged from 82 degrees F to 93.2 F. The pinto beans averaged 88 F and the green beans with carrots were an average of 82 F.</p> <p>On 09/17/24 at 12:29 PM meal trays left the dining room to the 100 hall. 09/17/24 at 12:32 PM Resident #83 stated his food was always cold. The enchiladas temped at 74.7 F and the beans temped at 74.2 F. There was no rice on his meal tray as stated on the menu.</p> <p>On 09/17/24 at 12:36 PM Resident #85 stated his food was always cold. There was no rice on his meal tray as stated on the menu. On 09/17/24 at 12:41 PM Enchiladas 89.8 F and green beans and carrots 89 F.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 09/17/24 at 12:44 PM RN A stated the meal trays get delivered to the dining room and get checked for accuracy. RN A stated once the trays were checked they are passed out in the dining room and then the room trays are taken to the residents in their room. RN A stated usually by the time the residents in the dining room were done eating, the meal trays for the halls come out and are passed out to residents that were in their room. RN A stated the CNA's should be asking the residents if there was anything they need or if the food needed to be warmed. RN A stated the amount of time the meal trays were out on the meal cart, about an hour or longer, she thought the food would not have been warm by the time the food was served to the residents in the rooms but did not ensure food was reheated. RN A stated she was not sure about the process on what to do if the food was getting cold and would need to ask. RN A stated by the food being cold could cause the residents to eat less or possibly not eat at all which could lead to weight loss and a possible decline. RN A stated if residents were eating less, then they could become dehydrated and become weaker. RN A stated there was no one that was responsible that she was aware of to ensure the meal trays were passed out in a timely manner and the food was warm. RN A stated the expectation was for the residents to have warm food.</p> <p>In a phone interview on 09/18/24 at 3:45 PM, the RD stated the cold food was not her problem. The RD stated if residents were not eating because the food was cold, it could adversely affect the residents in that they could possibly have weight loss and depending on their disease processes, could cause other health problems such as dehydration. The RD stated she came to the facility twice a month and checked on new admissions, re-admissions, and any residents who triggered for weight loss.</p> <p>In an interview on 09/19/24 at 1:12 PM the ADM stated the facility put a QAPI in place and interviewed residents who said the food was cold. The ADM stated they did a root cause analysis on the process of getting food from kitchen to the residents, and it revealed they needed to change their process. The ADM stated they in-serviced the staff on meal service tray schedule and reviewed resident seating charts. The ADM stated the facility's dietary manager was responsible for overseeing the meal service process as to ensure meals are being delivered in a timely manner. The ADM stated she had ordered a plate warmer and a tray cart with a warmer inside and she would provide the invoice for that purchase. The ADM stated the facility was currently borrowing a meal tray cart warmer from a sister facility to ensure food is now being served warm and appropriate temperatures.</p> <p>Record review of kitchen staff in-service on Service Tray Schedule last dated 10/23/23.</p> <p>Record review of Dietary Service policy for Food, Sanitary Conditions dated 4/2023 stated:</p> <p>Procedures</p> <p>It is the policy of this facility to procure food from sources approved or considered satisfactory by Federal, State, and/or local authorities.</p> <p>2. Hot foods will leave the kitchen (or steam table) above 140 F and cold foods at or below 41 F.</p>		

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NAME OF PROVIDER OR SUPPLIER  Treasure Hills Healthcare and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE  2204 Pease St Harlingen, TX 78550	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748</b></p> <p>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 for 1 of 1 kitchen reviewed for storage, preparation and sanitation.</p> <p>The facility failed to ensure equipment was kept clean.</p> <p>The facility failed to ensure food holding pans were not dented.</p> <p>The facility failed to ensure spice in the dry storage area was sealed tightly.</p> <p>The facility failed to ensure there were no expired can goods in the dry storage area.</p> <p>The facility failed to ensure plastic dishes were clean on the clean rack.</p> <p>The facility failed to ensure personal items were kept out of the kitchen.</p> <p>The facility failed to ensure the floors were free of standing water.</p> <p>These failures could place residents at risk for complications from food contamination.</p> <p>The findings were:</p> <p>Observation and initial tour of the kitchen on [DATE] at 1:45 PM revealed 4 of 5 steam wells had a thick flaking whitish substance around the insides. The underside of the shelf above the steam table holding wells had dark brown and reddish substances hanging from it. There were 4 dented holding pans in use. One of the pans had a removable sticky yellowish stain inside of it. 1 of 11, 18 oz. container of spice was open to air and the lid would not close. There were 9, 6-pound cans of fruit with a use by date of [DATE]. There were 12 of 30 plastic coffee cups and bowls with debris inside of them on the clean rack. There was a paper plate (with another upside-down paper plate covering it) and an open, partially full 12 oz. can of soda on a shelf above the clean rack of dishes. The paper plate had a slice of pizza on it. The convection oven was not working and it was being used as a storage area for plates. There was a large light purple cup on the table next to the juice machine. The dry storage area and the area around the ice machine had a significant amount of water on the floor that required continuous mopping.</p> <p>In an interview with the DW on [DATE] at 1:55 PM, she stated the plastic dishes were on the clean rack and she was responsible for checking the dishes for cleanliness. She said the kitchen staff that served food and beverages checked them again. She said someone brought her pizza, but she did not have time to take it to the break room. She did not say who brought it. She would not say how far away the break room was. She said cross contamination could occur and make the residents sick.</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 - Some</p>	<p>In an interview with the DA on [DATE] at 1:57 PM, she stated the purple cup belonged to her and she knew it should not be there but did not know why. She said she did not wash her hands or use gloves before or after touching her cup in the kitchen. She said cross contamination could occur and make the residents sick.</p> <p>In an interview with the FPM on [DATE] at 2:00 PM, he stated he had a bid out for a replacement element for the convection oven. He said it had not been working for about a week. He said it should not be used for storage. He said the ADM knew about the bid. He said there must be a broken water pipe somewhere causing the water on the floor in the dry storage area and around the ice machine. He said he just noticed the water this morning, and he had already called a plumber. He said he just got the cans of fruit on a shipment. The dates written on top of the cans were [DATE]. He said he was responsible for checking items when they came off the trucks. He said nothing when asked if he checked the use by dates on the cans before he accepted them. He said he did not know when or why dented pans should be discarded. He said he did not know what the substance was inside of the holding pan, and said it must be some kind of food. He said he did not check the pans when they were on the use rack. He said the substance on the inside of the holding pans could come off in the food and it could make residents sick. He said he did not know how long the substance in the pan had been there. He said the lid on the container of spice would not close. He said leaving spices open to air caouls cause them to become old faster and not taste good. He was unaware spices left open to air could result in contamination of the spices and cause illness to residents if they consumed them.</p> <p>Re-visit to the kitchen on [DATE] at 3:36 PM revealed significant water remaining on the floor in the dry storage room and around the ice maker, requiring continuous mopping. The container of spice remained open to air. The walk-in freezer had significant icicles hanging from the back of the condenser fan.</p> <p>In an interview with the FPM on [DATE] at 3:45 PM, he said the plumber came in Monday [DATE] and stuck a wire in all the drains. He said the plumber told him they would be back and bring a camera, they might have to re-pipe, because all the water pipes were going into one. He said he was unaware of the ice in the freezer.</p> <p>Interview with the MS on [DATE] at 12:34 PM, she said the plumbers had not come back yet. She said they told her they would need a snake (auger) to run through the drains. She said the leak started on Monday [DATE] and she could not determine where it came from. She said the company that looked at the freezer today told her there were a lot of small holes in the condenser and they would have to patch the holes before they fixed an opening near the roof where the freezer exhaust was located. She said she was assigning 2 personnel to mop the water in the dry storage room and around the ice maker.</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 - Some</p>	<p>In an interview with the ADM on [DATE] at 1:33 PM, she said the breakroom for the kitchen staff was the same breakroom for everyone. She said it would take less than a minute to get there from the kitchen. She said personal items were not allowed in the kitchen area at any time due to cross contamination. She said she was made aware of the water on the floor on Monday [DATE]. She said the plumbers came in on Monday [DATE] and had to leave because they there may have been a leak and they needed to get an auger (snake). She said today there was a leak discovered in the walk-in freezer. She said it was checked by the company today and they told her the freezer had a leak on top of the freezer condenser that would require repair and they were awaiting a quote. She said the FPM was responsible for making sure the food that came from the kitchen was right, meaning the temperatures of the meals needed to be reasonable, accurate, and on time. She said the FPM and RD should be working together to make sure the meal trays were not getting cold, and the food matched the menus. She said the staff rotated for kitchen duty daily. She said there was a list of the kitchen duties they were supposed to follow. She said the FPM was responsible for everything the kitchen staff was doing but she was ultimately responsible. She said the residents could be affected because if the equipment went down, there would be no food coming out and if the kitchen staff were not paying attention to cross contamination, the residents could become ill. Policies requested: Personal Items in the kitchen, Distribution of food, Food holding temperatures, Food serving temperatures, cleaning dishware, Equipment-good working condition, storage of dishware, and following menus. Kitchen staff in-services/training and invoices for the condenser, convection oven element, and the plumbing also requested. The list of kitchen duties was also requested.</p> <p>Record review of kitchen staff in-services: [DATE]-lunch breaks, [DATE], [DATE], [DATE], [DATE], [DATE]-handwashing, [DATE]-cleaning/responsibilities included ovens/floors, steamers/table, grills/floors, coffee machine/table, hoods, all carts, juice machine/table, [DATE]-areas of opportunity included trash cans, pots and pans, 3-compartment sink, clean as you go, code dates, assigned equipment, and no eating or drinking in the kitchen!, [DATE]-dining duty included ensure staff assigned to meal monitoring is present in dining room, assures RN/LVN is present to verify diet with meal tray, use hand sanitizer before and after touching trays, remove dishes and utensils from tray and verify diet slip matched food served, assist residents with coverings and condiments, and feeding as needed/requested, report additional food requests from residents to the nurse for verification if allowed on diet and request from kitchen, assure entire table is served before proceeding to another table, any resident arriving after table has been served, request tray from FPM/kitchen staff, assure supervision is available in dining room for meal, [DATE]-dates, [DATE]-fruits, [DATE]-how do you know the meals we serve are correctXXX[DATE]-wet floors in kitchen/mopping schedule every hour and as needed, [DATE] tray times, distribution, meal times.</p> <p>Record review of facility kitchen policies titled, Food and Nutrition Services revised ,d+[DATE], Menus, it is the policy of this facility to assure that menus are developed and prepared to meet the nutritional needs of the residents and resident choices including their nutritional, religious, cultural, and ethnic needs while using established national guidelines. Procedures 4. If any meal served varies from the planned menu, the change and the reason for the change are noted on the posted menu in the kitchen and/or in the record book used solely for recording such changes. Dietary Services revised ,d+[DATE], Food, Sanitary Conditions for: Procedures 10. Personal food items or belongings are not allowed in the kitchen area.</p> <p>Record review of invoice #20464 dated [DATE] revealed checked walk-in freezer and found unit with ice formed on section of line. Will need to regulate and seal holes where condensation is coming in freezer box causing crystalized drops and ice to form in box. Will send quote.</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 - Some</p>	<p>Record review of FDA Food Code 2022 Ch. ,d+[DATE].20 Food Protection Manager Certification ,d+[DATE] Duties ,d+[DATE].11 Person in Charge. The PERSON IN CHARGE shall ensure that: (E) EMPLOYEES are visibly observing FOODS as they are received to determine that they are from APPROVED sources, delivered at the required temperatures, protected from contamination, UNADULTERED, and accurately presented, by routinely monitoring the EMPLOYEES' observations and periodically evaluating FOODS upon their receipt ,d+[DATE] Hygienic Practices ,d+[DATE] Food Contamination Prevention ,d+[DATE].11 Eating and Drinking.</p> <p>(A) Except as specified in (B) of this section, an EMPLOYEE shall eat or drink only in designated areas where the contamination of exposed FOOD; clean EQUIPMENT, UTENSILS, or other items needing protection cannot result. (B) A FOOD EMPLOYEE may drink from a closed BEVERAGE container if the container is handled to prevent contamination of: (1) The EMPLOYEE'S hands; (2) The container.ChXXX, d+[DATE] Reheating ,d+[DATE].11 Reheating for hot holding. (A) Except as specified under (B) and (C) and in (E) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the FOOD reach a temperature of at least 74 C (165 F) for 15 seconds. Ch. ,d+[DATE] Preventing contamination from the premises ,d+[DATE].11 Food Storage: FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination. Ch. ,d+[DATE] Cleanability ,d+[DATE].11 Food-Contact Surfaces. (A)Multiuse FOOD-CONTACT SURFACES shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; (3) Free of sharp internal angles, corners, and crevices; (4) Finished to have smooth welds and joints. Ch. ,d+[DATE] Maintenance and Operation ,d+[DATE] Equipment ,d+[DATE].11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts ,d+[DATE] and ,d+[DATE]. ,d+[DATE] Frequency ,d+[DATE].11 Equipment Food-Contact Surfaces and Utensils. (A) Equipment food-contact surfaces and utensils shall be cleaned: (5) At any time during the operation when contamination may have occurred. If used with TIME/TEMPERATURE CONTROL FOR SAFETY FOOD, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned throughout the day at least every 4 hours.</p>		