

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675945	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Wellington Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1506 Childress St Wellington, TX 79095	
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to protect the right of the resident to make choices about aspects of his or her life in the facility that are significant to the resident for 1 (Resident #22) of 13 residents reviewed for resident rights. The facility failed to ensure Resident #22 was allowed to shower in the mornings as was her preference. This failure could put residents at risk of feeling devalued and uncomfortable in their home. Findings Included: Record review of Resident #22's admission record dated 10/16/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, functional dyspepsia (impaired digestion) and personal history of transient ischemic attack (stroke), need for assistance with personal care, and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it, stroke) without residual deficits. Record review of Resident #22's quarterly MDS completed on 09/25/24 revealed the following: Section C: Resident #22 had a BIMS score of 12 which indicated moderately impaired cognition. Section G: Resident #22 used a walker and was independent across all ADLs. Record review of Resident #22's care plan completed 09/25/24 revealed Resident #22 had an ADL self-care performance deficit and required supervision as needed during bathing. Record review of Resident #22's task schedule for October 2024 revealed 5 of the 7 showers taken thus far in October 2024 were given in the afternoon. The shower dates/times were as follows: 10/02/24 09:22 AM 10/04/24 01:59 PM 10/07/24 01:59 PM (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675945	Facility ID: 675945 If continuation sheet Page 1 of 10

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/09/24 01:39 PM 10/11/24 01:59 PM 10/14/24 10:22 AM 10/16/24 01:59 PM During an interview on 10/16/24 at 10:30 AM Resident #22 stated she was scheduled for morning showers because she preferred to shower in the morning. She stated she wants her shower in the morning, gets ready for her shower in the morning, and was often told that staff were too busy, and she would have to come back after lunch for her shower. She said this had happened to her 4 times in the past month. Resident #22 stated she was waiting in the hall outside the shower with her supplies and clean clothes ready to shower and staff have told her they do not have time and she will have to come back after lunch. She said she would then have to change out of her shower shoes, put her clean clothes back in her room and put her regular shoes on to go to lunch. Then after lunch she would have to do all of that in reverse to take her shower. Resident #22 stated it annoyed her to have her shower postponed in this manner. She said, I know it is a nursing home, but it should feel like home, and it doesn't. During an interview on 10/16/24 at 01:01 PM CNA B stated she had worked for the facility for [AGE] years. She stated every time we are short staffed residents who are waiting to shower in the morning are told there is not time, and they will need to come back for their shower after lunch. She stated a possible negative outcome of this for residents was, They don't get to shower when they want, they have to wait. CNA B stated some residents are allowed to shower independently but staff have to stay in the shower room with the residents even if they are independent. During an observation and interview on 10/16/24 at 03:01 PM Resident #22 was returning to her room from her shower. She stated staff stay with her when she is showering because I am a fall risk. My blood pressure will just drop suddenly sometimes. During an interview on 10/17/24 at 08:37 AM ADON stated everyone was responsible to ensure residents were showered at the time they prefer. She stated nurses will shower residents if they have time and the CNAs need the help. She said showers were planned out and scheduled and residents were assigned shower times. ADON stated she did not think it would cause a negative outcome for a resident who preferred to be showered in the morning to have to wait until the afternoon. She said, I don't think it will affect them negatively as long as they get it that day and we reassure them (that they will be showered that day). During an interview on 10/17/24 at 09:37 AM LVN C stated she showers 3-4 residents per week as needed. She said if a resident wanted to be showered in the morning we would accommodate them to get what they want. During an interview on 10/17/24 at 10:23 AM DON stated charge nurses were responsible for assigning shower times and for overseeing showers. She said if a resident was scheduled for a morning shower and had to wait until the afternoon to shower it might just worry them a little more than was needed, but sometimes things just happen. (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy Resident Rights dated 2003 revealed the following: We believe each resident has a right to . self-determination . 8. Each resident is treated with consideration, respect, and full recognition of his/her dignity and individuality .		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to protect the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 2 (Resident #7 and Resident #20) of 12 residents and 3 of 6 anonymous residents reviewed for resident rights. 1. The facility failed to ensure Resident #7 and Resident #20 had a toilet that flushed properly. 2. The facility failed to ensure 3 of 6 anonymous residents had ready access to hot water in their rooms and/or in the shower. These failures could result in residents feeling frustrated and undignified in their living environment. Findings Included: 1. Record review of Resident #7's admission record dated 10/16/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), history of bladder cancer, and benign prostatic hyperplasia (the flow of urine is blocked due to the enlargement of prostate the gland; symptoms include increased frequency of urination at night and difficulty in urinating). Record review of Resident #7's annual MDS completed on 08/19/24 revealed the following: Section C: Resident #7 had a BIMS score of 11 which indicated moderately impaired cognition. Section GG: Resident #7 used a walker and was independent across all ADLs. Section H: Resident #7 was always continent of bowel and bladder. Record review of Resident #7's care plan completed on 08/22/24 revealed discharge from facility was not feasible due to his inability to care for himself. The intervention listed was, Respect resident's right to view nursing facility as his home. Record review of Resident #20's admission record dated 10/16/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), extrapyramidal and movement disorder (drug induced movement disorder resulting in abnormal involuntary movements, alterations in muscle tone, and postural disturbances), and muscle weakness. Record review of Resident #20's annual MDS completed on 08/02/24 revealed the following: Section C: Resident #20 had a BIMS score of 6 which indicated severely impaired cognition. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section GG: Resident #20 used a w/c and was independent across all ADLs except for bathing/showering where he required set up or clean up assistance. Section H: Resident #20 was always continent of bladder and occasionally incontinent of bowel. Record review of Resident #20's care plan completed on 08/02/24 revealed discharge from the facility was not feasible for Resident #20 due to his diagnoses. The intervention listed was, Respect his family's right to view nursing facility as his home. During an observation and interview on 10/15/24 at 11:26 AM Resident #20 stated his toilet does not flush. This surveyor attempted to flush the toilet in Resident #20's bathroom and discovered that when the handle of the toilet was pushed down the water would swirl in the toilet bowl slowly but would not empty down the drain. This surveyor attempted to hold the handle down and the effect was the same. Resident #20 stated when he had to flush the toilet he had to flush it and flush it and flush it for 15 to 20 minutes every time he used the bathroom. During an observation and interview on 10/16/24 at 08:14 AM Resident #7 stated the toilet in his room (the room he shared with Resident #20-therefore the same toilet) had not flushed every since I moved in here. He stated he had been in the facility for a year. Resident #7 stated he told several staff members about the toilet not functioning over the time he has been in facility. He stated the most recent conversation he had with a staff member about the toilet was 10/15/24 when he told the maintenance man (MS) the toilet would not flush. Resident #7 said when he needed to flush the toilet he would flush it and flush it and flush it and flush it. As he was speaking, Resident #7 was making the motion of pushing the handle on the toilet down repeatedly and in quick succession. During an interview on 10/16/24 at 01:36 PM ADM stated staff finally got the guys (Resident #7 and Resident #20) to agree to change rooms so they will have a functional toilet. During an interview on 10/16/24 at 01:53 PM ADM stated Resident #7 and Resident #20 declined to move rooms last time they complained about their toilet not working. She stated they complained about their toilet not working on 07/17/24. During an interview on 10/17/24 at 08:31 AM ADM stated Resident #7 and Resident #20 got a new toilet in their old room and had moved back to their old room and were happy now. 2. During an anonymous interview on 10/16/24 at 10:30 AM 3 of 6 residents complained of no hot water in their rooms and sometimes in their showers. One Resident said he did not have hot water in his room. One said he had warm water, but he had to let it run forever for it to get warm. One resident said she just came back from her shower and the water was cool. She said, Now I'm freezing. Residents said they have not had hot water for at least a month. They said facility replaced one of the hot water heaters 2 weeks ago, but it did not seem to help so now they are waiting on a hot water pump. On 10/16/24 at 10:32 AM A facility policy addressing homelike, safe, functional environment was requested. ADM provided Resident's Rights policy. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 08:39 AM ADON stated a possible negative outcome to residents of having a toilet that did not flush properly was, It could flood bathroom. She stated a possible negative outcome of a resident not having hot water in their room was, I just think it helps with sanitization and infection and no one likes to take a cold shower or wash their hands in cold water. She stated she had been aware of issues with the hot water in the facility for about a month. ADON stated, It will be super-hot and not so hot and one side (of hall C) had some (hot water) and one side didn't. ADON stated facility replaced a hot water heater and had plumbers come out and it is still not completely resolved. They (residents) have warm water but not as hot as they would like. During an observation on 10/17/24 at 09:30 AM ADM entered a resident's room on hall C and was heard tell him that his water could not be hotter because if his water was hotter the residents in the rooms at the other end of the hall would have water that was too hot and might cause burns. She offered to let the resident move to a room closer to the other end of the hall and he said, I don't want to move, I want to stay here. During an interview on 10/17/24 at 09:34 AM LVN C stated she had worked for the facility about a year. She stated a possible negative outcome of residents having a toilet that did not flush properly was it could back up or flood and could make the room stink. LVN C said, Not pleasant at all. She said a possible negative outcome to residents of not having hot water was, I mean when you take a hot shower you feel more clean; that is how you kill bacteria and germs and if it is their (resident's) preference (to have) hot water we should do what we can for them.' LVN C said she showered approximately four residents per week. She stated she had encountered cool water in the shower, but she had also had the shower water be too warm. During an interview on 10/17/24 at 09:40 AM CNA B stated she had run out of hot water when showering residents. She stated residents had complained to her that the shower water was too cold. She said, It is off and on, it will stay warm where you want it and all of a sudden it switches to cold. It just happened to me in there (gestures at the shower door). (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 09:49 AM MS stated he had worked for the facility for 4 weeks. He said he was aware of the issues with some residents not having hot water. He said the facility replaced a water heater and got a new water pump, but it did not solve the problem. He said the halls are plumbed in a U-shape and the rooms closest to water heater had water that was appropriately hot but those on the other end of the U had water that consistently measured at 90 degrees. MS stated the facility will need to buy a stronger pump or add two more water heaters to address the issue. He added, Which would be expensive. MS stated he checked water temperatures in resident rooms every Monday and the rooms on the half of the U-shape in each hall that were furthest from the water heater had water that did not warm past 90 degrees, while those rooms closer to the water heater were at 110 degrees-the hottest allowed. He said it took 5-7 minutes for the water to reach 90 degrees on one side of the hall and on the other side it took about a minute to reach 110 degrees. MS stated he did not think residents were negatively affected by the lack of access to hot water because we have public bathrooms close to water heaters they can get to if they need it (hot water). MS stated HSK D, Resident #7, and Resident #20 brought the dysfunctional toilet to his attention when I first got here. MS stated at that time he let ADM know about the toilet not flushing and he spoke to his regional manager and was told it was due to the facility's water pressure but it ended up not being our water pressure. MS said toilets usually last several years but when they get old, they stop flushing. He said the water in the toilet would go down if it was plunged. MS stated, But we can't do that every time. MS stated the toilet in Resident #7 and Resident #20's room had not worked for 4 weeks to his knowledge, but yesterday he installed a new toilet in their room, and it was working very well. MS stated a possible negative outcome for the residents of a toilet that would not flush was, That would be annoying. He added, There is a guest bathroom and our handicap bathroom so if there was an emergency, they could use that. During an interview on 10/17/24 at 10:23 AM DON stated a possible negative outcome of a toilet that did not flush properly was, It would fill up with urine and maybe cause an odor in the room. When asked what a possible negative outcome of no access to hot water would be, she stated, I only know of one (resident) who has complained, and I did offer him a different room and he did not want to move room. During an interview on 10/17/24 at 10:27 AM HSK D stated she had to plunge the toilet of Resident #7 and Resident #20 periodically but did not know it was not working properly. During an interview on 10/17/24 at 10:48 AM ADM stated the facility received their first complaint about residents not having hot water 2 months ago when a resident filed a grievance. She stated they ordered a hot water heater at that time and installed it about a month later and it is still the same story. ADM stated, I've asked resident who complained to let me move him somewhere with hotter water. He refuses. She stated, We've been working on it (hot water) a good 2 months. On 10/17/24 at 03:07 PM ADM stated the facility did not have a policy addressing plumbing but did have tasks to check water temperature monthly. Record review of facility grievances for the past 6 months revealed a grievance filed on 09/13/24 by a resident on C hall regarding a lack of hot water. Record review of the last 6 months of Resident Council minutes revealed the following: On 06/24/24 Resident #7 complained of his toilet not working. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/24 Residents complained of no hot water in bathrooms and the toilet in the room Resident #7 and Resident #20 shared not working. Record review of facility policy titled Resident Rights and dated 2003 did not address environment.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46534 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. The facility failed to label and date food properly. The facility failed to store frozen food properly. The facility failed to remove a dented can of mandarin oranges from circulation. These failures could place residents at risk of contracting foodborne illness. Findings Included: An observation on 10/15/24 at 09:47 AM of the upright freezer revealed the following: 1 resealable bag of what appeared to be breaded meat patties. No label no date. 1 box of green peas with blue plastic bag open leaving peas visible and open to air 1 box of mixed vegetables, blue plastic bag open leaving vegetables open to air An observation on 10/15/24 at 09:51 AM of the refrigerator revealed the following: 1 plastic basket of strawberries with a green-gray fuzzy substance on one of the strawberries 1 opaque, plastic, round storage container 2/3 full of cooked cauliflower florets dated 10/12/24 During an interview on 10/15/24 at 09:52 AM DM stated leftovers were dated with the date they were made. She stated gravy was good for 7 days and meat and vegetables were good for 3 days. An observation on 10/15/24 at 09:57 AM of the pantry revealed the following: 1 large can of mandarin oranges dented on the bottom seam. An observation on 10/15/24 at 10:03 AM of the chest freezer revealed the following: 1 box of beef patties lined with open plastic bag meat open to air During an interview on 10/16/24 at 08:08 AM [NAME] A stated she had worked for facility for 2 years and leftovers were printed with the date they are made and thrown out after 5 days. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/16/24 at 01:07 PM [NAME] A stated a possible negative outcome of not labelling and dating food in the refrigerator and not taking dented cans out of circulation was, They (residents) could get food poisoned. She stated kitchen staff were responsible for labelling and dating leftovers. During an interview on 10/17/24 at 08:41 AM ADON stated, People could get food poisoning if food was not labelled and date correctly and if dented cans were not taken out of circulation. During an interview on 10/17/24 at 09:36 AM LVN C stated food could grow bacteria or be spoiled if it was not labelled and dated correctly. During an interview on 10/17/24 at 10:10 AM DM stated all kitchen staff were responsible for labelling and dating food and she was responsible for taking dented cans out of circulation. She stated kitchen staff had been in-serviced at least monthly on labelling and dating. She stated a possible negative outcome to residents of food not being labelled and dated properly and dented cans not being taken out of circulation was food poisoning. She stated food being open to air in the freezer could ruin the food. During an interview on 10/17/24 at 10:18 AM DON stated residents could get spoiled food if food was not labelled and dated properly and dented cans were not taken out of circulation. She stated food open to air in the freezer could result in freezer burn. Record review of in-services from DM for last 12 months revealed 4 on handwashing, 1 on sanitization, and 1 on leftovers. The in-services were simply the sign-in sheet and did not reveal what was discussed/taught. Record review of facility policy titled Food Safety and dated 2012 revealed the following: We will ensure all food purchased shall be wholesome and manufactured, processed and prepared in compliance with all State, Federal, and local laws and regulations. Food shall be handled in a safe manner. 2. Food is to be tightly wrapped or sealed and covered in clean containers. Opened food shall be labeled, dated and stored properly. 7. Dented or otherwise damaged cans will not be used, unless inspected by the dietary service manager and found not to be dented on the top or seam, and not perforated. Dented cans will be stored in a separate location and returned to the food vendor for credit. 8. Do not keep potentially hazardous food in refrigerator past the labeled expiration date. Record review of facility policy titled Left - Over Foods and dated 2012 revealed the following: . 4. The guidelines from the 'Texas Food Establishment Rules' will be used when determining the shelf life of leftovers. Record review of facility policy titled Food Storage and Supplies and dated 2012 revealed the following: 4. Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened. However, if possible food spoilage is observed prior to the best by date, the product will be discarded.		