

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Shady Acres Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 405 Shady Acres Lane Newton, TX 75966	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22183</p> <p>Based on observation, interview and record review the facility failed to ensure accurate assessments were completed for 1 of 14 residents (Resident #5) reviewed for accuracy of assessments.</p> <p>The facility failed to ensure Resident #5's quarterly MDS assessment dated [DATE] was not inaccurately coded for injection and insulin use when Resident #5 had no diagnosis or order for insulin injections.</p> <p>These failures could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being.</p> <p>Findings included:</p> <p>Record review of Resident #5's face sheet dated 02/12/2025 indicated she was an [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included hemiplegia and hemiparesis following non-traumatic intracerebral hemorrhage affecting left non-dominant side (left-side paralysis and weakness from a brain bleed), hypertension (high-blood pressure, and anxiety. There was no mention of diabetes or that Resident #5 was diabetic.</p> <p>Record review of Resident #5's care plan dated 10/15/2024 did not indicate any diagnosis of diabetes mellitus or indication of insulin injections being used.</p> <p>Record review of Resident #5's quarterly MDS dated [DATE] indicated she was rarely/never understood and had short-term/long-term memory problems with severely impaired cognition. The same MDS indicated Resident #5 did not have an active diagnosis of diabetes mellitus also under the medications section she received insulin injections during the last seven days but did not indicate hypoglycemic (including insulin) under the section high-risk drug classes: use and indication.</p> <p>Record review of Resident #5's physician orders dated from 10/01/2024 to 2/12/2025 indicated there was no order for insulin or diagnosis of diabetes mellitus during this time.</p> <p>During an observation and interview on 02/12/2025 at 12:18 p.m., Resident #5 was in the dining room, sitting up in a non-emergency medical wheelchair. She was noted to be alert, oriented to person and eating a regular chopped meat textured diet. When Resident #5 was asked about her diet, incomprehensible words were spoken.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/12/2025 at 9:15 a.m., LVN E said Resident #5 did not have a diagnosis of diabetes mellitus and never had received insulin or any type of injections prior to the 10/19/2024 quarterly MDS. LVN E stated the ADON was responsible for completing the MDS and an inaccurate MDS could lead to improper care of the resident.</p> <p>During an interview on 02/12/2025 at 11:15 a.m., the ADON said she was RAC-CT (Resident Assessment Coordinator Certified) for [AGE] years and had been responsible for completing the MDS since January 2025. The ADON said Resident #5 did not have a diagnosis of diabetes and never received insulin injections. When asked about the documentation of insulin and injection use in the quarterly MDS dated [DATE], the ADON said it was coded wrong, and she would fix it. The ADON said the facility used the RAI Version 3.0 Manual as their guideline for completing the MDS accurately.</p> <p>During an interview on 02/12/2025 at 12:45 p.m., the DON said Resident #5's, quarterly MDS dated [DATE] was coded incorrectly for insulin use and injections. The DON said Resident #5 had never had a diagnosis of diabetes and never had an order for insulin or injections prior to the 10/19/2024 quarterly MDS. The DON said incorrectly coding the MDS could lead to inappropriate resident care.</p> <p>Record review of the facility's assessment and care planning policy titled, Comprehensive Assessments, revised dated March 2022, indicated .,</p> <p>Policy Interpretation and Implementation: 1. Comprehensive assessments are conducted in accordance with criteria and timelines established in the Resident Assessment Instrument (RAI) Manual . 8. A significant error is a error in an assessment where: a. the resident' overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and /or results in an appropriate plan of care; and b. the error has not been corrected via submission of a more recent assessment. 9. A significant error differs from a significant change because it reflects incorrect coding of the MDS .</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 41057</p> <p>Based on observation, interview, 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 3 of 6 residents observed for oxygen management. (Residents #1, #6, and #39)</p> <ol style="list-style-type: none"> 1. The facility failed to keep the oxygen concentrator (machine that takes air from your surroundings and extract oxygen and filters the air into purified oxygen to breath) filter clean for Resident #1. 2. The facility failed to failed to keep the oxygen concentrator (machine that takes air from your surroundings and extract oxygen and filters the air into purified oxygen to breath) filter clean for Resident #6. 3. The facility failed on 02/11/2025 to apply clean filters to Resident #39's concentrator and the facility failed to clean the area manufactured to hold the filters in place. <p>These failures could place residents at risk of a significant reduction in the quality of oxygen being delivered, inadequate oxygen support, and decline in health.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Record Review of Resident #1's face sheet dated 02/12/25, indicated he was a [AGE] year-old male admitted on [DATE] and readmitted [DATE] with a diagnosis of chronic obstructive pulmonary disease, COPD (a group of lung disease that cause persistent airflow limitation and breathing problems). <p>Record Review of Resident #1's most recent quarterly MDS assessment dated [DATE] indicated he was severely impaired of cognition.</p> <p>Record Review of Resident #1's care plan revised 11/06/24 indicated he had shortness of breath with interventions of oxygen at 2 liters per minute by nasal canula and to monitor breathing patterns and report abnormalities to the physician.</p> <p>Record Review of Resident #1's Physicians Order Summary dated 02/10/25 indicated he was prescribed oxygen at 2 liters per minute by nasal canula for oxygen saturation (a measure of how well the lungs work) was below 92% as needed for COPD.</p> <p>During an observation on 02/11/25 at 2:30 p.m., Resident #1 was lying in bed wearing oxygen per nasal canula at 2 liters/ minute. The oxygen concentrator was without needed air filters and two separate areas on the oxygen concentrator manufactured to hold the filters were covered with a thick grey powdery, dusty substance.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of admission sheet dated 02/10/25 indicated Resident #6 admitted on [DATE] was [AGE] years old with diagnoses including lung cancer, congestive heart failure, and high blood pressure.</p> <p>Record review of physician orders dated 02/10/25 indicated Resident #6 had an order for oxygen supplement at 4 LPM via nasal cannula. May titrate (adjust) to accommodate resident's O2 saturation (how much oxygen is being in the tissues). Keep O2 saturation above 92 % with a start date of 10/31/2024.</p> <p>Record review of the quarterly MDS assessment dated [DATE] indicated Resident #6 received oxygen therapy while she was a resident of this facility and within the last 14 days.</p> <p>Record review of the care plan dated 10/31/24 indicated Resident #6 had cancer in upper lobe of the lung interventions included O2 at 4 LPM per oxygen concentrator via to keep O2 saturation above 92%.</p> <p>During an observation and interview on 02/10/25 at 9:23 a.m., Resident #6 was in her bed, and she was receiving O2 at 4LPM via nasal cannula per oxygen concentrator. The filter in the back of the oxygen concentrator was covered with a thick whitish substance. Resident #6 said the nurse changed the water bottle and tubing; however, she was unsure who cleaned the filter.</p> <p>During an observation and interview on 02/11/25 at 9:15 a.m., LVN B looked at Resident #6's oxygen filter and said the filter needed to be cleaned. She said the dirty filter could lead to infection or prevent the concentrator from working properly. She said the maintenance supervisor or night shift was responsible.</p> <p>During an interview on 02/11/25 at 9:25 a.m., the Maintenance Director said he thought the rental companies serviced the concentrators and he had not serviced the concentrators.</p> <p>During an interview on 02/11/25 at 9:37 a.m., the ADON said she was the infection control nurse. She said the filters on the oxygen concentrator should be cleaned by the night shift weekly. The ADON said if the filter was covered with dust, it could prevent the concentrator from working properly and could cause infections.</p> <p>During an interview on 02/11/25 at 9:39 a.m., the DON said her expectation was for the filters on the concentrator to be cleaned weekly by the night shift.</p> <p>During an interview on 02/12/25 at 9:45 a.m., the Administrator said he expected the equipment to be kept clean and maintained.</p> <p>3. Record Review of Resident #39's face sheet dated 02/10/25, indicated she was a [AGE] year-old female admitted on [DATE] and readmitted [DATE] with diagnoses of acute respiratory failure with hypoxia (a medical condition where the lungs are unable to adequately exchange oxygen leading to dangerously low level of oxygen in the blood) and heart failure (chronic condition in which the heart does not pump blood as well as it should).</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record Review of Resident #39's most recent annual MDS assessment dated [DATE] indicated she was moderately impaired of cognition and had diagnoses of heart failure and acute respiratory failure with hypoxia. The assessment indicated she received oxygen therapy in the last 14 days.</p> <p>Record Review of Resident #39's care plan revised 01/07/25 indicated she had acute failure with interventions of oxygen at 2 liters per minute by nasal cannula as needed and to monitor for signs and symptoms of respiratory distress and report to the physician.</p> <p>Record Review of Resident #39's Physicians Order Summary dated 02/11/25 indicated she was prescribed oxygen at 2 liters per minute by nasal cannula as needed for shortness of breath as of 02/11/25. The resident's previous order was oxygen at 4 liters per minute by nasal cannula with a start date of 10/29/24.</p> <p>During an observation and interview on 02/10/25 at 9:45 a.m., Resident #39 was lying in bed wearing oxygen per nasal cannula on at 4 liters/ minute. The oxygen concentrator filter was covered with a thick grey powdery, dusty substance. Resident #39 said she wore her oxygen all the time except when smoking.</p> <p>During an observation and interview on 02/11/25 at 2:30 p.m., LVN A said she was providing care for Resident #1 and #39 today and they were both currently wearing oxygen. LVN A said the filter spaces on the oxygen concentrator of Resident #39 should have been cleaned and dirty filters replaced, and it was not done. She said Resident #1's oxygen concentrator filter should have been cleaned and it was not done. She said the nurses were responsible for ensuring oxygen concentrators had filters and were cleaned and, on the concentrators correctly. She said the night nurses were the back up to double check the oxygen concentrator filters. She said it was overlooked. LVN A said she was educated on ensuring the oxygen concentrator had filters on and the filters were cleaned. LVN A said the resident risk of missing and dirty oxygen concentrator filters was decreased air flow to the concentrator.</p> <p>During an interview on 02/12/25 at 11:02 a.m., the DON said the night nurse was responsible for ensuring oxygen concentrator filters were cleaned or replaced every Sunday night and as needed. She said LVN C was the nurse working on 02/08/25 and should have cleaned Resident #1 and #39's concentrator and filter. The DON said the charge nurse the next shift was the back up to double check and ensure the oxygen concentrators had clean filters. She said all the nurses were educated to ensure all oxygen concentrators have clean filters on them. She said it was overlooked. The DON said the resident risk was possible decreased air flow to the concentrator. The DON said her expectation was all oxygen concentrators have clean filters, be cleaned weekly and as needed and the next shift double check to ensure the oxygen concentrators had clean filters.</p> <p>During an attempted phone interview on 02/12/25 at 11:15 a.m., LVN C called with a message left to return call but did not return call prior to exit.</p> <p>During an interview on 02/12/25 at 11:20 a.m., the Administrator said the charge nurse was responsible for ensuring the oxygen concentrator filters were cleaned and applied to the concentrator. He said the staff were educated to ensure the oxygen concentrator filters were clean, but it was overlooked. He said the resident risk was respiratory illness. The Administrator said his expectation was all oxygen concentrators have filters and be cleaned.</p> <p>(continued on next page)</p>		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of a facility policy revised October 2010, titled, Oxygen Administration indicated, . The purpose of this procedure is to provide guidelines for safe oxygen administration.12. Check the mask, tank, humidifying jar, .to be sure they are in good working order and are securely fastened.15. Periodically check oxygen tubing and delivery device . to ensure cleanliness and change as necessary.2. Report other information in accordance with facility policy and professional standards of practice.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460</p> <p>Based observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #6) of 14 residents reviewed for Infection Control.</p> <p>The facility failed to ensure Resident #6 pleural (tissue that lines the chest cavity and covers the lungs) drain bag (this is a flexible tube that drains fluid from the pleural space into in a drainage bag) and the drain port was not on the floor on 02/11/2025.</p> <p>This failure could place residents at risk of cross-contamination and the development of infections.</p> <p>Findings included:</p> <p>Record review of admission sheet dated 02/10/25 indicated Resident #6 admitted on [DATE] was [AGE] years old with lung cancer, congested heart failure (chronic condition in which the heart does not pump well), and high blood pressure.</p> <p>Record review of the quarterly MDS assessment dated [DATE] indicated Resident #6 had long term and short-term memory problems. Resident #6 diagnosis included cancer. She was dependent with ADLs.</p> <p>Record review of the care plan dated 10/31/24 indicated Resident #6 had cancer in upper lobe of the lung with interventions including Enhanced Barrier Precautions related to wound and pleural drain with a start date of 12/13/2024. The goals included Resident #6 will remain free from increased occurrence of infections throughout the review date. The goal was that residents, staff, and family will implement enhanced barrier precautions as directed. Interventions included: ensure residents, family and staff are educated on enhanced barrier precautions protocol. Supplies available to implement precautions.</p> <p>Record review of physician orders dated 02/10/25 indicated Resident #6 had an order to drain the pleural drain bag daily and as needed with a start date of 11/20/24.</p> <p>During an observation on 02/11/25 at 8:30 a.m., Resident #6's pleural drain (this is a flexible tube that drains fluid from the pleural drain bag was on the floor under her bed and the drain port was on the floor.</p> <p>During an interview on 02/11/25 at 8:45 a.m., LVN B said Resident #6 drain bag should not be on the floor to prevent infection and the risk of the tube being pulled out.</p> <p>During an interview on 2/11/25 at 9:37 a.m., the ADON said she was the infection control nurse and the drain bag for Resident #6 should not be on the floor. The drain bag should be kept in the blue bag attached to the bed unless it was being emptied by the nurse to prevent infections and to prevent tube being accidentally pulled out. The ADON said the facility did not have a policy.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/11/25 at 9:39 a.m., the DON said her expectation was for the pleural drain bag to be kept in the blue bag attached to the bed. She said to prevent the drain bag from touching the floor to prevent the spread of germs.</p> <p>Record review obtained per internet at 02/18/25 at https://www.iskushealth.com/wp-content/uploads/2021/12/PleurX-iskus-drainage-guide-complete-2017.pdf indicated . Keep the tip on the PleurX Catheter and the access tip on the drainage line clean. Keep them away from other objects to help avoid contamination.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>41057</p> <p>Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in a safe operating condition for 1 of 1 kitchen reviewed for essential equipment.</p> <p>The facility did not ensure the gas stove in the kitchen was in a safe operating condition when on 02/10/2025 one of six burners did not light when turned on.</p> <p>This failure could place the residents at risk of a fire and not receiving their meals in a timely manner.</p> <p>Findings included:</p> <p>During an observation and interview on 02/10/25 at 8:30 a.m., the DM turned on the gas stove burners with 1 of 6 burners not lighting. The left front burner did not light but no gas was smelled. He said it lit up until now and no staff had informed him the stove was not working. The DM said he thought a pot may have over splashed yesterday evening and blew out the pilot light. The DM said he was responsible for ensuring all equipment in the kitchen worked properly. He said the staff were all educated to inform him or the Maintenance Director if any equipment was not working. He said the resident risk was gas could come out if a knob was hit and the pilot did not light up immediately. The DM said his expectation was all burners to light immediately when turned on and the staff to notify him if they did not.</p> <p>During an interview on 02/10/25 at 8:33 a.m., [NAME] D said all the burners on the gas stove lit the last time he cooked yesterday morning. He said he was not sure why one did not light now. [NAME] D said possibly a splash out of a pot caused the pilot light to go out. [NAME] D said if a burner did not light, he was to notify the DM and Maintenance Director and not use it until fixed. He said all the staff know to notify the DM and Maintenance Director immediately if the burners do not lite and to not use it until the burner was repaired.</p> <p>During an interview on 02/12/25 at 11:00 a.m., the Maintenance Director said the DM was responsible for ensuring all equipment in the kitchen was working properly. He said he was the backup and made weekly rounds. The Maintenance Director said the burners on the stove all lit on 02/07/25 on his last rounds. He said he was educated in maintenance and repairs and could relight the pilot light if needed. The Maintenance Director said the pilot nozzle may have filled up with grease. He said he was notified on 02/10/25 and ordered a part to replace it. He said the resident risk was food could be cooked in a less-than-optimal time because it would take more time to relight the pilot light. He said the gas would shut off if the pilot light was off. The Maintenance Director said he expected the dietary staff to notify him if any equipment was not working so he could repair it.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 02/12/25 at 11:30 a.m., the Administrator said the DM and Maintenance Director were responsible for ensuring all equipment in the kitchen was in working order. The Administrator said he was ultimately responsible. He said he made weekly rounds with the last round on 02/02/25 and the burners all worked. The Administrator said the pilot nozzle possibly had carbon build up causing it not to light. He said the staff were educated to notify the DM and Maintenance Director of any equipment not working. The Administrator said the resident risk was it would slow down food prep time. He said the gas shuts off when the pilot was off. The Administrator said his expectation was to make the staff report immediately or as soon as possible any equipment not working and the Maintenance Director to repair the nonworking equipment as soon as possible.</p> <p>Record Review of a facility policy revised 2009, titled, Maintenance Service indicated, . Maintenance service shall be provided to all areas of the building, rounds and equipment. The Maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.</p>		