STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676108	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vidor Health & Rehabilitation Center	470 Moore Dr Vidor, TX 77662

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32217 Based on interview and record review, the facility failed to consult with the physician regarding a change in condition for 2 of 20 residents reviewed for physician notification. (Residents #5 and #17) The facility failed to consult physician when Resident #5 consistently had above normal blood glucose levels. The facility failed to consult physician when Resident #17's medications were held due to patterns of low heart rate. This failure could place residents at increased risk for complications due to delayed physician intervention. Findings included: 1. Record review of Resident #5's face sheet indicated a [AGE] year-old male admitted to facility on 02/11/25 with diagnoses including diabetes and dementia. Record review of the Quarterly MDS dated [DATE] indicated Resident #5's BIMS score was 03, which indicated severe impairment of cognitive abilities. Record review of Resident #5's care plan dated 07/09/18 indicated a diagnosis of diabetes. Interventions included diabetes medication as ordered by the doctor. Monitor/document for side effects and effectiveness. Review of Resident #5's physician orders dated 05/20/25 included Lantus insulin 16 units subcutaneously one time per day related to diabetes (in the evening). Resident #5's blood glucose level was checked twice daily prior to receiving prescribed dosages of insulin. There were no physician orders to notify the MD of any results outside a parameter. Record review of a May 2025 MAR indicated on the following dates, Resident #5's blood glucose levels were elevated: *05/03/25 - BS was 222; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*05/04/25 - BS was 276; *05/05/25 - BS was 184; *05/07/25 - BS was 184; *05/09/25 - BS was 219; *05/10/25 - BS was 200; *05/13/25 - BS was 197; *05/14/25 - BS was 191; *05/15/25 - BS was 304; *05/16/25 - BS was 214; and *05/18/25 - BS was 246. During an interview on 05/21/25 at 9:40 a.m., LVN L said sliding scale insulin usually has parameters to administer when blood glucose level is between 150 - 400. She said the physician should have been notified of Resident #5's abnormal levels when the readings were high on these dates. LVN L said Resident #5 needed an order for sliding scale insulin to help bring glucose levels back to normal ranges. During an interview on 05/21/25 at 1:45 p.m., the DON Resident #5's blood glucose levels bottom out easily in the mornings (drop levels drastically). She said her expectations were to notify physician each time abnormal elevated blood glucose level. She stated, Obviously he should have had an order for sliding scale insulin to control levels. 2. Record review of Resident #17's face sheet indicated a [AGE] year-old female admitted to facility on 02/03/25 with diagnoses including congestive heart failure (chronic condition in which the heart does not pump blood as well as it should) and hypertension (high blood pressure). Record review of the quarterly MDS dated [DATE] indicated Resident #17's BIMS score was 14, which indicated she was cognitively intact. Resident #17 required moderate to maximum assist with most activities of daily living. Record review of Resident #17's care plan dated 07/28/21 indicated a diagnosis of heart failure. Interventions included report to physician if pulse falls below 60 or rises above 110 or detect skipped beats or other changes in rhythm. Review of Resident #17's physician orders dated 05/20/25 included Digox tablet 125 mcg - give one tablet by mouth one time per day. Hold if heart rate is below 60. Notify physician if above 100. (Digox is used to improve the strength and efficiency of the heart, or to control the rate and rhythm of the heartbeat). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a May 2025 MAR indicated on the following dates, Resident #17's Digox 125 mcg was held: *05/01/25, heart rate was 58; *05/06/25, heart rate was 55; *05/11/25, heart rate was 52; *05/12/25, heart rate was 50; *05/13/25, heart rate was 58; and *05/14/25, heart rate was 48. Record review of Progress Notes dated 05/01/25 through 05/19/25 gave no indication Resident #17's physician was consulted regarding the resident's patterns of low heart rate, and of Digox 125 mcg being held six of 20 opportunities. During an interview on 05/21/25 at 09:30 a.m., LVN L said nursing staff were to document in progress notes anytime a physician was consulted. She said the physician should have been consulted regarding Resident #17's pattern of low heart rate and of medication being held. LVN L said not notifying the physician could affect Resident #17's overall health. During an interview on 05/21/25 at 09:55 a.m., MA M said anytime medications were held for any reason, the charge nurse was to be notified. She said if a resident's heart rate or blood pressure was outside parameters, she would recheck vital signs prior to notifying the charge nurse. MA M said the charge nurses would then assess residents and should notify physicians, especially if a pattern of being held was noted. During an interview on 05/21/25 at 1:45 p.m., the DON said her expectations were to make notifications to physician when vital signs were outside physician ordered parameters and to document notification and results in the resident's electronic medical record. A policy titled medication Administration and General Guidelines labeled as v3-2025 indicated the following: . Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and 2. Medications are administered in accordance with written orders of the attending physician. 12. The physician must be notified when a dose of medication has not been given.

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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** 33460 Based on observation, interview, and record review, the facility failed to provide a safe and comfortable environment for 3 of 18 residents (Resident #21 #23 #74) and 1 of 2 shower rooms (Hall 100/200 shower room) for Resident #36 reviewed for safe environment. The facility failed to ensure Resident #21, #23 and #74' s hand sink water was maintained at or below 110 degrees. The facility failed to ensure shower room between Hall 100 and Hall 200 was maintained at or below 110 degrees for Resident #36. This failure could place residents at risk of burns, pain, unsafe environment and a diminished quality of life. Findings included: 1. Record review of Resident #21's admission record, dated 05/21/25 reflected a [AGE] year-old female admitted to facility on 01/15/2015. Her diagnoses included stroke and slurred speech. Record review of Resident #21's quarterly MDS assessment dated [DATE] indicated a BIMS score of 14 which indicated cognition was intact. She required substantial/maximal assistance for bathing and personal hygiene. Resident #21 had no burns or pressure wounds indicated on her MDS. During an observation on 05/19/25 at 9:00 a.m. in Resident #21's room revealed the water temperature at the sink felt too hot. Requested maintenance supervisor to check water temperatures. During an interview on 05/19/25 at 9:03 a.m., Resident #21 said she had not had any problems with the hot water being too hot. During an interview and observation on 05/19/25 at 9:08 a.m., the Maintenance Supervisor was taking the temperature of the water at Resident #21's hand sink in room [ROOM NUMBER]. The temperature of the water was 114.2 degrees. He said last week the water temperatures were fluctuating, so the plumber came out and gave an estimate for a new mixing valve. He said he checked temperatures on Friday (05/16), but he did not document the results. He said, the temperatures were about the same as got in this room on Friday. He said the water temperatures should be from 100 to 120 degrees. He said the water temperature could be too hot or too cold for the residents and that could be uncomfortable for the residents. 2. Record review of Resident #23's admission record, dated 05/19/25 reflected a [AGE] year-old male admitted to facility 02/25/2021. His diagnoses included traumatic brain injury, epilepsy and colostomy. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #23's quarterly MDS assessment dated [DATE] indicated a BIMS score of 8 indicating moderate cognitive impairment. He was dependent on staff for bathing and personal hygiene. Resident #23 had no burns or pressure wounds were indicated. During an observation on 05/19/25 at 9:30 a.m., the Maintenance Supervisor checked the water at the hand sink with his thermometer in Resident #23's bathroom and the temperature was 112.2 degrees. During an interview on 05/19/25 at 9:50 a.m., Resident #23 said he had never been burned or had water in the sink or shower that was too hot. 3. Record review of Resident #74's admission record dated 05/19/25 reflected a [AGE] year-old female admitted to facility on 05/17/24. Her diagnoses included kidney failure and obesity. Record review of Resident #74's quarterly MDS assessment dated [DATE] indicated a BIMS score of 15 which indicated cognition was intact. She required substantial/maximal assistance for bathing and personal hygiene. Resident #74 had no burns or pressure wounds indicated on her MDS. During an observation on 05/19/25 at 9:30 a.m., the Maintenance Supervisor checked the water at the hand sink in Resident #74's bathroom with his thermometer and the temperature was 111.3 degrees. 4. Record review of Resident #36's admission record dated 05/21/25 reflected a [AGE] year-old female admitted to facility on 05/07/21. Her diagnoses included stroke and anxiety. Record review of Resident #36's quarterly MDS assessment dated [DATE] indicated a BIMS score of 15 which indicated cognition was intact. She required substantial/maximal assistance for bathing and personal hygiene. Resident #36 had no burns or pressure wounds indicated on her MDS. During an observation on 05/19/25 at 9:35 a.m. the Maintenance Supervisor checked the water at the sink in the shower room between Hall 100 and Hall 200 was 115 degrees. The water in the shower was 111.4 and he said the shower could be lower temperature because the staff had just finished giving a shower. He said he would adjust the hot water. During an interview on 05/19/25 at 9:40 a.m., Resident #36 said she had just received her shower and denied getting burned or that the water was too hot. During interview on 05/19/25 from 10:10 a.m. to 10:55 a.m., LVN D, LVN E, LVN F, MDS Coordinator LVN G, CNA H, CNA J, CNA K and OT. said knew to monitor the water temperatures when assisting the residents with grooming or showering to prevent burns. During an interview on 05/19/25 at 11:00 a.m., the Administrator said he notified nursing management on Friday about the water issues. He said he assigned the weekend supervisor to check the water temperatures to prevent problems for the residents. He said the water could be too hot or too cold. He said corporate required 3 bids before they would approve the needed repair. During an interview on 05/19/25 at 12:00 p.m., the MDS Coordinator LVN C said she was the MOD (manager on duty) on 05/17/25 or 05/18/25. She said she monitored the water temperatures by checking water temperatures with a thermometer. She said the temperatures were below 110 and no issues were noted. She said the water was supposed to be under 110 to prevent burns. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the manager on duty forms dated 05/17/25 and 05/18/25 indicated MDS Coordinator- LVN C monitored the water temperature on Hall 100. There were no issues noted. During a group interview on 05/20/25 at 10:30 a.m., 5 alert and oriented residents, Resident #8, Resident #38, Resident #36, Resident #50, and Resident #83. denied having issues with the water temperatures being too hot. They said they had no knowledge of anybody being burned with hot water. During an interview on 05/20/25 at 8:30 a.m., the Administrator said he had read the water temperature could be from 100 to 120 from a website with resources for Long Term Care Administration. He provided the water temperature log, and it indicated the water temperature should be at least 100 to 110 degrees. He denied having a policy about water temperature and said water should be comfortable. Record review of the water temperature check log dated 05/06/25 indicated water temperatures ranged from 100 to 108 degrees by the Maintenance Supervisor. Record review of the water temperature check log dated 05/13/25 indicated water temperatures ranged from 100 to 110 degrees documented by the Maintenance Supervisor. Record review of temperature logs for 05/20/25 - 05/21/25 indicated water temperatures were checked by the Maintenance Supervisor 4 times a day and were below 110 in the shower and the hand sink between Hall 100 and Hall 200 and in Resident #23 hand sink in his bathroom.

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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** 36214 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 18 residents reviewed for care plans. (Resident #40) The facility did not have a care plan to address Resident #40's diagnosis of pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid). This failure could place residents at risk of not having individual needs met and not receiving needed services. Findings included: Record review of a face sheet dated 05/21/25 indicated Resident #40 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included pneumonia, pleural effusion (a buildup of fluid between the tissues that line the lungs and the chest), and chronic obstructive pulmonary disease (a group of lung diseases that block air flow and make it difficult to breathe). Record review of a physician order dated 05/15/25 indicated Doxycycline Hyclate (an antibiotic that is commonly used to treat respiratory tract infections, such as bronchitis and pneumonia) 100mg, give one tablet by mouth two times a day for pneumonia until 05/28/25. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #40 had a BIMS score of 3 indicating she had severely impaired cognition. She required partial/moderate assistance with most ADLs, and she had an active diagnosis of pneumonia. She had shortness of breath with exertion, when sitting at rest, and when lying flat and was dependent on continuous oxygen therapy. Record review of a care plan last revised 08/19/20 indicated Resident #40 had altered respiratory status/difficulty breathing/ shortness of breath/ acute respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily function)/ disorders of the lung/ asthma/ prior history of tuberculosis/ anxiety. Interventions included monitor for signs and symptoms of respiratory distress and report to MD at needed. There was no care plan addressing Resident #40's recent pneumonia diagnosis with interventions. During an observation and interview on 05/19/25 12:30 p.m., Resident #40 was up in her wheelchair in the dining room. She was receiving oxygen by nasal cannula from a portable oxygen tank attached to her wheelchair. She said she had been out of her room this morning. She was unable to answer any other questions. During an interview on 05/21/25 at 11:20 a.m., LVN B said Resident #40 had a bad cough and increased shortness of breath and a chest x-ray was completed. She said the chest x-ray indicated pneumonia and the physician ordered Doxycycline for the resident. She said Resident #40's cough had lessened, and her shortness of breath was better since beginning the Doxycycline last week. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/25 at 12:25 p.m., the DON said she was responsible for writing care plans involving any residents newly diagnosed infections. She said she was aware that Resident #40 was diagnosed with pneumonia and was taking Doxycycline. During an interview on 05/21/25 at 10:25 a.m., the DON said she expected the residents to have care plans that covered all their needs. She said if they did not have one their needs could be missed. She said she had not updated Resident #40's care plan to include her pneumonia or her antibiotic treatment. She said the previous Infection Control Nurse resigned 05/14/25 and she assumed the role on 05/15/25. She said she was notified of Resident #40 pneumonia on 05/16/25 at the morning care meeting but she had not completed a new care plan. She said the resident already had care plans for respiratory issues including pleural effusion and respiratory failure and she could see no negative outcome of not including the new pneumonia diagnosis in the care plan. During an interview on 05/21/25 at 3:25 p.m., the Administrator said that his expectation was for care plans to be completed timely and accurately., He said the care plan for Resident #40's pneumonia was missed because the previous Infection Control Nurse left on 05/14/25 and the care plan was missed in the transition. Record review of an undated Comprehensive Care Planning policy indicated The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 32217

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41057 Based on observation, interview, and record review, the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 2 medication rooms (the main medication storage room) reviewed for drug labeling and storage. The main medication storage room had 11 over-the-counter medication bottles that were in stock to be used after their expiration date. These failures placed residents at risk for receiving biologicals and medications which were ineffective and/or not safe. Findings included: During an observation and interview on 05/21/25 at 9:10 a.m., in the main medication storage room, LVN A discovered 11 unopened over-the-counter medication bottles after their expiration date including: *1, 12-ounce bottle of Acid Gone Antacid alumina and magnesium carbonate (treats heart burn and acid indigestion) an unopened liquid with an expiration date of 01/25; *1, 12-ounce bottle of Dulcolax (treats constipation) an unopened liquid with an expiration date of 04/25; *1, 16-ounce bottle of mineral oil lubricant laxative (treats constipation) an unopened liquid with an expiration date of 08/15/24; *2 bottles of Glucosamine and Chondroitin 500 mg/ 400 mg (treats symptoms of osteoarthritis) unopened supplement with 60 caplets and an expiration date of 03/25; *3 bottles of Folic Acid 400 mg (a B vitamin that helps make healthy red blood cells, which carry oxygen around the body) unopened with 100 tablets, 2 bottles with an expiration date of 03/25 and 1 bottle with an expiration date of 04/25; *2 bottles of Vitamin E (supplement that is important for vision and fighting disease and health of the blood, brain, and skin) 180 mg (400 IU) unopened with 100 tablets and an expiration date of 04/25; *1 bottle of Lactobacillus (a probiotic that is used to help maintain the number of healthy bacteria in your stomach and intestines) unopened with 50 tablets and an expiration date of 04/25; and *1 bottle of Bisacodyl 5 mg (treats constipation) unopened with 100 tablets and an expiration date of 04/25. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN A said the Medical Records Clerk was responsible for ordering and stocking supplies and over the counter medication and removal of expired medication. LVN A said she was unsure who the backup was, but she always double checked any medication she removed from the medication storage room to use on her nurse's medication cart. She said medication was stored with the oldest medication in front and newest medication in the back. LVN A said the expired medication bottles were possibly overlooked or someone grabbed the medication from the middle or back of the line of medication instead of the medication stored nearest the front which should be the older medication. LVN A said the resident's risk of expired medication in the medication storage room was it could be given to a resident and the medication may not be as effective as it should be. During an interview on 05/21/25 at 9:33 a.m., the DON said the Medical Records Clerk was responsible for ordering supplies, removal of expired medication, and organization of stored medication on the shelves with the oldest medication in the front and newest medication in the back. She said the Pharmacy Consultant was the backup who checked the medication room for expired medications. The DON said the expired medications in the over-the-counter storage were possibly overlooked. She said the resident's risk of expired medication in the over-the-counter medication stock was the medication may not be the correct potency if given to a resident. The DON said her expectation was all medication in the medication storage room be in date and staff to use the older medication before the newer medication. During an interview on 05/21/25 at 9:50 a.m., the Medical Records Clerk said she was responsible for ordering over-the-counter medication, stocking, and removal of expired medication from the medication room. She said she organized the medication on a shelf with the older medication in the front and newer medication in the back of the line. She said the nurses were the back up to ensure any expired medication was removed from the over-the-counter medication supply. The Medical Records Clerk said she checked monthly for expired medication with 04/20/25 as her last check for expired medication. She said her new Regional Consultant was scheduled to visit the facility on 05/27/25 and do a complete check of all the medication in the medication storage rooms for expired medication along with her. She said she was educated to check all over-the -counter medication and remove and dispose of expired medication properly. The Medical Records Clerk said the resident's risk of expired mediation in the over-the-counter medication supply was it could be given to a resident and the medication may not be as effective as it should be. During an interview on 05/21/25 at 9:50 a.m., the Administrator said the Medical Records Clerk was responsible to ensure the over-the-counter medication supply was stocked and all expired medication removed and disposed of properly. He said the new Regional Consultant had not rounded in the facility yet and was coming on 05/27/25 to do a check of the medication rooms along with the Medical Record Clerk. The Administrator said the resident's risk of expired medication in the over-the-counter medication supply was possible side effects to residents if used. He said his expectation was all medication in the medication room be organized, and expired medication removed and disposed of properly. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/25 at 1:17 p.m., the Pharmacy Consultant said she periodically checked the medication rooms for expired medication by doing a random inspection but not checking every medication. She said she checked the medication rooms about 4 months ago. The Pharmacy Consultant said last month she checked the medication carts. She said the nurses were ultimately responsible to ensure all expired medication removed from the over-the-counter supply and disposed of properly. She said the resident's risk of expired medication in the over-the-counter supply was the medications would still be potent but may not the same strength as current medication but not unsafe for residents. The Pharmacy Consultant said as medication expired the medication would start to decline in strength. Record review of, Executive Summary of Consultant Pharmacist's Medication Regimen Review, dated 05/09/25 indicated review of medication cart audit but no indication of review of the medication supply room.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22183 Based on observation, interview and record review, the facility failed to employ sufficient staff with the appropriate competencies, and skills set to carry out the functions of the food and nutrition service for 1 of 1 activity aide (Activity Aide B) and 1 of 5 dietary aides (Dietary Aide L) reviewed for qualified dietary staff. The facility failed to ensure Activity Aide B and Dietary Aide L had their Texas Food Handler's License. This failure could place residents at risk of not having their nutritional needs met and place them at risk for food born illnesses. Findings included: During an observation on [DATE] at 12:00 p.m., Activity Aide B was standing at the prep table preparing shredded cheese. Record review of Activity Aide B's personnel file indicated a hire date of [DATE]. No prior or current food handler certificate was found. Record review of Dietary Aide L personnel file indicated a hire date of [DATE] no prior or current food handler certificate was found. During an interview on [DATE] at 9:00 a.m., DM said Activity Aide B and Dietary Aide L did not have current food handler certificate and she could not locate any prior food handler certifications for Activity Aide B or Dietary Aide L. She said not having a current certification places the residents at risk of not having food prepared correctly. During an interview on [DATE] at 2:40 P.M., the Administrator said it was important for anyone who prepared or cooked in the kitchen to have their food handler's license to ensure everyone knew the best practices across the board. He said they needed to know to follow the rules and regulations, ensure proper sanitation, and how to not cross-contaminate. He said the certification was normally done 30-days after hire and when expired, and the DM was responsible for ensuring they were completed. He said that obviously, some were missed, and the facility did not have a policy on Food Handler Certifications. During an interview on [DATE] at 3:32 p.m., Activity Aide B said she had a food handler certification, but it was expired. She said on [DATE] she was in the kitchen getting shredded cheese for the residents' appetizers. She said on [DATE] she retook the food handler's certification. She said not having a current certification put the residents at risk of not having best practice followed when preparing their food. Dietary Aide L was unavailable for interview via phone. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	After surveyor intervention: Record review of the Activity Aide B Texas Food Handler Training Program certification, reflected the effective date as [DATE]. Record review of and Dietary Aide L Texas Food Handler Training Program certification, reflected the effective date as [DATE]. Record review of the facility's policy titled, Infection Control, revised [DATE], read: Procedure: .4.b. The facility will follow all state and local regulations concerning initial hire and annual health examinations for dietary associates. C. the Dietary Service Manager should use the following guidelines concerning health examinations and documentation. If required, post a valid food handler's card for each dietary associate in the department at all times, keep current examination documentation and food handler's cards in personnel file on all department associates .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22183 Based on observation, interview, and record review, the facility failed to properly store, prepare, distribute, and serve food in accordance with the professional standards for food service safety 1 of 1 kitchen reviewed for safety requirements. 1. The facility failed to ensure food items in Icebox #1 were labeled, dated, sealed, and not expired. 2. The facility failed to ensure the floor in Icebox #2 was free from standing water spills and unpackaged food. 3. The facility failed to ensure Activity Aide B, Dietary Aide G, and Dietary [NAME] H's hair was completely contained with an effective hair restraint. 4.The facility failed to ensure the left wall in the milk-box cooler - was free of ice build-up and accumulation of food crumbs and debris. 5.The facility failed to ensure food items in the dry pantry were labeled, dated, sealed, and not expired and failed to ensure dented cans were not stored and co-mingled with non-dented food cans ready for use. 6.The facility failed to ensure the flat sheet pans and stock pots were free of black and brown cooked on build-up. These failures could place residents, who received food and beverages from the kitchen, at risk for health complications, foodborne illnesses, and decreased quality of life. Finding included: During an observation and interview on [DATE] at 8:30 a.m., in Icebox #2 there were two cases of ,d+[DATE] gallon cartons of milk, wet from exposure to half-inch to 1-inch deep of standing water. The DM confirmed the milk cartons were sitting in water and were wet on the bottom. During an observation and interview on [DATE] at 8:35 a.m. of Icebox #1 with the DM indicated there were: - a gray bin labeled Yoplait yogurt with two small 6-ounce clear cups with lids not labeled and not dated of orange-colored pieces of a substance. The DM said they were cantaloupe slices and she put them in a large gray bin of peaches. Also, in the gray bin (labeled Yoplait) were 2 more small 6-ounce clear cups with lids of a yellow pudding substance. The DM said those were super pudding used for medication pass. - 1-container pint of [NAME] small tomatoes not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 1-large bag of broccoli undated, unlabeled, ripped open from the seam exposing the broccoli to the elements. The DM said the bag was opened and exposing the broccoli to air. The DM said the count of broccoli were 8-heads that were left from Friday's meal. - 1-gallon Ziploc bag of sliced tomatoes with a white coating on them in 2inch height of pink tinged slimy liquid. The DM confirmed the tomatoes were losing their color and had a white coating. During an observation on [DATE] at 8:45 a.m., Dietary [NAME] H was in the kitchen, near the food preparation table. She had a hairnet on with approximately ,d+[DATE] inches of hair in the nape (back of her head) and wisps of her hair (around front profile of face) not covered with the hair net. She was standing at the prep table preparing canned beans in a pot. During an observation on [DATE] at 9:00 a.m., Dietary Aide G was in the kitchen, near the food preparation table. She had a hairnet on with approximately ,d+[DATE] inches of hair in the nape (back of her head) and wisps of her hair (around front profile of face) not covered with the hair net. She was standing at the prep table. During an observation on [DATE] at 12:00 p.m., Activity Aide B was in the kitchen, near the food preparation table. She had a hairnet on with approximately ,d+[DATE] inches of hair Bang (front of her head), in the nape (back of her head) and wisps of her hair (around side profile of face) not covered with the hair net. She was standing at the prep table preparing shredded cheese. During an observation and interview on [DATE] at 8:50 a.m., the milk box cooler had clear ice build-up approximately 2-inches thick to the left wall in the milk box and along the rubber gasket seal weather strip was an accumulation of brown-tinged grime, dirt and crumbs. The DM confirmed the ice on the wall of the milk box and build-up of dirt and crumbs to the rubber seal. During an observation and interview on [DATE] at 9:05 a.m. of the pantry with the DM indicated there were: - 20, 4-ounce containers of thickened cranberry cocktail juice in their original container with a manufacturer expiration date of [DATE]. The DM said she would remove them from the pantry and discard. She said if used, residents could get sick. - Two, 6-pound cans of [NAME] Farms Sliced Peaches heavy syrup dented cans co-mingled with non-dented food cans ready for use. One can had a large dent in the middle of the can and the other had a large dent at the bottom seam. The DM place the dented cans in the dented can section of the pantry and said using dented cans could contaminate food. - 1 opened and used folded down bag of vanilla wafers that was folded down on itself, not sealed and exposed to the elements. The DM said not being sealed the wafers could get stale. - On the shelf of the ready to use foods was an expired jar of Zatarain's Prepared Horseradish 5.25-ounce, manufacturer expiration date [DATE] and instructions to refrigerate after opening. The DM said she thought she threw that away, and it could cause food illness. (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 [DATE] at 09:33 a.m., Dietary [NAME] H said she received orientation training on different types of meals to include how to serve plates, menus, reading the meal ticket, hair nets, glove use, hand hygiene, using scoops for serving food, and many other topics. She said without a date, she would not know when it had been placed in the refrigerator and would discard the food to ensure it was safe for residents and not make them sick. Dietary [NAME] H said she was not aware of her hair sticking out. During an observation and interview on [DATE] at 9:05 a.m . of the storage area for pots and pans with DM indicated there were: - 5, large cooking pans with build-up of a cooked on black and brown substance. - 2, large cake sheet pans with build-up of baked on black and brown substance - 4, large flat cooking sheet pans had baked on build-up of a brown substance. - 1, large stock pot with build-up cooked on black and brown substance. During an interview on [DATE] at 2:20 p.m., the DM confirmed the cans of peaches contained dents and should have been stored separate from non-dented cans. The DM said hair restraints should be worn at all times while in the kitchen, including bangs and little hairs around the face. She said hairnets prevent cross contamination and foodborne illnesses from getting in the food. The DM said she was responsible for making sure staff in the kitchen were following the facility policy, checking the pantry, refrigerator, and freezer for expired or spoiled foods at the end of each week, and cleaning the kitchen and pot and pans. The DM said she could not explain why the expired or spoiled foods had not been removed from the refrigerator, freezer or why the weekly schedule for cleaning the pots and pans was not done. The DM said she was purchasing new pots and pans. The DM said the Maintenance Supervisor was aware of Icebox #2 having standing water on the floor, but she could not remember when she notified him. She said all kitchen staff completed the required food preparation and food storage trainings. The DM said the potential harm to residents would be food poisoning, diarrhea, sickness, and bacteria on food. The DM said the failure occurred due to staff not paying attention. During an interview on [DATE] at 2:40 p.m., the Administrator said if any staff entered the kitchen, they were expected to wear a hair net. He also said if a staff's hair was not completely covered, the risk would be hair getting in the resident's food, and he had no complaints of hair in the food. The Administrator said he was not aware of the ice and water build up and told the Maintenance Supervisor that day ([DATE]) he found out to check the equipment. The Administrator said his expectation was all products in the kitchen be labeled and dated correctly. The Administrator said if residents were served out of date food products it could result in stomach aches, diarrhea, causing them to get sick. The Administrator said it was the responsibility of the DM to ensure all products were labeled correctly and equipment in the kitchen was cleaned regularly and in good working condition. (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 [DATE] at 3:00 p.m., the Maintenance Supervisor said he checked the milk box cooler and Icebox #1 in the kitchen and there was nothing needed to be repaired. He said the ice was from the rubber seal needed cleaning, which caused a slightly opened area and caused ice to buildup on the left side of the milk box cooler. The Maintenance Supervisor said the water was because the drain was clogged in the Icebox #1, and he unclogged it. He said the milk box cooler and Icebox #1 was in good working order. The Maintenance Supervisor said he was made aware of what equipment needs repair from the morning meetings and from checking his phone notifications about it. He said he learned how to use the facility electronic reporting system about a couple weeks ago. The Maintenance Supervisor said requests were entered but he could not retrieve them from the electronic reporting system and did not know how to do it. The Maintenance Supervisor said that he was not aware of the kitchen equipment needing repair until [DATE] when the Administrator told him to check it. The Maintenance Supervisor said the risk to residents could be food spoilage and cause them to get sick. During an interview on [DATE] at 3:32 p.m., Activity Aide B said she did not work in the kitchen and said she was just preparing cheese for the dining room resident's appetizers. She said she had been trained on how to properly wear a hair net, covering the entire hair. She said the reason she was supposed to wear a hairnet is because it keeps the hair out of the food. Record review of the facility's policy titled, Food Storage and Supplies, dated 2012, read: Procedure: .4. Opened packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened . Record review of the facility's policy titled, Equipment Sanitation, dated 2012, read: : Procedure: .6. Pots and Pans: .b. Prior to washing, all utensils and equipment shall be pre-scraped or pre-flushed and when necessary, pre-soaked to remove gross waste . Record review of the facility's policy titled, Infection Control, revised [DATE], read: : Procedure: .1. Clean hair is required. It is to be covered with an effective hair restraint. Review of the Food and Drug Administration Food Code, dated 2022, reflected, XXX,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food ,d+[DATE]. 11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32217 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 20 residents (Resident #5) reviewed for medical records accuracy. The facility did not accurately document Resident #5's daily vital signs on the May 2025 MAR. Staff signed off on physician ordered daily vital signs as taken and were repetitively documented with identical findings on 05/01/25, 05/02/25, 05/03/25, 05/04/25, and 05/05/25 and identical findings on 05/06/25, 05/07/25, 05/08/25, and 05/09/25. This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment. The findings included: Record review of Resident #5's face sheet indicated admitted to facility on 06/05/18 with diagnosis including dementia, hypertension, and diabetes. Record review of Resident #5's physician orders dated 05/20/25 indicated on 03/09/25, the facility initiated a QAPI PIP Data Collection for hospital rehospitalization prevention. This included obtaining vital signs daily on the morning shift. Record review of the quarterly MDS dated [DATE] indicated Resident #5's BIMS score was 03, which indicated severe impairment for cognitive abilities. Record review of Resident #5's care plan dated 06/06/18 indicated a diagnosis of hypertension (high blood pressure). Interventions included to obtain blood pressure readings at least weekly unless ordered by the physician to be obtained more frequently. Record review of Resident #5's May 2025 MAR indicated identical documentation of vital signs as BP- 144/68, Temperature- 97.4, Pulse- 72, Respirations- 18, and Oxygen saturation as 96% on the following dates: *05/01/25, *05/02/25, *05/03/25, *05/04/25 and *05/05/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's May 2025 MAR indicated identical documentation of vital signs as BP- 129/67, Temperature- 97.5, Pulse- 82, Respirations- 18, and Oxygen saturation as 96% on the following dates: *05/06/25, *05/07/25, *05/08/25, and *05/09/25. During an interview and record review on 05/21/25 at 9:40 a.m., LVN L reviewed Resident #5's May 2025 MAR with surveyor. She the recordings were repetitive and were false results. LVN L said it appeared staff were recording from previous documentation and not taking their own set of vital signs. She said the proper procedure was to take the resident's vital signs per orders. She said her routine was to take each resident's vital signs every morning prior to administering medications and to document on each individual resident's MAR. During an interview and record review on 05/21/25 at 10:00 a.m., the DON reviewed Resident #5's May 2025 MAR with surveyor. She said the vital sign findings documented 05/01 thru 05/05/25 were the same each day as well as the vital sign findings for 05/06 thru 05/09/25. The DON said nursing staff obviously were not checking Resident #5's vital signs daily as ordered. She said vital signs were to be documented on the MAR, and with their electronic medical record, each vital sign would also be pulled to the vital sign tab in their record. The DON said the electronic record program had a feature that would allow staff to use an option to document the last reported value and it appeared staff were using the feature instead of taking daily vital signs and documenting their new findings. The DON said by not assessing residents and documenting correctly, it could jeopardize resident's health. She said her expectations were for all nursing staff to obtain daily vital signs per physician orders and document accordingly.

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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** 22183 Based on 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 2 of 4 residents (Resident #32 and Resident #64) reviewed for infection control practice. The WC Nurse failed to perform hand hygiene and change gloves while providing wound care to Resident #32's great toe wound. The WC Nurse failed to perform hand hygiene and change gloves while providing wound care to Resident #64's coccyx area wound. These failures could place residents at risk for the spread of infection. Findings include: 1. Record review of Resident #32's face sheet, dated 05/21/25, indicated a 66- year- old male who was admitted to the facility on [DATE], with diagnoses of diabetes mellitus, edema, and kidney disease. Record review of Resident #32's quarterly MDS assessment, dated 04/27/25, indicated Resident #32's skin conditions included a venous and arterial ulcer. Record review of Resident #32's care plan, dated 04/01/25, indicated the resident had arterial/ischemic ulcer of the left great toe related to peripheral arterial disease with interventions to treat wound as per facility protocol . Resident #32 was also care planned for enhanced barrier precautions related to wound, with interventions .to perform hand sanitation before entering the room and prior to leaving the room and gloves and gowns should be donned if any of the following activities are to occur: .wound care . Record review of physician orders for May 2025 for Resident #32 indicated: Cleanse arterial ulcer to the left great toe with wound cleanser and pat dry. Apply Sureprep and leave open to air. During an observation on 05/21/25 at 11:30 a.m., the WC Nurse provided wound care to Resident #32's wound. She donned gloves before the start of care and prepared a clean field before commencing care. The WC Nurse took her supplies to the resident's room and placed it on his bedside table. The WC Nurse touched Resident #32's left great toe with her gloved hands then with the same contaminated gloves went into her clean field and retrieved wound cleanser-soaked gauze to cleanse Resident #32's left great toe. She balled up the gauze, placed the gauze on the same wax paper as her clean dressing, took off her gloves and placed the dirty gloves on the same wax paper as her clean dressing next to the gauze used to clean the wound. The WC Nurse did not perform hand hygiene and donned a fresh set of gloves, went back into her now contaminated field to retrieve the Sureprep and applied it to Resident #32's left great toe wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Fundamentals of Infection Control Precautions, undated, read: .1. Hand Hygiene .before and after entering isolation precautions settings, .before and after changing a dressing, .after handling soiled .dressings .after removing gloves .Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infection .