STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676214	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falcon Lake Nursing Home, LLC	200 Carla St Zapata, TX 78076

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 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** 44748 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen and 1of 2 unit (unit 1) nutrition refrigerators reviewed for sanitation. The facility failed to maintain the kitchen freezer that had a large section of ice build-up in it. The facility failed to provide clean coffee cups for the resident's use. The facility failed to ensure the nutrition room refrigerator had labeled and dated items in them. The facility failed to ensure the nutrition room did not have expired items. The facility failed to ensure the nutrition room snack tray items were labeled, dated, and refrigerated. The facility failed to ensure the freezer temperature logs for the unit refrigerator were documented. The facility failed to ensure there was a thermometer in the unit freezer. These failures could place residents at risk of living in an unsafe, unsanitary environment and place them at risk of foodborne illness. Findings were: Initial tour and observation of the kitchen on [DATE] at 9:45 am revealed a large section of ice build-up around the upper walls, over electrical conduit, around the fans and across the upper back ceiling of the freezer, potentially impeding airflow, water flow, and causing failure and/or potential fire. The freezer was approximately 8 feet long by 3 feet wide and 8 feet high inside. There were 14 of 14 coffee cups on a clean rack in the dining area near the coffee set-up that had heavy dark brown stains and scratches in them. (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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the cook on [DATE] at 9:50 am, she stated she worked at the facility for 7 years. She stated the ice build-up in the top back of the freezer and freezer walls had been doing that for a long time, since the end of last year (2023). She stated the MS would go in and remove the ice, but it always came back. She stated she thought the fans blowing up there were what caused the ice build-up. She stated the ice could cause the freezer to stop working, and they had nowhere to put everything from the freezer. She stated the residents might not get the food they were promised, and the food from the freezer would have to be thrown out. In an interview with the MS on [DATE] at 10:10 am, he stated he worked at the facility for [AGE] years. He stated the ice build-up in the freezer had been there for a couple of days on account of the ice needs to be defrosted. He stated the pipes could get clogged and cause the freezer to stop working. He stated he did most of the work on the equipment at the facility. He stated the last service that was done on the freezer was about a year ago when they repaired the fans but did not fix the fans. He stated he had not called the freezer service company. He stated he broke off the ice, but it would keep coming back. He would not say how many times he had to break the ice off inside the freezer, indicating the ice had been there longer than a couple of days. Maintenance service policy, the maintenance log, and invoices requested. In an interview with the DS on [DATE] at 10:15 am, she stated the ice build-up in the freezer was on-going, and she did not know what the MS was doing about it. She stated the cups on the clean rack by the coffee set-up were used by the residents to self-serve. She stated she would not want to use the dirty cups herself, and the residents could get sick. Observation of the nutrition room refrigerator (unit 1) on [DATE] at 3:09 pm revealed 3 small, 3-oz. lidded cups with cookies in them that were unlabeled and undated, a 1-gallon bag with the same type of cookies dated [DATE], but not labeled. There was a 6-oz. Styrofoam container opened to air with several slices of fruit that were shriveling and turning brown, a 3-oz unlidded container opened to air with what appeared to be slimy and shriveled watermelon, undated and unlabeled, an 18-oz. partially empty jar of what appeared to be red jam unlabeled and undated, a 35 ml container of sweet juice unlabeled and undated, a 20-oz. container of bacon, unlabeled and undated, and a 48-oz. container of cream cheese that was unlabeled and undated. There was a 16-oz. open, partially empty can of energy drink that was unlabeled and undated. There was a tray on the counter with 6, ,d+[DATE]-bananas and 8 small bundles of cookies that were wrapped in plastic, 4, 4-oz. small bags of cheese chips with expired use-by dates of [DATE], and 2, 6-oz. containers of pudding that were unlabeled and undated. There was a full pitcher of what appeared to be iced tea on the counter with condensation on the outside. All items on the tray and the pitcher were unlabeled and undated. There was an open quart-size bag of ice open to the air in the freezer, unlabeled and undated. There was no thermometer in the freezer. There was a printed 8 ,d+[DATE] x 11 green paper sign on the outside of the refrigerator stating in all capital letters, Resident items only! and in smaller capital letters, the sign stated, Any food or beverages must be labeled with the resident's name, date, time, and initials of who placed items in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the ADON and DON on [DATE] at 3:10 pm revealed they were unaware of the unlabeled, undated items in the nutrition rooms. They both stated they were not sure who was responsible for the nutrition room refrigerators. Both stated they did not know why the freezer temperature was not being documented or why there was no thermometer in the freeezer. The ADON stated having exposed food in the nutrition refrigerator could make residents sick if they consumed any of it. They both stated the undated, unlabeled, uncovered and expired food was a danger to residents because of cross contamination and any decomposition of food was unsafe. Neither would say why there was no thermometer in the unit freezer. A food storage policy was requested. In an interview with the DS on [DATE] at 3:15 pm, she stated the kitchen forgot to date the items on the tray. She stated the tray of bananas and snacks that was on the counter should have been put in the refrigerator. She stated everyone was responsible for the nutrition room refrigerator and the kitchen was responsible for bringing the snack trays, but they should have been labeled, dated, and placed in the refrigerator. She stated if snack items were left unrefrigerated too long, bacteria could grow and make residents sick. In an interview with the ADM on [DATE] at 3:25 pm, she stated she was unaware the freezer in the kitchen was icing up. She stated she was also unaware the nutrition refrigerator was not being monitored. She stated the process for repairs to the facility was for staff to place requests in the hand-written maintenance log that was kept at the nurse's station. She stated she did not check the maintenance log because the MS assured her everything was fine and he was taking care of things. She stated she could not locate the maintenance log at the nurse's station. She stated she would in-service staff about the nutrition refrigerator. Record review of the refrigerator log dated [DATE]-[DATE] revealed 2 checks for the refrigerator: one in the mornings and one on nights for the refrigerator, and no checks for the freezer. There were no concerns identified with the refrigerator temperatures. Record review of the nutrition refrigerator revealed a printed 8 ,d+[DATE] x 11 green paper sign on the outside of the refrigerator stating in all capital letters, Resident items only! and in smaller capital letters, the sign stated, Any food or beverages must be labeled with the resident's name, date, time, and initials of who placed items in the refrigerator. Record review of the facility policy titled, Food Receiving and Storage revised [DATE] revealed under the policy statement, Foods shall be received and stored in a manner that complies with safe food handling practices. 7. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). 13. Food items and snacks kept on the nursing units must be maintained as indicated below: a. All food items to be kept below 41F must be placed in the refrigerator located at the nurse's station and labeled with a use by date. B. All foods belonging to residents must be labeled with the resident's name, the item, and the use by date. C. Refrigerators must have working thermometers and be monitored for temperature according to state specific guidelines. D. Beverages must be dated when opened and discarded after 24 hours. E. Other opened containers must be dated and sealed or covered during storage. F. Partially eaten food may not be kept in the refrigerator. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility policy titled, Maintenance Service revised [DATE] revealed under Policy Statement Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. B. Maintaining the building in good repair and free from hazards. 3. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 9. Records shall be maintained in the maintenance director's office. 10. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned. Record review of a copy of a facility check written for various services included invoice numbers 007141, 007142, and 007275. The date on the check was [DATE]. Invoice details for numbers 007141 and 007142 were not provided. Record review of invoice number 007275 revealed no date. The description of services noted Check freezer-found coil totally frozen, removed ice and bypass bad sensor. Replace sensor with new. Record review of invoice number 007831 dated [DATE] revealed the description of services noted Install evaporator motor in freezer and level out evaporator unit for water drainage. The maintenance log was not provided. References: U.S. Food and Drug Administration Food Code http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ : Ch. ,d+[DATE] Pg. 96 Time-maximum up to 4 hours, (2) The food may have an initial temperture of 70F or less if; (a) It is a ready-to-eat fruit or vegetable that upon cutting is rendered a time/temperature control for safety .(c) The food temperature does not exceed 70F within a maximum time period of 4 hours from the time it is rendered a time/temperature control for safety food; and (d) The food is marked or otherwise identified to indicate the time that is 4 hours past the point in time when the food is rendered a time/temperature control for safety (3) The food shall be marked or otherwise identified to indicate the time that is 4 hours past the point in time when the food is removed from temperature control. (5) The food in unmarked containers or packages or marked to exceed a 4-hour limit shall be discarded. Ch. ,d+[DATE].112 Pg. 115 Temperature measuring devices. (A) in a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit. (B) .cold or hot holding equipment used for time/temperature control for safety food shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display. TAC 554.1111 (b) The facility must store, prepare, and serve food under sanitary conditions, as required by the Texas Department of State Health Service sanitation requirements.

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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** 44748 Based on observation, interview, and record review, the facility failed to 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 disease and infection for 1 of 3 residents (Resident #3) reviewed for infection control, in that LVN A failed to wash her hands, change gloves, or sanitize her hands while providing peg tube care on Resident #3. LVN A failed to follow enhanced barrier precautions for an indwelling medical device (PEG tube). This failure could place residents at risk for infection due to improper care practices. Findings include: Record review of Resident #3's admission record revealed a Resident #3 was admitted on [DATE]. Diagnoses included she was non-verbal, blind, and spoke Spanish only. She had a stroke, a PEG tube, and was incontinent. Observation of PEG tube care for Resident #3 on 07/16/24 at 3:27 pm revealed LVN A did not exercise EBP (Enhanced Barrier Precautions-an approach of targeted gown and glove use set forth by the CDC {Centers for Disease Control} during high contact resident care activities with any wound(s), indwelling medical device(s), or infection or colonization with an MDRO (Multi Drug Resistent Organism) designed to reduce transmission of germs.) prior to care. LVN A did not wash hands or use hand sanitizer prior to care. LVN A donned gloves and supplies: sterile 4x4 gauze, 4x4 gauze, normal saline, a large medicine cup, tape & gloves. LVN A did not change gloves or sanitize her hands after collecting her supplies. LVN A touched the feeding pump to place it on hold and touched the bed control to position Resident #3. LVN A did not change gloves or sanitize after touching the feeding pump and bed control. LVN A poured the normal saline into the large medicine cup & soaked the 4x4 gauze with the normal saline. LVN A then repositioned Resident #3 with the same gloves. LVN A stated she was checking the PEG site for redness, odors, or swelling when she removed the dressing. LVN A changed her gloves and removed the soiled dressing. LVN A threw the soiled dressing into the trash. LVN A did not change her gloves or sanitize after discarding the soiled dressing. LVN A reported slight redness to the upper right side of the PEG site under the tape that secured the dressing. LVN A voiced she would tell the nurses. LVN A cleaned the PEG site in individual passes with the normal saline soaked gauze x3 with the same gloves. LVN A patted dry the PEG site with clean 4x4 gauze, with the same gloves. LVN A did not change gloves or sanitize before opening the sterile 4x4, then placed the sterile gauze on the site using the same gloves. LVN A did not change gloves or sanitize after placing the sterile 4x4 on the PEG site. LVN A stated her gloves were still clean and picked up the roll of tape. LVN A secured the dressing with the tape and restarted the tube feeding without changing gloves or sanitizing. LVN A did not wash her hands after the dressing change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN A on 07/16/24 at 3:45 pm, she stated she took only 2 pair of gloves in the room. She stated the process for hand washing was to lather for 20 seconds, minimum. She stated not washing her hands was my mistake. She stated she had been sanitizing so much, she forgot to wash her hands. She stated she did not wash her hands or sanitize before or after the dressing change and she should have. She stated not washing hands or sanitizing could cause cross contamination and infection. She stated that was why they used contact precautions, and spreading germs was #1. She stated contact precautions was used when any bodily fluid could come out. She stated that was when staff should gown up and mask-the whole shabam. She stated the soiled dressing was considered contaminated with bodily fluid. She explained she thought EBP was PPE and she was confused. She stated the DON and ADON explained to the staff that they had to be extra cautious. She did not know what EBP was. LVN stated staff was supposed to use EBP before and after every patient, to protect them because they could be immunocompromised. She stated Resident # 3 did not have the EBP and that was why she did not use PPE. She stated the resident did not have Covid and was moved to this hall, but her EBP did not come with her. In an interview with the ADM on 07/16/24 at 4:15 pm, she stated staff were trained on handwashing and EBP regularly. The ADM stated she would be embarrassed to find out her staff were not following guidelines for infection control. The facility policy for hand hygiene was requested. Record review of the facility policy titled; Handwashing/Hand Hygiene revised August 2015 revealed in the Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 70% alcohol, or alternatively, soap and water for the following situations: b. before and after coming into direct contact with residents, d. before performing any non-surgical invasive procedures, e. before and after handling an invasive device, g. before handling clean or soiled dressings, gauze pads, etc., h. before moving from a contaminated body site during resident care, i. after contact with a resident's skin, j. after contact with blood or bodily fluids, k. after handling used dressings, contaminated equipment, etc., l, after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident, m., after removing gloves, 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 10. Single use disposable gloves should be used a. before aseptic procedures, when anticipating contact with blood or body fluids. Procedure Washing Hands-1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds or longer under a moderate stream of running water at a comfortable temperature . Applying and Removing Gloves-1. Perform hand hygiene before applying non-sterile gloves. 4.remove the gloves 5. Perform hand hygiene.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for one of one laundry reviewed for environment. The facility failed to ensure the doors in the laundry would open and close safely and had functioning doorknobs. The facility failed to ensure the washing machine in the laundry was not leaking water into a basin and attracting mosquitoes. The facility failed to ensure the walls in the storeroom inside the laundry did not have dark patches showing through the paint. These failures could place residents at risk for diminished quality of life due to the lack of a well kept environment. Findings included: Initial tour and observation of the laundry room on 07/17/24 at 11:30 am revealed the entrance door (door #1) was difficult to open. Once unlatched, the door fell enough to stick badly on the floor when opening it. There were deep grooves through the tiles and into the concrete where the bottom corner of the door dragged when it was opened and closed. The heavy door had to be physically lifted back onto its jamb to close it. There was a hole approximately 6 inches x 4 inches in the wall in alignment where the handle of the heavy door would go through the hole. The other door (door #2) had no inner handle. There was a room inside the laundry that had dark patches on all the walls and missing an inner door handle. One of the washing machines was leaking water into a basin. A stray cat was observed coming into the laundry through door #1, as it would not shut completely. In an interview with HSK on 07/17/24 at 11:35 am she stated the doors were difficult to open and close since she started working in the laundry room going on 4 years. She stated sometimes, she could not get door #1 shut all the way and stray cats would enter the laundry room. She stated sometimes the wind would blow door #1 open when it did not get shut all the way and blow all kinds of things into the laundry. She stated the doors without the handles had to be closed from the inside and the doors were heavy. She stated the doors were not very safe and she was afraid she could hurt herself lifting door #1 all the time. She stated the MS was in the laundry room often and she had mentioned the doors and door handles problems multiple times. She stated when there was a problem for maintenance, she would go to the MS directly. She stated there was a handwritten maintenance log at the nurse's station, but she was not sure how often he checked it. She stated the room inside the laundry room was a restroom, but the toilet did not work, and they were not using the room because the MS was renovating it. She stated the dark patches on the walls in the room had been there since the beginning of this year and were worsening. She stated the room had what she thought was patches of mold all over the walls. She stated the washing machine had been leaking for a week and in the mornings, there was tons of mosquitos in the laundry. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the MS on 07/17/24 at 1:10 pm, he stated he was renovating the room inside the laundry, and he had not had time to get to the doors in the laundry. He stated he worked at the facility for [AGE] years. He stated he did most of the work on the equipment in, at, and on the facility. The Maintenance service policy and the maintenance log was requested. In an interview with the ADM on 07/18/24 at 3:25 pm, she stated she was unaware of the laundry room doors and washing machine. She stated the process for repairs to the facility was for staff to place requests in the hand-written maintenance log that was kept at the nurse's station. She stated she did not check the maintenance log because the MS assured her everything was fine and he was taking care of things. She stated she could not locate the maintenance log at the nurse's station. She stated she was working on getting an electronic maintenance log, so repairs could be tracked and monitored better. Record review of the facility policy titled, Maintenance Service revised December 2009 revealed under Policy Statement Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. B. Maintaining the building in good repair and free from hazards. 3. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 9. Records shall be maintained in the maintenance director's office. 10. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned.