

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/31/2024
NAME OF PROVIDER OR SUPPLIER  Royal Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  9101 Panther Way Waco, TX 76712	

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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065</b></p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications for 1 of 1 resident (Resident #32) reviewed for medication administration via a gastric tube.</p> <p>The facility failed to ensure Resident #32's gastric tube was flushed according to the physician's order and the facility's policy during resident's medication administration.</p> <p>This failure could place residents at risk of gastric tube clogging, which could have required the resident to repeat an unnecessary invasive procedure (gastric tube replacement).</p> <p>Findings include:</p> <p>Record review of Resident #32's undated face sheet, revealed she was a [AGE] year-old female admitted [DATE] with diagnoses of stroke, dysfunction of bladder, dysphagia (swallowing difficulties), gastrostomy (stomach tube), and heart failure.</p> <p>Record review of Resident #32's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated the resident's cognitive ability was not impaired.</p> <p>Record review of Resident #32's Care Plan, reflected a Focus area was initiated on 5/14/20 and revised on 11/15/24 for risk for malnutrition related to dysphagia and receives nutrition and hydration by PEG tube with interventions including:</p> <p>Provide liquids as ordered.</p> <p>Provide medications per tube as ordered. Flush tube with 30 cc of water before and after medications.</p> <p>Record review of Resident #32's Orders, reflected the following:</p> <p>12/08/23 order NPO diet Tube Feeding texture, for meals.</p> <p>1/3/24 order Flush G tube with 30 cc before and after medications.</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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7/13/23 order for Free water 150 cc QID per peg</p> <p>Record review of Resident #32's December Medication Administration Record reflected the following:</p> <p>1/4/24 order for Flush G tube with 30 cc before and after medications signed off (indicating done) by RN-A on 12/30/24 night shift when medication observations were done at 10:11 PM.</p> <p>3/28/24 order allowing medications to be crushed and combined into a cocktail was also signed off on 12/30/24 night shift by RN-A</p> <p>Observation on 12/30/24 at 10:11 PM revealed RN-A at bedside of Resident #32 after she had crushed and dissolved the resident's medications according to orders. RN-A checked the residual and only 1-2 cc was found. Placement was verified with air according to orders. No water flush was observed at this step prior to medications. Medications previously crushed and dissolved were placed in gastric tube and gravity flow was good and medications completely emptied from the tube. 150 cc of water flush was run through the feeding pump after the medications were completed to flush the tube. Medication administration completed at 10:17 PM. Observed electronic monitoring device (camera) in place on resident.</p> <p>In an interview on 12/30/24 at 9:18 AM with Resident #32's family member he stated, RN-A did not do pre-flushes when giving medications into the gastric tube per their electronic monitoring in September and they complained to the DON. He stated the DON said she addressed the concern with the nurse.</p> <p>In an interview on 12/30/24 at 10:17 PM RN-A stated, she used the feeding pump to flush 150 cc of water into the G tube after the medications.</p> <p>In an interview on 12/31/24 with LVN -A at 11:40 AM he stated, prior to each medication administration he flushes the Gtube with water then also flushes it after the medications are completed. He stated this was done to prevent the tube from becoming clogged which could result in a tube replacement if clogged. He also checked residual and verified placement as ordered and said medications are mixed as a cocktail.</p> <p>In an interview on 12/31/24 at 11:45 AM with DON she stated, the orders to flush the G-tube prior to each medication and after applies to each medication pass and not just per shift. She stated that prior to each medication cocktail administration they should flush the G tube with water then also flush it after the medications are complete. She stated this was done to prevent the tube from becoming clogged which could result in a tube replacement if clogged. She also stated the family requested the medications be mixed as a cocktail instead of done one medication at a time.</p> <p>In an interview on 12/31/24 at 4:15 PM with LVN-B she stated, when giving medications in a G tube the process is to check residual and verify placement by auscultation (air and listening), flush 30 cc of water before and after medications if order allows a medication cocktail. She stated the flush was important to prevent the tube from clogging and to make sure hydration clears the tube. LVN-B stated if flushing was not done the resident could need the G tube replaced. She stated this could cause the resident to miss food, hydration, and medications.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a second interview on 12/31/24 at 4:37 PM with DON she stated, when giving medications in a G tube it was important to follow the amount of water ordered for the flush before and after medications. She stated the flush is important to prevent clogging of the G tube. DON stated a clogged G tube could have to be replaced.</p> <p>A record review of Facility September 2024 Grievance Log reflected a grievance filed and resolved on 9/9/24 that a nurse did not flush the gastric tube with medication administration.</p> <p>A record review on 12/31/24 of the undated facility policy titled, -Administering Medications-Enteral Tube reflected the following:</p> <ol style="list-style-type: none"> <li>10. Insert the feeding syringe in the enteral tube and flush tube with 15 cc air bolus .</li> <li>11. Pull plunger back to check for residual. If less than 100 cc return content to stomach. Flush tube with 30 cc of water.</li> <li>12. Administer medication</li> <li>13. Flush enteral tube with 30 cc of water after all medications are administered.</li> </ol>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>49065</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's, to meet the needs of each resident for 1 of 1 medication storage rooms.</p> <p>The facility failed to ensure that expired medication administration supplies were removed from 1 of 1 medication storage rooms.</p> <p>This failure could place residents at risk for ineffective treatments and unnecessary invasive procedures. Use of these expired supplies and medications would not meet acceptable standards of medical practice and could cause a Central Line Catheter to need replacement due to dislodgement or infection.</p> <p>Findings included:</p> <p>Observation on 12/30/24 at 4:49 PM of the Medication Storage Room located by the nurse's station revealed the following:</p> <p>3 IMED Dressing Change Kits (Item number IM46023) expired 1-17-2024.</p> <p>In an interview on 12/31/24 at 4:15 PM with LVN-B she stated, the policy on expired medical supplies was to destroy them or give them to the DON and everyone who goes in the room was responsible for checking the medication room. She stated the negative outcome to residents if expired items are used is that residents can have a reaction, or the supplies could begin to breakdown.</p> <p>In an interview on 12/31/24 at 4:22 PM with ADM he stated, the policy on expired sterile medical supplies was they should be pulled and disposed of. He stated the nurses are responsible for checking the medication room and the negative outcome to residents if expired items are used was that medications can lose efficacy.</p> <p>In an interview on 12/31/24 at 4:37 PM with DON she stated, the policy on expired medical supplies is they should be thrown away and that the nurses are responsible for checking the medication room. DON stated the negative outcome to residents if expired items are used was that residents could potentially get sick or an infection. She stated the supplies would not be as effective.</p> <p>Record review of the facility undated policy titled -Proper Storage of Discontinued or Expired Medications reflected, when a medication is changed or expires, the medication was to be removed (no specific policy on expired supplies.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48917</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure menus were followed for all residents for 2 of 3 meals observed.</p> <p>The facility failed to follow the posted cycle menus for two lunch services served at the facility on Sunday, 12/29/24 and Tuesday, 12/31/24.</p> <p>These failures could place residents that eat food from the kitchen at risk of poor intake, and/or weight loss.</p> <p>The findings included:</p> <p>Record review of Resident # 34's admission face sheet undated reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of neurocognitive disorder with Lewy bodies (a progressive disease that causes a decline in thinking abilities).</p> <p>Record review of Resident # 34's quarterly MDS dated [DATE] reflected a BIMS score of 6 indicating severe cognitive impairment.</p> <p>Record review of Resident # 34's care plan dated 05/24/2019 and revised on 06/11/2024 reflected problem of nutrition: at risk for/HX of weight changes and malnutrition: resident has a lipoprotein metabolism disorder (a disorder of lipoprotein overproduction or deficiency that results in elevation of total cholesterol); resident is at risk for metabolic acidosis (accumulation of too much acid in the body). Interventions include observe meal intake, record, and offer alternative if eats less than 50% of meal. Offer preferences when available. Provide regular diet with regular texture as ordered with thin liquids.</p> <p>Record review of Resident # 122's admission face sheet undated reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of 4-part fracture of the surgical neck of the right humerus (upper portion of the leg bone by the hip joint), subsequent encounter for fracture with routine healing.</p> <p>Record review of Resident # 122's comprehensive MDS dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment.</p> <p>Record review of Resident # 122's care plan dated 12/16/2024 and revised on 12/27/2024 reflected problem of nutrition: resident at risk for/HX of weight changes, dehydration, and malnutrition related to poor dentation/chewing problems. Interventions include observe meal intake, record, and offer alternative if eats less than 50% of meal. Provide regular diet with food cut in bite size pieces as ordered with regular thin liquids.</p> <p>Record review of Resident # 220's admission face sheet undated reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of encounter for surgical aftercare following surgery on the digestive system.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident # 220's nursing home and swing bed tracking MDS dated [DATE] reflected a BIMS score was not documented as a comprehensive MDS had not been completed and uploaded.</p> <p>Record review of Resident # 220's care plan dated 12/11/2024 and revised on 12/27/2024 reflected problem of nutrition: resident at risk for/ HX of weight changes, dehydration, and malnutrition related to dysphagia (problem swallowing foods or liquids). Interventions include observe meal intake, record, and offer alternative if eats less than 50% of meal. Provide regular pureed texture diet as ordered with thin liquids. Offer preferences when available.</p> <p>Observation on 12/29/24 at 9:23 AM revealed a 4-week cycle menu posted in the dining room with week 2 Sunday lunch meal consisting of roast turkey, cheesy squash casserole, crumb topped brussels sprouts, fruit cobbler, and beverage. The week 2 Tuesday lunch meal consisted of smothered pork, corn casserole, country green beans with bacon and onion, pineapple upside down cake, and beverage.</p> <p>Observation on 12/29/24 at 12:06 PM of dining room lunch meal trays being served consisting of roast turkey, cubed butternut squash, steamed plain brussels sprouts, fruit cobbler, and beverage.</p> <p>Observation on 12/29/24 at 12:40 PM of dining room lunch meal service revealed multiple meal trays left on tables with butternut squash still on tray and hearing multiple residents discuss amongst themselves how the squash was too hard to eat.</p> <p>Observation/Interview on 12/29/2024 at 1:06 PM revealed Resident # 34 finishing her lunch tray stated lunch was ok, but the squash was not cooked to be soft enough to eat.</p> <p>Observation on 12/31/24 at 10:30 AM of kitchen staff preparing lunch meal items consisting of BBQ pork ribs, creamed corn, black-eyed peas, cornbread, pound cake, and beverage.</p> <p>Observation on 12/31/24 at 10:32 AM of kitchen posting of 4-week cycle menu with week 2 Sunday lunch meal consisting of roast turkey, cheesy squash casserole, crumb topped brussels sprouts, fruit cobbler, and beverage. The week 2 Tuesday lunch meal consisted of smothered pork, corn casserole, country green beans with bacon and onion, pineapple upside down cake, and beverage.</p> <p>Observation on 12/31/24 at 12:30 PM of dining room lunch meal trays being served consisting of BBQ pork ribs, creamed corn, black-eyed peas, cornbread, plain pound cake, and beverage.</p> <p>Observation on 12/31/24 at 12:45 PM of dining room lunch meal service with residents eating the BBQ pork ribs.</p> <p>Observation on 12/31/24 at 4:55 PM of posted menus revealed sitting in a dining room chair 3 feet away from menus the menus are not large enough print to be able to read. Standing in the dining room [ROOM NUMBER] feet away from menus the menus are not large enough print to be able to read.</p> <p>In an interview on 12/29/2024 at 2:30 PM revealed Resident # 122</p> <p>In an interview on 12/31/2024 at 12:48 PM with Resident # 220</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with DM on 12/31/24 at 4:00 PM revealed the DM stated when menu substitutions are made it is noted on the QAPI meeting minutes. DM stated the exact items substituted are not documented just the number of times the menus were changed in the past month. DM stated the facility sometimes must make menu changes due to not receiving a product in or if it is resident preference with not liking a certain food that is on the cycle menus. DM stated the cycle menus posted will not always match the daily menu posted if she has had to make any substitutions and that is why she posts the daily menu. DM stated as for why the cheesy squash posted on the daily menu for Sunday week 2 was not the item served that the residents were still served squash just a different type. DM stated as for why the smothered pork posted on the daily menu for Tuesday week 2 was not the item served that the residents received smothered BBQ pork ribs, so the item was in fact smothered pork. DM stated the facility does not use a substitution log to document any menu substitutions.</p> <p>In an interview with DON on 12/31/24 at 5:16 PM revealed the DON stated their expectation concerning the kitchen staff following the menus would be that the kitchen staff would follow the menus and let staff and residents know if menu changes were required and to offer the residents an alternate of the same nutritive value. DON stated they expected the cycle menus and the daily menus to match therefore there would not be any resident confusion. DON stated by not following menus this could negatively affect residents by them not eating and maintaining good health status.</p> <p>In an interview with ADM on 12/31/24 at 5:21 PM revealed the ADM stated their expectation concerning the kitchen staff following menus would be that kitchen staff would follow the menus and follow the company policies and procedures pertaining to menus. ADM stated by not following menus this could negatively affect the resident's nutritional status by being compromised. ADM stated the DM is responsible for ensuring menus are followed.</p> <p>Record review of Menus policy undated reflected under heading purpose: Menus will be prepared in advance, be nourishing, palatable, well-balanced, and will meet the daily nutritional and special dietary needs of the residents.</p> <p>Under heading procedures:</p> <ol style="list-style-type: none"> <li>1. The dietitian will approve all menus.</li> <li>2. The resident council will be included in menu planning.</li> <li>3. If any meal served varies from the planned menu, the change and the reason for the change will be noted on the posted menu in the kitchen and/or in the record used solely for recording such changes.</li> <li>4. Menus will provide a variety of foods and indicate standard portions at each meal. Menus will be varied for the same day of consecutive weeks. When a cycle menu is used, the cycle will be of no less than three (3) weeks duration and revised quarterly. Menus will be adjusted to include seasonal foods.</li> <li>5. Menus will be prepared in advance.</li> <li>6. Menus will be reasonably planned with consideration of the religious, cultural, and ethnic background and food habits/preferences of residents and resident groups.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. A copy of the menu (as served) will be kept on file for at least 180 days.</p> <p>8. A copy of menus will be posted in at least one (1) resident area and will be posted low enough and in print large enough for residents to read them.</p> <p>9. Menus will reflect the religious, cultural, and ethnic needs of the current resident population as determined via the resident's preferences and resident group input.</p> <p>Record review of Food Substitutions policy undated reflected under heading purpose: Food substitutions will be made as appropriate or necessary.</p> <p>Under heading procedure:</p> <ol style="list-style-type: none"> <li>1. The dietary manager may make food substitutions as appropriate or necessary.</li> <li>2. An exchange list identifying the seven (7) exchanges of food groups is posted in the dietary manager's office.</li> <li>3. The dietary manager will consult the dietitian as necessary prior to making a substitution.</li> <li>4. Residents' likes and dislikes are considered when making substitutions.</li> <li>5. All substitutions are noted on the menu and filed in accordance with established dietary policies.</li> </ol>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917</b></p> <p>Based on observations, interviews, and record review, the facility failed to serve foods that were palatable and attractive and prepare food by methods that conserve nutritive value, flavor, and appearance for 1 of 1 kitchen observed.</p> <p>1. The kitchen test tray of the lunch meal foods was unappealing and lacked flavor. The kitchen test tray lacked condiments and the dessert of pound cake was unappealing and very dry. There was no garnishment on any foods or meal tray.</p> <p>2. The lunch meal tray on 12/31/24 for Resident # 220 who has an order for a pureed diet consisted of a packaged plastic ware utensils with one salt and one pepper packet, a glass full of ice and 1/4 full of water as the beverage, a scoop of pureed BBQ brisket, a scoop of pureed creamed corn, a scoop of pureed black-eyed peas, and a container of packaged applesauce. There was no gravy or sauce present on any of the food items and no garnishment present on the meal tray.</p> <p>3. The lunch meal served on Sunday 12/29/2024 consisting of cubed butternut squash was complained of by 2 residents (Resident # 34 and Resident # 122) of being not cooked properly and too hard to be able to eat.</p> <p>These failures could place residents at risk of decreased food intake, hunger, unwanted weight loss, and diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident # 34's admission face sheet undated reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of neurocognitive disorder with Lewy bodies (a progressive disease that causes a decline in thinking abilities).</p> <p>Record review of Resident # 34's quarterly MDS dated [DATE] reflected a BIMS score of 6 indicating severe cognitive impairment.</p> <p>Record review of Resident # 34's care plan dated 05/24/2019 and revised on 06/11/2024 reflected problem of nutrition: at risk for/HX of weight changes and malnutrition: resident has a lipoprotein metabolism disorder (a disorder of lipoprotein overproduction or deficiency that results in elevation of total cholesterol); resident is at risk for metabolic acidosis (accumulation of too much acid in the body). Interventions include observe meal intake, record, and offer alternative if eats less than 50% of meal. Offer preferences when available. Provide regular diet with regular texture as ordered with thin liquids.</p> <p>Record review of Resident # 122's admission face sheet undated reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of 4-part fracture of the surgical neck of the right humerus (upper portion of the leg bone by the hip joint), subsequent encounter for fracture with routine healing.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident # 122's comprehensive MDS dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment.</p> <p>Record review of Resident # 122's care plan dated 12/16/2024 and revised on 12/27/2024 reflected problem of nutrition: resident at risk for/HX of weight changes, dehydration, and malnutrition related to poor dentation/chewing problems. Interventions include observe meal intake, record, and offer alternative if eats less than 50% of meal. Provide regular diet with food cut in bite size pieces as ordered with regular thin liquids.</p> <p>Record review of Resident # 220's admission face sheet undated reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of encounter for surgical aftercare following surgery on the digestive system.</p> <p>Record review of Resident # 220's nursing home and swing bed tracking MDS dated [DATE] reflected a BIMS score was not documented as a comprehensive MDS had not been completed and uploaded.</p> <p>Record review of Resident # 220's care plan dated 12/11/2024 and revised on 12/27/2024 reflected problem of nutrition: resident at risk for/ HX of weight changes, dehydration, and malnutrition related to dysphagia (difficulty swallowing food and drinks). Interventions include observe meal intake, record, and offer alternative if eats less than 50% of meal. Provide regular pureed texture diet as ordered with thin liquids. Offer preferences when available.</p> <p>Observation /Interview on 12/31/2024 at 12:48 PM with Resident # 220 revealed observation of resident lunch meal tray had scoop of pureed BBQ brisket, scoop of pureed creamed corn, scoop of pureed black-eyed peas, container of applesauce, packaged plastic ware utensils, 1 packet of salt and pepper, and glass of ice water filled with ice and 1/4 full of water. Further observation revealed no gravy or sauce on any of the food items and no garnishment on the meal tray. Interview with resident revealed resident stated the food is not good it does not taste good and is normally cold and therefore I don't eat much. Resident stated they are still on a pureed diet, but the food in general is just unappealing. Resident stated breakfast is the best meal, but the portion sizes have been cut down. Resident stated this morning's breakfast consisted of oatmeal, sausage, and orange juice and that is it. Resident stated the trays never have condiments and you always must request to get any condiments. Resident stated the food is always cold but is slowly improving now that her meals are served with a heated tray that the plate sits on. Resident stated the lunch meal is lukewarm. Resident stated the dinner meal on 12/30/24 was very cold and the heated tray was not under her plate.</p> <p>Observation on 12/31/2024 at 1:00 PM of the lunch meal test tray revealed the tray consisted of smothered pork ribs, black eyed peas, creamed corn, pound cake, and grape Kool-Aid, with no condiments present on the tray, and no garnishment on tray. Temperatures were adequate. The test tray lacked flavor, and the pound cake very dry and unappealing. It needed sauce or whipped topping for palatability.</p> <p>Interview on 12/29/2024 at 1:06 PM revealed Resident # 34 stated lunch was ok, but the squash was not cooked to be soft enough to eat.</p> <p>Interview on 12/29/2024 at 2:30 PM revealed Resident # 122 said the food is ok. Resident # 122 stated the food is frequently served cold and that the squash served at lunch today was too hard to eat.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Royal Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  9101 Panther Way Waco, TX 76712	
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 12/31/2024 at 4:00 PM with DM revealed DM stated all food items are to be prepared and presented to the residents in an appealing and appetizing manner. DM stated if a resident complains of food being served cold then the resident is given a hot warmer plate with all their meals to ensure the proper temperatures are maintained for the meal to be appealing. DM states paper goods and plastic ware are only used when the dish machine is down or if there are issues like a power outage. DM stated the facility has a variety of condiments available and that the appropriate condiments are put on the meal trays for each meal service such as salad dressings when a dinner salad is served or mustard and mayonnaise for a sandwich or burger and that if resident is requesting a different condiment, they are always available. DM stated they were unaware of residents complaining that the squash was too hard to eat and that they would be speaking with the cook about cooking that type of squash longer in the future. DM states the cooks taste test the food prior to serving the meal.</p> <p>Record review of Food Service policy undated reflected under heading purpose: Meet the nutritional needs of each resident. Provide a well-balanced, flavorful, visually appealing, and varied food service program. Under heading procedure:</p> <p>5. Meals will be prepared in a way that is visually appealing and should include a garnishment.</p> <p>Record review of grievance report form dated 12/29/2024 reflected Resident # 220 had completed a grievance form in reference to meals being served cold when they are delivered. The resolution was for the resident to receive a hot warmer plate moving forward with all three meals. The complaint was resolved by the DM on 12/30/2024.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48917</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for sanitation.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure sanitation practices (cleaning the ice machine in the nourishment room, cleaning the juice machine dispenser, cleaning the can opener from buildup, cleaning the inside of the microwave, leaving dirty mop water in the mop bucket in the chemical storage closet, ensuring the dish machine sanitizer levels are within the required range, storing the ice scoop in the nourishment room in an ice scoop receptacle that was free from standing water accumulation, ensuring staff utilize hair restraints while in the kitchen, ensuring trash receptacles in the kitchen had lids secured covering contents, ensuring food items are not being stored on the floor, cleaning the range cook top drip pans of food debris, ensuring hand wash sinks have paper towels available and are only being used for handwashing)</li> <li>The facility failed to ensure equipment temperature logs were being completed.</li> <li>The facility failed to ensure all items were covered and stored properly.</li> <li>The facility failed to label and date all food items in the kitchen.</li> <li>Dented can of mandarin oranges in the dry storage area stored with all the other cans of fruit.</li> </ol> <p>These failures could place residents at risk of foodborne illness.</p> <p>Findings included:</p> <p>Observation on [DATE] at 9:24 AM of kitchen hand wash sink near kitchen entrance door from dining room revealed to be out of paper towels to dry hands as hand hygiene.</p> <p>Observation on [DATE] at 9:26 AM of front stand-alone refrigerator near kitchen entrance door from dining room revealed 2 sandwiches saran wrapped unlabeled and undated, a tub of drinks including what appeared to be apple juice, orange juice, and milk uncovered, unlabeled, and undated, a gallon pitcher of what appeared to be tea unlabeled and undated.</p> <p>Observation on [DATE] at 9:28 AM of kitchen juice dispenser machine revealed orange and red sticky buildup on underside of dispenser near dispenser nozzles.</p> <p>Observation on [DATE] at 9:32 AM of kitchen table mounted can opener revealed black and brown buildup on inside of can opener.</p> <p>Observation on [DATE] at 9:32 AM of back kitchen prep area of 2 55-gallon trash cans without lids secured and trash debris inside.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on [DATE] at 9:33 AM of kitchen microwave revealed inside of microwave to be dirty on all surfaces and inside wall to be rusty with paint peeling off.</p> <p>Observation on [DATE] at 9:34 AM of kitchen chemical storage closet revealed a rolling mop bucket of dirty mop water with the mop stored inside of the bucket.</p> <p>Observation on [DATE] at 9: 38 AM of kitchen equipment temperature logs revealed temperature logs were not completed on refrigerators and freezers for ([DATE],28,29,30,31 [DATE],29,30 [DATE],28).</p> <p>Observation on [DATE] at 9:43 AM of kitchen back stand-alone refrigerator revealed a package of processed American cheese slices wrapped in saran wrap unlabeled and undated, a half of a red onion wrapped in saran wrap unlabeled and undated.</p> <p>Observation on [DATE] at 9:46 AM of kitchen dry storage area revealed a dented can of mandarin oranges dated ,d+[DATE] stored stacked on a shelf with all the other canned fruit products, a gallon bag of fruit rings cereal unlabeled and undated, a gallon bag of cheerios cereal unlabeled and undated, a gallon bag of raisin bran cereal unlabeled and undated, a gallon bag of puffed rice cereal unlabeled and undated, a gallon bag of frosted flakes cereal unlabeled and undated, a storage tote of brown sugar with lid unsecured unlabeled and undated, an opened bag of gravy mix wrapped with saran wrap unlabeled and undated, and a box of orange juice base stored on the floor.</p> <p>Observation on [DATE] at 9:52 AM of kitchen cooktop range drip pans revealed drip pans to have spilled dried food debris on them.</p> <p>Observation on [DATE] at 9:52 AM of shelving in front of kitchen with dishes stored on it and on top shelf a tray of individual cereal bowls prepared with different types of dry cereal with each bowl individually wrapped with saran wrap unlabeled and undated. Observation of box of white assorted plastic cutlery on floor underneath shelving.</p> <p>Observation on [DATE] at 10:00 AM of dish machine cycle revealed dish machine not to have proper sanitizer levels running in machine. Sanitizer levels undetectable during dish machine cycle.</p> <p>Observation on [DATE] at 1:49 PM of back of kitchen hand wash sink revealed dried brown liquid staining appearing to be tea in bottom of sink. Hand wash sink is located near beverage preparation area.</p> <p>Observation on [DATE] at 1:50 PM of [NAME] C with beard guard down under chin with exposed facial hair while running dish machine.</p> <p>Observation on [DATE] at 9:00 AM of [NAME] D with beard guard down under chin with exposed facial hair while wiping down prep table. When [NAME] D saw surveyor [NAME] D put beard guard on correctly to cover all facial hair.</p> <p>Observation on [DATE] at 9:06 Am of [NAME] C with beard guard down under chin with exposed facial hair putting up delivery of grocery items in refrigerators located in back part of kitchen.</p> <p>Observation on [DATE] at 9:12 AM of DA washing emptying meal carts of dirty dishes with beard guard down under chin with exposed facial hair. When DA saw surveyor DA put beard guard on correctly.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on [DATE] at 10:20 AM of [NAME] C with beard guard down below mustache while in kitchen.</p> <p>Observation on [DATE] at 11:18 AM of [NAME] D making pureed lunch items with beard guard underneath chin with exposed facial hair. When [NAME] D saw surveyor watching [NAME] D stop applied beard guard correctly and performed hand hygiene before going back to finish the pureed meal items.</p> <p>Observation on [DATE] at 9:08 AM of kitchen prep area near dish machine and 3 compartment sink revealed 55-gallon trash can without lid secured with trash debris inside.</p> <p>Observation on [DATE] at 10:24 AM of kitchen prep area near dish machine and 3 compartment sink revealed 55-gallon trash can without lid secured with trash debris inside with trash can lid propped against wall beside 3 compartment sinks.</p> <p>Observation on [DATE] at 7:44 PM of nourishment room ice scoop receptacle with standing water in bottom of ice scoop holder. Observation of nourishment room ice machine revealed inside lid of ice machine to have black and brown mold appearing substance coating inside of door and around door seals.</p> <p>Observation on [DATE] at 10:02 AM of back kitchen prep area revealed a 55-gallon trash can without lid secured with trash debris inside.</p> <p>Observation on [DATE] at 10:20 AM of [NAME] C with beard guard down below mustache while in kitchen.</p> <p>Observation on [DATE] at 12:20 PM of DA in kitchen passing completed lunch meal trays to nursing staff for residents with beard guard down under chin exposing facial hair.</p> <p>Interview on [DATE] at 10:05 AM with DM revealed DM stated they would be contacting the dish machine chemical provider to come out and service the dish machine and address the sanitizer level problem. DM stated until the sanitizer problem could be fixed the facility would be using their dish machine for washing and then using their 3-compartment sink for running all dishes thru the sanitizer.</p> <p>Interview on [DATE] at 10:15 AM with [NAME] D revealed [NAME] D stated the facility hair restraint policy is to keep all hair and beards covered while in the kitchen. [NAME] D stated sometimes he forgot to pull his beard guard up to cover his facial hair.</p> <p>Interview on [DATE] at 10:20 AM with DA revealed DA stated the facility hair restraint policy is for all hair to be covered with a hair net and all facial hair to be covered with a beard guard.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on [DATE] at 4:00 PM with DM revealed DM stated their expectations concerning hair restraints was that they expected all hair to be covered including facial hair. DM stated everyone entering the kitchen including delivery staff are asked to wear a hair net and beard guard if they have facial hair. DM stated beard guards are to be worn above the lip directly under the nose and extend down under the chin to provide full facial hair coverage. DM stated if hair restraints are not properly worn then it could negatively affect residents by cross contamination. DM stated their expectations concerning labeling and dating of food items was very high and that all products will be dated upon receipt when opened or prepared with a preparation date and a discard date. DM stated if proper labeling and dating practices were not occurring this could negatively affect the residents by residents receiving expired or spoiled food products or food products, they have allergies to. DM stated concerning equipment temperature logs being completed they had high expectations of these logs being completed twice daily. DM stated if equipment temperature logs are not completed it could negatively affect residents by residents receiving spoiled food and possibly food borne illness.</p> <p>Interview on [DATE] at 4:34 PM with [NAME] C revealed [NAME] C stated the hair restraint policy for the facility is that all hair is to be covered while in the kitchen and dining room with a hairnet and a beard guard for staff who have facial hair.</p> <p>Interview on [DATE] at 5:16 PM with DON revealed DON stated their expectation concerning hair restraint for the kitchen is that they expect all staff entering the kitchen to wear hair restraints and beard guards if they have facial hair. DON stated if hair restraints are not worn this could negatively affect residents by having hair in their food. DON stated their expectation concerning labeling and dating of food products is that the kitchen follows the facility policies and if food labeling and dating policies are not followed this could negatively affect residents by residents receiving expired food or food borne illness.</p> <p>Interview on [DATE] at 5:21 PM with ADM revealed ADM stated their expectations concerning hair restraint is that they expect all staff to follow the facility policy and have their hair restrained including facial hair. ADM stated if hair is not restrained this could negatively affect residents by cross contamination and infection control. ADM stated their expectation concerning labeling and dating of food items is that the kitchen staff follow the facility policies concerning labeling and dating. ADM stated if labeling and dating practices are not followed this could negatively affect residents by diminished taste, spoiled food, and diminished health status. ADM stated their expectation concerning kitchen cleaning and general sanitation is that the kitchen follow company policies for cleaning and general sanitation. ADM stated if the policy for cleaning and general kitchen sanitation is not followed this could negatively affect residents by diminished health status and possible food borne illness.</p> <p>Record review of Dry Storage and Supplies policy undated reflected under heading policy: All facility storage areas will be maintained in an orderly manner that preserves the condition of food supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects.</p> <p>Under heading procedure:</p> <p>1.b. All food and supplies are to be stored six (6) inches above the floor on surfaces which facilitate thorough cleaning.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. Dry bulk foods (flour, sugar) are stored in seamless metal or plastic containers with tight covers or bins which are easily sanitized. Containers are labeled. Scoops should not be left in food containers or bins. Containers are cleaned regularly.</p> <p>4. Open packages of food are stored in closed containers with tight covers and dated as to when opened.</p> <p>Record review of Storage of Food in Refrigeration policy undated reflected under heading procedure:</p> <p>6. All containers must be labeled with the contents and date food item was placed in storage.</p> <p>Record review of Hair Net policy undated reflected under heading procedure:</p> <p>It is MANDATORY that all dietary staff wear hairnets while on duty in any food preparation area while in facility.</p> <p>Any person with a beard must wear a beard net.</p> <p>Bald persons are excluded from wearing hairnets and clean-shaven persons are excluded from wearing beard guards.</p> <p>Record review of Cleaning policy undated reflected under heading procedure:</p> <p>2. Surfaces must be cleaned with a sanitizing agent/solution. Chlorine, iodine or quaternary ammonium compounds are approved sanitizing agents.</p> <p>3. All food surfaces will be cleaned at the end of each food preparation session.</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>Provide and implement an infection prevention and control program.</p> <p>49065</p> <p>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 transmission of communicable diseases and infections for 1 of 1 laundry.</p> <p>The facility failed to ensure laundry staff handled and stored linens in a manner to ensure cleanliness and protect from dust and soil to prevent cross-contamination and the spread of infections.</p> <p>This failure could place residents at risk for development of communicable diseases and infections that could diminish a residents' quality of life.</p> <p>Findings included:</p> <p>Observation on 12/31/24 at 01:22 PM of the laundry revealed a well separated clean side and dirty side of the laundry. Two shelves of clean linens were located on the right side designated to be the dirty side. The first was a covered shelf located near the door used to bring dirty laundry inside. The shelf had clean blankets and linens. Multiple used house cleaning carts were located next to the shelf in the same room. The second shelf with neatly folded and stacked clean linens, gowns, and sheets was also located on the designated dirty side of the laundry room within a few feet of the housekeeping carts. The 2nd shelf was completely open with no cover.</p> <p>In an interview on 12/31/24 at 13:22 PM with LA, he stated they had extra clean linen stock, so they organized it on the shelves. He stated that he did not know it should not be located on the dirty side, but they could move the shelves.</p> <p>In an interview on 12/31/24 at 4:00 PM with LS he stated, the policy for storing clean and dirty laundry in the laundry room is to stack and cover clean laundry. If too much linen, then store on the left, dryer side of the laundry (clean side). He stated it is important to keep clean and dirty laundry separated because it can become cross-contaminated if together. If it is together then the clean must be rewashed. He also stated the negative outcome to residents if the clean is not kept separated is that the laundry may have a smell or have something on it. It would not be clean then, so that is not good, and it can make residents sick if they get other patients' sicknesses.</p> <p>In an interview on 12/31/24 at 4:15 PM with LVN-B she stated, clean and dirty laundry is kept separated to prevent cross-contamination. She stated the negative outcome to residents if linen is contaminated is that it could spread contamination/germs to patients and expose them to infections.</p> <p>In an interview on 12/31/24 at 4:22 PM with ADM he stated, the policy on storing clean and dirty laundry is store dirty on one side and then after washed it goes to the clean side and is distributed. He said it is important to keep separated to prevent cross-contamination. He further stated the negative outcome to residents if laundry is not kept separated is it could spread contamination to other residents. He said viruses, like Covid for example, can live and spread like that. ADM stated that they already started moving the clean linen out of the dirty side of the laundry.</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>In an interview on 12/31/24 at 4:37 PM with DON she stated clean and dirty laundry is kept separated and that it is important to separate to prevent cross-contamination. She stated the negative outcome to residents if it is contaminated is that it could potentially spread infections.</p> <p>On 12/31/24 a Record review of the facility's undated policy titled Linens reflected the following:</p> <p>All clean linen will be stored in a secured area. The linen cart will be covered.</p> <p>Clean and soiled linens will be stored in separate areas.</p>		