

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

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Morada Temple		STREET ADDRESS, CITY, STATE, ZIP CODE 4312 S 31st St Temple, TX 76502	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 2 of 5 residents (Resident #6 and Resident #13) reviewed for assessments. The facility failed to accurately document in the assessment Resident #6 and Resident #13's dental status. This failure could place residents at risk of inadequate care. Findings include: 1. Record review of Resident #6's, undated, face sheet revealed [AGE] year old female admitted on [DATE] with diagnoses of dysphagia (difficulty swallowing), chronic respiratory failure, cerebral infarction (stroke) and chronic heart failure . Record review of Resident #6's initial nursing assessment, dated 06/18/2024, reflected she had her own teeth and she had broken teeth. Record review of Resident #6's initial dietitian assessment, dated 07/08/2024, reflected missing/broken teeth were not selected for oral dental status. Record review of Resident #6's follow up dietitian assessment, dated 07/31/2024, reflected missing/broken teeth were not selected for oral dental status. Record review of Resident #6's admission MDS assessment, dated 06/20/2024, reflected in Section L Oral/Dental status tooth fragments, obvious or likely cavity or broken teeth were not selected. 2. Record review of Resident #13's, undated, face sheet reflected a [AGE] year old female, admitted on [DATE] with diagnoses of type two diabetes (when the body does not respond to insulin), dementia (loss of cognitive functioning), obstructive sleep apnea (repeatedly stop breathing while you are asleep) , and cerebral infarction (stroke). Record review of Resident #13's care plan, dated 08/21/2024, reflected no information regarding dentures. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #13's initial nursing assessment, dated 04/16/2024, reflected the resident had own teeth option was selected and no information was recorded regarding dentures. Record review of Resident #13's initial dietitian assessment, dated 05/01/2024, reflected dentures was not selected under oral dental status section. Record review of Resident #13's follow up dietitian assessment, dated 08/20/2024, reflected dentures was not selected under oral dental status. Record review of Resident #13 initial NP encounter, dated 04/26/2024, reflected dentures (upper and lower) were recorded under the ADL section. Record review of Resident #13's progress notes from NP, dated 08/09/2024, reflected dentures (upper and lower) were recorded under the ADL section. Record review of Resident #13's initial MDS, dated [DATE], reflected in Section L, no natural teeth, dentures, or obvious broken teeth were not selected. Observation on 08/21/2024 at 10:30 AM revealed Resident #6 with several missing and broken teeth. During an interview on 08/20/2024 at 1:40 PM with Resident #13, she stated she had dentures. During an interview on 08/22/2024 at 11:00 AM, CNA D she stated Resident #13 had top and bottom dentures. CNA D stated she brushed Resident #13's dentures. During an interview on 08/22/24 at 11:05 AM, LVN B she stated an initial assessment was completed first thing after a resident admitted to the facility. LVN B stated it was considered head to toe and everything was looked at including mouth and teeth of the resident. LVN B stated the staff looked if the resident had dentures or broken teeth. LVN B stated it should have been marked on the initial nursing assessment. LVN B stated Resident #13 had dentures. LVN B was observed viewing the initial nursing assessment for Resident #13 and stated Resident #13 having dentures was not marking on the initial assessment. LVN B stated Resident #6 had her own teeth. She stated Resident #6's initial assessment was marked as having broken teeth . During an interview on 08/22/24 at 11:10 AM, RN A stated an initial assessment was completed shortly after admission, and it should have been marked if a resident had partials, full dentures or broken teeth. RN A stated the admission assessment was completed for every patient within 24 hours of admission. She stated Resident #13 had her own teeth and stated Resident #6 had very broken teeth. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 11:45 AM, LVN C stated she was the MDS Coordinator. LVN C stated she was responsible for the MDS stated that the activities and social worker were responsible for their sections. LVN C stated the care plan was a collaborative effort by typically her and IDT . LVN C stated she believed there was a section for dentures and for broken teeth on the MDS. LVN C was observed viewing the MDS and confirmed there was a section for oral/dental status. LVN C stated if residents had broken teeth or dentures that should be on their MDS. She stated when she completed this section for the MDS she looked at the nursing admission assessment because it asked about their oral status. She stated she expected the nursing admission assessment was accurate and it reflected the residents status at the time of admission. LVN C stated Resident #13 and Resident #6's MDS assessments were not marked correct regarding their MDS and oral status. She stated she was not sure why this occurred unless there was an oversight. LVN C stated this was an oversight for Resident #6 and the MDS may need to be modified. LVN C stated if Resident #13 had dentures at admission should be on the admission assessment. LVN C stated she was not aware if anyone reviewed the assessments and MDS to avoid oversight. LVN C stated oral status should be care planned. LVN C stated she did not review dietician assessments when completing the MDS. During an interview on 08/22/24 at 12:54 PM, the DON stated assessments completed should accurately reflect the resident's status. The DON stated admission assessments should accurately reflect the resident's oral status and it did ask if the resident had partials, broken teeth or full dentures. The DON stated she was unsure how information was gathered for the MDS because she did not gather information for the MDS. The DON stated she glanced through the MDS but did not know if the information was accurate and she signed the MDS as the RN. The DON stated she would expect the MDS accurately reflected the resident's status. The DON stated that a potential outcome of an inaccurate assessment was the facility losing money and potentially affecting resident's care. During an interview on 08/22/24 at 12:59 PM with the ADM, she stated assessments should have been completed to accurately reflect the residents status. She stated she did not know if the DON evaluated the information prior to signing off on the MDS. The ADM stated she would expect the MDS accurately reflected the resident's status. The ADM stated a potential negative outcome of an inaccurate assessment would be financial implications and some care issues and overall negative outcomes with care issues. Record review of the facility's policy titled Admission Assessment and Follow Up: Role of the Nurse, dated September 2012, reflected the purpose of the admission assessment is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission. Further review reflected the purpose is also to initial carpal and complete required assessment instruments including the MDS. Review reflected that a physical assessment should be conducted and include teeth and gums. Record review of the facility policy titled Certifying Accuracy of the Resident Assessment, dated November 2019, reflected any person completing a portion of the MDS must sign and certify the accuracy of that portion of the assessment.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50001 Based on observation, interview and record review the facility failed to ensure residents who were unable to conduct activities of daily living (ADLs) received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for three of ten residents (Resident #9, Resident #287 and Resident #238) reviewed for quality of life. 1. The facility failed to ensure Resident #238's nails were cleaned and trimmed. 2. The facility failed to ensure Resident #238's chin hair was trimmed. 3. The facility failed to ensure Resident #9, Resident #287 and Resident #238 chin hairs were trimmed. These failures could place residents at risk for poor hygiene, dignity issues, and decreased quality of life. Findings include: 1. Record review of Resident #9's face sheet, dated 08/22/2024, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #9 had diagnoses which included Hypoglycemia (high blood sugar that affects people with diabetes), Pain, Malaise (general feeling of bad health) and Left Bundle-branch block (electrical impulses to the heart are blocked). Record review of Resident #9's Quarterly MDS Assessment, dated 06/26/2024, reflected the resident had a BIMS score of 9, which indicated her cognitive status was moderately impaired. Record review of Resident #9's Comprehensive Care Plan, dated 07/11/2024, reflected Resident #9 had potential for impairment to skin integrity related to fragile skin. Goal: The resident will maintain or develop clean and intact skin by the review date. Long dirty unkempt nails could put the resident at risk of scratching her skin causing a break in her skin and putting her at risk of infections. Observation on 08/21/2024 at 11:50 AM revealed Resident #9 was in her room laying in her bed resting. The resident had a blackish substance underneath all her fingernails on her right and left hands, and her nails were long. Resident #20 was not interviewable. 2. Record review of Resident #287's face sheet, dated 08/22/2024, reflected a [AGE] year-old male who was admitted to the facility 5/30/2024 with diagnoses which included: Enterocolitis (inflammation in both intestines at once) due to clostridium difficile, traumatic subdural hemorrhage (bleeding near your brain that can happen after a head injury) with loss of consciousness, sepsis and weakness. Record review of Resident #287's Quarterly MDS Assessment, dated 05/07/2024, reflected Resident #287 had a BIMS score of 15. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 08/21/2024 at 11:56 AM revealed Resident #287 was lying in bed in his room. She had a long noticeable chin hair hanging on her chin. The resident voiced she had one chin hair that she knew of that needed to be pulled out but staff didn't offer to do it and she couldn't pull it out herself. Observation and interview on 08/22/2024 at 09:08 AM revealed Resident #287 voiced that her big toenails needed to be trimmed and she couldn't reach them to do it herself. The toenails were long and thick. She was not a diabetic. 3. Record review of Resident #238's face sheet, dated 08/22/2024, reflected a [AGE] year-old female who was admitted to the facility 8/9/2024 with diagnoses which included: Wedge compression fracture of third lumbar vertebrae (type of compression fracture that occurs when one side of your vertebrae collapses and creates a wedge shape) , subsequent encounter (Routine follow-up care for a condition that previously had a treatment plan. for fracture with routing healing and pain in right knee. Record review of Resident #238's Quarterly MDS Assessment, dated 08/12/2024, reflected Resident #238 had a BIMS score of 15 indicating the resident was cognitively intact. Observation on 08/21/2024 at 11:47 AM revealed Resident #238 had a long noticeable chin hair hanging on her chin. Resident #238 fingernails were long and had a blackish substance underneath her nails on her forefinger, middle finger, and index finger on his right hand. In an interview on 08/21/2024 at 11:48 AM revealed Resident #238 stated her nails were very dirty but she was afraid to ask someone to trim and clean them because she thought they would charge her for the services. Resident #238 voiced she knew she had long chin hairs but couldn't see them and didn't have a mirror. In an interview on 08/21/2024 at 01:50 PM, CNA K stated the nurses and CNAs were responsible for nail care if residents asked. She stated the nurses were responsible to clean, trim and file all resident's nails with a diagnosis of diabetes. CNA K voiced staff would trim chin hair if it was noticed. CNA K stated they offered residents mirrors during morning hygiene while brushing their teeth in the restroom they bent the mirror down for residents to see themselves. CNA K voiced if residents did not have clean trimmed nails, it could make residents feel dirty, nasty and unkempt. Long chin hairs would make a resident feel bad. In an interview on 08/21/2024 at 01:55 PM, CNA L stated the CNAs were responsible for nail care unless a resident was a diabetic, then a doctor went in and did that for them. For non-diabetic residents CNAs trimmed their nails. CNA L voiced staff tried to offer to trim residents nails at least once a week and only if residents requested it. CNA L stated she asked residents if they would like their chin hairs shaved. She stated if residents had long nails that might make them feel bad. She also stated if residents had long chin hairs that might make them feel like a man. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/21/2024 at 02:01 PM, the Director of Nurses stated the CNA's or Nurses were responsible to cut, trim, and clean residents' nails. She stated the nurses were responsible for the residents with a diagnosis of diabetes. She stated the staff were required to trim, cut, and clean nails during their showers and as needed. She voiced staff should be offering to shave residents or trim chin hair on shower days. The DON voiced residents would not feel at their best and would not feel presentable if they had chin hairs. She stated residents would feel pretty dirty if they had long dirty fingernails. The DON stated staff should be offering mirrors and allowing residents to see themselves when they were brushing their teeth. Record review of the facility's policy on Fingernails/Toenails, Care of, reviewed 02/2018, reflected General Guidelines: 1. Nail care includes daily cleaning and regular trimming 2. Proper nail care aid in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. 5. Watch for an report any changes in the color of the skin around the nail bed, blueness of the nails, any signs of poor circulation, cracking of the skin between the toes, any swelling, bleeding, etc., 6. Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or to thick to cut with ease. Record review of the facility's policy on Shaving the Resident, reviewed 02/2018, reflected Purpose: The purpose of this procedure is to promote cleanliness and to provide skin care.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50001 Based on interview and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 5 residents (Resident#3) reviewed for pharmaceutical services. The facility failed to ensure Resident #3's Mirabegron Extended Release (prescribed to treat overactive bladder) tablet was not crushed. This failure could place residents at risk of discomfort or decrease residents quality of life. Findings include: Record review of Resident #3's face sheet, dated 08/22/2024, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included degenerative diseases of nervous system, lack of coordination and repeated falls. Record review of Resident #3's quarterly MDS assessment, dated 07/31/2024, reflected a BIMS of 0, which indicated his cognition severely impaired. Record review of Resident #3's, undated, care plan reflected a goal that Resident #3 would maintain involvement in his preferred activities 3 times weekly over the next 90 days. Record review of Resident #3's Orders, start date 07/24/2024, reflected an order for Mirabegron ER Oral Tablet Extended Release 24 Hour 25 MG (Mirabegron). Give 2 tablets by mouth one time a day for overactive bladder related to Benign Prostatic Hyperplasia (enlarged prostate) with lower urinary tract symptoms. Record review of Resident #3's physician orders dated 7/24/2024 reflected the resident was given the following medications in conjunction with the scheduled Mirabegron: 1. Vitamin D3 25 mcg 1 tablet given Expires 09/2024 2. Vit B12 1000 mcg 1 tablet given Expires: 09/2024 3. Zinc 50 mg 1 tablet given Expires: 08/2024 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Sennosides (natural veg laxative for overnight relief) 8.6 mg (1 tablet given) Expires 07/2025 5. Atorvastatin 10mg tab equiv: to Apotex Take 1 tablet by mouth every day (1 tablet given) Expires: 06/23/2025 6. Divalproex 500 mg EC tablet Take 1 tablet (500 mg total) by mouth 2 (two) times daily 1 tablet given Expires: 04/25/2025 7. Finasteride 5mg tablet Take 1 tablet (5 mg total) by mouth daily 1 tablet given Expires: 05/25/2025 8. Memantine 10 mg tab macleods Take 1 tablet by mouth two times a day Expires: 05/24/2025 9. Fluticason prop 50 mcg Spray Nasal Spray inhale 1 spray in each nostril every day Expires: 07/22/2024 In an observation of medication pass on 8/20/2024 at 11:01 AM, MA I started the medication pass, at 11:13 AM MA I left the cart, went to the nurses station and asked LVN A if Resident #3's meds were to be crushed. LVN A voiced yes and MA I returned to the cart and crushed all of the medications to include Resident #3's Micrabegron Extended Release tab. At 11:15 AM, the crushed medications were administered to Resident #3 in a medication cup mixed with pudding. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per phone interview on 08/21/2024 at 10:30 a.m., MA I stated there was a list of residents that had crushed and don't have crushed medications, the facility went by that list. That's what she was taught during orientation. She was told to follow the list but when she started her shift on 08/20/2024 the list was not on her cart. She voiced she had it on her cart and someone in the office took it off, she stated because they knew State was coming in. MA I voiced on 08/20/2024 it was her first day alone doing medications and she was nervous. MA I stated there was not anything on the medication name that would alert her that it is a do not crush medication. It was listed on the list that was on the MA cart or in the MAR. Interview on 08/21/2024 at 10:55 AM., MA J stated most of the time a do not crush med was noted in the MAR. If it was not in the system staff were to inform a nurse or, staff were supposed to get that information in report from the nurse who worked before they came on to the new shift. MA J stated it won't tell you on the name (if a medication is do not crush) you have to read the back of the med book, that's usually on the cart, it had a list of meds listed on there that were do not crush. MA J stated adverse effects for a resident if they received crushed medications that did not require crushing were their blood pressure could go up, they could get dizzy, they could throw up and some residents may break out in hives. Interview on 08/21/2024 at 10:40 a.m., LVN A stated if a medication needed to be crushed it was noted in the MAR. She voiced the medication would not work the way it supposed to, it would not do it's job if it is crushed and not supposed to be crushed. Interview on 08/21/2024 at 10:45 a.m., the DON stated all med aides were trained to not crush anything enteric. There was a list of do not crush medications on the med cart and if it was not on the cart, staff were to inform the DON or nurses so, it could be replaced. She voiced adverse effects of receiving crushed medications were the resident could get too much medication, the medication would not be absorbed properly, and it would make it non-effective. Per the Policy Crushing Medications with a revision date of April 2018. Policy statement: Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders. Policy interpretation and implementation: 3. In addition, the following guidelines shall be followed when crushing medications: D. Crushing each medication separately and administering each with food is considered best practice.		

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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. 42600 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 1 of 1 kitchen reviewed for food and nutrition services. 1. The facility failed to ensure kitchen staff (Cook E, Server F, Server G and Server H, and the dishwasher) wore mustache or beard guards and hair coverings while in the kitchen . 2. The facility failed to ensure food in the freezer, refrigerator, and dry storage room was properly stored, dated and labeled. 3. The facility failed to ensure the kitchen was free of pests/insects. 4. The facility failed to properly thaw chicken. These failures could place residents at risk of food-borne illness. Findings include: Observation on 08/20/2024 at 9:13 AM revealed uncovered desserts stacked in baking dishes on food preparation area. Observation on 08/20/2024 at 9:13 AM revealed [NAME] E with no beard guard preparing lunch for later that day. Observation on 08/20/2024 at 9:14 AM revealed three bags of shredded cheese in clear bags which were undated and not labeled in cooler. Further observation revealed three tubs of ice cream were not dated and one tub was uncovered. There were three clear bags of bagels that were unlabeled and undated. Observation on 08/20/2024 at 9:15 AM revealed eighteen small bowls of Jello were uncovered and not dated in the refrigerator. There was rust at the bottom of the refrigerator near the Jello and ran down along the back of the inside of refrigerator. Observation on 08/20/2024 at 9:17 AM revealed a bag of white sugar, dated 5/21/2024, in an opened plastic bag within a cardboard box. There was a Styrofoam cup in the sugar. Observation on 08/20/2024 at 9:17 AM revealed sweet potatoes and bananas stored under the food prep table were uncovered with no date. Observation on 08/20/2024 at 9:18 AM, in the dry storage, was an unknown item in a blue plastic bag was unlabeled and undated and the bag was knotted as a seal. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 08/20/2024 at 9:20 AM revealed flour in a plastic bin with an expiration date labeled as 7/25/2024. Observation on 08/20/2024 at 9:20 AM revealed an unknown item in plastic wrap was unlabeled with date of 07/22/2024 in dry storage. Observation on 08/20/2024 at 9:21 AM revealed tortilla chips were unsealed and undated. An additional bag of chips was wrapped in plastic wrap and was unlabeled and undated. Observation on 08/20/2024 at 9:22 AM revealed two bags with shredded carrots were unlabeled and undated. One bag of carrots was observed tied at the top of the bag in a knot in cooler. Observation on 08/20/2024 at 9:23 AM revealed four bags of shredded cheese were undated and unlabeled and wrapped in plastic. Observation on 08/20/2024 at 9:23 revealed green vegetables that were browning sitting in cup of water unlabeled and undated. Observation on 08/20/2024 at 9:25 AM revealed warm water running over bag of chicken in sink. Observation on 08/20/2025 at 9:27 AM revealed the dishwasher was not wearing a beard guard while washing dishes. Observation on 08/20/2024 at 9:29 AM revealed an open bag of unlabeled and undated unknown food in the freezer. Observation on 08/20/2024 at 9:39 AM revealed [NAME] E took the temperature of thawing chicken. The thermometer temperature was 66.2 degrees Fahrenheit. Observation on 08/20/2024 at 11:00 AM revealed thawed chicken placed in the refrigerator. Observation on 08/20/2024 at 11:01 AM revealed turkey breast and thigh roast on a cutting board warm to touch in packaging. Observation on 08/20/2024 at 11:02 AM revealed a cockroach crawling on floor of the kitchen. Observation on 08/20/2024 at 11:04 AM revealed several gnats flying around the dishwashing area of the kitchen. Observation on 08/20/2024 at 11:43 AM revealed small dead bugs behind the food prep area. Observation on 08/20/2024 at 11:52 AM revealed Server F staff entered the kitchen with no beard guard and grabbed a tray. Observation on 08/20/2024 at 12:21 PM revealed maintenance entered and walked through kitchen with no hair restraints. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 08/20/2024 at 12:21 PM revealed [NAME] E plated food and was not wearing a beard guard. Observation on 08/20/2025 at 12:32 PM revealed DC throw away thawed chicken. Observation on 08/21/2024 at 10:55 AM revealed [NAME] E prepared food and was not wearing a beard guard. Observation on 08/21/2024 at 10:59 AM revealed the dishwasher was not wearing a beard guard. Observation on 08/21/2024 at 11:08 AM revealed Server G wore hairnet with the front of hair exposed. Observation on 08/21/2024 at 11:10 AM revealed staff Server H in the kitchen plating food with the front of the hair exposed from hair net. During an interview on 08/20/2024 at 9:25 AM, [NAME] E stated he was preparing chicken breast and chicken thighs for dinner tonight. He stated the water should be cool when it ran over the chicken. [NAME] E turned the cool water knob up during this interview. [NAME] E stated he was going to put the chicken in the fridge after it was thawed. During an interview on 08/20/2024 at 9:58 AM, the DC stated the chicken was taken out of the freezer forty-five minutes prior to the State Surveyors arrival. She stated it was supposed to be taken out 3 days in advanced to thaw but it was not. She stated thawing meat was not supposed to be maintained at a certain temperature. She then stated it was supposed to be below 40 degrees. The DC stated if the meat was at 66 degrees Fahrenheit while thawing it would not be used. She stated she was unsure how it would be at sixty-six degrees if it was just taken out. During an interview on 08/20/2024 at 12:32 PM, the DC stated turkey roast could be cooked in the package. She stated she would had expected the cook to review the outer packaged if the instructions said to do so. She stated she did not think there was any harm in cooking it with the packaging on and assumed the plastic would have melted. She stated the roast was okay to consume. During an interview on 08/20/2024 at 12:46 PM, with company of turkey breast thigh roast, customer service representative stated the plastic packaging did not contain BPA and that it would need to be prepared following the instructions on the packaging. During an interview on 08/21/2024 at 11:11 AM with Server C she stated anyone who entered the kitchen should have a hairnet on. She stated anyone with facial hair should have a beard cover on. She stated she was unsure if her hair was fully covered. She stated if hair was not covered it could enter the food. (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 08/21/2024 at 2:01 PM with [NAME] A, he stated all items that stored should be labeled with the date in and use by date and the date they were opened. He stated they could also have a prepared date. He stated the label did not have to include the contents if the package was clear. He stated normally items that were not being served or plated should have been covered. He stated items should not be stored in areas with rust. He stated the kitchen director was responsible for checking and labeling. He stated if an item was not labeled, it should be thrown away. He stated all items should have an open date and this should be put on the item at the time it was opened and not later. He stated once air hit the item it was altered. He stated the facility had issues with cockroaches for a while. He stated that a company came in and sprayed weekly and this caused the roaches to come out the following day. On 08/21/2024 at 2:14 PM, the DC stated everything was supposed to be labeled and dated. She stated it did not matter what the packaging looked like, it should have a label on it of what it was. She stated if an item did not have a date, then it should be thrown out. She stated food was supposed to be stored six inches off the ground. She stated vegetables and fruits were supposed to be stored in the cooler. She stated hair nets were supposed to be worn in the kitchen with all hair covered. She stated you were only required to cover facial hair if it was more than a mustache. She stated anyone who stepped into the kitchen should have a hair net on. She stated food should not be stored anywhere that had rust. She stated the process for thawing was it was usually thawed two days before by being removed from the freezer and put in the cool but sometimes it was not thawed in time, and it could be thawed under cool water. She stated the temperature for food being thawed under cool water was monitored by a temperature but was not logged anywhere. On 08/22/204 at 1:01 PM, the ADM stated it was expected food service staff followed thawing procedures outlined in the facility policy. She stated it was expected that food be prepared in accordance with the safe handling instructions/cooking instructions listen on the food item. The ADM stated food borne illness could occur if food was not properly thawed or prepared. The ADM stated any staff who entered the kitchen had hair restraints on. She stated hair restraints should be worn covering their head and all hair tucked in. She stated all facial hair should also be covered by a beard guard. The ADM stated if hair was not properly covered in the kitchen it could get into the food. She stated if hair was not properly covered it could also make staff want to touch it. The ADM stated pests were not supposed to be in the kitchen. She stated if pests were in the kitchen, it could cause illness and sanitation issues. The ADM stated it was the expectation that food should be stored, sealed, labeled, and dated and maintained according to shelf life and date. She stated sealed meant a Ziploc bag or sealed with a clip. She stated if food was not properly labeled or stored it could attract pests or cause food borne illnesses. The ADM stated food should not be stored directly on the floor. Record review of 2022 Food Code U.S. Food and Drug Administration revealed, Section 3-501.17 specifies ready-to-eat, time/temperature control for safety (TCS) food prepared in a food establishment and held longer than a 24 hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises. Record review of the facility's, undated, policy titled Pest Control reflected this facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility policy titled Personal Hygiene/Safety/Food Handling/Infection Control, dated 05/18/2023, reflected wear a clean hat or other hair restraint. Hair must be appropriately restrained or completed covered . beards, mustaches or any body hair that may be exposed must be covered. Record review of the facility's policy titled Temperatures and Safe Food Handling, dated 09/18/2018, reflected bacteria need temperatures between 40 degrees Fahrenheit and 140 degrees Fahrenheit to grow. Thawing procedures include thaw under refrigeration, according to the menu's program's meat pull schedule. Further review reflected that thawing under cold water is not recommended because the product must remain below 41 degrees at all times, and this is difficult to monitor. Record review of the facility policy, dated 04/10/2023, titled Labeling and Dating for Safe Storage of Food reflected all products should be dated upon receipt, all products should be dated when opened and to utilize use-by dates on all food once opened and stored under refrigeration. Further review revealed when food is taken out of an original container write the name of the food being stored on the container, the placed date and the use-by date. Record review of the facility policy, dated 07/11/2024, titled Food Storage reflected all food should be stored away from the walls and off the floor. Further review revealed any opened products should be placed in seamless plastic or glass containers with tight-fitting lids and labeled and dated. Reviewed revealed remove food stored in bins from their original packaging and label and date all stored containers or bins. Review also revealed that lids need to be tight fitting. Facility policy revealed to check for pest infestation regularly.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 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 4 of 5 residents (Residents #6, #1, #14 and #27) reviewed for infection control . 1. MA I failed to properly sanitize the blood pressure cuff when moving from one resident to another resident when administering medications and obtaining the blood pressure for Residents #1, #14 and #27. 2. RN A failed to wash or sanitize her hands while going from a dirty to clean surface while performing wound care for Resident #6. These deficient practices could place residents at risk for cross contamination and the spread of infection. Findings include: 1. Record review of Resident #27's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #27 had diagnoses which included Nodular Lymphocyte Predominant [NAME] Lymph Nodes of head, face and neck (cancer of head, face and neck)and COPD (a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitation). Record review of Resident #27's Significant Change MDS dated [DATE], reflected a BIMS score of 15, which indicated she was cognitively intact. Record review of Resident #27's Care Plan, dated 08/20/2024, reflected Resident #27 had COPD with a goal to be free of signs and symptoms of infection. 2. Record review of Resident #14's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #14 had diagnoses of unspecified dementia (loss of brain function that affects a person's ability to think, remember, and perform daily activities), mild, without behavioral disturbance and Diabetes (chronic metabolic disease that occurs when the body is unable to produce enough insulin or use insulin properly). Record review of Resident #14's Annual MDS, dated [DATE], reflected a BIMS score of 07, which reflected she was severely impaired cognitively. Record review of Resident #14's Care Plan, dated 07/18/2024, reflected Resident #14 had a diagnosis of COPD and would be free of signs and symptoms of infection. 3. Record review of Resident #01's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #01 had diagnosis which included disturbance, psychotic disturbance, mood disturbance and anxiety. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #01's Quarterly MDS, dated [DATE], reflected a BIMS score of 00, which indicated the resident was severely impaired cognitively. Record review of Resident #01's Care Plan, dated 07/09/2024, reflected Resident #01 had the potential for moisture associated skin damage (MASD) related to frail elderly skin and incontinence. Observation on 08/20/2024 at 10:36 AM revealed MA I did not sanitize the blood pressure cuff in between each resident before and after checking blood pressures for Residents #27, #14 and #01 . Further observation revealed MA going to Resident #27 to apply the blood pressure cuff to check his blood pressure and she (MA) did not wipe the blood pressure cuff before or after she applied it to his wrist. Observation of Resident #14 revealed MA going up to Resident #14 without sanitizing the blood pressure cuff, MA applied the cuff on his wrist and after the reading was complete MA removed the cuff off of Resident #14 and did not sanitize it when she returned to her (MA) medication cart. Observation of Resident #01 revealed MA using the blood pressure cuff on Resident #1's wrist without wiping it before or after usage. Observation of MA medication cart revealed that there were no sanitizing wipes available on her (MA) cart and inside her (MA)drawers. In an interview on 08/21/2024 at 10:24 AM, LVN B said that when taking residents blood pressures, you are supposed to sanitize the cuff in between each resident. The LVN voiced if you don't sanitize the cuff, you could cause contamination and you don't want to pass infections to others. In a phone interview on 08/21/2024 at 10:30 AM, MA I stated that was her first day (08/21/24) on the floor after her training and she has had been a medication aide for 8 years now. She usually sanitizes sanitized the blood pressure cuff in between residents but someone moved the sanitation wipes off her cart. So that is was why she didn't sanitize the blood pressure cuff in between each resident. She voiced that there could be some cross contamination in between residents if she doesn't didn't sanitize the blood pressure cuff. In an interview on 08/21/2024 at 10:45 AM, the DON said staff should be cleaning the equipment in between each resident. She voiced if they don't didn't sanitize the cuff, they infections could be transferred in between residents. Record review of the policy on cleaning and disinfecting non-critical resident care items with a revision date of June 2011. General Guidelines: C.) Non-critical items are those that come in contact with skin but not mucous membranes. 1. Non-critical resident-care items include bedpans, blood pressure cuffs, crutches and computers. 4. Record review of Resident #6's face sheet, dated 08/21/24, reflected a [AGE] year-old female with an admitted [DATE]. Resident #6 had diagnoses which included dysphagia (difficulty in swallowing), cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain), anxiety (an emotion which is characterized by an unpleasant state of inner turmoil and includes feelings of dread over anticipated events), and congestive heart failure (when your heart cannot pump enough blood to provide your body with the blood and oxygen it needs). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the most recent quarterly MDS assessment, dated 07/22/24, reflected Resident #6 had a BIMS score of 13, which indicated Resident #6 was cognitively intact. Resident #6 required supervision or touching assist with eating, required substantial or maximal assist with bathing, and was fully dependent on staff for toileting and personal hygiene. Resident #6 was always incontinent of bowel and bladder and Resident #6 had a surgical wound and a surgical wound care. In an observation on 08/21/24 at 10:04 AM, RN A performed wound care on Resident #6's lower right abdomen while being assisted by the ADON. RN A washed her hands, applied her gloves, then applied another pair of gloves over the first pair, and removed the soiled dressing from Resident #6's wound. RN A then removed her gloves from her hands where she already had another pair of gloves applied. RN A cleansed the wound and discarded the soiled dressing. RN A then removed her gloves and re-applied another pair of gloves without washing or sanitizing her hands. RN A applied the new dressing and wound vac to the residents wound, made the resident comfortable and gave resident her call light. In an interview on 08/21/24 at 10:20 AM, Resident #6 stated she saw staff using sanitizer all the time, but she did not pay attention to that often. In an interview on 08/21/24 at 10:25 AM, RN A stated after she removed Resident #6's wound dressing and before cleaning Resident #6's wound, and when she had changed her gloves after cleaning the wound but prior to applying a new dressing, she did not wash or sanitize her hands. She stated she had double gloved her hands prior to starting the wound care and when she removed the first layer of gloves after she removed the soiled dressing, her gloves would still had been clean. She stated she was trained on washing and sanitizing her hands between a dirty and clean surface and also on infection control. She stated not washing or sanitizing her hands when going from a dirty to clean surface could cause contamination. In an interview on 08/21/24 at 10:39 AM, the ADON stated he saw RN A had double gloved and not washed her hands in between going from a dirty to clean surface. He stated he was not sure what the facility policy said but he would find out. In an interview on 08/21/24 at 12:14 PM, the DON stated staff should have always sanitized or washed their hands when going from a dirty to clean surface or when changing gloves. She stated staff should have removed their gloves, washed their hands, and applied new gloves when they performed any type of care and went from a dirty to a clean surface. She stated it was not the facility policy to double glove and staff should only have used one pair of gloves at a time. She stated staff were trained on handwashing when going from a dirty to a clean surface and infection control. She stated if staff had not washed or sanitized their hands when going from a dirty to clean surface, it could have caused an infection or it could have caused a wound to not heal. In an interview on 08/21/24 at 2:01 PM, the ADM stated staff should always wash their hands when going from a dirty to clean surface. She stated she had not encountered any staff who were double gloving, but double gloving was not following facility policy. She stated staff were trained on washing or sanitizing their hands when they were going from a dirty to clean surface and also on infection control. She stated handwashing was one of the facility's focused in-services. She stated if staff had not washed or sanitized their hands when going from a dirty to clean surface, it could further the infection or spread the infection somewhere else. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's in-service titled Report of Employee Education, dated 07/18/24, with a subject of Hand Hygiene reflected staff, had been trained on hand hygiene. The document read Hand hygiene must be completed correctly to ensure the chain of infection is broken. Hand hygiene is indicated: before touching resident, before performing an aseptic task (blood sugar, placing an indwelling device), after contact with blood, body fluids or contaminated surfaces, after touching a resident, after touching a resident's environment, before moving from work on a soiled body site to a clean body site on the same resident, immediately after glove removal, between delivering meals to residents. Hand hygiene can be either by washing hands or using alcohol-based hand rub of 60% or higher. Help us to keep from spreading infections. Wash your hands for 20 seconds (sign Happy Birthday or Twinkle Twinkle Little Star twice, if you don't know how long 20 seconds is). Record review of the facility's Handwashing/Hand Hygiene policy, dated 2001 and revised October 2023, reflected the following: Policy Statement: The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation: 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol based hand-rub (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughout the facility. Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal Record review of the facility's Negative Pressure Wound Therapy policy, dated 2001 and revised February 2014, reflected the following: Purpose: The purpose of this procedure is to provide guidelines for establishing and maintaining negative pressure wound therapy (NPWT). Steps in the Procedure: 1. Identify and size the wound to be treated. 2. wash hands and apply gloves. 3. clean wound according to facility protocol, or as ordered. 4. Remove gloves. 5. Wash hands and apply clean gloves		