

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

Printed: 07/18/2026
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 09/04/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food storage, food safety, and nutrition services for 1 of 1 kitchen. 1. The facility failed to ensure that food was stored in sealed, airtight packages in the freezers and food on kitchen surfaces are securely covered and closed when not in use. 2. The facility failed to ensure kitchen staff wore facial hair restraints when preparing and serving food. Findings included: On 9/2/2025 at 9:05 AM an observation of walk-in freezer revealed the following: - A brown cardboard box, labeled Pie Dough Sheets, was opened/unsecured and pie dough was exposed to air. - A brown cardboard box, labeled Bread Sticks was opened/unsecured. The bread sticks were in a clear, plastic, unsecured bag inside the box and exposed to air. - A brown cardboard box, labeled Cut Okra was opened/unsecured. The okra pieces were in a clear, plastic, unsecured bag inside the box and exposed to air. - A brown cardboard box, labeled Sliced Carrots was opened/unsecured. The carrot pieces were in a clear, plastic, unsecured bag inside the box and exposed to air. - A brown cardboard box, labeled Garlic Toast was opened/unsecured. The garlic toasts were in a clear, plastic, unsecured bag inside the box and exposed to air. On 9/4/2025 at 11:03 AM an observation of preparation area revealed the following: - A 5-6-inch stack of sliced ham was sitting on the cutting board in prep area. It was uncovered and no staff were in proximity. - A bag of sliced bread ripped open at the bottom was sitting on a metal table, beside a stack of plates. Two pieces of bread were protruding from the bag and hanging above the metal table. On 9/4/2025 at 11:05 AM an observation of walk-in freezer revealed the following: A brown cardboard box, labeled Hamburger Patties, was opened/unsecured. The hamburger patties were in a clear, plastic unsecured bag inside the box and exposed to air. On 9/4/2025 at 11:07 AM an observation of the stand-alone freezer where ice cream is stored, revealed the following: Five individual size serving bowls sitting on the waist-high shelf, each with a melted scoop of ice cream and/or sherbet, which were uncovered and unlabeled. On 9/4/2025 at 11:48 AM an observation of the LC preparing sandwiches at the griddle and was not wearing a beard/facial hair restraint. The LC had a thick, black mustache above his upper lip and the hair was approximately three quarters of an inch in length. During an interview on 9/4/2025 at 2:05 PM the LC stated all food items should have been covered, labeled, boxes closed, and bags tied in the freezers. He said adverse outcomes were that food come have become frostbitten and items could have fallen into the bags. He stated everyone in the kitchen was required to wear hair and beard restraints. He said he had forgotten to replace his facial hair restraint after he took a short break to hydrate. He said adverse outcomes were cross-contamination or hair and germs could have fallen on the food. He said the kitchen staff were responsible to wear hair/beard restraints, and it was the DCS's responsibility to reinforce it. On 9/4/2025 11:55 AM an observation of the DCS as he entered the kitchen from the resident serving area. He informed kitchen staff a resident had spilled their plate and needed a replacement quickly. The DCS was scooping an unknown item (pudding or ice cream) into a bowl and was not wearing a beard/facial hair restraint. The DCS had a thin mustache above his upper lip and the hair was approximately one quarter in length. During an interview on 9/4/2025 at 2:30 PM the DCS stated opened food in the freezers should have been (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	labeled and tightly secured. He said adverse outcomes could have been cross contamination, frost bite, and changes in texture of the food. He said kitchen staff were trained initially when they received their Food Handlers training, and he conducted in-services with the kitchen staff to keep them informed and reminded of the basics of safe food storage. He said hair/beard restraints were a must at all times, when in the kitchen. He said he was primarily responsible for ensuring kitchen staff were wearing hair/bear restraints in the kitchen, although the shift supervisor was also responsible. He said cross contamination, hair in the food, and disciplinary action were potential adverse outcomes. He said he was unaware a beard/facial hair restraint was required for his thin mustache. During an interview on 9/4/2025 at 2:46 PM the ADM stated her expectation was kitchen staff should have securely stored food items according to the facility's policy and to avoid foodborne illness. She said her expectation was kitchen staff should have worn hair, beard, and facial hair restraints while they were in the kitchen. She said it is the responsibility of the DCS to ensure kitchen staff were wearing beard/facial hair restraints. A record review of the facility's policy titled Food Storage; revised 7/11/2024 reflected the following: PolicyUpon delivery all food items should be inspected for safe transport and quality upon receipt. Food items should be stored, thawed, and prepared in accordance with good sanitary practice. Any expired or outdated food products should be discarded. During a power failure, frozen and refrigerated foods are properly handled. Original food packaging containers are not permitted to be reused.Frozen Meat/Poultry and Foods3. Storage: Store items promptly at 0 F or less or at a temperature that maintains the food frozen. Foods should be stored in their original containers if designed for freezing. Foods to be frozen should be stored in airtight containers or wrapped in heavy-duty aluminum foil or special laminated papers. Label and date all food items.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement within seven days and make available to staff a comprehensive person-centered care plan that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental/psychosocial needs that were identified in the comprehensive assessment for one (Resident #28) of six residents reviewed for care plans in that: The facility failed to ensure Resident #28 had a comprehensive person-centered care plan implemented in the EMR. This failure could place residents at risk of not receiving the necessary care to meet his medical, nursing, and psychological needs. Findings Included: A record review of Resident #28's Face Sheet reflected an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. The admission diagnoses were Unspecified Dementia (decline in cognitive function), low back pain, nondisplaced transverse closed fracture of shaft of the left ulna (simple broken elbow), Atherosclerotic Heart Disease (buildup of plaque in arteries), Obstructive Sleep Apnea (repeated breathing interruptions during sleep), Burn of unspecified degree of head, face and neck, and muscle weakness (muscles cannot exert enough force). A record review of Resident #28's MDS dated [DATE] reflected Section A - Identification Information was completed by the MDS nurse on 8/4/2025. There was no additional information for review and there was no BIMS score for the resident. A record review of Resident #28's Care Plan was attempted on 9/3/2025 at 3:30 PM. There was not a care plan in the EMR. During an interview on 9/3/2025 at 3:35 PM the DON stated he was unable to see a care plan on his computer. He then spoke with the MDS C and return to the conference room and said, She said it was in the EMR; however, it was not launched. She could not see it when she looked in her computer. He said, It is in there now. A record review of Resident #28's Care Plan in the EMR was visible and focus areas were loading every few minutes. Review of the focus areas reflected initiation dates of 8/7/2025, 8/11/2025, 8/30/2025, and 9/3/2025. During an interview on 9/4/2025 at 9:32 AM, the MDSC stated she was responsible to implement resident care plans in the EMR. Regarding Resident #28, she said, The resident's care plan had been launched (i.e. initiated) in the EMR and it was invisible to others. She said, The SW and I met with the [family member] of Resident #28 last week and went over his care plan. She said she did not have the care plan available during that meeting. She said his care plan implementation in the EMR may have been overlooked. She said the care plan dated 9/3/2025 had three focus areas initiated on 9/3/2025 because it was incomplete, and the care areas were not initiated when the care plan was originally launched in the EMR. She said care plans were important for staff would have known how to care for each resident and in the absence of a care plan, Resident #28 would not have been cared for properly. During an interview on 9/4/2025 at 9:54 AM the SW stated the MDSC was responsible to initiate the care plan in the EMR. She said staff cannot provide care for the residents without a care plan. During an interview on 9/4/2025 at 2:15 PM, the ADON stated he oversees the MDSC. He said comprehensive care plans should have been initiated within seven days of admission and the facility should have realized sooner there was no care plan for Resident #28. He said without a care plan, he theoretically would not have known what was going on with Resident #28. During an interview on 9/4/2025 at 2:40 PM, the DON stated the MDSC, and nursing leadership were responsible to ensure care plans. He said care plans were important because they tell us how to care for residents. He said Resident #28 not having a care plan could have caused a delay or misunderstanding in the care he received. He said his expectation was a care plan for Resident #28 should have been implemented within seven days. During an interview on 9/4/2025 at 2:46 PM, the ADM stated the MDS C was responsible to initiate the care plan in the EMR and her expectation was person-centered care plans should have been implemented within seven days of admission. She said without a care plan, Resident #28 may not have received the services he needed. A record review of the facility's policy (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Care Planning - Interdisciplinary Team, revised March 2022 reflected the following: Policy Statement: The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation and Implementation: 1. Resident care plans are developed according to the timeframes, and criteria established by 5483.21.2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and were not accessible to unauthorized staff, visitors, and residents for one (Medication Cart A on North Hall - Rooms 301 - 316) of two medication carts reviewed for medication storage in that: Medication Cart A was unattended and unlocked outside a resident room, facing outward, in the middle of the hallway. This failure could allow residents, visitors, and unauthorized staff unsupervised access to prescription medication. Findings Included: An observation on 9/3/2025 at 4:19 PM revealed Medication Cart A was left unattended and unlocked. There was a silver key ring with 10-12 keys attached, laying on the top of Medication Cart A. There were no staff and no residents visible to the surveyor. The surveyor locked the cart, took the keys to the DON at the nurses' station, and reported the medication cart was found unlocked and unattended. During an interview on 9/4/2025 at 2:40 PM, the DON stated the LVN responsible for the cart had gone to grab something and forgot to lock the medication cart. He said the LVN was immediately counseled on the importance of locking the medication carts. He said it was the assigned nurses' responsibility to ensure the medication carts were locked when they stepped away from the cart. He said his expectation was the medication cart should have been locked. During an interview on 9/4/2025 at 2:46 PM, the ADM stated her expectation was medication carts should have been locked when they were unattended. She said an adverse outcome was that items could have gone missing. It was the nurse's responsibility to lock the medication cart when they were not attended. A record review of the facility's policy titled Security of Medication Cart; revised April 2007 reflected the following: Policy Statement: The medication cart shall be secured during medication passes. Policy Interpretation and Implementation 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 2. The medication cart should be parked in the doorway of the resident's room during the medication pass. The cart doors and drawers should be facing the resident's room. 3. When it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.		