STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Road Midlothian, TX 76065

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 47172 Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one of six residents (Resident #6) reviewed for activities of daily living . The facility failed to ensure Resident #6 was fed her lunch in a timely manner. This failure could place residents at risk for not receiving adequate care and services to prevent infection, injury, and diminished quality of life. Findings include: Record review of Resident #6's, undated, admission record revealed a [AGE] year-old female, who was admitted to the facility on [DATE]. Resident #6 had diagnoses which included senile degeneration of brain (progressive deterioration of brain tissue), dementia (symptoms affecting memory, thinking, and social abilities), and discitis (infection of the intervertebral disc space causing severe back pain, leading to a lack in mobility). Record review of Resident #6's quarterly MDS, dated [DATE], revealed Resident #6 had a BIMS score of 03, which indicated the resident had severe cognitive impact. Resident #6 required supervision or touching assistance for eating. Record review of Resident #6's care plan, dated last revised on 06/24/2024, revealed Resident #6 had an ADL self-care performance deficit related to disease process, she was unable to handle hot liquids and required assistance with meals. Observation of the dining room lunch tray pass on 12/02/2024 at 11:34 AM revealed the ADON oversaw tray pass to the residents seated in the dining area. A lunch tray was placed in front of Resident #6 at 11:49 AM, she was the only resident seated at her table and she was in a Geri chair (specialized recliner). She did not begin eating and continued to watch as the staff passed trays to the rest of the residents. Four other residents at different tables were given their trays and had CNA's sit beside them and began feeding assistance before Resident #6 was assisted with her lunch. The ADON sat next to Resident #6 at 11:59 AM after all residents received their trays to assist Resident #6 with her lunch . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #6 was attempted on 12/02/2024 at 12:05 PM. Resident #6 was asked if she enjoyed her lunch and she responded with a yes, it is good. Resident was unable to follow along for a more in-depth conversation .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observation, interview, and record review the facility failed to ensure menus met the nutritional needs of residents in accordance with established guidelines and was followed for 2 (Resident #7 and Resident #30) of 6 residents reviewed for food and nutrition services . The facility failed to serve Resident #7 and Resident #30 the posted lunch and dinner on Sunday 12/01/2024. This failure could place residents at risk of poor intake, chemical imbalance, and/or weight loss. Findings include: Record review of Resident #7's, undated, admission record revealed an [AGE] year-old female, who was admitted to the facility on [DATE]. Resident #7's had diagnoses which included dementia (symptoms affecting memory, thinking, and social abilities), cognitive communication deficit, unsteadiness on feet, repeated falls, high cholesterol, and high blood pressure. Record review of Resident #7's quarterly MDS dated [DATE], revealed the resident had a BIMS score of 12, which indicated moderate cognitive impairment. Resident #7 had impaired vision-sees large print, but not regular print in newspapers/books. Interview on 12/02/2024 at 12:45 PM with Resident #7 revealed she used a wheelchair to ambulate and could not see the posted menus in the kitchen due to their height, when she got to the dining room. She stated she had a pureed diet and could choose from the meal on the ticket brought each morning or another item, but her meals always came pureed. Record review of Resident #30's, undated, admission record revealed a [AGE] year-old male, who was admitted to the facility on [DATE]. Resident #30 had diagnoses which included heart failure, morbid obesity, congestive heart failure (a long-term condition in which your heart can't pump blood well enough to meet your body's needs), tachycardia (heart rate that exceeds the normal resting rate), and high blood pressure (a condition where the blood pressure in the arteries is persistently elevated). Record review of resident #30's MDS dated [DATE] , revealed the resident had a BIMS score of 15, which indicated intact cognition. Resident #30 had impaired vision-sees large print, but not regular print in newspapers/books. Interview on 12/02/2024 at 10:52 AM with Resident #30 revealed he only left his room to go to rehabilitation therapy and did not go to the dining room. He stated he did not know what was on the menu for the day until the CNA brought the meal tickets in the morning for him to choose if he would like the lunch and dinner on the ticket or an alternate meal item. He stated breakfasts were usually the same. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/02/2024 at 9:59 AM revealed the dining room's 3 menu showcase board to be empty, and did not contain the current days breakfast, lunch, or dinner within residents' accessible view. A 5-week menu and the current weeks meal tickets were stapled close to the kitchen entryway at eye level of a standing person. Record review of the lunch and dinner meal tickets for 12/01/2024 revealed residents were served chicken spaghetti, Italian vegetables, garlic bread, and peaches for lunch. The dinner tickets reflected residents were served ravioli, broccoli, dinner roll, and banana pudding. Record review of 2 meals posted on menus dated 12/01/2024 revealed menu items for the lunch meal service on 12/01/2024 was roast beef with gravy, mashed potatoes, seasoned peas with onions, roll with margarine, and trifle pie. The dinner meal service was chicken spaghetti casserole, Italian blend vegetables, bread stick and gelatin/peaches. Interview on 12/02/2024 at 12:56 PM, the DM stated she changed the menu on 12/01/2024 because she felt the posted dinner sounded better as a lunch meal. She stated the lunch and dinner meal tickets were taken around to each resident the morning of the meals on the ticket and the residents were to circle if they wanted the posted meal or an alternate menu item for either meal. The meal tickets were then taken to the kitchen. Interview on 12/03/2024 at 4:01 PM, the DM stated the substitution logs were not filled out for the month of November or December, and stated she did not use the substitution log to document the two meal changes she stated she just changed the meals because the original dinner sounded better as a lunch. Interview on 12/04/2024 at 11:45 AM, the ADM stated the lunch and dinner meal tickets were taken from the resident and given to the kitchen staff after the residents made their selections. If residents were unable to recall what they chose, they could go to the nurse's station to view a blank meal ticket. She stated for residents who did not leave their rooms often or could not see the menu in the dining area by the kitchen entryway, staff could take them a copy of the meal ticket. Record review of the food and nutrition service menus policy, dated last reviewed 1/2022, reflected: If any meal served varies from the planned menu, the change and the reason for the change are noted on a log in the kitchen and/or in the record book used solely for recording such changes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 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 the facility's only kitchen and one (Nourishment room [ROOM NUMBER]) of two nourishment rooms reviewed for food and nutrition services. 1. The facility failed to ensure the DA wore an effective hair and beard restraint while in the kitchen. 2. The facility failed to ensure expired instant oatmeal packets, vegetable juice blend cans, pure corn starch and vitamin D milk items were discarded. 3. The facility failed to ensure the nourishment room refrigerator contained items with a name and date on a lunchbox in Nourishment room [ROOM NUMBER]. These failures could place residents at risk for health complications, foodborne illnesses and decreased a quality of life. Findings include: Observation of the kitchen pantry on [DATE] at 9:34 AM revealed a large brown box of variety loose pack instant oatmeal with a best by date of [DATE], with approximately 16 pouches remaining out of an original 64 pouches remaining. Observation of the kitchen pantry on [DATE] at 9:37 AM revealed four vegetable blend juice cans remained out of a 6 pack of cans with an expiration date of [DATE]. Observation of the kitchen pantry on [DATE] at 9:40 AM revealed five boxes of Pure Corn Starch all with best by dates of [DATE]. Observation of the refrigerator on [DATE] at 9:49 AM revealed two cartons of Vitamin D milk with best by dates of [DATE]. Observation on [DATE] at 12:24 PM revealed the DA wore a grey hoodie over his head with no proper hairnet to cover all of his approximately 3-inch hair or a beard net to cover all of his approximately 1-inch length beard . Observation of the kitchen pantry on [DATE] at 9:01 AM revealed 3 boxes of Pure Corn Starch all with best by dates of [DATE], four vegetable blend juice cans remained out of a 6 pack of cans with an expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation in the Nourishment room [ROOM NUMBER] on [DATE] at 9:39 AM revealed red signage on the refrigerator that stated Resident only fridge place resident name on item. Date the item that's being placed in fridge. All staff items will be discarded. Inside the refrigerator was a blue lunch bag on the top shelf with no name of who it belonged to or date. Interview with the DA on [DATE] at 9:13 AM revealed he knew the policy for hairnets was to put it on every time he crosses the threshold into the kitchen . The DA stated yesterday ([DATE]) was the first time he put a beard restraint on in a while . Interview with the RD on [DATE] at 9:25 AM revealed she came to the facility on ce or twice per month. She came in to do a sanitation audit, assist with in-services, watch meal service, went through panty and freezer items for dating, addresses any concerns, made recommendations, and followed up with the ADM. She stated the kitchen followed the TFER for guidance . She stated hair restraints are to be worn by anyone who entered the kitchen to prevent contamination of food. Interview with the ADM on [DATE] at 1:49 PM, she stated if the disposal of expired items was not listed in their policy, the kitchen deferred to the TFER. Record review of the TFER revealed that ,d+[DATE].11 Food Storage. (A) .food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety . Record review of the facility's infection control policy for dietary services, dated last revised [DATE], reflected under subheading Personal Hygiene: Proper attire for food handlers should include a hair covering (hair nets or caps) . Moustaches and sideburns must be kept trimmed. Beards must be covered. Record review of the facility's policy entitled Nourishment Refrigerators in Nursing Facility, dated ,d+[DATE], reflected, If foods are retained in the refrigerator, they shall be covered and clearly identified as to contents and date initially covered .

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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. 49065 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 medical supplies stored in 1of 2 Medication storage rooms (800 Hall) and for 1 of 2 medication carts (800 Hall) reviewed for infection control /drug storage. The facility failed to ensure expired and contaminated medical supplies were removed from the medication storage room and 1 of the medication carts (located by the 800 Hall). This failure could place residents at risk for infection, ineffective treatment, and harm. Findings include: Observation on 12/03/2024 at 1:52 PM of the Medication Room near the 800 Hall revealed the following items: #1 Blood collection set (Butterfly Needle) expired on 7/6/2023. #1 Sterile Irrigation tray Medline DYND20302 - was opened and no longer sterile. #1 Pack of gauze was opened and stored non-covered in a cup under the sink. Observation on 12/03/2024 at 1:55 PM of the Medication Cart near the 800 Hall revealed the following items: #13 Syringes 1 cubic centimeter with needle; 28 Gauge expired 5/23/24. In an interview on 12/4/2024 at 1:15 PM with MA, she stated the policy on expired medications and/or opened sterile supplies was to get them out of the cart and medication room and put them in the DC (Discard) box. She stated all staff with keys to those areas, were responsible for checking the medication rooms and carts. The MA also stated the negative outcome to residents if expired or opened items were used would be to give them negative side effects. She stated it would not be as safe or correct to use those items. In an interview on 12/4/2024 at 1:22 PM with LVN, she stated the policy on expired medications and/or opened sterile supplies was to toss it in the medication room disposal. She stated, nurses and anybody who could access the medication rooms and carts were responsible for checking the medication room and carts. The LVN stated the negative outcome to residents if expired items were used was that items would not be as effective as they should be, or they could turn bad and have a poisoning affect. The LVN stated sterile items were not sterile if they were opened and the items could give residents an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/4/2024 at 1:35 PM with the ADM, she stated the policy on expired medications and/or opened sterile supplies was to not use and to throw them away. She stated the expired items should not be used; they should be destroyed and disposed of. The ADM stated the nurses and medication aides were responsible for checking the medication rooms and carts and after that management would be responsible for checking the medication rooms and carts. She stated the negative outcome to residents if expired or opened items were used was possible infection or they could be less effective. In an interview on 12/4/2024 at 1:45 PM with the DON, she stated the policy on expired medications and/or opened sterile supplies was they were to be discarded in the box. She stated the Assistant Director of Nursing was responsible to check behind nurses, but all nurses were responsible for checking the medication rooms and carts. The DON stated the negative outcome to residents if expired or opened items were used could be infection or death. Record review of the facility's policy, revised 7/2023, and titled, Policy/Procedure-Nursing Clinical, reflected in the Care and Treatment/Pharmacy section the following: Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures .