STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676387	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Meadows Health & Rehab	1870 S John King Blvd Rockwall, TX 75032

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403 Based on observations, interviews, and record review the facility failed to follow their policy regarding storage of foods brought to the residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption of the food and beverages for 9 Residents (#7, #54, #264, #92, #33, #21, #55, #10, and #28) out of 9 reviewed for personal food storage. The facility did not have documentation of temperature checks for the resident's personal refrigerators. The facility staff did not label, date, and clean the nourishment refrigerator for the residents. The deficient practice placed one hundred and ten residents who had used the nourishment refrigerators at risk of food borne illness. The deficient practice placed nine residents who had personal refrigerators at risk of food borne illness. The findings included : Observation on [DATE] at 8:00 AM revealed Resident#7 did not have documentation of temperatures for personal refrigerator. Observation on [DATE] at 8:05AM revealed Resident#54 did not have documentation of temperatures for personal refrigerator. Observation on [DATE] at 8:10 AM revealed Resident#264 did not have documentation of temperatures for personal refrigerator. Interview revealed that she does not use her refrigerator that much and she would clean it out. Observation on [DATE] at 8:13 AM revealed Resident#92 did not have documentation of temperatures for personal refrigerator. Observation on [DATE] at 8:17 AM revealed Resident#33 did not have documentation of temperatures for personal refrigerator. Interview revealed grandson brought food and cleaned it out refrigerator. (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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 8:22 AM revealed Resident#21 did not have documentation of temperatures for personal refrigerator. Observation on [DATE] at 8:24 AM revealed Resident#55 did not have documentation of temperatures for personal refrigerator. Interview revealed she did not know who cleaned out the refrigerator. Observation on [DATE] at 8:28 AM revealed Resident#01 did not have documentation of temperatures for personal refrigerator. Observation on [DATE] at 8:33 AM revealed Resident#10 did not have documentation of temperatures for personal refrigerator. Observation on [DATE] at 8:37 AM revealed Resident#28 did not have documentation of temperatures for personal refrigerator. Observation on [DATE] at: 11:00 AM of the nourishment room refrigerator revealed, the freezer had: *1 open gallon of [NAME] ice cream *1 open pint of vanilla ice cream *1 unopened pint of vanilla ice cream not labeled and not dated. Observation of the nourishment room refrigerator revealed: *1 bowl of pho not labeled or dated *2 bowls (unidentified items- dark red broth and white broth) not labeled or dated * 2 half sandwiches not labeled or dated * 3 pieces of pizza in a Ziploc bag, labeled [DATE] * Yellow and red sticky stains at the bottom of the refrigerator Interview on [DATE] at 11:45 am the Director of Nursing revealed, residents can get sick from eating expired food. The Director of Nursing stated the nursing staff and dietary staff were responsible for cleaning and dating items brought in by the family to the nourishment room. The Director of Nursing stated personal refrigerators in the resident's rooms were the residents and family's responsibility. Interview on [DATE] at 12:00 PM the Dietary Manager stated, she had gone into the nourishment room refrigerator on Monday and cleaned it out. The Dietary Manager stated families were responsible for labeling and dating food. The Dietary Manager stated, family members have access to put items in the nourishment refrigerator themselves. The Dietary Manager stated she would throw out anything that was not labeled and dated. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Dietary Manager stated there was not a schedule in place stating when to clean out the refrigerator in the nourishment room. The Dietary Manager stated residents could get sick from eating expired foods. The Dietary Manager stated she was not responsible for refrigerators in the resident's room . In an interview on [DATE] at 12:20 pm the Assisted Director of Nursing stated, she would assign a Certified Nurse Aide and Medication Aide to clean, check labels, and dates in the nourishment room refrigerator. The Assisted Director of Nursing stated for resident's personal refrigerator a Certified Nurse Aide/Medication Aide are assigned shift duty's and they change every 2 weeks. Assisted Director of Nursing stated it was honestly hard to keep up with the nourishment refrigerator, since families can go in and out of the refrigerator. The residents can be at risk of getting sick from old food. The Assisted Director of Nursing stated this concern could be an Infection control issue because of people not washing their hands. The Assisted Director of Nursing stated temperature logs were the responsibility of the residents and their family to keep up with the temperatures of personal refrigerators. When the managers do rounds daily, they should be checking the temperature logs. Residents could be at risk of eating spoiled food. To have a refrigerator in the room, residents should be able to clean it, and label and date the items in the refrigerator. It really should be just drinks, nothing from the kitchen should be in the personal refrigerator. In an interview on [DATE] at 1:28pm the Licensed Vocational Nurse T stated She had not cleaned the residents personal refrigerators on her hall before. The Licensed Vocational Nurse T stated that the night nurse was responsible for documentation of temperatures and cleaning out the nourishment room refrigerator and resident's personal refrigerator. The Licensed Vocational Nurse T stated residents could get exposed to bacteria if food is not being dated and labeled residents could get sick. In an interview on [DATE] at 1:34pm the Medication Aide A stated it is not in her job description to clean the nourishment room refrigerator or residents personal refrigerator. Medication Aide A stated residents can get sick from eating expired food. Record review of the facility policy titled foods brought by family/visitors, dated, ([DATE]): 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. 6. The nursing staff will discard perishable foods on or before the use by date.

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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. 47030 Based on observations, interviews, 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 three of three residents (Resident #21, #95, and #88) reviewed for infection control. 1. MA A touched medications without gloves and administered to Resident #21. 2. MA A failed to clean the blood pressure machine while checking the blood pressure for Resident #21 and #95. 3. CNA B failed to complete hand hygiene while providing incontinent care to Resident #88. These failures could place residents at risk for contamination and infection. The findings included: Observation on 02/13/24 at 09:45 AM reflected MA A checked Resident #21's blood pressure and then proceeded to prepare the medications for Resident #21 and put them in the medication cart. While getting the medications from the medication bottle, MA A picked up the medications without gloves. MA A than administered the medications to the resident. MA A completed hand hygiene then proceeded to Resident # 95's room and checked her blood pressure. In an interview on 02/13/24 at 10:14 AM with MA A stated she was aware that she was not supposed to touch the medications with ungloved hands, but she forgot. MA A stated her hands were considered contaminated, so she was not supposed to touch medications without gloves. MA A stated she was not supposed to clean the blood pressure machine unless she had residents who were in isolation. She stated since there were no residents on isolation, she did not need to clean the blood pressure machine. MA A stated she was supposed to maintain infection control to prevent the spread of infection from one resident to another. Observation on 02/14/24 at 01:43 PM revealed CNA B providing incontinent care to Resident #88. The resident was in bed, CNA B went in the room gloved and positioned the resident. CNA B proceeded to unfasten the resident's brief and positioned the resident on her side. Resident#88 had small amount of bowel movement, which was loose. CNA B cleaned the resident and then realized she did not have a trash bag. She then ungloved and left the room. CNA B came back in the room and gloved without any form of hand hygiene. She had a packet of wipes in her hands and trash bag. She then continued to clean the resident's bottom area with wipes and took off gloves after cleaning the resident and donned clean gloves without any form of hand hygiene. CNA B proceed to apply the clean brief, fastened the brief, and positioned the resident, then bagged the trash and left the room without any form of hand hygiene. (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 02/15/24 at 12:34 PM with CNA B she stated she was to complete hand hygiene after taking off the dirty gloves before donning the clean gloves, and she forgot during incontinent care. She stated she was supposed to use hand sanitizer or wash hands after taking off the dirty gloves to prevent cross contamination. She stated she had an in-service on infection control last week, on Monday. In an interview on 02/15/24 at 12:42 PM with the (ADON), she stated she was the Infection Preventionist. The ADON stated the In-service for infection control was ongoing and she could not remember the last time the facility completed one. The ADON stated the staff was not supposed to touch medications without gloves, then it was considered contaminated, and the staff was to discard the medications. The ADON also stated the staff was to clean the blood pressure machine between residents. She stated while providing incontinent care, the staff was to complete hand hygiene before donning gloves. The ADON stated hand hygiene was to be completed to prevent the spread of infection and cross contamination. Review of the infection control/hand hygiene in-service reflected the staff were in-serviced on 10/30/23. In an interview on 02/15/24 at 01:01 PM with the DON, he stated the staff were not supposed to touch medications without gloves and give to the resident because it was considered contaminated. The DON stated regardless of the residents being in isolation or not, the staff was supposed to clean the blood pressure machine in between each use, and the staff were supposed to complete hand hygiene after taking off gloves. The DON stated the staff were supposed to maintain infection control to prevent the spread of infection. Review of the facility policy titled, Hand Washing, effective 05/2017 reflected, It is the policy of this home that hand hygiene is the primary means to prevent the spread of infection. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub) shall be readily available and convenient for staff use to encourage the compliance with hand hygiene. PROCEDURE Washing hands: 1. The use of gloves does not replace proper hand washing. Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: . o After removing gloves or aprons;